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A three year follow-up study based on ward admissions to the Massachusetts Memorial Hospitals during January and February, 1951.

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Boston University
A THREE YEAR FOLLOW-UP STUDY BASED
ON WARD ADMISSIONS TO THE MASSACHUSETTS MEMORIAL
HOSPITALS DURING JANUARY AND FEBRUARY, 1951

A thesis

Submitted by
Eleanor Louise Goldberg
(B.S., Boston University, 1949)

In Partial Fulfillment of Requirements for
The Degree of Master of Science in Social Service
1954
Preface

The writer wishes to express her gratitude to The National Foundation for Infantile Paralysis for their scholarship which made possible her second year of graduate study.
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CHAPTER I

INTRODUCTION

Purpose

Chronic, long-term, or better still, prolonged illness has been receiving increased attention in recent years as the major medical-social problem of our time. In an era characterized by dramatic victories over disease in general, the increasing incidence of prolonged illness presents a challenge to all those concerned with the provision of adequate care for the sick.... The challenge that confronts us now is how to provide adequate care for a large number of patients over a prolonged period of time and how to succeed where we have hitherto failed, both in prevention and treatment.

Minna Field

The National Health Survey conducted a study during the winter of 1935-1936 for the purpose of determining the prevalence of certain chronic diseases, covering eight-hundred thousand families in nineteen states. On the basis of this study, it is estimated that one out of every six persons in the United States is suffering from some form of prolonged illness and that the total number of people affected is about twenty-three million. One local study in Massachusetts, for example, points

1. Minna Field, Patients are People, p.7.
out that there are many people who have an undetected or unsuspected illness. On the basis of this one study, it appears that about 18.8 per cent of the population suffers from some form of prolonged illness or permanent impairment.²

Chronic illness has even larger social implications. According to Dr. Boas:

Chronic illness has so profound an effect upon the patient's external life, on his career, on his occupation, his economic status, his amusements and his hobbies, on his family relationships, on his habits of eating, drinking, sleeping and social intercourse, that he is often overwhelmed by the necessary readjustment of his mode of living.³

The United Community Services, Committee on Chronic Illness, was interested in studying a limited number of discharged chronically ill patients from four teaching hospitals in 1951 in an effort to determine what has happened to them since that time. Also of importance, United Community Services wanted to know what community resources these patients used to meet their needs.

The purpose of this thesis is to make a follow-up study of a group of aged people who had been hospitalized

². Ibid., p. 24-25.
³. Ernst P. Boas, The Unseen Plague: Chronic Disease, p. 20.
at Massachusetts Memorial Hospitals.

In undertaking this study, the writer had several questions in mind: 1) What were the most prevalent diseases among these patients? 2) What problems were most evident among the patients? 3) How did the social worker help the patient in achieving a satisfactory adjustment to his illness? 4) What facilities were used to meet the needs of the patients after hospitalization? 5) What was the status of these patients economically, socially, emotionally, and physically in December, 1953?

Scope of Study

This thesis is a three-year follow-up study based on the first twenty-five patients that were admitted to the Massachusetts Memorial Hospitals during January and February, 1951, which met the criteria for selection. The following criteria were used in the selection of these cases:

1. that the patient be sixty-five years of age or older at the time of admission.
2. that the patient live in the Boston area or its vicinity.
3. that the patient be a ward patient.

This project was sponsored by the United Community Services, Committee on Chronic Illness, and is a portion of a pilot study being conducted at three other teaching
hospitals in the Boston area, each contributing its share of knowledge to the vast problem of chronic care. The basis for selection of cases to be studied was determined for the writer by the United Community Services.

Method of Study

The Committee selected the personal interview as the method of study to be used by the writer in determining the three-year follow-up status of the twenty-five patients studied. Two patients had died on the second Massachusetts Memorial Hospital admission in 1951 and nine patients had died since discharge from the hospital in 1951, making a total of eleven patients that were deceased in 1953. Of the nine patients that had died since discharge in 1951, the writer interviewed the survivor in two cases. Social service records and consultation with a social worker were used to obtain information until the time of death on the remaining seven deceased patients. It was agreed not to visit a relative if the patient had died in the hospital regardless of whether it was a first or second admission, since this study is limited to post-hospitalization adjustments. A relative was to be visited if the patient died after discharge from the hospital.
The writer interviewed the fourteen surviving patients. Two patients among this group refused to be interviewed, therefore, the writer selected the next two admissions that met the requirements for selection. In order to analyze the cases, the Committee devised a schedule which covered the following points: description of the patient in regard to his age, sex, marital status, race, medical diagnosis and follow-up care recommended upon discharge in 1951, and living arrangements, physical and financial status in 1951 and 1953.

A survey of books, pamphlets and journals from the fields of medicine and social work as they relate to the medical and social problems of old age and illness were utilized to provide background material for this study. Tables were used to present the statistical data. Case examples were given to illustrate the role of the social worker with the chronic sick.

**Sources of Data**

The sources of material used in this study were social service records, social service cards where contact was limited, social consultation sheets in medical records, medical records, out-patient records, and, in a few cases, verbal information given by members of the Social Service Department. In one instance,
verbal information was given by the physician to whose care the patient was discharged. This patient was deceased in 1953, had no relatives in the state, and was not known to social service.

Limitations

The outstanding limitation of this study is in the inadequacy of social service records. Of the twenty-five cases selected for study, six had social service records. Five of these patients were deceased in December, 1953, so that follow-up was not possible. Seven patients had a social service card or a consultation sheet in the medical record indicating a limited contact. Eleven patients had no contact with social service at all either in 1951 or in 1953. Case studies refer to the patients that were known either to the Social Service Department of the Massachusetts Memorial Hospitals or the Home Medical Social Service Department of the Massachusetts Memorial Hospitals in 1951.

Six patients with acute illnesses were included in this group. Although this study is concerned principally with the chronic patient, the six acute patients were included in all phases of the statistical analyses.

Due to the above-mentioned limitations, the conclusions
reached are limited and do not apply beyond the scope of this study.
CHAPTER II

THE HOSPITAL SETTING

Brief Survey of the Massachusetts Memorial Hospitals

The Massachusetts Memorial Hospitals is a voluntary, non-profit institution, which was founded in 1841 and incorporated in 1855 under the name of the Massachusetts Homeopathic Hospitals. The hospital maintains a comprehensive three-fold program: to give care to the sick, to add to the body of scientific knowledge of health and disease through research, and to provide opportunities for teaching. Free or low cost medical care is provided for those who need it regardless of race, religion, color, creed, social or economic status. The hospital consists of five memorial units: Evans Memorial for research as well as for private and ward patient care; Talbot Memorial, which was the original building and was erected in 1876 by the Homeopathic Medical Society, for out-patient care; Robinson and Collamore Memorials for ward and private bed care; Haynes Memorial for infectious diseases; and the recently added Medical Associates for group practice as well as for teaching and research. The hospital became associated with the
Boston University School of Medicine in 1871 and serves as a teaching hospital for this school and gives instruction in infectious diseases to the students of the Harvard Medical School and the Harvard School of Public Health. The hospital also maintains a School of Nursing and a School for Technicians.

The Massachusetts Memorial Hospitals is a general disease hospital offering medical services by fifteen separate medical and surgical staffs which represent all the major divisions of medicine and most of the specialties. The present accommodations are for three hundred and sixty adults and forty babies. There are thirty-five clinics for out-patient care and a department providing home care for the medically indigent. There are also considerable facilities for educational and research purposes. In 1952, eight thousand two hundred patients received hospital care from thirty-six states. While the hospital is primarily for residents of Boston, one thousand two hundred thirty-four or 16.6 per cent of the patients came from other cities and towns in Massachusetts.¹

Extensive investigations are being carried on in the field of cardiovascular diseases and cancer, the two leading causes of death. Research projects in

¹ Massachusetts Memorial Hospitals, Annual Report, 1952.
hematology, radioactive isotopes, metabolism and endocrinology are also carried on at this hospital.

