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Factors Hindering Public Health Nursing of Tuberculosis Patients

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FACTORS HINDERING PUBLIC HEALTH NURSING OF TUBERCULOSIS PATIENTS

by

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Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Science.

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CHAPTER I

INTRODUCTION TO THE STUDY

In recent years drug therapy has greatly increased the effectiveness of the tuberculosis control program and has shortened the period of hospitalization for patients with active tuberculosis.[1] Some individuals are not being hospitalized at all but are being treated at home without hospitalization.

Public health efforts are required to assure that patients in the community continue on prescribed medical regimen. As the number of cases treated at home continues to grow, problems in adequate public health supervision are amplified by the increase in home care.[2,3] It is speculated that the tuberculosis patient of the private physician may have an attitude of resentment or misunderstanding toward the district public health nurse. He may feel that contradiction exists between his physician and

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[1] I. Jay Brightman, "The Present Status of Tuberculosis Control," American Journal of Public Health, 49:757, May, 1963.

[2] Paul Pamplona, "The Unhospitalized Tuberculosis Patient," Rhode Island Medical Journal, 40:545, August, 1957.

[3] I. D. Bobrowitz, "The Changing Pattern in Hospital Treatment of Tuberculosis," Annals of the New York Academy of Sciences, 106:11, February 28, 1963.

the Public Health Department as each one seems to require different follow up care. Follow up care for tuberculosis patients in San Bernardino County is provided either by a private physician or the County Health Department and County General Hospital. This care consists of sputum cultures, chest x-rays, drug therapy and physician evaluation. If the care is from County General Hospital and the Health Department, it is accomplished through patient use of a weekly chest clinic where patients are seen every three months the first year after discharge from the hospital; then every six months for the second year, and after that on a yearly basis.

I. THE PROBLEM

Statement of the problem. The problem of this study was to discover and identify some of the factors that interfere or hinder the public health nursing of the private physician's tuberculosis patient. If these factors could be identified, the resolution of the interference or hindrance could provide a basis for assuring adequate follow-up care.

Two factors of major importance in the notable decline of tuberculosis mortality are: The improvement of care available to tuberculosis patients and the increased success in the prevention of new cases through public health

methods[4] which include better sanitation, nutrition and socioeconomic conditions.

Tuberculosis is an infectious and communicable disease which not only affects the patient but also effects his immediate family and those who come in contact with him. The California Health and Safety Code places the responsibility of tuberculosis control upon the local health department.[5] This responsibility is shared by the district public health nurse and other public health personnel who are directly responsible to the local health officer who in turn is responsible to the State Department of Public Health.

To effectively control tuberculosis, all known cases and all suspects must be under periodic surveillance by responsible authorities. There must be a continuing plan for case finding through recognized methods such as community surveys and tuberculin testing.[6] In order for these measures to succeed, the public must be educated in the methods of tuberculosis prevention and control. In many

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[4]H. W. Hetherington and Fannie Eshleman, Nursing in Prevention and Control of Tuberculosis (New York: G. P. Putnam's Sons, 1950), pp. 3-4.

[5]A Manual for the Control of Communicable Diseases in California, (California State Department of Public Health, 1960), p. 350.

[6]Gordon Kincade, "Newer Methods in Tuberculosis Management," Nursing Outlook, 11:291-282, April, 1963.

instances, the public health nurse is responsible for the periodic surveillance of former tuberculosis patients and education of the public. Her role is teaching the patient and his family about the disease process, protection of the family, prevention of further illness and instruction of the family to give streptomycin injections as needed.

Need for the study. In the nursing field there is a recognized need for more patient-oriented research.[7] Previously, many nursing studies have focused upon the nurse as a practitioner rather than upon patient oriented research.[8] This study focuses upon the private physician's tuberculosis patients, who are receiving follow up care from the district public health nurse assigned to the case, to ascertain and identify the hindrances which may exist.

Information communicated to the patient concerning the nature of his problem, the significance of his symptoms, and the course of his illness may make the difference between a poor therapeutic result and many years of productive life.[9] It is also important how he is told and by whom.

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[7] Loretta E. Heigerken, The Improvement of Nursing Through Research, (Washington, D.C.: The Catholic University Press, 1959), p. 4.

[8] Ibid.

[9] Carlton Ernestene, "Explaining to the Patient - A Therapeutic Tool and a Professional Obligation," Journal of the American Medical Association, 165:1110, November 2, 1957.

There is a need, then, to identify the factors that cause interference or hindrance to the relationship between the private physician's tuberculosis patient and the public health nurse assigned to the case, for in a large measure she is responsible for the in-depth teaching of these patients.[10]

Assumptions. For the purpose of this study it was assumed that:

1. The fifty-one tuberculosis cases chosen from the Tuberculosis Register were typical of other tuberculosis patients under the care of private physicians within the given county.
2. Patients can remember significant information regarding their experiences with the public health nurse who visited in their home.
3. Patients are willing to express their true feelings regarding their disease and their care received from the public health nurse.

Limitations. The study was limited to those tuberculosis patients of private physician's who were willing to

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[10] J. Woodrow Savocal, "Public Health Problems Related to Home Treatment of Tuberculosis," Pennsylvania Medical Journal, 60:1135, October, 1957.

participate in the study and who lived within a twenty-five mile radius of San Bernardino city. A further limitation was the fact that all data were obtained during one home visit.

II. METHOD USED IN THE STUDY

The descriptive survey method of research was chosen for this study. Brown describes it as:

> All studies purporting to present facets concerning the nature and status of a group of persons, a set of conditions, a class of events, a system of thought, or any other kind of phenomenon under study may be classified as descriptive investigations.[11]

This method seemed best suited to identify the factors that interfere or hinder the public health nursing of the private physician's tuberculosis patient.

Permission to conduct the study was obtained from the San Bernardino County Health Officer after an explanatory letter (Appendix A) and a personal interview. The private physician's permission to interview their patients was secured by letter (Appendix A) which explained the purpose of the study and included the proposed interview guide and a self-addressed post card (Appendix A) to be returned with their answer. A follow-up contact was made

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[11] Amy Brown, Research in Nursing, (Philadelphia: W. B. Saunders Company, 1958), p. 153.

by telephone if the physician did not return the post card within two weeks.

The individual patients were contacted by letter (Appendix A), giving the purpose of the study and the proposed time for a home visit to interview them. The researcher identified herself with the University rather than with the Health Department. The data were collected during one home visit which usually was thirty to forty-five minutes in length. Either a day time or evening visit was made according to the patient's preference. All patients whose physicians had given permission to interview them were contacted. The data were collected with the aid of an interview schedule.

Selection and Development of the Tool. An interview was the tool used for collecting the data. It was designed to elicit: The patient's feelings toward and expectations of the role of the health department and the public health nurse; his particular problems with accepting and understanding his disease.

