Study of Irregular Discharge TB Patients at San Francisco General Hospital

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THE IRREGULAR DISCHARGE patient has been one of the most complex and most troublesome problems of tuberculosis hospitals and tuberculosis control. Physicians have spent much time studying the problem and a variety of solutions have been offered. None has been completely adequate, although each has had some measure of success. The problem appears to be essentially the same throughout the country.

At San Francisco General Hospital the rate of irregular discharges of patients with active tuberculosis reached such alarming proportions during the 3 years 1952–54 that in 1955 it was decided to do a special study to determine, if possible, the characteristics of the group who left the hospital against advice; to find the underlying cause or causes of their leaving; and to suggest a solution or partial solution to the problem. The success of the newer chemotherapeutic regimens in shortening the period of hospitalization, with the resultant more frequent availability of empty beds, made it possible to concentrate on this serious institutional and public health problem.

Irregularly discharged patients at San Francisco General Hospital fall into two categories: patients who leave against medical advice by signing a release, and those who walk out before completing hospital treatment. The former was designated the AMA (against medical advice) group in this study, and the latter the AWOL (absent without leave) group.

Before 1955, any tuberculosis patient was allowed to leave against medical advice if he signed a prepared hospital release form. Before permitting him to sign this form, a member of the medical staff explained to the patient his condition, the necessity for and type of treatment recommended, and the inadvisability of terminating hospital care at this particular time. The patient was then permitted to sign a release and be discharged against medical advice. The practice has been altered since the study.

Now a patient is discharged as absent without leave from San Francisco General Hospital if he leaves the institution before completing hospital treatment, against or without medical advice, and without signing the release form. The AWOL patient leaves with or without the medical staff's being aware of the impending departure, and always without medical consent. These patients usually leave surreptitiously, most frequently during the night.

During the 3-year period (1952–54) there were 711 irregular discharges from San Francisco General Hospital, of which 434, or 61 percent, were against medical advice, and 277, or 39 percent, were absent without leave. Investigation into the history and background of these patients revealed that they were basically two distinctly different types of persons, and that each group had characteristics common and peculiar to itself.

The AMA Irregular Discharges

The first group was composed primarily of patients who had one, two, or occasionally three episodes of leaving the hospital against medical advice for short periods of time, but who always returned voluntarily to resume treatment. These patients were characterized by having

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had in common, upon first admission, problems which seemed to them more important than uninterrupted hospitalization. The problems were emotional, familial, financial, or a combination of all three.

Frequently, the patient was so overwhelmed by the diagnosis of tuberculosis that he had given no thought or made no preparation for the proper disposition of his personal effects, family or business affairs, and financial obligations before entering the hospital. The majority were hospitalized the day the disease was first diagnosed or suspected. A few weeks later the patient became cognizant of the fact that by following prescribed medical treatment he could expect to get well and resume his position in society. After the original shock subsided, the patient began to worry about various personal problems.

The majority of women in this group were housewives and mothers who were concerned with the well-being of their homes and families. Of frequent concern to the wife and mother, a few weeks or months following the original admission, was the position which the housekeeper was assuming in the home and family group. Once the patient had been reassured that she had not been displaced or replaced in the home, she returned to the hospital and cooperated in completing her treatment. Her male counterpart was concerned primarily with the well-being and financial integrity of his family. Once reassured that his wife and children were receiving adequate care, he returned to the hospital and remained as a cooperative patient. The rest of the group, usually unmarried or unattached, were concerned with the proper care and storage of clothes, furniture, or tools during hospitalization, with certain legal matters, or with making arrangements for previously incurred financial obligation.

