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—Editorial—

An Opportunity for Leadership

In recent years we have been witnessing a steady broadening of the horizons of public health. The emphasis has shifted, to a great extent, from the microbiological effects of disease to the study of man in his socioeconomic setting. This has brought us closer to the roots of individual and family health but it has also made our job more complex and thrust on us many new responsibilities.

Many examples may be cited of the application of this concept to public health practice. The goal for each person suffering from ill health or disability of any kind, for example, is a multiple one. The person must be found, he must be given the best medical treatment that can be provided, he must be physically and mentally rehabilitated, and he must retake his place in society, insofar as possible, by making full use of all his resources. For some, of course, recovery may not come very quickly and when it does come, it may not be complete. Nonetheless, we must be guided by the principle that everyone can make *some* recovery and can be helped toward a sound adjustment. This is not a Pollyanna attitude but a sober realization based on the advances which modern scientific knowledge have made possible.

Almost all the health and social services implicit in such an approach must be made available to the victim of tuberculosis. Early control efforts were based primarily on the fact that tuberculosis is an infectious disease. This was, of course, sound; but it was also limited because it resulted in programs devoted almost exclusively to isolation and bed rest. Now we know that adequate tuberculosis control requires the whole gamut of psychological, social, and economic, as well as medical services.

How can those responsible for tuberculosis control activities make sure that all the elements essential to success become an integral part of the program? Obviously not by attempting to do everything alone. That would not only be unwise and unnecessary, it would be impos-

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sible. Obviously not by trusting to luck that various services will reach people when and where they are most needed. That would be a basic neglect of responsibility. Tuberculosis control workers must, however, take an essential role not only in stimulating the development of necessary services but in spearheading the movement toward an *integrated* approach in every community. They must draw upon all the agencies, public and private, medical and social, economic and occupational, in building a strong control program.

One of the important responsibilities of all public health administrators is coordination. The very process of adding new services to make our structure complete creates the danger of getting lost in a maze of isolated fragments. New and specialized services must, of necessity, be parcelled out to the health workers and community agencies best qualified to provide them. The problem then becomes one of fitting the various segments of the program together in the interests of the individual patient. By putting the pieces together we get something more than the mere sum of the parts. We get an approach that is unified and we get a program that sees the patient as a whole person.

Although the teamwork principle is now receiving belated recognition by public health administrators, it is still more honored in the breach than in the observance. In an accompanying article, Drs. Anderson and Blomquist make an eloquent plea for the team approach in tuberculosis control programs. In examining current practices in tuberculosis control, they find the fragmented and "isolationist" approach all too common.

It is quite appropriate that tuberculosis control be subjected to this searching analysis, not because tuberculosis control officers are more remiss than other administrators but because this program can serve as a guide mark to other and newer public health activities. In an era when the chronic diseases and the health problems of the aging are beginning to draw increasing attention, we can profit greatly from the experience of tuberculosis control workers. Tuberculosis has many characteristics in common with such diseases as heart disease, diabetes, and arthritis, as far as program considerations are concerned. These include the prospects of early diagnosis, the important social and economic components, the possibility of extended periods of hospitalization, and the necessity for rehabilitative and restorative services.

Tuberculosis control workers have, step by step, established successful patterns for meeting each of these problems. This is not to say that the nascent chronic disease control program will or should be a replica of tuberculosis control. The infectious nature of tuberculosis sets it somewhat apart from conditions such as diabetes and heart disease.

Nevertheless public health administrators have much to learn from the tuberculosis program, particularly in meeting the socioeconomic problems which are so basic to effective control.

Tuberculosis control has reached the stage where it can lead the way in the whole field of social medicine. Armed with a wealth of technical and administrative experience, tuberculosis control administrators have much to contribute toward the development of effective chronic disease control programs. Their position of leadership will be immeasurably strengthened, however, if they see the tuberculosis control program as a unified whole, rather than as a series of separate segments, and if they put the teamwork principle into practice.

The goal of tuberculosis control must be, as Drs. Anderson an Blomquist emphasize, recognition of the patient as a person and of the program as a coordinated community undertaking. In that way, tuberculosis control can fulfill its promise of trail blazer and road marker for the newer programs in public health.

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Tuberculosis Control: A Total Program

By Robt. J. Anderson, M. D. and Edward T. Blomquist, M. D.*

In the past we have tended to think of the tuberculosis program in segments. We have thought in terms of case finding, medical care, or financial need. We have drawn sharp lines between these segments as if the whole program were divisible like a circle. It is not. There are no sharp lines. The "segments" are not segments but names we have given to activities in an overlapping, interlocking, and really continuous process. It is this total process which must be our concept and which must replace our traditional focusing on fractions of the circle.

It is interesting that we have fallen into this trap in two areas. For years, in tuberculosis, we approached the patient as a pair of lungs. We are learning not to do this any more. We have begun to think of the patient as a total person. We are concerned today not only with his medical problems and ways to meet them but also with his personal problems, his reactions, and his feelings.

Modern medicine knows that unless we deal with the total man we do not meet the problems of his illness. The medical profession—in public health, the health department—is taking the responsibility for leadership not only in recognizing the "patient as a person" but in attempting to marshall the forces that can help him as a person. We find recurring evidences of this kind of medical and public health consciousness. In some places we have eliminated the means test for admission to tuberculosis hospitals. In other places residence requirements have been relaxed. Some departments of welfare try to meet special needs caused by illness and will provide additional money for food or rent or clothing. Also hopeful, in a few places, is the absence of harsh and punitive attitudes in the use of forcible hospitalization for the so-called recalcitrant patient.

As suggested earlier, we are doing better for the individual patient. We are beginning to meet his tangible needs. More than that, we are trying to meet some of his intangible needs, the psychological and emotional problems and the resulting changing personal relationships caused by a crisis like tuberculosis. Health departments are beginning to employ medical social workers to help patients from the moment tuberculosis is suspected. We have found that much personal tragedy and hardship can be averted when the patient's prob-

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lems are recognized soon enough and dealt with before they reach such proportions that the medical treatment is jeopardized.

In some tuberculosis hospitals there are medical social workers giving direct social case-work services to patients and helping them meet their personal problems. We know from experience that when these personal problems are met the patients are able to stay in the hospital and make full use of medical services offered.

Our approach to the individual patient has become more comprehensive because our understanding of his needs has broadened. Now we must, in like fashion, broaden our thinking about the operation of our tuberculosis control programs so that they become the unified and total processes we mentioned earlier.

It is true, of course, that in tuberculosis control we have been severely handicapped by shortages of resources. We have had to worry about paying for X-ray machines, about providing clinic sessions, hospital beds, nurses, laboratory technicians, and medical personnel. We have had to find ways to meet our patients' financial and psychological problems with hospital budgets that hardly pay for pajamas—much less for psychiatrists. We still must develop more effective techniques for vocational rehabilitation, for example, of the semiliterate man who must not go back to heavy labor if he is to stay well.

We are not ignoring these gaps in our techniques and our facilities. They are real—and we must be very earnest about them. There are times when there is no substitute for 10 needed hospital beds. But this paper will discuss—not the need for more facilities, but the possibility of better use of those we have so that tuberculosis control can become an orderly process and not just a conglomeration of case finding, sanatorium care, and rehabilitation.

There can be no doubt that one of the greatest achievements in tuberculosis control within recent years was the development and growth of mass radiography. With the photofluorograph, it is economically sound and entirely feasible to X-ray entire communities. The fact that we can now screen vast population groups in a matter of weeks or months has great significance indeed for the future control of tuberculosis in this country.