With these inclusive activities in the care of sick people, medical education and research, the Massachusetts Memorial Hospitals makes its contribution towards the progressive development of medicine and improvement of health in Boston. The Massachusetts Memorial Hospitals has become one of the leading health centers of the world.

The Social Service Department of the Massachusetts Memorial Hospitals

The Social Service Department within the hospital began unofficially in 1910 with a social worker who was a nurse. She worked at the Robinson Memorial which at that time was a maternity hospital and the problem of the unwed mother who came to the Pre-natal Clinic was the first social problem to come to the attention of the social worker. In 1920, the Social Service Department developed officially with a trained social worker and the department has continued to expand to meet the medical and social needs of its patients. In 1953, there were nine social workers in the out-patient department including the Director of Social Service,
and one social worker in the main hospital. Of the social workers in the out-patient department, one worker covers the Home Medical Service, one works principally on a cardiac study, one worker is attached to the out-patient admitting office, and the remaining workers cover the various clinics in the out-patient department. The social worker in the admitting office determines the clinic fee according to the patient's ability to pay. Often many problems are picked up and they are referred to the social worker who covers the clinic the patient will attend. Sometimes, the doctors in the various clinics refer patients to the social workers for help. The out-patient department employs a case aid who does social admitting for patients who have previously been known to the clinic. A code is given each patient according to his ability to pay, and is revised as the situation warrants.

The medical social workers have been giving guidance and help both within and outside the hospital for over twenty-five years. This help may be in the form of casework services, direct services, or cooperation with other agencies, both public and private, depending on the medical and social needs of the patient. The medical social worker works in close collaboration with the
doctors and the patients, interpreting the social situation of the patient to the doctor, and the doctor's diagnosis and recommendations for treatment to the patient. The medical social worker keeps in close touch with the patient when he attends the clinic, or the wards when he is in the hospital, or by visits to the home when that is indicated, and keeps in close contact with the Visiting Nurse Association which supplements the care given by the clinic.

The Home Medical Service of the Massachusetts Memorial Hospitals

The Home Medical Service of the Massachusetts Memorial Hospitals had its inception about 1875 when the hospital inaugurated a district service to provide medical care for the indigent poor of the South End area. The program was operated from the out-patient department and was then called the District Service. It is a joint service offered to the community by the Massachusetts Memorial Hospitals and the Boston University School of Medicine. The Annual Report of the hospital for 1878 indicated that in the previous year 1,507 patients had been treated at home and had received
5,887 visits.  

In July, 1948, there was a re-organization of the service and the assumption of responsibility for medical care and teaching on this service was given to the Department of Preventive Medicine at the Boston University School of Medicine. This association of appointments allows a centralization of authority and control which makes possible a fairly intensive integration of service and continuity of medical care as well as a correlated experience in medical practice.

The district that the Home Medical Service covers is approximately one square mile of the hospital in the South End area and adjacent portion of Roxbury. It contains a population of varied backgrounds numbering fifty thousand and includes the lowest economic stratum of the city. Home visits are made to patients who are not under the care of a private physician and have an income within the limits acceptable for out-patient admission as established by the Hospital Council of Metropolitan Boston. The upper limit of eligibility for a single person is

forty dollars a week. Approximately one third of the annual services are provided for individuals receiving financial assistance from a public welfare agency, two thirds of the annual services are provided for medically needy individuals and practically the entire cost of care for this group must be subsidized by the hospital.3

The function of the Home Medical Service today is twofold: to give direct service to the community and to teach medical students to see the patient in his natural environment so that they can learn to approach the patient as a whole person in relation to his social environment.

The regular staff of the Home Medical Service consists of a director, two residents who review the calls which the fourth year medical students have made the previous morning, a full-time social worker, nurse, and nurse-secretary. The nurse-secretary receives and screens the calls from individuals, social agencies, relatives or other hospitals until three o'clock each afternoon. Each month a group of from four to six fourth year

medical students from the Boston University School of Medicine are assigned to practice on this service. For the past few years, two social work students from the Boston University School of Social Work have been assigned to the Home Medical Service for field work placement under the supervision of the social worker covering this service. There are also two student nurses who rotate on the service each month and provide bedside nursing care under the Supervisor of Nurses of the Home Medical Service. The service has access to laboratory and diagnostic facilities in the hospital and consultation with other departments in the hospital are available when needed. The service maintains a close working relationship with the Visiting Nurse Association.

The Home Medical Service cares for patients with both acute and chronic illness. It covers all age groups and is aided by a grant from the Commonwealth Fund.

The Social Worker on the Home Medical Service

The social worker participates in the teaching program as well as giving direct service to the patients referred to her by the fourth year medical students.
Each month when the new group of medical students is assigned to the Home Medical Service, the social worker holds an orientation conference with them to help them understand the importance of the teamwork relationship, the function of the medical social worker and the social and emotional implications of illness. The social worker also participates in the weekly Social Service Conference led by the Director of the Home Medical Service and attended by all the medical students, social work students, and representatives of the Visiting Nurse Association and other social agencies which are interested in the patients discussed at the conference. The medical students are encouraged to discuss any medical-social situation that has come to their attention from their experience on the service. Often, the other members of the team enrich the medical students' knowledge so that the patient is viewed in an all encompassing framework.

Also, in a teaching capacity, the social worker supervises a social work student who has been assigned to the Home Medical Service for her second year field work assignment.

The Home Medical Service provides a diversity of medical and social situations. The cases vary from the somewhat simple one to the more complex, from the young
to the old, from those acutely ill to those chronically ill. Some of the problems that come to the attention of the social worker on this service are: obtaining temporary financial assistance, providing temporary housekeeping services, terminal care placement, nursing home placement, evaluation of current medical status of patients at the request of public welfare agencies, marital problems, financial and emotional problems as they relate to the illness situation.
CHAPTER III

SOCIO-ECONOMIC AND EMOTIONAL ASPECTS
OF CHRONIC DISEASE

The social consequences of chronic disease include long periods of invalidism, disruption of personal and economic family life and dependency. With illness, economic problems and emotional adjustments must be made to help insure some measure of security within the family unit.

If the head of a household has a chronic illness and there are no savings, complete dependency follows. Relatives can sometimes help in emergencies, but not over long periods of time. The spouse cannot take a position outside the home to alleviate the financial burden, as her services are needed to care for the invalid. Often welfare assistance seems the only solution and this may mean an adjustment in terms of standard of living. If the provider of the family is not the victim of the illness, its influence is nevertheless exerted upon him in innumerable ways. Housekeeping services may be needed in the home, children may have to be boarded out. The provider is besieged by worry and tension with increasing financial problems so that the
impact of chronic illness is felt very strongly within the family unit. This also manifests itself when the care of chronic patients becomes so exacting and demanding, that relatives find it impossible to continue home care with the subsequent problems of planning nursing home or terminal care.

Chronic disease has a high correlation with poverty and poor living conditions.\(^1\) Low standards of living, overwork, overcrowding, the effects of poor diet, and unhygienic surroundings frequently found among low income groups are contributing factors to some forms of prolonged illness. Also, poor financial circumstances may mean delayed medical attention or the total lack of it, turning many acute illnesses into chronic illness.\(^2\)

The National Health Survey showed that the chronic disease disability rate varied from 2.87 per cent among public assistance families to 1.4\(^4\) per cent among families with income under $1,000 a year, to 0.4\(^6\) per cent among families with incomes under $1,500 to $2,000 per year.\(^3\)

Very often the poor cannot afford the proper food and

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1. Minna Field, *Patients are People*, p. 87.
medications. Poor housing conditions, inadequate sanitation, overcrowded living quarters and low income all impede rehabilitation.

