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The contribution of the medical social worker to the care of the patient with venereal disease:

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CHAPTER I.
INTRODUCTION.

In recent years it has become apparent that the control of venereal diseases is peculiarly influenced by the social attitudes of the public. Whereas medical science can now diagnose, treat, and in many instances cure these diseases, the social attitudes are such that they delay and hinder medical progress. As syphilis and gonorrhea, the two most common diseases of this group, result frequently in the disability of various systems of the body if untreated, this situation makes a strong appeal to those persons who are concerned with the welfare of the population as a whole to cooperate with the doctor in attempting to bring these diseases under control. As Vonderlehr and Heller have said,

Medicine alone cannot succeed. It can succeed if aided by the forces of education, law enforcement and social welfare, of moral and ethical integrity, and of civic and national pride. We believe success -- victory over venereal disease -- can come within our generation.

The medical social worker, as one member of this group which is thus concerned, is interested not only in the patient's medical needs, but also in the social problems whose solution insures effective treatment and lessens the likelihood of reinfection. The sexually promiscuous individuals, the prostitutes and the juvenile delinquents are all human beings with human problems. They may be arrested and may be medically treated, but both of these functions leave their basic emotional needs untouched. The need for social service has been

1 R. A. Vonderlehr and J. R. Heller, Jr. The Control of Venereal Disease, p. 15.
accepted for this reason as an integral part of the treatment of venereal disease patients. The Federal Security Agency has expressed this point of view regarding infected persons as follows:

They developed into VD carriers for many different, individual reasons. Poverty may have given them a push into promiscuity or delinquency. Sometimes broken homes, family neglect or emotional factors were responsible. Often bad community conditions -- such as poor schools, lack of good recreation, and tolerated red-light districts -- helped them to get off on the wrong foot in life.

Unless these human problems and the defects in community living are brought out into the open and explored and dealt with, detention and treatment of our promiscuous VD carriers will have little permanent value. If we ignore this fact, the chances are good that these persons will return with the same personal problems to their old worlds of poor companions, and unhealthful community environments.

And once more they will go back -- again infected -- to the police and the clinics and the courts.

One of the factors which recently may have influenced the contribution of the medical social worker to the care of the patient with venereal disease is the present shortened medical treatment. While formerly the medical social worker had the opportunity to see the patient on his many trips to the clinic over a long period of time, she now has a relatively brief opportunity to see him in the medical setting, since the medical treatment today is a matter of days and not years.

Purpose

It is the major purpose of this study to examine the activities of the medical social worker in contributing to the care of the patient with venereal disease. The minor purpose is to discover what effect the present rapid treatment of the venereal diseases has had on the timing and intensity of the medical social case work.

2 Social Protection Division, Office of Community War Services, Federal Security Agency, Meet Your Enemy -- Venereal Disease, p. 22.
Method

The data for this study were obtained from three sources: literature, informed persons, and social case records. The literature provided information concerning the history of the diseases and their treatment, as well as authoritative medical standards of the present. Books and articles written from the social case work and the medical social work points of view contributed material in the social aspects of these diseases.

The Director of the Social Service Department of the Massachusetts Memorial Hospitals and the Executive Secretary of the Massachusetts Social Hygiene Society contributed information on the progress that has been made in the care of the patient, as well as points of view concerning the place of the medical social worker in the total care of the patient. Background material relating to the clinic set-up was obtained from personnel who are at present employed in various capacities in this clinic.

The social case records were selected from the files of the Social Service Department of the Massachusetts Memorial Hospitals for the years 1936, before the present clinic set-up was in practice, and 1946, when the clinic procedure had become well established. It was felt that this selection would permit a comparison of the medical social worker's activity in the two periods, before and after the clinical use of the improved chemo-therapy. In 1936 there were one hundred and eleven venereal disease patients referred to the medical social worker. Of these, sixty-two had a brief contact with her. The other forty-nine cases were comprehensive, and of these twenty-five were selected in order of their referral from the first of January
through the year. The selection comprised case records opened in every month except March and January. Only cases from the dermatology clinic, that is, syphilitic cases, and not gonorrhea cases, were used, as the type of disease was not thought to affect the social problems presented.

In 1946 there were sixty-three cases opened, of which twenty-five were minor cases, and twelve were active cases still being carried by the medical social worker. Of the remaining twenty-six cases, twenty-five were selected, which included cases opened in every month of the year except February and March. The twenty-five cases from 1936 and the twenty-five from 1946 were studied by means of a schedule.

**Scope**

Due to the limited number of cases studied, no generalizations will be attempted concerning problems of venereal disease patients as a whole. The scope of this study will be limited to the answers to the following general questions related only to the fifty cases which were examined: Does the social treatment differ in these two years, and, if so, in what respect? Is there a typical social as well as medical problem in these cases? Is there a typical contribution of the medical social worker? Is there an apparent difference in the attitude of the worker toward the patient in these years? Is there an apparent difference in the attitude of the patients concerning their diseases in these years?
CHAPTER II.
MEDICAL DATA.

In order for a medical social worker to understand a patient, it is frequently necessary that she be cognizant of the disease which he has, and of how it may affect him. Since the group of patients with which this study is concerned all have the problems which genito-infectious diseases create, it seems pertinent to see first what these medical implications are.

The term "venereal disease" is a classification including five different maladies caused by five different organisms, and producing dissimilar pathology. These are the diseases syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphopathia veneræum. They are grouped together due to the common characteristic of being spread chiefly by sexual intercourse due to needing a certain temperature range and a certain moisture content in order to maintain life. For the purposes of this study only syphilis and gonorrhea will be discussed, since the other three are rare in this country, and none of the patients in these two groups was infected by them.

Syphilis

There is a great deal of controversy among medical historians as to the origin of syphilis. There are those who say that Christopher Columbus' men were infected by the American Indians and took it back to be spread throughout the old world. Again, there are those in Europe who have always blamed it on their enemies, and so syphilis has been called the French disease, the Spanish disease, etc. Still others have gone back into antiquity and shown that the disease existed long before any of these historical incidents occurred. Richmond
Holcomb has stated, in disproving the theory of American origin, the evolutionary perspective of syphilis reaches far into remote antiquity. Much of its evolution is a result not of changes in its manifestations, but to the evolving of newer theories to explain and improve understanding.

Butler, too, has pointed out that in Biblical days, the priest, and not the doctor, treated diseases, so that there was no differential diagnosis. He points out that Moses stated that the Lord "will by no means clear the guilty; visiting the iniquity of the fathers upon the children and upon the children's children, unto the third and to the fourth generation." This is indicative of its historical origin, Butler says, since syphilis is the only infectious constitutional disease which is transferred congenitally.

Diverse and interesting as these various theories are, they are of little assistance in analyzing the problem as it exists today. The war which has just ended has furnished figures indicating the prevalence and incidence of syphilis in the selectees, which may be taken as indicative of the total population. The following list presents some of the conclusions which have been reached:

**FACTS ABOUT SYPHILIS PREVALENCE**

1. The estimated prevalence of syphilis in the United States is 3,200,000. The three and a fifth million persons with syphilis are divided one-for-one between white and colored races; two-for-one between urban and rural residents.

2. The per cent of syphilis in the nation's population is 2.4 to 1.3 for white, 11.9 for colored, 2.9 for urban, and 1.8 for rural.

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2 Charles Butler, Syphilis Sive Morbus Humanus, p. 9.  
3 Thomas Parran and R. A. Vonderlehr, Plain Words About Venereal Disease, p. 211.
3. One in every 42 persons in the United States has syphilis NOW. The ratio is one in every 77 white and one in every 8 colored persons; one in every 34 urban and one in every 56 rural residents.

4. Syphilis is 9 times more frequent in the colored than in the white race; 1.5 times more frequent in urban than in rural residents. It is slightly more frequent in white males than white females; in colored females than colored males.

Syphilis in Industry

5. An average of approximately 3 per cent were positive for syphilis among 425,000 workers tested in 800 miscellaneous industrial establishments in 25 communities.

Syphilis in Persons about to Marry

6. Seventeen of every 1,000 applicants for marriage licenses have syphilis.

Paresis

7. Syphilis is the cause of insanity in one of every twelve first admissions to mental hospitals; paresis alone is the cause of one of every fourteen.

The organism that causes syphilis is a spirochete called treponema pallidum, or spirocheta pallida, which, if untreated, runs a characteristic course. This may be divided into three stages: the early, latent, and late. The early stage is itself divided into two stages, the primary and the secondary. The primary is characterized by the chancre, a primary sore, usually found at the point of contact from ten to twenty-eight days after the infection has been acquired. These chancrees are not painful, and, if untreated, will disappear within four or more weeks. The secondary stage occurs from six weeks to six months following the healing of the chancre, and is characterized by skin eruptions which have many variations which thus simulate almost every known skin disease. These persist for weeks, but eventually fade and disappear entirely. These two stages are the stages in which
Syphilis can be the most easily cured — and the most easily communicated.

Following the early stage, there is a stage when there are no symptoms at all. This is called the latent stage, which may persist for as many as twenty to thirty years before further symptoms appear. In about half of the untreated cases, symptoms do appear after this period of latency. They appear as affecting various systems of the body, most commonly the brain, causing paresis (insanity); the spinal cord, causing a peculiar stumbling walk (locomotor ataxia or tabes dorsalis); the heart, causing one of the forms of heart trouble; and the eyes, causing blindness. It is obvious from these involvements why syphilis has been called the great imitator, and also the great killer.

