



**POLIO, TUBERCULOSIS, &
HIV/AIDS EPIDEMIC HISTORY (LEST WE FORGET)**

POLIO, TUBERCULOSIS, HIV/AIDS, CORONAVIRUS EPIDEMIC/PANDEMIC (LEST WE FORGET)

(SELECTED GEOGRAPHICAL PERSPECTIVES)

GOALS

1. Appreciate the frontier history of Poliomyelitis, Tuberculosis, and HIV/AIDS.
2. Compare the history of treatment and presentation of Poliomyelitis, Tuberculosis, and HIV/AIDS.
3. Remind all administrators/leaders that disease and accompanying outcomes are still happening and will continue to be challenging.

KEYWORDS FOR APPLICATION

1. Polio
2. Poliomyelitis
3. Infantile Paralysis
4. Polio Virus---1,2,3
5. Salk Vaccine
6. Sabin Vaccine
7. Trivalent Vaccine
8. Paralysis
9. Gamma Globulin
10. Tuberculosis (T.B.)
11. Nobel Peace Prize
12. Sanitarium
13. Pneumothorax
14. Chemotherapy
15. Rifampin
16. World Health Organization (WHO)
17. Lobectomy
18. Plombage
19. Pneumoperitoneum
20. Thoracoplasty
21. Streptomycin
22. Mantoux
23. Tine Test
24. Antibodies
25. Typhoid
26. Epidemic
27. Smallpox
28. Cholera
29. Influenza
30. Typhoid
31. Pirquet Test
32. PPD

33. HIV/AIDS

34. Coronavirus (Covid-19)

WE CANNOT BE PREPARED FOR THE FUTURE WITHOUT BEING KNOWLEDGEABLE ABOUT OUR PAST. AND—OUR FUTURE IS IN THE MAKING AS AN OUTCOME OF THE CORONAVIRUS. SINCE THE OUTCOME OF COVID-19 IS YET TO BE DETERMINED, WE CANNOT, YET, PREDICT NEW ADMINISTRATIVE CONCERNS AND CHALLENGES. KNOW THIS—THERE WILL ALWAYS BE NEW CHALLENGES!

POLIOMYELITIS (INFANTILE PARALYSIS)

In 1909, this deadly virus was discovered and affected only humans. At first, it was thought to be restricted to babies (hence the name Infantile Paralysis). However, Polio was just as common in older children and young adults. It was common in temperate climates in the summer and with no weather seasonal pattern in the tropics. The virus, being harbored in the gastro-intestinal and mucous membrane of the nose and throat, then traveled into the bloodstream to the nervous system. It then destroyed the motor neuron cells, which control swallowing, circulation, respiration, trunk, arms, and legs. The virus's spreading was through fecal-oral transmission and respiratory secretions, with symptoms appearing three to six weeks after exposure. The signs of infection were sore throat, upset stomach, headache, and muscle stiffness.

There were/are three types of Poliovirus: 1, 2, and 3. Type one is the most virulent and common. The Salk and Sabin vaccines are "trivalent"—acting against all three types. Type 2 has not been detected anywhere in the world since 1999. A Polio victim was/is immune to future infection from the virus type that caused the Polio.

With the spread of Polio across the United States in the summer of 1916, six thousand children and young adults in the United States died that year, and at least twenty-seven thousand were permanently disabled. One-percent became paralyzed. The total number infected with the virus was in the millions! Montana, however, had more cases per 100,000 than New York City. Why--? Using our current knowledge about viral infections, we believe that in more populated areas (like New York City), the few sporadic cases spread enough of the virus to secure some immunity and subclinical cases.

Dr. Louis Allard (a native of Laurel, Montana) arrived in Billings in 1914 from Rush Medical College in Chicago to help with the frontier epidemic. In the summer of 1916, Montana had 111 cases resulting in 24 deaths. In 1922, Yellowstone County had 41 cases and four deaths. In 1924, 182 youngsters were paralyzed, and 23 died. "Polio Panic" and a warning of the "Awful Scourge Creeping West, Baby Paralysis Yet Unchecked" was proclaimed boldly by the Helena Independent Newspaper. During 1920-21, a total of 50 victims were paralyzed. Dr. Allard and Sister Arcadia Lea from Sisters of Charity of Leavenworth began a treatment program at St. Vincent Hospital (SCL Health Care) in Billings, thereby treating 467 patients by 1922 from all over the country. During the summer of 1924, 182 Montana young people were paralyzed, and 23 of that number had died.

