

Treatment Taken Before Reporting at a Tuberculosis Clinic

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Summary: A study was carried out at the New Delhi Tuberculosis Centre to analyse the problem of time lag between appearance of symptoms and diagnosis. 41% of the patients took some remedial action within one month whereas almost 33% delayed such action for even longer than 3 months. 54% of the patients sought relief from G. Ps, 28% from hospitals and dispensaries, 12% from specialised TB institutions and 6% from practitioners of indigenous medicine. Patients reporting after several previous actions were found to have a higher rate of bacteriological positivity even though many of them had at least some specific anti-tubercular treatment. Proportionately, the greatest financial burden of treatment before reporting at a TB Clinic was borne most by patients least capable of doing so. Economic difficulty was the deciding factor in finally coming to TB Clinic in half the patients.

The basic principle of TB control is to reduce the period of infectivity of tuberculosis patients to the minimum. With a number of efficient chemotherapeutic regimens it has now become possible to reduce the infectivity period after diagnosis to a very great extent. Whether such a reduction has occurred in the period of infectivity before diagnosis is the subject of this paper.

Since several systems of medical and many types of facilities for diagnosis and treatment, of varying degrees of efficiency, are available in the country, it is not unusual for patients to go through a series of actions before they finally land up in a specialised TB institution dealing with modern medicine. A large part of our population, even in cities, is still steeped in ignorance and superstition, many patients still waste a lot of time and money before they reach a specialised institution, with proper facilities for diagnosis and free treatment. The present study was intended to determine the behaviour pattern of the patients in this respect and also to quantify the losses in time and money incurred by them. An earlier study carried out at the Centre during 1970 and reported by Pamra et al (1971) would serve as a basis for drawing conclusions regarding any changes that might have occurred in the intervening years.

Material and Methods

The study was carried out on freshly diagnosed cases of pulmonary tuberculosis reporting at the

New Delhi TB Centre and residing in the domiciliary treatment area under the Centre's jurisdiction. All such patients were personally interviewed by one of the authors (P.S.) and after establishing the necessary rapport, a questionnaire was filled in, incorporating all necessary information on this subject.

The study covered 256 cases of respiratory tuberculosis newly diagnosed during 1986. Of these, 106 were bacteriologically positive at start, 148 were bacteriologically negative and for 2 patients (both young children) bacteriological examination could not be carried out. With the exception of these 2 cases all others were adults above the age of 15.

Results

Table 1 shows the time lost by patients before they took the first remedial action ('Patients' Delay'). In other words, this table charts the gap between onset of symptoms and the first action taken by the patient. One can see that 41% of the patients took some remedial action within one month. On the other hand almost 33% delayed such action for even longer than 3 months. The table also shows that long delays were more frequent in the uneducated sector. Unfortunately, the proportion of patients (or their guardians) who had education is so low that this conclusion, however plausible, can only be regarded as suggestive.

In the first instance, 54% of the patients sought relief from general medical practitioners, 28% from hospitals and dispensaries and 12% from specialised TB institutions (Table 2). Only 6% went to practitioners of indigenous medicine.

How many patients continued running from pillar to post, without adequate relief, before they landed up at the TB Clinic can be seen from Table 3. Nearly 12% came straightaway, 40% after one earlier action, 25% after 2 actions, about 15% after 3 actions and nearly 8% after 4 or more actions. It is not unnatural that, in the first instance, a patient having prolonged cough should visit a G.P. or a general dispensary for relief but it is worth noting that even though the New Delhi TB Centre has been running a fairly efficient domiciliary treatment programme in the area for over 45 years, almost half the patients visit two or more facilities before reaching the Centre. Interestingly, this is as much true of the educated group as of the uneducated although detailed data are not being presented. What price the patients pay for this delay in terms of clinical deterioration can be seen from Table 4. Charted in this table is the rate of bacteriological positivity among patients who come to the Centre after 1, 2, 3, 4 or more actions

* New Delhi Tuberculosis Centre, New Delhi. Paper presented at the 41st National Conference on TB and Chest Diseases, Hyderabad, 1986.

