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Medical Social Service in a Tuberculosis Sanatorium

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Workers in tuberculosis control—physicians, public health nurses, social workers—are faced daily by a complexity of problems whenever they attempt to arrange hospitalization for patients who have a diagnosis of active tuberculosis. In a particular instance, several members of the health department may have participated in the diagnostic study. They may have referred the patient to appropriate social agencies, and they will have helped determine legal residence and ability to pay for hospital care and arrange for transportation, before the final decision that on a given day the patient will enter a sanatorium. Once the patient actually starts forth in car or ambulance on the trip to the sanatorium, these workers may well breathe a sigh of relief, for the patient has been given new opportunity to regain his health and he is also no longer a source of infection to his family and community.

For the patient, the road that leads to the sanatorium is a new beginning; it leads to an experience different from any he has ever known, one that precipitates him into living in a new place under restrictions that may feel limiting or, on the contrary, may seem properly protective to him. The sanatorium offers each patient two major opportunities essential in the treatment of tuberculosis: first, medical care—not alone the knowledge and skill of doctors and surgeons, and of nurses and X-ray technicians, but also the resources and equipment of pharmacy and laboratory and of related services; and second, an environment conducive to rest, by reason of the regularity of routine, the isolation from demands and pressures of

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family and job, and frequently the physical beauty of the grounds and the stillness of the place. Under the best conditions, this environment is conducive also to some inner quiet.

While the sanatorium offers the patient medical care and quiet and removal from immediate demands of the outside world, it in turn makes certain demands of him with which he must come to terms in his own way. He must learn to live within medical regulations; he must learn to accept some restrictions that are necessary because he is living in an institution and in a group; and he must learn to live within the limits of energy which his illness imposes on him. The patient must also learn that the sanatorium is something different from and more than a hospital, though it is that too; and something different from and more than a custodial institution, though, for a small number of patients it must serve as a custodial institution as well.

These aspects of sanatorium living will impinge in varying ways upon the patient and, influenced by his needs and feelings of the moment, he will accept them as opportunities or resent them as arbitrary, authoritative restrictions. The experience of undergoing treatment in the sanatorium can help develop dependency and invalidism, resulting in unduly prolonged and recurrent hospitalization or in years of care at home that are burdensome to the patient, his family, and the community. The patient, in other words, may use this experience negatively. Or he may find that, despite all of its pain and frustration, the stay in the sanatorium may result in new self-understanding, discipline, maturity, and a realistic acceptance of limitations.

Through this experience of illness he will almost certainly work out a new relationship to himself. If he has never taken time to know himself, he is almost inevitably forced to that preoccupation now. If he has never thought much about his values in living, now he must almost surely begin to sift them out and make decisions for himself. He may try either to drop his burdens completely or to maintain full control of his affairs from his hospital bed. Whether he wants health or even life itself enough to put his full energy and capacity into getting well, or whether he is so indifferent to living that he will spend himself in evading medical recommendations, is the all-important choice for each individual patient. The patient's personal answer to this question will determine whether he uses the sanatorium for regaining health, and whether, in fact, he stays in it until he can go out under medical advice and take his place in the community again.

What use he makes of the experience is important not to the patient alone but to the community, which is interested not only in the welfare of the individual patient but, of necessity, in tuberculosis control in

the community. For despite our large resources of medical knowledge, nursing and laboratory techniques, the control program can be defeated in large part unless each patient with active tuberculosis can mobilize himself to undergo the long-drawn-out process of first regaining health and after discharge of continuing to live in a disciplined fashion. If it requires self-discipline and a goal of well-being to get well, to remain well after leaving the sanatorium requires equal determination, self-control, balance of judgment, and capacity to use medical help fully.

Patients by and large come into a sanatorium with the avowed purpose of regaining their health as soon as possible. They have obviously been deterred from this purpose when they walk out against medical advice, when they indulge in careless or even willful disregard of medical recommendations, or when they are reluctant to leave when discharged.

A persistent question in treatment for tuberculosis is what the individual has to cope with, in himself and in his relationships, that may interfere with his medical plan and progress. Will he himself help or hinder the efforts of the medical staff and nurses in the management of his tuberculosis? Can the new patient take what he must live through in the months ahead in adjusting to a new setting and regime, in physical setbacks and uncertainties, in discomfort and pain, in a dependency role which he must accept? Can he bear the changes in family living and shifts in relationships, subtle or gross, temporary or permanent? Will he be able to resist the pull to settle into the sanatorium as a total way of life; will he be able to retain his intent of getting well and be prepared to accept discharge with readiness to pick up living on the outside in a mature and responsible way? What, in short, is the emotional pattern of the individual, the personality of the "patient as a person" with whom we are working?

War, mental ill health, and tuberculosis are among major crises which result in family separation, and each of them takes its toll in the uprooting of children, in financial stress, and in broken homes. The hurt and tear of separation for both parent and child, the shifting of children from "home" to "home," the failure of plans made for the care of children especially when the mother is the sick person, again and again deter patients from continued stay in the sanatorium. "What good will it do for me to regain my health," patients ask again and again, "if in the meantime my wife breaks down because she is carrying too much responsibility," or "If I lose my wife," "If I have no family to go to"; "If I have no home when I get out"? Long continued family separation sometimes precipitates a break in a relation that would have remained intact, weathering lesser storms, without this added strain.

What sustains these people through so much longing and isolation

and fearfulness was the question that recurred most often to the writer as she worked with patients in the sanatorium and felt the heavy weight of their social and emotional problems. It must be kept in mind that the sanatorium not only serves the needs of the patient, it also serves the community's needs in isolating the patient from others. The community asks the person ill with tuberculosis to take on a social burden—protecting others from his illness—often at great cost to himself, the price of separation from family and associates and from the setting which is familiar to him. In the individual case, the patient's home may well offer full opportunity for treatment, yet the patient must learn to put aside his own desires and personal preference because to remain at home jeopardizes the health of his family and of others who may come in contact with him.

Can we anticipate the phases of living in the sanatorium and the kinds of personal circumstance which will present problems to the individual and on which his determination will flounder or be undermined? Do we have at hand knowledge and techniques to help patients learn to use their experience in the sanatorium constructively? Can we put anything into the program of tuberculosis management to accelerate the process of adjustment to sanatorium living, to minimize its negative aspects, and to convert aggressions to purposeful motivation in treatment? Can we help patients find relaxation of spirit in the face of the reality of illness?

This paper will direct itself to these questions. We propose to follow a few patients into the sanatorium, to see them in process of accepting treatment there. We will study the role of medical social work in assisting the doctor and in helping the patient accept the medical program prescribed for him. The paper will be limited to adult patients, not without full recognition that an equally detailed study of children as patients in a sanatorium is long overdue.

The writer recognizes throughout that the determination and movement toward a goal of well-being is individual. But people who stand in varied relationships to the patient play a part in sustaining him in his goal, chief among them, of course, those persons to whom he is closest in affectional ties. They as well as the patient at times need practical and psychological help in what they have to live through by reason of his tuberculosis. For in tuberculosis, the goal of well-being is elusive, and the patient must often follow a long and tortuous path in which he may well lose his way.

We shall try to show how the social worker meets the individual where he is in his feeling, and lets him establish himself in the sanatorium in his full stature as a human being, capable of drawing upon all of his capacities in the process of recovery or, if need be, in the process of accepting death. "I am not an ordinary man," said a critically ill patient as the social worker sat at his bedside the day of

his admission. Reaching out to her, he wanted recognition not as a sick and dying man but as a complete human being unique in his individuality.

In presenting characteristic individual and family circumstances that bear upon the patient's capacity to undergo treatment—circumstances that are entirely familiar to every doctor, nurse or social worker—it is recognized that the problems themselves are less significant than the patient's response to them and to his illness. We will attempt to offer a picture of the interrelationship of social and emotional factors with the medical condition of the individual patient.

The Setting

The material presented in this paper as well as the generalizations specific to medical social work with patients in a tuberculosis sanatorium are drawn from the writer's experience in working as a medical social worker in a sanatorium serving a metropolitan area of approximately 800,000. The sanatorium was located 15 miles from the center of the city it served, and was therefore relatively accessible to families of patients, although special busses going directly to and from the sanatorium were provided by the bus company only on three visiting days a week.