Clinics began to appear on the Montana frontier that rivaled larger Polio health facilities elsewhere. Anaconda filled their swimming pools with dirt, and kids were restrained from all normal activities that made life fun and worth living like a youngster. The message went out loud and clear: “Wash your hands, cover your mouth when you sneeze, pasteurize milk, dispose of garbage frequently, and do everything you can do to get rid of those flies!” Despite the fear of other childhood fatal illnesses in 1920-1940 (diphtheria, tuberculosis (T.B.), scarlet fever, whooping cough, measles, and strep throat), which was stated to occur much more frequently than Polio, the crippling disease of Polio was the most dreaded of infectious diseases! Such Polio related disabilities of being “different” or being in a wheelchair brought about ridicule, which, for some, was worse than death. Since farm work was the usual way to survive on the frontier, such disability was a severe detriment to a homesteader’s survival. At that time, the hard truth was there was no treatment or cure for Poliomyelitis—just offering help for the paralysis!

Nursing was comfort, care, prevention of secondary infections, aspirating airways, providing oxygen, and assisting with tracheostomies. Nurses isolated patients from family and friends because it was necessary. They cared for patients isolated in Iron Lungs (rigid cylinders sealed at one end with alternating air pressure for the paralyzed lungs). Elizabeth Kenney, an Australian nurse, applied hot wool packs and performed a passive range of motion to re-educate weakened muscles.

In 1950, Gamma globulin from the plasma of multiple blood donors (containing many antibodies) was used for treatment. In 1955, the Salk Vaccine (inactivated Poliovirus/attenuated live virus) was discovered as a prophylactic treatment. In 1961, this vaccine was administered orally on sugar cubes replacing the original injected vaccine. Jonas Salk and Albert Sabin used the knowledge that the body’s immune system would produce antibodies as the basis of their successful research for the development of two different vaccines. The Polio cases in the United States fell from 13.9 per 100,000 in 1954 to 0.5 in 1961. The incidence of Polio decreased each year after that.

We see polio cases confined to a few instances in the world’s under-developed countries of Southern Asia and Central Africa.

TUBERCULOSIS (T.B.)

Sometimes known as consumption, this highly contagious bacterial disease was known as early as the 1880s to spread through coughing, sneezing, hemoptysis, and spitting. Symptoms of hoarseness and dyspnea were among the signs and symptoms of the disease. It was especially contagious during the late stages of the disease. The young and the old were the most vulnerable.

Historically, this dreaded infection was caused by *Mycobacterium tuberculosis*. Infection by this tubercle bacillus usually affected the lungs but could affect other parts of the body. It was caused by inhaling the tubercle bacilli of a person with increased susceptibility by being malnourished, living in a crowded environment, or compromised immune system. The chances of contracting this disease were enhanced through prolonged exposure and increased virulence of the bacilli. The condition had been around for thousands of years. Many pharaohs, kings, and the wealthy over thousands of years to the poorest of the poor succumbed to this persistent and unforgiving disease, which caused inflammation in the lungs’ alveoli resulting in primary tubercle nodules.

The effective diagnosis of T.B. was accomplished through the invention of the stethoscope in 1816 by Rene Laennec. X-rays were performed starting in about 1866 by a Nobel Peace Prize winner named Wilhelm Rontgen. Sanitariums were placed in quiet, peaceful areas to treat patients by exposure to fresh air, proper nutrition, individually designed treatment, complete bed rest, daily vital signs, frequent exams, moderate exercise, teaching about hygiene, and surgery treatment, as needed. These activities and procedures nurses were responsible for performing or participating in as a total recovery treatment program. The first sanatorium was established in Poland in 1892. By 1938 seven hundred T.B. sanitariums existed in the United States.

Galen Hospital in Galen, Montana, was an attempt to meet the health care needs for isolation of T.B. patients in Montana. Out of fear for the disease, the facility was built on 40 donated acres near Montana State Hospital just outside Butte, Montana. The first patient was admitted in 1913, and by 20 months later, there were 115 patients. The major theme of treatment was isolation. Patients slept outside to get the prescribed fresh air—despite the weather. Patients were allowed in a closed room only while dressing and during a storm. Children were admitted in 1924 with the treatment (in addition) to include progressive sunlight therapy, naps from 1 to 3 p.m., and bedtime at 9 p.m. There was an effort to have a healthy, happy atmosphere, especially for the children. Due to advances in chemical cures and out-patient treatments, Galen Hospital closed on July 1, 1993.

The public health nurses established by Lillian Wald became a vital part of curbing T.B. In New York City, the public health nurses were expounding the public health requirements to “NOT SPIT ON THE FLOOR, NO SLEEPING IN A ROOM WITH A PERSON WITH CONSUMPTION, AND NOTIFY THE PHYSICIAN OF SOCIAL RELATIONS WITH A PERSON SUFFERING FROM CONSUMPTION!” The nurses managed the education, prevention, and community recognition of the disease. The proclamation went forth:

“Public health is purchasable—within natural limitations, a community can determine its own death rate.” Hermann Biggs

TB TREATMENT HISTORY

1800’s:

Artificial Pneumothorax (collapsing a lung by introducing air into the pleural space)

Pneumoperitoneum with Phrenicotomy (crushing or surgical division of the phrenic nerve leading to ipsilateral paralysis of the diaphragm).