The interview schedule contained seven questions, two were open-end questions and the remaining five requested the patient to classify or rank items. (Appendix B). Responses to the open-end questions were recorded verbatum where possible. The feelings toward the Health Department

were sought (Questions One and Six) and the expected role in tuberculosis control (Question Four). In two questions the respondents were asked their expectation of the public health nurses role (Questions Two and Seven). Two other questions were designed to elicit the patient's problems with accepting and understanding his disease. It was felt that the answers secured from these questions would identify some of the factors that interfere or hinder the public health nursing of the private physician's tuberculosis patient.

A pilot study was conducted to test the interview schedule; five patients were interviewed and a revision of Question Five to include a choice regarding surgery recommendations was added. These five patients were included in the study because the change was minor.

Selection and Description of the Sample. Patients for this study were selected from the Tuberculosis Register of the San Bernardino County Department of Public Health. The criteria for selection were: 1) Patient diagnosed as having pulmonary tuberculosis. 2) Patient under supervision of any private physician, clinic or military facility but not under supervision of San Bernardino County General Hospital. 3) Public health nursing services given by district public health nurse. 4) Patient residing within

a twenty-five mile radius of San Bernardino City. 5) Diagnosis made within the past six years. The tuberculosis register is a visible record of all the tuberculosis cases within San Bernardino County. It gives the following information about each patient: Name, age, sex, address, diagnosis, medical supervision and X-ray, sputum culture and drug therapy reports.

Twenty-six physicians were contacted to secure permission to interview their patients. Of these, fourteen allowed their patients to be interviewed, eleven did not. The majority of the patients were cared for by internists or general practitioners rather than by chest surgeons. An equal number of internists and general practitioners allowed and refused the interview while no chest surgeons refused to allow their patients interviewed. Table I below gives the twenty-six physicians according to their speciality.

TABLE I

CLASSIFICATION OF PHYSICIANS ACCORDING TO SPECIALITY

Speciality	Interview Allowed	Interview Refused	Total Number
Internist	6	5	11
General Practitioner	5	5	10
General Surgeon	1	1	2
Chest Surgeon	3	0	3
Total	15	11	26

A total of fifty-one patients met the criteria for participation in the study. Nineteen were successfully interviewed, the primary reasons for the reduction in number were: 1) The private physician refused to allow the interview, 2) The patient had moved and was not located, 3) The patient refused to be interviewed.

A more detailed explanation of why the physicians and patients refused to participate will be given below. (See Table II) It is interesting to note that several of the physicians who refused to give their permission stated the patient would be too upset by the interview.

The physician's of thirteen patients didn't think it advisable for the researcher to interview their patients. Not all gave a reason; however, some did. The reasons given were:

-- Patient too confused to talk with anyone.

-- Patient very uncooperative and hostile, I doubt if he could be of help to you.

-- Patient would be too upset by an interview.

-- I would rather you wouldn't visit this patient, he is already too upset.

-- This is a delicate medical-legal problem and I'd rather not have my patients interviewed.

Five patients whose physicians had given permission for the researcher to interview chose not to participate

TABLE II

REASONS ELIGABLE PATIENTS DID OR DID NOT PARTICIPATE

Completion of Interview	Number		Per cent
Agreed to be interviewed	19		37
Refused to be interviewed	32		63
Reasons for refusal			
Private physician refused		13	
Patient moved, not located		10	
Patient refused		5	
Deceased		1	
Other *			
1) P.H.N. did not visit		1	
2) Permission of Surgeon General USAF needed		2	
Total	51	32	100

* 1) In one instance the patient had not been visited by the public health nurse as he was not referred for supervision.

2) Permission to interview two patients who received their care from Norton was not secured as the Surgeon General of the USAF would have to approve.

for the following reasons:

-- No public health nurse had visited, and that the patient was too busy for an interview even in afternoon or on weekend. This patient was a registered nurse. Nursing records in the Health Department indicated that home visits had been made by a public health nurse.

-- One patient's wife, a registered nurse, refused to allow an interview with her husband because she felt he would be too upset. However, she talked with researcher for forty-five minutes. (Appendix C)

-- One patient called and said she wouldn't be at home at the time the interview was planned; a subsequent home visit was made in the evening and the patient's husband refused to allow the researcher to talk with his wife. His reason was: "My wife just doesn't want to talk to anyone about this whole mess."

-- One patient, a licensed vocational nurse, refused by letter. (Appendix C)

-- One patient agreed to be interviewed and set a new date and time; then he was not at home. Three other attempts to talk with him failed because he was not at home.

CHAPTER II

REVIEW OF LITERATURE

I. INTRODUCTION

In the review of literature the investigator found no research on the possible misunderstandings which might be found among private patients who have tuberculosis and who are being visited by the public health nurse. Studies most directly related to this topic were reviewed.

Tuberculosis, the chronic disease known as the "Captain of the Men of Death," remains a major health problem.[1] As early as 1000 B.C. the clinical features and communicability of tuberculosis were known. It was called phthisis by the hippocratic physicians. At the time of Christ a lung nodule (Phyma in Greek) became tuberculum in Latin.[2]

Soper recently stated that tuberculosis is the most

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[1] George Silver, "Care of Tuberculosis Patients in Organized Home Care Program," Pennsylvania Medical Journal, 39:1490, December, 1956.

[2] Robert L. Yeager, "Opening Remarks," Annals of the New York Academy of Science, 106:3, February 28, 1963.

widespread of human ills, the most chronic and persistent of infections, with the longest period of infectivity of any disease known to man.[3]

Although fewer persons die of tuberculosis today than in the past, there is not a corresponding decline in the number of persons suffering with the disease.[4] It is apparent that tuberculosis case rates have not declined as rapidly as death rates.[5] In 1963, a published report stated that tuberculosis was responsible for 50,000 new cases and 10,000 deaths in the United States Annually. At that time there were 2,000,000 individuals living with tuberculosis or having had active disease, and over 30,000,000 individuals infected with living virulent tuberculosis bacilli in their bodies.[6]

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[3]Fred L. Soper, "Problems to be Solved if the Eradication of Tuberculosis is to be Realized," American Journal of Public Health, 52:734, May, 1962.

[4]G. M. Candau, "No Truce for Tuberculosis," American Review of Respiratory Diseases, 89:589, April, 1964.

[5]The Arden House Conference on Tuberculosis (Public Health Service Publication, U.S. Government Printing Office, Washington, D.C., 1961), p.6.

[6]James E. Perkins, "The Significance of Tuberculosis in Public Health," Annals of the New York Academy of Sciences, 106:5, February 28, 1963.

