A study of the role of the medical social worker in the treatment of fifteen patients with rheumatoid arthritis referred to the social worker on the Home Medical Service at the Massachusetts Memorial Hospital during 1950-1952.

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Submitted by
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CHAPTER I

INTRODUCTION

Purpose.

The role of the medical social worker is affected by the emotional, social, and physical problems the patients have in relation to their illness. The purpose of this study is to analyze the role the social worker plays in the treatment of the patient with rheumatoid arthritis. The management and treatment of the patients with this chronic disease of the joints for which there is no known cure presents a challenge to the medical profession and to the medical social worker, as social and emotional problems have a marked affect on the disease process.

In order to fulfill the purpose of this study an attempt will be made to answer the following questions.

1. What was the role of the medical social worker in the treatment of these patients?

2. What were the problems these patients presented?

3. How did these problems affect the social worker's role in the treatment of these patients?

These questions were chosen to examine the problems these patients had in relation to their illness and to examine
the role the social worker played in meeting their needs and providing them with a well rounded program of medical care.

Source and Scope.

The cases used in this study were obtained from the Social Service Department of the Massachusetts Memorial Hospital. They were fully recorded cases and the material was obtained from the case records. The study is limited to fifteen patients with rheumatoid arthritis who were referred by the doctor to the social worker on the Home Medical Service. It includes all those cases of rheumatoid arthritis known to the Home Medical Service and referred to the social worker over a three year period from 1950 through 1952. This time was necessary in order to have a sufficient number of cases to analyze and to obtain an adequate picture of the problems the patients presented, as well as the services rendered.

Method of Procedure.

This subject was approached by analysis of case material in accordance with an outline to examine the case worker's role and the social factors present in each case. Each case was read and analyzed and the medical situation, the problems presented by the patient, the environmental situation, the family history, the reason for referral to social service and the services rendered by the social worker were noted.

1 Outline: For outline see Appendix.
The cases selected for presentation will be those that best exemplify what the social worker did in the treatment and care of the patient. A detailed abstract of these cases will be presented, followed by an interpretive summary.

Chapter II is devoted to a description of the Home Medical Service at the Massachusetts Memorial Hospital. This chapter also includes a discussion of the role of the social worker connected with this service and her relationship with other members of the medical team. A review of the literature on the subject and a discussion of the illness adds to the background information and is presented in Chapter III. Chapter IV is a series of tables presented to give a clearer picture of the patient group. Chapter V is devoted to a discussion of the cases showing the problems of the patients and how they were met by the social worker. The general summary and the conclusions made by the writer are found in Chapter VI.

Limitations.

The small number of cases available for study and the amount of material included in the case histories necessarily limits the validity of the conclusions when applied to the arthritic in general.
CHAPTER II

THE HOME MEDICAL SERVICE, MASSACHUSETTS MEMORIAL HOSPITALS

The Massachusetts Memorial Hospitals are a group of Memorial Buildings which are combined to form one of the outstanding medical centers in New England. It is a voluntary non-profit institution and carries on a comprehensive program of patient care, education and research. Founded in 1841, the hospital has expanded to include five buildings, and here are centered the activities necessary for a well rounded medical care program. Bed patients are cared for in the Collamore, Robinson and Evans Memorial Buildings, and patients having communicable diseases are admitted to the Haynes Memorial. The Evans Memorial is the research center and Talbot Memorial houses the out patient department. Since 1871, this institution has been closely affiliated with the Boston University School of Medicine and all its facilities are available for the teaching of the medical students.

The Social Service Department had its beginnings in 1920, when the first trained social worker was hired. Previous to that time private volunteers interested in doing charitable work with the sick functioned within the hospital. As the science of medicine rapidly progressed, there came the beginnings of specialization. With new treatment for disease
and more accurate diagnosis more and more people were admitted to the hospitals. With the rise of the specialist and the expert, the family doctor, who previously treated the patients and was acutely conscious of his social as well as his physical needs, was retreating into the background. Leaders in the field were conscious of the fact that in the hospital the needs of the individual patient, which were outside of the realm of medicine but a vital factor in the plan for treatment, were being neglected. The recognition of this need resulted in the beginnings of the Department of Social Work at the Massachusetts Memorial Hospitals. In a ten year period the Department rapidly expanded to include five social workers to cover all the important hospital departments. The present Social Service Department includes twelve trained workers, two case aides and the Director. The House and all the Out-Patient Clinics are covered by a social worker, and since 1949 there has been a social worker at Haynes Memorial Hospital.

The Home Medical Service is located in the Talbot Memorial Out-Patient Department, and through this Service patients, who live in the district and cannot come into the Out-Patient Department, are treated in their homes. The district covers approximately one square mile in the area surrounding the hospital and includes most of the South End and part of Roxbury.

This program is carried on with the close cooperation of the Boston University School of Medicine and is operated as
a community service and as an educational experience for the medical students. Each fourth year student is assigned to the service for one month. The Director of the Home Medical Service is the Professor of Preventive Medicine at the Medical School. Two full time resident physicians supervise the students and are always available for consultation.

A special section of the Out-Patient is set aside for the use of this service, and here are found the offices, conference rooms and laboratory equipment necessary for carrying on the well rounded medical care program.

Calls requesting a visit from the doctor are taken by the staff nurse. She writes down the vital information and if the case seems to be an emergency, she refers the patient to the Emergency Ward at the Boston City Hospital. The student doctor, who is called an extern, makes an initial visit to the home on the day the call is made and makes a tentative diagnosis. If there is any question in his mind he consults with the resident physician upon his return to the hospital. The latter may return to the home with the extern if he deems that such a procedure is necessary. At the daily morning conferences the externs make a detailed report of the patients seen the previous day. When it is a new case a diagnosis is made and a treatment plan is formulated. Those patients who are receiving follow up care are carefully discussed in regard to future planning, and a decision is made as to whether the patient needs continued care, should be referred when able to
the Out-Patient Department for a thorough work up, or arrange­ments made for his admission to the hospital. Certain patients are on the chronic list and are seen routinely by the extern at least once a month or more frequently as the occasion demands. In these conferences the students have the oppor­tunity to discuss a differential diagnosis and are helped to reach an acceptable decision as to the diagnosis, treatment and disposition of the patient.

The laboratories are available to help the doctor make an accurate diagnosis. He can make routine blood studies and urinalysis. A portable electrocardiograph machine and scales are available to be brought to the patient's home. The Chest Survey Clinic connected with the Massachusetts Memorial Hospi­tals provides photofluorograms and the facilities of the Depart­ment of Bacteriology can be used by the extern.