Medical standards in the sanatorium are maintained at a high level. Under the supervision of an excellent medical staff there is an active program of collapse therapy, including surgery, and chemotherapy, and the use of specialized consultation services in all phases of medicine. Psychiatric consultation is increasingly available but is primarily for purposes of diagnosis and disposition rather than for treatment of patients who will remain in the sanatorium.

The period of service to patients covered in this paper is from July 1, 1947, to June 30, 1950. This includes a period in which a community-wide X-ray survey was conducted in the community served by the sanatorium, under the joint auspices of the local tuberculosis association, the city health department, and the U. S. Public Health Service. While the survey itself covered only 6 months, some of the continuing effects of the survey in the lives of individual patients are evident throughout the 3-year period which the paper covers.

With one medical social worker on the staff serving a sanatorium of 600 patients, the work done with individual patients was partially in the nature of demonstration. In presenting some of the representative case situations in the next sections the writer is keenly aware of the patients whose needs were fully as great as these and whom she nevertheless failed to reach. The material presented here is given with as much fidelity to the facts as the limitations of space and protection of the identity of the patients permit. With the same

concern further to safeguard the patients' identity, the sanatorium is not named in the article.

Emotional Adjustments

Both the patient who says, "Another day, certainly another week here, and I will go out of my mind," and the patient who says, "I have never known such peace of mind as I have found here; I am afraid to go out and lose all this,"—throw into sharp relief the emotional problems with which patients struggle in the effort to regain health in the sanatorium. Patients who cannot bear their inactivity or their separation from home and community life, and patients who sink into the sanatorium because they are overwhelmed by their outside responsibilities can fail to make the kinds of emotional adjustments demanded to undergo treatment in the sanatorium. These two extremes of attitude represent a failure in adjustment which fosters tendencies to leave the sanatorium too soon or to remain too long.

What pitfalls along the way lead to these failures in adjustment? Can we not anticipate the pitfalls, and stand ready to help patients over them?

One could go so far as to draw a chart of emotional reactions and experiences commonly encountered by patients in a sanatorium. All persons who are told they have tuberculosis must come to know the meaning of this illness to them and make some adjustment to it as a reality in their lives. All patients who decide to come into a sanatorium for treatment must make major adjustments to a changed living situation for themselves, in large part relinquishing relationships and habits specific to their home setting and adapting themselves to new demands and ways prescribed by medical regulations and sanatorium living. All patients will need to find their own solutions in accepting or fighting dependency. Illness itself and living in the sanatorium require the patient to allow others to meet personal and physical needs that he has largely met for himself since infancy. Probably all patients will feel the temptation to shut out responsibility and sink into chronic invalidism, a tendency nurtured alike by their illness and its treatment which emphasizes rest, and by the institutional life of the sanatorium. Many of them will struggle to withhold themselves from this tendency. Many patients will have to face recommendations regarding surgery and other medical procedures which are painful or otherwise distasteful. In the course of time many will encounter emotional crises in personal relationships, because illness and family separation and the passage of time itself change social and economic circumstance. And most patients will find themselves somewhat in conflict at the point of leaving the sanatorium, unsure of themselves as they go out to resume responsibilities which they have left for so long.

This section will consider these emotional problems and we shall leave to later sections the specific detail of patients with financial problems and of those with problems of child care.

Acceptance of the Diagnosis

With a diagnosis of tuberculosis, the patient does not thereby cease to be the person that he was. If anything, he becomes more deeply himself at this time of crisis, as he mobilizes himself in defense against this threat to his life, responding to the crisis in ways that are characteristic and peculiar to him.[1] Because in the not-too-distant past the outcome of tuberculosis was so frequently fatal, the response of persons confronted with the fact that they have tuberculosis is still one of alarm. The entire self is alerted to danger and responds in fear. Dependent on the individual's basic and characteristic ways of meeting threat and on his fundamental feelings about living and dying are the impulsive reactions of flight and withdrawal, or of aggression and hostility.

In the first moments and days of knowledge of his diagnosis, when he may well withdraw into himself with his feeling still amorphous, the patient may find himself incapable of decision and action. He tends, rather, to examine past behavior and habits over and over again, reviewing such conduct as keeping late hours, working hard to achieve some too-earnestly pursued personal goal, indulging in excessive drinking to compensate for persistent fatigue. In fact he goes over and over all the detail of daily habits and relationships to see what in his background could have led to breakdown from tuberculosis and what he might have done to avoid the illness that he has acquired.

By the time the patient is admitted to the sanitorium, he has lived a little with his knowledge that he has tuberculosis and he may have worked through his initial response of incredulity, anger and shock that this could happen to him. He may, as often happens, come into the sanitorium determined to forget or negate the full implications of his tuberculosis, determined to take his illness in the tradition of good sportsmanship. If one can penetrate the attitudes of dignity, devil-may-care casualness, or surface sportsmanship, and get to the man or woman beneath the facade with which he meets the world at large, one finds almost without exception an underlying surprise that fate has dealt this blow, together with a considerable amount of guilt for sins, real and imagined, that may have caused the descent of disease, and a profound fearfulness that the illness may indeed be prelude to death.

As the patient begins to take in the fact that he really is ill, that he does need care and medical treatment, and that he can or must give

[1] The intensity and unpredictable range of personal response to the diagnosis of tuberculosis have been well described in the literature (*1–4*).

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up his responsibilities temporarily, he can begin to work on specific pieces of the problem—detailed arrangements about further appointments with the doctor, decisions about whom to tell of his illness, discussions regarding job or home. Each detail that must be met and acted upon involves the patient in a process of breaking up the all-engrossing emotional response and coping with the new situation piece by piece. And gradually he comes to the time when he can call to his aid his intellectual powers and thereby gain further release from stark fear.

How much directness and clear-sighted planning the patient displays in coping with the problem of acceptance of his diagnosis, or how much evasion and readiness to use his diagnosis to obtain advantage over spouse or children or in-laws depends on how this particular person has met and dealt with difficulties, loss, and change in the past and how this illness fits his emotional need at the moment. If in the past he has met obstacles and frustration with some perspective and equanimity, he is likely to do so in respect to his tuberculosis. He can set aside immediate personal aims and projects at home and at work and safeguard himself and his family by realistic planning. On the other hand, a rigidly organized and less secure person, afraid of new problems and unable to assimilate drastic change into his personal scheme of things, is likely to overreact to the fact of tuberculosis. The person's customary ways of accepting or refusing to accept responsibility, brought into his encounter with tuberculosis, may be particularly significant in the extent to which he can bear to let his doctors plan for him medically, and can himself assume an active part in furthering his medical progress.

Initial Adjustment to the Sanatorium

Regardless of the degree to which he has accepted or rejected the diagnosis and planned well, or poorly, or not at all, each patient coming into the sanitorium is employed in the universal psychological process of adjustment to change and new experience. A new setting for everyday living—the sanitorium—confronts him, unfamiliar and different.

The experience of moving into a new situation is readily at hand in the personal experience of most people—leaving home to go to college, taking a new job, undertaking a long voyage. Changes such as these are generally self-initiated and actively sought, and curiosity and eager anticipation may therefore accompany them. At the same time they often evoke some misgivings as to the wisdom of so far-reaching a step, some question as to how the new venture will turn out, some uncertainty as to how one will establish himself with new people, and definite regret for loved people and favorite things that will be left behind. Once the new experience has been embarked upon, is there not invariably an effort to take into it some

tangible reminders of the old situation, to tie past and present together as quickly as possible?

Actually, of course, the patient's situation is quite different from that of the person who has actively reached out for and decided upon a new experience. For the patient is faced with change that, far from being self-sought, seems rather to be entirely imposed from without, from some whim of fate. A person with tuberculosis has probably rarely sought illness or come into the sanitorium with a sense of happy anticipation, whatever his unconscious motivation may be, except, perhaps, in the case of those who are acutely ill and feel the need for skilled medical care, or who are deeply uncomfortable about their continuance at home as a source of infection.

If there is question and fear in any major change, then we can surely expect to find patients who are to enter a sanatorium questioning and resisting the new situation, preparing for the move with a heavy sense of the tear of separating from relationships and activities in which they have been vitally involved.

Before coming into the sanatorium the patient has already undergone a continuous process of adaptation to his tuberculosis, beginning with his awareness of illness or knowledge of his diagnosis. He has, as a rule, been much engaged in the business of putting his affairs in order, including such tangible acts as disposing of property or personal possessions, valuable not only for themselves but also as symbols of one's place in the community, and such intangible acts as separating from members of the family and associates and leaving unfinished work in job or school. Separation from the familiar and established aspects of one's life requires a capacity to face the extended nature of the illness and to give up that which cannot realistically be maintained. The patient's psychological movement involves a process of "letting go" which is in the same direction, fundamentally, as that in which he is turned by reason of the very diagnosis: a "giving up" which often seems to him like the giving up of life itself.