Another form of syphilis is that which is congenital, due to the birth of a child to an untreated or inadequately treated syphilitic mother. The child may be aborted, miscarried, or be stillborn. It may be born with no obvious symptoms of syphilis, but react later in various intensities, just as adults do. Allison and Johnson have commented that, "Congenital syphilis is preventable. If every pregnant woman who has syphilis is treated adequately and early during her pregnancy, congenital syphilis would practically disappear." 4

The diagnosis of syphilis is made by clinical history (which uncovers possible contacts, signs, and symptoms), physical examination (which gives direct evidence of possible syphilitic lesions), and laboratory procedures: dark field examination, precipitin and comple-

4 Samuel D. Allison and June Johnson, VD Manual for Teachers, p. 66.
ment-fixation tests of the blood and spinal fluid.

The final diagnosis of primary and secondary syphilis is a laboratory procedure: either positive dark field examination or positive serological examination being necessary. The diagnosis of latent syphilis is made by obtaining a positive spinal fluid or serological test. The diagnosis of late syphilis is made by a combination of clinical and laboratory procedures. In a small number of cases both spinal fluid and blood will give negative precipitin and complement-fixation reactions but certain pathological lesions give incontestable proof of the presence of syphilis. The precipitant and complement-fixation tests in common use are the Hinton, Mazzini, Kahn, Wasserman, Eagle, and Kolmer tests. These may be done on both the blood and the spinal fluid.

The treatment given varies according to the individual patient and according to the stages of the disease. Until the early 1900's, mercury was the treatment of choice. In 1907 Ehrlich discovered arsphenamine, which was found to be as effective, but not as toxic as the mercury. In 1921 it was found that bismuth was also effective, although not adequate when used exclusively. It was, therefore, alternated with arsphenamine. Treatment consisted of thirty doses of arsphenamine and forty of bismuth given over a period of seventy weeks, with a cure rate of 80-90 per cent. Unfortunately, due to the length of time involved, there were only 70 per cent of the people who completed the course of treatment. An attempt to abolish this time element was made before World War II by means of hospitalizing the patient and giving three doses of arsphenamine and one of bismuth a week. With the discovery of penicillin, this hospitalization was reduced to nine days during which
time the drug was administered day and night. This treatment had one hundred per cent completion. Up to the present time, this is the most effective method. Since syphilis is characterized by symptoms which may not appear for a number of years after the early stage, penicillin can not be said to have proved itself as yet. As Dr. Stokes has said, "From A. D. 1943, it will take a year to guess, two years to intimate, five years to indicate, a decade or more to know what penicillin does in syphilis." 5

Gonorrhea

The origin of gonorrhea is not known, although it is apparent that it is a very old disease. As early as 460 B.C. Hippocrates knew of the disease. In the third century, Galen, the great Greek physician, believed that it was an involuntary flow of semen, and so named it from the Greek words "gonos" meaning seed, and "rhoia" meaning flow. Moses has been called the first health officer to try and control the disease. In 15 Leviticus he says, "And the Lord spake unto Moses and to Aaron, saying, Speak unto the children of Israel, and say unto them, When any man hath a running issue out of his flesh, because of this issue he is unclean." During the seventeenth and eighteenth centuries, it was erroneously thought that gonorrhea and syphilis were the same disease in varying form. It was not until 1831 that Ricord, a French surgeon, proved conclusively that they were two separate and distinct diseases. In 1879 Neisser, a German physician, discovered the cause of the disease, the gonococcus.

The prevalence of gonorrhea is of far greater magnitude than is

usually realized.

Actually, more people in the United States suffer from gonorrhea than from any other dangerous disease. Only measles and the common cold are more prevalent. Like syphilis, it runs in epidemics by intimate contact from person to person. ... About 2,000,000 people are infected each year. 6

The cause of this disease is the gonococcus, a microscopic organism, bean shaped, and occurring in pairs. Its transmission is mainly through sexual intercourse, for, just as the treponema pallidum, the germ is very delicate, dies on drying, or at temperatures varying from that of the human body. It also has a definite affinity to the mucous membranes of the genital tract of the body. The primary infection usually appears after an incubation period of about three to eight days following the infection. The symptoms are urinary frequency and pain on urination, plus a yellowish discharge. In many instances, if untreated, the disease may clear up of itself, providing that there is proper drainage. If there is no spontaneous cure, however, and if the patient is untreated, it may cause heart disease, arthritis, and sterility. Unlike syphilis, gonorrhea is contagious throughout its course.

The diagnosis of this disease is made fairly difficult due to the fact that there is no blood test to determine its presence, such as there is in syphilis. In 1884, however, a Danish bacteriologist named Gram discovered a stain by which the disease could be diagnosed from a smear of the discharge. This made three methods of diagnosing gonorrhea:

a. Clinical examination and the taking of a person's history by
the doctor.

b. Smear--microscopic examination.
   A Gram stain is made of the slide on which a little of the pus is placed. Diagnosis is made by finding the characteristic organisms.

c. Culture--growing of the organisms.
   This is a further aid to diagnosis. The organisms are grown on special media in the laboratory and checked further by special tests. 7

For many years the treatment of gonorrhea was an ineffective one. Prior to the discovery of the sulpha drugs, the only treatment consisted of that used for the symptoms. Discharge from the urethra was dealt with by injections or by irrigations.

   At that time it was a fact that treatment which was too rough or vigorous was often the cause of severe complications. Except for one in whom a surgical operation was indicated, the patient often fared better if he received no treatment at all. 8

In 1939, it was discovered that the sulpha drugs were potent in curing gonorrhea. Although they were effective at first, it soon became apparent after a few years that more and more people were not being cured. It was presumed that there was a special strain of the gonococcus which had built up a resistance to the sulpha drug. By 1945 only about half of the persons who were thus treated were cured, as opposed to the seventy per cent which had previously been successfully treated. Also, it was found that while some persons appeared to be cured by the sulpha drugs, they actually still had the gonococcus which they could transmit, even though they themselves suffered no complications from it. In 1943 penicillin was found to be effective, and proved not to have the toxic effect on the patient which the sulpha

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7 Samuel Allison and June Johnson, op. cit., p. 80.
sometimes produced. Until recently the dosage has been five or six separate injections into the hip muscle at intervals of two to three hours. Recently it has been ascertained that if the penicillin is suspended in beeswax and peanut oil, the absorption rate is slowed down, and continuous action against the gonococcus is assured from one injection. The cure rate for this treatment is close to one hundred per cent.

In commenting on the advantages of penicillin, which has so revolutionized the treatment of syphilis and gonorrhea, Vonderlehr and Heller have said,

It would be most dangerous to believe that penicillin has provided for all time the means to achieve control of syphilis and gonorrhea. Yet this could be the outcome if the germs of gonorrhea and syphilis do not establish a tolerance to the mold extract, and if people generally can be induced to limit promiscuous sex contacts. Should there be no limitation of these contacts and should the public assume that the availability of penicillin offers complete freedom to indulge in licentiousness, it is quite within the realm of probability that venereal disease rates will increase materially. In that event, the physical impairment from venereal disease will only be a small fraction of the damage these diseases caused a few years ago. In other words, more people will get gonorrhea and syphilis more often, but fewer than ever before will have serious complications. 9

CHAPTER III.

COMMUNITY RESOURCES FOR THE CONTROL OF VENEREAL DISEASE.

It is clear from the extent of the venereal diseases, and the serious physical and mental complications which they impose, that facilities for control are warranted. The medical profession for many years has worked for the abolition of the venereal diseases, but, due to public sentiment and prudishness about anything concerning sex, little could be done in the way of public health measures.

Federal Participation

With the entrance of this country into World War I, however, it became apparent that venereal disease was one of the most common reasons for the rejection of selectees. The military authorities became alarmed over this situation, and this sentiment was transmitted to the public as a whole. In 1917 the Public Health Service urged, without legal authority relating to the venereal diseases, that the health officers of each state should inaugurate measures aiming at the control of the venereal diseases. With the increased public interest, congress recognized the seriousness of the problem by passing the Chamberlain-Kahn Act of 1918. Under this law, an Interdepartmental Social Hygiene Board was set up, consisting of representatives of the Army, Navy, and Public Health Services. Their duties consisted of those which dealt with the problems in social hygiene which were brought on by the war, especially the problem of prostitution. This Act also created in the Public Health Service a Division of Venereal Diseases, with the following functions:

1. The study and investigation of the cause, treatment, and prevention of venereal diseases,
2. Cooperation with state boards or departments of health for the
prevention and control of venereal diseases within the state, and
3. The control and prevention of spread of the venereal diseases in interstate traffic. 1

The government also allocated one million dollars for this Division to be used in 1919 and 1920 as grants-in-aid to the states for the promotion of this program. This effort was successful in many ways, and great strides were made in the curtailment of the venereal diseases.

With the termination of the war, public interest in the control of the venereal diseases lost much of its stimulation. This lack of interest was reflected in governmental action in that grants-in-aid dwindled, and eventually became non-existent.

Overt action for the control of venereal disease remained dormant for approximately fifteen years. In 1926 Dr. Thomas Parran was appointed Chief of the Division of Venereal Diseases, and initiated its revival. Although he put a great deal of effort into his work, he was constantly hampered by the prudish public attitude. The words syphilis and gonorrhea could not be used in the press or over the radio; the public was not only uninformed, but was apathetic, and he gained little cooperation. He did manage, however, to lay the foundation for the present day venereal disease control.

In 1936, Dr. Parran became Surgeon General, and in this new position continued his efforts toward the control of this group of diseases. In this same year he wrote an article published in the Readers Digest entitled "Why Don't We Stamp Out Syphilis?" Almost over night the public interest was aroused, and lent the necessary catalyst to the program which the medical profession, Public Health Service, and social

1 Ibid. p. 7.
organizations had attempted for so long. Vonderlehr and Heller, in commenting on this action, said,

Through Dr. Parran's work, the people at long last heard about syphilis and gonorrhea publicly. The venereal disease control program began then, and it has developed comprehensively since, because the people of the United States wanted to stop the venereal diseases. The nation was ready for leadership and action. 

Following this first step, funds were made available to the states through the provision of Title VI of the Social Security Act. Additional funds were made available through an amendment to the Chamberlain-Kahn Act of 1918, when it was ascertained that the funds under the Social Security Act were insufficient to meet the needs embraced by all of the special health services, and that special funds were necessary for the control of venereal disease. By 1942 and each subsequent year, approximately $12,500,000 have been appropriated for this control.