The Meaning of Illness

People react differently to illness and disability, some reacting to it with frustration, others with pleasure. It may be considered a negative, anxiety-provoking event as it exerts temporary control over an individual's affairs. It affects family economics by entailing additional costs, by loss of income and by creating debts.

Illness carries with it some satisfactions. The ill person receives special attention and consideration from others. He may enjoy his state of dependency and the personal physical care from those attending to him. Illness carries with it elements of regression, demanding attitudes and irritability, which diminish as health is restored.

It is very important to distinguish between the physical and emotional factors in the etiology and treatment of disease. When there is a strong emotional component to illness, the patient's physical progress will
be hampered unless he has made a satisfactory adaptation to his total life situation. Each individual's psychosocial growth and development is somewhat different and how an individual handles anxiety resulting from illness will depend on his ego strength. The individual sets up defense mechanisms to handle his anxiety and the use he makes of the various defense mechanisms depends on his age, the tension and stress the individual is under and the extent to which these defenses are used.

The Aged

The problems of old age are largely one of illness. Diseases of the cardiovascular system are the most frequent, followed by diseases of the bones, joints and muscles. Next in importance are diseases of the respiratory system, followed by diseases of the genitourinary system, organic diseases of the nervous system, diseases of the eye and ear, skin disease and malignant neoplasms.4

Since 1900 the number of persons sixty-five years and over has almost quadrupled. There are today about eleven million persons aged sixty-five and over in the

United States.\textsuperscript{5} The increase in longevity is largely the result of lives saved at early ages through the conquest of causes of infant mortality and infectious diseases. Knowledge of public health, improvements in living conditions, plus concerted research programs on chronic disease will eventually result in lower death rates from chronic disease.

**Needs of the Aged**

The satisfactions desired by the aged and the methods used to meet his needs are fundamentally the same for every age group. The elderly person, like the child, needs to be loved, he needs opportunities to express a desire for independence, he needs emotional and physical security. The aged person wants to be a living part of his own world and feel that he is playing a useful and productive role in it. This desire to be useful and needed is perhaps the most frequent problem of the aged.

**Role of the Medical Social Worker**

**in Chronic Illness and Old Age**

Living arrangements constitute a major social problem with the aged sick. Some people are obliged to finally

\textsuperscript{5} Ernst P. Boas, The Unseen Plague: Chronic Disease, p.149-50.
give up their homes because of financial or physical inability to maintain the home or because of peculiarities. The social worker can be useful in the selection of care on an individual basis involving finding a home suited to the client's needs, helping him to accept placement in this type of home, and follow-up contact to help him adjust to the new life. The aged need help in understanding the natural slowing-up process of old age, in accepting these as natural and planning activities commensurate with their present realistic abilities.

A medical social worker must remember that behavior patterns are more rigid and re-adjustment to new situations is a slower process. The worker must take into consideration the social, emotional and psychological factors in making any plans. Movement is slower with older people, but they must be encouraged to assume the fullest responsibility of which they are capable. It is important to evaluate the strengths of the aged person which involves the acceptance of some regression concomitant with old age. The social worker also must remember that elderly persons have both the right and ability in varying degrees to plan their own lives.6

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The medical social worker's prime consideration is to prevent personal and family deterioration as a result of the illness and to help the patient use medical care constructively. The patient must be encouraged to understand his illness and to function as effectively as possible within the limitations imposed by the illness. Strengthening of family ties is also important during illness. Guilt, shame, fear and pain, which are part of the emotional components in illness, tend to turn the patient's feelings towards himself and his illness.7 The social worker should make every possible effort to help the patient see himself as a member of the family and of the community of which he is a part. The medical social worker should assist the patient with reality planning relative to his care, clear understanding of the care recommended by the physician, explanations about medical resources, about diagnosis, prognosis, and treatment. The patient needs help in understanding the nature of his disease, the nature of treatment, and the prognosis with and without treatment. The patient should be prepared for pain and discomfort.

Supportive casework is very important with older patients since many are lonely and unhappy. Supportive casework may help strengthen family relationships and help the patients function better within their physical limitations.

When prolonged illness creates a financial problem, the social worker should help the patient and his family make use of available social resources. Sometimes it is difficult to accept economic dependence and the need to use a community resource. Sometimes the reverse is true and a patient will use illness to secure financial support and to fulfill dependency needs.

Occasionally, the medical social worker must help a family adjust to separation, if this seems the best choice for the welfare of the family. Help in resolving family conflicts and accepting the reality situation is necessary so that the family may be saved from disintegrating due to the prolonged illness of the patient.

**Existing Community Resources for the Chronic Patient**

The vast majority of persons afflicted with chronic illness must turn to the community for whole or partial assistance to obtain adequate treatment for their
illness.\(^8\) The chronic sick are found in out-patient clinics, in general hospitals, in convalescent homes, and in homes for the aged and incurable.

**Out-patient Clinics:** The chief obstacle to this type of treatment plan is the lack of continuity in treatment. The patient is seen by a different doctor at each visit and the patient-doctor relationship does not exist. The doctors become discouraged at the lack of improvement and at the doctor's inability to remove the cause of the symptoms. The medical social worker is very helpful in working with the underprivileged group to help the chronic patient function at maximum capacity within his limitations.

**General Hospitals:** Often chronic patients are seen in general hospitals because of a lack of other appropriate facilities, and once admitted it is often difficult to discharge them. Sometimes the social situation sends a patient to the hospital because there is no one to care for him. Sometimes he is sent back to his previous living arrangements and the benefits of previous medical care are lost. The medical social worker understands the needs of the patient and

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8. Ernst P. Boas, *op. cit.*, p.34.
is able to interpret medical recommendations to the patient at time of discharge to continue to improve in health.

**Convalescent Homes:** Often convalescent homes are forced into a position where they must receive chronic patients in spite of inadequate facilities for active medical treatment. Other homes are more adequately equipped to accommodate chronic patients.

**Homes for the Chronic Sick:** These homes have the stigma of 'incurable' attached to them and the entire medical policy is a very negativistic one. It is based on the assumption that the patients are hopelessly and incurably ill and beyond any possible medical treatment. These homes tear down any hopes that the patient has, with the end result that the patient receives only custodial care whereas palliative treatment might help.

**Homes for the Aged:** Planned essentially for the older well patient, these homes are not staffed or equipped to take care of chronic patients with the results that many patients receive insufficient medical care.

**Home Care:** This is essentially a medical home care program for the chronic sick who are not in institutions and are confined to their home, which may
be dirty, cold, and inadequate. Collaborative medical resources, such as the Visiting Nurse Association, doctor and social worker attempt to meet both the medical and emotional problems of the patient. This program offers many possibilities and is helping to meet the need for medical social care in underprivileged areas.

Facilities for the treatment of disease and for rehabilitation are far from adequate. The extent to which these services can be available depends upon the extent to which a community is willing to support its medical and welfare programs. It also depends upon an awareness by the community of the need for these facilities plus appropriation of funds for this purpose.