In the past several years, the technique of community-wide surveys has been developed. Using this technique, we attempt to X-ray all the adults in a city, not just those in schools or industries or selected neighborhoods. The program is conducted not by one agency, but by joint action of all pertinent groups in the community.

The significance of the community-wide chest X-ray approach, however, is not confined to its speed and comprehensiveness as a tuberculosis screening device, or for that matter, to the numbers of unsuspected cases of tuberculosis it succeeds in revealing within a

community, or the number of sick people who get medical care. What is of far greater significance is the approach to tuberculosis control which the community-wide chest X-ray survey epitomizes—an approach which should operate against the kind of practice which may be found in every part of the Nation.

1. There is the tuberculosis control program in which the health officer or tuberculosis control officer has no part in hospital admissions and discharges although he should be in the best position to know who needs hospitalization and what priority would contribute most to the public health. Or in the matter of discharges, the health department often receives no prior notice that a patient will be discharged from the sanatorium so that proper planning for supervision is palpably impossible. It is a perennial paradox that those who possess the basic information and ultimate responsibility for communicable disease control are not consulted about determinations for patients with tuberculosis.

2. In hospital construction programs the same thing happens. All too often, when States are planning expanded tuberculosis hospital construction, the hospital planning commission does not include representatives of the tuberculosis control program or representatives of the local tuberculosis association.

3. Nursing services too are a severely handicapped segment. Because the division of nursing and the division of tuberculosis are administratively distinct entities within a health department, sometimes even located in different buildings, it becomes exceedingly important that we insure medical supervision, consultation, and easy interchange of information. When medical supervision is lacking and medical policies of follow-up are ill-defined it is inevitable that the public health nurse's services will be dissipated. When there is no medical direction in the selection of cases for home visits, for example, we find staff nurses burdened with pursuing casual contacts while sick patients with positive sputum go without nursing supervision.

When there is insufficient exchange of information, it is clear that all services must be handicapped. Although this applies throughout the program, it seems highly appropriate to mention it in connection with nursing. Not only are nurses checkmated because we do not give them the medical direction they need, but they are exasperated because they know that they have an understanding of the patient and his family problems and half the time we do not realize that they have this information and much of the time we develop no means for them to communicate it to us.

4. The sanatorium suffers too from the lack of coordination and planning, even from extreme isolation sometimes. Often the sanatorium director must make decisions regarding admission, with a minimum of medical information and no information regarding the

patients' personal and family problems. Patients come to the beleaguered sanatorium director totally unprepared for their course of treatment. They are rushed into the sanatorium without the slightest idea of what is to be expected of them or what they can expect of their period of hospitalization. Many enter the sanatorium over-optimistic about their prognoses. They are told to "go into the sanatorium for a month or so and get some rest." These practices make for some of the most serious problems with which the sanatorium director must deal and often lead to the kind of behavior which we who cause it call "recalcitrant." In matters of selective discharge, too, the sanatorium director's decision must sometimes be made without reference to the patient's home situation or general social problem.

5. Perhaps the least utilized resource for tuberculosis control is the social agency despite the fact that its services can contribute materially to our control efforts. It is true that we all remember instances where we attempted to use these agencies and were disappointed because patients did not receive the services we had hoped for, and it is equally true that agencies are frequently hamstrung by appropriations which are pathetically inadequate for community needs. But it is also true that we health workers often do not realistically interpret patients' problems to the agency and do not interpret the agencies to our patients so they can use the agencies effectively. It is essential that in the future we work for more coordinated planning between health and welfare agencies if we are to get the most from our community resources. In our community-wide surveys we have found that efforts toward such coordination are well rewarded, and social agencies gain a new understanding of the problems associated with tuberculosis.

6. And most important is the patient himself. He is confronted by the diagnosis of tuberculosis, beset by fears and anxieties about himself and his family, and overwhelmed by immediate and urgent problems of financing his medical care, providing for his family, and caring for his children. Moreover, he has been told firmly that he is a menace to the community! What has been happening to sick men and women as a result of our lack of direction, our almost haphazard management?

—How soon will the public health nurse learn of the diagnosis so that she will be able to give prompt assistance to the patient and the family?

—How will your sanatorium director know that the young woman on the waiting list who has positive sputum has a young baby and is deeply troubled at the prospect of hospitalization because she sees no way of arranging for satisfactory care for her child?

—Has the social worker in the health department fully interpreted tuberculosis and the needs of tuberculosis patients to the social and welfare agencies in the community?

—Will social resources of the community be called upon to provide available case-work or financial assistance?

—Are policies, rules, and regulations about hospital admission, for example, medically and socially sound?

—What happens to our patients whose needs are unmet largely because they are unrecognized by the persons who are in a position to do something about them?

There are many instances in which lack of coordinated planning between various agencies responsible for patients results not only in lack of full utilization of existing resources for the individual patient, but also results in incomplete tuberculosis control. Actually, agencies can almost nullify each other's efforts. For example, in one community 179 tuberculosis patients are waiting to be admitted to the hospital and the hospital serving the community has several dozen empty beds. This has occurred because the policies regarding medical eligibility and financial payment are restrictive, yet the aim of public health is to hospitalize all sputum-positive tuberculous patients.

In all of this, what is lacking is not a willingness to do the job properly, but a basic failure to grasp the patients' problems and the total process of tuberculosis control. What is lacking is coordination—not only coordination in action, but coordination in planning.

In many communities, it is not at all uncommon to find three separate and totally independent official agencies all responsible for tuberculosis control activities. There will be the public health department, another agency responsible for providing hospitalization for the tuberculous, and still another responsible for providing social assistance to tuberculosis patients and their families. This may be an excellent way to proceed; certainly we are not suggesting one supersized organization for all facets of tuberculosis control. But too often these agencies work separately and independently, each addressing itself solely to the specific problem falling under its own jurisdiction. Nor will we achieve tuberculosis control by adding one activity to another even though we arrive at a long, long list of activities. Tuberculosis control will not be found in the sum of case finding, medical care, and social assistance—it will be found rather in the coordination of these activities, and in the manner in which they are knit together.

In almost every community in the country there are many well-established organizations that are capable of offering both direct and indirect services not only to individual tuberculosis patients, but to the tuberculosis control program itself. We have learned from our experience in surveys that not just official health and welfare agencies, but also many voluntary civic, religious, business, and labor organiza-

tions are not only prepared to share in public health programs—they are in actual fact eager to do so. It is the proper function of an official health agency to stimulate the interest of these many organizations in tuberculosis control and to make them aware of the contribution which they can make to the process. More important, it is the proper function of the official health agency to promote coordinated planning and action among all the agencies and organizations interested in and capable of giving service to tuberculosis patients.

In a chronic, recrudescent disease like tuberculosis, it is particularly important that we think of the total needs for control in terms of the total needs of the individual patient. Certainly, a hospital bed is essential for every case of active tuberculosis. But the provision of hospitals alone is not enough. We must help patients so that they will want to stay in the hospital until they are restored to health and prepared to remain well. Adequate financial assistance will provide support for wives and children and will help fathers to remain in the sanatorium. In like manner, the provision of a housekeeper could keep a family intact, and thus prevent a mother from leaving the sanatorium too soon. And if the provision of social case-work services and necessary vocational rehabilitation and educational services during and after a patient's stay in a tuberculosis hospital will assure his remaining well after his discharge, these services should certainly be provided in order—at the very least—to protect the community's investment in that patient's restoration. In other words, the patient's specific needs must be determined and community resources called upon in an orderly fashion to satisfy these needs directly and promptly. This can come about only through joint consultation, planning, and effort on the part of all the agencies and organizations within a community prepared to meet these needs—even though they can be met only partially.