The program has as its goal the provision of total care to the patients who are known to the service. Through the joint efforts of the Department of Medicine, Pediatrics, Psychiatry, Preventive Medicine, Social Work, the School of Nursing, and community health agencies, regular conferences are held where the externs participate in the discussions of all the aspects of the illness situation, "diagnostic, therapeutic, preventive, emotional and social."²

Every new group of externs is instructed by the nurse who is a member of the Home Medical Service. She orients the student in the use of equipment available to the Service, supervises the use of medicine and diagnostic materials, and instructs them in basic nursing procedures used in the home. The nurse is also in charge of the records which the externs keep on the patients they have seen.

The Home Medical Service works in close contact with the Visiting Nurse Association. At the beginning of each month the students participate in a conference with this Association. Here the procedures and the role of the visiting nurse in providing patient care within the home are carefully explained. There is a constant exchange of information between the visiting nurse and the extern when the former is active in a case known to the Service. On referral from the doctor, the nurse can administer medication, do surgical dressings, provide physiotherapy treatments and give nutritional advice. They are often called upon by the externs to educate the patients to a more healthful routine of living.

Student nurses from Massachusetts Memorial Hospitals, who are attached to the Service for a four week training period, supplement the work of the visiting nurse. Under the close supervision of a registered nurse, experienced in home care, the student nurses visit some of the homes known to the Service to carry out the recommendation made by the extern.
There is a full time social worker connected with the Service who is available at all times to consult with the extern when a social or emotional problem arises out of the illness situation. The social worker on the Home Medical Service functions as a teacher and a case worker. A Social Service Conference is held weekly with the externs. The purpose of the primary conference held with each new group of students is to increase the extern's understanding of the role of the social worker in a medical setting, and to increase his knowledge of the resources available to the patient with social and emotional problems. The subsequent conferences are devoted to a discussion of cases known to the social worker and to the extern. The concept of the team approach to patient care is emphasized. These conferences are attended by the visiting nurse, the student nurse and if the case is known to another community agency their staff member is invited to attend. The extern presents a detailed report of the patient's present medical findings. The social worker presents the results of her contact with the patient and her interpretation of the problems which have arisen out of the illness situation. The visiting nurse also participates in the discussion that follows which is concerned with forming a treatment plan wherein all the patient's needs will be met.

The ultimate solution is reached as a joint result of professional medical, social, nursing, and community-agency thinking. In participating in these activities, however, each student
develops an understanding of the role played by the other. The social worker becomes familiar with the problems of the physician, and the latter becomes thoroughly aware of the contribution of the social worker and community agency. This period of education through participation sets the pattern for a broad understanding of the interdependency of roles in patient care.3

The social worker on the Home Medical Service helps the patient with a variety of social and emotional problems that arise out of the illness situation. The social worker focuses on the social functioning of the patient and how it has been interrupted by illness. As the majority of patients referred to the social worker on this Service are seen at home, she has the opportunity to obtain a clear picture of the patient, his environment and his social relationships. The referrals made by the externs cover a wide variety of medical social problems. The extern discusses the possibility of the social worker's visit with the patient and, if it is advisable, accompanies the worker to the patient's home on the initial visit and introduces her. Through the case work relationship the worker gains a better picture of the patient, the meaning of his illness, and his medical social problem. The treatment plan may be confined to helping the patient meet a minor reality problem which has arisen out of the illness situation, and with a minimum amount of support the patient may be able to meet his own future needs. Other cases necessitate a sustained supportive relationship. The social worker aims at giving the

3 Bakst, op. cit., p. 16.
patient greater insight into his own problems and greater self-awareness so that his needs may be met and he can make a better adjustment to his illness. The social resources in the community are made available to those patients for whom such services can meet a specific need. The social worker has a wide knowledge of the resources available, and through the case work relationship the social worker helps the patient accept the services offered by the other agencies.

The tangible services that the social worker offers include arranging for nursing home care or chronic hospital care, housekeeping service and the placement of children. She consults regularly with the public assistance agencies when the recipient has a financial need arising out of the medical situation, assists those patients who cannot pay for expensive prosthesis and arranges for transportation into clinic. Throughout her contact with these patients the worker makes use of the basic concepts of social case work in order to effectively diagnose and treat the patients who have a social and/or emotional problem arising out of the illness situation.

The social worker on the Home Medical Service functions as teacher and as a case worker. In the conferences and in her contacts with the externs she aims at increasing their understanding of the social component of illness and interpreting to them the role the social worker plays in treatment.
The social worker is also responsible for the supervision of two second year students from the Boston University School of Social Work.

The Department of Psychiatry cooperates with the Home Medical Service to give the student a well rounded educational program. In weekly two hour conferences the externs discuss with the psychiatrist those problems which may be psychosomatic in nature or origin. Special emphasis is put on the effect the patient's background and interpersonal relations have on his reaction to his illness situation. The social worker also participates in these conferences. She often contributes to the group's greater understanding of the patient's needs by her knowledge of the patient's background which is gleaned from the social records as well as from her contacts with him.

The Home Medical Service also includes a program for the instruction of third year medical students. This program is aimed at maintaining the best possible state of health for the patient. There are about seventy patients selected for this service, and the majority represent problems of chronic illness. Each third year medical student is assigned a patient whom he follows throughout the year as a health advisor. Under the expert guidance of two physicians and a psychiatrist, the student is encouraged to help these patients and their families with medical problems and emotional conflicts which may arise out of the illness situation.
The Home Medical Service has been in existence since the founding of the hospital, when doctors went into the homes of patients residing in the district surrounding the hospital. It was not a well organized program, however, and there was little supervision given to the student doctor. Medical care was given on a perfunctory basis. In 1948 a cohesive program was developed between the Boston University School of Medicine and the Massachusetts Memorial Hospitals. In this new program the responsibility for the organization and direction of the Home Medical Service was assumed by the Department of Preventive Medicine. The objectives of this new program were to improve medical care and to provide teaching facilities for the students.

The aims of the Service included:

1. Primary responsibility for the student, under adequate supervision, in his relationship with patients.

2. Experience for the student in the varied and inclusive problems of general practice.

3. The teaching of medicine with the patient in his natural environment.

4. Emphasis on social and environmental factors in illness.

5. Attention toward preventive medicine at the level of the individual patient and his family.

6. Familiarity with the use of public and private agencies in the care of the patient.

7. Coordination of the interests of specialties into a careful approach toward the patient and his problem.
8. Emphasis on the concept of medicine as a social as well as a natural science.⁴

In November 1949 a full time social worker was assigned to the Service in order to fulfill the objective of developing a well rounded medical care program.