1940’s:

Phrenicotomy (a surgical division of the phrenic nerve to secure collapse of a diseased lung by paralyzing the diaphragm on one side)

Plombage (Insertion of a “plombe” to collapse the lung—e.g., fat, paraffin wax, ping-pong balls, plastic sponges, Oleo/oil)

Lobectomy (surgical removal of a lobe of the lung)

Pneumothorax (artificial collapsing of a lung)

Thoracoplasty (removal or resecting one or more ribs to obliterate the pleural cavity and collapse a diseased lung)

Chemotherapy using the antibiotic, Streptomycin.

1950's: Chemotherapy: Isoniazid (INH)/Rimifon, pyrazinamide, Cycloserine.

1960's: Rifampin was introduced as a treatment for T.B., Leprosy, and other infections.

1980's: Drug-resistant strains of T.B. emerged, increasing T.B. cases.

Today: Chemotherapy includes multiple drug use. Refapentine was introduced in 2000.

As of 1993, the World Health Organization (WHO) declared T.B. a global emergency—even though death from T.B. in the United States decreased significantly from 300/100,000 in 1786. (In 2010, .02/100,000 deaths occurred as a comparison.) The highest number of cases is found in third world countries, with approximately 10,000 patients diagnosed during 2013. *The overprescribing of antibiotics of one-half million of the world's population has caused antibiotic resistance that once treated tuberculosis successfully.* The truth seems to be—TB CAN NOW BE CONTROLLED. Often, the combination of T.B. drugs is used as a part of today's so-called, simple, and inexpensive eradication of T.B.

The well-known Mantoux screening test, tuberculin sensitivity test, Pirquet test, or PPD (purified protein derivative) are the most used skin tests worldwide. They have primarily replaced the multiple puncture tests, such as the Tine Test. Positive reactions to these tests include determining induration (palpable swelling) within a 48 to 72-hour period. A reddened area with no induration during that time-frame indicates a negative response. The evidence of induration suggests a possible development of antibodies against the tubercle bacillus. The findings indicate a need for nurses to teach regarding the results of the skin test. Teaching is an independent and essential aspect of the practice of nursing!

HIV/AIDS

When a nurse lives a professional life at the bedside of many patients, sometimes situations are best not to be thought about too strongly. It is difficult to remember the patients who could not be helped, only to watch them suffer and die.

I usually do not talk/write about my personal experiences. However, so touched was my daughter, she asked me to share my historical pain with you as a nurse in an unknown disease/pandemic era.

The babies I have held tightly due to the mother's use of addicting drugs, the dying patients from disease and accidents, and how could I forget the numerous young paralyzed people I helped take off the helicopter. There were times at the operating table when only one physician was present, and I helped as the so-called surgical assistant and then, in the next breath, become the scrub nurse and then the circulating nurse. As a business owner, there were times of performing in-home care for patients who chose to stay at home or train aides to learn to care for patients in the home that had no idea what a "bowel program" procedure was or even desired to perform. But, the one nursing experience that tore at my maternal heart-strings and brought me to tears each night due to the isolation was the thwarting of, for the most part, young people with HIV/AIDS. As team nurses on that night shift, we must have "bagged" at least two bodies a night after sitting at bedsides of these youngsters who

admitted their family (especially crying for their mother) would not call or come to see or be with them on their death bed!

Dressed in protective garb from head and toe, we went to the previously unused hospital floors only available through back elevators not used for years. We hesitantly went through “only access” doors known to staff. Yes, we wandered those lonely halls in San Jose, California, in the late 1980s. Tired from the night shift and unable to sleep during the day, many nurses tried to sleep during the day in their car or R.V. in the parking lot. Our nightmare was continually thinking about what was causing this terrible health problem of our (for the most part) younger generation. We even wondered if we, as nurses, were also being exposed to something we did not understand.

To bring it even closer to home, I had an uncle whose son lived in San Francisco and was diagnosed with HIV/AIDS. He, too, feeling extreme shame for the possible cause of his son’s condition, disowned him, never once called him, and did not come to his bedside during his son’s dying days. As I heard of this uncle going into the hills to die, I could not think of another reason for such a suicide than the guilt felt from disowning his only son.

