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UNIVERSITY OF LOUISVILLE

A STUDY OF FORTY-THREE PATIENTS WHO LEFT
WAVERLY HILLS SANATORIUM
AGAINST THE DOCTOR'S ADVICE
DURING THE PERIOD
SEPTEMBER 1 THROUGH DECEMBER 31, 1942

A Dissertation
Submitted to the Faculty
Of the Graduate School of the University of Louisville
In Partial Fulfillment of the
Requirements for the Degree
Of Master of Science in Social Administration

Graduate Division of Social Administration

By

Frances Fanelli

Year

1944

NAME OF STUDENT: Frances Panelli

TITLE OF THESIS: A Study of Forty-three Patients
Who Left Waverly Hills Sanator-
ium Against the Doctor's Advice
During the Period September 1
Through December 31, 1942

**APPROVED BY THE READING COMMITTEE COMPOSED
OF THE FOLLOWING MEMBERS:**

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NAME OF DIRECTOR: John J. Cronin

DATE: 6/9/44

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INTRODUCTION

INTRODUCTION

Purpose of the Study

Why do patients leave tuberculosis sanatoria against the doctor's advice? This study of home conditions of patients who left Waverly Hills Sanatorium, Waverly Hills, Kentucky, against the doctor's advice is an attempt to answer that question. We believed that by studying data regarding age, sex, occupation and marital status of the patients who left against the doctor's advice, the Sanatorium and the community could come to some understanding of the reasons for the patient's actions. How many patients were leaving against the doctor's advice? What was the size of the problem? Did these patients have active or arrested cases of tuberculosis? How many were in need of help from social agencies at the time of discharge or at the time of admission? Were they a source of infection to the community? How long did they stay at the Sanatorium? Were the reasons the patients left within the control of the Sanatorium or beyond the control of the Sanatorium?

Other questions were those in connection with the patient's ability to adjust within the community to which he had returned. What clinic supervision did they have after

leaving the Sanatorium? What follow-up was there by the Sanatorium? Did they return to work? If so, was it injurious to their health? What was the patient's attitude toward his family? To what kind of homes did they return? These and many other questions as well entered into the initial thinking on the study. Dr. Brock, Medical Director of Waverly Hills, hoped that interviews with these patients to secure their reasons for leaving would disclose the underlying factors of the problem.

Method

After checking figures at Waverly Hills regarding the total who left Waverly Hills against the doctor's advice, we decided to visit those who left during the period September 1, 1942 through December 31, 1942. This decision was reached as it was closest to the time that we were able to visit and it was thought that there would be less time elapsed between the time the patient left Waverly Hills and the time of the home visit, than if those who left earlier in the year were selected. The number who left during this period, September through December, 1942, totaled sixty-eight.

Using as a guide, the schedule of the National Tuberculosis Association in "A Study of Patients Discharged Alive from Tuberculosis Sanatoria in 1933",¹ an experimental schedule was drawn up and the fifteen who left during the month of December, 1942, were visited.²

When these visits were completed, the schedule was revised.³ There seemed to be little use for the question regarding the female's maiden name, and it was omitted in the revised schedule. We originally thought it might be helpful for identification purposes for clearing through Social Service Exchange, or some similar function, but this did not prove to be the case. In making the revision, additional questions were added regarding the problems in the home, as it was noted that the patients brought out points regarding home conditions that were not covered in the original schedule.

¹Jessamine S. Whitney and Mary V. Dempsey,
"A Study of Patients Discharged Alive from
Tuberculosis Sanatoria in 1933".
National Tuberculosis Association Research
Series No. 8 (National Tuberculosis Associ-
ation, 1942) p. 55

²Cf. Appendix A

³Cf. Appendix B

Data concerning age, case number, admittance address, sex, color, occupation at the time of admittance, dates of admission and discharge, diagnosis on admission and discharge, condition on discharge, and sputum on discharge was secured from the Sanatorium's Book of Admissions and Discharges. Marital status, education, employment history, previous and subsequent admissions and discharges, family composition, financial status of the family, problems in the home, sources of income, home conditions and medical supervision since discharge were secured from the interviews with the patients, or friend or relative. Verification of previous and subsequent admissions and discharges were found on the face sheet of the patient's medical chart at the Sanatorium. The number of days the patient was in the Sanatorium was also found on the face sheet.

On the basis of the data secured at Waverly Hills, it was decided to make no attempt to reach ten of the sixty-eight patients as eight of them lived outside of the city limits, and two of them were erroneously listed as LOA (left own accord) the term used by the Sanatorium to classify those who left against the doctor's advice.

In addition to the ten mentioned above, fifteen others were omitted after attempts to reach them were made without success. Nine of these fifteen had moved and their whereabouts

could not be traced. Three had returned to Waverly Hills and had died before an interview was held and two others had moved out of the city. It was not possible to locate anyone for information regarding those who died at Waverly Hills.

We were able to obtain data on forty-three patients and this number is used for the analysis of the findings. A total of sixty-five visits were made on these forty-three patients. On twenty-three patients, it was necessary to secure the information from someone other than the patient because the latter either was not at home at the time of the visit, or he had moved out of the city, or the patient had died, or for some other reason. The information on the four patients who had died was obtained from relatives. Twenty interviews with patients were held. Additional steps were made to secure data through the Social Service Exchange. Twenty-nine of the forty-three patients were identified by the Exchange. Reports from the Tuberculosis Clinic were secured on twenty patients.⁴ Information on other thirty-five members of the patient's family was obtained from the Tuberculosis Clinic. Reports were received from private physicians when the patient indicated he had had follow-up treatment from this source. Information regarding problems existent in the home at time of discharge and other similar data was secured from records of social agencies the patient or his

⁴Cf. Appendix C

family may have known. It was not always possible to get data from the sources mentioned above so that some questions on some of the schedules necessarily remained unanswered. When a relative or a friend was interviewed, information on the patient's education, or some similar points sometimes was not known. In these instances, these questions were not answered on the schedule.

The aforementioned study made by the National Tuberculosis Association on patients discharged in 1933 was used throughout this study for comparative purposes. Articles from newspaper clippings were a source of data. Facts on the history of Waverly Hills were taken from unpublished material "Waverly Hills" compiled by Mr. W. R. Livermore, Hospital Administrator at Waverly Hills. Letters were written to the National Tuberculosis Association in New York, and to the Vocational Rehabilitation Division, United States Office of Education, Washington, D. C., to secure information pertaining to bibliography and other data on the subject. It was learned from these sources that no similar studies had been made.

Material from Waverly Hills' Annual Reports was gathered to compile certain figures. Figures on patients who left against the doctor's advice have been kept only since 1939.

CHAPTER I

A BRIEF HISTORY OF WAVERLY HILLS

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A BRIEF HISTORY OF WAVERLY HILLS

In making the study of the patients who left Waverly Hills, we became interested in how long the Sanatorium had been in existence, and what factors led to its establishment. In January, 1907, Waverly Hills' first Board was appointed by the Major, and the first building was erected in 1909. The Sanatorium with a bed capacity of forty was opened for patients July 26, 1910; Dr. A. M. Forster, the first Medical Director, had a staff consisting of one graduate nurse and three student nurses. In 1911, funds were appropriated by the City of Louisville for the erection of a hospital for the care of advanced cases of tuberculosis. By 1916 Waverly Hills was overcrowded with a total of two hundred and one patients. A committee appointed to make a survey recommended on December 29, 1921, a \$1,000,000.00 Bond Issue for the construction of a new sanatorium. This report was accepted, and Senate Bill No. 72 authorized a City Ordinance for a \$750,000.00 Bond Issue to be voted on at the November 1922 election. After this was passed, Jefferson County added an appropriation of \$300,000.00.

The new building was begun in January, 1925, and completed in August, 1926. Immediately following the opening of the new building, the unit used for advanced cases was arranged

for colored patients, and a complete staff of colored employees, including resident physician and nurses, were employed. A nurse's home was built and other provisions for the increasing staff were made. In 1931 the Board purchased the property at 235 East Chestnut Street to be utilized for the City Dispensary (Waverly Hills Tuberculosis Dispensary).