CHAPTER III

UNDERSTANDING THE ILLNESS

The word arthritis is derived from the Greek word "arthrone" meaning joint and the ending "itis" meaning of the nature of. It is one of the oldest disease states known to man, and is described as a "constitutional disease of long duration which manifests itself by inflammation and destruction of the various bony and soft tissues which make up a joint or lie over close to a joint." The disease runs an unpredictable episodic course and it can have a disastrous crippling effect.

The etiological factor in this disease is unknown but the imbalance of the autonomic nervous system and certain psychical reactions combine to make a patient particularly susceptible. "A severe physical or emotional shock or a prolonged period of mental or physical fatigue often precede the onset of rheumatoid arthritis." Thus stress is the trigger mechanism that precipitates the sudden onset and the acute symptoms of fever and painful swollen joints which are

5 Maurice F. Lautman, Arthritis and Rheumatic Disease, p. 3.

characteristic of this disease. The acute symptoms may subside and leave the patient well and active but the attacks usually reoccur at frequent intervals. The inflammatory process can spread from joint to joint, and they become stiff, painful and immobilized. When the disease has progressed over a period of months and there have been frequent attacks and remissions the muscles around the joint waste away and the joint becomes permanently deformed. The attacks may be severe, spread rapidly with virtually continuous protracted pain or they may be characterized by musculo-skeletal complaints or mild attacks which occur over a long period before the disease has any crippling affects. It is not a fatal disease, the first symptoms usually appear at middle age, but once the patient is diagnosed as having rheumatoid arthritis there is no known cure and he is subject to attacks until his death.

A great deal of study has been done in regard to the emotional component in the disease process and the affect that the emotional reaction has on the metabolic process. Rheumatoid arthritis is one of the main subjects for current psychosomatic investigations.

Doctors Cobb, Bauer and Whiting attempted to evaluate the psychogenic factors in rheumatoid arthritis in a study of fifty patients and concluded that "environmental stress, poverty grief and family worry had more than a chance relationship in the onset and exacerbations of rheumatoid
The observations of physicians and the studies done on these patients have resulted in the belief that there are certain psychological features common to the patient with rheumatoid arthritis but that they are not universal. The patient has been described as an outwardly well adjusted individual who is actually disturbed underneath. He is fearful of the intensity of his emotions and the immobility of his joints prevents him from striking out against the world. He represses his emotions, dislikes being influenced by others and is very often resistant to taking help. If treatment is to be successful the emotional factors must be considered.

The emotional counterparts of the disease formidable though they may be are often obscured by superficial physical manifestations or as is more often the case by the observer's own blind spots. To miss these psychic attributes implies disregard for one of the intrinsic mechanisms of the disease and precludes the opportunity of therapeutic attack along the broadest front available. 8

The main purposes of treatment in this disease are to relieve pain, to prevent deformity and to rehabilitate those who are severely crippled. The patient needs careful pain-staking, time consuming care and success depends on his whole-hearted cooperation. The benefits of treatment often take a


long time to appear and it may be weeks or months before the patient notices any improvement. Complete and prolonged rest is the key note to successful treatment coupled with active and passive exercises. The patient must rest because over exertion results in further irritation of the disease process. Physiotherapy treatments consist of light massage and the application of heat to the infected joints. The patient is also taught to exercise in order that every motion in the joint may be maintained. The application of heat to the infected joints is also advised. The patients need a nutritious well balanced diet, and medication usually consists of salicylates for the control of pain.

The injection of gold salts and cortisone therapy have been used with some success in the treatment of these patients. Adrenal cortisol extract and ACTH produce marked symptomatic relief and rapid specific improvement in the arthritic process, but it is used very conservatively in treatment. The conclusions reached by Doctors Montgomery, Ziwin, Streck reflect the current thinking of the medical profession in regard to the use of this hormone.

Accumulative experience in the treatment of rheumatoid arthritis patients with ACTH and cortisone has shown these substances are not curative but in full dosage produce a suppressive effect on the inflammatory process, a marked analgesic effect, and a euphoria and a sense of well being. Any improvement the patient makes is dependent upon continued use of the hormone, and it may have a toxic affect. Withdrawal may
result in an acute depression as well as a recurrence of symptoms.\(^9\)

The patient with rheumatoid arthritis has many problems. The disease often strikes those who are least able to bear the burden of a chronic crippling disease. Struck down in his productive years, the arthritic must often change his whole way of life. Often it afflicts a wage earner or a housewife and presents a permanent frustration to their aggressive drives. As the patient sees his painful stiffened joints become gradually worse, or he improves only to have another joint infected, the patient becomes discouraged and depressed. He can see no results from his daily rigorous exercises, and it is easy for him to become completely immobilized and a dependent hopeless cripple. The patients need to be relieved of their physical distress. Emotional upsets and traumatic events should be minimized as much as possible in their environment. They need continual follow up care, encouragement, reassurance and sympathetic understanding.

Tactful psychological guidance to the patient and eventually to the members of his family, social service and other measures of that kind are no less important in the care of the arthritics than in the care of neurotics and psychotics. The psychotherapeutic approach is met with peculiar difficulties, and it is important to give physical therapy and social measures a fair chance when they

are employed with psychological understanding and tact.10

Home Care of Arthritics.

The lack of adequate facilities for the care of the patient with rheumatoid arthritis and the difficulties which the crippled patients encounter when trying to get to an out-patient department for daily physical therapy treatments, and the length of time involved in treatment are all factors which make a home care program particularly effective in the treatment of this disease. In a home care program the patient can often maintain his place in the family structure and live a comparatively normal life despite the fact that his illness imposes on him many restrictions.

A realization of the importance of a home care program must first be made clear to the patient and his family. This is not always easy and arthritics must realize that such a home care program may mean the difference between recovery with good joint function and recovery with burned out crippled joints. Patients must understand that a home care program, although it does not cure the disease or even arrest it as some medications do, is a very essential part of the treatment directed to the prevention of crippling.11


11 Arthritis and Rheumatism Foundation, Home Care in Rheumatoid Arthritis, p. 3.
CHAPTER IV

DESCRIPTION OF THE PATIENT GROUP

The following tables are presented in order to give a clearer picture of the patient group. The information included in these tables show the social factors and the background information necessary for a better understanding of the needs of the patient group and the role of the medical social worker in the treatment of the arthritic.