**Current Trends in Medical Care**

**Preventive Programs:** Preventive programs are a very important part of a community health program, which is usually under the auspices of a public health agency. Many public health agencies, besides protecting the health of the community, have undertaken broad educational programs as a step towards improving general health. Public health has taken leadership in the control of tuberculosis and venereal disease and has instituted many cancer detection centers.
Community Resources: Medical science is constantly expanding its knowledge both in prevention, care and causation of illness. The strong emphasis on research for diagnosis and treatment of disease and rehabilitation are limited, and the availability of these services depends upon community awareness and willingness to support such programs.
CHAPTER IV

DESCRIPTION OF THE GROUP

As eleven of the twenty-five patients included in this study were deceased by December, 1953, the data on the twenty-five patients pertains to 1951 and the data on the fourteen surviving patients pertains to 1953.

Age, Sex and Race

All patients studied were over sixty-five years of age at the time of admission to the hospital in 1951. Nineteen patients had some form of chronic illness while six patients were hospitalized for acute illness. The acute illnesses included: viral pneumonia and enteritis; fracture, external malleolus, left ankle; inguinal hernia; bilateral displacement of the great toe; bilateral varicose veins and acute cellulitis; and benign prostatic hypertrophy. Of the twenty-five patients studied, ten were women and fifteen were men. The racial distribution was twenty white and five Negro patients.

Eleven of the twenty-five patients studied were deceased in December, 1953. Nine died since discharge from the hospital in 1951 and two died on the second Massachusetts Memorial Hospital admission in 1951. Fourteen
patients were living in December, 1953.

Economic Status

TABLE I

SOURCE OF INCOME OF THE TWENTY-FIVE PATIENTS STUDIED IN 1951 AND FOURTEEN SURVIVING PATIENTS IN 1953

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<th>Source of Income</th>
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<th>1953</th>
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<tr>
<td>Aid to the Blind</td>
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<td>1</td>
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<tr>
<td>Relatives</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Old Age Assistance</td>
<td>9</td>
<td>5</td>
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<td>Pension</td>
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<td>Social Security Benefits</td>
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<td>Own Resources</td>
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<tr>
<td><strong>Total</strong></td>
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The 1953 total figure is lower because eleven patients were deceased by 1953. Among the twenty-five studied in 1951, fourteen patients received some form of public assistance, social security benefits, pension
or combination. Six patients had multiple sources of income in 1951 and nine patients had multiple sources of income in 1953.

Marital Status in 1951 and 1953

Among the twenty-five patients studied in 1951, six were single, thirteen were married, four were widowed, one was divorced and one was separated. By 1953, the marital status of the fourteen surviving patients were as follows: eight were married, four were single, one was widowed, and one was separated.

Living Arrangements of the Twenty-five Patients Studied in 1951 and of the Fourteen Surviving Patients in 1953

Of the twenty-five patients studied in 1951, three patients utilized social service at discharge to help with nursing home plans. Of these three patients, two had no relatives to care for them while the other patient felt that a nursing home would help her convalescence and alleviate the family of the burden of her care. Three patients returned to their own room or apartment alone after discharge from the hospital in 1951, two of whom were re-admitted to the hospital and utilized a nursing home upon discharge. Two patients returned
to rooming houses with their spouses after discharge.

It is significant to note that among this older group of patients a nursing home was utilized only when there was no other method of choice, except for the one patient who lived with her family. This would seem to indicate that if the patient could go to the home of a relative or a relative help in the patient's own living quarters, this was definitely preferred over a nursing home.

The writer interviewed two of the four patients who went to a nursing home (two were deceased in 1953). One patient went to a nursing home near his room because it was very convenient. This patient was satisfied with the treatment and care. The other patient was very dissatisfied with the treatment and care and type of person she found as patients.

The living arrangements of the fourteen surviving patients in December, 1953, were the same as prior to admission to the hospital in 1951. Nine patients lived in either their own apartment or home with relatives or spouses, three patients were living alone in their rooms, one patient was living in a room with his spouse, and one patient was living in her own home alone.
Medical Diagnosis in 1951

Of the twenty-five patients included in this study, the discharge diagnosis in 1951 revealed that five patients had only one disease each; the other twenty patients all presented a combination of illnesses. The illnesses that occurred alone were: fractured ankle, benign prostatic hypertrophy, inguinal hernia, arthritis and hallux valgus.

Heart disease was the most prevalent chronic disease among this group of patients. Eight of the twenty-five patients studied had some form of heart disease. Six patients had some form of cancer; one patient had cancer of the lung, one patient had cancer of the stomach, three patients had cancer of the prostate, and one patient had cancer of the blood. Cancer is the second cause of death today, preceded only by heart disease. Of the patients that were diagnosed as having cancer in 1951, four have since expired and two patients with adenocarcinoma of the prostate were living in 1953. Of these two patients, one had eight re-admissions to the hospital since 1951 and the other patient has not been re-hospitalized at all since 1951 and was in good physical condition. Four patients were afflicted with emphysema,
followed by varicose veins, benign prostatic hypertrophy, and inguinal hernia, with three patients suffering from each of these illnesses.

Medical diagnosis for the fourteen surviving patients in 1953 was not available as this information was not included in the schedule.

Physical Limitations - 1953

Data on the physical limitations of the twenty-five studied in 1951 was not available as this information was not included in the schedule. The following information refers to the physical limitations of the fourteen surviving patients in 1953.

Ambulatory, bed-chair, and bedridden are the general terms employed to describe the patients physical status in 1953. These terms are used here with qualifications. Ambulatory is divided into unlimited and homebound. Homebound refers to a patient who is ambulatory within the house, but is unable to leave the house. A bed-chair patient is one who is able to sit up in a chair for several hours or all day, but is unable to walk about the room. A bedridden patient needs complete bed rest and nursing care.
### TABLE II

**PHYSICAL LIMITATIONS OF THE FOURTEEN SURVIVING PATIENTS IN 1953**

<table>
<thead>
<tr>
<th>Physical Limitations</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory</td>
<td>13</td>
</tr>
<tr>
<td>Unlimited</td>
<td>10</td>
</tr>
<tr>
<td>Homebound</td>
<td>3</td>
</tr>
<tr>
<td>Bed and Chair</td>
<td>1</td>
</tr>
<tr>
<td>Bedridden</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Among the fourteen surviving patients, thirteen were ambulatory, three patients of which were limited to the home. Of these three patients, one was blind and two were crippled with arthritis. One patient with Parkinson's Disease was confined to a bed and chair existence and is unable to care for himself.

**Health Services of the Twenty-Five Patients Studied in 1951 and of the Fourteen Surviving Patients in 1953**

Of the twenty-five patients studied in 1951, twenty-two were followed at the Massachusetts Memorial Hospitals.
out-patient clinics and three patients had no out-patient follow-up care at this hospital. Sixteen patients were re-hospitalized since their 1951 discharge from the hospital, twelve were re-hospitalized at the Massachusetts Memorial Hospitals and four patients went to other hospitals. Eight patients were not re-hospitalized since 1951.

Of the fourteen surviving patients in 1953, six patients received Massachusetts Memorial Hospital out-patient clinic services. One patient received out-patient clinic services at another clinic and seven patients did not receive any out-patient clinic services. Of the fourteen surviving patients, seven had repeat Massachusetts Memorial hospitalizations, three patients had other hospitalizations, and five patients had no repeat hospitalizations. Of the seven patients that were re-hospitalized, two patients were re-hospitalized for acute illness; one for cholecystitis and one for a streptococcal abscess of the left foot. One patient with a chronic illness was re-hospitalized because of a fall resulting in a fractured left rib. The remaining four patients were re-hospitalized due to exacerbation of their previous illness or additional complicating factors relating to old age.
Occupation and Leisure Interests of Twenty-Five Patients in 1951 and Fourteen Surviving Patients in 1953

The twenty-five patients studied in 1951 showed the following occupational interests: Fourteen patients were retired, five patients were wage earners, five patients were housewives and one patient was self-employed. Information was not available on the leisure-time interests of the twenty-five patients in 1951.