Coping with fear that is so fundamental and threatening—even though in the particular case it may be essentially groundless—and deeply concerned with himself, exhausted emotionally and often physically from preparing for the move into the sanatorium, the patient comes into the sanatorium struggling to keep from others and even, at times, from himself the basic underlying death-fear which pervades all his attitudes and conduct.

Colored by this fear, innocent or even attractive aspects of this new situation become threatening and forbidding. "How tranquil and beautiful the sanatorium looks in the morning sun," said a doctor on the staff who had first known the sanatorium as a patient, "How barren and prison-like it looked to me as I first came in as a patient."

Once in the sanatorium the patient soon hears of long periods of

hospitalization experienced by other patients and unsuccessful efforts to control the course of the illness in individual cases. Sounds of coughing and sighing, and the restlessness of the first nights in the unfamiliar setting, reactivate his misgivings about himself and the step he has taken.

The patient will certainly ask himself, once he has had time to think about what has happened to him in recent days or weeks—and the sanatorium regime will give him much time to think—whether he and his family have made the wisest decisions in the circumstances. He may, despite all the statements of doctors and nurses who interested themselves in his hospitalization, still question whether he should have left job and home, knowing what his leaving means to his family. Unfinished business on the outside may still concern him, so that he cannot rest in any true sense until communication with employer or insurance company or public assistance agency assures an income for the family. And as long as he remains insecure about the plan temporarily agreed upon for the care of the children he is likely to remain uneasy. Whether the patient sees the sanatorium as a prison closing in on him or as a haven from storm, each person will have time to take stock and evaluate what he has been through and think about whether he has acted well in coming into the sanatorium at all.

The more mature person often quite consciously and with little help from others puts himself into the program of medical care in the sanatorium with all the force of his determination to get well and to protect others from his infection. "This is where I must live now," one such patient said, "and I have decided that I must leave to my wife decisions as to how she will manage until I am well. It puts a lot on her shoulders, but this business of getting well is my job now. If I come out, I can pick up on the other things." How often the phrase recurs, *If I come out,* not *when.*

To give up "the other things," to know that for the present they are less important than the recovery of health, a man or woman must be able to sift and weigh values and goals and "to hold his ground before reality." The patient who is secure in his basic independence is able to accept a temporary dependent role in relation to his wife and to the nurses and the doctors in the sanatorium. If the patient can also detach himself somewhat from the anxieties and intrigues and tragedies of his associates in the sanatorium, he can find in this life a measure of peace which, as far as we know now, offers the setting in which the curative process goes forward most effectively.

Not all persons have the strength and integration that enables them to say, "This is where I must live now," without bitterness or reservation and with an honest desire and capacity to bring themselves, all of themselves, into the sanatorium for the purpose at hand.

By contrast with the patient who accepts the sanatorium as the place where he must live for the present, there is the person with little flexibility or with little inclination to give up immediate pleasures and satisfactions for a more assured future. He finds the slow, tedious process of treatment in a sanatorium galling and tends to resist submitting to it. Basically dependent, he is often fearful of overt expression of his need to lean on others. He therefore resists and fights medical authority, the regulations of the sanatorium, and the submission to a necessary dependent status. With his underlying fear about the ultimate outcome of his illness and, therefore, a sense that his conduct of his affairs matters little, the patient may evade medical instructions about bedrest, sexual relationships, drinking, or the use of the hated bedpan. He thereby gains a childlike pleasure in defying the authority of the sanatorium at his own expense. Not infrequently this pattern of behavoir which we sometimes mistakenly interpret as "irresponsible" or even "stupid" is in reality based on the patient's conscious or unconscious need to prolong illness. Indeed, his basic dissatisfactions may be so great as to give rise to behavior which may be a manifestation of suicidal intent (*2*).

Role of Social Service

It is in this emotional environment that medical social work in the sanatorium offers its services. Are there ways in which each patient can be helped in terms of his own needs and individuality to make a successful adjustment to the setting and the medical program of the sanatorium? Can his transition from living at home to living in a sanatorium be facilitated, so that he becomes better able to accept the reality of his diagnosis and of his new situation? Can he be helped to put himself fully into the sanatorium, to accept the uncertainties of prognosis and the realities of inactivity and separation, and to cease from straining toward the outside?

Ideally, the medical social worker should be available for such help to all newly admitted patients. The new patient should be able to tell to the medical social worker what problems on the outside were left unresolved and decide with her on practical ways of meeting them, or, face the fact that they must be left unresolved. If he can tell what was hardest to give up, whether child or job or school, and if he can be himself with someone in the sanatorium who accepts him quite as he is, who is prepared to help him come to his own realization that he can tie up some pieces of life on the outside with his life in the sanatorium, he is more likely to find that he can bear to live in this situation. And last, because it is most difficult and most important of all, if the patient can be helped to bring his fear of death to consciousness, if he can face it fully and share it with another,

he is likely to discover that its heavy oppressive weight has been somewhat lightened and that it has been robbed of its terror in parts.[2]

Psychiatry

Although this paper is concerned primarily with the ways in which social service meets the problems of hospitalized tuberculosis patients it goes without saying that some of the personal problems presented by patients require the services of a psychiatrist. In this sanatorium, as in most of those in the Nation, there is no staff psychiatrist to consult with other staff members—doctors, nurses, social workers—and help them in their dealings and relationships with patients. When available, psychiatric services to patients are usually limited to diagnosing and planning for the severely emotionally disturbed or the frankly psychotic patient. It is a rare tuberculosis sanatorium that is able to offer psychiatric treatment to those other patients who are not psychotic nor even greatly disturbed but who seek and can respond to psychiatric help. As such service becomes more available, those patients whose emotional and psychological needs and problems are beyond the reach of the skills of other hospital personnel will be helped to achieve a sufficient resolution of fears and sufficient inner security to cope with their personal problems. And they will be able to cope more successfully with the problems more specifically related to tuberculosis.

One Patient's Experience in Adjustment

The story of Mrs. Douglas serves to highlight some of the necessary adjustments patients need to make. One morning in May 1948, a tray hurled across the room barely missed a nurse's aide. It had been thrown by a young woman in a temper because she had been kept waiting too long for her cup of coffee. What was back of this anger and moment of revolt and what action should the hospital take in such a situation?

Mrs. Douglas was a handsome 25-year-old woman, a French war-bride and the mother of three very young children. She had entered the sanatorium the week before and had been restless, dissatisfied and tearful all week, threatening almost daily to leave against advice. The culmination of the week's stresses occurred when she threw the tray. Such an incident of overt rebellion demoralizes a ward for several days and reverberates in the taut nerves of the more anxious, frustrated, and depressed patients. To let Mrs. Douglas stay in the sanatorium and risk further temper tantrums therefore seemed unfair to other patients, and unfair as well to the hospital attendants, whose uneasiness about exposure to tuberculosis tends to be accentuated by such outbursts especially if directed against them. But the wisdom of giving Mrs. Douglas a disciplinary discharge was also questionable, since such a course of action would jeopardize her chance

[2] A note about Dr. Wittkower who interviewed a large number of persons ill with tuberculosis is of interest in this connection: "For many years I have watched . . . Dr. Wittkower's interview technique . . . . At the end of an hour the patient knows a great deal more about himself than he ever knew before, not because of what Dr. Wittkower says to him, for he says remarkably little during the first hour, but because being free and feeling free to talk, the patient's narrative becomes a kind of self-discovery" (*3*).

at recovery, and because in her infectious state she would become an immediate danger to the health of her children and to others in the community.

After weighing these factors carefully the medical staff decided to give the patient another chance to adjust herself to the sanatorium on a different ward where the episode of the breakfast tray might be forgotten. The case was also referred to the medical social worker who, recognizing the fact that Mrs. Douglas would need regular and consistent help, made arrangements for a series of weekly interviews. These were scheduled, at the patient's request, during one of the visiting hours, when Mrs. Douglas felt most keenly her isolation from family and friends and the desertion of her husband, for he failed to visit or respond to her telephone calls. After a 3-month period of regular interviews, the patient was seen only on her special request, approximately once a month, until she left the sanatorium.

