Success of Outpatient Clinics Tied to Human, Social Factors

Recommendations that can have a far-reaching effect on outpatient services in tuberculosis control programs were outlined at a special conference on the followup and supervision of tuberculosis patients and potential patients, held February 16–19, 1965, in Chicago. Public health workers will note that many of the recommendations are adaptable to programs other than tuberculosis, and, if implemented, could have an impact on operation of clinic services in a variety of settings.

At the conference, called by the National Tuberculosis Association, not only the medical problems of what to do for the patients were considered, but also the social and human problems of how to do it. Caseholding, it was pointed out, is now becoming as important in tuberculosis control as casefinding, since control methods require intermittent contact with persons for years and often for a lifetime. As one speaker said, "We are interested not only in developing programs but also in developing the means to make these programs work."

The Arden House Conference in 1959 stimulated improved treatment of tuberculosis by recommending intensive chemotherapy and other medical procedures, and it brought into view the concepts of tuberculosis eradication. The 31 invited participants at the 1965 Chicago conference concentrated on how to get these effective treatment measures to the persons who need them now and to those likely to need them in the future. The primary problem in tuberculosis today, they said, is followup care and supervision of persons with presently active or recently active cases of disease; of household and other close contacts of persons with active cases; and of persons suspected of tuberculosis activity or at high risk of developing such activity. We need facilities and services such as outpatient clinics, public health nursing visits, and care by private physicians, the conferees said, but we also need to know more about the patients themselves in order to gain and keep their cooperation throughout long-term outpatient treatment programs.

Behavioral scientists, administrators, and health educators joined physicians and nurses in scrutinizing the successes and failures of outpatient clinic operations and in analyzing the possible reasons for either outcome. As a result, many of the recommendations centered around the premise that medical advances have been made and should be utilized to capacity, but that tuberculosis workers should now become more aware of the human being harboring the tubercule bacillus—his attitudes, beliefs, values, and feelings. Underlying many of these recommendations was the suggestion that clinic personnel look at themselves and their own attitudes to see if they themselves are creating barriers to patient cooperation, and perhaps there was an admonition to look at the patient as a person rather than as a case, a chart, or a statistic.

Three speakers set the stage for the discussion sessions that followed. Dr. David J. Sencer, deputy chief of the Communicable Disease Center, Public Health Service, Atlanta, Ga., reported on current trends in outpatient services, citing statistical data from 31 areas where special tuberculosis project grant programs are in operation. Using three bases for evaluating the supervision of patients with active tuberculosis in those 31 areas, he said that 62.5 percent of these patients were known to have had a bacteriological examination during the previous 6 months; slightly less than one-third

were overdue for X-rays and medical examinations (one-tenth of the active cases had not been examined in more than a year); and 86 percent currently were receiving drug therapy.

Dr. Francis J. Curry, assistant director of public health, San Francisco Department of Public Health, analyzed problems and solutions from the agency point of view. He showed how changing the attitudes and policies in the outpatient clinic program in San Francisco had made the clinics more accessible and more acceptable to patients with tuberculosis problems. "We took the stand," Dr. Curry stated, "that the agency did not exist for the agency itself—that it existed for the patients, and, therefore, the philosophy of our activities was to provide patient services and to try to get a job done."

Analyzing health problems and their solution from the patients' point of view, Dr. Julius A. Roth, department of sociology and anthropology, Boston University, pointed out that patients being served in clinics do not hold the same values or have the same goals as persons working for the clinic; in many cases the patients do not see at all the value of the clinic. He said that if we want patients to attend clinics and to take part in other aspects of tuberculosis control or other health programs, we may have to cater somewhat to them, much as competitive businessmen must cater to the public in order to get customers. Dr. Roth deplored the lack of research on tuberculosis outpatient clinics and suggested studies of the clinic operation, location of patients, patients' perceptions, and of the outpatient career as helpful beginnings in analyzing the overall treatment problem.