These statistics give only a partial picture of human damage, misery and economic loss. They do not tell of thwarted lives, disrupted families and human waste which are such important by-products of this disease.[7]

The former long periods of hospitalization, complete bed rest and collapse therapy have yielded to short hospitalization, ambulatory chemotherapy and surgical resection.[8,9] This present regime has increased the number of patients who are being treated in their homes; it has also increased the number of those who have been discharged from the hospital but who will need drug therapy for a long time.[10,11]

This very dramatic and significant change which has occurred in the past decade is undoubtedly due to effective chemotherapy.[12] Just a little over ten years

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[7]Dwight R. Rieman, "Working with Tuberculosis Patients," Nursing Outlook, 3:394, July, 1955.

[8]I. Jay Brightman, "The Present Status of Tuberculosis Control," American Journal of Public Health, 52:758, May, 1962.

[9]W. R. Barclay, "Limitations of Home Treatment of Tuberculosis," Canadian Journal of Public Health, 52:78, February, 1961.

[10]Helen M. Woolard, "New Problems in Tuberculosis Nursing," Nursing Outlook, 4:229, April, 1956.

[11]Brightman, loc. cit.

[12]I. D. Bobrowitz, "The Changing Pattern in Hospital Treatment of Tuberculosis," Annals of the New York Academy of Sciences, 106:9, February 28, 1963.

have elapsed since isoniazid, probably the most potent antituberculosis drug, became available.

Effective chemotherapy has also brought about changes in the concepts concerning the need for complete bed rest. Strict bed rest is usually indicated only for those patients with extensive disease and cavitation and who are febrile or hemorrhaging. There is a tendency toward early and appreciable ambulation for the average case where the foregoing conditions do not exist.[13]

In doing a review of literature the investigator divided the problem into the following three areas:

(1) Current trends in incidence, mortality, and morbidity

(2) The role of the Health Department and public health nurse in tuberculosis control

(3) The role of the private physician in tuberculosis control

II. TRENDS IN INCIDENCE, MORTALITY AND MORBIDITY

The national tuberculosis death rate has declined from a rate of 154 per 100,000 persons in 1910 to a rate of 4.9 per 100,000 persons in 1963. Within the last decade there has been a 77 per cent decline in death rate due to tuberculosis.

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[13] Ibid.

For many years tuberculosis ranked first as cause of death, it ranked 18th in 1963. The death rates have shown a more consistent annual rate of decline than have case rates. In 1963 there was an increase in new active cases for the first time since a gradual decline began in 1910.[14,15]

To consider the world-wide picture, it is estimated that at least 15 million people suffer from infectious tuberculosis in the world today. It still claims more than three million lives each year. These are cautious estimates of the situation.[16]

According to the managing director of the National Tuberculosis Association we have done quite well in the treatment of tuberculosis patients but we have failed to prevent people from developing the disease.[17]

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[14] The Arden House Conference on Tuberculosis (Public Health Service Publication, U.S. Government Printing Office, Washington, D.C., 1961), p. 6.

[15] Reported Tuberculosis Data (Public Health Service Publication, U.S. Government Printing Office, Washington, D. C., 1965), pp. 1,2.

[16] Candau, loc. cit.

[17] James E. Perkins, "No Truce for Tuberculosis," American Review of Respiratory Disease, 89:590, April, 1964.

III. ROLE OF THE HEALTH DEPARTMENT AND PUBLIC HEALTH NURSE IN TUBERCULOSIS CONTROL

Tuberculosis appears to be an ideal problem for public health action. As public health workers we know the cause; we have at our disposal the means of identifying it early; and can stop its spread.

The ultimate legal responsibility for communicable disease control resides in the State Health Department. The local Health Departments give the direct service to the patient and his family but must report all findings and control factors to the State Health Department.[18]

Local health departments have long maintained tuberculosis case registers and the follow up of post-hospital and clinic patients has been a well recognized responsibility of the public health nurse.[19]

Authorities have pointed out that tuberculosis control is primarily a local task and that health agencies must recognize their responsibility in developing control programs which include planning for mass surveys, contact examination

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[18] California State Department of Public Health, A Manual for the Control of Communicable Diseases in California, 1960, p. 350.

[19] Brightman, op. cit., p. 757.

and maintenance of non-hospitalized patients on drug therapy.[20,21,22]

As the periods of hospitalization for active tuberculosis shorten, the responsibility of the health department in tuberculosis control may be expanded.[23]

It has been shown by national and local studies that none of the aspects of tuberculosis control are being conducted adequately throughout the country. Seldom are the recommendations of the Arden House Conference on tuberculosis adequately implemented.[24] Continually, patients who are discharged from the hospital fail to continue adequate drug therapy. Some of the contacts of new cases are not being examined for tuberculosis infection with proper follow up, and adequate case finding programs are not being conducted in most communities.[25]

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[20] Soper, loc. cit.

[21] James E. Perkins, "Can Tuberculosis be Eradicated?", Public Health Reports, 78:420, May, 1963.

[22] Brightman, loc. cit.

[23] Ibid.

[24] Perkins, "Comments on Soper," American Journal of Public Health, 52:746, May, 1962.

[25] Ibid.

Approximately 30 per cent of new active cases reported each year are found by examining contacts of other active cases.[26] Usually the immediate investigation of contacts of active tuberculosis is completed. However, often overlooked is the importance of following the contacts for a period of two or three years to determine whether tuberculosis infection can be identified by tuberculin conversion.[27] It is now usually agreed that four months follow-up after contact is broken is adequate.

It is usually appropriate to hospitalize all active, infectious cases of tuberculosis until the sputum becomes negative and the lesion stable.[28] However, much individualization should also be exercised in determining the type of treatment for a given patient.

The relative ease with which symptoms can be abated and infectiousness controlled by administration of specific antibiotics should not blind us to the responsibility shared by the private physician, public health worker,[29] general public and patient.

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[26] Brightman, op. cit., p. 749.

[27] Ibid.

[28] Paul Pamplona, "The Unhospitalized Tuberculosis Patient," Rhode Island Medical Journal, 40:455, August, 1957.

[29] Sydney Jacobs, "Tuberculosis: A Community Project," Journal of the Louisiana State Medical Society, 111:124, April, 1959.

Close cooperation between the tuberculosis hospital, public health department and private physician is necessary for the best care of the tuberculosis patient.[30] An integral part of the health department's function is to augment the physicians emphasis upon the patient's responsibility to his family and the community as well as to himself.[31]

The law usually requires public health officials to instruct tuberculosis patients and their families in measures to protect themselves as well as the community.[32] Most often it is the public health nurse who visits the patient to see that prophylactic measures are understood and carried out. "Compulsory restraint or isolation of a rebellious patient is sometimes necessary in the interest of community health. Such action, however, should be the last resort."[33] Sixty years ago Doctor William Osler said,

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[30] James Matthews, "Basic Treatment of Tuberculosis in Relation to Home Care," Medical Times, 89:568, June, 1961.