The fourteen surviving patients in 1953 showed the following occupational interests: Seven were retired, five were housewives, one was self-employed and one patient was a wage earner. Their leisure-time activities were as follows: ten patients enjoyed reading, five enjoyed radio and television, four patients did a great deal of visiting, three enjoyed knitting and sewing, one patient took a practical nursing course, one patient did odd jobs, one patient attended church regularly, one patient took yearly trips, one patient enjoyed watching wrestling matches and three patients did not mention any leisure-time activities. Many of these patients presented a variety of leisure-time activities.
Social Service in 1951 and 1953

<table>
<thead>
<tr>
<th>Social Service</th>
<th>1951</th>
<th>1953</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief contact with hospital social worker</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Known to other agencies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not known to hospital social service</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Casework services by hospital social service</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

One patient was known to another agency, but was not known to the Social Service Department of the Massachusetts Memorial Hospitals in 1951.

Of the eleven patients that were not known to the Massachusetts Memorial Social Service Department in 1951, two were deceased in 1953. The survivors were interviewed, but were not able to relate any problems as of December, 1953. It is very difficult to evaluate the reasons why the remaining nine patients who were living in 1953 saw no need for social service help. On interview, the
writer was told that the patient was able to manage his own affairs without the help of a social worker or expressed ignorance of the services performed by a social worker. The nine patients were in good health at the time of interview. One patient was confined to bed due to a recent fall, but otherwise managed the home. These nine patients did not express any medical problems in 1953. Seven of the patients that were unknown to social service were living in comfortable circumstances. Some owned their own home, had been self-supporting for many years or were supported by spouses in their earlier years. Some were receiving support from relatives plus other sources of income. One single patient was working in December, 1953.

The writer on interview tried to determine if the services of a social worker were needed in 1953 to help with any problems relating to the patient's past or current illness situation. Of the sixteen people interviewed (two were survivors of patients), thirteen patients were reluctant to discuss any personal problems relating to the patient's past or present illness. One patient discussed a current financial problem and the writer directed the patient to the proper source of help. This patient had a limited contact with the Social
Service Department. One patient said that he would have liked to have seen a social worker about his large hospital bill in 1951, but added that he was glad he had the money to pay the bill and that he felt so well. The writer had difficulty in communicating with one patient since he spoke only Italian, but was able to determine that the patient had difficulty paying for medication. This patient is known to the hospital Social Service Department. Two patients among this group were known to other agencies, one to Boston City Hospital Social Service Department and one patient to the Aid to the Blind. Both patients were receiving social service help from these agencies. Of the eighteen patients interviewed, therefore, two patients received limited Social Service help from the hospital and two patients received help from other agencies in 1953.

Analysis of Problems known to the Social Service Department in 1951

The problems of the six patients that were known to the Social Service Department of the Massachusetts Memorial Hospitals in 1951 fell into eight categories. They were: 1) need for emotional support while in the hospital, 2) need for emotional support after hospitalization, 3) help with discharge plans, 4) help with trans-
portation to clinic, 5) interpretation of social situation to doctor, 6) need for better living arrangements, 7) interpretation of medical situation to relatives and 8) interpretation of medical status to other social agencies. These categories were based on an evaluation of the social service records.

Four patients needed emotional support during their hospitalization at the Massachusetts Memorial Hospitals in 1951 and two continued to need support after hospitalization. In addition to these problems, one patient also needed help with transportation and help with making new living arrangements. Interpretation of this patient's medical status to relatives was also given by the social worker. The social worker interpreted the patient's social situation to the doctor in another case.
### Analysis of Brief Contact Problems

#### TABLE IV

**ANALYSIS OF PROBLEMS KNOWN TO THE SOCIAL SERVICE DEPARTMENT IN 1951 FOR BRIEF CONTACT ONLY**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans for Care</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Nursing Home Placement</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Application for Terminal Care</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Care for patient at home</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Arranging for Transportation</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Need for Medical Appliances</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
**Summary**

The group included both white and Negro patients and more men than women. All patients were over sixty-five years of age at the time of admission to the hospital in 1951. Economically, fourteen patients were being supported by some form of public assistance, social security benefits or pension in 1951. In 1953, eleven out of fourteen surviving patients were supported in this manner. In 1951, thirteen patients were married, six were single, four were widowed, one was divorced, and one was separated. The marital status of the fourteen surviving patients in 1953 were: eight were married, four were single, one was widowed, and one was separated. Eighteen of the twenty-five patients studied in 1951 returned to the same type of living arrangements after discharge from the hospital as prior to discharge. Three patients went to a nursing home upon discharge and four patients went to the home of a relative upon discharge. By 1953, the fourteen surviving patients retained the same living arrangements as prior to admission to the hospital in 1951. In 1951, the discharge diagnosis revealed that five patients had one disease each and twenty patients presented a combination of illness. This material was unobtainable for the fourteen surviving
patients in 1953. The most prevalent diseases among the twenty-five patients were: 1) heart disease, 2) cancer, 3) emphysema, 4) varicose veins, and 5) benign prostatic hypertrophy. Data on the physical limitations of the twenty-five patients in 1951 was not available. Among the fourteen surviving patients in 1953, thirteen patients were ambulatory; ten unlimited, and three patients were confined to the home. One patient was confined to a wheelchair. In 1951, twenty-two patients were followed at the Massachusetts Memorial Clinics and twelve of these patients were re-hospitalized at this hospital since 1951. Of the fourteen surviving patients in 1953, six patients received Massachusetts Memorial Hospital outpatient clinic services and seven patients had repeat Massachusetts Memorial Hospital admissions.

Further follow-up data on the fourteen surviving patients in 1953 revealed that seven patients were retired, five were housewives, one was self-employed and one was a wage earner. These patients enjoyed a variety of leisure-time activities.

Six patients were known to the Social Service Department in 1951. Five of these patients were deceased in 1953 and one patient was living and well in 1953. Seven additional patients had a brief contact with the
Social Service Department in either 1951 or 1953. Of these eleven patients, two were deceased and nine were living in 1953. An analysis of the problems of the six patients that were known to the Social Service Department in 1951 revealed that four patients needed emotional support during their hospitalization and two continued to need support after hospitalization.
CHAPTER V

CASE STUDIES

In this chapter, six cases will be presented to illustrate the nature of the problems encountered among the patients studied and how the social worker helped meet their needs. Of these six cases, three were known to the main Social Service Department and three were known to the Home Medical Service of the Massachusetts Memorial Hospitals in 1951. Due to the inadequacy of social service records among the twenty-five patients studied in 1951, the writer used the case studies to illustrate the problems of the six patients that had social service records and how the social worker helped in each case.

Of the six case studies, five patients were deceased in December, 1953. There is, therefore, no follow-up social service material on these patients. One patient was living and well in December, 1953.

Four patients needed emotional support during their hospitalization at the Massachusetts Memorial Hospitals in 1951. This case illustrates the emotional support given by the social worker so that the patient was able to live within her limitations.
Case 1

The patient was an eighty-two year old, white, single, woman with arteriosclerotic heart disease, angina pectoris, congenital heart failure, and anemia. She was referred to the social worker on the Home Medical Service in 1949 for review of her Old Age Assistance budget to include cost of medication. The patient lived alone in her apartment.

The patient had been seen periodically in 1950, and in January, 1951, the case was re-opened for a supportive relationship during the patient's hospital stay and for continued support upon the patient's discharge home.

The worker reassured the patient that her medications were included in her Old Age Assistance budget and that she would continue to receive Old Age benefits upon discharge from the hospital. The social worker helped the patient adjust and live within her cardiac limitation.

