Solving the Problems of the Tuberculous War Veteran*

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A great deal has been written about the problems of the tuberculous war veteran. The impression has been created that he is an individual set apart from the rest of the communal family and is somewhat of a problem child. Public attention having been focused on this thought, it has been assumed that all the problems in connection with the hospitalization of the tuberculous veteran, are indigenous to this particular group of people.

It has been generally accepted that the most serious problem of the tuberculous war veteran is the difficulty in keeping him continuously hospitalized until his disease has become arrested or until he has attained the maximum benefit from hospitalization and will no longer be a menace to the community.

However, a careful study of the subject indicates that a similar problem exists in most tuberculosis hospitals in this country. Tuberculosis Topics1 reports that approximately 30 per cent of the patients in all the tuberculosis hospitals in the United States left institutions against medical advice during the war years. Drolet2 made a survey of tuberculous patients discharged from 41 institutions in the New York metropolitan area, which includes adjacent New Jersey. He found that out of 10,620 patients discharged during the year of 1945, approximately 29 per cent left against medical advice. In one of these hospitals, out of a total of 257 discharges, 89 per cent left against medical advice and in another hospital 55 per cent left against medical advice out of a total of 1,045 discharges.

It is generally recognized that an arrest of the disease can be attained in the majority of cases of minimal and moderately advanced and in a considerable percentage of far advanced cases of pulmonary tuberculosis, if the patient remains continuously hospitalized long enough under appropriate treatment.

The study of the causes for irregular discharges from tuberculous hospitals in this country indicates that many factors, such as dependency on public aid, the economic burden of hospitalization, the influence of friends and relatives, and a lack of medical knowledge, are involved.

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tuberculosis hospitals and of measures to be taken for their prevention
must therefore be high on the agenda of every organization
interested in the control of tuberculosis.

Undoubtedly the reasons vary to a certain extent among dif-
ferent groups of patients and in different types of hospitals. It
is, however, a known fact that the standard of medical care is
very rarely the cause. A review of the table prepared by Drolet
shows a high rate of discharges against medical advice among
hospitals having the most modern buildings and equipment and
known to be very well staffed and well managed. A patient is,
as a rule, not in a position to know which treatment is standard
and which is substandard. Hence, the great success enjoyed by
patent medicines, fads and quacks.

During the war a considerable number of tuberculous veterans
left the veterans hospitals soon after they were transferred from
army hospitals. The World War II veteran was sent to a veterans
hospital nearest his home directly from the army. While he was
a soldier, he followed orders and went wherever he was directed.
His discharge from the army became effective upon his admission
to the veterans hospital. In most instances the soldier was
away from home a long time. He was tired of restrictions and
discipline, was homesick and craved to be with his family again,
permanently, not just for a visit.

It is easy to understand the man's state of mind that when
the long-awaited day of his discharge from the army finally
arrived, instead of being free again, he found himself once more
away from home, restricted and regimented by the necessary but,
nevertheless, distasteful routine of a tuberculosis institution. This
was particularly irksome to the many World War II veterans who
had early lesions, were practically symptom free, and who looked
and felt well. It is not surprising that many of these men left
the hospitals as soon as they acquired a civilian status and were
free to follow their own inclinations. This condition was duly
recognized and liberal allowances were made for granting leaves
of absence to these patients. However, such privileges did not
solve the problem in the majority of instances. This problem was,
however, temporary and solved itself with the complete demobili-
ization of the armed forces to a peace-time status.

Another frequent cause for veterans leaving hospitals of their
own accord was a provision of the law which called for a consider-
able reduction in the pension when a patient without dependents
entered a veterans hospital. This provision placed a premium on
leaving the hospital against medical advice. Legislation to correct
this situation was enacted by Congress in September 1946.

Generally speaking, the most common reasons why patients
leave civilian tuberculosis hospitals against medical advice are considered to be economic. Among war veterans, however, the reasons are inherent in the laws governing the hospitalization of veterans. Paradoxically, the ease of admissions and readmissions to any one of the many veterans hospitals scattered throughout the country and the better economic condition of the average tuberculous war veteran by virtue of a pension, are responsible for a considerable percentage of irregular discharges.