It has been said often that one of the major problems of public health today is to bridge the gap between scientific knowledge and public health service. In tuberculosis control, coordinated planning and action are the tools which can help most in building that bridge. In attempting to meet the needs of tuberculosis patients, the health department, the sanatorium, the social agency, the tuberculosis association, and all the official and voluntary organizations within a community are actually working toward the common goal of controlling the disease. The effectiveness of each depends in large measure on how well the others discharge their responsibilities. By planning together, by understanding each other's limitations, and by making the best use of the services and facilities each of the agencies is prepared to offer, all will benefit—and the needs of the tuberculosis patients and of the tuberculosis control program as a whole will be more directly and more intelligently met. This would seem to be

an effective way of working toward tuberculosis control in this country.

We must develop in our towns and our cities a central source of direction and planning for tuberculosis control. When this does not exist, the patient is subjected to a complexity of forces pulling and pushing him in every direction. And those things which are most important to him as a human being and most necessary to insure sound medical planning are not necessarily the things that will get attention.

As tuberculosis control activities are conceived and mature, the health department must discharge its responsibility for total planning and direction. We must not only cure the ills of the tuberculosis patient, but provide for his reentry into useful citizenship. The growing up process of tuberculosis control has brought with it many adjunct professions to which the official health department can turn—social service, occupational therapy, vocational counselling—all sharing in this comprehensive program. In the future, let us begin to think of all the pertinent activities in tuberculosis control as inseparable, and let us so administer our activities that they do indeed produce the greatest possible good for each patient and family as they endure the struggle with tuberculosis.

Community-Wide Chest X-ray Survey

III. Social Work

By Sophia Bloom, A.M.*

Many efforts have been made to meet the medical problems and some of the personal problems of sick people, but only rarely has a community had, or taken the opportunity to consider and try to meet its social responsibility for health. The community-wide chest X-ray survey offers such an opportunity for one public health responsibility—tuberculosis control. In the survey cities, the efforts to mobilize the social resources of the community help bring together the sick person in trouble and the community which wants to assist him.

In the earlier community-wide surveys, social work was represented through the selection of a social worker, or representative of the council of social agencies, to serve on the executive committee of the survey. Her principal responsibility was to help facilitate the referrals to community social agencies. No formal plans were worked out whereby social work was included as one of the professional services contributing to the overall planning for the total survey, nor were social workers used in the health department and survey activities.

The first time social work as a profession was introduced into a survey organization was in 1947 when the community-wide survey of the District of Columbia was planned. In this program a committee of social workers was set up as part of the formal survey organization. This committee concentrated upon two major questions: (1) the existing and new ways in which the social agencies of the community could help meet the needs of patients and their families, and (2) the contribution social work could make through community planning for a major health program. In other words, just as medicine has a responsibility to the total health of the community over and above caring for patients, and just as nursing has a community responsibility, what is the overall responsibility of social work?

As a result of the efforts of the Washington group a basic pattern of social work in community-wide surveys emerged. The pattern of social services has since been modified and expanded in each community in accordance with particular needs, but the basic structure remains the same. It is this structure, service, and philosophy which the following sections will describe.

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The Presurvey Period

When the local official health agency considers having a survey, ways to meet the social needs of the patients who will be discovered are explored as part of the presurvey planning.[1]

In all communities there have been, to a greater or lesser extent, attempts to evaluate and deal with the social problems of people in need, and public and private social agencies have long been concerned with these problems. The services provided reflect both the community's understanding of, and its ability and willingness to meet, the health and social needs of its people.

Health departments have daily faced the problems caused by illness in the lives of individual patients, and hospitals bear a share of the social dislocations created or aggravated by tuberculosis. The health and social welfare agencies, in dealing with patients and their families, have had to do so in terms of the law, regulations, and attitudes of the community. The need to know these factors is not created by the survey; this need exists whether or not there is a survey. However, the survey, because of its scope, precipitates an immediate opportunity for pulling together the existing information so that the survey planners may have the benefit of all available information about the social potentials of the area, its resources, its lacks, its plans and trends. Over and above facts or figures, what is of utmost importance to the survey planners is the community attitude toward its responsibility for the people.

A medical social consultant from the Division of Tuberculosis visits the city to pull together the kinds of information listed below:

1. Health and medical programs—general and specific, related to tuberculosis.
2. Laws and regulations affecting the eligibility of the tuberculous for medical care and public assistance, such as means tests, residence requirements, administrative policies on hospital admissions.
3. Local social resources and present social agency structure in the community, including public assistance, public child welfare, medical and psychiatric social services, private family and children's services, and other social services. Adequacy, coordination, and standards of such services.
4. Special programs or provisions for the tuberculous, or others from which the tuberculous may benefit (e. g., vocational rehabilitation services, social insurance, disability insurance, special financial assistance).
5. Sociological data—culture patterns and trends, minority groups, current intergroup relationships.

[1] For a description of survey planning *see* Community Wide Chest X-ray Survey. I—Introduction. Pub. Health Rep. 65: 1277-1291 (October 6,) 1950.

6. Major medical social problems of the tuberculous (e. g., discharge against advice, bed shortages, financial assistance, etc.).

7. Number and location of medical social workers, scope of activities and quality of medical social services in medical settings where tuberculous patients are being served, including the health department.

8. Number of tuberculous patients receiving social services, sources or types of such services, and adequacy of coverage.

9. Methods of correlating medical and social planning and care.

10. Relationships between medical social work and other professional groups within and outside the health department.

11. Methods of handling social problems in the absence of social services in medical diagnostic and treatment centers and health department.

12. Research projects, completed or anticipated, relating to the social factors in tuberculosis, and potentialities for other studies.

13. Trends or definite plans for development of the community social resources.

14. Other special factors which might affect the survey.

This presurvey period, if so utilized, can offer a genuine opportunity for consideration of mutual problems and for joint planning between the health, medical, and social agencies, and the doctors, nurses, and social workers. Good coordination between the social agencies and health and medical care facilities and among the social agencies themselves will mean a more effective total service to the people of the community. The community must ask itself whether it will take advantage of the opportunity offered by a community-wide program to plan for extension of needed services.

In one large community presurvey discussions were held with more than 25 people from Federal, State, and local agencies: public health officials, tuberculosis control officers, State health department social workers, medical social workers in tuberculosis agencies and in other medical settings, public assistance and child welfare workers, social workers in the community, schools of social work, veterans administration, social workers from professional organizations, rehabilitation workers, administrators, welfare council representatives and tuberculosis association representatives. It became clear that these people were keenly aware of the tuberculosis problems; many undiscovered patients, a bed shortage, a severe housing shortage, inadequate public assistance, inadequate child care facilities, insufficient medical social case-work services, differing admission policies among the tuberculosis hospitals so that some patients were not eligible for admission anywhere.

There was great strength and forcefulness in the medical, public health, and social work leadership in that community. Determined efforts had been made for years to deal with the problems, and many

people looked forward to the possibilities offered by the survey to find the unknown patients, and to meet the specific medical and social needs of the tuberculosis population. In other words, the local people were prepared to use the survey not only for the immediate benefits to be gained by case finding, but to help them plan to meet the long time health and social problems revealed in a major community health program.

The Public Health Service Medical Social Consultant

The medical social consultant of the Public Health Service participates in the early planning of the survey and is available throughout the program. She serves in an advisory capacity to the health department and helps State and local health departments, tuberculosis associations, and community social workers work out plans to mobilize community social resources and develop any additional needed social services for the tuberculosis control program and the survey. She brings to them the experiences gained in previous surveys.

