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A study of forty-four syphilitic patients under treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

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A STUDY OF FORTY-FOUR SYPHILITIC PATIENTS UNDER TREATMENT AT THE LOUISVILLE RAPID TREATMENT CENTER FROM MARCH 1, 1947 TO APRIL 15, 1947

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Venereal diseases are almost as old as humanity itself. Unfortunately, because these diseases are venereal in character (transmitted by sexual intercourse) they have been kept shut away in dark closets.

It has been said that medicine has been dramatic in its progress; that scientists and research workers have primarily been preoccupied with those diseases that have impressed societies because of their dramatic outbursts. Millions of dollars have been spent in search to discover the causes of diseases such as yellow fever, poliomyelitis, small pox etc.. Yet syphilis has a higher incidence than any of these illnesses.

Why, if not because syphilis and its sequelae, have been linked with sex and sex with sin, have these disabling, killing diseases been kept for so long untouched, unapproached, untreated?

It is not the purpose of this dissertation to present a detailed history of syphilis. That field has been covered by several persons of vast knowledge and ability. I have given a brief history of it and presented some data on the problem it still constitutes so as to give a background to my main field of interest: the emotional problems it may create for the luetic patients. I am also interested in showing how we, as social workers,

can help the patients for whom syphilis have caused conflicts.

Diagnosing the disease is the doctor's job. Administering the treatment is the nurse's field. Social workers do not possess either the body of knowledge or the skills they require. But studies and experience have shown that an infected patient in order to be returned safe and cured to society, and keep him like that, needs more than shots of arsenicals, bismuth or penicillin. Both doctors and nurses have failed in preventing re-infections and in keeping out-patients under treatment, or in having them keep their appointments for follow-up. It is felt that these evils could be corrected to a large extent if the patient could be given more individual attention. If he could receive enough education so as to have a better understanding of his illness and if his emotional problems which may be contributing to make him a delinquent and a repeater could be met.

This thesis is an attempt to show that the luetic patient is a human being; that he may also present the same or more of the social, economic and emotional conflicts and problems that the patients suffering from cancer, tuberculosis or any disease may present.

Due primarily to the lack of time, I limited myself to the study of forty-four male patients under treatment at the Louisville rapid treatment center. Although there are many studies done with women patients

and with men in the armed forces, I do not know of any done with civilian patients.

From the findings of the study it is evident that a large number of patients interviewed showed anxiety over several aspects of the illness and the hospitalization. They may be sign posts of deeper emotional conflicts that should be studied more intensely.

It shows that there is a gap in the treatment and that a medical social worker, because of the body of knowledge and special techniques that she possesses, is the best qualified person to fill it.

It also presents a number of questions that I am not able to answer. There is for instance the question whether penicillin will be a help or a hindrance to the control of venereal diseases; whether by making the treatment so short and effective patients will lose the fear of contracting the disease and will show more laxness in their sex behavior. Will we ever eradicate syphilis with the present methods of control? Will medical social workers be able to reduce the number of syphilitic infections by helping patients with their emotional problems? These questions can not be answered now. The rapid treatment is too recent to give conclusive evidence yet. I hope though, that some more people will accept the challenge that these questions present to those interested in public health and community welfare. I hope they will do further

and more detailed studies on the subject. There is still so much to be done....!!

CHAPTER I

A BRIEF HISTORY OF SYPHILIS

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Although diseases of all kinds have existed in every period of the history of man, the way in which they were transmitted and what caused them remained obscure for centuries. Yet, because of their terrific consequences, man has always shown great interest in them. Thus, we have had innumerable theories presented and developed through the centuries. Because they were uncontrollable and unexplainable, they remained linked with the supernatural, spirits and deities until the fifteenth century when the first theories of "miasms" began to develop. From there on, efforts to prove that some kind of organism caused diseases started to take shape. The invention of the microscope opened a new world to the scientists. It was Pasteur who finally proved this theory true. His discovery was the culmination of all these years of work by all his predecessors in the field of microbiology.

As I said before, for centuries the idea that plagues, diseases and misfortunes were the acts of God lived with men. If we take a peek at history we will see the pagan gods with all their human qualities. They possessed their virtues and their weaknesses. They punished and took revenge upon the human beings of earth that offend-

ed them in any way. Often these revenges took forms of deformities, illnesses and plagues when the punishment was directed toward the community.

The Old Testament depicts Jehovah, god of the Hebrews, as some one of whom to be afraid. Again we see a great deal of misfortunes being sent to punish the sinners.

Jesus-Christ brought to us a more merciful God; a Father. He devoted a great deal of his time to the sick and the New Testament is abundant in the relation of his cures of lepers etc. But even this new conception of God as Father was not to free us from the fear of physical punishment.

The Age of Darkness - the Middle Age - and the Renaissance show little difference as far as the treatment of epidemics and certain illnesses are concerned. For instance the insane, the epileptic, etc., were considered as being possessed by demons. When a person had a sudden attack of paralysis or became blind or deaf suddenly, it was thought not to be caused by late syphilis but to be a punishment from heaven.

Sex relations, particularly promiscuity, have been one of the sins or taboos most commonly found in different cultures and societies. We have them in our civilization. This is also true of the European and Asiatic countries and they are found among remote and "uncivilized" peoples

such as the tribes of the Samoan Archpelago and the Island of Madagascar.

It is interesting to see how early gonorrhea and sexual relations were linked together. As early as the days when Moses lead the Israelites, it was distinctly recognized as a venereal disease (contracted through sexual relations). He made regulations in an effort to prevent its spread among his people.

Around 460 A.D. Hippocrates described some of its symptons and it was Galen, the other "Father of Medicine" who gave to it its name.[1]

Syphilis made its debut on the stage of history under the name of "Morbus Gallicus," somewhat later.[2] It came at the same time as that other big stage show attraction - the discovery of America. It appeared in an epidemic form in Barcelona, Spain, very shortly after the return of Columbus and his men from their second voyage. The chronicles of Columbus' historians: Ruiz de Isla, Oviedo and Las Casas, often mention syphilis although with different names. (It was not until 1530 that the well known Italian scientist, Girolama Frascastoro gave it the name when he published his poem "Syphilis." In it his hero, a shepherd,

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1. Ernesto Quintero-"Datos de Utilidad en la Lucha Contra las Enfermedades Venereas," (Gobierno de Puerto Rico, Departamento de Salud, Division de Salud publica), PP 66-67 Unpublished Manuscript.

2. Ibid p.p. 66-67.

is a victim of the disease).[1]

Today, we still have not been able to decide the problem as to whether the American Indians gave the infection to the Spaniards or if these carried it with them to America and brought it back in a virulent form. Reading through the books on the history of syphilis I find authorities cited in favor of both theories. This is particularly true of the books published by Ruiz de Isla.

One thing we know and that is that it appeared in a very virulent form in Spain around 1495. At that time Charles III of France was getting ready for his campaign against Italy. The mercenary troops he hired from Spain carried the disease to France. His troops carried it to Italy and soon it was spread all over Europe.

As we have seen syphilis has been known for over 400 years. The question may arise as to why it is still so prevalent; why it has not been controlled as so many other diseases such as yellow fever, small pox, etc. have. This may be easily explained by the fact that syphilis is a venereal disease. Sin is connected with sex and sex with venereal diseases. Sex is a thing that still is discussed in a hushed voice. The same atmosphere of secrecy

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1. Irving Simons, Unto the Fourth Generation. (New York: E.P. Dulton and Co. Inc., 1940), pp. 104.

and taboo has surrounded syphilis. This has been a terrific handicap in the progress against the fight to control it.

It was not until 1936 when the Surgeon-General of the United States Public Health Service unmasked it, that the papers dared to print the word "syphilis" in their columns. After a bitter fight against prudishness, ignorance and victorian puritanism a steady progress has been achieved in the battle against the venereal diseases.