One of the strongest factors in this program has been the establishment of rapid treatment centers in general hospitals. In 1945 Congress allocated to the Public Health Service five million dollars for these centers, and for hospital beds. Since good clinic and hospital management are important to the control of these diseases, the Public Health Service has set up criteria which must be met before funds are provided. The Federal Security Agency has outlined the groups of persons whom these clinics are set up to serve:

The local health department is responsible for using the services of these centers to capacity. Persons eligible for admission to the centers are patients referred by the health department and private physicians, and infected persons who seek treatment voluntarily. In addition, persons on probation from a court may seek

2 Ibid, p. 11.
treatment voluntarily or may be referred by the health department under quarantine, as a condition of probation. Statement on ability to pay is not a condition of eligibility for admission. 3

With the opening of World War II, there was immediate recognition of the danger of an increase in the venereal disease rate which has always accompanied war. To counteract this, the May Act was passed by Congress in 1941. Its purpose was to prohibit prostitution in certain areas near military establishments, which areas were defined by the military authorities. The May Act became permanent law on May 15, 1946.

State Participation

A framework of five points has been suggested by the U. S. Public Health Service for any state wishing to have an active and efficient public health control of venereal disease. The program in Massachusetts follows these points:

1. Every State and large city health department should have a special division devoted to control of gonorrhea and syphilis under the supervision of a trained, full-time public health officer.
2. An efficient and workable system of case-reporting should be set up in sufficient detail so that the health officer may learn the extent and trend of the venereal disease problem with which he is dealing.
3. Approved and practical diagnostic laboratory services should be available without charge to all physicians treating venereal diseases.
4. Treatment facilities with both in- and out-patient service should be available for the control of all infectious venereal disease. Drugs for treatment should be provided to all venereal disease clinics and to physicians without charge by the State.
5. Sufficient number of trained personnel for contact tracing and case finding. 4

It is obvious that the fifth point is a necessary one due to the nature of venereal disease itself. Since it is spread chiefly by sexual intercourse, prostitution plays a large part in its epidemiology.

Chart I illustrates this point. The contact tracing deals, however, not with seeking out prostitutes alone, but anyone who may have been exposed to venereal disease infection.

The particular laws in Massachusetts relating to venereal disease control for the most part follow an ideal program. Whenever a Board of Health receives a report that a certain person has been named as a contact, they advise this person. If he is not under care in two weeks after this, he is isolated until his infection is no longer communicable or he is under medical care. That force can actually be used in removing contagious persons from the community is indicated in the excerpt from the following law:

A magistrate authorized to issue warrants may issue a warrant directed to the sheriff or to any police officer, requiring him, under the direction of the Board of Health, to remove any person infected with a contagious disease to a hospital. 5

There are also laws which are aimed at the prevention of the venereal diseases. These are the pre-natal and pre-marital examinations which are legally required, and the law requiring that prophylaxis for ophthalmia neonatorum (blindness in the new-born caused by gonorrhea) be used within two hours following the birth of a child.

Thus there are both federal and state laws which aim at the prevention and control of the venereal diseases through enforcement of medical treatment.

5 Massachusetts Society for Social Hygiene, Inc., "Selected Massachusetts Laws Relating to Syphilis and Gonorrhea"
CHART I.
CASES OF SYPHILIS TRACED TO ONE PERSON IN ONE YEAR

Initial Case

Prostitute A

Prostitute B

Prostitute C

Infected by Prostitute A

Infected by Prostitute B

Dead Prostitute C

Daughter

Wife

Wife

Infected by Daughter

Child

Infected

CHAPTER IV.

CLINICAL SETTING.

It has been noted that one of the most effective modes of attempting to eradicate the venereal diseases is the federally subsidized rapid treatment centers. Locally, one of these centers is found at the Massachusetts Memorial Hospitals from which the cases for this study were obtained. In order to fully understand the facilities available to this group of patients, it is necessary to have a clear picture of the clinic setting wherein they sought treatment for venereal disease.

The Genito-Infectious Disease Clinic of the Massachusetts Memorial Hospitals is one of the eight clinics in Boston, which treat venereal diseases by grants from the state. The clinic is provided and administered by the hospital itself, but the funds are furnished by the State Health Department, which uses state and federal financial resources. This clinic is the only one in Boston which treats all the venereal diseases in the same clinic, since other hospitals have different clinics for the different diseases.

The clinic began to function in February, 1944. Previous to this time syphilis had been treated in the Dermatology Clinic, gonorrhea in women in the Gynecology Clinic and that of men in the Genito-Urinary Clinic. A study was instituted, and, after several months of planning, the facilities were centralized, and all the venereal diseases were combined for treatment in this one clinic, which was included in the medical division of the out-patient department. This plan resulted in better service to the patient as well as yielding sound material for research. At the same time that the clinic was set up in this manner, it was also designated as one of the six clinics in the country
to do special research on the use of penicillin in treatment and on the effects of syphilis.

The initial clinic under this new plan was organized with the intent of meeting all the requirements of an ideal clinic for the treatment of patients with venereal disease. At the time that the clinic was opened, the following analysis was made of its features:

1. All genito-infectious diseases are to be handled in one department as a branch of Internal Medicine.
2. Essential functions carried out:
   a. Care of the sick.
   b. Facilities for graduate and undergraduate teaching.
   c. Research.
3. Atmosphere for service to patients. Prompt sympathetic attention, adequate privacy, complete medical check-up, laboratory facilities of the highest quality. Good follow-up of contacts and sources of infection. Also beds were available for the treatment of those who needed hospitalization.
4. There is provision for social and economic rehabilitation of patients, particularly the promiscuous girl who is a potential source of infection and dangerous not only to the civilian male partners but of special concern to the men in the armed services.

At the time that the clinic was set up, the war was at its peak, and protection of military personnel was of vital concern. To avoid confusion and to facilitate treatment, the contacts that were named by members of the armed forces were referred to the clinic at the Massachusetts Memorial Hospitals.

The Medical Staff.

The medical staff consists of a full-time medical director and nine staff assistants. The assistants are all associated with the hospital medical staff. The clinic is also used as a teaching facility for the Boston University Medical School, with medical students regularly assigned to the clinic.

1 D. W. Miller, "Twenty-four Hour Service at New Clinic for Genito-infectious Diseases."
The Nursing Staff.

The administrative functioning of the clinic is supervised by a public health nurse who is known as a clinic executive. Her responsibilities encompass:

1. Interviewing all new patients.
2. Explanation of the patient's diagnosis and his treatment.
3. Investigation of all contacts.
4. Follow-up of all clinic cases by
   a. referral to the epidemiologist
   b. letters to patients
   c. referral of lapsed cases to Boards of Health.
5. Arrangement for admission and discharge of hospital patients with venereal disease.
6. Abstract medical records to be sent to other hospitals and treatment agencies.
7. Follow-up of all positive serologies in the hospital.
8. Supervision of nurses and clerical personnel.

This extensive number of duties has been carried out by the same clinic executive since the clinic was first organized in 1944.

Under the clinic executive there is an assistant clinic executive and three graduate nurses. The nurses assist the doctors in the necessary physical examinations of the patients and in administering treatment.

Four clerical workers provide an office force. Their duties include typing and filing medical records and other reports. They also act as receptionists to the clinic.

The Epidemiologist

There are five epidemiologists who are assigned specific areas in
Boston. The headquarters for one of these happens to be at the Massachusetts Memorial Hospitals, although her duties go beyond the needs of the Genito-Infectious Disease Clinic. She does the necessary follow-up for all the patients who reside in her district.

The Medical Social Worker. 2

The medical social worker functioned as an important factor in the treatment of the patient with venereal disease even before the clinic was reorganized. Before this time the medical social worker had the dual assignment of case work service to the patients and also other duties relating to clinic management. In order to facilitate the former duty, the medical social worker interviewed all new patients, and selected those who she thought would benefit from case work services. Her responsibilities included:

1. Interpretation to the patient regarding the meaning of the diagnosis, health regulations, and the plan for medical care as seemed advisable for each patient.

2. Securing of pertinent data regarding medical care in other clinics.

3. Arranging for transfer of patients to other resources for treatment when this was indicated.

4. Reporting to the State Department of Health.

5. Routine medical follow-up and referral of lapsed patients to the epidemiologist.

6. Clinic management.

When the treatment facilities were reorganized, the medical social

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2 Material obtained from an unpublished report of the Social Service Department of the Massachusetts Memorial Hospitals.
worker's responsibilities were altered, since some of her duties overlapped those of the clinic executive. The primary responsibility of the medical social worker was to give case work service to the patient. The new clinic routine did not permit her to have contact with all new patients, so it was necessary for her to depend on other clinic personnel for referrals. The director of the Social Service Department drew up a list of categories on which such referrals should be based. This list was subsequently approved by the medical director of the clinic. The areas were:

1. Patients nineteen years and under with syphilis and gonorrhea.
2. Where the social situation interferred with the making of plans for hospitalization.
3. Where changes of employment or other unusual responsibilities are imposed upon the patient in order to carry out the medical recommendations.
4. Instances where there is a persistent lapse in clinic attendance, and the patient does not respond to regular follow-up by the epidemiologist.
5. Where there are disablilng forms of syphilis and gonorrhea such as those which involve the central nervous system, cardio-vascular syphilis, charcot joint, and arthritis.
6. In cases where there are complicated or serious medical problems other than the genito-infectious diseases, such as tumors and rheumatic fever.
7. Patients known to other social agencies. For example, the Court and the Family Society.
8. Where there are co-existent social problems which are not re-
lated to the medical problem.