In September, 1951, the patient received a notice that a first floor apartment was available in a housing project. The patient moved but was very apprehensive after the move as it was so sudden. The social worker visited several times during this period and the patient began to spend more time in the living room rather than in bed.

In June, 1952, the extern on the Home Medical Service, requested an eye evaluation as the patient was complaining about her eyes. The patient was found to have developing bilateral cataracts. The social worker prepared the patient for dimming vision and possible correction by surgery. The social worker continued in a supportive relationship so that appropriate plans might be made when the patient herself gradually realized that
it would not be possible for her to continue to live alone. Hospitalization again became necessary for the patient and she was admitted to Haynes Memorial in February, 1953, where she remained until May, 1953. At this point, the case was transferred to the social worker at the Haynes Memorial. The patient was subsequently transferred to another hospital where she died in May, 1953.

In this case, the social worker interpreted the patient's medical status to Old Age Assistance so that her budget would be revised to include the cost of medication. The social worker was very helpful in allaying the anxieties that the patient had concerning her Old Age Assistance check while in the hospital. She encouraged the patient and offered the necessary reassurance so that the patient no longer felt the need to remain in bed all day and was able to assume a more cheerful attitude. Likewise, when the patient's eyesight began to fail, the social worker supported her during her depressed states to enable the patient to plan realistically when she would no longer be able to care for herself. Through a supportive relationship, this patient was able to function within her cardiac disability until this became impossible and hospitalization was necessary.
Case 2

This case illustrates the help that the social worker provided where a chronic illness was not involved. The patient's social situation necessitated hospitalization because he was unable to manage alone after he had fractured his ankle. The social worker helped the patient plan realistically within his budget and supported the patient while in the hospital.

The patient was a sixty-six year old divorced man on Old Age Assistance who lived alone in a rooming house with no relatives in this area. He was referred to the social worker in November, 1952, by Dr. W. because the patient needed help in planning his budget as he went without food to buy medications. Also, his landlady could not continue to care for him as her own home required her time. The patient had been hospitalized from January 4, 1951, to January 12, 1951. The diagnosis was fracture, external malleolus, left ankle.

The worker visited while Mr. S. was in the hospital and this relieved many of his anxieties concerning his Old Age Assistance check and the loss of his room while in the hospital. The patient requested the social worker to notify his daughter who lived out of state that Mr. S. had been hospitalized. Nursing home arrangements were arranged for the patient at his request. The worker continued in a supportive role and offered reassurance about his room while in the nursing home. The social worker continued to see the patient in the Orthopedic Clinic. He was discharged to his room as ambulatory. Upon his return home, the social worker helped plan
his budget so that he was able to make a more judicious use of his money.

The case was closed in February, 1951, as the patient was able to budget his money adequately.

Mr. S. was taken to the Boston City Hospital on March 19, 1951, and was dead on arrival. There was some question that he had taken an overdose of sleeping pills.

The social worker offered support in the following ways: she reassured the patient that his Old Age Assistance checks would resume after discharge from the hospital and that his room would be available after discharge. When Mr. S. was in the nursing home, the social worker again reassured him that Old Age Assistance would pay his room rent for at least four weeks and that his eligibility was not affected by hospitalization. The social worker interpreted Mr. S.'s social situation to the Resident on the Orthopedic Service, stating that his landlady was unwilling to continue to care for him and that he lived alone. The Resident at first saw no reason for Mr. S. to be hospitalized and felt that Mr. S. could be cared for at home. The social worker performed some other services, such as notifying Old Age Assistance of the patient's return to his room upon discharge from the nursing home and of his relationship with his landlady. The social worker
helped Mr. S. plan his budget so that he would have enough money both for food and medication.

Case 3

The following case illustrates the help that the social worker rendered in planning new living arrangements. She also interpreted the patient's medical status to relatives.

The patient was a seventy-year old widowed woman on Old Age Assistance who lived alone in her South End apartment. She was referred to the Home Medical Service by Dr. R. to help make living arrangements as her married daughter, Mrs. P., does not have room for the patient permanently and Old Age Assistance cannot continue indefinitely to pay rent for the patient's own apartment. The patient was admitted to the Massachusetts Memorial Hospitals on January 11, 1951, and was discharged on February 2, 1951. Her diagnoses were: active duodenal ulcer, hypothyroidism, urinary tract infection, urethral stricture, and traumatic cataract, left eye. Upon discharge, she went to live with her married daughter for an indefinite period.

The patient's main concern while in the hospital was about the possibility of losing her furniture and apartment. Therefore, the patient was anxious to return home and felt that she could manage alone. Mrs. P. has three children and thought that: 1) in view of the crowded condition of her own three-room apartment; 2) the patient's desire to return to her own apartment; and 3) the uncertainty of continued Old Age Assistance payment while the patient was living with her daughter, that the best plan would be for the patient to return to her own apartment since she would be happier there.
The social worker explored the possibility of housekeeping services with Mrs. P., of Mrs. P. finding a larger apartment so that her mother could stay with her, or of another relative staying with Mrs. P. when she returned home. The social worker also explored nursing home services, but the patient was not interested in that. None of these plans seemed available to meet the present acute need. The patient returned to her own apartment in March, 1951, and Mrs. P. helped the patient to get settled.

The patient was re-hospitalized from April 11 to 16, 1951. The diagnosis was obstruction, ureter, left, cause undetermined. The worker supported the patient while in the hospital. The patient's main concern was over her Old Age Assistance check. The patient returned home and was re-hospitalized again from May 31, 1951, to August 11, 1951. The diagnosis on this admission was "tumor, renal. The social worker continued to visit while in the hospital, reassuring the patient that her daughter would attend to the bills in her absence. She discussed discharge plans with Mrs. P. and the patient. Another daughter who lived out-of-state offered to care for the patient upon discharge. The worker further helped by directing Mrs. P. to discuss her change in living arrangements with the Old Age Assistance social worker as the patient would need to make re-application in the new state. The worker interpreted Dr. T.'s medical recommendations to Mrs. P. who now felt that a nursing home would be the most suitable plan.

The patient was discharged from the hospital, but her whereabouts were not made known to the social worker. Later, Mrs. P. informed the worker that the patient was living with another daughter out-of-state and will be getting medical care from a local doctor.

The case was closed in August, 1951, as the patient was no longer living in Boston. The patient died in September, 1951.
The medical social worker explored the various facets of living arrangements both with the patient and her daughter. The patient returned to her own apartment, but her physical condition went rapidly downhill and the patient was re-hospitalized twice, each time the social worker offering support, understanding and reassurance. The worker interpreted the patient's medical status to the patient and to relatives with the goal that nursing home arrangements might be the most suitable plan. The social worker had close contacts with the patient's relatives in this case and helped them to evaluate the patient's medical and social needs so that the best possible plan for the patient could be made.

Case 4

The following case illustrates a brief contact with a patient who had been known to the Home Medical Service since August, 1950. The case was re-opened in March, 1951, to arrange nursing home plans after hospitalization.

The patient was a seventy-seven year old widowed man on Old Age Assistance who lived alone in a rooming house in the South End. There were no living relatives in Boston. The patient was
admitted to the hospital on January 5, 1951, and was discharged on January 10, 1951, to his room. The diagnosis was anemia of unknown etiology, and opaque lenses. He was re-admitted to the hospital from February 25, 1951, to March 16, 1951. The social worker made nursing home arrangements upon discharge. Discharge plans were discussed with the patient and he expressed no resistance to a nursing home placement. The patient followed medical recommendations and was receiving adequate care at the nursing home.