During the 3-year period studied, the AMA group of 434 patients constituted 16.1 percent of total admissions (table 1). There were 265 males and 169 females, a ratio of 1.6 to 1 (table 2). At the time of AMA discharge, 104, or 24.2 percent, of the group had sputum positive for *Mycobacterium tuberculosis.*

Procedures initiated in 1955. The study revealed that many things could be done immediately to reduce the number of irregular discharges in this group, and in 1955, the findings were incorporated into a new program including the following procedures:

1. All personnel working with the patient before and immediately following hospitaliza-

Table 1. Total irregular and AMA [1] and AWOL [2] irregular discharges in relation to total admissions for 10 years (1952–61)

Year	Total admissions	Total irregular discharges		AMA irregular discharges		AWOL irregular discharges	
		Number	Percent of total admissions	Number	Percent of total admissions	Number	Percent of total admissions
1952	900	235	26.1	149	16.6	86	9.6
1953	923	289	31.3	187	20.3	102	11.0
1954	870	187	21.5	98	11.3	89	10.2
1955	845	92	10.9	12	1.4	80	9.5
1956	806	94	11.7	[3] 35	4.4	59	7.3
1957	849	57	6.7	13	1.5	44	5.2
1958	838	59	7.0	13	1.5	46	5.5
1959	743	33	4.6	5	.7	28	3.9
1960	696	42	6.0	[3] 17	2.4	25	3.6
1961	608	21	3.5	8	1.3	13	2.2
1952–54	2,693	711	26.4	434	16.1	277	10.3
1959–61	2,047	96	4.7	30	1.5	66	3.2

[1] Against medical advice (but having signed a hospital release form).
[2] Absent without leave (against or without medical advice and without having signed a hospital release form).
[3] Five wards were closed in 1956 and in 1960 for remodeling and renovation. An administrative decision permitted 23 selected patients in 1956 and 10 in 1960 to leave the hospital AMA and to be isolated and treated at home.

tion are asked to assist the patient with problems:

a) When hospitalization is first recommended, the chest clinic physician explains the disease to the patient, the proposed studies and treatment, the probable length of stay, the importance of continuous, noninterrupted therapy, the prognosis, and finally that the patient is expected to resume his usual place in society.

b) Unless specifically contraindicated, the patient is given 24 to 72 hours to arrange family, financial, and legal affairs. This time interval reduces problems to a minimum, and those which arise during hospitalization usually can be handled adequately with the assistance of the district public health nurse and the medical social worker.

c) The district public health nurse visits the home of every person in the county who has, or is suspected of having, tuberculosis, whether under private or public medical care. During the visit the home is evaluated for potentials for isolation of communicable tuberculosis, early home care, and the length of time the patient should remain out of this environment. The nurse attempts to determine what, if any, financial, educational, social, or emotional problems exist. She attempts to educate, counsel, and reassure the family group, and she arranges for examination of contacts. It is most frequently through the efforts of the public health nurse that the family is directed to the proper agency for assistance with problems. A complete written report is forwarded to the chief of tuberculosis control, and a summary is prepared for the patient's hospital chart.

d) The medical social worker within the hospital is the liaison between the hospitalized patient and the outside world. Only experienced workers, adept and interested in unearthing the problems of patients and in bringing about a satisfactory solution, are assigned to the tuberculosis division.

e) Nurses, ward attendants, teachers, occupational therapists, chaplains, and ancillary personnel in the hospital keep alert for signs of worry or emotional strain and report such findings to designated key personnel. Appropriate measures for assistance are thereby initiated early and before tensions mount to a point where the patient will leave against medical advice.

2. The family and the patient, individually and collectively, are thoroughly informed concerning tuberculosis. The public health nurse in the district and the nurse-educator in the hospital explain to the family the problems of the hospitalized patient, and to the patient the problems his absence may produce in the home.

3. No patient with tuberculosis is allowed to sign a release and leave the hospital against medical advice except:

a) Those whose tuberculosis is inactive

Table 2. AMA [1] and AWOL [2] irregular discharges, by sex and number with positive sputum

Year	Against medical advice					Absent without leave				
	Total	Male		Female		Total	Male		Female	
		Total	Positive sputum	Total	Positive sputum		Total	Positive sputum	Total	Positive sputum
1952	149	80	24	69	22	86	71	36	15	11
1953	187	120	27	67	14	102	79	34	23	6
1954	98	65	13	33	4	89	69	32	20	2
1955	12	8	1	4	0	80	52	14	28	6
1956	35	20	1	15	0	59	36	14	23	5
1957	13	10	0	3	0	44	31	9	13	1
1958	13	9	1	4	1	46	32	14	14	2
1959	5	4	0	1	0	28	24	7	4	3
1960	17	9	1	8	1	25	21	12	4	2
1961	8	6	0	2	0	13	10	7	3	2
1952–54	434	265	64	169	40	277	219	102	58	19
1959–61	30	19	1	11	1	66	55	26	11	7