The State Medical Social Consultant

In most of the States there are medical social workers in one or another of the State health or medical care programs. Their customary consultative relationships with local areas have made it possible for them to contribute greatly to the local program, and the Public Health Service consultant works closely with them. They serve on various social work committees of the survey and help particularly with overall planning. In a number of States, they have assumed considerable responsibility for helping the social worker in the local health department in the development of the service.

Social Work Coordinator

Because of the many survey interests and activities of the social workers in the community, it is essential, especially in the larger communities, that some one social worker be designated to coordinate the social service activities involved in the case-finding program including those in the health department, retake center and community. This may be a social worker from an official or other agency. On one occasion a medical social worker from the Division of Tuberculosis was assigned as the coordinator. The full-time services of one person may be required if the community is large.

Social Work in the Survey Organization

Social work functions in the survey as part of the professional services division of the survey. This division is concerned with the pro-

fessional services offered to persons discovered in the survey. As the survey is of short duration but intense activity, additional services, particularly contributions of service by persons outside the official health agency, are required. The professional services division is responsible for stimulating these contributions. It helps set the professional standards of the survey and is responsible for interpreting it to the various professional groups involved. It is generally agreed that joint thinking and planning of the three professional groups involved—medical, nursing, and social work—will result in greater coordination of community services and in more effective services for the individual in need of help. It is in this regard that the professional services division can be very effective when joint medical, nursing, and social work considerations are brought together and merged into the overall problem of adequate care for tuberculosis patients and their families.

Social work is represented in the professional services division by a social work committee. Since no one professional organization represents all the social workers, the health officer calls together representatives of the various social work organizations such as the Council of Social Agencies, schools of social work, key social agencies, and the social workers in the State and local official health agencies, explains the program and asks them to choose the chairman and vice-chairman. This original temporary group then dissolves and the newly appointed chairman and vice-chairman (usually one medical social worker and one social worker from another field) appoint the social work committee consisting of social workers from public and private social agencies, hospitals, and other health and medical settings, all of whom have a contribution to make to the tuberculosis control program of the community. The committee varies in size, each community choosing the number it finds is appropriate; membership has ranged from 13 to 54. This over-all social work committee of the survey can be used in an advisory capacity by the health officer if he wishes.

The social work committee is responsible for the effective mobilization of the social workers of the community but needs the help of the health department and the rest of the survey organization. The health officer, the tuberculosis control officer, the public health nurses, the survey program manager, the health educators, the survey publicity representatives all contribute, together and individually, to the social workers' knowledge of the total program and to their understanding of the ways in which the health department functions. As social workers become familiar with the objectives of the tuberculosis control program and the methods by which the tuberculosis control officer hopes to achieve control, and as they learn how the problems are dealt with, they begin to see their own roles more clearly.

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Moreover, the growth of understanding is mutual. The health workers and the lay people in the survey organization learn more of the objectives, methods, and problems of social work and utilize the social workers in other phases of the survey program, such as community organization. In the survey cities greater mutual understanding and coordination between the health agency and the social agencies has developed as a result of joint activities. A number of health officers have expressed gratification for the support given them by the social agencies; and, in turn, the social workers feel that they have a part in the health program. In several cities, after the survey, the health divisions of the Councils of Social Agencies have developed permanent committees of social workers interested in the health programs of the city.

The committee as a whole considers specifically the social needs of tuberculosis patients and families, determines whether there are sufficient resources for the patients who will be discovered in the survey, points out gaps in services and helps with recruitment of social work personnel for the health department and the retake center. The social workers in the health department and retake center can bring to the committee data on social problems of patients which because of the number involved will throw greater light on the total problems of the community. The committee is in a position to focus the attention of the social workers in the community and other professional and lay groups on the specific medical-social problems which the survey emphasizes.

Social Work Subcommittees

There are usually a number of subcommittees of the social work committee. These vary with situations in the survey cities and with the specific needs that arise as the survey progresses. The chairman of the social work committee appoints the chairmen of the subcommittees, and their membership may be drawn from the full committee or include other social workers from the community. Sometimes the chairmen of the subcommittees serve with the chairmen of the social work committee as a steering group, so that it is not necessary to have frequent meetings of the full membership. Long-range planning to meet community needs revealed by the survey is, of course, a function of the full committee, but preliminary work on it can be handled by the steering group. In every city, however, there has been a subcommittee on interpretation, which has had responsibility for bringing to the social workers of the community facts about the survey, facts about the control of tuberculosis, and suggestions as to the role social agencies can play. This committee informs social agencies about the program, provides social workers for neighborhood committees and for the speakers bureau, and helps develop some of the publicity

materials—press, radio, television—on social needs so that the community will learn more about them. One of its important responsibilities is to sponsor an institute in which the social workers in the community can learn more of the medical and social factors in tuberculosis. An example of this kind of institute is the program sponsored by the Greater Cleveland Chest X-ray Survey Foundation. Many of the agencies in the city operated with skeleton staffs for the day so that all the social workers could attend and there would have to be only one meeting instead of many small ones. In most of the communities the institute follows this general pattern.

Subcommittees to consider problems requiring further study have been established in every survey. Consideration is given to the effect on tuberculosis patients and tuberculosis control of such matters as:

1. Adequacy of local public assistance allowances.
2. Adequacy of provision for child care and housekeeping services.
3. The residence laws.
4. The means test.
5. The effects on patients of long waiting periods for beds.
6. Problems of the single, homeless person.
7. Emotional factors contributing to acceptance or rejection of the diagnosis.
8. Financial factors contributing to refusal to enter the hospital.
9. Effects of disciplinary discharges from tuberculosis hospitals.
10. Vocational needs of patients.
11. Income of patients.

There have also been subcommittees appointed to carry out certain other responsibilities like the compilation of a list of social agencies available for tuberculosis patients, indicating the specific kinds of services offered, recruitment of social work personnel, pointing out gaps in services.

As in all the survey committees, activity among the social workers is great during the planning of the survey and during its operation. Considerable enthusiasm and excitement are engendered. Committees, large and small, meet frequently and spend hours working out problems and outlining procedures. That the range of interests is broad is indicated by the subjects and reports described in the minutes of one meeting of a social work committee.

1. A statement of social needs of patients with a list of social resources—to be included as part of a larger statement of medical, nursing, and social information to be printed in the local medical journal.

2. A letter containing current reports on the survey, such as the number of persons X-rayed, and current social work activities to be sent to all social agency executives in the area.

3. A presentation by the health department social workers of some of the social needs as revealed in the health department activities.

MEDICAL and SOCIAL ASPECTS of TUBERCULOSIS

10:15—Significance of the X-Ray Survey For Our Community

Deon Donald V. Wilson,
Chairman Social Services Committee

10:30–11:30—Tuberculosis—As the Doctor Sees It

Dr. Myron M. Perlich,
Instructor in Medicine, Western Reserve Medical School,
Visiting Staff Physician, Cleveland City Hospital

Dr. Perlich will discuss the diagnosis of tuberculosis. He will review the most recent treatment methods, including surgery; care of patient before, during and after hospitalization; the doctor's use of the social worker, the public health nurse and rehabilitation resources; and chances of infection both for members of the family and to the social worker.

11:30–12:30—Tuberculosis—The Role of the Public Health Nurse

Miss Lucia Sweeton,
Ass't Professor, Frances Payne Bolton School of Nursing,
Western Reserve University

Miss Sweeton will discuss the procedures of the Public Health Department and the Public Health Nurse, including care of the patient waiting for hospitalization; interpretation and follow-up with the family; instruction in isolation techniques and their application to the social worker; continuing service to the patient and family upon patient's return home.