To this date it is still going on. Unfortunately, private citizens have not been very generous and most of the research has to be carried out with public funds.[1] In spite of all the odds, a great deal of progress has been achieved. For instance, people go to clinics and hospitals to receive treatment. They are more concerned in being cured than in hiding their disease from their neighbors. Treatment has been reduced from a period of one or two years to that of nine or ten days. The same public which ten years ago would not allow the papers or the radio to discuss or even mention the word "syphilis", now not only consents to this but allows posters to be displayed. But in spite of this public acceptance when it comes close to their family group, the old prejudices come out again. People receive treatment but feel ashamed

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1. Thomas Parran, "The Next Plague To Go", Survey Graphic, V. XXV, No. 7, p. 408.

and try by all means to keep it secret from everyone they know. There are many who approve the anti-luetic campaigns but believe that "nice people do not have and do not talk about syphilis". Maybe it is too soon yet for these people to have a scientific understanding of the disease and a more positive attitude toward it.

The war made necessary a stronger educational campaign and a great deal of the progress has been achieved since then. The government realized the need to check the infections and no effort or money was spared. We still need a good, efficient program so as to be able to have a healthy country. It will be cheaper in the long run!

CHAPTER II

SYPHILIS A PUBLIC HEALTH PROBLEM

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In an article by Dr. Robert H. Felix, of the Mental Hygiene Division of the United States Public Health Service, he quotes Dr. Thomas Parran as having given the following definition of what a public health problem is: "whenever a disease is so widespread in the population, so serious in its effects, so costly in its treatment that the individual unaided can not deal with it himself, it becomes a public health problem."[1]

With this definition in mind I will analyze the question as to whether or not syphilis is a public health problem and if so, how serious a one.

In 1944, it was estimated that there were 230,000 new cases every year in the United States. Of these, only three-fourths were discovered and treated long enough to insure against the infectious relapse. About one half of these new cases do not remain under treatment. The undiscovered and the insufficiently treated cases constitute the source of infection for the annually recurring crop of new cases. They accumulate year in and year

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1. Mental Hygiene, (The National Committee for Mental Hygiene Inc., N.Y. July 1946), Volume XXX, No. 3, PP. 381-389.

out to form the great reservior of latent and late syphilis.[1]

These patients suffering from late luetic conditions are the ones most likely to develop complications that will handicap them in one way or another. Dr. Parran has reported that syphilis is responsible for ten percent of all insanity, eighteen percent of all cardio-vascular diseases in the United States and that it does nine hundred times a year as much damage as the dreaded infantile paralysis.[2]

In terms of figures, we know that in 1938 there were in the United States, 40,000 deaths every year from syphilitic heart diseases. This represents a loss of 850,000 years of life expectancy. Many of the victims were trained workers. There were 4,500 deaths due to syphilis of the brain (paresis) and 1,100 deaths due to syphilis of the spinal cord (tabes dorsalis). These deaths represented a loss of 100,000 years of life expectancy due to syphilis of the central nervous system.[3]

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1. J. R. Heller, "Problems of Venereal Disease Control of Tomorrow". Proceedings of the National Conference on Post War Venereal Disease Commission, St. Louis, Mo. November 1944,(Washington: U.S. Government Printing Office, 1945), P.9

2. Thomas Parran, "Why Don't We Stamp Out Syphilis." Readers Digest, July 1936.

3. Albert Russell-"Syphilis and the Industrial Worker." Reprinted from the proceedings of the 28th, Annual Meeting of the Medical Section of the American Life Convention by permission of the American Life Convention, (June 1938).

Today as in the first years when Dr. Parran presented his figures, we still do not have the exact numbers of all the deaths caused by luetic complications. This is due in part to the fact that private doctors fail to report them and in part is due to the few numbers of autopsies. If they had been performed might have revealed syphilis as the true cause of many deaths due to all sorts of apparently not complicated illnesses.

If we could get exact statistics as to the number of stillbirths and miscarriages, of luetic children who die within their first years of life, and those who are crippled, blind, paralitic, etc., the total loss of life expectancy caused by syphilis would easily reach the millions.

The cost of syphilis to the community is something that can not be easily overlooked. In his report Dr. Russell says that State Institutions cared for 18,700 cases of general paralysis due to syphilis. There were 43,000 beds in private and public institutions for patients suffering from mental and nervious disorders caused by syphilis. Assuming that the cost for each one of these patients will be at the rate of $2.00 a day, the annual cost would be more than $31,000,000.[1]

Let us remember that this would be the cost only of those cases that are institutionalized. What about

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1. Ibid. p. 193.

the ones that are cared for at home and have to be supported by their families or receive relief? If the patient is the breadwinner we have to consider the family as well for it will be in need of financial assistance. If it is the mother, and there are children these might need institutional care which will add to the public burden too.

The cost of private anti-luetic treatment is too high for the average American worker. The prevailing minimum fees of practice is $5.00 for one injection of arsenicals and $2.25 for one injection of bismuth. (This does not include serological service from the Board of Health). The total cost of treatment amounts to a minimum of $350.00.[1] It spreads over a period of fifteen months. If a patient can not afford a private doctor, he may attend clinics which run under private auspices which have a minimum charge. The treatment as already has been said, usually stretches over a period of fifteen months and the patient has to receive at least one injection a week. At Johns Hopkins Hospital this kind of clinic care costs the patient $78.00.[2] In addition there are tax supported clinics where the treatment is free for the patient. Stokes says that the per capita basis of cost in an efficient pro-

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1. Joseph E. Moore - The Modern Treatment of Syphilis (2nd Edition; Illness; Charles C. Thomas, 1941), p. 54.

2. Ibid. p. 54.

gram for the treatment of syphilis is now commonly set at ten cents.[1]

In spite of the high cost of private treatment and the inconveniences suffered by the patients attending public clinics, Dr. Moore says that in the period between 1939-1940, half a million patients sought treatment. He believes safe to assume that the minimum annual attack rate for syphilis would be 75 per 100,000.[2]

From what has already been said there can be no doubt that syphilis is a public health problem and a very serious one too. It is widespread and the incidence in the United States, as shown by the statistics, is very high.

The effects of its complications, not only in terms of money and lost years of life expectancy, but also in terms of emotional suffering, are serious. Its treatment if undertaken by the patient himself or by the government is expensive. Therefore, according to the definition given by Dr. Parran, we have in syphilis, another public health problem to cope with.

The government spends annually large sums of money in anti-luetic treatment centers. The House approved an

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1. J. Stokes, H. Herman and N. Ingraham, Modern Clinical Syphilology, (Philadelphia: W.B. Saunders Co., 1944), p. 1203

2. Moore, op. cit. p. 570.

appropriation of $17,399,500 for venereal disease control program, for the fiscal year of 1947.[1] This provides the same amount as is available during the present fiscal year ($11,949,000)[2] plus $516,500 additional funds for grants to states made to assure continued operation of the rapid treatment centers. This appropriation includes provisions for grants, subsidies, and contributions to the states amounting to $12,615,749.[3]

The fight that is being carried on by the United States Public Health Service is slow and hard. It is a struggle not only against the disease itself but also against indifference, ignorance and prejudices. Efforts have been made to educate the people, one of the basic parts of any public health campaign. Something has been accomplished in terms of recognizing the early symptoms, and the importance of receiving early treatment as soon as possible. Now there are about 200,000 - 250,000 annual new cases as compared with 500,000 in 1936. We have decreased the number of syphilitic children from 35,000 to 12,000 per year. The death rate from congenital

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1. "Social Legislation", Social Legislation Information Service, Inc., (Washington: March 31, 1947), Issue #14, pp. 74-75.

2. Ibid. July 16, 1945, Issue #27, pp. 112.

3. Ibid. March 31, 1947, Issue #14, pp. 74-75.

syphilis has dropped from 79 to 25 per 100,000 live births.[1]

The war brought out the need for mass education and the armed services carried out an intensive program. They realized what a complicated problem control of syphilis is, and that the educational programs have to deal with such related problems as those presented by promiscuity, prostitution, proverty, housing, etc..