Since 1923, the Woman's Advisory Board, appointed by the Mayor, has served the patients of the Sanatorium.⁵ Until the merger of Louisville Health Department, Jefferson County Board of Health, and the Board of Tuberculosis Hospital in 1942, Waverly Hills was governed by the Board of Tuberculosis Hospital, a bi-partisan Board composed of ten men appointed jointly by the County Judge and the City Director of Public Health. The merger of the health departments was prompted by a recommendation made in a study of Louisville's city government in 1935, and as a result of the study made in 1940 of the health department of Fayette County, Kentucky. A committee appointed by Mayor Scholtz in 1940 studied the possibility of such a merger, and in January, 1942, a Bill in the Kentucky Legislature (Senate Bill 35) was passed consolidating the above-mentioned boards of health. This Bill placed the administration of Waverly Hills under the Louisville and Jefferson County Health Department, which is governed by a five-man Board under the leadership of the executive officer.

⁵W. R. Livermore, "Waverly Hills" (n.d.) pp. 1-5

At the present time, Dr. Hugh Leavell holds this position. It was expected that the merger of the two departments would make for greater efficiency in the avoidance of duplication of work.⁶ However, there was a great deal of readjustment necessary and the period covered by this study, September-December, 1942, falls within that period of readjustment.⁷ Dr. Leavell brought out that not a single member of the Sanatorium staff was changed by the Administration after the consolidation. There has been a considerable shift of employees in recent years due to war conditions, physicians going into military service and other matters of a similar nature.

The addition in 1942 of the greatly needed new building for the Negro patients brought the bed capacity of the Sanatorium to five hundred and seventy-five. Patients are admitted to the Sanatorium only through the Waverly Hills Clinic, and they must be residents of Louisville or Jefferson County. Payment for care is not accepted, and the institution is operated entirely with city-county funds.

⁶Newspaper clippings from Louisville Courier-Journal and Times, 1940-1942.

⁷See p. 11 for Superintendent's statement in 1942 Medical Report.

CHAPTER II
THE PROBLEM OF PATIENTS WHO LEAVE AGAINST
THE DOCTOR'S ADVICE

CHAPTER II

THE PROBLEM OF PATIENTS WHO LEAVE AGAINST THE DOCTOR'S ADVICE

The problem of patients who left against advice has been an increasing problem to the Sanatorium as indicated by Table I.

TABLE I

ADMISSIONS, LIVE DISCHARGES, AND DISCHARGES
AGAINST ADVICE, AND PERCENTAGE OF LIVE
DISCHARGES WHO LEFT AGAINST ADVICE
FROM WAVERLY HILLS SANATORIUM
1939-1942⁸

Year	Admissions adults and children	Live discharges	Discharges against advice	Percentage live discharges who left against advice
1939	388	299	120	43.01
1940	417	334	110	32.93
1941	452	368	160	43.47
1942	498	360	183	50.83

Of the 6,906 patients studied by the National Tuberculosis Association, 2,047 or 30% were found to have left against the doctor's advice.⁹

⁸Book of Admissions and Discharges

⁹Whitney & Dempsey Op. Cit. p. 29

The problem had reached such proportions in 1942 that it was discussed at some length by the Superintendent at Waverly Hills. We quote from the Sanatorium's 1942 Medical Report:

"A larger percentage of patients left the Sanatorium against the advice of the Staff during the year than in previous years. This may be accounted for chiefly because of general unrest brought about directly or indirectly by the war. The changing of our medical personnel, more particularly the physicians directly in charge of the patients, caused some confusion among the patients. This has largely been corrected, however, and it is believed that this factor will be of lesser importance in the future. Economic difficulties in the home, and homesickness continue to lead as causes for leaving against advice. It is believed that a full-time social worker would do much good in helping to alleviate this problem".¹⁰

Dr. Brock brought out in a conference that he thought the current possibilities of making more money was an additional factor that drew patients away from the Sanatorium without the doctor's consent.

It would appear that although the general unrest brought on by the war may be a factor, the problem was a large one before the war started. As pointed out below,¹¹ economic factors and homesickness were not primary factors for leaving the Sanatorium against the doctor's advice.

¹⁰Annual Medical Report 1942, p. 5

¹¹See Table II, p. 14

Although the group studied, forty-three patients, is small when compared with the total number who left the Sanatorium against the doctor's advice, one hundred and eighty-three; or, when compared with the total who were discharged or died (476) in 1942 at Waverly Hills, the findings of this study should indicate the problems one might find in a study of a larger sample. The forty-three patients represent 11.9% of those discharged alive in 1942 and 23.6% of those who left against advice in 1942.

Reasons Patients Gave for Leaving Sanatorium

The main purpose of the study was to determine the reasons why patients left Waverly Hills Sanatorium. In many instances the reasons were multi-causal rather than uni-causal.

The reasons listed in Table II are those given by the patients in the personal interviews with them. Although the patients often gave only one reason for leaving, we were conscious of the fact that in most instances there were often underlying reasons. Financial reasons as listed in Table II were given as an additional factor contributing toward the leaving. This point should be kept in mind in interpreting the figures. For example, some of the nine who left the Sanatorium because of lonesomeness, also indicated

TABLE II

REASONS GIVEN FOR LEAVING BY 43 PATIENTS
WHO LEFT WAVERLY HILLS DURING
SEPTEMBER-DECEMBER, 1942

		<u>White</u>			<u>Negro</u>	
Reasons for Leaving		<u>Total</u>	<u>M</u>	<u>F</u>	<u>M</u>	<u>F</u>
Connected with Institution	Total	54	22	23	1	8
Poor Treatment at Sanatorium	Total	29	9	13	1	7
Bored with Sanatorium		9	4	2	1	2
Under impression left with Advice		6	1	5	0	0
Objected to Proposed Treatment		5	1	2	0	2
Sanatorium Depressing		3	1	1	0	1
Inadequate Medical Attention		3	1	1	0	1
Sanatorium in Politics		2	0	1	0	1
Not Connected with the Institution		1	1	0	0	0
Lonesomeness	Total	25	13	10	1	1
Financial		9	2	6	0	1
Worried about Children		8	8	0	0	0
Not Sick by Self Diagnosis		3	0	2	1	0
Marital Problems		2	2	0	0	0
Death of Husband		2	1	1	0	0
		1	0	1	0	0

financial or other worries. Likewise, this same thought should be kept in mind in interpreting the nine of the forty-three patients, who gave poor treatment at the Sanatorium as a reason for leaving. They enumerated along with this, other reasons, such as, boredom or objection to proposed operation. It is interesting to note that thirty-four of the forty-three patients studied indicated no dissatisfaction with the Sanatorium. Since the reasons patients gave for leaving were secured from one interview only, it was not possible to ascertain to what extent the reasons they gave had reality factors.

One should keep in mind that the patients may have had personality difficulties within themselves which contributed toward their negative feelings regarding the Sanatorium. In reality there may have been no basis for their feelings.

The interviewer concurs with the statement made in the 1942 Medical report¹² that frequently patients left because of the turnover in the medical staff at that time. The difficulty of making the transfer from one physician to another is readily understood when we recognize the importance of the relationship between patient and doctor.

¹²See p. 11 re: statement of Medical Report

In order to present a clearer picture of the data in Table II, case illustrations of the patients' reasons for leaving are given:

Mr.C. is one of the patients who gave more than one reason for leaving. He objected to a proposed operation, and felt that he received poor treatment at the Sanatorium. At the time he left, he had become progressively worse, and had not responded to the new doctor in whom he lacked confidence. After leaving the Sanatorium, he secured treatment from the physician he had known at Waverly Hills, and in whom he had confidence. He went ahead with the operation, his condition improved and he planned shortly to return to work.

Although Mr.C's family was able to make a financial adjustment during the period of his illness, we might concur that the underlying motivation of Mr.C's actions might readily have been his desire to reassume the role of main wage-earner and head of his family.