[31] Leon Galinsky, "Reduction of Irregular Discharge Rates in a Tuberculosis Hospital," Diseases of the Chest, 37:618, June, 1960.

[32] California State Department of Public Health, op. cit., pp. 351-352.

[33] Jean South, Tuberculosis Handbook for Public Health Nurses, (New York: National Tuberculosis Association, 1955), p. 19.

"There are three to educate: The public, the profession and the patient."[34]

Immediately after the diagnosis is made it is important to draw all appropriate agencies and persons toward early action in support of the family. The authoritative voice of the physician is probably the most important.[35]

Tuberculosis patients have unique needs because of their reaction to long term treatment, uncertainty of the outcome of their illness and changed relationships with those they love most.[36] Often they cannot seem to accept their diagnosis and refuse to follow through with doctor's recommendations. The public health nurse can help these patients if she understands and accepts their reasons for denying their diagnosis and refusing the necessary treatment.[37] In the home situation the public health nurse must

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[34]William Osler, "Address of the Vice President," Transactions of the First Annual Meeting of the National Tuberculosis Association, (New York: Irving Press, 1906), p. 20.

[35]Jeanne Richie, "The Tuberculosis Patient Who Refuses Care," Nursing Outlook, 8:622, November, 1960.

[36]Agnes B. Bowe, "Inservice Education in Tuberculosis Nursing," Nursing Outlook, 5:472, August, 1957.

[37]Elizabeth Fulcher, "When Tuberculosis Patients Ignore Medical Advice," American Journal of Nursing, 56:1573, December, 1956.

use her skills in analyzing the family health needs and appraising their competence to meet these needs, deciding what nursing activity would be indicated for the specific situation.[38]

Patients are often labeled "uncooperative" when they simply need more, better, or different types of help in understanding and accepting medical recommendations.[39]

It is a known fact that between 35 and 50 per cent of patients with tuberculosis do not complete residential treatment of their disease. This is striking evidence that something is wrong with the manner in which these patients are handled. The emotional problems of the patient which are not handled properly are in a broad sense the reasons for these failures.[40]

IV. ROLE OF THE PRIVATE PHYSICIAN IN TUBERCULOSIS CONTROL

The responsibility for diagnosis and treatment of tuberculosis rests with the physician. In recent years, as

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[38] H. Wilson, "Role of the Public Health Nurse in Tuberculosis Control," Canadian Journal of Public Health, 56:13, January, 1965.

[39] Ruth Taylor, "Patients Who Disregard Medical Recommendations," Public Health Reports, 71:905, September, 1956.

[40] T. E. Coburn, "Emotional Problems in the Treatment of Tuberculosis," American Review of Tuberculosis, 71:299, February, 1955.

the out patient treatment of tuberculosis has grown due to shorter periods of hospital care, more private physicians are treating tuberculosis patients than ever before. The supervision of patients under these circumstances is a mixed blessing[41] and brings with it new problems for the physician and community agencies dealing with tuberculosis.

In California the law authorizes public health officials to give instructions to tuberculosis patients and their families in methods for controlling the spread of the disease.[42]

> In all instances it is advisable for the public health nurse to safeguard the relationship between the private physician, patient and official agency by consulting the physician before she visits his patient even though she may be within her legal rights in visiting without his sanction.[43]

There are problems that arise in the treatment of private patients by a family physician who is not completely familiar with modern tuberculosis management.[44] In such cases the local health department is responsible to see

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[41] C. W. Tempel, "The Responsibility of the Physician in Tuberculosis Control," Diseases of the Chest, 45:445, April, 1964.

[42] California State Department of Public Health, loc. cit.

[43] South, op. cit., p. 7.

[44] J. W. Savocool, "Public Health Problems Related to Home Treatment of Tuberculosis," Pennsylvania Medical Journal, 60:1336, October, 1957.

that adequate drug therapy and systematic, periodic examination of private patients is accomplished.

When patients turn to their family physician for guidance, it is essential that the tuberculosis patient be advised in conformity with the best principles of tuberculosis follow-up.[45] Often the difference between what should happen and what does happen to the individual patient is determined by the attitudes and teaching of the physician who first made the diagnosis of tuberculosis.[46]

Patients who leave the hospital or sanitarium and decline further treatment present a challenge to the private physician as it is from him they often seek help. It is postulated that these patients are seeking an easy way out;[47] that they have never accepted their diagnosis and, therefore, cannot understand the implications of tuberculosis as a disease.[48]

When active tuberculosis is diagnosed, it is the responsibility of the attending physician to inform the

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[45] Ibid.

[46] J. D. Riley, "The Psychological Moment in the Treatment of Tuberculosis," American Review of Tuberculosis, 54:341, October-November, 1946.

[47] Savocool, op. cit., p. 1337.

[48] Riley, op. cit., p. 342.

family that the disease is contagious. It is also advisable to inform the family of the importance of contact investigation to prepare them for the subsequent home visits by the public health nurse. Although contact investigation is initiated by the physician, the completion of contact investigation is largely the responsibility of the health department. When this is explained to the family, the procedures of such follow-up may be regarded as a safeguard to the welfare of the entire family rather than an official and irritating invasion of their privacy.[49]

It is the recommendation of the American College of Chest Physicians that the treatment of tuberculosis be undertaken preferably by a physician who is a specialist in this field. They also recommended that, whenever possible, the patient with active tuberculosis be hospitalized, at least during the early stages of illness.[50]

V. SUMMARY

Although fewer persons die of tuberculosis today than in the past, there is not a corresponding decline in the

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[49] Riley, op. cit., p. 342.

[50] Katherine H-K Hse, "Contact Investigation: A Practical Approach to Tuberculosis Eradication," American Journal of Public Health, 53:1767, November, 1963.

number of persons suffering with the disease. Great progress has been made in the treatment of tuberculosis, but the progress toward preventing people from developing the disease has lagged.

Drug therapy has greatly augmented the effectiveness of the tuberculosis control program, but greater public health efforts are required to assure that patients in the community whether or not previously hospitalized for tuberculosis continue to take their prescribed drugs regularly.[51]

Most writers agree that if the emotional problems of the tuberculosis patient are not handled properly, poor therapeutic effects or failure may result. These patients have unique needs because of their reactions to long term treatment, uncertainty of the outcome of their illness and changed relationships with those they love. If the health workers providing care for tuberculosis patients could have close cooperation and understanding of each team member's role: Private physician, public health nurse and health department; perhaps the care given the patient could be greatly increased in efficiency and adequacy.

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[51] Brightman, op. cit., p. 758.

CHAPTER III

PRESENTATION AND INTERPRETATION OF DATA

In this study, an interview schedule was used to gather data about factors that interfere or hinder the public health nursing of the private physician's tuberculosis patients. This chapter will include the description of the sample, the responses of patients to the questions asked during the interview, and a report of the findings.