Age and Sex

The highest incidence of rheumatoid arthritis occurs between the ages of thirty and fifty years. It does strike people in the younger age groups with attacks and remissions continuing on through middle age. In this group of patients the ages ranged between twenty-three and seventy-eight. The disease is three times as common in women as in men, and in this group three of the patients were men and twelve were women.
TABLE 1

DISTRIBUTION BY AGE OF THE FIFTEEN PATIENTS STUDIED

<table>
<thead>
<tr>
<th>Ages in Years</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>3</td>
</tr>
<tr>
<td>50-59</td>
<td>6</td>
</tr>
<tr>
<td>60-69</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Marital Status

Marital status is an important factor in planning for the care of these patients. Ten of the patients studied had lost their marital partner through death, separation or divorce. Thus, the majority of the patients included in this study did not have the support of a husband or a wife to whom they could turn for help and support.
TABLE II

MARITAL STATUS OF THE PATIENTS STUDIED

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

Income

The majority of the patients studied were receiving some kind of public assistance. The district that the Home Medical Service covers, and the fact that care is offered by this Service to the medically indigent, would account for the high percentage of the group being public welfare recipients. None of these patients were self-supporting while known to the social worker.
TABLE III
SOURCE OF INCOME IN PATIENT GROUP

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. A. A.</td>
<td>5</td>
</tr>
<tr>
<td>Disability Assistance</td>
<td>2</td>
</tr>
<tr>
<td>General Relief</td>
<td>5</td>
</tr>
<tr>
<td>Supported by Relatives</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Mode of Living

The mode of living of these patients was an important factor in planning for their care. The patient living alone suffering from a crippling chronic disease presents many problems, and many of their needs are not met in such an environment. It means a great deal to patients having families to remain within their family group and to assume as much responsibility as possible.
### TABLE IV

**MODE OF LIVING IN PATIENT GROUP**

<table>
<thead>
<tr>
<th>Mode of Living</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Friends</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Family</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

**Occupation**

The majority of the patients had a long work history and all of them gave their illness as the reason for giving up their respective jobs. The women whose main duties were within the home had gradually decreased their activity. Two of the women who are described as secretaries were also housewives but formerly held positions that required special training. One patient had had his own business and was now in greatly reduced circumstances. All these patients, but one, had been self-supporting during some time of their life.
TABLE V

OCCUPATIONS OF PATIENTS PRIOR TO ILLNESS

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitress</td>
<td>3</td>
</tr>
<tr>
<td>Counterman</td>
<td>1</td>
</tr>
<tr>
<td>Laborer</td>
<td>1</td>
</tr>
<tr>
<td>Housewife</td>
<td>3</td>
</tr>
<tr>
<td>Secretary</td>
<td>2</td>
</tr>
<tr>
<td>Businessman</td>
<td>1</td>
</tr>
<tr>
<td>Housekeeper</td>
<td>3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

History of Disease

Of the fifteen patients considered in this group, only one had suffered from rheumatoid arthritis less than three years. In two cases when the patients had been ill for three years, the disease had progressed rapidly. The majority of the patients included in this study had suffered from the disease over a long period of time.
TABLE VI

HISTORY OF RHEUMATOID ARTHRITIS IN PATIENT GROUP
WHEN REFERRED TO SOCIAL SERVICE

<table>
<thead>
<tr>
<th>Number of Years</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td>4</td>
</tr>
<tr>
<td>10-19</td>
<td>3</td>
</tr>
<tr>
<td>20-29</td>
<td>6</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Physical Limitations

As rheumatoid arthritis is a progressive disease of the joints, there was some variation in the patient group as to the degree of disability the chronic infection had caused. Two of the patients suffered from acute attacks and, although disabled during these episodes, upon remission they retained complete mobility of the joints. In the majority of the cases that were studied the disease process had progressed to the point where there was some joint damage. Nine of the patients included here were not ambulatory, they retained the complete use of their arms, hands, and maintained a limited degree of activity. In the third group are those patients who suffered from severe involvement of several joints or suffered severe
muscle atrophy resulting from a bed and chair existence and a lack of exercise over a long period of time. Thus in thirteen out of fifteen of the cases which made up the patient group, the disease had progressed to the point where complete rehabilitation was impossible.

TABLE VII

PERMANENT PHYSICAL LIMITATIONS OF PATIENT GROUP

<table>
<thead>
<tr>
<th>Physical Limitations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Degree of Disability</td>
<td>2</td>
</tr>
<tr>
<td>Marked Disability with Limited Activity</td>
<td>9</td>
</tr>
<tr>
<td>Severely Disabled</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Referral

In the cases originally referred to the social worker for financial help, all four had additional problems. One patient was concerned about refusing hospitalization, two had family problems and one lacked motivation for seeking employment. Two of the patients were resistant to recommendation by the doctor that they accept hospitalization and with the help of the social worker were able to accept this plan. Two were referred for help in working through a treatment plan that was
most satisfactory to their needs and the help of the social worker was requested to increase the motivation of these patients towards accomplishing the goals of medical treatment. Seven of the patients were referred for nursing home care but in only two cases was this plan acceptable to the patient, or considered advisable following investigation of the situation by the social worker. Three of the referrals were made by the visiting nurse and the remaining twelve referrals were made by the doctor.

TABLE VIII

REASON FOR REFERRAL IN PATIENT GROUP

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Problems</td>
<td>4</td>
</tr>
<tr>
<td>Resistance to Hospitalization</td>
<td>2</td>
</tr>
<tr>
<td>Planning for Further Medical Care and Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

**Length of Contact**

Contact with four of the patients was continued for less than three months. In two of these cases the contact with social service was broken by the patients themselves,
and in two of the cases a transfer to a nursing home was arranged in less than three months time. The remaining twelve cases were seen regularly by the social worker for a period of four months or longer.

TABLE IX

LENGTH OF CONTACT BY SOCIAL SERVICE WITH PATIENT GROUP

<table>
<thead>
<tr>
<th>Months</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>4</td>
</tr>
<tr>
<td>4-7</td>
<td>4</td>
</tr>
<tr>
<td>8-11</td>
<td>4</td>
</tr>
<tr>
<td>12-16</td>
<td>2</td>
</tr>
<tr>
<td>16-19</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>
CHAPTER V

CASE ILLUSTRATIONS

The patient group under consideration were found to have three main problems that were effecting their adjustment to their illness and their response to medical treatment. These problems were environmental pressure, personality maladjustment and severe disability. They affected the role that the medical social worker played in the treatment of these patients.