The patient has three subsequent admissions to the Massachusetts Memorial Hospitals with the diagnoses of aplastic anemia, bilateral opaque lenses, arteriosclerotic heart disease, and viral respiratory infection. Approximately one month after his last discharge from the hospital, the patient entered Boston City Hospital and died on the day of admission despite transfusions with packed red blood cells.

The social worker was helpful in procuring a nursing home for the patient as his medical and social needs did not permit him to return to his previous living arrangements. The social worker helped the patient adjust to the nursing home routine. Unfortunately, due to the severity of his illness, he had repeated hospitalizations, five at Massachusetts Memorial Hospitals in 1951, and social service had no further contact beyond his adjustment at the nursing home.

Case 5

The following case was referred to the social
worker for a supportive relationship during the patient's hospitalization.

Mr. O. was an eighty-eight year old widowed man who lived with his single daughter in a middle-class neighborhood in Boston. His wife had died in 1900 in a fire. Miss O. worked and supported her father.

The patient was first known to the social service department in 1948 when the social worker became concerned about Mr. O.'s ability to go home alone from the Cardiac Clinic as he appeared so feeble.

The case was re-opened in February, 1951, when Miss O. telephoned the social worker stating that her father was in the Massachusetts Memorial Hospitals and for worker to visit. The patient was hospitalized from February 19, 1951, to March 1, 1951, and the discharge diagnoses were: herpes zoster, varicose veins, and osteoarthritis. The worker visited the patient on the ward, but the patient was very ill and uncomfortable. The doctors said there was nothing they could do for the patient. Upon discharge, the patient was referred to the Neurological Clinic of the Massachusetts Memorial Hospitals and from this clinic he was referred to the Boston City Hospital Neurological Clinic. The patient was admitted to Boston City Hospital on April 26, 1951, and the social worker visited every day. Mr. O. was concerned about the cost of hospital care. The social worker reassured Mr. O. that he would not have to pay if he did not have the money. Mr. O. was discharged from Boston City Hospital on May 10, 1951, and the case was closed as the patient was under the care of Boston City Hospital.

Follow-up information revealed that the patient died on June 7, 1952.
The greater part of the social worker's contact with this patient was prior to 1951. The patient was seriously ill while in the hospital and the worker supported the patient and relieved his anxieties around the cost of medical care. The worker continued her interest while Mr. O. was hospitalized at Boston City Hospital, but since he was to be followed in their out-patient clinic, the case was transferred to that hospital in May, 1951.

Case 6

This case illustrates the use that the social worker made of interpretation of the patient's medical needs to the Welfare Department. This patient was living in December, 1953.

Mr. M. was a seventy-eight year old single man on Old Age Assistance who lived in a rooming house in the South End. He had no relatives in Boston. The patient was hospitalized at Massachusetts Memorial Hospitals from January 5, 1951, to January 13, 1951. The diagnosis was a bilateral inguinal hernia, left. He has been followed in the Medical and Gastrointestinal Clinics since 1951.

Mr. M. was first known to the Social Service Department in 1939. He was referred by himself because he was unable to pay for dentures.

Each year since 1949 medical inquiries from Old Age Assistance were received and answered.
In November, 1952, Mr. M. showed the social worker a card from a masseuse stating he must have massages for pains in his legs. He also wanted a diet because his budget had been cut. The social worker discussed the patient's situation with the doctor who recommended ace bandages for his legs, and the worker referred his food problem to the dietician. The worker secured a copy of his diet which was sent to Old Age Assistance. The case was closed in November, 1952.

The case was re-opened in June, 1953, when the Old Age Assistance worker telephoned saying that the patient was receiving physical therapy in a commercial shop and the bills were being sent to them. Old Age Assistance wanted verification of need. The social worker discussed the situation with the doctor, who stated that there was 'no need' and a letter to Old Age Assistance indicating this fact was sent.

The case was closed in June, 1953. This was the last social service contact with this patient.

The social worker, throughout her years of contact with this patient, did a great deal of interpretation of the patient's medical needs to the Welfare Department. She also interpreted the patient's activities which pertained to his physical condition to the doctor to determine if these were warranted.

As this patient was living in December, 1953, the writer interviewed him to determine how he was getting along and if he had any particular problems related to his past or present illness. Mr. M. was very concerned about his health and generally seemed to be preoccupied with physical complaints. He did not mention any specific
problems, but stated that his health was not too good, yet he did not want to go to the out-patient department for a check-up because he felt that the doctors could not help him. He seemed to enjoy his physical complaints, namely of a gastric nature, and his negativistic attitude towards medical care would confirm this. Mr. M. did not seem too alert mentally and appeared to have a slight impairment of memory for the recent past.

**Summary**

Of the six patients with social service records, five patients died since discharge from the hospital in 1951 and one patient was living in 1953. Three of these patients were known to the Home Medical Service and three to the main Social Service Department.

Many of these aged sick patients were faced with similar problems while in the hospital. Emotional support was the technique most often used by the social worker to sustain the patient while in the hospital and during the post-hospitalization period. It is interesting to note that among the six patients with social service records, five lived in the South End area of Boston and one lived in Dorchester. Five of these patients had no living relatives in Boston and five patients
were on Old Age Assistance with one patient being supported by his daughter. Five patients had been known to social service before their 1951 hospitalization, and one patient was referred to social service in 1951 to help with new living arrangements.

Social service has helped to meet the needs of these aged, medically indigent, lonely, sick patients and to support them during and after their hospitalizations. It has dealt with both the medical and psychological needs of the patient and has tried to strengthen the patient's ego so that he may be able to function more adequately and face his problems more realistically.
CHAPTER VI
SUMMARY AND CONCLUSIONS

This thesis is a three-year follow-up study of the first twenty-five ward admissions to the Massachusetts Memorial Hospitals during January and February, 1951, who were sixty-five years of age or older at the time of admission and who lived in the Boston area or its vicinity. The questions which the writer raised in this study were: 1) What were the most prevalent diseases among these patients? 2) What problems were most evident among the patients? 3) How did the social worker help the patient in achieving a satisfactory adjustment to his illness? 4) What was the status of these patients economically, socially, emotionally, and physically in December, 1953?

As this study was limited to a small number of patients, since acute and chronic patients were selected for study, and since only six patients had social service records, the conclusions drawn from this study can be applied only to this group.

The most prevalent diseases among the patients studied were: heart disease, seven patients having some form of cardiac impairment. After heart disease came
cancer, with six patients afflicted. Four patients had emphysema, and three patients each had varicose veins, benign prostatic hypertrophy and inguinal hernia. Five patients had one illness each while the remaining twenty patients had illnesses occurring in combination.

It was found that many of the patients had similar problems. Among the six patients that were known to social service in 1951, various social, emotional and financial problems were noted that impeded medical progress. Four patients needed emotional support during their hospitalization at the Massachusetts Memorial Hospitals in 1951 and two continued to need support after hospitalization. One patient needed help with transportation and help with making new living arrangements. The social worker interpreted this patient's medical status to relatives. The social worker interpreted the patient's social situation to the doctor in another case.

Four patients out of the six with social service records disclosed emotional disturbances that could be harmful to their recuperation. Anxiety over various problems, particularly financial conditions, loss of room while in the hospital, and concern over welfare status while in the hospital existed among these four
patients. One patient had a problem pertaining to family and landlady relationships.

The types of services offered by the social worker to help the patients meet their needs were mainly supportive casework, interpretation and environmental manipulation. Supportive casework relieved many patients of their anxieties concerning loss of their Old Age Assistance check while in the hospital or loss of their room. It also helped many patients to achieve a more satisfying and realistic relationship with family or landlady, and helped the patients develop more ego strength to function better within their physical limitation.