I. DESCRIPTION OF PATIENTS

A total of fifty-one patients met the criteria of the study. Of these, nineteen were successfully interviewed. This group consisted of eleven males and eight females. Tables III and IV. Most of the cases were either moderately advanced or far advanced. The ages varied from 24 years to 83 years. The majority were diagnosed after 1963.

No differences were noted in these nineteen patients as to ethnic group membership, or whether the disease was a reactivation or not. It is interesting to note that 66.6 per cent of the women were in the 25-44 age group; this is compared with only 12.5 per cent in the males. The male group were generally much older, with 54.5 per cent being in the 65+ age group, only 12.5 per cent of the females were

TABLE III

DISTRIBUTION OF FEMALE PATIENT BY AGE, ETHNIC GROUP, EXTENT OF DISEASE, REACTIVATION AND MORBIDITY DATE

Age	Ethnic Group			Extent Disease			Reacti- vation		C.M.R.		Total
	Cauc.	Spanish American	Negro	F.A.	M.A.	M.	yes	no	-63	-63	
0-24		1			1		1		1		1
25-44	4	1			2	3	1	4	2	3	5
45-64	1			1			1		1		1
65+	1			1			1			1	1
Total	6	2	0	2	3	3	3	5	3	5	8

TABLE IV

DISTRIBUTION OF MALE PATIENTS BY AGE, ETHNIC GROUP, EXTENT OF DISEASE, REACTIVATION AND MORDIBITY DATE

Age	Ethnic Group			Extent Disease			Reacti- vation		C.M.R.		Total
	Cauc.	Spanish American	Negro	F.A.	M.A.	M.	yes	no	-63	-63	
0-24											0
25-44	1				1		1			1	1
45-64	3	1		1	1	2	1	3		4	4
65+	5		1		6		2	4	2	4	6
Total	9	1	1	1	8	2	4	7	2	9	11

in this category.

Another area of interest is the extent of disease category. Seventy-two per cent of the males had moderately advanced cases. Only 37.5 per cent of the females received this diagnosis. Proportionally, twice as many women as men had far advanced cases. Three of the nineteen had active tuberculosis and were on home isolation at the time of the interview.

The average tuberculosis case, in terms of this study, will vary according to sex: Males will be Caucasian, age 65+, with a probable diagnosis of a moderately advanced case of tuberculosis; The female case will be Caucasian, age 25-44, with an almost equal chance of having minimal tuberculosis, as she has of being moderate to far advanced.

II. PATIENT PERCEPTION AND RESPONSE TO HEALTH DEPARTMENT AND PUBLIC HEALTH NURSE

The patients were asked to describe their feelings when they found the Health Department was following their case. (Question One) This question was intended to elicit a response on their initial concept regarding Health Department involvement. Difficulties were encountered when classification of feelings toward the Health Department was attempted. After study it was discovered that these feelings

could be more meaningfully discussed as attitudes or predispositions to respond in a favorable or unfavorable manner toward Health Department personnel. A favorable response would be a positive attitude; an unfavorable response a negative attitude. When the response revealed a feeling of hostility, or when fear was revealed the attitude would be classified as a negative or unfavorable response. It was discovered that 76 per cent of the respondants were unfavorable or negative toward the Health Department no matter how they saw the nurses role.

In the interview, the patients responded to the question concerning what responsibility they thought the Health Department had for their care (Question Four) in terms of: none, some, or great responsibility. Table V illustrates that the majority of the patients do understand the responsibility of the Health Department and the public health nurse, but there is some indication they might resent it.

When the patients were asked what they thought the public health nurse could do for them, (Question Two), only 50 per cent recognized the role of the public health nurse and seemed to expect such services as prevention of disease, teaching or explaining about the disease process, and giving of medications. Approximately 50 per cent of those who recognized the role of the public health nurse

TABLE V

RESPONSES CONCERNING PUBLIC HEALTH NURSES ROLE, FEELINGS TOWARD HEALTH DEPARTMENT, AND RESPONSIBILITY OF HEALTH DEPARTMENT FOR TUBERCULOSIS CONTROL

Patients Perception of P.H.N. Role	Patients Feeling Toward Health Department		Patients Perception of Health Depts. Responsibility		
	Favor	Unfavor.	None	Some	Great
Prevention	2	1		1	2
Explanation Disease	1	1			2
Medications	1	4	1		4
Unsure	2	3	2	1	2
Home Making		1			1
No Help		3	3		
Total	6	13	6	2	11

saw it as giving of medications.

In terms of the public health nurse working with the patient, this suggest that few difficulties would be encountered if 1) public health nurse role is clear, 2) attitude toward Health Department is favorable, 3) responsibility of Health Department is considered great. More difficulties or failure would be expected if 1) public health nurse role unclear, 2) attitude toward Health Department unfavorable, 3) responsibility of Health Department is considered some or none. Where the attitude for all three responses were negative, a need to educate the patient and/or the private physician exists.

Fifty-two per cent (or ten) indicated they had some conception of why the public health nurse visits. According to the sample 26 per cent (or five) will understand the public health nurse role and the primary function of prevention of disease spread and explanation of disease process. Those who had no clear perception of the nurses role (37 per cent or seven) were also unfavorable toward Health Department.

The Health Department is responsible for the control of communicable disease as well as being a community resource for positive health. When the role of public health personnel is not clearly perceived by the people they serve, this may cause a hindrance to the services rendered.

III. PATIENTS' SATISFACTION WITH REPLIES, BY MEDICAL PERSONNEL, TO THEIR QUESTIONS

It was felt that if the tuberculosis patient's questions were not answered this would be an interference force. If their questions were answered to their satisfaction then this hindrance would be lessened. Consequently the question was asked to determine how they felt their inquiries were answered. Sixty-three percent (or twelve) replied their questions were answered fully. Table VI.

TABLE VI

PATIENTS REPLIES CONCERNING DEGREE OF SATISFACTION WITH QUESTIONS ANSWERED BY MEDICAL PERSONNEL

Degree of Satisfaction	Number	Per cent
Answered fully	12	63
Answered partially	4	21
Questions were avoided	3	15
Questions were encouraged	0	0

* per cents are rounded individually and may not add to 100.

No respondent stated his questions were encouraged. Less than 15 per cent (or three) felt their questions were avoided. When the answers to these questions are compared with the responses received to Question Five where they were asked to list the three things that were most difficult for them to

understand about tuberculosis, all but three patients were able to list items that were difficult for them to understand. Three patients volunteered sources of additional help with questions they had had about their disease. One patient, who was in a private sanitarium in Los Angeles County, reported that she received the most help from the hospital library. Two patients in San Bernardino County mentioned that they benefitted greatly by the lectures which were given every two weeks while they were in the hospital.