Theoretically, all patients would have been referred in accordance with this list. When it was put into actual practice, however, it was found that not all the patients who should have been referred were referred. In order to correct this situation, an agreement was made between the medical social worker and the clinic executive by which all referrals were made on the basis of the clinic executive's awareness of the social problems present in each situation. This was put into effect in January, 1945. This new system allowed for more constructive cooperation between the clinic executive and the medical social worker.

Until April, 1946, there had been a full time medical social worker affiliated with this clinic. At that time she was put on a half-time basis, with the worker allocating half of her time to the clinic, and the other half to other duties within the Social Service Department. With the realization that she was equipped to interview patients with deep underlying problems with more skill than other clinic personnel, an attempt was made to make the medical social worker more available to the patients. With this in mind, the worker began in May, 1946, to have an interview with as many of the new patients as her half-time in the clinic allowed. This interview usually came at the end of the clinic procedure, which consisted of physical examination, treatment, and an interview with the clinic executive. In this way the medical social worker could observe what effect the clinic routine had on the patient, as well as ascertaining how much understanding the patient had of his disease and its treatment. This method appeared to have many advantages over the old system in that the medical social worker
felt that her services were being more adequately used, and that she was serving those patients who needed her the most. This new method also served to demonstrate her services to the total clinic team on a case by case basis, and thus had certain teaching values in that it made the other personnel more alert to the patients' problems and thus stimulated them to make more referrals.

**Laboratory Facilities.**

The laboratory facilities in the clinic are diagnostic tools in the discovery of venereal disease, and in checking the progress of its treatment. The clinic has its own laboratory which facilitates prompt diagnosis, and thus earlier treatment. Smears, culture work and qualitative blood tests are made under ideal laboratory conditions.

**Sources of Referral.**

The following are the sources of referrals which are made to the Genito-Infecitious Disease Clinic:

1. The Public Health Department to whom the patient has been named as a "contact". This includes the "military contact".

2. Private doctors.

3. Other clinics. This is due primarily to the two evening clinics which are provided by this clinic.

4. Veterans Administration for follow-up service to discharged servicemen.

5. Other clinics in the out-patient department and patients discharged from the hospital with a positive serology.

6. The patient may refer himself for examination.

The clinic service is available to patients every day Monday through Friday and a half a day on Saturdays. It is also open Monday
and Thursday evenings until seven o'clock.

Clinic Routine

When the patient first comes to the out-patient department, he is given a clinic card and number by the registrar, who also determines his ability to pay the clinic fee which is now $1.50. If the patient is unable to pay, he is admitted as a free patient, and the State Health program provides the stipend. No patient is denied treatment on the basis of inability to pay.

The patient then reports to the Genito-Infectious Disease clinic receptionist who gives him a number. He is seen by the doctor according to the number he holds. When he is called to the treatment room, he is referred to by number rather than name. The doctor then makes progress notes in the patient's medical record, which accompanies him into the clinic room.

In the case of a new patient, he is first referred to the clinic executive who sets up the medical record by recording identifying information. She also includes significant information which has been secured from the source of referral. The patient is then seen by the doctor who makes the necessary examination and tests. After the diagnosis has been made, the patient is again seen by the clinic executive who interprets the diagnosis and the treatment. If required, she also makes arrangements for hospital care. In addition she also attempts to ascertain other possible infected "contacts" in the situation. If the patient presents problems within the emotional and environmental areas which should be dealt with by the medical social worker, a referral is made. The referral process is carefully planned so as to produce as little emotional trauma to the patient as possible. It was
previously pointed out that the medical social worker has been seeing most of the new patients on a routine basis. This is done after the executive has seen the patient the second time.
CHAPTER V.
DESCRIPTION OF PATIENTS

The problems of venereal disease and what is being done about them on the federal, state, and specific clinic levels have been noted above. It is now pertinent to analyze the patients who have utilized this set up. The descriptive data for the two groups of patients selected for this study will be compared in order to denote the differences between them.

Age

In Chart II it is apparent that these diseases are in reality the "diseases of youth". In 1936 the youngest person in the group was eight years old, the oldest, fifty-six. The mean age was thirty and two-tenths years. In 1946, the youngest person in the group was fifteen years old, the oldest forty years. The mean age was twenty-three and four-one hundredths years. Although the discrepancy in ages of these two groups can not be taken as indicative of the general trend in the age groups of patients with venereal disease, it is in accordance with the increase of youth delinquency. The Federal Security Board has stated:

The records of many official agencies show that youth delinquency is on the upswing; no one knows how high it has gone. In a study of records from 83 juvenile courts all over the country, the U.S. Children's Bureau found that the number of cases coming before these courts rose from 65,000 in 1940 to about 75,000 in 1942, an increase of roughly 16 per cent. Not all courts reported an increase -- the number of cases in 19 areas dropped during the same period. 1

Whether or not this factor explains the differences in ages of these two groups of patients is not certain. It is apparent, however,  

that both groups fall within the age groups fifteen to thirty years, in which seventy-five per cent of all venereal diseases are found.  

Race and Sex

Chart III indicates that the distribution of white and colored patients in these two years is approximately the same for this group of persons. In 1936 there were six white males, five colored females, and fourteen white females. In 1946 there were one colored male and six white males, five colored females and thirteen white females. The comparison in race is what one might expect in Boston. In both years, however, there was a preponderance of females which one would not expect for two reasons. One is that the clinic was used, as has already been noted, for referral of men discharged from service. Another is that figures for 1946 in Boston show that there were more cases of venereal disease in men reported than in women. The Massachusetts Division of Venereal Disease has collected the following figures for the total number of cases in 1946 in Boston:

**Syphilis**
- 3223 - male
- 1747 - female
- 4970 - total

**Gonorrhea**
- 3710 - male
- 1352 - female
- 5062 - total

**Total Venereal Disease**
- 10,032 3

Although similar statistics were not available for 1936, there is no reason to believe that there would be factors which would change

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2 Ibid., p. 11.
3 Information obtained from Executive Secretary, Massachusetts Society for Social Hygiene.
CHART IIa

AGES OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936

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CHART IIb

AGES OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1946

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CHART IIIa

RACE AND SEX OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936
CHART IIIb

RACE AND SEX OF SELECTED GROUP OF PATIENTS
UNDER TREATMENT FOR VENEREAL DISEASE
AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1946

<table>
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<tr>
<th>No.</th>
<th>White</th>
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<td>Male</td>
<td>Male</td>
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<td>13</td>
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</tbody>
</table>

Male | Female | Male | Female
these figures radically enough so that there would be more women than
men in the total number of cases of venereal disease. It is possible
that the medical social worker selected more women than men for case
work services in these two years due to the fact that prostitution
plays such a large part in the epidemiology of venereal disease. No
such reason was indicated in any of the cases, however, so this must
remain only a surmise.

Marital Status

The marital status of the two groups of patients differed some-
what as shown in Chart IV. In 1936 there were two women divorced, two
women separated, and one woman widowed, which closely compares with
1946 when four women were separated. In 1936 there were no men in
the divorced, separated or widower groups, whereas in 1946 there was
only one man divorced and one man separated in these groups. The
difference between the two groups is most pronounced in that there
were four married men and ten married women in 1936, as opposed to
the two single men and four single women in this same year. This
situation was almost the opposite in 1946, when two married men and
four married women opposed the three single men and ten single women.
This difference may be accounted for by the age differences which has
already been noted.

Religion

The religious element was approximately the same in the two years.
In 1936 there were eleven Catholics, nine Protestants, one Greek
Orthodox, one Hebrew, and three persons who did not specify their
religion. In 1946, there were twelve Catholics, nine Protestants, and
four persons who did not specify their religious affiliation or interest.
MARITAL STATUS OF SELECTED GROUP OF PATIENTS
UNDER TREATMENT FOR VENEREAL DISEASE
AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936

<table>
<thead>
<tr>
<th>1936 Status</th>
<th>Married</th>
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<td>7</td>
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Key: Male: □  Female: □
CHART IV b

MARRITAL STATUS OF SELECTED GROUP OF PATIENTS
UNDER TREATMENT FOR VENEREAL DISEASE
AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1946

<table>
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<tr>
<th>Status</th>
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<tr>
<td>No.</td>
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Key: Male: ☐ Female: ☐
The racial stock and the number of siblings were not specified in a sufficient number of cases to provide any useful statistics.

Medical Data.

Tables Ia and Ib show the number of patients who were infected by early syphilis, late syphilis, latent syphilis, congenital syphilis, gonorrhea, both diseases, and those who were not infected at all. There were a certain number of patients who came to the clinic for a routine blood test either as a follow-up for treatment of one of the diseases, or as a check subsequent to being reported as a contact. There were also a certain number of cases of persons who came to clinic due to anxiety, but were found to be uninfected.

As is noted in this table, there were, in 1936, no cases of gonorrhea alone, although in some cases it was present with syphilis. This is true because the cases were selected from the Dermatology Clinic alone, and not from the other two clinics which treated gonorrhea. The treatment in this year was seldom specifically given in the cases, but was, instead, denoted as "clinical", which was assumed to be a series of arsenical drugs rotated with bismuth. In the table these cases have been listed under unspecified treatment.

There were two cases in 1936 which were transferred from the clinic. One case was referred to another hospital. This was an eight year old boy whose mother had been treated for a year for syphilis, and who himself had congenital syphilis. Since the Massachusetts General Hospital was interested in the treatment of such children, the case was referred to them.