This patient's temperament and her social circumstances combined to make her continued stay in the sanatorium particularly difficult. She suffered the loneliness of a war-bride facing illness in a foreign country, remote from family and friends and those associations which can lessen the sense of unfamiliarity which hangs over a sanatorium. And, most important, she was neglected by a husband whom she needed psychologically and physically.

Mr. Douglas, who was alcoholic, had many periods of irresponsibility and unemployment. Mrs. Douglas was fiercely in love with him and was devoted to her children to the point of possessiveness, yet she was so much in conflict with her husband that she had left him twice, supporting herself and children by working as a waitress, maid, and cigarette girl in a nightclub. Two years earlier she had been hospitalized in another State but had walked out against medical advice after 6 weeks. She had refused hospitalization three times before her admission to our sanatorium. It was only after one of the children suffered from convulsions, a patch test was positive for the oldest child, and both Mrs. Douglas and the oldest child had gone through a severe attack of pneumonia, that the patient had agreed to sanatorium care. By this time her illness had progressed; the diagnosis of "minimal" 2 years earlier had become "moderately advanced" and she had a positive sputum.

While Mrs. Douglas had refused hospitalization again and again, it was not because she minimized her illness. On the contrary, she was profoundly fearful of tuberculosis, so fearful that she wrote to her grandmother saying that she was in a mental hospital.

The patient was found to need a great deal of help from the social service department. Frequent reports of the children were obtained from the child welfare agency and these were transmitted to her in detail. She needed to draw upon the small welfare fund available for toilet articles and for the repair of her radio. She hated these additional signs of dependency and her husband's part in subjecting her to it. Apprised of her financial and social situation, the occupational therapy department supplied materials without cost, and the patient busied herself with handiwork. That department also discovered, in giving Mrs. Douglas bedside instruction in shorthand, that she had fine intellectual capacity, an asset which the social worker could stress and help the patient use to fuller advantage.

There were frequent conferences between the doctors and the social worker as various crises arose in the life of the patient which threatened her ability to stay with the medical treatment. The medical social worker's interviews with Mrs. Douglas herself were scarcely tranquil. They usually started with the patient in a belligerent or depressed mood, expressed as much by the intentness with which she leaned forward with hands clenched against the arms of the wheel chair as by words and tears. Longing for her children and both love and hate for her husband preoccupied her constantly. Notes from the case record indicate the

nature of one such interview: "The patient said that it was quite likely that her husband was going to desert her. Even if he didn't, he wasn't too responsible. To go on without him would mean that she would have to find some way of supporting herself and the children. In view of her physical condition she would probably not be able to work and support all of them by her own effort. She would therefore have to place them. She felt that life apart from the children would have no meaning for her and that she and they might as well be dead. I accepted her feelings as she presented them. She went on to say there was nothing at all, nothing ahead for her, adding however, that the oldest child, Terry, needs her. As she talked about him and the other children, she moved from her sense of complete bleakness and ended with the conclusion that she was 'too young to die!' Much as she hated it here, she did not want to do the kind of thing that would jeopardize her chance of ridding herself of her tuberculosis."

Again and again the same process is followed: the patient is given opportunity to present all the negatives in the picture as she sees them, to evaluate the alternatives before her, and to come to her own decision to remain or not to remain in the sanatorium.

The report of another interview states: "Mrs. Douglas was reminded that she had met her problems to date by striking out at her opponents, fighting hard and persistently for what she wanted. In this situation, coping with tuberculosis, she would find that the aggressiveness which she put into meeting her problems formerly would have to take a new form, since relaxation and patient waiting represent the type of weapon that has a place in coping with this problem. She recognized that this kind of demand was hard for her."

Each interview indicated that she was working on understanding herself more fully, however. For example, she reported an episode on the ward involving another patient which led her to say that it was a new experience for her to think about another person's feelings; and that she was not sure that she wanted to change that much—she wanted to hold on to the more self-centered "me" that was familiar to herself, she thought. It was suggested that possibly no one could respond successfully in a sanatorium without changing somewhat, and that that was perhaps especially true for Mrs. Douglas whose whole personality was geared to action. She became quite thoughtful, concluding with: "Being in the sanatorium is like being in the army—it either makes you or breaks you." She decided, too, that she would like her husband to have some form of psychological help, saying that she had been confused and at odds with herself and the world until she had accepted help from the social worker, and that now she felt clear as to her direction and goals.

With the help she had had in her struggle to make peace with living in the sanatorium, Mrs. Douglas was able to remain 7 months. She had had successful minor surgery, her sputum had been converted, and she felt that the period of convalescence ahead, including regular pneumothorax treatment, was one that she could best bear if she could work something out with her husband and see the children from time to time, now that she was not an immediate source of infection to them.

The patient did leave the sanatorium at the end of this period, without full medical consent. She managed to communicate messages to the social worker at long intervals, and a letter from her when she was finally discharged from the clinic is of interest if one attempts to evaluate the expenditure of medical and other service on behalf of this patient. The letter which came a year and a half after the episode of the tray stated: "The doctors at the clinic told me last week that I am classified as an arrested case. I am very happy about it. We bought a little home through the GI Bill and that adds to my almost complete happiness, and we have brought Terry and Ann home. Everything turned out so wonderful,

it's almost unbelievable. We don't have much furniture, but we will get a piece at a time. . . . After all I have been through I have developed a lot of patience and I can surely wait until we can afford things. . . . "

The problem throughout the period of case-work service with Mrs. Douglas was to find ways in which this patient's very eagerness for living could be mobilized and utilized in her treatment. With all of her fears about tuberculosis and its effect on her family situation, her acute longing for her husband and children, and the financial problems with which she struggled throughout her sanatorium experience, it was necessary to find a way to help her remain in treatment. Her positive desire for living, manifest in her very eagerness to be with her husband as wife and homemaker and in her delight in her children, had to be so utilized that it would not destroy her but would, rather, result in development of capacity to hold to a goal—recovery from tuberculosis. Leaving the sanatorium when she was no longer infectious, continuing her treatment at home under medical advice from the chest clinic, working out a more stable relationship to her husband and children, she developed a capacity for responsible action that was a far cry from the childlike rebelliousness symbolized by throwing a breakfast tray at an attendant. Mrs. Douglas had to achieve real change within herself and she did so, though she approached failure more than once.

Surgery

Facing a decision as to whether to undergo surgery focuses at one point the most negative aspects of treatment. Surgery, probably more than any other medical procedure or requirement, involves the patient most deeply in the helplessness which sickness always prescribes in some part. To put one's life into the hands of another, the surgeon, requires a yielding of the self in full faith and trustfulness, together with a sustaining determination to get well even at the cost of considerable pain and possible deformity.

Listening carefully to what the patient himself says, a simple enough procedure, is still a neglected factor at times in the management of a patient's tuberculosis. Days and weeks of indecision can at times be saved for a patient who is resistant to surgery if he has help in stating his doubts and fearfulness, in letting him sift out for himself what is reasonable from what in his feeling is sheer fantasy.

Patients do not always themselves see the relationship of social and medical developments and sometimes wait too long before they turn to anyone in the sanatorium for help. A young man of 30, whose tuberculosis had seemed almost under control, suddenly reversed his uneventful course towards recovery, suffered a spread of his disease, and eventually underwent surgery. This was followed by complications that were almost fatal, further spread of the disease to other

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parts of the body, and a steady downhill course medically. Talking to the social worker about his personal problems, he said, in reference to the timing of the turn of events, "It was the week I went up for the operation that my wife wrote me her plan for divorce. I spent most of the day before the operation reading every letter she has written me here, to see when this change in her feeling towards me really started." Was it entirely coincidence that the patient had developed serious complications following that kind of emotional strain the day before his operation? Had doctor, nurse, or social worker been close enough to this patient to know what he was going through, would not delay of the operation until his despair was less acute have possibly changed the outcome of surgery and perhaps averted further physical deterioration?

Watching patients in their conflict between accepting and rejecting surgery, one could not but conclude that in some cases a patient does not want to risk recovery and discharge from the hospital. Many complex and often contradictory forces play upon him. Even the will to get well may be modified by an opposing desire to not get well. The patient who loses his desire to get well, or perhaps never firmly had it, presents possibly the most subtle and elusive demand upon the skill of the sanatorium staff.