These conditions are unavoidable and, though just, may be a handicap to some veterans in the same nature as the excessive wealth of a parent is at times to a child.

To a non-veteran tuberculous patient, only one, rarely two, sanatoriums are available in his respective state. Admissions to the institutions that are available can be secured, in most instances, only after a long interval of waiting. To the tuberculous war veteran there are available many tuberculosis hospitals scattered over the country, some of them situated in the most beautiful locations and in the most pleasant climates. They are quite a temptation to a foot-loose individual, particularly since he knows that admission of a war veteran with active tuberculosis to any one of these beautiful institutions is practically mandatory. All a war veteran with active tuberculosis has to do to gain admission to a Veterans Administration tuberculosis hospital is to enter the front door and present evidence to prove that he is a bonafide war veteran.

Should a non-veteran tuberculous patient with limited funds become tired of the monotony of a tuberculosis institution and venture away from his home state, he will most surely become stranded in a strange land without friends and without eligibility for admission to a sanatorium for free treatment. It may be said without equivocation that there is probably no sanatorium in the country, whether state, county, municipal or private, which would admit such a patient coming to its doors. Furthermore, a war veteran has a host of loyal and helpful friends among the veterans service organizations all over the country and his funds are regularly augmented by the government in the form of pensions.

These conditions allow for the greater mobility of the veteran to follow an urge for a change of place or climate in search for the mythical land where, he believes, he may be cured by merely inhaling the “health-giving” air.

All possible measures are being undertaken by the Veterans Administration to solve the problems of the tuberculous war veteran. Whenever necessary and possible, laws are being amended toward that end. A very comprehensive follow-up system and a
case registry for tuberculous war veterans have been established and contact will be maintained with all tuberculous veterans, either directly or through the local health agencies. It can be seen, however, from the very nature of the problems, that the Veterans Administration alone cannot solve all of them. This requires the concerted efforts of the state and local health and welfare agencies in cooperation with the Veterans Administration. It is, for instance, beyond the jurisdiction of the Veterans Administration to enforce hospitalization, impose quarantine, examine contacts or indoctrinate members of the family. It is apparent then, that the state and local health and welfare agencies must step in where the Veterans Administration must leave off.

It is hardly necessary to emphasize that an open case of pulmonary tuberculosis is more dangerous epidemiologically than a case of diphtheria or scarlet fever. While the area menaced by these exanthematous diseases is usually limited by the acuteness of the disease to the patient's home, the area menaced by the open case of pulmonary tuberculosis is as wide as is his ability to travel.

Compulsory hospitalization laws for pulmonary tuberculosis have been adopted in several states in order to control the movements of open cases of pulmonary tuberculosis. This will, undoubtedly, have a tendency to prevent patients from leaving the institution against medical advice in many instances. To expect, however, that similar laws would be enacted in all the 48 states within a reasonable time, would be unduly optimistic. Experience has shown that serious problems of national scope frequently require federal laws for their solution. The need for periodic mass x-ray examinations of the entire population of the country is obvious and not beyond reach.

Simultaneously, hospitalization facilities must be provided to accommodate all active cases of pulmonary tuberculosis as soon as the disease is discovered. Without this, a compulsory hospitalization law has no meaning.

A more active and aggressive nation-wide educational campaign against tuberculosis is urged. It should be conducted not only among the various communal groups but it should be aimed particularly at the legislators, strongly emphasizing the communicable nature of the disease, the importance of continuity of treatment and the comparative ease with which it could be controlled by appropriate measures. There should be no hush-hush about a patient with active pulmonary tuberculosis who refuses hospital care, and whose home conditions and supervision are not considered adequate by competent authority.
Intramural Measures

Indoctrination of tuberculous patients in the nature and treatment of tuberculosis is recognized as a fundamental necessity. All other intramural measures designed to uphold the morale of these patients have been heretofore almost exclusively of a recreational nature. The conventional occupational therapy, consisting of various arts and crafts, a circulating library, radio broadcasts and motion pictures are employed in almost all tuberculosis institutions as a diversion to break up the monotony of a long period of hospitalization and to discourage discharges against medical advice. And yet almost one-third of the discharged patients left against medical advice in 1946 from 41 civilian tuberculosis hospitals in a well organized community like metropolitan New York.