[1] Against medical advice (but having signed a hospital release form).
[2] Absent without leave (against or without medical advice and without having signed a hospital release form).

and who have other medical or surgical conditions which require further treatment before they may receive a regular discharge.

b) Those whose tuberculosis has been stabilized and who have had repeatedly negative sputum or gastric cultures monthly for 4 or more months, but who, in the opinion of the attending staff, should have surgery before receiving a regular discharge. These are usually patients who have had one or more reactivations of tuberculosis, the major portion of their disease being well localized, but who have a destroyed lobe or segment or an open cavity and negative sputum.

c) Rarely, certain persons with terminal disease who "prefer to die at home," and, also, certain selected patients whose homes are suitable for strict isolation. Such cases are kept under close surveillance by the health department. It is medically more prudent to allow patients in these three categories to leave the hospital against medical advice rather than to give them a regular discharge. The simple procedure of not permitting patients to leave the hospital by signing a release, except when they fulfill these three criteria, combined with the cooperative effort of the entire staff in assisting patients with their problems, has reduced the AMA Irregular Discharge group to an irreducible minimum.

Reduction of AMA discharges. Evidence of the success of the new program in reducing AMA discharges is shown in table 1.

During 7 years of the new program (1955–61) 103, or 1.9 percent, of the total admissions were discharged against medical advice; males predominated over females by a ratio of 1.8 to 1, or 66 males to 37 females. Furthermore, only 6, or 5.8 percent, had sputum positive for *M. tuberculosis* at the time of discharge (table 2).

When the 3-year periods 1952–54 and 1959–61 are compared, the results of the program stand out: the AMA irregular discharges decreased from 16.1 percent of the total admissions in 1952–54 to 1.5 percent in 1959–61.

The AWOL Irregular Discharges

The AWOL group was found to have entirely different characteristics from the AMA group. Patients absent without leave were predominantly single or unattached, were frequently alcoholic, and often had a long history of emotional problems, evidence of antisocial behavior, poor work habits, and usually long police records.

During the 3-year period of 1952–54 males predominated over females in this group by a ratio of 3.8 to 1, or 219 males to 58 females. At the time of irregular discharge, a recently positive sputum had been obtained from 102, or 46.4 percent, of the male patients and from 19, or 32.8 percent of the female. The age of the group ranged from 21 to 60 years, the majority (63 percent) being less than 46 years. Alcoholism was a problem to 67 percent, and was a greater problem among the men than the women. Only 23 percent of the group were married; 26 percent were single; 51 percent were separated or divorced. The occupational history revealed a poor work record with frequent changes in employment, usually in the unskilled and untrained labor market. Evidence of emotional problems and antisocial behavior was found in a large number of the group, exemplified by numerous arrests. Many had a long history of recidivism, usually for misdemeanors but occasionally for felonies. Arrests were most frequently for drunkenness, vagrancy, begging, and disturbing the peace. However, a significant number had been arrested for felonies: assault with a deadly weapon, manslaughter, and murder. A few had received psychiatric treatment in State and private mental hospitals.

It was found that 66 percent of the group had left the hospital within 3 months of admission, but that the alcoholic male who remained more than 4 months frequently remained to complete hospital treatment.

The men who remained until regularly discharged were most often in an older age group, single or unattached, without a home or a place to go, without a trade or a job; they finally decided it was better to accept the security and shelter of the hospital than to return to their former precarious existence.

Efforts to control AWOL group. Many attempts had been made in the past to establish better control over the AWOL group, but efforts were unsuccessful except in individual instances. Returned patients were offered, with-

out discrimination, all the services available to other patients. Punitive action was not taken at the General Hospital, but many patients were incarcerated at the State Medical Facility through court action, following an AWOL irregular discharge.