After the keynote session, conferees met in small groups to discuss problems and possible solutions and to develop preliminary recommendations which were later submitted to the entire group for final action. Some were approved, some were rejected, some were revised, and some were combined with similar proposals in order to avoid ambiguity or duplication.

The National Tuberculosis Association will publish and distribute in June 1965 the full list of conference recommendations and the supporting material. In this issue of PUBLIC HEALTH REPORTS we are attempting to report what we perceive to be the conferees' major recommendations, not necessarily in the order of their importance or priority, and to mention a few of the points discussed in considering them.

Recommendations

1. **Minimal services.** The following minimal services should be made available for all tuberculosis patients, contacts, suspects, and other persons at high risk: tuberculin testing, chest X-rays, sputum examinations including cultures, consultation with a physician having training in tuberculosis, and chemotherapy.

All patients and potential patients should receive an adequate initial medical evaluation, as well as procedures, such as X-rays, sputum cultures, and diagnostic skin testing and serology for fungal diseases and atypical mycobacteria, that will enable the physician to arrive at a definitive diagnosis and classification within 3 months.

The same medical standards should apply to all clinics, whether located in an urban or rural area. Differences in practices should depend on feasibility and the personnel available to do the work.

2. **Patient relations.** A physician should see each patient or potential patient on first referral to a clinic and at appropriate intervals thereafter; adequate physician and nursing time should be allotted for each patient. During scheduled clinic hours, the physician needs to be available for all patients who want to see him.

Every effort should be made to assure a long-term personal relationship between patient and physician and between patient and nurse. Attitudes of clinic personnel should reflect personal concern for each patient's welfare. Discussion on this point included advocating that the physician be sure the patient understands his disease, treatment, and progress and receives an explanation for any changes in treatment.

Scheduling should provide services with a minimum of inconvenience for the patient. The clinic appointment system should be designed to save him undue waiting. Location and timing of clinics should be based on the needs of patients rather than the convenience of staff. This may require special incentives

if staff members are required to work unusual hours. The location of clinics to meet patients' needs should take into consideration the living, travel, and trading patterns in the community rather than be dictated by political boundaries. Patients with conditions co-existing with tuberculosis should be cared for in the chest clinic insofar as possible, or referral should be made and communications maintained with the appropriate physician or clinic.

3. **Interagency communication.** Lines of communication should be established and maintained among all agencies involved in the care of patients, including hospitals, clinics, welfare departments, rehabilitation departments, public health nursing services, and others. Examples of specific ways to do this might be by using social service workers as liaison and through interagency case conferences, predischarge conferences, and special consultations.

4. **Laboratory services.** All initial sputum specimens should be submitted to a highly competent centralized laboratory for culturing, testing of drug susceptibility where necessary, and identificiation of atypical mycobacteria. When such full analysis is not immediately possible, all specimens should be cultured and initial cultures stored for an adequate period until determination of therapeutic responses is established. (Warm aerosol should be used as a routine procedure for collecting sputum when sputum is not readily available.) In order to provide these refined bacteriological studies, it may be necessary to provide laboratory services on a regional basis rather than in local areas.

Provisions should be made for keeping physicians and laboratory technicians abreast of developments in mycobacterial techniques.

5. **Priorities.** Definite priorities should be established and followed for medical supervision of various groups. Those needing services are: persons with active cases, including primary active; persons with inactive or with quiescent cases for whom drug treatment has been recommended; all of the recent converters (within 1 year) regardless of age; reactors under 4 years of age; contacts to persons with active cases; tuberculosis suspects; persons with inactive cases not under drug therapy; and other persons at high risk of exposure to tuberculosis.

The application of these services should be based on the American Public Health Association's "Guide for Followup of Tuberculosis Cases, Contacts, and Suspects" (1963). Also available as a guide is the National Tuberculosis Association's "Tuberculosis Handbook for Public Health Nurses" (1965).

6. **Barriers to treatment.** Artificial barriers impeding receipt of treatment and services by those in need of them still remain an inexcusable obstacle to tuberculosis control. Services necessary for tuberculosis control should be made available to all persons who need them regardless of their ability to pay or their legal residences. These services should not be withheld as a means of punishment.