2:00–3:00—Tuberculosis—The Emotional Aspects

Dr. George A. Streeter,
Teaching Fellow in Psychiatry, W. R. U. Medical School

Dr. Streeter will discuss some of the more personal problems and emotions of the patient. Such topics will be considered as the patient's initial reaction to his tuberculosis, difficulties in accepting bed rest therapy and the readjustment problems of a prolonged disability.

3:00–4:00—Tuberculosis—From the Standpoint of the Social Worker

Miss Mary E. Hartzell,
Medical Social Worker, Greater Cleveland
Chest X-Ray Survey Foundation, Inc.

Miss Hartzell's discussion will center about the impact of the diagnosis of tuberculosis on the patient; the social and emotional adjustments which must be made if the patient is to complete successfully a long hospitalization and convalescent period; the clinic and hospital social worker's cooperative work with the public health nurse and social agencies in the community; resources available for use with the tuberculosis patient; the importance of rehabilitation work in the maintenance of the patient's physical and mental health and in his restoration to useful function in the community.

4. Report of social work activities in the retake center.

5. Publicity to be released to the newspapers, radio and television on social aspects of tuberculosis.

6. Discussion of a proposed study project on unattached men and women.

Social Services in the Health Department

An increasing number of local health departments are employing social workers to serve patients. This number, however, is still limited and in most of the communities in which chest X-ray programs take place, social service has not yet been established in the health departments. Our discussion here is concerned with those health departments which have not had social services before.

During the planning period for the survey the social problems of tuberculosis are discussed with the health department officials, the experiences of other survey cities are examined and the health officers have time and opportunity to decide how they wish to initiate social services for tuberculosis patients and plan for service through the follow-up period. Recruitment begins early so that the service may be started as far ahead of the survey as possible. This enables the health department to set up an administrative structure and enables the social worker and others in the health department to clarify functions and work out procedures and methods. Because the survey is tuberculosis case finding, social service is usually started in the tuberculosis division of the local health department. Care is always taken to so organize that later extension of service for other diagnostic groups is possible and expansion into a social service department is feasible.

Social workers for health departments have beeen secured by various means. Some are employed by local health departments, some with survey funds, others have been loaned by State health departments and, in two cities, the local tuberculosis association has provided funds. Medical social consultants from the Public Health Service are loaned upon request and on one occasion the National Tuberculosis Association made one of its social workers available. In some of the surveys only one social worker has been available at a time; in others there have been as many as six on the staff.

The problems confronting the social workers who are starting service in the local health department in preparation to the tuberculosis surveys are essentially no different from the problems involved in initiating social service in a local health department at any time, except for the necessity of preparing for the immediate survey case load. After the social worker comes, there are additional conferences within the health department, again with the health officer, the tuberculosis control officer, and the director of nursing. During

these discussions there is clarification of the needs of the patients served by the health department and a beginning is made toward the determination of the ways in which the social worker will function. Because the service is new, flexibility in development is essential. Basic principles of social work are discussed and an administrative structure is established. One of the purposes of these conferences is to try to determine the kinds of social problems with which various people in the health department have already been dealing and the ways in which the social workers can help. The health department physicians, social workers, and nurses together arrive at a mutual understanding of how social service can add to the services already given by the health department and try to delineate the specific functions and various activities of the social workers. It is usually determined that the social worker will offer social case-work services to patients and families and consultation services to other health department personnel and to the community social agencies.

Administratively, the social workers are always responsible to the physician in charge of the division of tuberculosis for the work in the tuberculosis program. In most of the survey cities, the health officers have taken considerable responsibility in the development of overall policies which will influence further social service developments in the health department.

Usually, a statement of the functions of the clinic social worker is worked out. There is no set pattern and the functions are adapted to each clinic. The following kinds of services are usually included:

1. *Social Case Work*

The social workers give direct case-work services to patients who need help with those social, emotional, and financial factors which affect their ability to accept the diagnosis and to follow recommendations for medical care. The following are thumb-nail examples of the kinds of problems requiring social case-work service:

Acceptance of the diagnosis

The social workers have found that, along with the doctors and nurses, they must devote much of the first interview or interviews to consideration of the patient's fears about himself—fear of death, of physical deformity and crippling, of permanent incapacity. After patients are given ample opportunity to release their emotions and to gain reassurance, the related social problems such as the need for financial assistance or planning for the care of children are more easily faced and solved.

Hospitalization

They have also found it necessary to deal with the factors creating resistance to entering the hospital. A certain amount of resistance is, of course, normal but some patients require help in working their way through the mixture of reactions of fear, resistance and acquiescence so that they can come to the decision to enter the hospital and can find the way, with help from the clinic social worker or community agencies when necessary, to care for their children, make financial arrangements, etc.

Financial problems

The social workers in the clinics often devote much time to helping patients and their families plan to meet the severe financial strains caused by tuberculosis. Some need immediate referrals to public assistance agencies; a large number of tuberculosis patients, it has been found, do not apply for such aid, and, indeed many are not eligible. Because of the disaster created in the majority of families, patients need a great deal of help to face the necessary readjustments, such as reduced living standards, curtailment of education, employment of wives and children, and the necessity to seek relief. Much time may be required before patients can make the practical and emotional adjustments necessary to enable them to enter hospitals or follow other medical recommendations.

Along with the actual cost of maintaining their families, many patients must meet some of the costs of hospital care. Although there may be efforts to rate patients according to ability to pay, the sum charged may be more than the patient can handle, especially over a sustained period of time. Some people, when frightened and unaware of the length of time required by treatment, will agree to almost any charge. To be certain that the iilness is understood and that plans are not made on the basis of 6 months when it is more likely that 2 years will be required, social workers help patients with the necessary planning. Much bitterness among patients and much leaving hospitals against advice can be prevented when patients have an opportunity to absorb the impact of the diagnosis at the beginning and to plan in terms of reality.

Residence laws

In all but a very few of the States these laws are a genuine source of difficulty to the patient, to the health department, to the hospital, to community social agencies, and to the control of tuberculosis. If the nonresident patient has legal residence in his former home the social worker can help him accept the necessity of returning there for treatment. Sometimes the social considerations along with the patient's medical needs and the community's public health responsibility, make it possible for the responsible authorities to waive the residence requirements. On occasion, nonofficial hospitals will admit the patients. Sometimes, especially when the patient has no place of residence, he can receive no medical care until a year or more has passed. During this period, he often needs considerable help from community social agencies.

2. *Cooperation With Community Social Agencies*

Although all the patients referred to the social workers have social difficulties which are intertwined with the illness and therefore need some help in the medical setting as part of the medical treatment, others need additional social services from other agencies. Bed shortages can create the need for additional social resources. For example, when sick people must remain at home, it is often necessary to remove the children, sometimes to foster homes and institutions.

In the survey cities up to one-third of the patients have been referred to other agencies for services. In one city the range of services required by patients necessitated the use of the following agencies:

Vocational Rehabilitation
County Tuberculosis Hospital—Social Service
County Welfare Department
Family Society
Juvenile Court
Guidance Council
Mental Hospital
Three other County Health Departments
Marine Hospital
Social Security—Old Age
Four Local Health Departments in other States
Social Service Exchange
Urban League

Veterans' Administration
Tumor Institute
Visiting Nurse Society
County Veterans Aid Bureau
American Red Cross
Disabled American Veterans
Convent of Good Shepherd
County Hospital
County Health Department
Public Welfare Department
Children's Home
St. Vincent de Paul Clinic—Social Service
Catholic Church
Catholic Children's Bureau
Municipal Court
Memorial Hospital
Medina Children's Service
Traveler's Aid

The social worker in the health department develops a close working relationship with other social agencies in the community. At times she functions by bringing to them an interpretation of the medical conditions and the social factors involved. By dealing with the patients from the point of diagnosis, referrals to community agencies are made earlier and some further social strain is prevented. The social agencies in turn learn through these experiences to use the health department more effectively for all the people under their care.