Mr.D's situation further illustrates a patient who gave more than one reason for leaving:

Mr.D., age 44, father of seven children, also complained of poor treatment of the Sanatorium. He blamed the recent merger of the City-County Health Departments as the reason for the Sanatorium's inefficiency, and summed up the whole situation as "politics". His condition when he left the Sanatorium was far-advanced. When he was visited, he was not working, but felt well enough to be up and about and visit around the neighborhood. He was satisfied that he was supervising the children adequately while his wife worked. When questioned about home conditions, he indicated that there were no problems. One of his children had been a school delinquent until Mr.D. returned home.

In the following case story, we get a detailed picture of a patient who thought she was discharged with the doctor's consent; whereas, she was listed on the records as L.O.A.:

Mrs.A., 36-year old mother of Nancy, age 11, returned home under the impression she had left with the doctor's consent. Her diagnosis was moderately-advanced when she left the Sanatorium. When visited, she explained that she was under the care of a private physician, and understood that this plan was agreeable to the doctor at the Sanatorium. When asked for more details, she volunteered that a mix-up of understanding regarding her leaving the Sanatorium may have occurred as the whole matter came up when Sergeant A. received a furlough. Mrs.A. secured permission from her physician to leave when the sergeant arrived. The latter arrived unexpectedly. The doctor with whom Mrs.A. had planned the matter was away from the Sanatorium, and Mrs.A. left of her own accord as the physician-in-charge could not grant permission to leave. Mrs.A. was of the impression that when her doctor returned that her discharge was "with consent" of the Sanatorium.

Shortly before and during the period of this study, September-December, 1942, the Sanatorium began granting discharges to patients if they worked out adequate arrangements to receive treatment from a private physician; or, if they made other satisfactory plans of treatment. Prior to this time, no patient was discharged with the doctor's consent unless his condition was diagnosed apparently arrested. In the natural confusion that arose with the change of policy, some patients misunderstood the basis of their discharge. This seemed to be the explanation of those patients who understood they left with the doctor's consent.

When inquiry was made into certain facts surrounding the manner of discharge in a study made by the National Tuberculosis Association of patients discharged from tuberculosis sanatoria in 1933, it was learned that it was difficult to distinguish between those who left with the full advice of the medical director, and those to whose departure he gave reluctant consent. Among the latter group were found emotionally unstable patients, those worried by financial considerations or family problems, and some who tired of the sanatorium. It was pointed out that these factors must be taken into consideration when the statement that 64% of the patients (4,437) left the sanatoria in 1933 with the "consent" of the medical director, is considered. Although he "consented" to the patient's departure, he may not have "advised" it. The 2,047 that were listed as leaving against advice, was much more clearly defined.¹³

In the following situation, we have an illustration of a man who apparently had been quite active until suddenly faced with the extreme limitations made necessary by his tuberculous condition. As a result, Mr.W. found the Sanatorium depressing:

¹³ Whitney & Dempsey, Op. Cit., p. 29

As Mr.W. could not be located because he had deserted his family, Mrs.W. gave the necessary information about her husband's leaving the Sanatorium. He was a restless, nervous man, who found the Sanatorium depressing. His diagnosis when he left the Sanatorium after staying five months was the same as when he was admitted, moderately-advanced. He had been a restaurant owner, a gambler, and altogether, a very active individual. Knowledge of his tuberculous condition came to him as quite a shock. The quiet routine of the Sanatorium proved to be too great a contrast for Mr.W.

Reasons for leaving given by some of the other patients were influenced by factors "not connected" with the Institution. The following illustrations show that family problems and personality difficulties contributed to a patient's leaving against the doctor's advice. Mrs.F., for example, left the Sanatorium because of lonesomeness.

Mrs.F. was given a pass at Christmastime to visit in town with her family. She prolonged her stay and then as she put it "was afraid they wouldn't let her come back after that". Mrs.F., a fearful individual of 67 years, did not ask the interviewer in but talked with her in the hallway. She spoke readily nonetheless. Ultimately when the interviewer verbalized for Mrs.F. her lonesomeness at the Sanatorium, she agreed that this was the real reason she left the Sanatorium. Before she went to the Sanatorium, her son, grandson and nephew visited her infrequently, but she welcomed these visits and missed them while she was at Waverly Hills. Her relatives and friends did not visit her there because they claimed it was too far to the Sanatorium. Before going to the Sanatorium she had lived a lonely life with another elderly woman, as a companion. She preferred this to the Sanatorium. Besides, she had lived in the Haymarket area for years, and was more "comfortable" just being around old familiar objects.

This illustrates how relatives and friends who are not deeply attached to a patient use the inadequacies of transportation to Waverly Hills as an excuse for not visiting and cause discontent among the patients.

Two examples of individuals drawn home by family problems; namely, worry over children and marital problems, are illustrated by the cases of Mrs.G. and Mr.E.:

Mrs.G. returned home because of worries regarding her children. Her condition was diagnosed as Minimal when she left the Sanatorium after being there a month. Although her 36-year old husband, 14-year old daughter Betty, and her 10-year and 12-year old sons, Ned and John, were managing very well, Mrs.G. was concerned because she thought the children had too much responsibility. Since she returned home, she carefully watched her activities so that she would not get tired. Her children were of great help to her.

Mr.E. found it impossible to remain at the Sanatorium when he learned that his wife was unfaithful to him, and that she wanted a divorce. He hastily returned to this city to attempt to effect a reconciliation. His wife insisted on the divorce. Mr.E. continued to find it necessary to remain away from the Sanatorium to complete final plans for the divorce and make arrangements for the children.

Sometimes the husband or wife who is left at home to face alone the plans for the children and other family needs finds the going rather difficult. His or her anxieties may increase to the extent that there may be unreasonable resentment toward the patient's illness, which resentment is

great enough to cause separation of the couple. This resentment may also explain a seemingly unsympathetic attitude on the part of the patient's family. In any event, the patient, such as Mr.E., finds it necessary to leave the Sanatorium to attempt to work things out.

The fact that many individuals do not feel or look sick when they have tuberculosis accounts for the general restlessness of some patients. Sometimes they think the doctor does not know what "he is talking about". Mr.H. is an example of this kind of patient:

Mr.H. left Waverly Hills with a diagnosis of moderately-advanced tuberculosis. He had been there five months, and just could not believe he was sick enough to stay. His chart indicated he was active improved; his sputum was negative. He continued to see a private physician in Louisville and understood that his condition had improved. This was later verified in an interview with the doctor.

We see from Table II that patients were drawn from the Sanatorium not only because of family worries, but also because of boredom with the Sanatorium and lonesomeness. It is possible that these problems might be met in part by a medical social worker. The Sanatorium now has an arrangement whereby a patient is recommended by the physician for road exercises and occupational therapy. Possible extension of this program as it suits the individual might be considered as an important part of the Sanatorium's program.

An In-Sanatorium Vocational Training Program would be highly desirable, in that such a program initiated in the Sanatorium would tie up with the State Rehabilitation Service rendered to acceptable discharged patients. The aim, obviously, is to discover patients' vocational possibilities and to see that necessary training is obtained, so that employment becomes available when the patient's physical condition permits and after training has been completed. If proper occupational plans are made and carried out, the dangers of relapse and the need for further Sanatorium care are diminished. The program has a distinct value to the community as well as to the patient, once it definitely is a part of the tuberculosis control program. In addition, it provides a goal for the patient which aids in maintaining his morale and in obtaining his cooperation in the prolonged treatment required in tuberculosis.

The fact that treatment of tuberculous persons is primarily social and personal is discussed in an article in the Family, October, 1932. When complete rest from all social and mental activities is prescribed, the patient faces a complete change from his usual way of life in family and home responsibilities, occupation, recreation and sex life. Although social elements in both cause and treatment are recognized, the greatest contribution of the social worker in

connection with tuberculosis has not been in the form of individualized case work with the patient himself, but largely in the field of prevention. Emphasis for the most part has been placed on community and educational work, on promotion of better housing conditions, higher standards of living, and on facilities for examination and treatment of tuberculosis. The patient's personal cooperation is strongly needed in the treatment of tuberculosis.