Of particular interest was the one patient who felt his questions were avoided and he further elaborated: "I really didn't ask very many questions because I only got more muddled up, for instance, one doctor said I was O.K. and then my sputum was positive again; I just wish they would let me alone."

IV. THE THREE ITEMS THAT WERE MOST DIFFICULT FOR PATIENTS TO UNDERSTAND ABOUT TUBERCULOSIS

In the interview (Question Five) patients were asked to rank in order of difficulty the three items most difficult to understand. The items regarding sputum specimens and disease prevention were each ranked eleven times among the first three, or 24 per cent of the total responses. Table VII gives the order and frequency of responses in regards to items difficult to understand.

TABLE VII

ITEMS MOST DIFFICULT FOR PATIENTS TO UNDERSTAND ABOUT TUBERCULOSIS

Response	Number ranked in top three	per cent
Questions Regarding sputum test	11	24
" " Disease Process	11	24
" " Medications	8	18
" " Health Dept. Involvement	4	9
" " P. P. D.	4	9
No problem in understanding	3	7
*Other	3	7
Questions regarding why people avoid me	1	2
Total	45	100

* a) "that I can't do what I want"
b) "why I don't feel sick if I'm as sick as they say"
c) "why a definite diagnosis is so difficult"

There were eleven choices from which the respondants could list the three things that were most difficult for them to understand. It is interesting to note that one of these choices was used only one time and two other choices were not used at all. These were "why people avoid me," "why I can't get a job" and "why surgery was or was not recommended." This possibly suggests that the patients are denying the disease and what it really means to them. The problems with employment and friends are usually rather substantial ones to tuberculosis patients.

Five patients listed items that were not included in the eleven listed in the interview schedule. These responses are reported as far as possible in the patients' own words. One, who was under Home Isolation Order, listed: "that I can't do what I want" and "why I don't feel sick if I'm as sick as they say." Another who had a reactivation of tuberculosis stated "I have never been able to understand why a definite diagnosis is so difficult." Three patients reported they found no difficulties in understanding any of the items listed. Two of these were patients with reactivations and one had a relative who had had tuberculosis.

V. PATIENTS' FEELINGS CONCERNING THE NECESSITY OF ADDITIONAL X-RAY OR SPUTUM CULTURES

In Question Six the patients were asked if they felt

additional X-ray or sputum tests required by the Health Department were necessary or not necessary. It was felt that if they saw the role of the Health Department as great they would also recognize that additional X-ray or sputum tests were necessary.

When the data were analyzed it was discovered that twelve patients, (63 per cent), felt that if the Health Department required more frequent X-ray or sputum cultures it must be necessary. Seven, (19 per cent), felt this was not necessary. This correlates with the findings of Question Four which indicated that a majority of the respondents recognize the need for Health Department intervention.

Further correlation was noted by the manner in which the respondents agreed or disagreed. There were varying degrees of positiveness or negativeness as evidenced by statements such as:

Necessary:

"It is necessary -- look what happened to me." *

"This is for my own good."

"It is necessary but we don't like it."

"It is necessary but very distasteful."

Not Necessary:

"My doctor says the same thing."

"My doctor looks after me." *

---

*Responses of patients who had a reactivation.

"Both agreed." *

"This is not necessary, I never had tuberculosis."

"My doctor is perfectly capable and the Health Department really isn't needed; but that's the way it is." *

More than half of the reasons if given were negative, only four reasons were considered positive. Table VIII illustrates the patients agreement with the necessity of additional x-ray and sputum tests and also his negative attitude toward the Health Department. He gives verbal assent, but apparently has his reservations.

VI. PATIENTS' RANKING OF IMPORTANT PERSONAL AND PROFESSIONAL TRAITS OF A PUBLIC HEALTH NURSE

The respondents were requested to list in order of importance six personal and professional traits of a public health nurse (Question Seven). Tabulation of their choices revealed they felt friendliness was most important. Professional knowledge and honesty tied for second. Least important to them was the ability to give reassurance, Table IX. Six points were given to the first place choice which was friendliness, the second place choice was given five points and so on to one. Each choice was multiplied by the number of times it appeared in that position to give the over all score. Friendliness received a score of 94, or

*Responses of patients who had a reactivation.

TABLE VIII

PATIENTS' FEELINGS TOWARD ADDITIONAL X-RAY OR SPUTUM SPECIMENS

Feelings Concerning Health Department required sputum & x-ray	Feeling toward Health Department		Perception of Health Department Responsibility		
Necessary	Favorable	Unfavor	None	Some	Great
A for Pts. Benefit	2	6	1		2
B Necessary Evil	2	6	2	1	5
Not Necessary					
A Repetition of Private physician	2	4	2	1	3
B Don't have T.B.		1	1		
Total	6	13	6	2	11

TABLE IX

PROFESSIONAL AND PERSONAL TRAITS OF PUBLIC HEALTH NURSE AS RANKED BY THE PATIENTS

Personal and Professional Traits	Frequency of Traits as Ranked by Patients						
	1st	2nd	3rd	4th	5th	6th	Sum of Rank X Frequency
A. Honesty	4	2	4	6	1	2	72
B. Friendliness	9	4	4	1	0	1	94
C. Professional Knowledge	3	6	2	3	3	1	72
D. Good listener	0	2	4	3	8	2	53
E. Ability to Answer Questions	1	2	4	3	7	2	57
F. Ability to give Reassurance	2	3	1	2	0	11	48

Standardized Order of Importance	Total Points Received
Friendliness	94
Professional Knowledge	72
Honesty	72
Ability to Answer Questions	57
Good Listener	53
Ability to give Reassurance	48

22 points above the tie for second place, at a score of 72. The patients would appear to rank honesty as equally important with professional knowledge.

When analyzing this question in retrospect, it was recognized that strength would have been added to this study if the patients had been asked if the nurse who visited in their homes possessed these traits, rather than asking them to state their ideals for the public health nurse. However some clues were revealed in the interview as to what the patient thought of the public health nurse who visited in his home. One striking example was a re-activated case who said "The thing that irked me was that miserable, wretched nurse who came." He further described how the nurse told his prospective land lord that he was a tuberculosis patient and advised the owner not to rent to him. Another case, also a reactivation, felt the nurse snooped and in general asked many more questions of him than were necessary. He felt the nurse should use more discretion and not insult patients. Two other patients, one a reactivation and one not, felt the nurse always visited them at inconvenient times and that she imposed upon their privacy.

On the positive side, three patients explained how their physician had told them the public health nurse would visit and they seemed pleased with her services.

VII. SUMMARY OF FINDINGS

The private physicians tuberculosis patient recognizes the role of the public health nurse and the responsibility of the Health Department but seems to resent its authority. However, the patients do not have a clear perception of the nurses role which may color their reactions. When the patients perception of the public health nurses role is unclear and the attitude negative, or when the patient perceives her role as limited to giving medications this may be a contributing factor to the unfavorable attitude toward the Health Department. The implications for the public health nurse are: make the nursing supervision as agreeable as possible and upon first contact with patient clarify the nursing role.