A great deal of importance was given by them to the use of chemical and mechanical prophylactic measures and sex hygiene in general. In an article by Captain G.W. Larimore and Lieutenant Colonel Sternberg they say, "it is believed that the best single criterion for determining the immediate Venereal Disease in the Army is the extent to which prophylactic materials and facilities are used. It is considered that this is a legitimate yardstick with which to measure the effectiveness of our educational program. The importance of the role which prophylactics plays is indicated by the current Army requirements of more than fifty million individual prophylactics monthly."[2]

In this study of 8,000,000 men it was their experience that in order to reach all of them, they had to use every possible method of education. The program followed two

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1. Ibid. June 15, 1946, Issue #81, pp. 440.

2. Granville W. Larimore and Thomas H. Sternberg - "Does Health Education Prevent Venereal Diseases?" American Journal of Public Health, Vol. 35, No. 8, pp. 803.

main courses of action:

1. The Imparting of Technical Knowledge.
2. Motivation.[1]

In the first group they included the use of motion pictures, posters, pamphlets and lectures on specific information about syphilis: how you contract it, use of prophylactics, etc.. In the second field they had to cope with a bigger task. They found that what may appeal to one individual does not move the other. A great deal depended on the individual himself, his social, religious, and economic background. They tried various means of motivation such as:

a) Fear - of the consequences of venereal diseases. They stressed the fact that it might affect their future sex capacity or their fertility. They appealed to their religious fears and presented it as a punitive measure for having violated their religious and moral codes.

b) Intelligence - here they presented the idea that acquiring syphilis was evidence of their stupidity.

c) Pride - in their race, their nation, their individual military unit, etc.

d) Sense of Patriotism - by showing that it

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1. Ibid. pp. 799-802.

was unpatriotic to be ill and unfit for military duties because of having contracted syphilis.

CHAPTER III

THE LOCAL PROBLEM

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When Dr. Parran was able to demonstrate the high incidence of syphilis in the United States, the Federal Government became interested and decided to give a helping hand to the states in the fight against venereal disease control. People travel from town to town and from state to state, carrying with them the syphilis producing spirochettes and thus creating a national problem.

In 1938 the Venereal Disease Control Act was passed by which the Federal Government was authorized to appropriate funds for the prevention, treatment and control of venereal disease. These appropriations could be increased as necessary. In this way, the Federal Government assumed and is still assuming its share of the responsibility in the program.

Each city has to develop its own program for the control of venereal diseases. Although they may receive assistance both from the state and the Federal Governments, it is primarily a local responsibility. The success of the program will depend to a large extent on the acceptance and cooperation of the community itself.

Louisville has been aware of the serious problem that its high incidence of luetic infections presents. In order to have a better picture of the problem, the Louis-

ville Health Council of the Community Chest undertook a study of the medical and social aspects of venereal diseases and in May, 1945 published their report.

From this report we can see that "the extent of syphilis in Jefferson County is much higher than in most other counties of its composition. Taking the twenty-three counties in the United States, which have within them cities similar in size to Louisville, the Selective Service examinations showed that Jefferson County's rate was higher than the rate for fifteen of the counties."[1] Louisville, with a rate of 89 per 1,000, is the lowest of the southern states but it has the eighth highest of all the twenty-three counties. During the period from January, 1942 to December, 1944, 76,000 men including 16,000 Negroes were examined for the Selective Service. The white selectees showed 4.6% positive for syphilis as compared with 26.7% positive for the Negroes. Of 27,000 pregnant women that were given prenatal blood tests 1,925 were Negroes. The white women showed 1.1% positive for syphilis, while the Negro showed 6.3% positive.[2]

According to the statistical report of the Louisville and Jefferson County Board of Health for the year 1946,

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1. Louisville Health Council of the Community Chest, Venereal Diseases-Their Medical and Social Aspects, (Louisville: May, 1945). pp. 34.

2. Ibid. pp. 15.

3,875 patients were admitted to medical service for venereal diseases. Of these, 2,036 cases of syphilis were diagnosed and 1,614 of gonorrhea. There were 3,599 admissions to field service (medical and nursing visits), and 37,476 clinic visits (or office). Of these, 24,550 were syphilis and 11,208 gonorrhea; 7,355 field visits were made of which 3,494 were to syphilitic patients and 464 were to patients suffering from gonorrhea.[1]

At the Louisville Rapid Treatment Center a total of 724 patients were treated between June 1945 and December, 1946.[2]

TABLE I

Patients With Syphilis Under Treatment at the Louisville Rapid Treatment Center from June 1945 to December 1946.

Month	1945	1946
January	--	66
February	--	39
March	--	49
April	--	35
May	--	47
June	17	57
July	20	69
August	30	76
September	34	50
October	31	60
November	42	93
December	35	83

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1. Report prepared by the Louisville and Jefferson County Board of Health, Serving the Community for Better Health, (Louisville: 1946) pp. 99.

2. This figure has been kept by Miss Boyd, Nurse-in-Charge at the Louisville Rapid Treatment Center for her own records and has not been published.

It is interesting to see that the number of patients per month during the year of 1946 has at least doubled. This does not mean necessarily that the number of new cases has increased that much in Louisville. It is due primarily to the fact that the "Center" has become known and patients pass the information from one to the other. It has been noted that often patients live approximately in the same neighborhood. In the study carried out by the Community Chest a survey of cases among negro areas was carried out.

CHART I

Syphilis Among Negroes in Seven Census Tracts Reported Cases in 1944 per 1,000 Population in 1940.

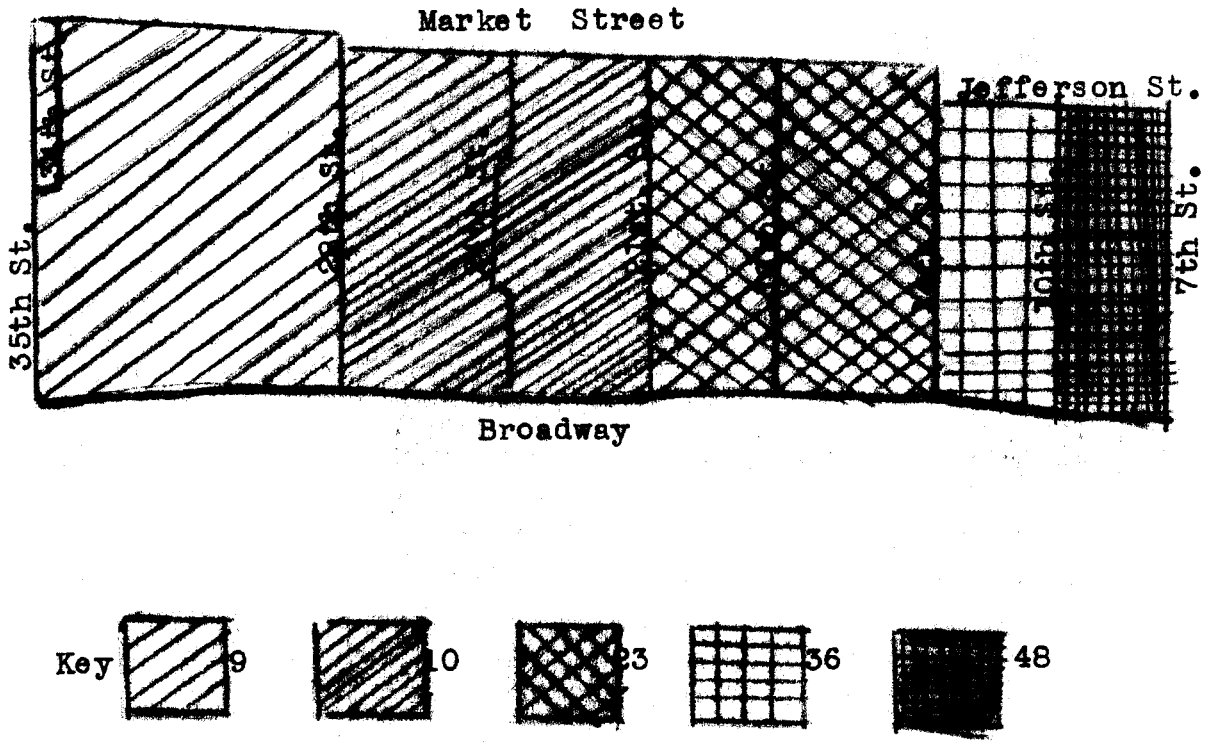

Chart No. 1 shows the number of cases of syphilis of Negroes in 1944 related to 1940 population.[1] As we can see the highest incidence rate is found in the area covering from 14th to 7th Streets and between Jefferson and Broadway Streets. This area is inhabited mostly by Negroes. Louisville is no exception in having a higher percentage of syphilis among its Negro population. You will find that syphilis is more prevalent in the slums or among people of low income. These areas are usually the breeding places of most of the communicable diseases. This is understandable when we think that with low income comes the problems of overcrowding, and poor housing facilities. The amount of education is small. Often the ambition or desire to better themselves is crushed under the many frustrations experienced early in these persons' lives. In most of the cities of the United States the Negroes constitute the highest percentage of the inhabitants of the slums. H. H. Hazen in his study of syphilis in the Negro shows that "in the population group an annual income of $1,000 or less, the syphilis rate is 3.5%, while in the group having an income of over $3,000 a year, the rate is about one-half of one percent."[2]