Although it is well known that many tuberculous patients show a marvelous strength of character, helpfulness and thoughtfulness for others, instances of rapid changes of mood from optimism to discouragement, depression and fears are found. We also find the selfish and the reckless jeopardizing their own and their families' welfare and the gradual change from adult altruistic attitude to destructive self-centered traits. There is a need for understanding of their behavior. The optimism, the spes phthisica formerly mentioned so often has been found to be somewhat mythical. Quite often when it does occur, it is because of the patient's desire to show he is playing the game. The social worker should understand and may be able to help the patient who drinks to forget his condition or the one who selfishly impregnates his wife because he wants her to suffer as he does,

or the one who feels inadequate regarding the possibilities of his return to work.¹⁴

It is possible that case work services to Mr.E., Mrs. G., or Mrs.F., might have helped the patients remain at the Sanatorium. One would hardly expect Mr.E., possibly to lie in bed and wait patiently while Mrs.E. left him for another man. Since his condition was moderately-advanced, he in all probability felt well enough to use his energies to try and prevent the breaking up of his home. Since the divorce proved to be inevitable, the availability of a case worker to talk this through might have helped Mr.E. accept the situation, and draw what potentialities he had within himself to plan a future of his own. Certainly, plans regarding placement of his children could have been handled by a case worker. These steps might have been factors contributing toward release of tension within Mr.E., and helped him face the long stay at the Sanatorium.

Visits by a case worker to the G. home might have helped Mrs.G. remain longer at the Sanatorium. Mrs.G. had lots of time to think of possible ways her family was mismanaging her home. Interviews with her might have helped her to understand the reality of the home situation. Adjustments might

¹⁴Irene Grant, "Social Work With Tuberculous Patients", Family, October, 1932, pp. 190-198

have been effected by the case worker through relatives or some other source.

Mrs.F. spoke very positively of the treatment she received at the Sanatorium. If she could have been interviewed at the Sanatorium, she might have been helped to bring out her feeling of lonesomeness and been encouraged to stay. Relatives and other friends could have been seen for her. Interpretation of Mrs.F's need of attention, and an occasional visit might have been interpreted to relatives and friends.

It is possible that if a social worker could have talked with those who gave reasons for leaving that possibly had no reality basis, she may have been able to help them bring out the underlying personality difficulties. This might have helped them modify their plans so that they would be realistic and directed toward the goal of complete recovery.

The above discussion seems to point out some of the areas in which the case worker could be of service. One can only conjecture what may have happened since other factors of which we are not aware at this time may have played an important role.

CHAPTER III
CHARACTERISTICS OF PATIENTS STUDIED

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CHARACTERISTICS OF PATIENTS STUDIED

As we had hoped when we began our study of the forty-three patients who left Waverly Hills against the doctor's advice during the period September-December, 1942, compilation of figures on the characteristics of the patients did indicate significant findings. The reader will note these findings in the tables regarding sex, race, marital status, age and education. The significance of information such as the majority of the patients studied were married is brought out in the discussion. Similarly, other conclusions were drawn from the figures regarding age, sex and education.

Race and Sex

The forty-three patients on whom data was secured were made up of thirty-five white persons and eight Negroes; fifteen males, and twenty-two females. The fact that the Negro group studied is small is understandable in view of the fact that bed space for Negroes at the Sanatorium is limited. Of the total admissions in the year 1942, four hundred were white and ninety-eight Negro. Of the total adult patients discharged in 1942, three hundred forty-five were white and ninety-two were Negro.

The total admissions and discharges for 1942 indicated that there were more males than females in both groups. However, for the period studied there were more females (28) than males (15) who left against the doctor's advice.

Age on Admission

The largest number of the patients studied were in the age group thirty-five to forty-four (See Table III). There were no Negroes in this group. The males and females were equally distributed as there were seven in each classification. The next largest number of patients studied was in the age group, fifteen to twenty-four. There were three Negroes in this group and nine white patients; all but one of the total were females.

The Sanatorium's policy regarding the admission of children has been somewhat influenced by the three phases that treatment of tuberculosis has undergone. During the first phase, emphasis was placed on discovering the symptoms of tuberculosis, such as, night sweats, tired feeling, etc. It was eventually learned that by the time a patient manifested such symptoms, his condition was frequently too far along to benefit by treatment.

When this was recognized a new plan of action was tried, and the second phase of treatment began. The tuberculosis test was given to all school children with the result that fifty percent of all children examined were found to have some indication of need for treatment. During this period many children were admitted to Waverly Hills. The difficulty of hospitalization soon became apparent. When it was learned that children for the most part got along just as well in their homes, and that they were not apt to be infectious, general admissions for children were discontinued. Children are now admitted on the basis of their individual need for treatment.

Because of the findings in the second phase, which for the most part eliminates sanatorium care for children, emphasis in the third phase has been placed on finding minimal cases through case finding programs in factories, schools, clubs, churches, etc.

Marital Status

The most consistent information regarding the marital status was secured at the time of the home visit. This information was not always available from the records and occasionally was inaccurate. The largest group of patients

studied were married, as shown in Table IV. The total twenty-six consisted of twenty-four white and two Negro patients. Ten were males and sixteen were females.

TABLE III
AGE OF PATIENTS ON ADMISSION CLASSIFIED BY
SEX AND RACE

Age	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Under 15	1	0	0	0	1
15 under 25	12	1	8	0	3
25 under 35	8	3	3	1	1
35 under 45	14	7	7	0	0
45 under 55	3	0	2	0	1
55 and over	5	2	2	1	0

TABLE IV
AGE OF PATIENTS ON ADMISSION CLASSIFIED BY
MARITAL STATUS

Age	Total	Single	Married	Wid.	Div.	Sep.
Total	43	5	26	6	2	4
Under 15	1	1	0	0	0	0
15 under 25	12	3	6	1	0	2
25 under 35	8	0	6	0	1	1
35 under 45	14	1	11	1	0	1
45 under 55	3	0	1	2	0	0
55 and over	5	0	2	2	1	0

Eleven of the twenty-six fell into the age group thirty-five through forty-four. Since the distribution in the classifications other than marriage was much lower (17), we can conclude from this fact that the strain of family problems may be a strong factor contributing toward a patient's leaving the Sanatorium against advice. We may also infer that since a large proportion of the married group are men (Table V) that they may have been concerned about leaving as they were the main wage-earner in the home. Even though the possibilities of their returning to the home as wage-earner were slim, the fact that some adjustment in the home set-up was needed may have influenced the man to leave before it was acceptable for him to do so. Mr.S. illustrates the case of a male drawn home by financial reason:

Mrs.S., 37-year old wife of Mr.S. 42 years, began working when Mr.S. was admitted to the Sanatorium. It was necessary to leave four children--the oldest a boy of sixteen, and the youngest, a six-months old baby. When Mr.S. was interviewed after leaving the Sanatorium against the doctor's advice, he indicated that his chief reason for returning home was because of the inadequate income in the home, caused by his not being there. He was concerned also because of the increased responsibility placed on his children with both parents out of the home. The S's lived in a semi-industrial section of the city in three rooms on the second floor of a building in poor repair. Mr.S. had returned to work and had received no medical attention since he left Waverly Hills of his own accord.

One could discuss at length the potential problems indicated in this situation. Mr.S. mentioned only the

financial problem. Continued contacts might have revealed potential problems of the adolescent. We wonder also to what extent Mr.S. is infectious to his baby.

TABLE V

MARITAL STATUS AT THE TIME OF HOME VISIT CLASSIFIED BY
SEX AND RACE

Marital Status	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Single	5	2	1	0	2
Married	26	9	15	1	1
Widowed	6	0	5	0	1
Divorced	2	2	0	0	0
Separated	4	0	1	1	2

Educational Background

Data concerning educational background of the patients was secured at the time of the home visit. We were unable to get the data for seven patients either because we secured the information from a collateral source and the interviewee did not know it; or, because the interview did not offer the opportunity to secure the information.

Of the remaining thirty-six, the largest group were

those who completed less than the eighth grade. Of the twenty-three in this group, nineteen were females and four males. Four were Negro and nineteen were white. (See Table VI).