3. *Consultation Services*

In addition to giving direct services to some patients, the social worker also functions as a consultant to other health department personnel. As pointed out earlier, she deals directly with a limited number of patients, those who by the nature of their medical problems and the related social situation particularly require a specialized social case-work service. Very often, the social worker is used by other staff members in a consultative capacity. At times this is in relation to over-all administrative policy; at other times, it is in relation to specific patients.

In some clinics, the tuberculosis control officer calls case conferences at intervals to discuss individual patients. Doctors, nurses, and social workers have an opportunity to think and plan together for the patient's benefit. These are the more formal conferences. In every clinic there is, every day, a constant informal exchange of information and thinking. This is essential, so that the patients can receive the most effective help.

4. *Collection of Social Data*

In addition to dealing with the individual patient, the social worker in the clinic has the means of collecting the social data which the community can use to develop additional resources. Community needs may be highlighted. The health department is in a particularly strategic position to acquire the data as many patients pass through its doors, either for some kind of medical service or on the way to the hospital.

The problem of single people, particularly men, is an example of this kind of activity. Community attitudes toward the single, unattached people, particularly the men, vary and are frequently hostile. It seems to be generally assumed that the single person can draw upon unknown intangible resources, and should be able to get along somehow. In public assistance programs, for example, there are often provisions which set up different standards for the single person as opposed to the rest of the population. It is frequently harder for him to prove his need and he often receives less than other people. In the tuberculosis field, single men are often assumed to be, and said to be, the most irresponsible and socially undesirable segment of the total population—the wanderers, the alcoholics, the feebleminded; and they are often believed to refuse hospitalization. Reports from social workers in various surveys show that, in fact, the single men are often eager, because of their homelessness and need of care, to enter the hospital. In one survey city nearly 60 single men, most of them from the skid row area, were inter-

viewed. Almost all entered the hospital. Reports from doctors and social workers in many tuberculosis hospitals show that the single homeless people are among those who find it hardest to leave the security and protection of the hospital. Data such as these can enable a community to approach the problems of sick, homeless people more realistically.

Even before the arrival of the social worker certain essentials in the physical setting are considered. Privacy for interviewing is very necessary. A private telephone is also an essential. Adequate secretarial assistance is essential because much of the value of social case work is lost unless it can be transmitted quickly in usable form to others: the doctors, the nurses, the hospital or clinic caring for the patient, and the other social agencies. Face sheets are developed so that social data may be systematically gathered and kept. Records are usually written in descriptive form. The records need not necessarily be long, but they must be adequate to meet the needs of the patient, and the medical and social personnel caring for him. Conversations between the social worker and the doctor or nurse will not meet this need, as the risk of losing the continuing value of the material is great.

Patients are usually referred to social service by the clinic physicians, clinic nurses, public health nurses in the field, private doctors, the community agencies, and others. Some come on their own initiative. In most surveys, the doctors are the principal source of referrals, with the nurses the second largest source. The use of the social workers by other personnel in the clinic increases steadily as experience begins to show the kinds of services that are given and as others begin to see how this service fits into the total tuberculosis control program.

Priorities for services must be established because of the size of the survey load and because there are usually not enough social workers in the clinic. For example, it may be agreed within the clinic that social workers will see all the newly diagnosed patients and all of those for whom hospitalization is recommended. These two groups are usually given priority because it is obvious that among the newly diagnosed and among those who are to go to the hospital there are many personal problems. Adequate attention paid to these problems at the start will cut down resistance to entering hospitals or refusal to follow medical recommendations. Social service, however, is not restricted to these two groups and is available for other patients referred by doctors, clinic nurses, field nurses, other clinic personnel, and outside agencies. Often patients who know of the service will come themselves to ask for help.

In many clinics, after the doctor sees the patient he sends him to the nurse and then to the social worker. This is not necessarily a set pattern, and at the discretion of the doctor or nurse or the wish of

the patient, the social worker may be called in at any time. The doctor explains the reason for referral to the patient and makes the referral to the social worker in person so that the social worker has the opportunity of learning what social problems he believes require attention. The start of joint medical-social thinking about the patient takes place at this time.

The length of time necessary for interviews and the number of interviews required per patient cannot be standardized. Many social workers estimate that approximately an hour should be set aside for the first interview with the patient. Sometimes less time is actually used, on other occasions more may be necessary. With some patients one interview is enough in which to gain an understanding of the patient's problem, his attitudes toward his problem and the effect of this on his social situation and to help him begin to make his plans. In other instances more than one interview is necessary. There are some patients whose understanding and acceptance of the diagnosis and the demands it makes upon them in terms of hospitalization, jobs, and families is such that they can begin to chart their courses relatively quickly. Others, whose fear and uncertainty is greater, need help for a longer period. Sometimes it is necessary to see these patients more than once and it may be necessary to speak with relatives.

On occasion, home visits are needed. This is comparatively infrequent but again circumstances indicate the need. In a health department which serves primarily an urban community where transportation is good and where people have easy access to the clinic most of the interviews can be conducted in the office. If the health department although located in a city serves a rural area also, it may be almost impossible for a wife to arrange for the care of small children during the day while she takes a trip of many miles. In such an instance, the social worker goes to the home. On other occasions, too, the social worker may feel that an interview with the patient and his family in his own home may be more productive and may give her a better understanding of the whole situation than she can get in clinic interviews. This is particularly true where there have been indications that the interpersonal relationships between the family members are disturbed. Because the sick person is so dependent upon those who are closest to him and because his sense of security or insecurity will affect his attitudes toward the diagnosis and toward the recommendations for medical care, it is often important that the social worker secure sufficient first hand understanding of the family relationships to enable her to help most effectively.

Retake Center

The social worker in tuberculosis has worked in a variety of medical settings, as it has been recognized that patients have problems in

different phases of treatment. The needs of the patient who was preparing to return to work were first recognized. Experience with patients at this time pointed out the need for help earlier, at the time the patient was in the hospital. Then, because of the problems which arose in the hospital, it was apparent that there was a place for the social worker earlier, in the clinic where the patient was undergoing diagnosis. Now we are exploring the needs of persons who are suspected of having tuberculosis in order to determine how much social breakdown can be prevented from the very beginning of the long course of treatment.

In the retake center there is medical consideration of the problems of the suspected cancer and cardiac patients as well as the suspected tuberculosis patients. The principal focus of the social workers in the center is in the interest of furthering medical care for those suspected patients who are referred to the social workers by retake center personnel because of specific social and emotional problems.

The problems presented by persons suspected of having tuberculosis are, of course, similar to those already described in the preceding section, with emphasis on anxiety, and occasional need for the services of other social agencies. The experiences with those suspected of cancer or cardiac disease are the same.

This is an example of the way social service functioned for the suspected cardiac patients in one retake center. The State health department provided two social workers for the retake center, primarily for the suspected heart patients, although they also gave service to others. The following outline shows the basis of selection of patients and the kinds of service rendered:

Persons to be referred to the social worker

1. Persons who, following the small film, return for confirmatory films or consultation related to suspected cardiovascular disease, and who express marked concern or fear.
2. Persons who need help in finding and using appropriate medical facilities.
3. Specific referrals from private physicians for plans for social care or with the request that a different medical plan be worked out.