There is no stereotyped method for the management of tuberculous patients. The methods have to be varied with the intelligence, educational and cultural background and the ambition of the individual patient. Heretofore, the program did not take this sufficiently into account. It is particularly important to bear this in mind when dealing with World War II veterans, the vast majority of whom are in their twenties.

The intelligent person, whose mental processes are not impaired by the toxemia of an acute febrile disease or by severe bodily discomfort, finds it difficult to lead the vegetative life necessitated by the prolonged bed rest in the treatment of pulmonary tuberculosis. As desirable as complete physical and mental relaxation is, we must recognize the fact that the average young tuberculous patient cannot stop thinking of the present, the future, and the most valuable years which are being extirpated from his life. This large group represents a reservoir of salvageable human material which has not been heretofore adequately tapped. We should give due cognizance to this important group and adjust the management of their cases accordingly.

While the value of complete mental and physical rest in the treatment of tuberculosis cannot be disputed, the inflexible enforcement of the universally adopted rule which prohibits to all patients even reading during certain rest hours, is neither possible nor wise. In many cases, mental and physical relaxation can be more easily and effectively secured while reading an interesting book in a semi-reclining position than while trying to fall asleep in the daytime, which, if successful, would only make sound sleep at night more difficult. A book is frequently the antidote against far more disturbing thoughts. Individualization should be the keynote in applying even the all-important rest cure.
When the disease has come under control and has ceased progressing, the patient still has a long period of hospitalization ahead of him. As long as the lesion is retrogressing it is still unstable and is therefore considered active. Meanwhile, the patient has a sense of well-being which is at times a handicap. He chafes under the inactivity and is apt to leave the hospital prematurely. His energies must, therefore, be directed towards useful pursuits which will have a bearing on his future aims and ambitions, and will also be an added inducement to remain in the hospital until the completion of treatment.

Since the treatment of pulmonary tuberculosis is usually a matter of years, mental and spiritual deterioration are apt to take place and a sense of frustration is likely to result.

It is particularly vital to recognize this situation when dealing with a person in the twenties, a period when the foundation for the future economic life is usually laid. When a patient of this age spends several years in complete idleness, it may, and frequently does, change his entire outlook on life. He sees himself caught in an eddy going endlessly and aimlessly around and around, while the main stream of life is passing by him and flowing onward to greater opportunities. Under such conditions he is apt to disregard the sound, but less alluring advice of his physician, and is apt to leave the hospital of his own accord.

It is not enough to provide such a person with the usual occupational therapy in the form of some crafts or with some light reading matter. This is amusing to some extent, but a healthy and virile mind cannot continuously subsist on such poor mental fare.

Man’s two greatest fears are invalidism and dependency. When a person first learns he has tuberculosis, he is suddenly confronted with these two over-powering spectres, and worry over one aggravates the other, thus creating a vicious cycle. These two problems are so mutually interdependent that for best and surest results both should be tackled simultaneously.

In order to prevent the patient from lapsing into a state of mental stagnation and from losing years of valuable time, to stimulate his lagging morale and to provide an added incentive to remain in the hospital until his tuberculosis is arrested, it is necessary to start him on the road towards his rehabilitation almost simultaneously with the medical treatment.

In most cases, a reorientation of the man’s place in society and a complete revision of his plans for the future are necessary on account of his handicap. Expert guidance is as essential for this as for his medical condition. To leave his rehabilitation to chance
is as impractical and unscientific as to leave the management of his medical treatment to his own devices.

With these ideas in mind, there was organized on the Tuberculosis Service of this hospital, in November 1945, a rehabilitation team consisting of a trained vocational counsellor, an academic instructor, the social worker, and the ward physician.

Each patient found physically suitable was given an interest test, an aptitude and other indicated psychometric tests. If considered qualified for some academic or commercial studies the patient was offered every encouragement and opportunity to pursue the selected subjects with the help and guidance of the instructor.