Most of the patients felt their stated questions were answered fully, however it would appear that they do have some questions that are not being answered, as evidenced by their response when asked to list the three things that were most difficult for them to understand. The three items most difficult to understand assume primary significance when viewed in relation to the fact that most patients saw the role of the public health nurse as disease prevention, explanation of disease process and giving of medications. These areas are also the most difficult for

patients to understand; therefore the public health nurse has to teach the most difficult things for patients to comprehend to persons who do not clearly understand what she is doing and who also have a negative attitude toward the Health Department.

The majority of patients felt that if the Health Department required more frequent x-ray or sputum cultures that it was necessary to do so. When they elaborated on why they felt it was necessary or not necessary it was recognized that of those who felt it was necessary the majority saw this as a "necessary evil" while only four patients felt it was for their benefit. Those who felt it was not necessary saw this as repetition of what their physician was doing for them. Most of them were negative toward the Health Department. It was concluded that if the recommendation of private physician and the Health Department were more uniform the patients would cooperate more willingly with the follow up.

Friendliness found to be paramount to the patient. When the nurse is perceived as a friendly person she will be better received and her instructions will be more readily accepted. Also important were professional knowledge and honesty suggesting that the nurse must be a person whom the patient can trust. The above qualities or traits would give reassurrance of the nature needed by the patient.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The purpose of this exploratory study was to survey the factors that interfere or hinder the public health nursing of the private physician's tuberculosis patient.

A review of literature revealed no studies on the specific topic of the factors that interfere or hinder the public health nursing of private physician's tuberculosis patients. Referances concerning the role of the public health nurse and the role of the private practitioner, revealed a need for team work in the care of tuberculosis patients and an exceptional understanding of each team member's role. Most authorities agreed that the improper handling of the tuberculosis patient's emotional problems resulted in poor therapeutic results or even failure.

Of the original sample of fifty-one tuberculosis patients who received their care from private physicians rather than San Bernardino County General Hospital, nineteen were interviewed. There were three primary reasons for this reduction in the size of the sample interviewed. The physicians of thirteen patients refused to allow the interview, accounting for the largest number of patients not

interviewed. The second most common reason for failure to complete the interview was that the patient had moved. Five patients refused to participate.

The patient sample consisted of eleven men and eight women. Most of the patients were either moderately or far advanced tuberculosis cases and were diagnosed after 1963. Only three had active tuberculosis at the time of the interview.

It appears significant that of the twenty-six physicians contacted, fifteen allowed their patients to be interviewed while eleven refused. Perhaps the attitude of these eleven physicians, toward the Health Department is reflected in their refusal.

It was revealed that the majority of tuberculosis patients in this study, recognize the role of the public health nurse and responsibility of the Health Department but resent its authority. Most often the role of the public health nurse was not clearly perceived in terms of prevention of disease spread and explaining the disease process. The majority of patients perceived her role as giving medications or they were unsure of her role or else they felt she was of no help to them. Those who had no clear perception of the public health nurses role were generally unfavorable to the Health Department. Most patients felt that if the Health Department required more

frequent X-ray or sputum cultures, that it was necessary to do so.

In regards to their feelings of how medical personnel answer their questions, most responded that their questions were answered fully. However, when this was compared with the listing of things that were most difficult for them to understand about tuberculosis all but three patients were able to give the things most difficult for them to understand.

The three items most difficult to understand were found to be sputum specimens, disease process, and medications. Two of the eleven choices were not used at all. They were "why I can't get a job" and "why surgery was or was not recommended." There was one choice which was used only once: "why people avoid me."

Friendliness was the personal trait these patients felt was most important for the public health nurse to possess. Second most important were professional knowledge and honesty. Least important to them was the ability to give reassurance.

Another interesting finding was that of the total fifty-one patients, two stated that they did not have tuberculosis, of these one was interviewed and one was not.

Throughout the data gathering period the writer was

impressed with the negativeness which was expressed by both the patients and their physicians.

II. CONCLUSIONS

Within the limitations of this study and recognizing that only nineteen of fifty-one eligible patients participated, a few conclusions can be tentatively drawn from the findings. The majority of the patients had an unfavorable attitude toward the Health Department. Their perception of the Health Departments responsibility for control of communicable disease was clear; however, they seemed to resent its authority. Discrepency existed between the role perceptions by the patient and those by public health nurse. The patients felt their questions were fully answered, however no one felt his questions were encouraged. Most patients saw the necessity of additional X-ray or sputum cultures but did not appear to see this as being for their own good. Friendliness was the nursing characteristic found to be most important to the patient. Next most important were professional knowledge and honesty. Slightly less than one-half of the twenty-six physicians permitted their patients to be interviewed which suggests they did not see the importance of improving relationships between the public health nurse and their tuberculosis patients.

III. RECOMMENDATIONS

As a result of the survey of literature, the findings and the problems encountered in conducting this study the following recommendations for those serving tuberculosis patients were made:

1. That the Health Department should accept responsibility for communicating to the private physician the current surveillance program for tuberculosis.

2. That the district public health nurse become personally acquainted with the physicians in her area, to learn their program of tuberculosis control and therapy in order to promote uniformity of recommendations to the patient.

3. That the public health nurse take the responsibility for interpreting her role to the patient so that he realizes she is working with his physician.

4. That a public relations program be planned for the general public; such a program would emphasize the positive aspects of the Health Department and interpret the public health nurses role.

5. That a closer liaison be established between the staff nurses at the hospital and between the district public health nurses regarding what instructions are given to tuberculosis patients.

As a result of this study and the findings the

following recommendations for further study are suggested:

1. That a study be done on all the tuberculosis patients cared for by private physicians. (Considering reactions of ethnic groups and age groups).

2. That a study be done using the patients who receive their care from County General Hospital.

3. That a study be done to secure the private physician's perception of the Health Department and the public health nurse role in tuberculosis surveillance.

4. That a study be done to secure the opinion of public health nurses as to the problems of the tuberculosis patient.

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*The public health nurse desiring more understanding of how to implement the above approaches may receive help from the Seminar on Tuberculosis sponsered by the Communicable Disease Center.

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APPENDIXES

APPENDIX A

LETTER TO THE HEALTH OFFICER

10888 Evans Street
Loma Linda, California

Date

M. E. Cosand, M.D.
County Health Officer
San Bernardino County
316 Mt. View Avenue
San Bernardino, California

Dear Doctor Cosand:

Since I have been practicing public health nursing, I have noticed there have been problems between the private physician's tuberculosis patient and the public health nurse. I would like to have your permission to do a research study in an attempt to identify these problems in the San Bernardino County Health Department. I would be doing this under the guidance of the graduate faculty of Loma Linda University School of Nursing.