Services provided by the social worker

1. Effecting a referral to appropriate medical resources in the community.
2. Helping the patient overcome obstacles affecting the medical plan.

a. Discussing with the patient his attitudes, problems within his home, work or school situation, and other factors which affect

adversely his ability or readiness to follow recommendations for diagnostic procedures and treatment.

b. Determining with the patient what help he may require through family and community facilities and helping him to make the best possible use of all resources.

c. Sharing social information with other professional staff.

Conclusion

The social needs of the tuberculous cannot be considered as an entity. They stem from and are created by the overall problem of the necessary adjustments of man to his physical, social, and economic environment. Because there has been more and more emphasis in recent years upon the individual needs of people we have learned more about helping them to make satisfying adjustments.

We have learned not to do things "for" and "to" people, and know that we are of genuine assistance only if we help them to help themselves. Although the helping process takes place between individuals, the person who is helping reflects the desire of society to provide for the person in need. However, society must provide not only the person who helps—the doctor, or the social worker—but must also provide the hospital, the foster home, the social agency. Progress is being made in many directions but there are still wide gaps in our social provisions. This has been repeatedly demonstrated by the community-wide surveys.

The continuing economic and social changes of our industrial economy inevitably produce inequity and imbalance; and in our complex modern society, our social customs and laws are not always at the level of our modern scientific knowledge or even with modern social knowledge. We may know, for example, that prompt hospitalization is the best way to care for a person with positive sputum and the best way to prevent further spread of the disease, but our residence laws may prevent us from providing such hospitalization for the sick person who needs it even when we have empty beds in our hospitals. We may know that a man cannot easily rest in bed if he is worried about the deprivations his children suffer because of his illness, but we do not always provide adequate support for them. Medically, a particular program of treatment may be clearly indicated and outlined, but cultural and psychological attitudes about tuberculosis in particular, and dependency in general, may operate against the acceptance of scientific knowledge on the part of both the patient and society.

Our society has conflicts about dependency and people in need. Although we retain some archaic laws and customs, we want to meet the needs of people, to provide for the individual and the group,

medically and socially. Our laws governing health and social welfare, our institutions, our development of public education, our social historical precedents are all evidences of this desire to meet the universal needs of people. But as individual persons, and as a group, we all are subject to many contradictory impulses. We may recognize that a given person needs help; we may provide the means for such help; and we may then think the less of the man who takes it. In a culture which places such a high value on independence, most people, the well and the sick, are not able to set this aside easily and accept dependence themselves, nor see others do so. This is one of the reasons why it is difficult to accept full community responsibility even though we may acknowledge the needs of individuals and even though we know that in our complicated social order no man can be entirely self-sufficient.

In tuberculosis, our responsiblity lies in two areas: first, to provide public health services and second, to meet the social needs of patients. The first is accepted far more than the second. As a result, a very large portion of the social burden has fallen upon the shoulders of the sick and their families and many tuberculosis control efforts are thereby substantially weakened. We must ease the load if our efforts to control tuberculosis are to be fully successful.

ACKNOWLEDGMENT

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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 January 13, 1951

Salmonellosis

Dr. W. L. Halverson, Director of Public Health, California, has reported an outbreak of salmonella food infection following a family Christmas dinner. Among the 12 persons eating turkey, 11 became ill. *Salmonella anatum* was recovered from the turkey served and from the patients.

Bubonic Plague in Lea County, New Mexico.

Dr. J. R. Scott, Director, State Department of Health, New Mexico, has reported a fatal case of bubonic plague in a man in Hobbs, Lea County, N. Mex. The diagnosis was confirmed by laboratory examination. In 1950, two cases of bubonic plague were reported in New Mexico, one of which occurred in Lea County in January.

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
	Jan. 13, 1951	Jan. 14, 1950			1950–51	1949–50		1951	1950	
Anthrax (062)	------	1	1	(1)	(1)	(1)	(1)	1	1	1
Diphtheria (055)	96	205	219	27th	3,124	4,642	6,835	217	371	477
Encephalitis, acute infectious (082)	7	9	8	(1)	(1)	(1)	(1)	14	22	14
Influenza (480–483)	1,788	1,658	2,331	30th	42,044	13,887	19,882	3,637	3,303	4,565
Measles (085)	7,190	4,946	5,314	35th	[2] 41,258	27,120	34,207	[2] 12,557	7,990	8,083
Meningitis, meningococcal (057.0)	107	94	94	37th	1,164	1,080	1,080	203	167	177
Pneumonia (490–493)	1,558	2,262	-------	(1)	(1)	(1)	(1)	3,233	4,472	------
Poliomyelitis, acute (080)	149	123	91	11th	[3] 32,504	41,699	24,967	285	247	170
Rocky Mountain spotted fever (104)	------	3	1	(1)	(1)	(1)	(1)	-------	4	1
Scarlet fever (050)	1,835	1,425	2,336	32d	[4] 18,981	19,096	27,018	[4] 3,290	2,657	4,416
Smallpox (084)	2	1	4	35th	11	9	29	3	2	8
Tularemia (059)	18	27	32	(1)	(1)	(1)	(1)	28	51	64
Typhoid and paratyphoid fever (040, 041).[5]	73	42	41	11th	3,016	3,441	3,480	101	68	71
Whooping cough (056)	1,743	2,159	2,159	39th	24,918	25,355	28,434	3,316	3,819	3,819

[1] Not computed. [2] Additions: Nebraska, week ended Jan. 6, 3 cases; Indiana, week ended Dec. 23, 1950, 12 cases. [3] Deduction: North Carolina, week ended Dec. 16, 1950, 1 case. [4] Including cases reported as streptococcal sore throat. [5] Including cases reported as salmonellosis.

Reported Cases of Selected Communicable Diseases: United States, Week Ended Jan. 13, 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	**96**	**7**	**1,788**	**7,190**	**107**	**1,558**	**149**
New England	**5**		**1**	**233**	**3**	**50**	**1**
Maine				3	1	3	
New Hampshire					1	1	
Vermont				83			1
Massachusetts	5			134			
Rhode Island			1	12			
Connecticut				1	1	46	
Middle Atlantic	**5**	**3**	**15**	**1,221**	**9**	**189**	**28**
New York	3	2	[1] 5	335	3	65	16
New Jersey	1	1	10	328	1	84	5
Pennsylvania	1			558	5	40	7
East North Central	**6**		**16**	**1,813**	**22**	**122**	**4**
Ohio	5		13	625	10		
Indiana				34	3	19	1
Illinois	1		3	317	3	65	
Michigan				226	5	38	3
Wisconsin				611	1		
West North Central	**5**	**1**	**22**	**619**	**9**	**126**	**11**
Minnesota	2			87	2	7	3
Iowa	1			8	1	9	3
Missouri	2		2	187	3	4	1
North Dakota			20	11	1	97	
South Dakota		1		16			1
Nebraska					1		2
Kansas				310	1	9	1
South Atlantic	**15**		**868**	**461**	**26**	**192**	**24**
Delaware				7			
Maryland	1		9	12	3	33	4
District of Columbia			1	19	1	18	
Virginia	4		588	96	7	104	1
West Virginia	2		239	7	1	16	4
North Carolina	2			60	7		3
South Carolina	3		15	4	3	10	1
Georgia	1		16	244		11	5
Florida	2			12	4		6
East South Central	**18**	**1**	**85**	**193**	**11**	**79**	**12**
Kentucky	6		5	46	1	33	2
Tennessee	2	1	67	61	4		4
Alabama	7			7	3		1
Mississippi	3		13	79	3	46	5
West South Central	**32**		**470**	**966**	**13**	**668**	**26**
Arkansas	10		301	127	1	94	2
Louisiana	4		4	11	3	26	5
Oklahoma	4		165	81	2	32	4
Texas	14			747	7	516	15
Mountain	**4**		**297**	**612**	**3**	**74**	**7**
Montana			12	14		3	
Idaho				29			1
Wyoming	1			16			
Colorado	2		66	468	1	31	4
New Mexico			3	26		22	1
Arizona			216	42	1	[1] 8	
Utah	1			14			1
Nevada				3	1		
Pacific	**6**	**2**	**14**	**1,072**	**11**	**58**	**36**
Washington	1			568	2	2	8
Oregon	2		14	38		20	2
California	3	2		466	9	36	26
Alaska		1	5			1	2
Hawaii			8				

[1] New York City only.