Marital Difficulty

Important personal relationships that have failed him are most often causative factors in the patient's negation of living and he often needs help with his feelings about these relationships before he can think clearly about medical treatment. At times the relationship to the medical social worker is found to have significant bearing on the effort to get well, as he works out with her his conflicts about his social situation or his doubts about his potentiality for health and arrives at a realization of his failure to use the sanatorium's facilities fully. This was true in the Tomlinson case. The patient's family crisis coincided with important medical development in his case and he could not accept medical recommendations until he had worked through his emotional disturbance and reevaluated his immediate aims.

Late one afternoon, Mr. Tomlinson, a gaunt man in his early thirties, was brought to the office of the medical social worker in a wheel chair. With the muscles of his face tense and unsmiling he said, "Are you any good at domestic problems?" Without waiting for reply he told of growing strain in his relationship to his wife which had culminated in a scene the preceding Sunday. She had announced that this was the last time he would see her—they were entirely through as far as she was concerned. Three days later, after the medical conference, he had been advised that now, 18 months after his admission to the sanatorium, the doctors recommended thoracoplasty on the left side. He ended simply and emphatically, "I could only say to my doctor that I would not have

surgery. I couldn't possibly undergo surgery now—I would never pull through." His impulse was to leave the sanatorium in an effort to see what he could do to save his marriage, but he was not at all sure that he had the physical strength to go out into the city and engage himself in that undertaking. The doctor, after talking over the problem with him, had suggested that he see the social worker.

Following this interview the social worker and the doctor reviewed the situation together. The diagnosis was "pulmonary tuberculosis, far advanced, bilateral." Some months before, consideration had been given to an early transfer to the convalescent hospital, but a subsequent positive sputum and a spread of the disease resulted in a medical condition which finally led to the recommendation for thoracoplasty. The doctor felt that in spite of the urgency of this man's marital problem this patient could not be given permission to leave the sanatorium to try to settle his personal affairs. The doctor stressed the importance of time. The moment for surgery would pass quickly and there would be further spread of the disease if the patient did not undergo the operation soon.

During the next several weeks the medical social worker spent a good deal of time with this patient and had numerous telephone conversations with his wife, with friends of the family, with the minister who visited him at the sanatorium, and with legal aid and child welfare agencies. The facts were all too familiar in the sanatorium. Mrs. Tomlinson, at loose ends during her husband's long illness, had apparently had a series of affairs with other men and had left the city with one of them.

In interviews with the patient, the social worker brought him information which he requested regarding the whereabouts of his children and his legal rights regarding their custody. He was also concerned about his property. At the same time the social worker kept before him the alternatives that he himself saw in the situation: to put his energies into trying to locate and either win back or punish his wife; or to go through with the medical recommendation for surgery. Neither choice was palatable to the patient, and he continued to be afraid of surgery because of his state of confusion and anger. Gradually, in going over and over the situation with the social worker, the patient emerged from his bewilderment and hurt and arrived at the point where it became clear to him that he had not understood what his wife was really like and that he would do best to face that fact, put her out of mind, and turn his energy into getting well. The external situation itself remained unchanged, for the social worker could not bring back an unwilling wife. But, Mr. Tomlinson, with patience and understanding on the part of the social worker who could appreciate the strength of his conflict, was finally able to decide that whatever happened in the relationship to his wife, his life was important to him in and of itself. When he reached this clarity of thought and action, the doctor felt that the operation could be performed.

The patient agreed to surgery and went through with it, not without complications, however. There were some weeks following surgery when it was not at all clear to the medical staff that the patient would survive.

Several months after the last operation, Mr. Tomlinson passed through a period in which he felt depressed, as he realized that he had to face going out of the sanatorium with no home to which to go. He had been so near to relinquishing living, both physically and pyschologically, that it was almost with conscious effort that he took up personal problems and regained any desire for a life of his own on the outside. The social worker during this period let him state his sense of being different from what he was before. He said he had no "ambition" and that he was frankly unsure of himself; his old sense of personal adequacy and capacity to undertake new things, whether in jobs or sports or friendships, was gone. This new awareness of physical limitation was certainly realistic in view of

the patient's medical history. It seemed to the social worker, however, that the patient's emotional crisis over his wife's desertion and his proximity to death had left their mark on his personality so that he felt himself more limited both physically and in his capabilities than need be.

In an effort to engage his interest the social worker and rehabilitation counsellor attempted to discuss with him some plans for the future. However, he was unable, while in the sanatorium, to grasp hold of this. The sense of withdrawal from living remained, and the social worker could only hope that, as he faced actual problems, he would gradually be drawn back into a more vital relationship to things on the outside. Reports received about the patient from the convalescent center to which he was transferred indicated that this was possibly happening even before he returned to the outside community.

For purposes of this paper, it may be worth noting that the doctor believed that considerable time had been saved for the patient, and the help he had received from the social worker had made possible his chance to have surgery at all during this crisis in his life.

Dependency on the Sanatorium

The pattern of living in the sanatorium fosters egocentric attitudes, and some patients are in any case content to be relieved of responsibilities that they have found onerous or distasteful or uninteresting. The sanatorium necessarily places much emphasis on protecting the patient both from physical exertion and from emotional stress. Reduced to an infant-like dependency in physical matters, the patient at times finds it difficult to maintain his perspective as to areas of conduct in which he can still act responsibly, with full use of his mature powers of judgment and mentality. The medical social worker received frequent complaints from patients of the failure of relatives or foster parents or children to visit or write to them. Many of these complaints involved indifference or thoughtlessness on the part of those outside but, on examination, some complaints were found to be unjustified, and the patient had to be asked in detail about the extent to which he had himself tried to keep in touch with the relative, foster mother, or child by letters.

Sometimes, the sanatorium comes to fill the patient's life so fully that he has no need for the outside world, and this occurs not alone in cases of chronic long-persistent infectiousness but also in some situations in which the patient can, from a medical standpoint, look to discharge within a reasonable and fairly predictable period of time. In addition to maintenance and recreation, the sanatorium sometimes provides a part-time job at light work which yields the patient a small income. Or, with time on his hands and perhaps a weakening or severance of family ties, he forms new interests in books, and hobbies and recreation, and new relationships which may fill his need for companionship and, in some cases, for sexual gratification. And at the same time there are few or no demands on him for assumption of responsibility. Looking back over the life histories of some of the patients who tend to cling to life in the sanatorium in this way, one

can often understand clearly why they need to make of tuberculosis their whole way of life, limited and circumscribed though it is. Many of these patients have had lives so warped and unfulfilled that, like the woman who was quoted at the beginning of this section, they "come to love this place" for they had indeed known no peace until they found their way into the sanatorium.

Life in the sanatorium is seductive, and the maintenance of a balance between giving up responsibilities and carrying some of them is all important if the illness is not to destroy the individual as a person and impair or undermine his relationships as well. It is this writer's impression, further, that withdrawal from responsibility and outside relationships, which is partially forced upon the patient by medical needs, may in itself be a deterrent to his effort to get well. To the extent that the patient holds to established family relationships and associations that are meaningful in the outside world, he is motivated to greater effort in getting the business of treatment over and done with so that he can take up adult responsibility on the outside.

Alcoholism

Every sanatorium and every public health official dealing with tuberculosis has a more or less unresolved problem of management of tuberculosis in patients who are alcoholics and, incidentally, in the case of the husband or wife of an alcoholic. Admittedly large sums of money and effort in tuberculosis control are wasted because of failure to treat alcoholism itself. The medical social worker in the sanatorium can play a part in dealing with alcoholic patients and, here and there, may help a patient use his sanatorium experience to get his alcoholism as well as his tuberculosis under control. The problem, however, is not usually amenable to treatment by the social worker alone. The full array of knowledge and resources of medicine and, specifically, psychiatry, must be directed to this problem if alcoholism, like any other complicating disease, is not to undermine medical efforts to manage tuberculosis.

Leaving

Most patients are surprised to experience an element of strange reluctance to take the step of leaving the sanatorium. Patients who have waited tensely and with almost unbearable eagerness to leave may find themselves taken aback when the actual word of medical discharge comes, and almost without exception they feel guilty that they could not meet the news with unmixed feelings.