TABLE VI
EDUCATION PRIOR TO ADMISSION CLASSIFIED BY
SEX AND RACE

Education	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Less than 8 years	23	3	16	1	3
8 years less than 12 years	10	6	2	0	2
Over 12 years	3	2	1	0	0
Unknown	7	2	3	1	1

CHAPTER IV
MEDICAL DATA

CHAPTER IV

MEDICAL DATA

As will be noted the data compiled in the Tables in this chapter was secured for all of the forty-three patients studied. Information regarding the patient's diagnosis at the time of admission and discharge, sputum at the time of discharge, his length of stay at the Sanatorium and similar facts were secured from the records at Waverly Hills. Again, the significance of the findings is brought out in the discussion. The majority of patients who left against advice during the period studied, September-December, 1942, had tuberculosis in the far-advanced stages. This fact is discussed in the light of the total problem to Waverly Hills.

Stage of Disease on Admission

For the purpose of this study, we will use the definition of "stage of disease" as set forth by the Vocational Rehabilitation Division of the United States Office of Education:

"'Stage' - means the extent to which the disease has developed in the lung tissue. On the Medical Report this will be shown as "minimal" meaning that only a small area is involved; 'moderately-advanced' meaning that a somewhat larger area is involved; or 'far-advanced' meaning that an extensive area is involved."¹⁵

¹⁵U.S. Office of Education, Vocational Rehabilitation Division "Pulmonary Tuberculosis", Misc. 2328 (Revised) Washington, D.C., April, 1941, p. 5

It was noted in making this study that at Waverly Hills Sanatorium "moderately-advanced" (MA) and "far-advanced" (FA) were further described by the use of A, B or C. For example, MAA would indicate less activity from a clinical standpoint than MAB or MAC.

Of the twenty-one listed in Table VII as being in the far-advanced stage, one was FAA and one was FAC. Patients whose conditions were in the far-advanced stages numbered highest. Of the twenty-one in this group seventeen were females, and four were males. Four of the twenty-one were Negro, and 17 white. The next largest group consisted of those whose tuberculous condition was in the moderately-advanced stage. Of the total of sixteen, nine were females, seven were males. Thirteen were white and three were Negro. Those admitted in the minimal stage numbered only six, of whom five were white. (Table VII).

TABLE VII

STAGE OF DISEASE OF PATIENTS ON ADMISSION CLASSIFIED BY
SEX AND RACE

Stage of disease on Admission	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Minimal	6	3	2	1	0
Moderately-advanced	16	4	6	1	2
MAA	3	2	1	0	0
Far-advanced	19	4	13	0	2
FAA	1	0	0	0	1
FAC	1	0	0	0	1

Stage of Disease on Discharge

Eighteen of the twenty-three patients who left the Sanatorium in the FA stage were white (Table VIII). Seventeen were females; six were males. Twelve who left were in the MA stage; ten of those were white, and two Negro. Eight were females and four males.

The significance of these findings lies in the fact that the largest group (17 of the 23 far-advanced) with the most extensive activity were females. Here again, we become aware of the social problem created in the community. Since we know that the majority who left Waverly Hills against the doctor's advice were married, this additional factor might raise the question of what possible chance a mother might have of getting the rest required in view of the home demands of the mother. We readily tie up the fact that not only is the mother pulled away from adequate care too soon but also there is the possibility of the spread of the disease to the children.

TABLE VIII
STAGE OF DISEASE OF PATIENTS ON DISCHARGE CLASSIFIED BY
SEX AND RACE

Stage of Disease on Discharge	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Minimal	8	4	3	1	0
Moderately-advanced	11	4	5	0	2
MAA	1	0	1	0	0
Far-advanced	20	4	13	1	2
FAA	1	1	0	0	0
FAB	1	0	0	0	1
FAC	1	0	0	0	1

Sputum at Time of Discharge

Almost half of the group left the Sanatorium with a positive sputum. Twenty-three had negative sputum and twenty had positive (Table IX). Of those with positive sputum, seventeen were white and three Negro. Fourteen were females and six were males. The conclusion indicated above regarding the spread of the disease is further emphasized by these facts since here again the largest group is female, a large portion of which may be mothers. Also we assume that when a person leaves a Sanatorium with the doctor's consent, he is not ready in any way to return to employment. Figures later (Tables XII and XIII, p.44) will indicate that a large group of them did, yet the Rehabilitation Agent considers the status of the sputum a very important matter in helping the patient to become adjusted to normal life.

"The information on sputum has two purposes. First, it is an important item in diagnosis, a positive sputum being one of the principal symptoms of active tuberculosis; and second, the rehabilitation agent in accepting responsibility for the training and placement of a case must be sure that there is no danger that his client will infect other trainees or employees. It is, therefore, important to know first, that the patient has a negative sputum and second, how long it has been consistently negative.

Sputum or other tests should have been consistently negative for a period of at least six months before acceptance for service".¹⁶

¹⁶ Ibid, p. 12

TABLE IX

SPUTUM OF PATIENTS ON DISCHARGE CLASSIFIED BY
SEX AND RACE

Sputum on Discharge	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Negative	23	7	11	2	3
Positive	20	6	11	0	3

Clinical Status on Discharge

The clinical status (Table X) of the majority of the patients studied, twenty-one was active improved. Of these fifteen were white and six Negro. Twelve were females and nine males. None of the total forty-three was apparently arrested. This is understandable inasmuch as the Sanatorium's policy has been not to discharge a patient with the consent of the doctor unless he is apparently arrested. Eight of the patients were quiescent.

The above figures may have more meaning after we consider the following discussion from the National Tuberculosis Study and the Vocational Rehabilitation Division of the United States Office of Education:

"When a person who has had the disease in a far-advanced stage is discharged from the sanatorium as 'apparently arrested', his chance for recovery is almost as good as that of the minimal case who is likewise considered to be apparently arrested. A patient'

'with minimal tuberculosis has an excellent chance for survival, no matter what his clinical status on discharge,.....'"17

"No case of active tuberculosis should ever be accepted for rehabilitation.....
The 'quiescent' patient is not ready for rehabilitation service and none should be undertaken at any point at this stage.....They are not yet free of the symptoms of tuberculosis.....Apparently arrested patients have been free of the symptoms of tuberculosis for three months.....
Arrested:.....They have had a minimum of six months of freedom from symptoms....."18

TABLE X

CLINICAL STATUS OF PATIENTS ON DISCHARGE CLASSIFIED BY
SEX AND RACE

Clinical Status on Discharge	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Active Unimp.	12	4	6	0	2
Active Improved	21	7	8	2	4
Improved	2	1	1	0	0
Quiescent	8	1	7	0	0

¹⁷Whitney & Dempsey, Op. Cit., p. 23

¹⁸United States Office of Education, Op. Cit., pp. 16-17

Length of Stay in Sanatorium

The majority of the patients studied remained at the Sanatorium only a short period. Twenty-eight of the patients stayed less than four months, (Table XI) and ten of them stayed less than nine months. Three of the remaining five were in the Sanatorium almost two years. Only two remained more than two years. In the study of the National Tuberculosis Association of patients discharged in 1935, it was learned that in spite of the tendency for most patients to remain in sanatoria for relatively short periods, it was evident that the chance for survival subsequent to discharge increased with the length of stay.

The National Study further indicated that only forty-four percent of the patients who remained in the sanatorium for one to three months were alive five years later. Sixty percent of all of those who stayed more than two years and left before 1935 were still living in 1938. The largest proportion of survivors was found among those who remained in the sanatoria for more than three years. The most important point in connection with the length of stay in sanatoria is the material reduction in the general tuberculosis death rate which is affected by removing patients with active disease from their homes, thus eliminating them as sources of exposure to members of their households.¹⁹

¹⁹Whitney & Dempsey, Op. Cit., pp. 28-29

TABLE XI

LENGTH OF STAY OF PATIENTS IN THE SANATORIUM CLASSIFIED BY
SEX AND RACE

Length of Stay	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
0 - 4 months	28	8	15	2	3
5 - 9 months	10	5	4	0	1
10-14 months	0	0	0	0	0
15-19 months	0	0	0	0	0
20-24 months	3	0	2	0	1
Over 24 months	2	0	1	0	1

Readmissions

Only five of the patients studied returned to the Sanatorium. As a disciplinary measure the Sanatorium tries to adhere to the policy of refusing artificial pneumothorax treatments to patients who leave the Sanatorium against advice. Patients who are not receiving pneumothorax treatments, but who leave the Sanatorium against advice are readmitted at the discretion of the Out-Patient Clinic.²⁰ Six of the forty-three patients studied had previous admissions. They were all white. One was male; three of the five females attempted to work between admissions.