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1. Louisville Health Council of the Community Chest, "Venereal Diseases Their Medical and Social Aspects",(Louisville: May, 1945), pp. 16.

2. H. H. Hazen, Syphilis in the Negro,(U.S.P.H.S. Supplement #15 to V.D. Information, 1942). quoted in Louisville Health Council of the Community Chest,"Venereal Diseases-Their Medical and Social Aspects",(Louisville;May 1945).pp.15.

That syphilis among Negroes is in actual fact a social and not a racial problem is stressed by him. He says "the lowest income group makes up a much greater part of the syphilis population. In the higher income groups, White or Negro, the situation is reversed ..... It has been observed that Negroes in higher income brackets, just as white persons, have much lower syphilis and other morbidity rates."[1]

Jefferson County and Louisville reported a total number of deaths due to syphilis in 1945 as 53 and in 1946 as 42.

TABLE II

Deaths and Death Rates per 100,000 Due to Syphilis For the Years 1945 and 1946 as Reported to the State Board of Health.

	1945		1946	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate
Louisville	36	10.1	32	8.4
Jefferson County	17	20.5	10	11.3
Total	53	12.1	42	9.0

Syphilis was the largest cause of death among the infectious and parasitic diseases. Tuberculosis was the highest with a total number of deaths of 284 and a death rate of 64.6 in 1945, and a total number of 296 and a death rate of 63.3

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1. H. H. Hazen, "Syphilis in the Negro," (U.S.P.H. S. Supplement #15 to V.D. Information, 1942). quoted in Louisville Health Council of the Community Chest, Venereal Diseases-Their Medical and Social Aspects, (Louisville, Ky., May, 1945). pp 15.

for 1946.[1]

Infectious patients can receive treatment at the Kentucky Rapid Treatment Center at the State Fair Grounds; a State hospital with a capacity of 150 beds. Here patients from any county can come for rapid treatment. At the Louisville General Hospital a whole wing, with a capacity of 50 beds has been set up for the rapid treatment of syphilitic patients from Louisville and Jefferson County. They are selected according to the diagnosis. Cases in infectious stages and some latentcases (early or secondary) as well as certain cases of central nervous system syphilis are admitted for treatment.

Those cases in no need of hospitalization follow the weekly treatment method and can attend different clinics which are conveniently located throughout the community.

For Negro and White patients we have:

1. The Venereal Disease Clinic - 240 East Madison Street
2. The Portland Health Center - 2318 Portland Avenue
3. Highland Park Health Center - 3512 Crittenden Drive
4. General Hospital Clinic - 323 Chestnut Street.

Number 1 and 4 together form the "24-hour" clinic.

For Negroes only there is the

Central Louisville Health Center - 1125 Cedar Court.

For White only we have:

1. East Louisville Health Center - 620 East Jefferson Street

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1. Louisville and Jefferson County Board of Health, Serving the Community for Better Health, (Louisville, 1946) pp.121.

2. Fincastle Health Center - 3512 Fincastle Road.[1]

The Rapid Treatment Center at the General Hospital receives $7,156.01 from City and State funds and a sum of $97,139.15 from Federal funds.[2] The Federal Government in 1946 appropriated the sum of $337,893,000 for Venereal Disease Control in the State of Kentucky.[3]

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1. Louisville Health Council of the Community Chest, Venereal Diseases-Their Medical and Social Aspects, (Louisville: May, 1945), pp.8

2. Louisville and Jefferson County Board of Health, Serving the Community for Better Health, (Louisville: 1946). pp. 128.

3. Annual Report of the Federal Security Agency, Section IV. U.S.P.H.S. 1946 (Washington - U.S. Government Printing Office - 1946) pp. 394.

CHAPTER IV

SCOPE AND METHOD OF STUDY

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Once the doctor has diagnosed the illness the patient has to be hospitalized for Rapid Treatment. Here I am referring to the patient who can not afford private treatment.

The hospitalization has to be almost immediate. Very little time is given to him to notify his employer and make sure that he will have a job to go back to when his ten days of hospitalization are over. Most important for him is to have time to break the news to his wife or family and see how his illness is accepted. He probably would like to know what their attitude is and what their immediate future life is going to be like.

Very often we see the patient coming into the hospital because he is told to do so by the doctor. Some are unable to grasp the full meaning of their illness; they are too numb or too shocked to be aware of what is happening to them. Other patients are unable to accept the fact, the truth, and insist that the doctor must be wrong. Some of these do not verbalize their disbelief, but still can not believe it has happened to them.

A hospitalization is in most cases a traumatic experience. It severs the patient from his family, his

his community and his daily life. It is an interruption in the flow of his life. As Doctor Richardson has said, "all sickness has a social component. The patient does not exist by himself but as a member of the family unit."[1]

Unless it is an emergency, a patient is given time to "think it over" before he actually decides to be hospitalized. If it is an emergency the threat to his life is so great that it is his main concern to save it. That he is going to a strange place to be among strangers is of little importance. Because his life is in danger and because he is a threat to other people, he must surrender his freedom and comply with rules, regulations and orders.

A patient with syphilis, even if he has a chancre or a secondary rash, is in no terrible pain. He does not see his life immediately threatened. He can not understand the need for his hospitalization.

Even more, he can not see why it must be done so quickly. But it is the responsibility and duty of the health officer to protect this patient's wife, family group and the community where he lives. The patient is a person who can do a great deal of harm to others - he is dangerous.

Doctor Udo J. Wile, professor of dermatology and syphilology at the University of Michigan, in pointing out

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1. Henry B. Richardson, Patients Have Families, (New York: The Commonwealth Fund, 1945), p. 216.

some of the disadvantages of the rapid treatment method said, "we must cite first the loss of time incident to hospitalization. This entails an economic loss, not only to the patient but to the employer as well. A second obvious disadvantage is that in any program as large as the one under discussion, we are dealing essentially with a mass treatment. Under conditions of mass treatment procedures, we endorse the treatment of the disease rather than that of the patient. There is perhaps no other disease in human pathology in which a greater degree of individualization and appraisal is indicated than in syphilis."[1]

As long as it is necessary to hospitalize infectious luetics so rapidly, these may bring with them all kinds of problems: economic, social, emotional, medical, etc.

We undertook this study in an effort to discover whether this is true or not. If it is so, we want to know which are the most common types of problems and attitudes of the patients that were interviewed at Rapid Treatment Center.

Over a period of one and a half months (March 1, 1947-April 15, 1947) forty-four male patients were interviewed. They constituted the total number of male patients admitted at the Rapid Treatment Center for treatment. (See appendix for the schedule used during the interview).

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1. Udo J. Wile, "Rapid Treatment for Syphilis," Proceedings of the National Conference on Post War V.D. Control, St. Louis, Mo., November, 1944, (Washington: U.S. Government Printing Office, 1945). pp. 126.

Patients of both races were seen and no age limit or civil status categories were made. This was due mainly to the fact that a very small number of patients were admitted and also to the time limit that this writer had.