The State of California, through its Health and Safety Code, empowers the health officer to legally isolate any person known or suspected to have active tuberculosis in a communicable form. The place of isolation is usually a hospital or sanatorium, but it may be elsewhere if this is considered adequate or necessary for the protection of the health of the community. The health officer, furthermore, may stipulate, in the legal order of isolation, certain conditions for the protection of the public health and the health of the individual so isolated. Any person legally served with such an order of isolation who violates it or any of the conditions stipulated therein, is guilty of a misdemeanor which is punishable by 6 months in jail or a $500 fine or both. Any subsequent violation is punishable by 1 year in jail. Since only one county has adequate jail-hospital facilities for the treatment of patients with tuberculosis, the patients convicted of violating a legal order of isolation are usually sentenced to the California State Medical Facility, a maximum security prison. They are the only misdemeanants admitted to that institution.

During hospitalization at the State Medical Facility, the patients receive excellent care from qualified medical specialists. In addition, they are unable to obtain alcoholic beverages and are kept on medication for an uninterrupted 6-month period. At the completion of the sentence the prisoner is returned to the county by the sheriff, and, in San Francisco, is rehospitalized under an order of isolation at the General Hospital for evaluation. If the disease is found to be active and communicable, the patient is kept in the hospital under an isolation order. If the disease is active but with repeatedly negative sputum cultures for 3 or more months, further hospitalization may be recommended, but the order of isolation is removed. If the disease is found to be inactive and the patient can be adequately treated outside the hospital, he is discharged to the chest clinic.

Frequently, following discharge from the State Medical Facility, patients had a markedly belligerent attitude toward the hospital staff and the health department. Since the majority did not want to be imprisoned again, they adhered to the rules and regulations but only to the absolute minimum. They were antagonistic and resistive, fomented discord, distrust, and discomfort among other patients, and frequently incited some of the more easily led individuals to open rebellion and to going AWOL. An atmosphere of unpleasantness and unhappiness soon permeated any ward in which these persons were placed. They had returned from their incarceration and punishment not improved or mollified, but worsened in outlook, attitude, and reaction to enforced treatment. This method of resolving the problem was successful in removing the recalcitrant infected individual from society and protecting the public health, but it failed in the basic problem—the patient himself.

Procedure initiated in 1956. The changes introduced in 1955, which were immediately effective in reducing AMA discharges, had no appreciable effect upon the AWOL irregular discharges. It was not until a specially designed procedure for this particular group was initiated in 1956 that any improvement was noted.

Since January 1956, every person with active tuberculosis and a recently positive sputum or gastric lavage who is not under medical supervision and who has a history of being absent without leave is placed in San Francisco General Hospital under an order of isolation. Such action results in better control of the disease in the community and at the same time gives a legal hold over the recalcitrant patient. If the patient fails to cooperate, hospitalization can be enforced for at least 6 months. Many are thus rendered noninfectious and can be treated as outpatients at the chest clinic. Although this entire group had been antagonistic toward hospitalization up to 1956, many were fairly cooperative in reporting to the outpatient department. They kept their appointments fairly regularly when not in jail, although they frequently presented themselves in various stages of acute or postacute alcoholism.

Within the group, early in 1956, were a large

number of veterans who were receiving government compensation and who had had numerous admissions and irregular discharges from the Veterans Administration hospitals. These persons had been a problem not only to the Veterans Administration but also to local health departments. The Veterans Administration, in a public health sense, does not have any legal hold on the veteran; the power of isolation belongs to the local health jurisdiction. Although this power may be delegated to a designated physician in the VA hospitals, it is the policy of that organization not to place itself "in the position of being a policeman."

The veteran with service-connected tuberculosis receives compensation, not a Federal gratuity, and is entitled to compensation whether he complies with hospital instructions or not. He may leave the hospital any time he chooses, either by signing out against medical advice or just walking out. No disciplinary action is taken, except that he may not reenter a VA hospital for 90 days. However, should an emergency arise, the patient may be readmitted immediately.