²⁰ Louisville & Jefferson County Health Department, "To Help you Regain your Health", A GUIDE of Useful Information for Patients of the Waverly Hills Sanatorium. (n.d.)

Time Interval Between Discharge and Death

It was learned from collateral sources at the time of the home visit that four of the patients died. Two were white and two were Negro. Two lived less than two months after leaving the Sanatorium. One lived four months. One lived over five months. Again we indicate the small number studied, in considering these figures. We refer anew to the study made by the National Tuberculosis Association as their study was more comprehensive. Their findings were that only twenty-three percent of those who left with advice or consent in 1933 died prior to the end of 1938. Forty-nine percent of the 2,047 who left definitely against the advice of the medical director, died during the five-year period. In other words, sixty percent of those who left "with consent" survived the five years, while only a little more than one-third of those who left against advice, survived this period.²¹

²¹ Whitney & Dempsey, Op. Cit., p. 30

CHAPTER V
ECONOMIC AND SOCIAL DATA

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ECONOMIC AND SOCIAL DATA

Information regarding economic and social data as described in this chapter was secured chiefly from home visits. Statements regarding recent medical examinations were checked with the appropriate clinic or physician. A combination of medical and lay opinion is represented in the following tables and discussion.

Employment of Patients

As might be expected since the majority of the patients studied were females, the majority of the group were housewives by occupation. Nineteen of them were white and one Negro. No table was made of the kinds of employment as they varied to such an extent as to have little significance. The occupations of the men ranged from laborer, huckster, warehouseman, and truck driver to salesmen and restaurant owners. Forty were working at the time they were admitted. (Table XII). Twenty-two were working at the time of the home visit. (Table XIII).

The findings and conclusions of the National Tuberculosis Study regarding employment of patients helps us in interpreting the significance of Tables XII and XIII. Their findings show that in 1938, five years after the 1933 discharge, fewer than

one-half of the 3,576 patients then living could be classified as "well"; twenty-two percent stated they were in "fair" condition. Sixty-two percent of those who survived five years after discharge were reported to be working in 1938; this figure included those housewives presumably able to handle their home duties. Although medical information was scant, it was noted that two percent of the living patients were working, though suffering from unstable tuberculosis.

When the patients who survived the five-year period were classified according to their clinical status on discharge, more than half of those in each group proved to have been working in 1938. Sixty-nine percent of those who were apparently arrested on discharge were employed in 1938. Only fifty-two percent of those who were considered arrested or apparently cured were at work in 1938. Since the proportion of patients who were reported well in 1938 was smallest for the group with unstable lesions on discharge, and largest for those whose disease was apparently arrested, or arrested at the time of discharge, it seemed that the motivation to return to work depended not only on the patient's good physical condition but on the necessity for earning a living as well.

At a later place in the National Study, the comment is made that one cannot assume that all of the 625 patients who were never employed during the five years subsequent to discharge were too ill to work throughout this period; even though

there was widespread unemployment at the time, it was believed that this was the case in many instances. A further comment is made that some patients who may otherwise be well enough to work suffer from emotional instability to such an extent that they may be unable to secure a job or hold one. Whether emotional disturbances represent a cause or effect of tuberculosis is a point on which authorities differ, yet all agree that many patients suffer from this handicap.²²

TABLE XII

STATUS OF EMPLOYMENT OF PATIENTS AT TIME OF ADMISSION CLASSIFIED BY RACE AND SEX

Employment Status	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Working at time of admittance	40	13	21	2	4
Not working at time of ad- mittance	3	0	1	0	2

²² Ibid. pp. 35, 37, 40

TABLE XIII

**STATUS OF EMPLOYMENT OF PATIENTS AT TIME OF HOME VISIT
CLASSIFIED BY RACE AND SEX**

Employment Status	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Working at time of Home Visit	22	5	14	1	2
Not working at time of Home Visit	21	8	8	1	4

Financial Status

The data for information regarding financial status was secured from the patient at the time of the home visit. Agency records also indicated the family's financial status either before admittance or after discharge, in some instances. Forty-one of the patients or his family were self-supporting at the time of the home visit. Forty were self-supporting at the time of discharge and thirty-nine at the time of their admission (Table XIV). The fact that the possibilities of employment have been greater in the last few years as compared with earlier depression years, might be considered in connection with the above figures, inasmuch as the period studied is recent. We might conclude that the main reason that patients leave the Sanatorium is not for financial reasons as is sometimes generally thought.

However, many of the families did indicate (Table XXI p. 55) that there were economic problems in the home even though no relief from a social agency was secured. Although financial need may not be a direct reason for a patient's leaving, we might infer that financial problems were influencing factors.

TABLE IV

FINANCIAL STATUS OF PATIENT'S FAMILY
AT TIME OF ADMISSION, DISCHARGE AND HOME VISIT
CLASSIFIED BY RACE AND SEX

Financial Status	<u>On Admission</u>				<u>At Discharge</u>				<u>At Home Visit</u>			
	White		Negro		White		Negro		White		Negro	
	M	F	M	F	M	F	M	F	M	F	M	F
Self-Supporting	13	20	2	4	12	21	1	6	13	21	1	6
Receiving Relief	0	1	0	1	1	0	0	0	0	0	0	0
Unknown	0	1	0	1	0	1	1	0	0	1	1	0

Social Agency Contacts

More than half of the patients were known to various social agencies in the past (Table XV). Not all of the agencies were relief agencies. Health, Child Welfare, Delinquency, group work, Family Welfare and other agencies were listed also.

Since more than half of the patients sought service of one type or another, we might conclude that problems were existent in these families prior to the time that the knowledge that tuberculosis was in the home became an added difficulty to be faced. It is safe to suggest that the availability of social work services to these families at the time of their admission or at the time the patient expressed any anxiety, might have alleviated some of the patient's worry and helped him to face the long stay at the Sanatorium and possibly influenced his remaining longer. The problems created in the home that we have already mentioned, such as the spread of the disease to small children or other members in the home might be curtailed.

TABLE XV

PATIENTS IDENTIFIED AND NOT IDENTIFIED
BY SOCIAL SERVICE EXCHANGE
CLASSIFIED BY RACE AND SEX

	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Identified	29	8	15	2	4
Not Identified	14	5	7	0	2

The question of how the availability of a medical social worker to talk with patients regarding their anxieties helped the total medical problem is discussed in an article

from The Family, December, 1938:

Mrs.T. was referred by a surgeon to a medical social worker to discuss an impending operation. Mrs.T. was too "scared" to talk about it the first time the social worker saw her. The interview was directed to topics that were "more comfortable" for the patient to discuss and relationship was established whereby the social worker had an opportunity to suggest seeing Mrs.T. again and a definite appointment was made. During the two-day interval the patient had an opportunity to think through the fears she had and was prepared to discuss her feelings with the worker. Even so, the patient could not be hurried in her decision and several interviews were needed, until the patient reached the point where she was at ease about the impending operation.

This kind of medical social work is differentiated from the kind of medical social work that requires the attentions of the social worker outside of the institution or hospital. It is necessary for her to help the family left behind make an adjustment or help arrange for the patient's return home. Both types are essential in the field of medical social case work.²³

²³Harriett Bartlett, "Social Case Work: The Central Function of a Medical Social Service Department". The Family, December, 1938, p. 248.

Mrs.R. was visited in connection with the follow-up study of patients who left Waverly Hills. Although her problem was different from Mrs.T's, her situation might be discussed here as another illustration of how the services of a medical social worker might be helpful:

Mrs.R's tuberculosis was far-advanced. Family problems caused her to leave the Sanatorium on several occasions. Once it was necessary to work out placement plans for her children. When this was satisfactorily accomplished, she felt it necessary to leave the Sanatorium because of her husband's failure to support adequately. When interviewed, Mrs.R. expressed much bitterness in regard to her husband's behavior. Actually, although her children were taken care of by social agencies, Mrs.R. kept herself in an emotionally upset state by worrying about her husband's infidelities.