With some support by the medical social worker, patients can express their questions about what is ahead: "Will I be wanted at home, or will they be a little afraid to have me around the children?" "I

don't know whether I can get my old job back or one like it." "I wonder if I will be much use on the outside, having to be so careful of not overdoing." "I don't know whether I can study any more; this life changes your work habits." "I don't know how I can get along financially." "I hate it here but at least I am accepted as I am." "I am afraid of . . . a hundred different things . . . another breakdown, no job waiting for me, loss of chance at new job, being ostracized by friends, not having the old place in the family, or, even more serious, no husband to go to, everything changed and different in the household, no family, no home to go to." Almost all patients attest to some uncertainty as to their capacity to function adequately, or as adequately as before, when they anticipate going out into the community. Whether they will be able to maintain their gains in health, knowing how many patients with tuberculosis break down again, is a recurrent question.

The sanatorium, with all its restrictive features, has become familiar and acceptable. Friendships among patients, like those among men at war, take on special meaning because they are forged during crises lived through together and they continue over many months and years. It is with a sense of real loss that patients leave these friends, some of whom, they have reason to believe, will never recover.

If, as often happens, the patient has exhausted all his savings and cannot return to his old job, he is much worried about money. Not only is he concerned about long range problems of a home and a job but he is immediately confronted with the fact that he has gained 40 pounds and does not have a pair of pants to wear home. The more drastic the changes that have developed in the family, the more reluctant is the patient to return to the community outside, and the more grateful for a convalescent center to which he can go during the transition from the sanatorium to life in the outside community.

Many patients are fearful of being removed from doctors and nurses. All physicians have had experience with the patient who, on two or three occasions, springs a positive sputum, after all signs indicate that he will be considered medically ready for discharge within a few weeks. All also have experience periodically with the patient who, though medically ready for discharge, delays the date of departure, develops symptoms for which no organic basis can be found or which involve illnesses that can be treated outside the sanatorium equally well or better. It is these patients who, again and again, are found to have some major dislocation in their homes, or who are to return to a home which they left with considerable sense of escape.

The period following hospitalization is critical for many. Patients often require as much help in adjusting to living outside the sanatorium as they did to living within it. After leaving the protection of the hospital they find themselves again in an environment where good

health, rather than illness, forms the basis for the way of life around them.

A patient who had had five admissions to the sanatorium in 9 years reminded the social worker of all he had disclosed to her—his sense of having been cast adrift after his mother's death, his long-accumulated hatred of his alcoholic father, his despair at the break-up of his own marriage, which in turn left him with his father's home as the place to which he felt he had to return after each discharge—and he said, "These are the things you can't tell most people. But they explain why I hate to go out of the sanatorium though I dislike it here, goodness knows, and why I come back again and again."

At the point when the patient is being considered for discharge, his greater freedom of activity within the sanatorium and his need for vocational planning may make it possible for him to get from other departments, such as rehabilitation counseling, library, and occupational therapy, some of the emotional reassurance he needs for his movement out of the sanatorium. The matter of making the move out of the sanatorium should not, however, be left to the patient to handle as best he can, with such support as he happens to be able to draw upon from his various connections in the sanatorium. Under conditions of adequate staffing, the social service department has an opportunity to plan with all patients well in advance of the actual discharge. When there is an inadequate number of social workers, every effort should be made to have at least one interview with all patients who are planning to leave and the interview should take place at least 2 months before the patient goes home. This interview is important for those who have special problems awaiting them on the outside. It gives the patient a chance to review the aspects of living which he will face when he again takes his place among those outside the sanatorium walls. It is important for the responsible persons in the sanatorium to understand the patient's feelings about leaving and resuming responsibilities, and to have some understanding of his knowledge of the extent of his physical capabilities and the degree to which he may overreach, or overprotect himself.

The psychological support which the social worker offers at this time is of considerable significance in the individual's movement from illness to convalescence and health. He is confused by his contradictory feelings of eagerness, regret, and uncertainty about the future. He has a sense of having had an experience, for good or ill, that sets him apart from the world into which he is going. He needs opportunity to look at his inner world and sort out his feelings and his dreams, to see what is fact and what fiction, and to evaluate the reality that is his individual circumstance at this time. No words of reassurance can take the place of the self-understanding and self-evaluation achieved when a person expresses to another his real

feeling and not his sense of how he ought to feel. The questions which are put to him bring out his doubts and help him clarify his thinking and feelings about the situation he is leaving and the one he is going toward. Because he is helped through his problems he is sufficiently freed of indecision, of conflict and regrets so that he can take the necessary steps to get himself back into his home, and work, and community life.

For the patient to leave the sanatorium entirely reluctant is of serious consequence to the individual and a threat to the community. If the outside world appears to him to be too indifferent or even hostile he may respond by driving himself too hard and before long, he will be back in the protected environment of the sanatorium. It is therefore of the utmost importance that he have full opportunity to prepare himself—emotionally, intellectually, and physically—for leaving. And the sanatorium officials need to be as certain as possible that he is well prepared before they let him go.

Many patients who have really been able to come to grips with the hard and painful experience of hospitalization leave the sanatorium with greater inner strength, greater insight, and greater sensitivity to themselves and others. "This whole experience in the sanatorium has been ghastly," a sensitive and gifted young woman said as she came to bid good-bye to the social worker, and then she added thoughfully, "but I've got hold of something here. I came in a carefree person, and the world was mine for the asking. I used to go dancing and have dates and dinner parties all at once, and many of them. I've learned the hard way that I can't have everything." And then she went on to say almost poetically—"But how exquisite every ordinary experience can be just because you're alive to it, and what a treasure of delight there is in anything extraordinary, just because you can have only a limited bit of it at a time."

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Incidence of Disease

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

Reports From States for Week Ended July 14, 1951

Poliomyelitis

A total of 616 cases of poliomyelitis was reported for the current week, which is 50 percent greater than the 409 cases reported last week. For the same week last year a total of 662 cases was reported. The cumulative total for the calendar year is now 3,861 as compared with 4,318 for the same period last year. Since the seasonal low week late in March, 2,648 cases have been reported, which is 17 percent below the 3,187 cases for last year. The only States which have shown a significant increase, 50 percent or more, in the cumulative total since the seasonal low week for this year as compared with 1950 are (1950 total is shown first): Massachusetts (14–32), Wisconsin (39–63), North Dakota (1–15), South Dakota (8–26), Georgia (29–93), Florida (72–113), Alabama (65–117), Louisiana (66–146), Colorado (25–71), Arizona (33–55), and Washington (20–33).

The geographical regions which showed substantial rises in the number of cases for the current week as compared with the previous week were the East North Central, West North Central, and South Atlantic. In the East North Central States, the increase took place only in Ohio and Illinois. In the West North Central group, Iowa and Missouri accounted for most of the increase, and in the South Atlantic area Georgia and Florida showed significant increases. Although there was a moderate rise in the number of cases in the East South Central States, only Tennessee showed a significant increase. In the West South Central States, Arkansas, Louisiana, and Oklahoma reported essentially the same number of cases for the current week as for the previous week. Texas reported 92 cases as compared with 58 for the week ended July 7. The Mountain and Pacific States reported the same numbers as last week except for California, where the number rose from 39 last week to 58 for the current week.

Weekly summary reports from the various States showing county distribution of cases, which are available up to and including the week ended July 7, have not revealed any large concentration of poliomyelitis

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cases in localized areas except for those previously mentioned, namely, in northwestern Louisiana and in the Corpus Christi area of Texas. Reports would seem to indicate that there is a leveling off in the number of cases in both areas. When reports showing county distribution are available for the current week it may be possible to determine more definitely other areas or contiguous groups of counties with relatively high incidence of the disease.

Smallpox

One case of smallpox was reported in Kentucky for the current week.