The NTA should prepare a report on the experience of communities where residence and financial requirements for tuberculosis treatment have been removed, for the benefit of those who, for example, might wish to use the information in advising legislators and other officials.

7. **Standards.** A chest clinic manual, including adequate standards, should be prepared by the NTA to give guidance in the upgrading of clinic operations. Until such standards are available, recommendations of this conference can be applied as interim guidelines.

8. **Studies of social aspects.** The treatment of tuberculosis over long periods on an outpatient basis is practical, but the patient must assume a large part of responsibility for his treatment if it is to be effective. To make certain that this happens, the social and behavioral barriers to adequate outpatient treatment need to be studied as intensively as have the medical aspects of the disease. Such study, the group said, can help bridge the gap between the medical knowledge available and its full utilization in treatment. Pertinent discussion on this recommendation centered around the patient's perception of clinics and on attitudes of the personnel who staff them.

9. **Demonstration and training.** A number of demonstration and training centers should be established in existing or new clinics. In these centers, studies will need to be made of the social and behavioral patterns that influence

the effectiveness of outpatient treatment and of the design of effective outpatient programs. Studies also should be made of other factors in effective clinic operation, including staffing patterns and recordkeeping.

Such centers also should serve for training program directors and staffs of other tuberculosis clinics. The NTA should explore with the Public Health Service and other appropriate agencies and groups the feasibility of using special project grants for operation of these centers and of using Service training funds for the training function. Conferees pointed out that they did not necessarily advocate construction of a series of new facilities throughout the country. They urged, wherever possible, use of successful, existing clinics that could be adapted for demonstration and training purposes.

Regional conferences should be held in which information gathered by the demonstration centers can be used in the education of additional personnel of tuberculosis clinics as well as of those officials responsible for policies of such clinics. Here the discussion emphasized that reorienting the staff to new procedures and attitudes would have limited effectiveness if the top administrators and policy-makers were not also reoriented.

10. **Goals and standards.** The Public Health Service manual, "Goals and Standards for Eliminating Tuberculosis," should be used to determine whether services for patients and potential patients are effective for the community in which they are applied. The manual should be reviewed periodically so that it will continue to provide a stimulus for tuberculosis control efforts.

11. **Self-evaluation.** Tuberculosis clinics should conduct evaluations of their own operations. The following criteria may be used as a guide until such time as specific standards are established:

- Services of the clinic shall be available to all persons with tuberculosis in the community.
- Each patient shall have an adequate share of physician and nursing time.
- Scheduling of appointments shall be for the convenience of the patient, and therefore designed to save him unnecessary waiting time.
- Data shall be collected (with the patient regarded as the best source of information) on such items as the percentage of broken appointments, of clinic patients whose treatment has lapsed, and of patients discharged from the hospital for continuing care in the clinic who do not have their first clinic visit until more than 30 days after hospital discharge. It was pointed out that these percentages may be watched as informal indices of effectiveness and that any apparent imbalance should be investigated.

In time these and the other recommendations of the conference may stimulate advances in the operation of outpatient tuberculosis clinics just as the Arden House Conference stimulated advances in the medical treatment of tuberculosis. A look at the recommendations may well motivate program directors in a variety of clinic settings to appraise carefully their services and operations.—K.K.

Alcoholics in Mental Hospitals

The National Institute of Mental Health, Public Health Service, reports that one in seven patients newly admitted to State mental hospitals is an alcoholic, an 18 percent rise in 10 years. In nine States, disorders associated with alcoholism lead all other diagnoses in mental hospital admissions, according to the study conducted by the institute's Office of Biometry.

Recent figures also show that more than half of the alcoholics now in mental hospitals have a diagnosis of "chronic brain syndrome associated with alcoholism," the most severe and hopeless of the three classifications of the disease. This represents a 50 percent increase in patients with the irreversible form of alcoholism, occurring while the number of patients in public mental hospitals dropped from 531,981 in 1952 to approximately 495,000 today.