This situation illustrates to what extent outside home conditions can be adjusted and yet, a need for consultation about inner worries is evidenced. It is not possible to say whether or not Mrs.R. might be helped by regular interviews at the Sanatorium, but the availability of a medical social worker to talk with Mrs.R. and help her think through an acceptance of Mr.R's failure to support, etc., might have a positive effect on her total medical condition.

Home Conditions

Data regarding home conditions was secured in the interview with either the patient or some one who knew the

patient's situation. Twenty-six of the patients had a room alone (Table XVI), while thirty-one slept alone but may or may not have shared a room (Table XVII).

TABLE XVI

ROOM ACCOMMODATIONS FOR PATIENTS CLASSIFIED BY
SEX AND RACE

Room Accommodations	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Rooms alone	26	9	13	1	3
Does not Room alone	17	4	9	1	3

TABLE XVII

SLEEPING ACCOMMODATIONS FOR PATIENTS CLASSIFIED BY
SEX AND RACE

Sleeping Accommodations	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Sleeps alone	31	9	15	2	5
Does not Sleep alone	11	4	6	0	1
Unknown	1	0	1	0	0

The largest family studied consisted of nine people. Families consisting of two and four members comprised the largest group (Table XVIII). Three, four and five rooms seem to be in the main the number of rooms that the homes included. For the most part the study indicated that the patients returned to crowded home conditions.

TABLE XVIII

ROOMS IN PATIENTS' HOMES BY SIZE OF PATIENTS' FAMILIES

Number of Rooms	Total	<u>Size of Family</u>			
		<u>Under 3</u>	<u>3 under 5</u>	<u>5 under 7</u>	<u>7 and over</u>
Total	39	16	18	7	1
1	3	3	0	0	0
2	5	5	0	0	0
3	9	2	5	2	0
4	10	3	4	3	0
5	8	2	6	0	0
6	3	0	0	2	1
Unknown	1	1	0	0	0

When inquiry was made concerning the extent to which other members in the home received medical attention, we learned (Table XIX) that for the most part, other members of the household

did secure examinations. All reports regarding medical attention of other members of the family were verified by reports from the examining physician. The majority was examined in the Tuberculosis Clinic. The families of patients who may have received medical attention from a private physician, for the most part were examined at the Tuberculosis Clinic.

TABLE XIX

OTHERS IN PATIENTS' FAMILIES X-RAYED OR EXAMINED CLASSIFIED
BY SIZE OF FAMILY

Number in Family x-rayed or Examined	Total	<u>Size of Family</u>			
		<u>Under 3</u>	<u>3 under 5</u>	<u>5 under 7</u>	<u>7 and over</u>
Total	39	16	15	7	1
1	15	8	7	0	0
2	9	7	1	1	1
3	4	0	3	1	0
4	4	0	2	2	0
5	2	0	0	2	0
6 and over	1	1	0	0	0
None	4	1	2	1	0

Tables XVIII and XIX total only thirty-nine as the home conditions of some of the patients who returned to the Sanatorium could not be tabulated as the family had no home as such. The children were in foster homes, in homes of relatives, or in institutions and the other parent had made different arrangements. This was true of some of the families of patients who had died since discharge.

A study of the ages of the other members of the household (Table XX) indicated that for the most part the patients returned to homes where there were small children. Previous studies have indicated that tuberculosis takes its highest toll in the age group fifteen to forty-five. The figures show to what extent this age group was exposed to active tuberculosis by the return to the home of patients who left the Sanatorium against the doctor's advice.

Problems extant in the homes to which the patients returned are shown in Table XXI. Although the interviewee did not always bring out these problems as being the chief reason for leaving the Sanatorium, they were secured from the interview as a whole and may easily have been contributing factors in drawing the patients away from the Sanatorium. The reader should keep in mind in noting the problems listed in Table XXI

that these difficulties were brought out in the home visit. Since the patient was not familiar with the interviewer, he may not have discussed all of his problems nor the magnitude of them.

TABLE XX
AGES OF MEMBERS OF PATIENTS' FAMILIES
CLASSIFIED BY RACE

Ages of Members of Family	Total	White	Negro
Total	131	101	30
14 and under	34	27	7
15 - 24	24	20	4
25 - 34	17	13	4
35 - 44	26	23	3
45 - 54	8	4	4
55 and over	18	11	7
Unknown	4	3	1

TABLE XXI

PROBLEMS IN THE HOME CLASSIFIED BY RACE AND SEX

Problems Found	At Time of Discharge					At Time of Home Visit				
	Total	White		Negro		Total	White		Negro	
		M	F	M	F		M	F	M	F
1. Inadequate income	12	4	4	0	4	10	2	4	0	4
2. Unemployment	2	0	2	0	0	3	0	2	1	1
3. Illness or Disability	2	1	0	0	1	5	2	2	0	1
4. Broken Family	7	2	3	0	2	7	2	4	0	1
5. Behavior Problem										
(a) adult	13	3	7	2	1	10	2	7	0	1
(b) child	4	1	2	0	1	4	1	3	0	0
6. Domestic Difficulties	3	2	1	0	0	2	1	1	0	0
7. Inadequate Supervision of children	7	2	3	0	2	7	3	3	0	1
8. Problems of Adolescence	2	0	1	0	1	2	0	1	0	1
9. Conflict with relatives	5	3	1	0	1	5	2	2	0	1
10. Conflict with community	3	2	1	0	0	2	1	1	0	0
11. Mental Illness	0	0	0	0	0	0	0	0	0	0
12. Mental Deficiency	1	0	0	0	1	1	0	0	0	1

Incomes of the patients' families were principally from private industry (See Table XXII). Here again we become aware of the financial independence of the group studied, but we might tie up this point with the fact that the period studied was more prosperous than earlier years.

TABLE XXII

SOURCE OF INCOME OF PATIENTS' FAMILIES CLASSIFIED BY
SEX AND RACE

Source of Income	<u>At Time of Discharge</u>					<u>At Time of Home Visit</u>				
	Total	White		Negro		Total	White		Negro	
		M	F	M	F		M	F	M	F
Private Industry	33	10	17	1	5	35	11	17	2	5
Public Assistance	0	0	0	0	0	1	0	1	0	0
Pension from Industry	1	0	1	0	0	1	0	1	0	0
Court Orders	0	0	0	0	0	0	0	0	0	0
Assistance from Relatives	3	2	1	0	0	3	2	1	0	0
Boarders and Lodgers	0	0	0	0	0	0	0	0	0	0
Army and) Navy pay (	8	2	3	0	3	4	1	3	0	3
Private Agency	1	1	0	0	0	0	0	0	0	0
Unknown	1	0	0	1	0	0	0	0	0	0

Medical Attention Since Discharge

Thirty of the patients continued to receive medical attention after leaving the Sanatorium. All but ten of these patients obtained treatment either at Tuberculosis Clinic in Louisville or at Waverly Hills. The ten patients who were treated by private physicians were white; five females and five males (Table XXIII). [All patients discharged from the Sanatorium are requested to return to the Clinic at regular intervals. If this does not happen the Clinic requests them to come in for examination. The sick patients receive nursing service from Clinic].

TABLE XXIII

MEDICAL ATTENTION RECEIVED OR NOT RECEIVED BY PATIENTS
CLASSIFIED BY SEX AND RACE

	Total	White		Negro	
		M	F	M	F
Total	43	13	22	2	6
Receiving Medical Attention	30	8	16	2	4
Not Receiving Medical Attention	13	5	6	0	2

CONCLUSIONS

CONCLUSIONS

1. The majority of patients leave Waverly Hills because of boredom, restlessness and lonesomeness.

2. Although the group studied is small in relation to the total population at Waverly Hills, it would seem an indication that more mothers leave Waverly Hills against the doctor's advice than patients having other status.