The veteran with nonservice-connected tuberculosis receives a Federal gratuity when treated by the Veterans Administration and must comply with all its rules and instructions or lose his privileges.

Before the new program was instituted, the recalcitrant, alcoholic, irregularly discharged veteran with active tuberculosis who migrated to San Francisco usually lived in cheap hotels, frequently in the skid row section, and ate in the poorer restaurants. In this environment he assumed a position of relative importance by supplying a few bottles of cheap wine to close associates every "payday." The loyalty of friendship so purchased made this type of veteran-patient the most difficult person to find in this small area of 10 city blocks.

When the control program was tightened in January 1956, veterans with active communicable tuberculosis were placed in San Francisco General Hospital under an order of isolation, along with other known or suspected communicable cases. Many of the veterans proceeded to leave the hospital shortly after admission, before receiving a regular discharge. The legal force of the program was then set into motion. These veterans were apprehended by the police with a warrant for their arrest for violation of the State Health and Safety Code.

Before his court appearance the veteran recognized the seriousness of the situation: When convicted, which he surely would be, he would be sent to prison for 6 months. The veteran wanted to avoid this if possible, and requested transfer to a VA hospital, promising to remain there until regularly discharged. Since the health department was interested primarily in the treatment of the patient for tuberculosis and in control of the disease in the community, it was agreed that following conviction, the judge would be asked to place the veteran on 2 years' probation. The conditions of probation were that the patient abstain from alcoholic beverages while hospitalized; remain in the hospital, under treatment, obeying all instructions until regularly discharged; and following discharge maintain treatment as an outpatient until released by the health department.

The veteran on probation was returned to the General Hospital to await transfer to a VA hospital. The usual time required for such a transfer in nonemergencies is from 2 to 4 weeks. During the waiting period a marked change in attitude would be noted. The veteran-patient was no longer rebellious and antagonistic, but cooperative, cheerful, and apparently accepting hospitalization. After several such experiences, it was decided to try the same procedure with some of the nonveteran recalcitrant AWOL patients. They, too, were placed on probation for 2 years if convicted of violating an isolation order. The results were similar.

Results with AWOL group. During the 6 years of the new program (1956–61), 215 patients, or 4.7 percent of the total admissions, have been irregularly discharged as AWOL; males predominated over females by a ratio of 2.5 to 1, or 154 males to 61 females. At the time of the irregular discharge 78, or 36.3 percent of the group, had sputum positive for *M. tuberculosis*: 63, or 40.9 percent, of the males and 15, or 24.6 percent, of the females (tables 1 and 2).

When the 3-year periods 1952–54 and 1959–61 are compared, the results stand out sharply:

the AWOL irregular discharges decreased from 10.4 percent of the total admissions in 1952–54 to 3.2 percent in 1959–61.

Discussion

During the study it was found that persons in the AMA group sincerely desired to be cooperative but that they were improperly prepared for prolonged hospitalization. Many of the problems that caused them to leave against advice could be eliminated by allowing them 24 to 72 hours to arrange personal affairs before entering the hospital and by detailed and careful explanation and interpretation by the chest clinic physicians. When preconceived mistaken ideas have been eliminated, tensions and doubts relieved, and misinformation corrected, the patient has an opportunity to make proper plans for the future. Just as no intelligent person suddenly leaves on a prolonged trip without making necessary arrangements, it is even more important to make preparations when one is to be removed for months from family, friends, occupation, and sources of income.

There is no evidence that the delay in admission has been abused or that the health of anyone has been injured or endangered. Close associates of the immediate family group are usually the only persons exposed during the delay between diagnosis and hospitalization. Since these persons have been exposed repeatedly during the weeks, and often months, before the diagnosis, an additional day or two does not markedly increase their risk. Furthermore, contacts are followed closely by the health department, and exposed children with positive tuberculin reactions are treated.