Interpretation was needed in a few cases. Interpretation was given to other social agencies so that they would have a better understanding of the medical and social needs of the patient. Interpretation to the family or landlady was often needed so that they could plan intelligently and participate in the care of the patient. Interpretation of the patient's social and economic situation to the doctor was an important function of the social worker. The social worker's individualized knowledge of the patient helped the doctor in working out an adequate medical plan for the
patient.

Environmental manipulation was used to meet the patients' practical problems, such as providing transportation to clinic, housing problem, need for medical appliances, and the like, in order to facilitate the patients' rehabilitation.

This study revealed that the majority of patients returned to the same type of living arrangements used prior to hospitalization and that nursing homes were utilized in four cases. Two patients later went to chronic disease hospitals. Relatives were used wherever possible to provide convalescent care. Two patients died on the second 1951 hospital admission and nine patients had died since discharge from the hospital in 1951. Fourteen patients were living in 1953.

The following data pertains to the fourteen surviving patients in December, 1953. The financial status of the fourteen surviving patients revealed that in 1953 eleven patients were being supported by some form of public assistance, social security benefits or pension. Nine of these patients had multiple sources of income. One patient received wages and one patient had his own resources. The financial status of one patient was unknown. Seven patients were retired, five
were housewives, one was self-employed, and one was a wage earner. The majority of the fourteen surviving patients had some form of leisure-time activity. In the order of importance, they were: reading, television and radio, and visiting of friends. Many patients had a combination of social interests.

Of the fourteen patients interviewed, eleven were reluctant to discuss any social or emotional problems related to their past or present illness. Three patients discussed financial problems; one patient found it difficult to manage because her son was laid off from work and their entire source of income was a pension, another patient found it difficult to pay for the cost of medication, and the third patient would have liked financial help with his hospital bill in 1951. This patient was self-employed, lived in a comfortable home, and his jocular attitude reflected that these were thoughts in retrospect.

The physical status of the fourteen surviving patients revealed that in 1953 thirteen patients were ambulatory, ten of them unlimited, and three confined to the home. One patient was confined to a bed and chair existence due to Parkinson's Disease.
Comments on the Method of Study

Some of the patients' reactions to the interviewing method in a research study of this type may be considered if future studies of a similar nature are contemplated.

Two patients among the first twenty-five admissions refused to be interviewed, therefore, the writer was obliged to select the next two 1951 admissions to complete the necessary twenty-five patients for this study. One patient did not respond and the other patient said he was too old and did not wish to be bothered.

One patient spoke Italian so that communication was very difficult. Very little information was gained in this interview. One patient permitted the writer to visit, but refused to give any information. This patient told the writer that any information she wanted would be in the hospital records. She called the hospital the day after the interview to determine if the hospital was holding back on medical information since the writer was interested in her health at the present time.

The writer visited two spouses of patients that were deceased in 1953. These interviews were disturbing in that the spouses were forced temporarily to relive a
very painful experience.

Three patients had a very positive reaction to this type of study. They expressed their gratitude and appreciation for the interest the hospital has taken in them, both in the past and the present, and felt that more studies like this would be helpful. Several patients expressed the idea that this was 'something new' and were unaware that the hospital did follow-up work on their patients. For the most part, these patients accepted the writer's interpretation of the purpose of the study and were pleased at the hospital's follow-up interest.

The writer feels that many of the aged patients interviewed had limited understanding of research and the purpose of the study, even after interpretation, and that this may account for some of the initial resistance.

Another consideration is the fact that these patients did not ask to be interviewed, but rather the writer extended herself in seeking the patient's cooperation in this study. Many patients, therefore, may have been reluctant to talk during the interview because they did not ask for this type of service.

The writer recommends that this research method
needs to be examined more carefully so that the approach can be more fruitful to the research worker and less threatening to the patient.

Approved:

[Signature]

Richard K. Conant
Dean
BIBLIOGRAPHY

Books

1. Bartlett, Harriet N., Some Aspects of Social Casework in a Medical setting, Chicago: Committee on Functions American Association of Medical Social Workers, 1940.


Periodicals


Report
Massachusetts Memorial Hospitals, Annual Report, 1952.
<table>
<thead>
<tr>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Patient's Name</th>
<th>2. Hospital No.</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>3. Address</th>
</tr>
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</table>

|--------------|------------------|-----------------------------------|

<table>
<thead>
<tr>
<th>7. Date of birth:</th>
<th>8. Date of 1st 1951 admission to House:</th>
</tr>
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<table>
<thead>
<tr>
<th>9. Referred to house by:</th>
<th>Physician Other (specify) Emergency</th>
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<table>
<thead>
<tr>
<th>10. Date of 1st 1951 discharge:</th>
<th>11. Diagnosis</th>
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<tr>
<th>12. Treatment recommendation at discharge:</th>
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<table>
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<tr>
<th>13. Recommended to care of:</th>
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<table>
<thead>
<tr>
<th>a. Private physician</th>
<th>e. Nursing home</th>
</tr>
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<thead>
<tr>
<th>b. OPD (sp)</th>
<th>f. Convalescent home</th>
</tr>
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<tr>
<th>c. Other hospital (sp)</th>
<th>g. Other (sp)</th>
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<table>
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<tr>
<th>d. Public custodial inst. (sp)</th>
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<table>
<thead>
<tr>
<th>14. a. Was patient known to Hospital Social Service in January, 1951?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

b. If yes, social services given: |

<table>
<thead>
<tr>
<th>1. Finding nursing home</th>
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<table>
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<tr>
<th>2. Making other living arrangements</th>
</tr>
</thead>
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<table>
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<tr>
<th>3. Ancillary services</th>
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<table>
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<tr>
<th>4. Interpreting medical advice to patients</th>
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<table>
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<tr>
<th>5. Interpreting patient's condition to relatives</th>
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<tr>
<th>6. Referral to community casework agency</th>
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<table>
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<tr>
<th>7. Referral to group work or recreation agency</th>
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<tr>
<th>8. Casework with relationships and attitudes</th>
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<tr>
<th>9. Other casework services</th>
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Describe above services briefly:

<table>
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<tr>
<th>15. Later hospitalizations:</th>
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<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Dates</th>
<th>Diagnosis</th>
<th>Referred to:</th>
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<tr>
<th>16. Later OPD services:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Dates</th>
<th>Diagnosis</th>
<th>Referred to:</th>
</tr>
</thead>
</table>
17. Living arrangements:
   Immediately prior to 1st admission
   Immediately after 1st admission
   Intermediate Time
   As of December 1, 1953.

   Own home with spouse and/or children (specify)
   Own home alone
   In home of relatives (Specify)
   In rooming house
   In nursing home
   In hospital
   Other (specify)

Comment on reasons for any change in living arrangements that occurred between January, 1951, and date of interview:

Changes:

1.

2.

3.
18. (Optional) Financial situation:
   (a) immediately after 1st 1951 discharge
   (b) as of December 1, 1953

   Sources of monthly income:
   Wages:
   OAA
   DA
   AB
   General Relief
   OASI
   Private Pension
   Relatives
   Other (specify)

   Comment on any special problems related to finance:

All of the following questions refer to information as of December, 1953.

19. Physical condition
   a. Ambulatory
      1. Unlimited
      2. Homebound
   b. Bedridden

20. Describe health services being received
   a. In hospital (sp)  
   b. In OPD  
   c. In physician's office  
   d. In own home  
   e. Other (sp)

21. Is patient active with hospital social service Yes  No

Date of interview

Name of interviewer

Health Council
Health, Hospitals and Medical Care Division
United Community Services
14 Somerset Street, Boston