Patients are segregated according to race. In each room there are several beds. The first thing done was to approach them as a group. So that they would not feel signaled out in any way, I went into these large rooms and explained to them who I was, what the purpose of the study was and the confidential nature of the information that they may give. Then it was explained to them why we had their names - to make sure that each patient was seen. Also it was explained that the order in which they were going to be seen depended entirely on their date of discharge only. After this, each patient was interviewed separately in a room which offered privacy. Here patient was once more reassured that neither name, address or any information that might identify them would be included. Also it was emphasized that any information they gave was to be given on their own free will. They had the liberty to refuse to answer any of the questions asked.

The time spent in the group talks and individual preparation for the interview proved to be worthwhile. Not one of the patients refused to answer any of the questions in spite of the intimate nature of some of them (see appendix #1 for the schedule followed).

CHAPTER V

SOCIAL DATA

CHAPTER V

SOCIAL DATA

Although the number of cases studied is small the factual data obtained is revealing. There was a wide range in the ages of these patients. The youngest one was 17 years old and the oldest was 67 years of age. The median age was 25.

TABLE III

Age of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Age	Number of Patients
15 - 19	5
20 - 24	15
25 - 29	14
30 - 34	3
35 - 39	4
40 - 44	1
45 or over	2
Total	44

The largest number of infections are among those men between the ages of 20 and 24 followed very closely by those between 25-29 years of age.

Of the forty-four patients, 20 were of the white race and 24 were Negro.

Out of the forty-four patients interviewed, 27 were single and 10 were married. Thirty-four were unattached as we can consider the divorced, separated and widowers in this category.

TABLE IV

Marital Status of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Marital Status	Number of Patients
Married	10
Single	27
Divorced	2
Separated	3
Widower	2
Total	44

One of the patients classified as single was living in common law marriage with a girl. It was during the process of securing a marriage license that he was hospitalized. His blood test and that of his "wife" were positive. The girl was pregnant and received anti-luetic treatment too.

All these patients acquired their infection through extra-marital sex relations. The problem of extra-marital sex behavior is almost universal. In 92% of the existing cultures adultery is considered as a social practice and laws and taboos try to prevent its being practiced.[1]

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1. Ogburn-Nimkoff, Sociology, (Boston, Mifflin Co., 1946). p.56.

Dr. Brecker, City Health Officer of St. Louis, says, "The fundamental problem lies in man himself- homo sapiens. A better understanding of man himself should give us a better appreciation of the limitations that we work under in the control of venereal diseases.

"If there is a group of individuals that certainly need all the resources of the community, it is that group of sexually promiscuous individuals. We have failed with them simply because we have not set up the proper machinery whereby the local health department will direct these individuals to the welfare agencies in the community. The welfare agencies have not developed their resources as they should because we, as health officers, have not directed these individuals to them. Venereal diseases are truly a social problem and must be handled by society as a whole.

"Unless we can guide his instincts with reason and intelligence and his free will by discipline, he will not avoid illegitimate intercourse.

"We can not continue to ignore the sexually promiscuous by just examining them and turning them out. They should be studied by health department services with qualified personnel and properly directed, when necessary, to the social and welfare agencies in the community.

"We hear a great deal of discussion about reasons for the venereal diseases - proverty, housing and a host

of specific causes. Of course, circumstances and environment play a role in all social problems, not excluding venereal diseases. But to look to physical environment alone and neglect the intellect and will of man is to overlook the two most essential factors in the control of venereal disease. Only to treat those infected, without attempting to guide those who are promiscuous by using all the community resources, is to have those individuals at some future time report with a venereal disease."[1]

TABLE V

List of Occupations of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Occupation	Number of Patients
Unemployed	7
Food Handler	5
Farmer	2
Laborer	10
Construction	5
University Student	1
Unskilled Factory Worker	3
Skilled Factory Worker	4
Miscellaneous	7
Total	44

1. J.F. Bredeck, "Epidemiology of Venereal Disease," Proceedings of the National Conference on Post War Venereal Disease Control, St.Louis, Mo. November,1944.(U.S.Government Printing Office, 1945), pp. 131-133.

There was a wide variety in the types of occupation but for tabulating purposes they have been grouped into general headings. For instances, among miscellaneous we have included such occupations as jockey, exercise boy, porter, janitor, dry cleaner, orderly (hospital) etc.. Under laborer we have truck driver, truck helper, warehouse, foreman, etc.. Two of the unemployed were handicapped and several were ex-service men who are still receiving re-adjustment allowances. Among the group of food handlers we included bus boy, bartender, dishwasher and baker. Painters and carpenters were grouped into construction.

The knowledge that a patient has about his illness is very important in any disease. It is the best way of securing the patient's co-operation. In a transmissible disease such as syphilis, this is of paramount importance. Whether or not he will seek treatment as soon as he suspects an infection and before he gives it to someone else, depends on his ability to recognize his early symptoms. His desire and understanding of the need for follow up depend on his full knowledge of his illness. It was pointed out in a previous chapter that it is the number of untreated cases or not sufficiently treated cases which accumulate yearly to form the reservoir from where new infections will spring up.

This writer tried to evaluate the knowledge or understanding that the patients interviewed in this study

had of their infection. Only those who were able to recognize their symptoms and went for a blood test to confirm their suspicion were considered as having a good amount of information. They also knew why follow up is necessary, how a person can contract the infection and how he can transmit it. Patients with questions or lack of knowledge in any of the points mentioned, were considered as having a fair amount of information. Those practically ignorant as to cause, treatment, method of infection etc., were classified as having a poor knowledge of syphilis as a disease.

TABLE VI

Amount of Knowledge of Syphilis as a Disease of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Amount of Knowledge of Syphilis as a Disease	Number of Patients
Good	6
Fair	23
Poor	15
Total	44

It was interesting to this writer to see that many of the patients with poor knowledge about syphilis had had reinfections, came for treatment either when they had a blood test in order to get a job, or were given as source of infection or contracts by female patients of the "Center". Few of the patients with poor knowledge came for treatment

voluntarily after having been advised by friends or doctors to do so.

As far as the type of infection these patients had, they were classified as to new or first time they had contracted syphilis or as reinfections meaning that they had had syphilis at least once before. A third group recorded as relapse included those that had been treated with penicillin for a ten day period and had not been cured; also those who had received the long type of treatment and either dropped treatment or completed it but their serology was still positive.

TABLE VII

Type of Infection of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Type of Infection	Number of Patients
First	34
Reinfection	7
Relapse	3
Total	44

None of the patients interviewed received their infections from their wives. All of them contracted it in extra-marital relationships.

TABLE VIII

Source of Infection of Forty-Four Patients Under Treatment at the Rapid Treatment Center from March 1,1947 to April 15,1947.

Source of Infection	Number of Patients
Friend	11

TABLE VIII (Cont'd)

Source of Infection	Number of Patients
Pick-Up	23
Prostitute	4
Total	44

By prostitute this writer means those women who live in houses of prostitution. More so, that the sexual contact between the patient and his source of infection took place in a house of prostitution. It is safe to assume that many of the so called pick-ups are prostitutes but our patients met them in bars, taverns, street corners etc.. By friend is meant women whom the patient knew personally before having sexual intercourse with them. Although no wife was given as the source of infection, several "steady girl friends" were reported. Some of the men had given the infection to their wives. The result of this will be discussed in another chapter together with the problems brought to them and their reaction to it.

How the patient happened to come to the "Center" is interesting. In many cases it showed the degree of information that these patients had about their illness.

TABLE IX

Source of Referral of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Source of Referral	Number of Patients
Private Doctor	6
Public Doctor	2
Voluntarily	30
Given as Contacts	4
Sent by Employer	2
Total	44

By public doctor is meant doctors working for the City hospitals, clinics or health centers. Most of the patients who went first to private physicians came to the "Center" because they could not afford the treatment at the rate of private fees. One patient informed me that his doctor charged a fee of $3.00 for each injection of penicillin. He was told he would have to receive one every week for a period of at least six months. Several patients reported that they received no information whatsoever from their private doctors as to where they could receive free medical care. These have been included under the group who came for treatment voluntarily, that is, self referred. Here also have been included those who took blood tests for jobs but came on their own accord. Most of them knew of the existence of the Louisville Rapid

Treatment Center or were informed by friends. Those reported as contacts were either brought in by the police or came after a field visit of the follow-up worker.