Table 1
Interval between onset of symptoms and first action related to Educational Level

	<i>Uneducated</i>		<i>Below Hr. Sec.</i>		<i>Hr. Sec. & more</i>		<i>Total</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
< 1 month	47	35.6	50	45.4	8	57.1	105	41.0
1 — 3 months	37	28.0	26	23.6	3	21.4	66	25.8
> 3 „	48	36.4	34	30.9	3	21.4	85	33.2
Total	132	100.0	110	100.0	14	100.0	256	100.0

Table 2
Nature of First Action

	<i>Patients</i>	
	<i>No.</i>	<i>%</i>
General Practitioner	139	54.3
General Hospital or Dispensary	71	27.7
Indigenous Medicine	15	5.9
TB Institution	31	12.1
	256	100.0

Table 3

Number of actions before reaching TB Institution

<i>Actions</i>	<i>Patients</i>	
	<i>No.</i>	<i>%</i>
0	31	12.1
1	103	40.2
2	64	25.0
3	38	14.8
4 or more	20	7.8
Total	256	100.0

as also among patients who come there in the first instance. While assessing these data it should be borne in mind that with the widespread use of and knowledge about anti-TB drugs it is more than likely that many, if not most, of them have had at least some specific anti-TB treatment.

The total time loss due to delayed remedial action and frequent changes of treatment before patients reach the TB clinic is shown in Table 5. It can be seen that almost one-fourth of the patients take over 6 months to reach the TB Clinic and nearly 17% even longer than a year. An idea of the financial burden which earlier treatment had imposed on the patients can be had from Table 6. To begin with, one notices that practically all of them come from the poorest stratum of society, more than half with a declared income of less than Rs. 400/- p.m. The average expenditure incurred per patient on previous treatment varies from Rs. 188/- to Rs. 315/- in the various income groups. Even if one were to take into account the general tendency to declare an income less than the correct one, it is obvious that, proportionately, the greatest financial burden is borne by those least capable of carrying it. Similar finding was recorded by Pamra et al (1971) in the earlier study

Table 4

Bacillary status related to number of previous actions

<i>No. of Previous Actions</i>	<i>Bact. Positivity</i>	
0	8/31	25.8%
1	45/101*	44.5%
2	25/64	39.1%
3	16/38	42.1%
4 or more	12/20	60.0%
Total	106/254	41.7%

*Two children not examined bacteriologically.

but due to steep fall in the value of the rupee a more precise comparison is not possible.

How the patients ultimately reached the TB clinic is brought out in Table 7. In a very large proportion of cases it was the immediately proceeding treatment facility, be it the G.P. or the general hospital, which referred them to the specialised clinic. Even so, it is worth noting that economic motivation was the deciding factor in fully half of the patients.

Discussion

Before drawing any conclusions from this study one should keep in mind its limitations. In the first place, it is based only on patients who ultimately landed up at a specialised TB institution. There may be many others who never reached there, either because they were relieved of their symptoms or disease by previous treatment or for other reasons. Besides, data presented here are based almost entirely on replies furnished by the patients themselves which need not necessarily be accurate. Thus, only rough conclusions indicating trends rather than precise quantitative estimates are permissible.

It would appear from this study that in the first instance most patients complaining of chest symptoms report either to a general practitioner or to a general dispensary for relief. This is not unexpected in as much as most chest symptoms are not specific for tuberculosis and patients have no reason to suspect that they may be suffering from tuberculosis. What is alarming is that nearly 1/3rd of the patients wait for longer than 3 months before taking any remedial action.

A point of some importance is that the proportion of patients consulting practitioners of indigenous medicine in the first instance is only 6%. This is a considerable change from the situation about 15 years back when Pamra et al (1971) reported that this figure was of the order of 20%. Whether such a change has occurred only in urban areas or is indicative of a change all over the country can only be surmised.