Reported Cases of Selected Communicable Diseases: United States, Week Ended Jan. 13, 1951—Continued

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

Area	Rocky Mountain spotted fever (104)	Scarlet fever (050)	Smallpox (084)	Tularemia (059)	Typhoid and paratyphoid fever [1] (040, 041)	Whooping cough (056)	Rabies in animals
United States		**1,835**	**2**	**18**	**73**	**1,743**	**127**
New England		**186**			**3**	**314**	
Maine		12			1	42	
New Hampshire		5				15	
Vermont		10				57	
Massachusetts		134			1	120	
Rhode Island		10				42	
Connecticut		25			1	38	
Middle Atlantic		**263**			**5**	**340**	**16**
New York		[2] 137			3	126	16
New Jersey		52			1	148	
Pennsylvania		74			1	66	
East North Central		**489**		**6**	**6**	**237**	**15**
Ohio		149		1	1	58	8
Indiana		45			3	22	7
Illinois		84		5	2	16	
Michigan		183				80	
Wisconsin		28				61	
West North Central		**108**			**5**	**71**	**17**
Minnesota		16			1	22	3
Iowa		14			2	4	14
Missouri		16			2	2	
North Dakota		5				8	
South Dakota		2				2	
Nebraska		5				6	
Kansas		50				27	
South Atlantic		**164**		**10**	**6**	**239**	**13**
Delaware		2				6	
Maryland		12				25	
District of Columbia		8				3	
Virginia		32		4	2	71	
West Virginia		11		1		41	
North Carolina		74		3	1	58	
South Carolina		2				3	5
Georgia		11		2	2	22	7
Florida		[2] 12			1	10	1
East South Central		**140**		**1**	**6**	**91**	**19**
Kentucky		51		1	2	31	9
Tennessee		67			3	21	6
Alabama		15			1	37	1
Mississippi		7				2	3
West South Central		**117**		**1**	**17**	**265**	**43**
Arkansas		1		1		44	3
Louisiana		3			1	1	1
Oklahoma		19				9	2
Texas		94			16	211	37
Mountain		**119**	**2**		**2**	**104**	**3**
Montana		2				7	
Idaho		21					
Wyoming						1	
Colorado		14				28	1
New Mexico		5			1	30	
Arizona		11	2			37	2
Utah		[2] 66			1	1	
Nevada							
Pacific		**239**			**23**	**82**	**1**
Washington		90			1	33	
Oregon		28				11	
California		[2] 121			22	38	1
Alaska		1				3	
Hawaii		2					

[1] Including cases reported as salmonellosis.
[2] Including cases reported as streptococcal sore throat.

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FOREIGN REPORTS

CANADA

Reported Cases of Certain Diseases—Week Ended Dec. 23, 1950

Disease	Newfoundland	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Brucellosis						1					1
Chickenpox	1		56		188	516	67	98	119	223	1,268
Diphtheria					3				1		4
Dysentery, bacillary					39	4				1	44
German measles	1		1		7	63		12	24	97	205
Influenza			18				1			3	22
Measles	13		2		255	1,369	32	4	7	38	1,720
Meningitis, meningococcal					1	1			1		3
Mumps	23		24		140	403	30	99	249	142	1,110
Poliomyelitis				1		1					2
Scarlet fever				1	67	37	13	11	68	35	232
Tuberculosis (all forms)	2		5	9	83	22	13	1			135
Typhoid and paratyphoid fever					7	2					9
Venereal diseases:											
Gohorrhea	3		9	4	35	48	24	22	32	45	222
Syphilis	5		2	4	35	20	4	3	1	12	86
Primary					3	6		2	1		12
Secondary				1	2	4		1			8
Other	5		2	3	30	10	4			12	66
Whooping cough	5		7	1	52	102	14		5	18	204

CUBA

Reported Cases of Certain Diseases—4 Weeks Ended Oct. 28, 1950

Disease	Pinar del Rio	Habana		Matanzas	Santa Clara	Camaguey	Oriente	Total
		Habana City	Total					
Brucellosis		1	2					2
Cancer	4		12	13	31	10	11	81
Chickenpox		1	1				1	2
Diphtheria	1	2	4	1	2			8
Leprosy			3	1	2	3	2	11
Malaria		2	3			3	5	11
Measles							3	3
Poliomyelitis		1	2	1				3
Scarlet fever				1				1
Tetanus						1		1
Tuberculosis	3		22	22	14	9	11	81
Typhoid fever	8	9	14	7	12	6	9	56

NOTE.—Report for provinces of Cuba for week ended Oct. 7, 1950, not received.

JAMAICA

Reported Cases of Certain Diseases—5 Weeks Ended Dec. 30, 1950

Disease	Kingston	Other localities	Total
Chickenpox	3	6	9
Diphtheria		2	2
Dysentery, unspecified	3	1	4
Erysipelas		1	1
Leprosy	1	2	3
Meningitis, meningococcal	2		2
Poliomyelitis		2	2
Tuberculosis, pulmonary	34	56	90
Typhoid fever	4	66	70
Typhus fever (murine)	3		3

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 special interest and the occurence 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

India (French). During the week ended December 23, 1950, 20 cases of cholera were reported in Karikal, and 8 cases were reported in Pondicherry.

Plague

Burma. For the week ended December 23, 1950, seven cases (nine deaths) of plague were reported in Burma. During the previous week there were eight cases (five deaths).

Madagascar. During the period December 11–20, 1950, 29 cases (21 deaths) of plague were reported in Madagascar as compared with four cases (two deaths) for the period December 1–10.

Smallpox

Algeria. During the period November 21–30, 1950, 24 cases of smallpox were reported in Algeria.

Burma. During the period December 10–16, 1950, 17 cases (3 deaths) of smallpox were reported in Burma.

Dahomey. For the period December 21–31, 1950, 48 cases of smallpox were reported in Dahomey.

Great Britain. Information from London states that a total of 32 cases (8 deaths) of smallpox have been reported in Brighton since November 28, 1950.

India. For the week ended January 6, 1951, smallpox was reported in ports of India as follows: Calcutta 423, Madras 54, and Bombay 19.

Pakistan. During the week ended January 6, 1951, three cases of smallpox were reported in Karachi.

Togo (French). During the period December 11–20, 1950, five cases of smallpox were reported in French Togo.

Typhus Fever

India. During the week ended January 6, 1951, six cases of typhus fever were reported in Bombay.

Yellow Fever

Brazil. During December 1950 approximately 20 deaths (number of cases unknown) from jungle yellow fever were reported in Uruacu, Goiaz State. The area is located in the interior of the State between the Tocantins and Araguaia Rivers. One death was histopathologically confirmed.

SMALLPOX IN BRIGHTON, ENGLAND

The primary case was in a vaccinated person who developed the disease 2 days after arrival by air from Karachi on the west coast of India. A total of 15 confirmed cases has been reported, with 5 deaths. It is stated that 5 nurses in a hospital for infectious diseases, where earlier cases were admitted, have been infected.