The effectiveness of the program for the AMA group became apparent immediately in the changed attitude of newly admitted patients and is demonstrated statistically in tables 1 and 2. During 1952–54, 104 patients with sputum positive for *M. tuberculosis* were irregularly discharged against medical advice, in contrast to only 6 patients with positive sputum during the 7 years 1955–61. Furthermore, those six patients were isolated at home under strict surveillance of the health department, whereas the 104 patients of 1952–54 moved freely in the community until returned to the hospital. Before 1955, many new cases of tuberculosis were traced directly to the AMA group, but since that time no new case of tuberculosis or of a tuberculin converter has been traceable to a patient discharged AMA from the General Hospital.

Persons in the AWOL group have entirely different characteristics. Deep-rooted, long-standing emotional and social problems preceded the onset of tuberculosis by years, so that this disease and the hospitalization are not the underlying causes of their behavior. Tuberculosis is but one more in a long series of catastrophes in their lives.

Alcoholism and tuberculosis have often been discussed as though there is a direct cause and effect relationship. A thorough review of the tuberculous patients at San Francisco General Hospital reveals that 35 percent may be classified as alcoholic. However, if one accepts the definition of an alcoholic as a person whose drinking habits interfere with his social, emotional, or occupational well-being, then this figure can be reduced to 28 percent. Furthermore, it was found that the alcoholic tuberculous patients could be divided into three groups:

1. Patients whose drinking habits do not interfere with their social, emotional, or occupational existence in the community. These persons usually live in apartments or the less expensive downtown hotels and have good jobs or trades to follow after hospitalization. Some are pensioners. None have been arrested as a result of drinking. This group, representing 7 percent of the patients, are cooperative and remain in the hospital until regularly discharged.

2. Patients who have a severe drinking problem outside the institution but who are cooperative and do not drink during hospitalization. These patients will remain until regularly discharged but will begin drinking again as soon as they return to the community. The majority live in skid row, have deep-rooted emotional problems, are passive and dependent, have poor work records, and are unable to cope with the pressures of living outside an institutional environment, even in skid row. This group welcomes a reactivation of tuberculosis, because it means a return to the clean protective environment of the hospital for 6 months or longer.

A small number of these patients were placed in the welfare department's single men's rehabilitation center for 6 months to 1 year following hospitalization. During the entire period they were cooperative and hard working but returned to their former drinking habits upon discharge. Apparently, the alcoholic and tuberculosis problems of this group can be controlled only by indefinite institutionalization, perhaps for life.

3. Patients whose drinking habits are a serious source of interference with their social, emotional, and occupational well-being in the hospital and in the community. Nearly all have long histories of frequent arrests, usually for misdemeanors, but several had been arrested for felonious assault, manslaughter, and murder. This group includes the hard-core alcoholics and represents 67 percent of the AWOL irregular discharges.

In the hard-core group many had not completed the eighth grade, but a few had finished high school, two had attended college, and one was a college graduate. Only three were trained for a trade or a skilled job; two of these are dead from tuberculosis which was made worse by severe bouts of drinking, and one remains hospitalized. Of the three with college education, two rehabilitated themselves after being placed on probation by the court. It is interesting that although the three had been alcoholics for years, none had been arrested for a crime other than that related to excessive drinking. They differed from the remainder of this group in the degree of education, the pattern of arrests, and the lack of a belligerent or antagonistic attitude. Apparently the threat of being sent to prison for violation of an isolation order was sufficient motivation for two of them to reevaluate and rehabilitate themselves.

The remainder of the hard-core group acted as though they were "mad at society" and in the hospital presented moderate to severe behavioral problems. As outpatients they continue their nonconformist behavior but keep their appointments fairly regularly when not in jail, although many do so in various stages of acute or postacute alcoholism. These persons have no sense of obligation to protect the community from tuberculosis, since, in their opinion, society has singled them out and treated them unfairly for many years. Prolonged hospitalization with its restrictions is merely one more unjust encroachment of society upon their freedom and their rights.

Until 1956, when violation of an isolation order was promptly punished by 6 months to 1 year in prison, this group had looked upon the health department as an arm of the law, the hospital as a jail, the medical staff as policemen, and the nurses as jailers. The group as a whole was belligerent and antagonistic and spread discord and unhappiness in any ward in which they were placed. They made life almost unbearable at times for cooperative patients, but their hostility and uncooperativeness was directed primarily at the health department and its personnel.