The other case which was transferred was that of a fifty-six year old man who lived in a suburb of Boston. For economical reasons, he
### TABLE Ia
**DIAGNOSES AND TREATMENT OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Out Patient Department</th>
<th>Penicillin</th>
<th>Arsenicals</th>
<th>Bismuth and Bismuth</th>
<th>Unspecified</th>
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<tr>
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<td>Unspecified type Syphilis</td>
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<td>1</td>
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<td>Gonorrhea</td>
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</tr>
<tr>
<td>Syphilis and Gonorrhea</td>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not Infected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Penicillin</th>
<th>Not Infected</th>
<th>Infected, Not Treated</th>
<th>Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### TABLE I b

**Diagnoses and Treatment of Selected Group of Patients Under Treatment for Venereal Disease at the Massachusetts Memorial Hospitals in 1946**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Total Penicillin</th>
<th>Arsenicals</th>
<th>Bismuth and Bismuth</th>
<th>Unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Total</td>
<td>Arsenicals</td>
<td>Bismuth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>12</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Syphilis</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latent Syphilis</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Late Syphilis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Syphilis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified type Syphilis</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis and Gonorrhea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Infected</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hospital

<table>
<thead>
<tr>
<th>Penicillin</th>
<th>Not Infected</th>
<th>Infected, Not Treated</th>
<th>Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
was referred to his family doctor for treatment.

The one patient who was not treated, although she was infected, was a twenty-seven year old woman who was referred from the ward, but who could not be located either by the worker or the health department.

In 1946, it is interesting to note the absence of late syphilitic cases. This is due in part, presumably, to the fact that these cases were treated in the clinics which specialized in the system involved. Also some would have been transferred to other hospitals, as, for example, a patient with paresis to the Boston Psychopathic Hospital.

The proportion of syphilis cases to gonorrheal cases corresponds in the 1946 group to that generally found in society, which is about one to two. It is interesting to note the large number of persons -- a little less than one third -- who came to clinic and were not infected. Two of these were persons who had been named as contacts, but who, when tested, were proven not to be infected. Two were checked due to previous infections to see if there were any recurrences of the disease. One other person was brought in as a contact, but it was found that it was a case of mistaken identity. The remaining three patients who were not infected came to clinic due to symptoms simulating those of venereal disease. One of these was a twenty-eight year old man who referred himself due to a discharge. It was found that he had had gonorrhea while in the army two years previously, and, due to a great deal of guilt feeling about this, was afraid that it had recurred. His examination was negative, and he was referred to a psychiatrist. Another case was that of a sixteen year old boy who had been told by his uncle to come to clinic due to a discharge. He was found to have balanitis, an infection due, in his case, to a lack of personal hygiene. The
remaining case was that of a nineteen year old girl, who referred herself due to a vaginal discharge. It was found that all her tests were negative, and that the patient, having had sexual intercourse with a married man, had a great many guilt feelings. It is interesting to wonder from these cases if some of the population is not becoming aware of the dangers of venereal disease, and are seeking treatment as early as possible. This is encouraging, in view of the great amount of effort that has been put into the education of the public.

The other diseases which were reported either as directly connected with the venereal disease, or as unrelated, were not extensive. They varied over a large range of serious and minor conditions with the only repetitious ones being in pregnancy and mental diseases. In 1936, the other diseases were turpentine poisoning, abscess, general malaise, optic atrophy, alcoholism and diabetes, ulcer, recent histerectomy, aortic anevryism, and a recent mental illness. There were two cases of legitimate pregnancy. In 1946 there were a question of sterility, psychiatric difficulties, eye defect and carious teeth, pilonidal sinus, hearing defect, recent mental illness. There were five pregnancies, four of which were illegitimate. This last fact compared with the two legitimate pregnancies in 1936 and is in accordance with the previous findings that patients in this year were for the most part unmarried, and were younger in age than those of 1936.
CHAPTER VI.
REFERRAL AND CLOSING DATA.

Now that the descriptive data on these two groups of patients have been presented, it is pertinent to see what brought them to the medical social worker, and, following that, why the case was closed.

Referral Data.

In Table II it is interesting to note that the majority of referrals in 1936 came from the routine study by the medical social worker, whereas in 1946, the majority came from persons other than the medical social worker. Also, in 1936, a large number of referrals were made due to the patient's attitude toward the disease, or because he did not return to clinic for medical treatment. In 1946, the reasons for referral were more evenly distributed among the various problems. These two factors can be explained for the most part by clinic routine. It has been previously noted that the medical social worker saw every patient with venereal disease in 1936. Also, an epidemiologist was not assigned to the clinic until the latter part of 1936, so that, by necessity, the medical social worker took over her function.

In 1946, there were two referrals which did not come from the usual source, and so, in Table II, are shown under the "other" category. One of these was the case of a twenty-one year old girl whose aunt called the clinic and asked that the girl be helped, as she seemed to be emotionally maladjusted. The other patient was a twenty-two year old woman whose case was opened when it was found that she was the mistress of a patient also being seen in clinic. Both she and the man were married to some one else, and a record was opened for each of them.

The prevalence of family problems in 1946, as compared to those in
**TABLE II a**

**SOURCE AND REASONS FOR REFERRALS OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936**

<table>
<thead>
<tr>
<th>Reasons for Referral</th>
<th>Source of Referral</th>
<th>Social Worker</th>
<th>Epidemiologist</th>
<th>Executive Clinic</th>
<th>Clinic Nurse</th>
<th>Clinic Doctor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Family Problems</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude toward Diagnosis</td>
<td></td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Follow-up</td>
<td>8</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Readjustment to Civilian Life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Maladjustment</td>
<td></td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE IIb

**SOURCE AND REASONS FOR REFERRALS OF SELECTED GROUP OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1946**

<table>
<thead>
<tr>
<th>Reasons for Referral</th>
<th>Source of Referral</th>
<th>Social Worker</th>
<th>Epidemiologist</th>
<th>Clinic Executive</th>
<th>Clinic Nurse</th>
<th>Clinic Doctor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
<td>11</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Family Problems</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Youth</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>3</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude Toward Diagnosis</td>
<td>3</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readjustment to Civilian Life</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Maladjustment</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1936, is consistent with the figures for divorce which have been steadily rising for some time. Although divorce is not the only criterion for showing unhappiness, it is an index of unhappiness and hostility. A recent book \(^1\) has stated that more than one in every five marriages ends in divorce, while an equal number of persons would like to get a divorce but do not, for any of many reasons. The small number of cases in this study would preclude any conclusions of sociological significance, but it is interesting to note that the large number of family problems is consistent with present day trends.

It is discouraging to note that youth was a factor in so many cases in 1946, whereas it was not given as a reason for referral at all in 1936. While this might be expected due to the younger age level of this group as shown in Chart II, it is also interesting to speculate whether or not the additional concern over juvenile delinquency during the war did not influence the case selection to some extent.

The effort to prevent the disease in the newborn is suggested by the fact that pregnancy was a referral factor in 1946, while it was not in 1936. The new chemotherapy can prevent infection of the unborn child if the mother is treated soon enough. More important in referral, of course, was that illegitimacy was a factor in some of these cases.

As has already been noted, there was a great deal of emphasis on the attitude toward the diagnosis in 1936. These attitudes had a fairly extensive range. Ruth, a twenty-three year old single girl, had diagnoses of syphilis and gonorrhea. She apparently came from a good, moral family, and was extremely upset by her diagnoses, to the point of being

unwilling to accept them. Another patient was Rita, a thirty year old married woman with early syphilis. The referral statement says, as a reason for referral, "...the highly infectious nature of patient's and husband's condition, and the casual, phlegmatic way in which both accepted the diagnosis..." Yet another patient was Syble, a twenty-seven year old married woman with a diagnosis of primary syphilis, and a history of another syphilitic episode which had been treated. This patient was highly disturbed by the diagnosis, lax in treatment, and continually dictated to the medical advisors.

In 1946, there were only three patients which were referred due to the attitude about the diagnosis. It is interesting to conjecture about whether or not education about venereal disease has had a part in lowering the number since 1936. Also, of course, a number of patients would be treated successfully by explanation of the disease and its treatment by the clinic executive, and so make a referral to the medical social worker unnecessary. One of these patients who was referred in 1946, due to the attitude toward the diagnosis, was Betty, a twenty-four year old girl who had been referred for medical treatment for the third time in seven months. She seemed totally indifferent to the number of her infections. Another was John, a twenty-eight year old man, who had a great deal of guilt about having gonorrhea, and felt that he could never get married for this reason. The third patient was Lucille, an eighteen year old girl, who was considerably upset by the diagnosis, since she was afraid that it would break up her marriage of two months.

It would be expected that in fifty cases there would be some financial problems. It is surprising to note that there were only two, and both of these in 1936.
It has already been noted that clinical follow-up was a large part of the medical social worker's job in 1936. Therefore, it is not surprising to find eight cases giving this as a reason for referral. Molly was such a patient. She was a twenty-one year old girl who was married and was pregnant. She had not responded to the routine follow-up of the clinic following her diagnosis of late syphilis, which was discovered when she was tested in the prenatal clinic. Another patient was Margaret, a thirty-nine year old married woman with a diagnosis of syphilis (type not specified) who appeared to be a person of inferior calibre and seemingly low mentality and had not been coming to clinic for treatment.

It is to be expected that there would be some problems peculiar to the veteran in 1946, while there were none in 1936.

It is also what one might expect that there were a certain number of persons who were referred due to emotional maladjustment.

Under the miscellaneous reasons for referral in 1936, there were two persons selected by the worker when she held her routine interview. One of these was a forty-one year old married male, who had been treated at the Boston City Hospital, but who had lapsed treatment there, and was referred to the Massachusetts Memorial Hospitals. The other patient was a forty-five year old widow, who had also lapsed treatment at the Boston City Hospital, and on whom the worker also made a social review. The other miscellaneous case was one which involved an eight year old boy, who had been treated in the clinic, and about whom the Society for the Prevention of Cruelty to Children wished medical information.

In 1946 the clinic executive referred one patient, who fell into this miscellaneous category. This patient, a twenty-four year old woman, desired to adopt a child, and was referred for this reason. The
epidemiologist also referred a patient in this category. This was a twenty-two year old married woman who needed assistance in making plans for a ten day hospitalization.