The writer has divided the cases into three categories based on the outstanding problems which arose from the study made of the patient group. All of the cases will be discussed in the light of these three factors that had the greatest influence on the patient's adjustment to his illness but are divided according to the problem which appeared to be the outstanding one in each case. In the first group are six cases where environmental pressures were affecting the patient's adjustment to his illness and the following of medical recommendations. In the second group there are five cases where the patients emotional difficulties and personality problems were the main reasons for their need of the services of a social worker, and in the third group are four cases where the patients main problem was the limitation of activity
and their dependency which resulted from the disabling affects of the disease. The cases selected for presentation are representative of the others in the group in relation to the activity of the social worker.

The following table is included to show the number of cases in each category.

**TABLE X**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Problems</td>
<td>6</td>
</tr>
<tr>
<td>Personality Problems</td>
<td>5</td>
</tr>
<tr>
<td>Disability Problems</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

**ENVIRONMENTAL PROBLEMS**

In this first category the six cases can be divided into three sub groups. In two of the cases the patients' relationships with those people responsible for their care was causing friction, and their environment was becoming less conducive to carrying on a program of home medical care. In the second sub group there are two cases where financial problems brought on by illness are the cause of the environmental pressure. In the third sub group are the two cases where the problems and
the responsibilities the patient has as a member of the family group are affected by the illness situation. In all six of these cases the activity of the social worker was focused on minimizing environmental pressure and helping the patient adjust to his illness. The following are three cases which are representative of each sub group in this category.

CASE I

Patient was a 78 year old woman who had suffered from rheumatoid arthritis for sixty years. However, she had been active and she had been able to walk until six months previously when a severe attack of arthritis affected her knee joints. She was able to walk around her apartment but moved slowly and with difficulty. Her inability to climb stairs made it impossible for her to leave her second story apartment. She had limited motion in her finger joints, was not able to dress herself or prepare her own meals. The damage to her joints were severe, and the patient had not shown response to treatment. The doctor saw the patient once a month, and the therapeutic regime consisted of a high protein diet, medication for the relief of pain, vitamins and physiotherapy treatments twice a week. Physiotherapy was administered by the visiting nurse and consisted of hot packs and exercises.

Patient had been very active until her most recent attack; although crippled she had managed to get out and care for her own needs. She was extremely upset by the incapacitating affects of her disease, and by the fact that she had not shown any signs of improvement. This lack of improvement had caused her to wonder if she was receiving adequate treatment while she remained in her own home. She was depressed, anxious and had a great fear of the future.

Patient resided in a small apartment and was supported by Old Age Assistance. She resided with a friend, an elderly woman. They had been friends and roommates for thirty years. The friend prepared
the meals, did the shopping and took care of patient's needs that she could not meet herself. They had a close relationship but the patient was becoming more and more demanding and dependent. Her friend complained about the burden of patient's care. These complaints served to increase patient's anxiety about her condition and her fear of the future; thus friction developed between the two women.

Patient was one of six children. Her mother had died when she was a child. The patient spoke of a close relationship with her father who died at an advanced age, and she had cared for him in his last illness. In her teens she started working as a food checker in restaurants and remained at this work until she retired at the age of seventy-five. When she was sixty-eight she stopped working because of ill health, but she returned to work after one year when she had some remission of arthritis. At seventy-five she retired permanently because she could no longer do the work.

The patient's only living relative was a sister who visited her occasionally. Another sister had died three weeks before patient had the severe and incapacitating attack of arthritis. She was very close to this sister, missed her a great deal and her death had been a tremendous shock.

This patient was referred to the social worker by the visiting nurse to whom patient had expressed an interest in nursing home care. In the first interview with the social worker the patient spoke of her dislike of nursing homes, but stated that she would be interested in such a plan if it would mean better treatment and a quicker recovery. The social worker stated that she would discuss the patient's problem with the doctor to see what treatment plan would be most suitable for the patient's needs. The case was presented for discussion in the Home Medical Social Service Conference. The doctor, nurse and social worker all participated in the evaluation of the patient's medical and social needs. It was concluded that with the service provided by the visiting nurse and the doctor, patient's medical needs were being met in her present environment, and considering her attitude toward nursing home care, home care would be the best plan. It was felt that this plan would be more successful if patient could better adjust
to her illness through the contacts of the social worker. Although patient had joint damage in her knees and marked improvement was not possible, she could be rehabilitated to some degree. It was recommended that patient be motivated to exercise and increase her movements in the two hours following physiotherapy treatments, when such movements could be made when she was comparatively free of pain.

The social worker saw the patient at home at frequent intervals. She discussed with patient the plan for home care and told her the treatment routine would not differ in a nursing home. The worker interpreted to her the recommendations made by the doctor and emphasized that the final decision for whatever plan she made remained with her. The patient revealed her great reluctance to go to a nursing home and revealed her fear that because she was receiving Old Age Assistance, was dependent and helpless, she could be sent to an institution against her will. She considered a nursing home a lesser evil than a city institution. The worker continued to reassure patient of her right to control her own affairs, of the adequacy of the treatment she was receiving and that there was a possibility of some improvement in her condition. The patient was able to accept the fact that complete recovery was not possible, but was greatly encouraged that some improvement was possible. In the interviews the patient spoke freely of her past and of her present problems. She revealed a great deal of hostility toward Old Age Assistance and her feelings about being a public assistance recipient. She felt that she was being unfairly discriminated against and was not receiving the proper amount of aid. The social worker interpreted to her the laws which guided the amount of aid granted. She evidenced her interest in the patient's work and the years that she had been self-supporting and that she continued to do so long after the retirement age. The patient was thus helped to modify her feelings that she had lost her self-respect because she was receiving public assistance. Through contacts with the Old Age Assistance social worker, arrangements were made for an increase in patient's budget to cover the cost of the special diet recommended by the doctor, and through this agency steam packs were purchased for the patient, to facilitate physio treatments at home.

This patient is still being seen regularly by the doctor, social worker and visiting nurse. The social
worker's contact has continued over a six month period. The patient has shown some improvement in her ability to walk and care for herself. She continues to depend on her friend for the preparation of her meals but their relationship has greatly improved. She has made a better adjustment to her illness and is satisfied that her medical needs are being met. She is less anxious, more cooperative and cheerful.

