



Changing Emphasis on Problems of Domiciliary Management of Pulmonary Tuberculosis

by Mrs. M. Paul

THE National Sample Survey carried out in 1956, has shown that there are about 35-50 lakhs of tuberculosis patients in the country out of whom nearly 16,00,000 would be infectious. Our experience with local surveys has shown, that only 33% to 60% of the total infectious cases in a community, have been registered at the Clinics. If this proportion were to apply all over the country there would be at least 5,00,000 known infectious cases, whereas there are only 25,000 beds available for their isolation and treatment. The number of beds being so short of the demand, a large number of even infectious cases, (19 out of every 20) have necessarily got to be treated in their own homes even to-day, and for many years to come.

However, the last 15 years have seen great changes in the field of tuberculosis. There is some evidence, that the clinical manifestations of pulmonary tuberculosis are not so acute as they used to be. Whereas a moribund case was not an unusual sight then, such a case is seen very infrequently in a clinic nowadays. Further the advent of antimicrobials has ushered in an almost revolutionary change in the outlook for a tuberculosis patient. Recovery of an advanced case was rare in days gone by, and unless controlled by collapse therapy, majority of them steadily progressed to death. Death is now exceptional and a large majority of even advanced cases, are rendered non-infectious and they improve sufficiently to be up and about within a few months of starting treatment, even though about 10% of them may still remain infectious. These far-

reaching changes have necessarily led to reorientation of the activities of a Health Visitor, who, because of paucity of beds, will, for a long time continue to play an important role in the management of this disease in the patients' homes in our country. I shall try to indicate briefly, some of the important changes in their present day activities in the light of our experience in Delhi.

Isolation

Population of Delhi having risen sharply after 1941 the building of new houses has not been able to keep pace with its growth, with the result that the problem of isolation in the homes, is rather worse today than it was 10 years ago. A recent analysis of the patients, attending New Delhi TB Centre has shown that in nearly 70%, isolation is neither possible nor can be improvised in the patients' homes, whereas in 1949 such was the case in 53% only. A Health Visitor is helpless under such a situation. To expect the patient or the children, to spend most of the time out of doors as advocated by some, or boarding out of children during the period of infectiousness of the patient are impractical advices. Besides BCG Vaccination of the uninfected things left to the Health Visitor are education of the patients in what may be called 'cough hygiene' i.e., covering the mouth with a handkerchief while coughing, so that the risk of droplet infection is minimized, and ensuring that the patients take treatment regularly and properly. The quick sputum conversion will to some extent overcome the difficulties of isola-

tion. I shall refer to this later.

Disposal of sputum

It is our experience that whereas 60 per cent of the patients collected and disposed off the sputum properly in 1949, only 30% are satisfactory nowadays. The reason for this is obviously that a large majority of them become symptom free, and being up and about, they spit promiscuously. In old days if the sputum continued to be positive the patient was usually bed-ridden, and more amenable to advice; therefore repeated visits of the Health Visitors, did succeed to some extent in this respect. A certain number of patients no doubt will continue to be lazy and refractory to all advice, and beyond repeated advice, persuasion and explanation, there is little else to do. To make sure that this non-cooperation does not arise from lack of proper demonstration in the patients' homes, we have recently started, giving demonstrations of sputum collection and disposal, to patients attending the Centre daily for injections and advice. Whether it will improve matters is too early to say.

Quick conversion of sputum under antimicrobials therapy has already been referred to. It should also be noted that nearly 80% of the patients, there is no sputum after six months, which certainly reduces the hazards of an improper collection and disposal. Whereas this is certainly an advantage, the remaining 20% who continue to expectorate after six months are a big problem now. At least half of these patients are sputum positive and very often the bacilli are also resistant. Being

up and about, the circle of their infectivity is considerably wide, as opposed to pre-antimicrobial era when such patients being ill, were usually confined to their own homes and the circle of infectivity was narrow.

What should be done to contain this menace? Patients in the sanatorium, used to carry in their pockets, wide-mouthed sputum flasks for collecting sputum. This has no chance of general acceptance; by patients outside the sanatorium for aesthetic and social reasons. Effort has therefore to be redoubled, by the Health Visitors, to teach "Cough Hygiene" to these patients, and to see that they evacuate sputum in a drain or some other similar site, where its chance of infecting others is comparatively

less.

Supervision of treatment

Before the advent of antimicrobials, the Health Visitor had practically no part to play, in the treatment except once in a way to call a patient for a AP or PP refill, if the patient happened to miss a date. The antimicrobial therapy puts a great responsibility on the reduction of fever, cough and sputum, the antimicrobial treatment is considered a magical treatment and has become a very effective tool of prevention or one may even say, probably the only sure and effective weapon.

It needs no stressing that antimicrobial therapy has to be regular and prolonged in order to be adequate and effective. Yet because of

early amelioration of symptoms, patients become irregular or may even give up treatment prematurely as soon as the symptoms have disappeared. A recent analysis of our cases has shown that nearly 5% of the patients do not accept the diagnosis and advice and take no treatment whatsoever. Another 20%, give up treatment prematurely at varying periods. As for regularity during treatment, only 60% to 70% of the patients could be considered as fairly regular in treatment. It thus becomes the duty of a Health Visitor, to explain the deceptive nature of disappearance of symptoms and persuade the patients, to continue treatment as advised. This requires frequent visit, and advice to the ignorant patients.

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included here are social and recreational facilities, employee counselling, retirement plans, benevolent funds and facilities for rest and catering during duty hours. Social contact outside the nursing field is very useful to broaden the ideas and share the experiences of employees. It keeps up-to-date knowledge and develops personality by creating self-confidence realisation of nobility of nursing profession and satisfaction of the job in an employee. Provision for social and recreational programme, is a great blessing to the nurses. Their security and satisfaction can be increased by providing facilities in reading rooms, sports clubs, and co-operative societies. Their interest and sense of belonging can be secured by guidance, stimulation, direction and encouragement through proper counselling on personal and professional matters.

Their feeling of attachment to institution and profession can be stabilized and fortified by arranging for pension, benevolent funds and family welfare programmes.

Last but not the least the function of training of personnel should be carried out effectively. There are no words to express the primacy and importance of training which helps to develop skills, gain knowledge and create desirable attitudes and appreciations. On the job training by proper, competent and efficiently able trained personnel is essential to achieve the aim for which it is instituted. Training for leadership is one of the higher types of education and develops skill in supervising, instructing, and in improving methods and skill in human relations, who are being prepared for their jobs by necessary training.

"Human relations" is the

prime factor as it is said before and the best "interpersonal relationship" is most prominent factor for success. Assessing achievement, displaying confidence, recognizing and encouraging potential abilities, understanding based on human psychology and giving orders not as personal wishes but as law of situation and control by facts, as well as cultivation of proper attitudes and raising the morale of personnel by democratic methods is the core of administrative technique. It should be applied in all phases of administration, right from planning to evaluation, including organisation command and control as well as co-ordination and execution.

Bibliography

W H.O. Publication, H.A. Goddard, *Principles of Administration applied to nursing.*

Andhra Pradesh Members

Please note that the Notice for the State Branch conference appearing in the May issue is cancelled.

— I. Dorabji.