Subsequently when a rehabilitation program was established by the Veterans Administration in all hospitals under its control, the hospital rehabilitation committee was broadened to include, in addition to the members mentioned above, the Physician in Charge of Medical Rehabilitation Section as well as representatives of other departments concerned with the various phases of rehabilitation.

The training of patients has been carried out under a staff of full-time instructors and a great variety of subjects are offered to suit different patients according to their individual tastes, tendencies, training, education and culture. Diversification is very important if we are to take full advantage of our rehabilitation program and interest in it the greatest number of patients.

Under educational therapy the most popular subjects are those leading towards a high school diploma with special emphasis on English and mathematics. About twelve of our patients have been awarded high school diplomas thus far. Among the commercial subjects, bookkeeping, typing, and stenotyping are the most popular. Business law, stenography, and salesmanship are also offered. Fine arts and mechanical drawing are diligently studied by a group under an exceptionally well qualified instructor. Other patients are being trained in radio and motion picture projector repair and a class in watch repairing is being organized.

Since most World War I veterans are in their upper fifties they are not likely to be fit for rehabilitation. Diversional occupational therapy is available to this group of patients either on the ward or in the occupational therapy shops.

It was very gratifying to note the marked improvement in the morale among patients when the present program of rehabilitation was first inaugurated in November 1945. Instead of drifting aimlessly they found themselves purposefully engaged with a definite object in view. It is relatively uncommon for a patient
who is following a planned rehabilitation program to leave the hospital of his own accord.

All occupations are taken up with the view of fitting them into the eventual rehabilitation program which has been decided upon in each individual case. Thus, while still undergoing treatment for pulmonary tuberculosis, the patient can be advancing simultaneously toward his final goal which is complete rehabilitation.

Conclusions

The modern tuberculosis institution is a great deal more than a place where only the disease is treated. Due to the long duration of hospitalization, the frequent paucity of symptoms and the fact that the majority of the patients are in their early adult years, it is important to give due consideration to the eventual aim of treatment, namely, restoration of the patient to as normal a working capacity as possible. It is necessary to utilize the patient's time and energies in useful pursuits which will be helpful towards his rehabilitation.

A well planned and well executed intramural program of rehabilitation, carefully integrated with the therapeutic regimen, designed to fit in with the post-hospital program of rehabilitation, is a vital function of the modern tuberculosis institution.

Rehabilitation should be started as early as possible after admission, consistent with the physical condition of the patient.

Skillful guidance is required to guard the patient from lapsing into the hypochondriacal state of phthisiophobia, and this must be carefully balanced against the other extreme which is over-confidence to the stage of foolhardiness.

Treatment and rehabilitation are viewed as parts of one continuous program for the purpose of fitting the patient back into the social fabric as a useful, self-supporting, and self-respecting member of the community.

CONCLUSIONES

La institución moderna para tuberculosos es mucho más que un lugar donde solamente se trata la enfermedad. Debido a la prolongada duración de la hospitalización, a la frecuente escasez de síntomas y al hecho de que la mayoría de los pacientes se encuentran en los años adultos tempranos, es importante que se le dé la debida consideración al objeto final del tratamiento, a saber: restaurar al paciente a una capacidad para trabajar tan normal como sea posible. Es necesario que se utilicen el tiempo y las energías del paciente en ocupaciones útiles que contribuyan a su rehabilitación.

Un programa de rehabilitación bien planeado y bien ejecutado,
integrado cuidadosamente con el régimen terapéutico, y concebido para que encaje con el programa de rehabilitación posthospitalario, es una función vital de la institución tuberculosa moderna.

Debe comenzarse la rehabilitación tan pronto después de la admisión como sea posible, consistente con la condición física del paciente.

Se necesita una dirección hábil para evitar que el paciente caiga en el estado hipocondríaco de la tislofobia, y debe balancearse cuidadosamente esto con el otro extremo, la confianza en demás que lleva a la temeridad.

Se considera que el tratamiento y la rehabilitación son partes de un programa continuo cuyo propósito es el de restaurar al paciente a la sociedad como un miembro útil y pundonoroso de la colectividad que se gana su propia vida.

REFERENCES