Epidemiological Reports

Malaria

According to a summary prepared by Dr. A. L. Gray, Mississippi State Board of Health, seven proved and two probable cases of malaria were reported in Mississippi during the first 6 months of 1951. All of the cases have been reported since May 24, and have occurred only in military personnel who had served in Korea. The ages of the group varied from 19 to 27 years. Six *Plasmodium vivax* infections and one *Plasmodium malariae* were confirmed by laboratory examination. Two cases in which laboratory confirmation was not obtained had received treatment a short time before blood smears were taken. Six of the cases had suppressive treatment while in military service in Korea, and one had a history suggestive of malaria prior to military service. Dr. Gray states that this number of known cases of malaria

Comparative Data for Cases of Specified Reportable Diseases: United States

[Numbers after diseases are International List numbers, 1948 revision]

Disease	Total for week ended—		5-year median 1946–50	Seasonal low week	Cumulative total since seasonal low week		5-year median 1945–46 through 1949–50	Cumulative total for calendar year—		5-year median 1946–50
	July 14, 1951	July 15, 1950			1950–51	1949–50		1951	1950	
Anthrax (062)	------	1	------	(1)	(1)	(1)	(1)	40	26	29
Diphtheria (055)	40	60	89	27th	40	60	89	2,048	3,188	4,699
Encephalitis, acute infectious (082)	26	17	14	(1)	(1)	(1)	(1)	[2] 489	398	260
Influenza (480–483)	187	232	232	30th	130,147	148,951	148,951	115,605	138,367	128,110
Measles (085)	7,579	5,164	5,164	35th	479,741	295,664	569,415	451,040	276,534	533,201
Meningitis, meningococcal (057.0)	73	55	58	37th	3,533	3,314	3,195	2,572	2,400	2,223
Pneumonia (490–493)	574	888	(3)	(1)	(1)	(1)	(1)	43,616	57,110	(3)
Poliomyelitis, acute (080)	616	662	662	11th	[4] 2,648	3,187	3,187	[4] 3,861	4,318	3,601
Rocky Mountain spotted fever (104)	15	23	26	(1)	(1)	(1)	(1)	159	215	220
Scarlet fever (050) [5]	525	333	487	32d	67,668	55,502	79,279	51,977	39,063	56,735
Smallpox (084)	1	------	------	35th	16	43	67	8	23	46
Tularemia (059)	11	16	28	(1)	(1)	(1)	(1)	369	546	568
Typhoid and paratyphoid fever (040, 041) [6]	80	88	100	11th	809	1,086	1,119	1,244	1,596	1,604
Whooping cough (056)	1,170	2,363	2,176	39th	63,201	95,638	83,683	41,599	74,102	53,039

[1] Not computed. [2] Deduction: North Carolina, week ended June 23, 1 case. [3] Data not available. [4] Additions: Indiana, week ended June 30, 4 cases; Virginia, week ended July 7, 2 cases. [5] Including cases reported as streptococcal sore throat. [6] Including cases reported as salmonellosis.

returning to Mississippi is disturbing and indicates the possibility of local outbreaks being caused by them in the communities to which they return.

Shigellosis

Dr. D. S. Fleming, Minnesota Department of Health, has reported an outbreak of shigellosis in an institution for the feeble minded, which has a population of 2,900 persons. In 11 of the 71 clinical cases *Shigella sonnei* was identified in stool specimens. The investigation of the outbreak is still in progress.

Gastroenteritis

Dr. Morris Greenberg, New York City Department of Health, has reported an outbreak of food poisoning in which 58 persons became ill out of a total of 115 who were exposed to risk. All were employees in a general hospital. None were found in hospital patients, nurses, or physicians, whose food is prepared in other kitchens than the one serving the employees dining room. Preliminary investigation revealed that the probable cause of the outbreak was boiled ham which was not refrigerated after cooking. This food remained exposed in the kitchen for about 12 hours before serving.

Dr. W. L. Halverson, Director, California Department of Health has reported an outbreak of gastroenteritis at a recreational camp in Fresno County which occurred between July 8 and 14, inclusive. There were approximately 40 persons who had symptoms of vomiting and diarrhea. The county health department is conducting an investigation. The etiology has not yet been determined.

Reported Cases of Selected Communicable Diseases: United States, Week Ended July 14, 1951

[Numbers under diseases are International List numbers, 1948 revision]

Area	Diphtheria (055)	Encephalitis, infectious (082)	Influenza (480–483)	Measles (085)	Meningitis, meningococcal (057.0)	Pneumonia (490–493)	Poliomyelitis (080)
United States	**40**	**26**	**187**	**7,579**	**73**	**574**	**616**
New England	**2**	**1**		**570**	**2**	**13**	**20**
Maine				45		2	1
New Hampshire					1	2	
Vermont				44			
Massachusetts	1	1		378			17
Rhode Island				20		1	
Connecticut	1			83	1	8	2
Middle Atlantic	**6**	**4**	**1**	**1,809**	**15**	**94**	**44**
New York	4	3	(1)	1,008	10	49	26
New Jersey	1	1	1	457	2	14	7
Pennsylvania	1			344	3	31	11
East North Central	**7**	**13**	**1**	**2,489**	**16**	**61**	**111**
Ohio	4			1,331	6		24
Indiana	3			50		13	8
Illinois		8	1	321	3	38	40
Michigan		5		118	4	10	24
Wisconsin				669	3		15
West North Central	**2**	**1**	**5**	**239**	**2**	**41**	**53**
Minnesota	2		4	25	2	11	7
Iowa				75		1	12
Missouri			1	67			13
North Dakota		1		41		29	4
South Dakota				10			2
Nebraska				3			7
Kansas				18			8
South Atlantic	**11**		**56**	**639**	**9**	**57**	**73**
Delaware				20			
Maryland	1			251		21	6
District of Columbia				12	1	6	
Virginia	1		51	210	2	18	4
West Virginia	4			28			3
North Carolina	4			18	2		7
South Carolina	1		1	8	1	7	3
Georgia			4	46		5	32
Florida				46	3		18
East South Central	**2**	**3**	**4**	**88**	**8**	**73**	**60**
Kentucky			2	11	5	46	1
Tennessee	1	3		34			16
Alabama				32	2	7	27
Mississippi	1		2	11	1	20	16
West South Central	**5**		**26**	**460**	**10**	**163**	**155**
Arkansas	1		6	14		18	12
Louisiana				18		3	29
Oklahoma			20	32		22	22
Texas	4			396	10	120	92
Mountain	**4**	**3**	**78**	**271**		**34**	**33**
Montana	1		12	68		1	1
Idaho				31			
Wyoming				11			2
Colorado	1		1	16		9	20
New Mexico	1			36		6	3
Arizona		3	65	66		18	5
Utah				43			2
Nevada	1						
Pacific	**1**	**1**	**16**	**1,014**	**11**	**38**	**67**
Washington			4	68	2		5
Oregon			10	209	1	9	4
California	1	1	2	737	8	29	58
Alaska						2	
Hawaii			7	52			

[1] New York City only.

Reported Cases of Selected Communicable Diseases: United States, Week Ended July 14, 1951—Continued

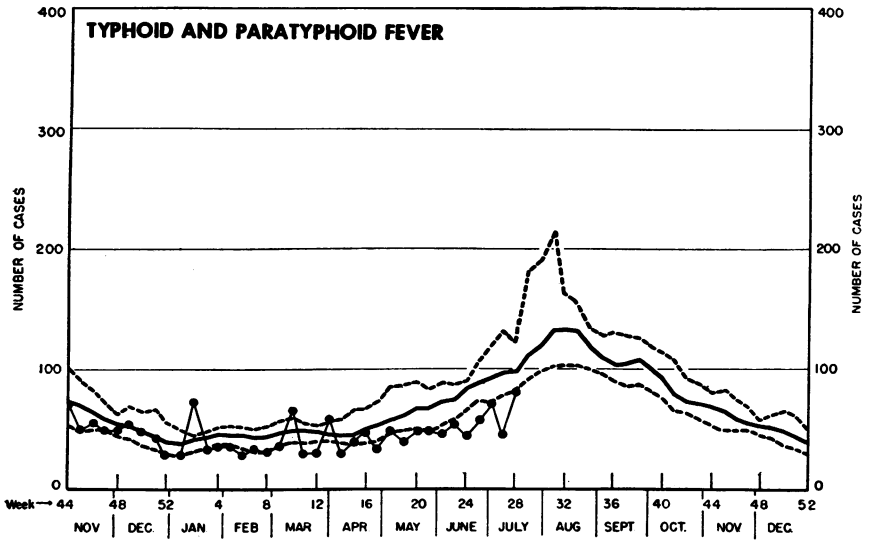
[Number under diseases are International List numbers, 1948 revision]