**Number of Interviews.**

It is interesting to speculate, as the discussion moves to the results of referral, what effect the change in medical therapy, regarding the time element, has had on the number of interviews that were held with the patients. Conceivably, it might be suspected that the worker would see the patients a great many more times in 1936, due to the opportunity offered by their many clinic visits. Also, as follows, it might be suspected that the interviews in 1946 would be comparably limited. The fact is, however, that in the two years there was no appreciable difference in the number of interviews per patient in these two groups. As a total, there were one hundred and two office interviews with patients in 1936, one of these patients having been seen thirty times, thus augmenting the total considerably. The average number of interviews per patient was thus four and two twenty-fifths. In 1946, there was a total of seventy-nine interviews, the largest number for any one patient being ten. The average per patient was thus three and four twenty-fifths. The other figures can be seen from the following table:

**TABLE III**

NUMBER OF INTERVIEWS HELD WITH SELECTED GROUPS OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936 AND 1946.

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of Interview</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office</td>
<td>Home</td>
<td>Doctor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With Patient</td>
<td>With Relative</td>
<td>With Patient and Relative</td>
<td>With Worker</td>
<td>With Patient</td>
<td></td>
</tr>
<tr>
<td>1936</td>
<td>102</td>
<td>36</td>
<td>12</td>
<td>30</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>1946</td>
<td>79</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>11</td>
<td>1</td>
</tr>
</tbody>
</table>
It is interesting to note that the largest difference comes in the number of home visits. This can, in some measure, be attributed to the fact that the worker in 1936 was doing follow-up clinical work, whereas the worker in 1946 was doing only social work per se. A difference which is not as easily explained is that in the area of conferences with the doctor. Although, again, the number of cases does not justify a generalization, one might suspect that there was a tendency to use the doctor-worker relationship less in helping the 1946 group of patients.

One factor which should be kept in mind when interpreting the above table is the fact that the time element has some bearing on the number of interviews which the worker held with either the patient or some interested party. Since 1936, there has been an opportunity for many of the cases to be reopened when the occasion warranted it. In fact, there were six cases which were originally opened in 1936, subsequently closed, and reopened again at least once, and closed only on occasion to be opened again. One of these cases was reopened four times. The average number of times of reopening after the original opening of the six cases was two more times. Obviously, this would give occasion for more interviews, which has not been afforded in 1946, since the time which has intervened between the original opening and the present writing has been insufficient. This would tend to even up the number of interviews held in these two years, and it would seem justifiable to state that in these groups of cases, there was no major difference in the number of interviews held with the patient and other interested persons.

Use of Other Agencies.

Another factor which lends itself to comparison is the use of
other agencies for the purpose of referring patients to them for additional and specialized help. In both years, there were referrals to those agencies which could be predicted: The Society for the Prevention of Cruelty to Children; Community Health Association (Visiting Nurse Association), Family Society, Young Women's Christian Association, Public Assistance Agencies, etc. The total numbers did not differ significantly. There were nine such referrals made in 1936, and fourteen in 1946. These referrals were not necessarily successful, but they were attempted. Included in this group are those referrals made to the psychiatric and psychosomatic facilities. The difference in number may be due to some extent, to the difference in available resources, there being more in 1946 than in 1936.

Closing Data

As the discussion approaches the function of the medical social worker in these cases, it is useful to see the reasons she gave for closing cases. The information for the following table is taken from the worker's own reason for closing a case.

TABLE IV

REASON FOR CLOSING SOCIAL CASES OF SELECTED GROUPS OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936 AND 1946

<table>
<thead>
<tr>
<th>Year</th>
<th>Successful</th>
<th>Patient Could Not Use Case Work</th>
<th>Patient Could Not Referred Elsewhere</th>
<th>Treatment Completed</th>
<th>Not Located</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1936</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>1946</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>--</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

As in the reason for referral, it is here apparent also that the
medical social worker in 1936 was focusing a great deal on getting the medical treatment completed. Those cases which are termed successful are those in which the worker has felt that the presenting problem has been overcome, either by being eliminated, or by the patient having become adjusted to it. Such statements by the worker as, "The patient seems to be adjusted...", come under this category.

Under the next heading, where it is stated that the patient could not use case work, were those cases in which the worker felt the patient could not benefit from case work, was uncooperative, or didn't want help. "Referred elsewhere" indicated those patients who accepted referral to another agency. Completed treatment included those cases which the worker closed with such phrases as, "Patient adjusted and coming regularly to clinic." The heading of "not located" was used for those patients who could not be located, or who had moved out of the community. Under "Other", were two patients. The one in 1936 was killed in an accident. In 1946, the patient's wife was also known to the agency, so his case record was closed, and notations concerning him were included in her record.

It is interesting to note in this table that the results for the two years are nearly the same. In 1936, when the worker said the case was closed because treatment had been completed, it implied at the same time that other problems were overcome which stood in the way of this accomplishment.
CHAPTER VII.
CASE WORK SERVICES

It has been shown in Table II that the reasons for opening these cases were not dissimilar in these two years, and that the reasons for closing were also comparable. It is now appropriate to discuss what has happened between opening and closing these cases -- that is, the case work services. These may be roughly classed under the following headings: Changing the attitude toward diagnosis and treatment, relieving family tension due to the nature of the illness, environmental manipulation, consultation with the doctor, and other. As has been shown, not all cases were successful, either because of the patient's inability to use case work services, or because of his leaving the community, or because of an inability to locate him. Some patients, naturally, will use more than one of these skills, some will use all.

The following table, no. V, shows the number of skills used, without attempting to classify them as to whether or not one or more was used in any one case.

TABLE V.
CASE WORK SERVICES OFFERED SELECTED GROUPS OF PATIENTS UNDER TREATMENT FOR VENEREAL DISEASE AT THE MASSACHUSETTS MEMORIAL HOSPITALS IN 1936 AND 1946.

<table>
<thead>
<tr>
<th>Year</th>
<th>Changing Attitude Toward Diagnosis</th>
<th>Relieving Family Tension</th>
<th>Environmental Service</th>
<th>Social Interpretation to the Doctor</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1936</td>
<td>19</td>
<td>7</td>
<td>12</td>
<td>36</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>1946</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>11</td>
<td>19</td>
<td>2</td>
</tr>
</tbody>
</table>
Services in 1936

It will be noted that in 1936 there was a great deal of interpretation done about the diseases, and an attempt to change the patients' attitudes toward them. This is consistent with the epidemiological work of the worker at this time. There were several cases where this alone was the only service attempted by the worker. Several case examples of this follow:

Jenny was a twenty-one year old colored girl, who was separated from her husband, and came to clinic for treatment of gonorrhea. She and all her siblings were illegitimate, and she herself had an illegitimate daughter. She was unconcerned about her infection, and felt that her husband probably was the source. She admitted numerous contacts, and seemed undisturbed about this. On two occasions she started conversations with men patients in the clinic, for which the worker reprimanded her. The patient resented this. The worker insisted that the patient return for treatment, making the comment that the patient "seemed to be of such inferior caliber that it was felt that she would respond only to coercion." The patient was killed when she jumped from a truck when the driver made advances to her, so no further aid could be given.

Mary was a twenty-seven year old married white woman who was sent to the clinic for treatment of syphilis, which was discovered by a routine blood test at the time of her giving birth at the hospital. She was seen once on the ward by the worker, who interpreted the need for treatment. The patient was emotional and upset at the diagnosis, and was afraid that her baby would be taken away from her. Further contact was not realized because she disappeared after release from the hospital.

Janet was a forty-five year old woman who had been a widow for some years. She was examined at the Boston City Hospital for sinus, and was found at that time to have late syphilis, for which she was reported to the clinic. The patient supported herself by work at a chemical company, and did not come to clinic as she did not understand the procedure. The worker explained this to her, and the patient thereafter conformed.

There were no patients in this group who received only interpretation to their families, which is understandable, as this contingency would not arise unless interpretation to the patient had also been necessary. There were two cases, however, where only environmental manipulation came under the function of the medical social worker:
Libby was a thirty-five year old Greek woman, who was married and had four children. She was very cooperative about clinic treatment, although she labored under the difficulties of financial limitations and a husband who was in and out of jail for stabbing and larceny. This woman was very hard to understand due to language difficulty, and for that reason, seemed to feel misjudged. Financial aid was not given, but the worker arranged for a housekeeper to be in the home when the patient was in the hospital for the delivery of her child.

Jake was a thirty-nine year old white man, an Italian, who was being treated in the clinic for syphilis and gonorrhea. He had been referred to the worker from the eye clinic for glasses which he needed but could not afford. The worker raised the necessary funds for these.

Under the other services which the worker offered, again there were only two cases which did not receive other forms of service:

Julie was a twenty-three year old white girl, who was being treated in the clinic for syphilis. She was referred to the worker due to a recent mental illness, and the complicated difficulties in which she was involved. She had a history of one forced abortion, and one illegitimate pregnancy, which child was being treated for congenital syphilis. She was treated previously to this delivery at the Psychopathic Hospital and at the Medfield State Hospital, for Manic Depressive Psychosis. During her clinical treatment she averaged once a month in calling the doctor and asking him to come and see her at various hotels in town, complaining that her "ovaries" hurt. The worker offered no aid other than to listen to the patient.

Jenny was an eight year old white girl, whose mother had been treated for about a year for syphilis, and who herself had congenital syphilis. The mother was on parole, but as soon as it was up, saw no reason for further treatment. The child was transferred for care to the Massachusetts General Hospital, and the worker's only function was to send all the pertinent information about the mother to the Society for the Prevention of Cruelty to Children.

There was only one case in this group with which the worker was unable to take any active part:

Susy was an eighteen year old single colored girl, who had completed treatment in Springfield for congenital syphilis, and who was referred to the clinic for follow-up. She questioned her diagnosis, and would not accept treatment. Although the worker made numerous attempts to locate her in the community, she was unable to do so.