Today, we know HIV as a Human Immunodeficiency Virus infection attacking the body’s CD4 cells, resulting in Acquired Immune Deficiency Syndrome (AIDS). It attacks the immune system, changes the DNA, and causes a spectrum of symptoms by destroying the white blood cells that fight infections and certain cancers. Symptoms are fatigue, decreased energy, persistent infections, swollen glands/lymph nodes, skin problems and rashes, fever, and night sweats. It is transmitted sexually, through blood contact, from a mother to a child during pregnancy, during child-birth, and during breastfeeding.

Over 39 million have died, with only one person being cured by a known cancer cure. Literature claims there is no known reason for that one cure---however, the fight continues in the hopes of progress for a treatment. Currently, as this article is written, there is no known “cure.”

LEST WE FORGET

Rocky Mountain Spotted Fever (in the Bitterroot Valley), Smallpox and Cholera (in Stevensville), Influenza, and Typhoid (in Gallatin County) were major epidemics in Montana history. HIV-AIDS continues to leave its mark on all of society.

Why do we care about our health care epidemic history as nurses? Because-- it (epidemic/pandemic) could happen again and because history could repeat itself-- perhaps by a different name and face!? (as it just has happened!) For those of us who have “bagged” the bodies of unfortunate diseased patients behind locked and isolated corridors during an epidemic, and as we stood over them in our protective garb and lamented with them the lack of family presence at the time of their death, those memories will never fade! Now, we move forward with a heavy heart caused by our memories and hope it will not ever happen--again! Unfortunately, it will! Will we be better prepared?

Through history, we have learned that NOW our nursing role is an outcome of more education and experience—not-with-standing our desire to nurture the human spirit. With that increased knowledge and experience, our future involvement in epidemic/pandemic resolution will be an outcome of our professional abilities of recognition, treatment, and prevention.

2019-20 PANDEMIC LESSONS ABOUT CURRENT GOOD AND BAD LEADERSHIP BEHAVIORS

Now—amid disease (again) as it strikes in the form of Coronavirus, we gather our nurse administrator and nurse leader strength. This story is yet to be told by nurses regarding the pain and suffering of patients and families they are currently experiencing during this difficult time. No other non-nursing person will ever truly understand these feelings!

We are also presently witnessing leadership (or management?) in its many forms as this current pandemic rages onward and national leaders attempt resolutions. In retrospect, try to learn from what you witness. This leadership crisis will result in learning for any leadership attempt. History will record situations of goodness, weakness, strength, and selfishness---a mixture of good and bad.

Learn from what you are witnessing! Consider these behaviors in your leadership future:

DO:

Be truthful and kind.

Be prepared.

Give others credit when credit for their input and behavior is evident.

Be respectful by using other people's correct names and credentials.

Accept responsibility for your behavior.

Plan for the inevitable happening—short and long-term.

Encourage others rather than blame others.

Listen and learn from other professionals.

Know what you say to be truthful.

Communicate clearly and concisely.

Listen and appropriately respond to other professionals.

Be a leader instead of a manager when appropriate. (Involving others in decision-making processes)

Communicate effectively, accurately, and often to anyone needing information.

DON'T

Be sarcastic.

Problem-solve extemporaneously.

Tell mistruths.

Embarrass anyone in front of a group.

Take inappropriate credit for another person's contribution.

Discredit others.

Boast about personal behaviors or accomplishments.

Blame others for your mistakes.

Call other people inappropriate or demeaning names—they have a *name*!

Misrepresent situations.

(I could go on and on-----)

LAST THOUGHTS

***IN OUR NURSING HISTORY, WE SHOULD RECALL THE DESCRIPTION OF THE TRUE ART AND CARE DEPICTED BY OUR PROFESSION (LEST WE FORGET!)**

***“NURSING IS AN ART, AND IF IT IS TO BE MADE AN ART, IT REQUIRES AS EXCLUSIVE A DEVOTION, AS HARD A PREPARATION, AS ANY PAINTER’S OR SCULPTOR’S WORK; FOR WHAT IS THE HAVING TO DO WITH DEAD CANVAS OR COLD MARBLE, COMPARED WITH HAVING TO DO WITH THE LIVING BODY— THE TEMPLE OF GOD’S SPIRIT? IT IS ONE OF THE FINE ARTS; I HAD ALMOST SAID, THE FINEST OF THE FINE ARTS.” FLORENCE NIGHTINGALE (1820-1910)**

CRITICAL THINKING QUESTIONS

1. As a modern practicing nurse of today, to what extent do you see yourself being able to deal with a new disease?
2. What differences do you see in your current nursing behaviors different from what was expected during a past health crisis?
3. What nursing skill/practice do you need to handle effectively and deal with a nursing care crisis?
4. With the current Coronavirus pandemic, what are the similarities in nursing challenges experienced during past health care crises?

AUTHOR: Carolyn R. Taylor, Ed.D. M.N. R.N.