Miss Annabil has suggested that the necessary data could be obtained from a review of the nursing notes kept by the public health nurse. I may also need to interview selected private physicians' tuberculosis patients in order to complete the study. Thank you for your consideration and reply.

Sincerely,

(Mrs.) Lida Mae Yeoman

LETTER TO PRIVATE PHYSICIAN

10888 Evans Street
Loma Linda, California

Date

Dear Doctor:

As a graduate student in Public Health Nursing at Loma Linda University, I am conducting a study to find out the reactions of tuberculosis patients to the follow-up care given by the public health nurse.

Dr. Cosand, San Bernardino County Health Officer, has approved the use of the public health nursing notes for the purposes of the study. I would like to obtain your permission to visit a selected few of your patients in order to complete my information. Any patient who would rather not participate will not be included. The individual patient and physician will not be identified by name or by recognizable code symbols.

It is my hope that the findings of this study may be used to make the necessary public health follow-up of tuberculosis as agreeable to the patient as possible.

You will find enclosed the proposed questions and a post card to be returned to me with your answer. If you should wish, a summary of my findings will be made available to you. Thank you for your cooperation.

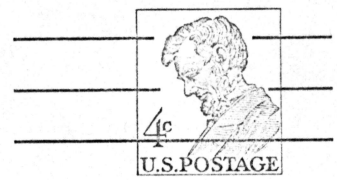
Sincerely,

(Mrs.) Lida Mae Yeoman

LMY:jeh

Enclosure

POST CARD TO BE RETURNED BY PRIVATE PHYSICIAN



THIS SIDE OF CARD IS FOR ADDRESS

Lida Mae Yeoman

10888 Evans Street

Loma Linda, California

_____ You may proceed without contacting me further

_____ I wish further information before giving my permission

SIGNED: _____ _____

LETTER TO THE PATIENT

10888 Evans Street
Loma Linda, California

Date

Dear

Nursing leaders are interested and most anxious to know of ways that the nursing profession can better serve tuberculosis patients. As a graduate student in nursing at Loma Linda University I am conducting a study to discover what those who have had tuberculosis feel is important for the follow up service given by a public health nurse.

Your personal opinion would be very helpful in this study. You can help by telling me about your experiences with the public health nurse who has visited your home.

This study is being conducted with your physician's permission, and all information given will be held in confidence.

I will call at your home on _____
about _____ a.m., p.m.

Thank you,

(Mrs.) Lida Mae Yeoman, R. N.

If any questions call:
TU 9-0111, Ext. 485 between 8-9 a.m.
or PY 6-5874 after 6 p.m.

APPENDIX B

INTERVIEW SCHEDULE

1) What was your first feeling when you found out the Health Department was following your case?

2) When the public health nurse first visited your home, in regards to tuberculosis, what did you think she could do for you?

3) When you are seeking information about tuberculosis from medical personnel, do you feel:
   a) Your questions are answered fully
   b) Your questions are partially answered
   c) Your questions are avoided
   d) Your questions are encouraged
   e) Other (there were contradictions)

4) What responsibility do you feel the Health Department has for your care?
   a) None
   b) Some
   c) Great

5) List in order the three things that were most difficult for you to understand about tuberculosis:
   a) How a person catches tuberculosis
   b) Why sputum tests take so long
   c) Why my Dr. has me take the medicine so long

d) How to protect my family

e) Why my children were given/or not given INH

f) Why the Health Department is involved

g) How the ppd or skin test for Tb. works

h) Why I had to take so many medications

i) Why people avoid me

j) Why I can't get a job

k) Why surgery was or was not recommended

6) In contrast with your private physician, the Health Department may require more frequent X-ray or sputum tests -- how would you describe your feelings toward this?

a) Necessary

b) Not necessary

7) List in order the following personal and professional traits which you feel are most important for the public health nurse to have:

a) Honesty

b) Friendliness

c) Professional knowledge

d) Good listener

e) Ability to answer your questions

f) Ability to give you reassurance

g) Other

APPENDIX C

Wife refused to allow researcher to interview her husband and her reason "it upsets him too much." She talked freely with the researcher for 45 minutes and without questioning she made the following statements.

1) In the County Hospital the patients were "treated like criminals and were called dogs."
2) Nurses in hospitals don't care about the patients.
3) "Public health nurses should just be polite and listen - it would get them a lot farther."
4) The City Health Department nurses were nice and friendly but the County Health Department nurse was "nosey and bossy and looked in every cupboard and closet."
5) The sputum tests results in the hospital were not truthful.
6) The Dr. wouldn't talk to the patients or explain anything.
7) We've had no more trouble since we have our private physician: he called the Health Department and told them not to send the public health nurse around any more. (Nursing record indicated Dr. had requested public health nurse not to make home visit.)
8) The social worker who was supposed to help was no help whatsoever.

LETTER FROM PATIENT REFUSING TO BE INTERVIEWED

San Bernardino,
California

Date

Mrs. Lida Mae Yeoman
Loma Linda,
California

Dear Mrs. Yeoman:

This is in answer to your letter date received 3-16-66.

I'm sorry but I have nothing helpful to add to your research about tuberculosis patients. Besides I work every day.

My association with the Public Health Nurse was a very short one (thank goodness) and a pleasant one. Because my nurse was a very nice person.

I feel that the information you seek should come from someone who has actually had tuberculosis. Sorry I can't be of more help.

Yours truly,

LOMA LINDA UNIVERSITY

Graduate School

FACTORS HINDERING PUBLIC HEALTH NURSING OF TUBERCULOSIS PATIENTS

by

Lida Mae Page Yeoman

An Abstract of a Thesis

in Partial Fulfillment of the Requirement

for the Degree Master of Science

in the Field of Nursing

June 1966

ABSTRACT

The study was conducted to identify some of the factors that interfere or hinder the public health nursing of the private physician's tuberculosis patient. Of fifty-one tuberculosis patients who received their care from private physicians, nineteen were interviewed. The sample was limited because patients had moved and because patient or physician refused to participate. Data were collected by use of an interview in the home. The overall findings indicated that the private physicians tuberculosis patient recognized the role of the public health nurse and the responsibility of the Health Department but resented its authority. It would appear that the patients transferred their negative attitude toward the Health Department to the public health nurse. The majority of the patients felt that the Health Department required X-ray or sputum cultures were necessary. However, they saw this as a "necessary evil" rather than for personal benefit. Friendliness was the personal trait deemed most important for the public health nurse to possess. They reported questions were not encouraged but inquires were answered fully. They were able to list items that had been difficult for them to understand about tuberculosis: disease prevention, disease process, and medications. Because the nurse must teach these items to patients who do not clearly

understand her role and are negative toward the Health Department she is hindered.