Almost 1/4th of the patients seek relief at 3 or more places before they report to a TB institution. How many of them receive anti-TB treatment and

Table 5

Total time lost before reaching TB Institution

0 — 31 Days	91	35.5%
31 — 90 "	63	24.6%
91 — 180 "	44	17.2%
181 — 270 "	10	3.9%
271 — 365 "	5	2.0%
> 365 "	43	16.8%
	256	100.0%

Table 6

Money spent on treatment related to monthly income

Monthly Income	No. of patients	Average expenditure
<Rs. 200	40 15.6%	188
Rs. 200-400	97 37.9%	216
Rs. 400-600	62 24.2%	213
Rs. 600-1,000	46 18.0%	315
>Rs. 1,000	11 4.3%	227
	256 100.0%	

Table 7

Why patients came to TB Clinic

	Patients	
	No.	%
Referred by General Hospital or Dispensary	90	35.2
" " General Practitioner	10	3.9
" " Friends/Neighbours	8	3.1
Not satisfied with earlier treatment	4	1.6
Attracted by free treatment facilities	128	50.0
Discovered in case-finding surveys	16	6.2
	256	100.0

whether the treatment prescribed is scientifically correct is not known. What is certain is that a large number of these are still in an infectious stage when they report to the TB institution. As in the earlier study (Pamra et al, 1971), it was found that, proportionately, the largest amount of money was spent by the poorest.

It is an index of the poverty of our patients that in fully half the patients the chief motivation for reporting at the TB Clinic was the availability of free treatment facilities. Nearly 35% were referred by general hospitals or dispensaries.

It is clear that much remains to be done by way

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Let Us Talk about Death

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loosing power on self, and on rest of the world, and some times death is welcome as a relief from worldly bondages. To academicians, scholars, achievers and ambitious adults, death is a nonfulfilment of life.

We can observe anger, fear, hopelessness, frustration, guilt, loneliness, a sense of humiliation and abasement in the dying adult. These emotions correspond to the meaning they developed of death. When death is seen as nonfulfilment and a failure, they experience frustration leading to anger. In our culture this expression of anger is not so common but some times this anger may be directed on to oneself. The fear is most common in our culture because of fear of going to an unknown place, fear of going alone, a fear of uncertainty of next life (was his 'karma' in this life good and sufficient to be reborn as a human being or going to be born as some animal?).

Hopelessness and feeling of humiliation can be due to the meaning he attributes as an 'unfortunate', loss of control and powerlessness. The most common thing is that fear of death actually is the fear of pain. He is most afraid of pain during death and after death. Guilt feelings are not uncommon because one is leaving behind the spouse, children and other loving persons.

Older people are commonly assumed to be having less fear of death. But it need not be true. However, death usually is not as frightening to the older persons as to an adult because, by this time, they have closely seen death of many near ones and friends; and had unique way of his life experiences. Some do invite death as a relief from suffering of old age, but still, every one wants to die 'peacefully', implying painless death. At this age, some may not have a feeling of loneliness in dying because he/she has already been left behind by the spouse. Intellectualization among less literate one, though literacy may

not always lead to less sentimentalization. The personality of dying individual also influences his reaction to death. Introverts and persons with low self-concept would solicit lot of care, constant assurances and physical presence of near ones compared to extroverts, highly positive in self concept. One common observable characteristic among dying adults and older persons is a compelling oscillation between hope to live and desire of death, desperate to live and desire of death.

What Do We Learn Out of it?

The most general implication is that there is a need to understand the meaning of death to other person to be able to help the dying one and the relatives. It would be possible only if we give those persons full opportunity to express to us. This occurs more readily if caregivers develop the ability and willingness to listen. There is much desirability of suspending our own personal convictions to learn what other people truly think and feel about death. A thanatologist Kastonbaum suggests: "Openness to experience is useful when we are interested in other persons' death".

Since it is obvious that mostly people are afraid of death because of the uncertainty of pain and amount of pain intervening the death process. Hence relief from pain may help people to face death boldly. Remember that a tablet is not always an answer to the pain. It is the presence of health professionals may simply give relief!

References

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of health education to reduce the losses in time and money referred to in this paper. It would, obviously, be a great help if general hospitals and dispensaries and general practitioners develop a high suspicion index in respect of patient reporting with chest symptoms. Further, the general practitioners themselves need to be informed about recent advances in chemotherapy. Where patients are not in a position to bear the cost of treatment, private practitioners would be well advised to refer them as early as possible to a specialized TB institution with

free treatment facilities. Only if action is taken along these lines can we expect some improvement in the present situation.

Reference

- Pamra, S.P. Pathak, S.H. and Mathur, G.P.: Treatment taken prior to reporting at specialised tuberculosis institutions; A medical-social investigation, Proc. 26th National Conference on TB and Chest Diseases, Bangalore, 1971, 293,

(Courtesy: *Indian Journal of Tuberculosis*)