There were fourteen cases in this group which utilized more than one of the services which the case worker had to offer. One which utilized almost all of the facilities was that of Clara:
Clara was a twenty-six year old married white girl, who was referred to the clinic by her family doctor for early syphilis. Both she and her husband were distraught about the diagnosis, and feared principally that other people, particularly her family, would hear about it. Clara had married against parental advice a man whom her family believed to be inferior to her. Her husband was the source of the patient's infection, and this, among other reasons, made the patient desire to leave him. She was undecided about this, however, particularly since this was against her religion. The worker attempted to help her make up her mind about leaving her husband, without much success. She suggested that the patient talk with her priest about it, which she did, receiving the advice to leave her husband. The worker also talked with the patient's mother who found out about the diagnosis, and was profoundly shocked, and attempted to separate the couple.

The worker arranged for the mother to talk with the doctor, which she did, and was somewhat reassured on getting an interpretation of the disease. The patient also talked to the doctor about her marital situation, and was advised by one that it was her own decision, and by another, to leave her husband. During a particularly bad financial period, the worker arranged for the patient and her husband to be treated without charge at the clinic, and obtained a doctor's statement for the Works Progress Administration that the husband could work without danger to others at his job. Treatment was fairly regular for one and one half years for both the patient and her husband, but then the husband refused further treatment for both of them. Interpretation was to no avail, and the case was closed, with the worker's comment, "Worker has watched patient adjust rapidly to husband's inferior standards, and accept his flagrant shortcomings without complaint... She must have been of weak and inferior caliber to adjust to and accept what she does. She seems lacking in character and decision, in that she fluctuates from one opinion to another according to the situation, has no positive ideas of her own, and is readily influenced by suggestion." The case was reopened in 1940 when the patient became pregnant. The worker attempted to have the child tested for syphilis, which was done. The baby had positive tests. The parents were extremely upset by this, but subsequent tests showed that the baby was not infected, and for this reason, the case was closed.

Herman was a thirty-six year old Jewish single man, who was being treated for latent syphilis. He was referred to the worker by the doctor who asked that he be helped to gain an adequate income for the ulcer diet which had been prescribed for him. The patient was extremely nervous, stuttered a great deal, was very depressed, and made suicidal threats. He stated that his family would have nothing to do with him, and that he was forced to be on relief because his health was not good enough for him to work. The Department of Public Welfare was unable to increase his allowance, and, since the patient was uncooperative, but was coming regularly to clinic, the case was closed. Approximately a year later, the case was reopened, again for financial aid. The patient still felt misused and mistreated when help was not immediate. He, at this time, was sentenced to two and one half years in prison because he had taught some young boys how to forge checks. When he was released, he was again referred for the same reason by the clinic doctor. This time the worker obtained some shoes and arch plates for the patient,
and, through conferences with his family, obtained additional funds for his support from them. The case was closed, with the worker's comment that, "Patient's physical condition is much improved and there is a decided change for the better in his emotional attitude. The family have continued to give supplemental aid." Also, at the time the case was closed, the patient was receiving malaria treatment at the Boston Psychopathic Hospital for his syphilitic condition, and so was under their care if further social need was indicated.

Mildred was a twenty-four year old married woman with two children, who was being treated in the clinic for syphilis. She had lapsed treatment, and had requested that the worker help her in making arrangements so that she might attend clinic regularly. Her husband was in prison on a charge of assaulting four children under ten years old, so that her income was inadequate. The worker arranged for the patient to get Aid to Dependent Children, and the patient was then able to report to the clinic regularly, so the case was closed. It was reopened when the patient needed glasses, which the worker obtained for her. Again it was reopened when the Department of Public Welfare requested a summary of the medical-social findings, and again when the patient needed a corset. The last time it was opened was when the patient, after her divorce, became nervous and upset. She herself was an illegitimate child, and had a great deal of feeling about this, as well as about her marital difficulties. The worker worked through with her a referral to the psychiatrist, which the patient accepted. The patient benefitted from this, seemed to be straightened out, obtained a job, and apparently was adjusted to her problems when the case was finally closed.

The above cases exemplify the problems and their treatment as seen in 1936. As can be seen, some received extensive service over a long period of time, whereas others had only short-term treatment.

Services in 1946

The figures for 1946 differ to some extent from those of 1936 in the form of services given to the patients. The fact that the diseases were not interpreted as much to this group of patients may, as has been stated, be accounted for by the fact that the worker did not have the epidemiological function, and also that the explaining was done for the most part by the clinic executive in this year. The other categories were near enough the same that they do not warrant comment.

There were two persons in this year, however, to whom interpretation of the diseases was the only service which was offered, aside from con-
sultation with the doctor in one of them, which is the first one to be presented:

John was a twenty-eight year old single white man who referred himself for treatment due to a discharge, which, he felt, indicated a recurrence of gonorrhea. His mother deserted him when he was two years old, and he was placed in many different homes subsequent to this. When he was in the army, he contracted gonorrhea while he was overseas, and had many guilt feelings about this. He felt that for this reason he could never consider marriage. He lived alone, and stated he had no friends, and no outside interests, aside from reading the newspapers and listening to the radio. Tests showed that he did not have gonorrhea, and, at the worker's request, the doctor reassured the patient of this fact, which the worker did also. It was felt that the patient's discharge was on a psychosomatic basis, which the worker attempted to interpret to him. A referral was made to the psychiatric clinic, but the patient did not accept it. At first he stated that he had had no further contacts with women since his infection overseas, but it later developed that he was living at times with a girl who was married. The worker was unsuccessful in attempting to follow-up this case, and closed it with the comment, "It would appear that the patient has had several sad experiences with women, which began with his mother, who deserted him when he was extremely young, and on through the girl in Italy who had infected him with gonorrhea. Worker believes that patient now has need to punish women for the suffering he has experienced from them."

Bill was a thirty-three year old white married man, who was referred to the clinic for a check-up from the army due to a positive Kahn test at separation from the service. He was referred to the worker when he appeared upset at the need for a blood check-up. He had contracted the disease three years previously from an extra-marital relation. He had always been promiscuous, according to the patient, and his wife had said that she could not satisfy him sexually due to her hysterectomy. He stated that his marriage was all washed up, that his wife had grounds for divorce, since he had always "run around". Patient stated that there was no benefit to be derived from discussing his marital difficulties, as there was no hope for the marriage turning out differently, a fact to which he seemed somewhat indifferent. For this reason the worker did not explore this area, but merely interpreted to him the need for check-ups for his previous infection.

There was no patient in this group to whom interpretation to the family was the only service. There were, however, two cases in which environmental service appeared to be the only service given to the patient by the worker:

Mary was an eighteen year old girl who had been having treatment for about a year in clinic for latent syphilis. She was referred to the worker because she was illegitimately pregnant, about which the patient was very happy. She had been maintaining an apartment with the
alleged father of the child, and seemed to have a good relationship with him. The patient herself made arrangements for her marriage before the child was born, whereas the worker arranged for her to obtain prenatal care through the Emergency Mother and Infant Care Program.

Sally was a twenty-two year old colored girl with two children, who was separated from her husband. She was referred to the worker as she was pregnant, and hospitalization was necessary for the treatment of early syphilis. The patient was annoyed that she had contracted the disease from her husband, and apparently had had no other relations outside marriage. She made her own plans for the care of the children during her hospitalization, whereas the worker arranged for the Aid to Dependent Children check to be mailed to her while she was in the hospital, and also for the necessary certificates showing that the patient was eligible for an increase in these checks due to her pregnancy.

There were several cases which came under the category of "other" services. For the most part, these were case work services involving the working out of problems by techniques other than aid with external circumstances. There were ten cases in all which received only this form of aid. Several typical examples follow:

Mary was a twenty-four year old girl who was being treated in the clinic for gonorrhea, and was referred to the worker due to her indecision about returning to her estranged husband. She had left home at the age of twelve when her father had attempted to rape her. She returned to her home at the age of fifteen and went to an industrial school, up to the time when she had a gun-pulling scene with her father. After this episode she lost contact with him, other than to hear that he was in prison for killing his seventh wife. The patient, on graduation from school, obtained a job as a hostess in a night club where she earned from seventy-five to one hundred dollars a week. She became engaged to a fisherman who she later found out was a bootlegger, was married, and had two children. He attempted to shoot the patient when she broke up with him, and he was put in jail for this reason. She later married her present husband, and all went well until he went into the service. He returned, bringing with him an English girl who was about to give birth to his child. Since this time he had had several other women, and the patient had left him. The patient herself had been going from man to man, although the worker pointed out that this does not lead to security. The patient felt, however, that we only live once, and we might as well enjoy it. Although the worker recognized that the patient was an upset person, she was unable to offer her any assistance since the patient could see no need for help, and because the worker was leaving the department.

Lucy was an eighteen year old girl, who was sent to the clinic following an arrest for fornication. She was a colored girl, who had come up from the south to visit her sister, and had stayed because she enjoyed the freedom which the independence of working gave her. Through
her work she met an older man who had had treatment irregularly for early latent syphilis. The police raided his house because they suspected that he was using it for illegal purposes. They were not able to prove this, and, at the time of the raid, found only the patient there. Before the case was closed, action by the court and the medical diagnosis was not known. The worker helped the patient recognize the fact that her sister's opposition to her fiancé was pushing her toward a marriage which she really did not want. The interpretation of the case was given to the probation worker, who was to keep in close and sympathetic check on the patient. Since the worker was leaving the department, the case was closed at this point.

Mary was a twenty-four year old girl who was being treated in the clinic for gonorrhea, and was referred to the worker because she was considerably upset by the diagnosis. She had been married at seventeen, when she was pregnant, and her husband's family had never liked her. At one point she separated from her husband for three or four days following a quarrel over money, and, at this time, went out with another man and contracted gonorrhea. She was afraid that this factor would ruin her marriage, and that her husband would no longer stay with her. At the worker's suggestion, patient was absolved from her sin by the church before telling her husband. When she did tell him, he told her to leave, but they finally came to good terms, particularly after it was discovered that he had had gonorrhea for about a year and was very possibly the real source of her infection. The worker saw her through the near break and the reconciliation, and advised her of community resources, such as family agencies, if she again had marital difficulties.