This patient's physical needs were being met in her environment. Most of the responsibility for her care had been taken by her friend with whom she had a close relationship. She was dependent on her friend for the greater part of her care, and there was evidence that patient's illness and dependence was causing increasing friction, and the situation was such that a program of home medical was becoming less and less satisfactory. The doctor believed that the patient could be treated adequately at home providing that the responsibility for her other needs continued to be taken by her friend.

The disease had progressed to the point where the patient had some joint damage. However, she was not completely disabled and moved around as much as her crippled limbs would allow her to.

This patient had fought the crippling affects of her disease over a long period of time. She had a tremendous drive to remain active and to direct her own affairs. She was alert and intelligent, and could not adjust to the situation brought on by her illness. Her anxiety had affected her relationship with her friend.
The social worker recognized that the patient was reluctant to accept nursing home care, that her handicap had resulted in an acute sense of helplessness, and that she would now have to surrender to the demands of others.

In a realistic approach the social worker presented two treatment plans to the patient and interpreted the recommendations made by the doctor. This approach and the use of the concept of self-determination assured the patient of the worker's recognition of her right as an individual to make her own decisions. She was able to reveal her anxiety and to accept the reassurance and support offered by the social worker. The patient was encouraged and motivated to follow the recommendations made by the doctor. The worker's use of environmental resources helped patient to be more comfortable at home and relieved some of her hostility toward Old Age Assistance.

Patient had a severe and crippling attack of arthritis shortly after the death of her beloved sister. This factor suggests a strong emotional component in the disease process. The patient had a close dependent relationship with her sister. In the case work relationship many of her dependency needs were satisfied and the shock of her sister's death was somewhat relieved. By her use of support and reassurance and environmental resources, the social worker helped the patient make a better adjustment to her disease and improve her relationship with her friend.
The social worker understood that there were emotional factors present in the patient's reaction to her illness and recognized that a change in environment might result in an exacerbation of the disease. Her activity resulted in the lessening of environmental pressures and a successful program of medical care at home.

CASE II

This patient was a 64 year old woman whose condition was diagnosed as rheumatoid arthritis and acute cholecystitis. In a two year period patient had three acute attacks of arthritis, but she had complete remissions and the disease had not caused any permanent damage to her joints. The doctor had recommended hospitalization both for treatment of her arthritis and the infection of her gall bladder. Although the patient lived alone and was confined to her bed during the acute attack of arthritis and was dependent on her landlady to bring her food, she refused to be hospitalized. Rest for a three month period was recommended by the doctor and the patient was told she could not return to work until the acute attack had completely subsided.

Patient was separated from her husband whom she had married four years before and she did not have any relatives to whom she could turn for help. She supported herself and was employed as a maid; work she had done for most of her life. Her income stopped, when, because of her illness, she had to give up her work.

Patient was referred to the social worker by the doctor for help with her financial problems as he was afraid that patient would return to work before she was completely recovered if she didn't receive some financial assistance.

Patient was anxious and upset when first seen by the social worker. She expressed her concern about her financial condition and felt that she had to return to work immediately. She referred
frequently to her very unsatisfactory marriage and stated that she had been the one to support her husband. She neither wished nor expected any help from him now. She related that she had been extremely upset by the doctor's recommendation that she be admitted to a hospital and although she continued to resist this plan, she believed now that she would never be well again. Patient responded positively to the worker's suggestion that she apply for public welfare for temporary assistance. At the request of the social worker the patient was re-examined by the doctor who found that the acute attack of cholecystitis had subsided and the doctor reassured the patient that hospitalization was no longer necessary and that she could be treated adequately at home for rheumatoid arthritis. The social worker arranged for patient's application for public welfare to be taken at home, and she was certified for this type of assistance. When these needs were met the patient became much calmer and more cooperative. Two months later the patient was well enough to return to work and in a visit to the social worker confided that in her work she found the greatest enjoyment, and that she now felt well enough to continue.

This patient had lived alone and had been self-supporting before being stricken by a sudden attack of rheumatoid arthritis. She did not have anyone to turn to for help and was without financial resources.

She was not crippled by the disease but the pain she suffered during an acute attack, complicated by a gall bladder infection, had incapacitated her for a temporary period.

The break up of her marriage had been a traumatic experience for this patient but she had become self-supporting and was getting along very well. Illness and the prospect of hospitalization was to her a frightening experience. Her refusal to accept hospitalization had left her fearful that she would never be well again.
In the relationship with the social worker the patient was able to reveal her concern about her physical condition and her financial situation. By her use of an environmental resource in the community the social worker helped solve patient's financial problem. The social worker's interpretation of patient's anxiety about her refusal to accept hospitalization resulted in a re-evaluation of her condition and she was greatly relieved to hear that hospitalization was no longer necessary.

Thus by the use of resources and by interpreting patient's needs to the doctor the social worker relieved some of the tension that sudden illness had caused and the patient was helped to accept the treatment recommendations which resulted in the remission of symptoms.

CASE III

This patient was a 47 year old woman who had suffered from arthritis for seven years. A diagnosis of hypertensive heart disease and obesity complicated her physical condition. Patient had severe joint damage in her knees, and she was not able to walk. She had a minimum amount of involvement in her other joints, and she had complete use of her arms and hands. Although she was confined to a wheel chair and suffered from occasional painful attacks of the disease, she was able to do most of her housework. She was seen regularly by the doctor on Home Medical Service who prescribed medication for the relief of pain, diet and exercise. The physiotherapist from the Visiting Nurse Association administered the exercises but the progress patient could make was necessarily limited by her heart condition and her obesity. As the patient did not have any teeth it was difficult for her to follow a diet.
The patient was divorced from her husband who was in prison and resided with her two children, ages seven and three. She had one daughter who was married and lived outside the home. Patient's brother and sister lived outside the home and contributed to her support. Her income was supplemented by ten dollars that she received from a boarder. She was dependent on her relatives to do those chores which required any activity.

The patient was born in the south and both her parents died when she was a child. She was married at sixteen and shortly after the birth of her first child her husband deserted. Seventeen years later her husband returned and two more children were born. He deserted again and shortly afterwards the patient became severely crippled by her disease.

The doctor referred this patient to the social worker because she was unable to pay for dentures which were vitally necessary if patient was to have an adequate diet.