3. Not only were the majority studied mothers, but the age group found most frequently in the homes to which the patients returned was less than fourteen. This leads us to conclude that in the main the group leaving against the advice of the doctor were drawn because of home responsibilities and care of the children.

4. Patients whose condition is farthest advanced are leaving the Sanatorium against the doctor's advice.

5. Almost half of the patients who leave the Sanatorium against the doctor's advice have positive sputum.

6. More than half of the patients who left Waverly Hills against the doctor's advice during the period studied had active pulmonary tuberculosis.

7. Since the majority of patients studied remained less than four months and since we know that a long stay is essential for any improvement of a tuberculous condition, we

can safely conclude that patients who leave sanatoria against the doctor's advice have less chance of improving their condition than those who remain the full term demanded to be cured. This point as well as conclusions 4-5-6 readily indicate to what extent there could be spread of the disease in the community.

8. The fact that chances of patients who leave sanatoria against the doctor's advice to make employment adjustment are lessened is concluded when we learn that half of the patients studied were unemployed when the home visit was made.

9. None of the patients came from homes that were receiving financial help from a social agency at the time of home visit. One patient was receiving relief at the time of discharge; only two at the time of admission. The financial status of only one patient was unknown.

10. Although no data was collected on actual family income, it would appear from problems listed by the patients that inadequate income was an important problem in many of the homes. This suggests that an adjustment of one kind or another in this area was needed. The problem of insufficient income was secondary only to behavior difficulties.

11. Almost a third of the patients studied received no medical attention since leaving the Sanatorium.

12. Home accommodations for the patients were limited. When the fact that the majority roomed and slept alone is compared with the fact that the average number of rooms for the families of the patients is less than one room per person, we arrive at the above conclusion.

13. On the whole the families of the patients had some medical attention. The majority was examined at Waverly Hills Clinic.

14. Less than eighth grade education was secured by the majority of patients studied.

RECOMMENDATIONS

RECOMMENDATIONS

Since the Sanatorium is concerned about the patient who leaves against the doctor's advice, and as the conclusions would indicate that many problems are created in the community by the patients' self-discharge, it is recommended:

1. That the Occupational Therapy Department expand their activities for patients both ambulatory and non-ambulatory, but who need some type of mental activity to reduce boredom and restlessness. Possible development of vocational training might be included.

2. That as a beginning plan, one full-time medical social worker be employed to interview the patients regarding their worries and problems.

- a. A social worker could arrange for the proper social agency to make contact with the patient's family to attempt to adjust the home situation if that is the problem, and thus relieve the patient from his anxiety regarding his return home.
- b. Follow-up of patients who leave against the doctor's advice might be done by the social worker. This might include help toward solving home problems which are bothering the patient. Then the patient might be encouraged to return to the Sanatorium.

- c. If the patient were unwilling to return, interpretation of the patient's needs could be made to his family with the hope that with better understanding of the problem, the patient, as well as the family, can benefit.
- d. Interpretation to the patients' families regarding visiting and the patient's need for outside contacts could be given so that the patient would have less chance to become morbid over a possible feeling of becoming "lost" to the outside world.
- e. The service of helping a patient talk through a worry that may have reached unreal proportions could be given by the social worker.

3. That Waverly Hills Sanatorium direct future planning to include employment of more than one medical social worker, depending on the extent of the need for social work in the Sanatorium.

4. That the services of a psychiatrist be employed to help the restless, nervous patient meet his complete change in situation.

5. That a plan be worked out between the health and welfare departments for adequate financial assistance to families of patients who are admitted to Waverly Hills. This might be readily accomplished since both departments are public

agencies supported by taxes. The plan might help the patient remain at the Sanatorium the full term required of him as economic worries would be minimized.

APPENDIX

1. Name of patient..... 2. Date of birth.....
3. Sex.... 4. S.M.W.D. Sep. (Check) 5. Color....6. Commitment address_____
- _____ 7. Other addresses.....
8. If female, maiden name.....
9. Education prior to admission (a) grade completed 123456789 10 11 12
(b) college 1 2 3 4 - post graduate 1 2 3 4
(c) special training
10. Employment before admittance
" intervals between admissions
11. Onset of disease (date)..... 12. Date of commitment..... 13. Date of discharge....., (a) length of stay (days) 14. (a) previous admission
..... (b) subsequent admissions (dates).....
15. If dead, (a) date of death.....
16. Diagnosis (a) on admission.....(b) On discharge.....
17. Condition on discharge (a) active..... (b) unimproved... (c) improved..
(d) quiescent..... (e) apparently arrested.....
18. Vocational training at Sanatorium, Yes.... No.....
19. Family (list all living in same household)

Name	Date of birth	Have or had T.B.	Present health (if T.B. tested or x-rayed indicate)
.....			
.....			
.....			
.....			
.....			
.....			
.....			
.....			
20. Financial status on admission: (a) is patient self-supporting?.....
if not, from whom is relief received?..... 21. Is family
self-supporting? If not, from whom is relief received?.....
22. Home conditions: (a) No. of rooms..... (b) Patient room alone?.....
(c) Sleep alone?.....
23. SSX Clearings:
(a) Name of agency active if any.....
24. What medical supervision since discharge?
(a) Dates: From..... To..... (b) By.....
25. Date (a) Of last examination..... (b) last X-ray..... (c) Result...
..... 26. What is present condition?
27. Why did you leave Sanatorium?.....

1. Name of patient..... Age..... 2. Case number.....

3. Admittance address.....

4. Name of husband or wife or relatives.....

5. Address..... 6. Other Addresses.....

7. Sex..... 8. S. M. W. D. Sep. (check) 9. Color.....

10 Education prior to admission: (a) grade completed 1 2 3 4 5 6 7 8 9 10 11 12
(b) college 1 2 3 4 post graduate 1 2 3 4
(c) special training

11. Occupation at time of admittance

12. Employment before admittance

" between admissions

" at time of home visit

13. Date of admission..... Diagnosis..... Date of discharge...Diagnosis..
Days in hospital.....

Date of previous admission....Diagnosis..... Date of discharge.....
Diagnosis..... Days in hospital

Date of subsequent admission..... Diagnosis... Date of discharge.....
Diagnosis... Days in hospital

14. If dead, date of death.....

15. Condition on discharge (a) active..... (b) improved.....
(c) unimproved..... (d) quiescent.....
(e) apparently arrested.....
Sputum on discharge (a) negative..... (b) positive.....

16. Vocational training at Sanatorium Yes.... No

17. Family (list all living in same household) Have or Present
Name Date of birth rel. to patient had T.B. Health
.....
.....
.....
.....
.....
.....
.....

18. Financial Status on admission (a) was patient self-supporting?.....
if not, from whom was relief received?.....

19. Financial status on discharge..... at time of home visit.....

20. Type of problems found: (a) on discharge (b) at time home visit
1. Inadequate or lack of income
 2. Unemployment
 3. Illness or disability
 4. Broken family
 5. Behavior Problem
 - (a) adult
 - (b) child
 6. Domestic difficulties
 7. Housing
 - (a) Inadequate
 - (b)
 8. Inadequate supervision children
 9. Problems of adolescence
 10. Conflict with relatives
 11. Conflict with community
 12. Mental illness
 13. Mental deficiency
 14. None
21. Income (a) on discharge (b) at time home visit
1. Source:
 - (a) private industry
 - (b) public assistance (state type)
 - (c) pension from industry
 - (d) court orders
 - (e) assistance from relatives
 - (f) boarders and lodgers
 - (g) Army & Navy pay
 - (h) describe any other
 - (i) no income
 2. Is family
 - (a) wholly self-supporting?
 - (b) partially self-supporting?
 - (c) wholly dependent on public or private agency?
22. Home Conditions: (a) No. of rooms... (b) Patient room alone?.....
(c) Sleep alone?...
23. SSX Clearings:
- (a) Name of agency active if any.....
24. What medical supervision since discharge?
(a) Dates: From.....to (b) by.....
25. Date (a) of last examination..... (b) last X-ray..... (c) Result.....
26. What is present condition?.....
27. Why did you leave sanatorium.....

APPENDIX C

[illegible]

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