Since the policy of placing these patients on probation for 2 years following conviction for violation of an isolation order has been established, their attitude and behavior in the hospital and toward the medical and nursing personnel has been completely reversed. A normal doctor-patient and nurse-patient relationship has developed, and the health department is now regarded as a friend trying to help them. One of the important factors in the success of the program has been the conditions of probation established by the court: abstaining from alcoholic beverages while in the hospital; remaining hospitalized until regularly discharged; and reporting to the chest clinic as directed.

During the 6 years 1956–61 there have been 10 violations of probation by nine patients, all of whom were hard-core alcoholics. Of the nine patients, eight were sent by the court to the State prison for 6 months for violation of probation; the ninth patient was sentenced to 6 months for the first offense and to 1 year for the second. Two of the nine patients are dead, one from acute alcoholism and the second from massive pulmonary hemorrhage due to tuberculosis. The patient with the hemorrhage had a minimal lesion when first diagnosed. This progressed to far-advanced bilateral disease with multiple areas of cavitation during repeated breaks in therapy, AWOL irregular discharges, and extremely long bouts of heavy drinking. One patient is alive with inactive tuberculosis and

has been discharged from the hospital for almost 2 years, although he is more frequently in jail for drinking than free in the community. Six patients are still hospitalized. The one patient who violated probation twice has no insight into his problem or his disease; he has gradually developed marked cerebral deterioration as a result of alcoholism; his disease has been active with positive sputum for 6 years and has progressed from minimal to far advanced.

It is the opinion of the preventive medical and institutional divisions of the health department that a law which will restrict the activities of isolation violators who have active communicable tuberculosis is necessary. However, any arbitrary, careless, discriminatory, or punitive misuse of it must be avoided. In some health jurisdictions, all patients with active tuberculosis are hospitalized under an order of isolation, so that all violators may be sent to the State prison. However, in many places only the recalcitrant, uncooperative, or ignorant patient is hospitalized under an isolation order.

In San Francisco, any patient who is being treated at home for active communicable tuberculosis receives an isolation order and is kept under strict surveillance by the health department. In addition, patients at the General Hospital who leave with an irregular discharge or who wander from the hospital for short periods of time have their activities restricted by an order of isolation. Therefore, when a patient from the General Hospital is taken to court for a violation of an order of isolation he has had at least one previous irregular discharge.

In 1961, there were 13, or 2.2 percent, AWOL irregular discharges among 608 admissions, which probably is almost an irreducible minimum. However, far more significant than the mere decrease in numbers or percentages are the human effects of the program: the development of proper doctor-patient, nurse-patient, and health department-patient relationships, and the disappearance of belligerent, antagonistic, and uncooperative attitudes in patients, especially in the hard-core alcoholics. Although the patients retain their antisocial behavioral problems, their hostility is no longer directed toward the health department and its personnel. As a matter of fact, many of these patients become cooperative and contribute to the development of a better environment on the wards.

An effective control program, which aims to completely control and ultimately to eradicate tuberculosis within a community, must take into consideration the total patient. This includes, in addition to the disease, emotional, social, cultural, and ethnic factors. Pharmacologically, treatment may be similar or identical for the majority of the cases, but total treatment for the individual requires an understanding physician who will attempt to view the patient in terms of the patient's social, cultural, and ethnic background. Control of tuberculosis demands maintaining the control and cooperation of tuberculous patients. The effectiveness of a program tailored to meet the needs of the individual patient is demonstrated by this report.

Summary

A 10-year study (1952–61) of the irregularly discharged tuberculosis patients at San Francisco General Hospital points to a possible solution for management of these patients. From 1952 to 1954, 26.4 percent of all admissions to the tuberculosis section received an irregular discharge; this was reduced to 3.5 percent in 1961.

The program that was developed satisfactorily resolved the recalcitrant hard-core tuberculous alcoholic problem by having the courts assume their rightful legal responsibility for the proper isolation of the infectious recalcitrant individual. This resulted in a change in the role of the medical staff from that of policemen to that of physicians and nurses, with resultant improved patient-physician and patient-nurse relationships.