Almost all of the patients who came on their own accord proved to have certain amount of information about syphilis, not as a "social disease" but as an illness. In the largest majority of the cases these were ex-service men who reported that during their period of military service they had received lectures and had been given pictures about syphilis. This tends to indicate the value of education as a means of helping patients to seek treatment early but not as a means of preventing their contracting the infection. As David Seabury says: "Sex delinquency is not primarily a matter of conduct but of motive."[1]

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1. David Seabury, Help Yourself to Happiness, (New York, McGraw Book Company, Inc., 1937), pp. 123.

CHAPTER VI

SOCIAL AND ECONOMIC PROBLEMS

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The social and economic problems of the syphilitic patient can not be measured in terms of the patient alone. As already said, he is part of a family group. Even a patient who is single may have dependents too. These individuals' hospitalization will affect in one way or the other the lives of the members of his family unit.

Of the forty-four patients interviewed at the Rapid Treatment Center, 27 had one or more dependents and 17 had none. Most of the married patients thought that their families were "getting along." Some of them had other relatives who were able to take over the economic responsibilities, thus preventing the family from suffering actual need and hunger. In some cases the patient had some savings or the family was living on his week's check. Others, more unfortunate had not been able to make any kind of provision for their family group, and had incurred debts so as to maintain themselves until they would be able to return to their work.

It was interesting to see how many of the unattached patients made remarks about their being lucky that they did not have to support or contribute to the support of anyone. When asked why they felt this way they said that at least they did not have "that" to worry about.

It is important to keep in mind that most of these men are wage earners. Because they depend entirely on their earnings, a whole week or ten days loss of pay means a great deal to them.

Under the older method of treatment which stretched over a period of months, efforts were made to help these patients overcome problems brought up by their treatment. Night and Saturday clinics were established so as to enable these men to receive treatment without fear of losing pay or their jobs. Under the new method of treatment this can not be avoided as the patient has to be hospitalized. The new type of treatment affects them in their earning capacity and creates economic problems as shown in the following table.

TABLE X

Types of Financial Problems Caused by Hospitalization of Forty- Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15,1947.

Type of Financial Problem	Number of Patients
Loss of pay	29
Loss of job	2
Others	4
No problems	9
Total	44

Of the four classified as "others", two had sick leave benefits, one was a student, and one was out on strike.

Those presenting no problems were mainly patients who are still receiving the Federal Readjustment Allowance. Although the unemployed were included among the ones presenting no problems, we must keep in mind that while the patient is hospitalized he is unable to look for a job, therefore his period of unemployment will be longer. Two of the unemployed were handicapped; one a crippled boy 21 years old, the other a 67 year old man who was practically blind. Both are supported by their families. The only patient who could not estimate his loss of income was a farmer. He works with his father and other brothers in their farm.

These patients should not, while hospitalized, have to go through a period of anxiety and worry caused by financial problems. They have enough in their minds with having contracted the disease. As we will see in the discussion of the next chapter, to most of them having syphilis has been a painful experience. Painful not because of the "shots" received every three hours, but because of the social and moral stigma attached to the illness itself.

Even if we wanted to be punitive and would say "it serves them right" or "it is their punishment" it would be unfair of society to punish also the innocents- the patient's family.

Probably all of us still remember the treatment that

illegitimate children used to receive. They had no rights and received no compassion because they were the sons of "sinners." But all this is changing now and we have come to an age when much is being done to give to these children the same opportunities that other children have.

Most general hospitals that have facilities for rapid treatment face a series of problems caused by the hospitalization of some of the patients. For instance, when a mother in need of hospitalization for anti-luetic treatment is admitted, if she has had no time to make the necessary arrangements for the care of the children, they are admitted to the chronic wards at the pediatric service. In a way this plan is preferrable to leaving the children with uninterested neighbors or resentful relatives. Yet, it is unfair to the children because most hospitals do not have "well baby wards" or facilities for isolating boarder babies. As a result, very often, the baby who comes as a boarder becomes ill during his stay in the ward.

In the majority of the hospitals the rapid treatment division is not served by social workers. There is no one there to take care of cases like this. By the time the pediatric social worker is able to see the mother and helps her to make adequate plans for the children, several days have been lost. The time during which the children

have to remain in the ward thus causes an extra expense to the hospital. They occupy beds that could be used by ill children, and crowd the already overcrowded wards. As we can see, all this brings extra work to the hospital staff, extra expense to the hospital and what is more important, extra risks to the children and more cause for anxiety to the mothers.

When it is the father or the breadwinner who is hospitalized, a new series of problems are presented to the family. It is not only that they may suffer want and privations during his period of hospitalization. Sometimes this period will be extended either because he has lost his job or because he will not be paid for another one or two weeks.

Miss Harriett Bartlett in 1934, said in relation to diabetes, "new scientific discoveries regarding disease open up new medical social problems and thus continually broadens its scope."[1] Today, the treatment of syphilis by the rapid treatment method creates social and economic problems non-existent during the days of the long method therapy.

One colored patient said he was not worried that his family would go hungry because he had good friends. His family had been able to borrow some money. But he was very much upset about this as he knew he could not repay this money right away. He would need to work several weeks

1. Harriett M. Bartlett - Medical Social Work, (Chicago American Association of Medical Social Workers, 1934), pp.52.

in order to save enough to pay for it as his salary was sufficient only to cover their immediate needs.

The number of excuses given to relatives for their absence during the period of hospitalization were varied. One young farmer, well known in his small community, said he could not let anyone know he had contracted syphilis. He left his home and told his mother he was going to Cincinnati to visit his sister. Once there, he left within one or two days and told his sister he was returning home. In this way, he hopes to keep his hospitalization a secret from both. It can easily be seen the extra expense and the amount of conflict and anxiety that this infection has created in this man. One hospital attendant was very upset because if he could not report on a certain day he believed he was going to lose his job. To this one we suggested that he discuss his problem with the doctor. In my next visit to the "Center" he came to me. By the way he was smiling I knew he had been granted this permission before he said so.

Employers were another source of worry to some of these men. Typical of the excuses made for this was what one man in his forties told me. He has worked for one company for several years and has a very good work record. When he contracted syphilis and was told he had to be hospitalized he called his employer and told him he had to leave town. He gave as the reason for the trip the death

of a relative.

Agencies in the community will be able to help these patients and their families if they were referred to them. It is obvious that many individuals would be highly benefited and their complications and conflicts could be reduced if some one in the hospital could direct them to these cooperating social service agencies.

CHAPTER VII

EMOTIONAL PROBLEMS

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EMOTIONAL PROBLEMS

In the previous chapters it has been pointed out that syphilis has been linked with sin and shame for centuries. It has not been until recently that a change in attitude towards this disease has begun to take place. Also mentioned was the fact that hospitalization is in itself a traumatic experience. Because of these two factors a patient with syphilis who is hospitalized goes through a period of emotional stress. An analysis of some of the emotional problems presented by the luetic patients who were interviewed follows.

I had one interview with each patient. In this interview I was able to determine which of the patients showed some anxiety about their illness. The feelings or attitudes they had toward having contracted a venereal disease were catalogued into several titles. Because the titles given do not follow any established nomenclature and may convey to different persons different meanings, I believe it is best to explain what I had in mind and what they meant to me.

Guilt feeling - the feeling of having done something wrong, no matter whether from the moral, religious or social point of view of the patient.

Fear - being afraid of the disease itself, of having already

suffered some physical damage, of suffering future consequences; and of not being able to be cured.

Shame - in this group were included only those patients who said they were ashamed of having syphilis. Those who claimed they were not ashamed but declared "it is nothing to be proud of" or did not want anyone to know where they were, were not included as I did not want to enter into the field of the unconscious feelings.

Self Pity - feeling of being sorry for himself; when the patient said he was "the unluckiest person in the world" or "everything happens to me" etc.