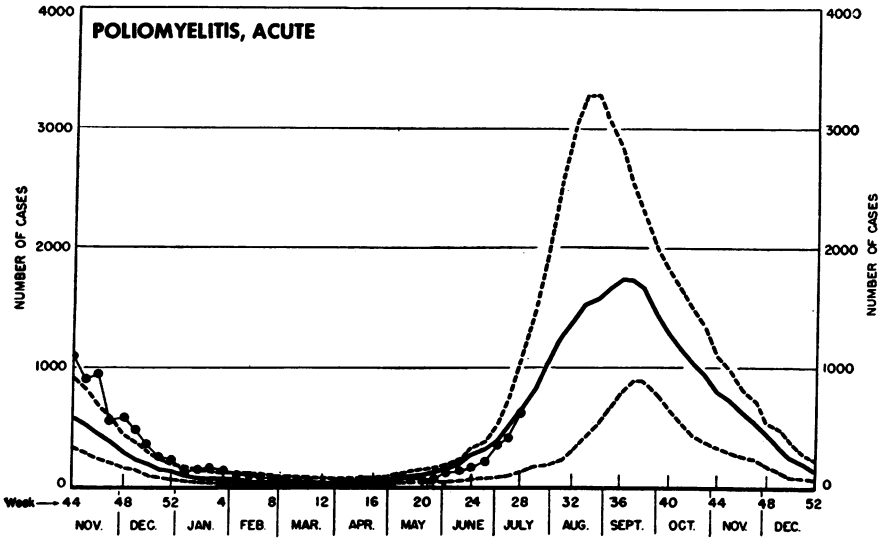
Area	Rocky Mountain spotted fever (104)	Scarlet fever [1] (050)	Smallpox (084)	Tularemia (059)	Typhoid and paratyphoid fever [2] (040,041)	Whooping cough (056)	Rabies in animals
United States	**15**	**525**	**1**	**11**	**80**	**1,170**	**151**
New England		**48**			**2**	**47**	
Maine						9	
New Hampshire		1					
Vermont						3	
Massachusetts		30			2	28	
Rhode Island		11				1	
Connecticut		6				6	
Middle Atlantic	**4**	**108**			**9**	**118**	**16**
New York	3	59				51	11
New Jersey	1	20			1	38	
Pennsylvania		29			8	29	5
East North Central		**161**		**1**	**11**	**143**	**16**
Ohio		72			1	24	3
Indiana		9			2	14	11
Illinois		13		1	4	27	
Michigan		48			4	39	1
Wisconsin		19				39	1
West North Central		**17**		**1**	**1**	**52**	**23**
Minnesota		1				2	7
Iowa						18	6
Missouri		7		1	1	14	7
North Dakota		4				1	
South Dakota						3	
Nebraska		2					3
Kansas		3				14	
South Atlantic	**7**	**31**		**1**	**14**	**183**	**11**
Delaware							
Maryland		4				4	
District of Columbia		1				3	
Virginia	4	5		1	5	36	3
West Virginia		3			1	28	1
North Carolina	3	13			2	51	
South Carolina					1	5	3
Georgia		1			5	30	4
Florida		4				26	
East South Central	**1**	**18**	**1**		**12**	**71**	**19**
Kentucky		3	1		4	16	17
Tennessee	1	12			4	18	
Alabama		2			3	13	2
Mississippi		1			1	24	
West South Central	**1**	**22**		**7**	**20**	**381**	**64**
Arkansas		2		3	4	30	3
Louisiana	1				5	1	[3] 26
Oklahoma		6		1	3	25	1
Texas		14		3	8	325	34
Mountain	**2**	**19**		**1**	**7**	**95**	**1**
Montana	1				2	8	
Idaho	1	5				14	
Wyoming						1	
Colorado		1			2	34	
New Mexico		1			3	9	1
Arizona		2				20	
Utah		10		1		9	
Nevada							
Pacific		**101**			**4**	**80**	**1**
Washington		5				14	
Oregon		11				3	
California		85			4	63	1
Alaska		2					
Hawaii						1	

[1] including cases reported as streptococcal sore throat. [2] Including cases reported as salmonellosis.
[3] Report for May.

Communicable Disease Charts

All reporting States, November 1950 through July 14, 1951





The upper and lower broken lines represent the highest and lowest figures recorded for the corresponding weeks in the preceding 5 years. The solid line is a median figure for the preceding 5 years. All three lines have been smoothed by a 3-week moving average. The dots represent numbers of cases reported weekly, 1950–51.

FOREIGN REPORTS

CANADA

Reported Cases of Certain Diseases—Week Ended June 23, 1951

Disease	Total	New found-land	Prince Ed-ward Island	Nova Scotia	New Bruns-wick	Que-bec	On-tario	Mani-toba	Sas-katch-ewan	Al-berta	Brit-ish Co-lum-bia
Brucellosis	6					3	3				
Chickenpox	1,236	4		24		104	731	56	33	123	161
Diphtheria	11					10			1		
Dysentery, bacillary	5										5
German measles	396	1		23		8	202		12	71	79
Influenza	39			33	1		4				1
Measles	1,334	4		151	8	115	364	49	33	378	232
Meningitis, menin-gococcal	3					1	1	1			
Mumps	633	7		38		77	264	17	93	48	89
Poliomyelitis	5					1	3	1			
Scarlet fever	308	2		1	1	61	40	38	26	45	94
Tuberculosis (all forms)	219	5		9	23	100	29	32	11	10	
Typhoid and para-typhoid fever	10			1		7	1				1
Venereal diseases:											
Gonorrhea	271	5		11	13	39	42	32	14	48	67
Syphilis	62	3		3	3	21	16	5	7	1	3
Primary	7						4	1	1	1	
Secondary	4				1	2			1		
Other	51	3		3	2	19	12	4	5		3
Other forms	1										1
Whooping cough	162	2				30	61	18	2	13	36

NORWAY

Reported Cases of Certain Diseases—April 1951

Disease	Cases	Disease	Cases
Diphtheria	11	Pneumonia (all forms)	2,738
Dysentery, unspecified	5	Poliomyelitis	14
Encephalitis, infectious	1	Rheumatic fever	92
Erysipelas	266	Scabies	811
Gastroenteritis	2,781	Scarlet fever	101
Hepatitis, infectious	59	Tuberculosis (all forms)	342
Impetigo contagiosa	1,400	Venereal diseases:	
Influenza	2,651	Gonorrhea	167
Malaria	1	Syphilis	46
Measles	2,622	Other forms	1
Meningitis, meningococcal	13	Weils disease	2
Mumps	117	Whooping cough	1,404
Paratyphoid fever	2		

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

The following reports include only items of unusual incidence or of special interest and the occurrence of these diseases, except yellow fever, in localities which had not recently reported cases. All reports of yellow fever are published currently. A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

Cholera

Burma. The incidence of cholera in the port of Mergui dropped to two cases for the week ended June 23, 1951, However, there was an increase during the next 2 weeks when 18 and 21 cases were reported.

India. Cholera has been decreasing continuously in Calcutta since the first week in May when 337 cases were reported. For the week ended July 7, 1951, the incidence was about a third (112 cases) as high as for the peak week.

Smallpox

Algeria. During the period June 11–20, 1951, 26 cases of smallpox were reported. This is the largest number reported for any 10-day period this year.

India (French). Twelve cases of smallpox were reported for the week ended June 23, 1951, as compared with 29 for the previous week. Of these, 4 were reported in Karikal and 5 were in Mahe.

Sudan (Anglo-Egyptian). During the week ended June 30, 1951, 10 cases of smallpox were reported in Darfur Province. For the two previous weeks there were no cases reported.

Typhus Fever

Afghanistan. During the week ended June 2, 1951, 22 cases of typhus fever were reported. These cases were chiefly in the Kabul Province. For the week ended May 27, eight cases were reported.

Algeria. Six cases of typhus fever were reported for the period June 11–20, 1951. Two of these cases were in the seaport of Philippeville.

Spain. During the week ended June 2, 1951, eight cases of typhus fever were reported in Granada Province. Previous to this report only one case had been reported in Spain for the year.

San Francisco Announces Examinations

The San Francisco Civil Service Commission will give Nation-wide examinations to fill two civil service vacancies in the field of public health—one for Chief, Division of Venereal Disease Control, and the other for Clinical Director of Psychiatry.

Entrance salary for the positions is $650 a month for a 5-day week of 40 hours. Provision is made for yearly increases to a maximum of $750. San Francisco city and county employees have liberal retirement, vacation, and sick leave benefits.

The Commission plans to hold the examinations at convenient places throughout the United States for those who cannot appear in San Francisco.

Applicants for the position of director of psychiatry must file by August 10, 1951, and applicants for the venereal disease control position must file by September 17. All inquiries will be given personal attention.

For information and application forms, write to Guy Hayler, Civil Service Examiner, San Francisco Civil Service Commission, Room 154, City Hall, San Francisco 2, Calif.