The patient was friendly and pleasant in the contact with the social worker. She spoke freely of her medical problem and of her determination to continue to be independent as possible. She was worried about paying for the prosthesis recommended by the doctor as she did not have any funds herself. She did not feel that her relatives could assume this extra responsibility. The social worker brought up the possibility of requesting public assistance to supplement her income but the patient exhibited marked resistance to this plan. In view of this the worker did not pursue this suggestion and found that the patient was agreeable to having worker request financial aid from a private agency to contribute toward the payments for a prosthesis. Together the social worker and the patient worked out a solution to this problem with patient arranging for her own dentist to come to her home to fit the prosthesis. The social worker was successful in raising the money from the L agency and from funds available in the hospital Social Service Department to cover the cost of the dentures. The worker saw patient regularly and helped with the problems that arose regarding contacting the dentist and arranging for payments. The social worker actively encouraged the patient to wear the prosthesis and to continue to request her dentist's assistance until the teeth were properly fitted.
Early in the contact the patient exhibited marked reluctance to discuss anything with worker outside of the immediate problem, but as the relationship grew stronger, she confided in worker that she planned to marry again and requested worker's assistance in carrying out her plans. She was planning to marry the boarder in her home but she was not sure of the legality of her divorce and her fiance wished to arrange to adopt her children. The latter was a positive influence in the home and had an excellent relationship with the children. The worker arranged for a referral of the problem to the Legal Aid Society and as the patient could not keep an appointment herself, the worker encouraged the patient's daughter to act as liaison. Her legal affairs were settled before her marriage.

This case was chosen for the Family Study Program and the worker's understanding of the patient and the family's problems enabled her to help the third year medical student get a better picture of the family's needs. The social worker and the doctor consulted regularly regarding the family's problems. When the doctor arranged for the patient's admission to the hospital for the removal of a tumor, the worker arranged for the necessary funds from a private agency so that the children could be temporarily placed during the patient's hospitalization. The patient developed an excellent relationship with her doctor and the worker discontinued her direct contact with the patient and continued to act as a consultant to the medical student and helped in his handling of various minor social problems that arose.

This patient's environment was most conducive to carrying on a successful program of medical care at home. Her relatives were willing to accept most of the responsibility for helping patient with those needs she could not meet herself. However, her financial resources were not sufficient to cover her medical needs.

Patient was severely handicapped by the crippling affects of her disease, and having lost the use of her legs, she needed help with many of the chores which fall to a busy
housewife and mother.

The patient had a strong desire to remain active and to maintain her independence despite her disease. She had adjusted well but became quite upset when faced with problems she could not work through herself.

In her relationship with this patient the social worker focused on the immediate problems and was able to relieve patient of the financial strain of meeting a medical recommendation. The patient responded to the worker's assistance and the support she offered and was able to reveal some of the problems that existed in the family situation.

The activity of the social worker in this case was centered around the situational problems that the patient faced and by her use of community resources the social worker helped to support the basically sound family structure minimized environmental pressure and helped the patient adjust to her illness and to follow medical recommendations. Her interpretation to the doctor of the family situation helped him to establish a good relationship with the patient which is so necessary for effective treatment.

The remaining three cases are similar to the three presented above in regard to the problem presented by the patient and the activity of the social worker.

The case of an elderly woman whose relationship with her daughter had resulted in the latter's refusal to continue the
responsibility for the patient's care is similar to the first case presented. In this case the social worker accepted the negative feelings which the patient's daughter had toward her mother and clarified for her many of the patient's needs and problems. The patient had been self-supporting and independent up until the time of her illness and was extremely upset and hostile as the result of her disease. Born out of wedlock, she had had a deprived childhood, and both of her marriages had ended in divorce. In the case work relationship the patient was able to reveal her anxiety and her great sensitivity to the fact that she was becoming more and more of a burden to her daughter both physically and financially. The social worker helped the daughter gain a better understanding of the patient's needs and to continue to bear the responsibility of patient's care. The financial pressure was relieved by the worker's use of community resources. In a supportive relationship with the patient, the social worker helped to relieve some of the anxiety about her disease and offered her strong emotional support during a difficult period when cortisone therapy was discontinued. The activity of the social worker helped to minimize the friction in the relationship between the two women and environmental pressures were relieved.

The other case in this group wherein the main activity of the social worker revolves around the financial problem that the patient presents is that of a twenty-three year old man, married with two children, whose employment had been
interrupted several times by severe attacks of rheumatoid arthritis. A tense immature man, the patient had had a very traumatic childhood due to the death of both parents, and illness which had caused him to be hospitalized several times. The patient was heavily in debt and the social worker met his immediate need by arranging for his application to be taken for public assistance. When the patient was able to return to work, the social worker helped to increase his motivation toward becoming gainfully employed by interesting him in accepting a referral to a community agency for advice regarding the initiation of bankruptcy proceedings.

The last case included in this category is similar to Case III as this patient's ability to function as a wife and mother was limited by her disease. A well educated woman, she described her childhood as a very unhappy one. Her mother died when she was a child and she was brought up by her grandmother, a rigid domineering woman. The patient's marriage had not been a happy one, and was characterized by frequent quarrels between husband and wife. Her husband's income was not adequate to meet many of her medical needs and the social worker was able to supplement their income by her use of private funds to help the patient follow the recommendations made by the doctor. This family came to the attention of a local protective agency, and the social worker interpreted the medical social situation to that agency. By minimizing the environmental pressure, the
severe attacks and remissions with progressing dis-
ability. For the last three years she had been
unable to walk and was confined to a wheel chair.
At the onset of the disease she had been hospitalized
at B hospital but had signed out against advice.
She was then treated by her family doctor and
experienced temporary relief from gold salts and
corticosterone therapy. Six months previous to the time
of referral she had been seen at the Massachusetts
Memorial Hospital Out Patient Department. There the
doctor had recommended hospitalization at C Hospital
for an extended course of treatment, but the patient
had refused to be hospitalized.

Patient had severe damage to her knee joints,
but she was able to use her hands and could cook,
sew and care for many of her own needs. She com-
plained of pain, and her physical condition was
complicated by her obesity.

The doctor from Home Medical Service saw this
patient once a month and the therapeutic regime
consisted of a low calorie diet, physiotherapy and
medication for the relief of pain. Patient had not
responded to physiotherapy treatments and made
little effort to cooperate with the nurse. She did
not follow the recommended diet. She was discouraged
and depressed and believed that unless she accepted
hospitalization she could not hope for any improve-
ment.

Patient was a widow who resided with her
twenty-one year old son. The latter supported her
and was employed as an apprentice printer. Patient
had only one sibling, a sister who was dead. Her
childhood had been an unhappy one due to the constant
squabbling of her parents. Their marriage ultimately
ended in divorce. Patient described both her parents
as being cold and undemonstrative, but had a close
attachment to her father who was now dead. Patient
had a lot of hostility toward her mother who was
still well and active and visited patient occasionally.