There were also several patients in this 1946 group who used more than one of the facilities of the worker. Some typical examples of these follow:

Maggie was a forty year old white woman, who had three children, all judged to be dull and neglected. She was being treated in the clinic for gonorrhea, and was referred to the worker for assistance with the problems of illegitimate pregnancy, lack of housing, and financial insecurity. The worker attempted to interpret the disease to her, but the patient refused to accept that it was infectious or had anything to do with sexual intercourse. She admitted promiscuity, and felt that her diagnosis was based on uncleanliness. The worker arranged better living quarters for the patient, gave her her transportation fee to the clinic, and arranged for her husband to change the birth certificate, which listed him as the father of the child. The worker also attempted to have the patient accept prenatal care, and confinement at the city hospital, the latter of which the patient rejected, as she wished to be delivered at this hospital. Since the patient came while in labor to see the worker, she was taken into the hospital for delivery. Referral was made to the Family Society to supervise the patient and the baby with the idea of working toward placement plans for the child when the patient's funds were exhausted, and she might become bored at being tied down by the infant. The birth
of this child crystallized the decision of her husband who had taken steps to obtain a divorce after many years of marital dissatisfaction. As another case work agency was supervising, and the medical care was completed, the case was closed.

Lida was a fifteen year old girl, who was sent to the clinic for a check-up after she was brought to court after running away from home with another girl. Her medical examination was negative. When the worker talked with the girl's mother, she found that she was concerned because the daughter ran away, and she had to send the police after her. Apparently this feeling was initiated through fear of losing one of her sources of income. The girl herself was unconcerned about the diagnosis, admitted promiscuity, stating that the reason she was promiscuous was that she loved excitement, and doesn't like "little girl games". The case was discussed with the probation worker, who planned to follow the girl closely, and refer her to the Judge Baker Clinic for recommendations, and psychotherapy, if necessary.

Billy was a sixteen year old boy, who was sent to the clinic by his friends and his uncle with a question of gonorrhea. His examination was found to be negative, although he was diagnosed as having balanitis, an inflammation of the glans penis, due, in this case, to a lack of personal hygiene. The boy was very concerned over the need for examination, and denied any sexual experience. He was also afraid that his mother would not believe his explanation of why he had come to the clinic. At the patient's request, the worker saw his mother and interpreted the fact that he did not have gonorrhea, and the necessity for him to adopt better hygienic habits. She also talked over with the patient and with the mother the patient's loss of his job, and aided him in securing another one.

As can be seen from the above case summaries, there was as much variety of problems in the year 1946 as there was in 1936. The difference seems to stem from the change of focus of the worker from those problems directly affecting treatment, to those problems which need solution, and can be dealt with either by the worker or by another agency. Again this can be explained by the clinical administrative set-up, and does not appear to be the result of a different philosophy of the medical social worker.
CHAPTER VIII.

SUMMARY AND CONCLUSIONS

It has been the purpose of this study to examine the activities of the medical social worker in contributing to the care of the venereal disease patient. Secondarily, an attempt has been made to clarify the influence of shortened medical treatment on the social treatment. In order to realize these two aims, two groups of patients were selected for study. Their medical problems and the community resources set up to meet them have been outlined, as well as the specific clinic facilities through which they sought treatment. It has been noted that this group of patients was predominately in the age group of fifteen to thirty years, with the 1946 group being younger than that of 1936; that there were more than five times as many white as colored patients; less than one third as many men as women; that more patients were married in 1936 than in 1946; and that almost all had one of the venereal diseases. It has been shown that the patient group was selected in 1936 largely on the basis of follow-up work or the patient's attitude toward the diagnosis, whereas in 1946, the reasons for referral were distributed more evenly among the emotional problems. Statistics have shown that the number of interviews held with the patient group was approximately the same for the two years, whereas those with the doctor were noticeably less in 1946 than in 1936. It was shown, according to closing data, that successful case work had been done by the medical social worker in the majority of cases in both years. It has been observed that the worker in both years contributed service to the patient by helping in the following areas: attitude toward diagnosis, relief of family tension, environmental service and consultation with
the doctor, with only a very few cases in which she could offer no service at all.

Conclusions

With the realization that conclusions must be limited to these fifty cases which have been studied, it seems warranted to make the following observations: The social treatment did not appear to differ in these two years. There were all types of problems presented by both groups with apparently the same amount of success in meeting them. There was no typical social problem which appeared in these cases, other than that of promiscuity, which is probably merely a symptom of the real problems which were present. Although some broad generalizations could be made on types of problems that these patients presented, actually there were as many problems as there were individuals. For this reason, one can not say that there was a typical contribution of the medical social worker. All her skills were used in various intensities and distribution in these cases. One thing that is quite apparent is that there is a difference in the attitude of the workers in these two years. It would probably be more valid to say that there is a difference in focus. In 1936, the worker's main objective appeared to be to get the patient to clinic as often as necessary to complete his medical treatment. In 1946, the attempt appeared to be focused more on helping with those problems related to the illness. It is obvious that the reason for this difference is that the clinical set-up was such that the worker in 1936 had a great many administrative duties, such as epidemiology, which prevented her from devoting herself entirely to case work. In 1946, the community resources had provided enough facilities to the clinic so that the worker could
concentrate wholly on case work, while others in the clinic took over the functions which formerly were hers.

One other observation can be made on the basis of these cases, and that is that, for these two groups, the attitude of the patient toward the disease had changed somewhat. In 1946, it was seen that patients coming to the clinic sometimes did not need medical treatment. Optimistically, it can be surmised that education is better preparing the public to help with this problem of venereal disease.

In conclusion, we see that fundamentally the medical social worker was contributing her part in the fight against venereal disease in 1936. She has been better able to perform her function, however, due to the increased awareness of the public that they have a responsibility in the battle also. As this realization has become more acute, better facilities for the patient have been provided, and thus unburdened the medical social worker of the responsibilities which inhibited her free use of case work services. In the growth which has already taken place, hope for the future can be found, and obliterating of the venereal diseases can be predicted. As Vonderlehr and Heller have said,

The way that lies ahead is not easy, but it is clearly marked. With continued support from the general public, with increased case finding and wider use of faster treatment methods by physicians and health agencies, with the continued dynamic cooperation of other public and private agencies, groups and organizations who can help in prevention, the objective can be reached. It is possible that within our time an ancient enemy will finally be brought to bay.  

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BIBLIOGRAPHY

Books


Periodicals, Etc.


Approved,

Richard K. Conant, Dean
APPENDIX
Schedule

I. General Information:

Case No: _______ Age: _______ Sex: _______ Marital Status: _______
Religion: _______ Racial Stock: Father: _______ Mother: _______
Color: _______ Siblings: _______ Comment: ________________________

II. Medical Data:

Diagnosis: _______ Related Medical Problem: ______________________
Other Medical Problems: ________________________________________
Treatment (current): Type: _______________________________________
Complete: Yes: ______ No: ______ Comment: _______________________

Previous Infection: Type: _______ Date: ________________________
Treatment: Type: _______ Complete: Yes: ______ No: ______ Comment: _______

III. Referral Data:

Date of referral: ___________ Closing Date: ________________
Source of referral: __________________________
Reason for referral: __________________________
Reason for Closing: __________________________

IV. Problems Patient Presented:

A. Emotional:

Response to Diagnosis and Treatment: ___________________________

Social Relationships: __________________________________________
Sexual Adjustment: ____________________________________________

__________________________________________________________________________________

Other: ____________________________________________________________________________

__________________________________________________________________________________

B. Environmental:

Recreation: ______________________________________________________

__________________________________________________________________________________

Employment: _______________________________________________________________________

__________________________________________________________________________________

Housing: __________________________________________________________________________

__________________________________________________________________________________

Other: ____________________________________________________________________________

__________________________________________________________________________________

C. Physical Disability:

__________________________________________________________________________________

Comment: _________________________________________________________________________

__________________________________________________________________________________

V. Case Work Services:

A. Changing Attitude Toward Diagnosis to Facilitate Treatment:

The Patient: ______________________________________________________________________

Correction of Misconceptions regarding diagnosis and treatment:

__________________________________________________________________________________

Giving Reassurance for future relationships: __________________________________________

__________________________________________________________________________________

Other: ____________________________________________________________________________

__________________________________________________________________________________
Relatives: (Specify)

B. Relieving family tension arising from nature of illness:

_________________________________________________________

_________________________________________________________

Other: ___________________________________________________

_________________________________________________________

C. Environmental Manipulation:

1. Relieving external pressures which block or affect treatment:

   Financial adjustment: Clinic fees-transportation:_____

   ____________________________

   ____________________________

   Readjustment of living arrangement:_____________________

   ____________________________

   ____________________________

   Encouragement of adequate social outlets:_________________

   ____________________________

   ____________________________

   Facilitate use of community resources to patient:_____

   ____________________________

   ____________________________

   Other: _____________________________________________

   ____________________________

   ____________________________

2. Consultation with Doctor:

   Interpretation of social factors affecting treatment:_____

   ____________________________

   ____________________________

   Number of conferences:______ Attitude of doctor: Before:
After: ______________________________________________________________

______________________________________________________________

Patient's relationship to Doctor: ________________________________

______________________________________________________________

Doctor's Interpretation to Social Worker: __________________________

______________________________________________________________

Other: ________________________________________________________

______________________________________________________________

D. Other: ______________________________________________________

______________________________________________________________

______________________________________________________________

VI. Nature of Contacts:

No. Office Interviews: _______ Patient: _______ Relative: _______

Other: _______ Outside Contacts: Home: _______ Other: (specify) _______

Use of Social Agency for Follow-up: (Specify Agency) _______

______________________________________________________________

______________________________________________________________

No. of Medical Contacts: ____________________________

- Remarks -