Self Punishment - by this is meant that the patient believed he was paying for his sins, that syphilis was his well deserved punishment for having done something wrong. It differs from guilt in that syphilis is used as a punitive weapon by the patient himself.

Loss of self -respect - when the patient believed that he had done something "dirty" and would never be able to have as good an opinion of himself as he had before having syphilis.

Revenge - the desire to punish his source of infection or the public health authorities for having hospitalised him.

Indifference - when the patient claimed not to have been affected at all by his illness, denied having any feelings about it or showed no interest in his treatment of illness.

With the exception of those patients who showed in-

difference, the rest presented one or several different kinds of feelings at the same time, with varying degrees of intensity.

TABLE XI

Feelings and Attitude Toward Syphilis Shown by Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Feeling	Number of Patients
Guilt	14
Fear	15
Shame	21
Self-Pity	6
Self-Punishment	5
Loss of Self-Respect	6
Revenge	4
Indifference	5

Feeling of guilt was strong in several of the married patients, particularly those who had infected their wives and children. There were two cases in particular where it was very intense. One white patient related the following story: His baby developed a rash on his head. When a blood test was taken, it was positive. Both his serological test and that of his wife were positive too. The three were admitted to the Rapid Treatment Center for treatment. Although patient had not been unfaithful to his wife, he had contracted his illness shortly before getting married. He claimed he would never be able to forgive him-

self for what he had done to them and felt terribly guilty about it. Another was a colored patient who had been married for several years. Their marriage was a childless one. He had received anti-luetic treatment from both private physicians and in free clinics. His blood was still positive. He was certain that the reason why they had not been able to have children was due entirely to his syphilitic condition. His wife shared his opinion. Although she had never accused him openly, he believed she was resentful of this. He had sought treatment again as his last hope of conquering his infection and had great hopes of being able to have children if cured. It can be seen that his marriage was not a happy one because of the lack of children and his guilt about it. The patient admitted all this, yet he had his doubts that it was all his fault. I advised him to go to a family agency if the treatment did not render him fertile. An interpretation of what an agency like the one recommended could do for them was given to the patient. He was also advised to have his wife examined to see if she could conceive children. Patient was very grateful for this advice as he wanted to keep his home and be "a little happier now."

Two single, young patients were very much upset because of fear of having been permanently handicapped by syphilis. One said he believed he would never actually "get rid of it." He was certain that if he ever married

and had children these would be born crippled. His fear was even greater, he was afraid that he would not be able to have any children at all. Yet, this patient who had had two infections, had come for treatment right away. His attitude was that as long as the damage had already been done he had nothing else to lose so he did not mind contracting syphilis again and again. The other one believed no one could cure him completely and had the same fear of having sick or crippled children. Although I realized that I could not accomplish much in one interview, yet I pointed out to both of them that defects in children were not necessarily caused by syphilis. Also the high percentage of cures with penicillin was explained to them. As far as being able to have children or not, it was suggested that they consult the clinic at General Hospital for genito-urinary conditions. These examples confirm what has already been said by students of the significance of syphilis to the patient. Maida and Harry Solomon, say, "For a complete understanding of the part played by syphilis in the family, and the importance of early diagnosis, with continous treatment, one must not only consider the physical effect on patients and their families, but one must also view the disease from the standpoint of the effects that it has upon ideas, emotions and the social life of the individual concerned. The atmosphere of the family life may be markedly tainted through the ideas that are engendered concerning the

possible effects of syphilis. Late attackk of conscience will be extremely frequent. Syphilis leads to phobias. Fear of infecting the spouse, children etc., will come out each time they get ill. If there is no complete understanding between the husband and wife, knowledge of syphilis may result in estrangement. Childless marriage because of syphilis have resentment and unhappiness."[1]

It was impossible to know the reaction and attitudes of the wives of these married patients because most of them did not know themselves. Those who had told their wives had had no time to discuss it fully. All they could do was to hope for the best and seemed optimistic about their future marital life. One colored patient said that when his wife knew about his infidelity, "she was so mad she said she wanted to kill me." Yet, he seemed somewhat unrealistic about their future relations because he stated he was sure she would accept him back and "everything will be as before."

It was very interesting to see that many of the patients who felt ashamed of having contracted syphilis, were not too much ashamed of their extra-marital behavior. Maybe this can in part be explained by Georgene Seward when he says, "Sex relations out of wedlock are sometimes used to work off unconscious hostilities against the spouse.

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1. Harry C. Solomon and Maida H. Solomon, Syphilis of the Innocent, (Washington: United States Interdepartmental Social Hygiene Board, 1922), pp. 157-160.

For the most part, extra-marital sex behavior of various sorts indicates personality maladjustments. In view of its relationship with general maladjustment, extra-marital interest, whether in deed or in fantasy, should be regarded in most cases primarily as a symptom rather than a cause of marital unhappiness."[1] It was shown in Table 11 that shame was the most common feeling presented by the patients interviewed. The social stigma attached to the illness was responsible for it in almost every case. The mere fact that they wanted to keep it a secret from those whom they knew, tends to show that it was more a matter of fear of loosing their social position or reputation than a matter of conscience.

Religion played its part in adding feeling of guilt and self-punishment. One of the patients was an usher in a protestant church. His fear of having any one know that he had a venereal disease was great, so was his belief that it was God's punishment for having sinned. This sentiment was not consistent. Some of the patients who were regular church-goers considered syphilis a natural consequence of having had relations with a stranger. The only significance I was able to find was that among those who were religious and believed syphilis was their punishment, the feeling was stronger than in those who did not attend church. In this case they believed it was punishment

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1. Georgene H. Seward, Sex and the Social Order, (New York: McGraw-Hill Book Co., Inc., 1946), p. 204.

but did not necessarily link it with God.

TABLE XII

Church Attendance of Forty-Four Patients Under Treatment at the Louisville Rapid Treatment Center from March 1, 1947 to April 15, 1947.

Church-goer	Number of Patients
Yes	11
No.	26
No Information	7
Total	44

Only those patients who stated that they attended church regularly were considered as churchgoers. Those who went to church services sometimes or occasionally were considered as non-churchgoers. This classification was preferred to that of their religious denomination because it seemed a better measure of the emotional conflicts around religion than a mere listing of church affiliation.

In any case it is safe to assume that syphilis means much more to its victims than needing medical treatment and hospital care.

Aside from the economic or financial difficulties that it may bring to the patient and his family unit there are other anxieties which disturb the luetic patient. The type and degree of emotional conflict centered around syphilis will vary according to the patient's personality and background. Some will probably have conflicts due to their religious, moral or social concepts. Others may

give more importance to the implication of sex and promiscuity that goes with the disease.

Miss O'Shaugnessey, Director of the Social Service Department of the New York Post-Graduate Hospital, in discussing patients with venereal diseases said, "the patient who acquires syphilis may also have other social and emotional difficulties resulting in an unhappy life. They should be helped toward realization, toward greater self-esteem, toward a greater sense of adequacy, or we will see them admitted again and again for treatment." [1]

This brings us to one of the problems of venereal disease control. We can not forget that there are still a few rapid treatment centers in this country. The majority of patients are treated in out patient clinics where the period of treatment is longer. These clinics have to have a full time employee for the follow-up of delinquent patients. With the development of the rapid treatment centers this particular problem has been reduced but there is still the one presented by the repeaters and the delinquents who do not come for follow-up blood tests.

Once more we see the need that the patients have a good understanding of their illness. It was my experience while working as a follow-up worker in a venereal disease

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1. Helen O'Shaugnessey-"A Challenge to Medical Social Workers in Venereal Disease Clinics," Journal of Social Hygiene, (May, 1945), pp. 294-299.

clinic that those patients to whom a good explanation was given were more consistent in their treatment. Even many of the prostitutes responded to this approach. They made a better use of the mechanical prophilactic that they were given and therefore they had a smaller number of reinfections than those who received no sex hygiene education or paid little attention to it.

Dr. C. W. Clarke hopes that the rapid treatment method in itself will serve as a check to the repeaters. In discussing this problem he says, "Ten shots in the hip are disagreeable; fear of syphilis is still strong and education can be carried out while the patient is hospitalized."[1]

It is difficult to believe that the fact that the treatment is painful will be a weapon against contracting venereal diseases. The longer method requires injections once or twice a week which in turn means a trip to the clinic and all the inconveniences of waiting for treatment. It is long and tiresome and yet in spite of this the problem of reinfections has been a persistent one. In the armed forces, restrictive and punitive methods against the luetic were abandoned because they proved to be more detrimental than good. The patients not only contracted the illness but because of the fear of being punished, hid it

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1. Charles Walter Clarke, "Penicillin Help or Hindrance in Venereal Disease Control," Journal of Social Hygiene, (November, 1945), pp. 600-605.

from the medical authorities. Many sought enough private treatment to safeguard them from the manifestations and symptoms of syphilis in its early stages but did not continue treatment long enough to cure them or render them non-contagious.

A patient who had the information or has had the experience of anti-luetic treatment but comes again and again with new infections does it because his need for sexual relations is very strong in him. Why this is so remains to be discovered. If we accept the thesis that often it is due to emotional maladjustment then that is the problem we have to attack. Whatever our opinion with respect to reinfections and delinquency among the luetic patients might be, the fact remains the same. We have to see the patient as a person, as a human being and find out his reasons for acting the way he does.

This is the function of medical social workers in any medical service. Because of her special techniques and body of knowledge the medical social worker is well equipped to deal with the problems of the luetic patients. As Harriett Bartlett says, "The Social Worker seeks first to understand the patient as a person and the implications which this particular experience of illness has for him.

"The Medical Social Worker although she starts with the individual patient, includes his family and the commun-

ity implications of the problem in her consideration of the situation."[1]

She continues, "The initiative is not left to the patient to seek help when he wishes it, but it is part of the public health program to seek him out and stimulate him to follow the desirable treatment regime. If community safety demands it, coercion may be used.

"Problems associated with care of communicable diseases bring out special features of the public health approach which are of particular significance to the social worker. In dealing with communicable diseases there must be a search for "contact" cases and an effort to place them under medical care as well as to hold the patient under regular treatment. If the patients' own desires conflict with the needs of others, this element of force may enter through the police power of the state. It then becomes important to the social worker to help the patient to face the reality of such legal limitations upon his conduct and to accept them as having validity from the point of view of society as a whole."[2]

It is evident that because the control of venereal disease is such a complex one the kind of problems that it may bring to the patients can have a wide range. This is one more reason why it is important to have a trained person in dealing with luetics. Some one is needed who

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1. Harriett M. Bartlett, Some Aspects of Social Case Work in a Medical Setting, (Chicago: Bonta Publishing Co., 1940), pp. 19-21

2. Ibid. pp. 200-203.

knows not one phase or type of problem but a large number of different kinds of problems. Someone who knows how to understand human beings and at the same time has a good understanding of society and community organizations and agencies. That the medical social worker is well prepared to do this and has been doing it can be ascertained by the discussion of her objectives in working with luetic patients presented by Miss F. Haselkorn. She says, "reactions to the treatment may range from disbelief and refusal to accept it, to stark terror and hysteria. Often there is considerable guilt and resultant behavior symptomatic of that guilt. Threat of security, happiness and family adjustment, loss of self respect, ego damage, self criticism, and morbid and irrational fear are some of the common attitudes and forms of behavior we encounter in these patients.

"The restoration of his impaired self prestige becomes one of our immediate treatment objectives. He needs to be shown by our behavior that we respect him as an individual. Self condemnation and rejection is a pattern frequently found in luetic patients. We must identify with them.

"Case holding is nothing else but the logical outcome of effective case work treatment. Studies of delinquent and lost cases invariably discloses psycho-

social factors."[1]

As she points out, it is absolutely necessary that the patient be respected. Let those who work with luetics remember that it is not their duty to judge the patient's morality and that if they have any prejudices against the disease, these should not be disclosed to the patients. If a generalization is made here it is because we must remember that a social worker can not function in a vacuum; she must work in close cooperation with all the staff of the medical unit. To those in the field of medical social work this is nothing new. Most of us know that often our efforts and work of weeks and even months can be destroyed in a few minutes by the attitude of anyone connected with the hospital or the clinic. From the doctor to the orderly, there must be a spirit of team work in order to insure the best functioning of the treatment unit and the welfare of the patient and his family group.

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1. Florence Haselkorn, "Case Work with Syphilitic Patients," The Family, Vol. XXIV, No. 3, May 1943. pp. 91-97.

SUMMARY

SUMMARY

- CONCLUSIONS -

This study has shown the following:

1. The forty-four patients who were interviewed during the period of one and a half months (March 1st to April 15th) at the Louisville Rapid Treatment Center, fifty-five percent were colored and forty-five percent were white. The median age was 25 years; the youngest patient was 17 years of age and the oldest one was 67 years old. Seven patients had had previous syphilitic infections, three had received treatment before for the same infection and thirty-four were now hospitalized with their first infection. None of them was infected by his wife. Twenty-three contracted syphilis from pick-ups, eleven from girl friends, and only four from prostitutes. Six had good knowledge, twenty-three, fair and fifteen, poor. There were twenty-seven single patients, ten married, two divorced, three separated and two widowers. We have no information as to church attendance of seven patients; eleven were regular churchgoers and twenty-six either did not go at all or only occasionally. Incomes varied from none to $65.00

per week. The largest number fell between $41 - $50 per week. Hospitalization represented an economic loss to thirty-one patients. To thirteen patients it brought no financial problem or complication, twenty-six had dependents and eighteen had none.

Not all of those who had dependents or who suffered some kind of economic loss presented economic problems. Most of them had been able to make some arrangement to insure some means of subsistence for their dependents. Yet in many cases how the patient was going to meet his obligations to these persons who were helping his relatives was a source of worry.

2. As we can see most of the patients had anxieties or conflicts of different types which are not peculiar to this rapid treatment center or this city. They are common to luetic patients all over the country and this is ascertained by such experienced persons in the field of venereal disease control as Misses Margaret Lumpkin, Louise Ingraham, Florence Ellis and Doctors Stokes, Vonderlehr, Parran, Heller (see bibliography).

3. The need for more individualization has not only been recognized but emphasized and recommended by them.

4. Education has proved valuable as a means of enabling the patients to recognize their early symptoms. In this way they are more apt to seek earlier treatment thus preventing further spread of the disease. The need to continue imparting education individually and in mass has been recognized.

5. Those persons who work with the luetic patient need to have an understanding attitude. Above all they should not have hostile feelings or be judgemental.

6. Unsolved conflicts are often the underlying cause for extra-marital sex behavior. As a result of this patients contract the infections and often are delinquents and repeaters. Therefore the need for treating these conflicts or helping the patient with them is imperative.

7. A medical social worker, because of her body of knowledge and special techniques is the person best qualified to help the patients with their problems. She can give case work services to those who will benefit from it and direct others to the proper persons or agencies.

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APPENDIX

SCHEDULE

I. Identifying Data

1. Age
2. Occupation or trade
3. Salary
4. Church Attendance
5. Dependents
6. Race
7. Civil Status

II. Source of Referral

1. Voluntarily
2. By private physician
3. By public physician
4. Given as contacts
5. Quarantine
6. Sent by employers
7. Others

III. Knowledge about Syphilis as a Disease

1. Good
2. Fair
3. Poor

IV. Attitude or Feelings toward Syphilis

1. Guilt
2. Fear
3. Shame
4. Loss of Self-respect
5. Self-pity
6. Self-punishment
7. Revenge
8. Indifference

V. Attitude of the Wife or Family Group to Patient's Illness

VI. Social Economic Problems Caused by Hospitalization

1. Loss of job
2. Loss of pay
3. Loss sick-leave or vacation days
4. Others

SCHEDULE

VII. Source of Infection

1. Friend
2. Pick-up
3. Prostitute
4. Wife
5. Others

VIII. Type of Patient in relation to present illness

1. First infection or new
2. Reinfection or repeater
3. Relapse of treatment