Patient had led a very active life. As a child
she had been very much interested in sports and out-
door activities and continued an avid interest in
gardening into her adult life. She had always been
interested in art but attended business school where
she took up accounting. She had a successful career
in the business world and worked during most of her
married life until the onset of her illness.
Patient was married twice and divorced her first husband, the father of her son. She described him as lacking ambition. Her second marriage ended with her husband's death. He died of cancer and patient took care of him during the four years of his illness. Shortly before his death she suffered her first attack of arthritis. She described this marriage as a very happy one.

Patient was referred to the social worker by the visiting nurse as patient had stated that she would like to make arrangements to be admitted to C hospital so that she might receive cortisone therapy. The patient related easily and quickly to the social worker and revealed that she had become greatly discouraged by her lack of improvement and had decided to accept hospitalization because she understood that there she could receive cortisone therapy which would enable her to walk again. However, she could not consider hospitalization right away, because she had to make plans for the care of her son. Patient revealed that he depended on her to wake him up in the morning for work and for many other things. He in turn helped her with many of her needs. She described her son as being in poor physical condition. As a child he had needed a lot of care as he had a congenital heart condition and had not been able to go to school. He had had a home teacher all through grammar school. Patient also revealed in this interview her anxiety about her condition, the burden she was to her son, and her fear of the future.

The case was discussed in Home Medical Social Service Conference. The social worker interpreted to the doctor and the nurse the patient's feelings about hospitalization and her disease. The doctor and nurse felt that patient's lack of cooperation had had a marked affect on her lack of response to treatment. It was recommended that home care be continued pending an evaluation by the social worker of the plan for hospitalization. It was recommended that the doctor interpret to the patient the methods of treatment that would probably be recommended during her hospitalization, and that one of these was surgery. He was advised to explain to patient what her role was in the treatment procedure and the results she could expect from a treatment at home.

The social worker saw this patient at frequent intervals. She readily revealed her past history
and her present reaction to her illness and the lack of satisfaction in her life. Her desire to improve was very strong but she felt that she would always be reluctant to leave her son and accept hospitalization. Following the interpretation by the doctor the patient revealed her determination to cooperate with the doctor and the nurse, to exercise and follow her diet.

The social worker recognized that patient's relationship with her son was such that she would never be able to accept hospitalization. She supported patient in her renewed efforts to cooperate in a home care program and she discussed with patient the possibility of developing interests which would provide her with more satisfaction. She encouraged patient's interest in art and together they explored the possible outlets for her talents. When the social worker found there was a market for jewelry made at home, the patient expressed an interest in this field and was enrolled in a jewelry making class.

This patient is still being seen by the social worker, the doctor and the nurse. The patient has revealed to the worker the difficulty she has in following the recommendations of the doctor and in doing her exercises. The worker offered her support and encouragement. She has shown marked improvement in her physical condition and has been able to stand for the first time in two years. She has become more cheerful, encouraged and has had more social contacts. She has begun to go out, and now has a much better outlook toward the future.

This patient had led an active life and had spent a great part of her life giving service to others. She had been aggressive and ambitious and many of her needs had been met by her self-sacrifice and her activity. As a mother she had been over-protective and solicitous and now had a very close relationship with her son. Neither patient nor her son seemed to be able to break away from the relationship in which both their dependency needs were being met. Patient sincerely
believed that her only hope for improvement lay in her accept-
ance of hospitalization. She could not overcome her resistance
to such a step, and the conflict left her tense and anxious.
She was convinced that she could not be helped by treatment at
home and was not cooperating or following the recommendations
made by the doctor. The onset of the disease came shortly
after the death of her husband, and patient's personality
showed certain psychological features common to a patient with
rheumatoid arthritis. These factors suggest a strong emotional
component in the disease process.

The patient's activity was greatly limited by the
crippling affects of her disease but she was able to care for
many of her own needs and could continue to do so.

Her home was pleasant and comfortable and provided an
excellent environment for carrying on a program of home
medical care.

The relationship with the social worker offered this
patient immediate relief from the tension and anxiety which
were affecting her response to treatment. She was able to
reveal her conflict, her great reluctance to accept hospitali-
zation and her despair that nothing could be done for her
unless she took this step.

The social worker recognized that patient's reasons for
refusing hospitalization were not too realistic but to work
through these feelings and press this plan upon the patient
would probably cause undue anxiety and further exacerbation of
the disease.

The social worker brought to the doctor a better understanding of the patient's needs. The resulting interpretation by the doctor to the patient in regard to the program she could make while receiving treatment at home helped to enlist her cooperation and furthered her understanding of the disease.

When the patient was ready to move ahead the social worker offered her constructive help and made use of those forces which were partly responsible for her illness. Her aggressive drives were channeled into a useful area.

The social worker's understanding of the personality factors which were causing the patient's resistance to hospitalization and her interpretation of these factors to the other members of the team resulted in a successful home care plan that was far more satisfying to the patient, and a treatment plan that may have been costly and wasteful was avoided.

CASE V

Patient was a 78 year old woman who had advanced rheumatoid arthritis. She has suffered from the disease for over fifty years with gradual involvement of both hands, wrists, elbows and shoulder joints. The involvement of her knee joints had resulted in less joint damage than the involvement of other parts of her body. Patient also had very limited vision as the result of bilateral cataracts.

The involvement of her finger joints left patient unable to prepare her own meals or use her hands. She never left her room and although the involvement of her knee joints was not severe enough to prevent her from walking, she had been confined to a bed and
a chair for the past year. Her poor eyesight also made her very fearful of falling. Patient never had received adequate treatment for her rheumatoid arthritis or for her eyes. She complained about being alone, her inability to go out and about being unable to read which had been one of her favorite passtimes.

Patient resided in a furnished room with a friend and was supported by Old Age Assistance. Her friend was thirty years younger than the patient. She was employed and patient was left alone in her room during the day. The two women were very devoted and the friend took care of patient's needs very adequately. She had lost her mother as a child and had lived with the patient ever since.

The patient was one of five children. Her mother had died when she was five. Her father had died at the age of seventy-four. She had cared for him in his last illness; they had always been very close and his death had been a great shock to her.

Patient was referred to the social worker by the doctor on the Home Medical Service because he felt that patient was very lonely and might be interested in a plan for nursing home care. In the first interview with the patient the worker met a great deal of resistance. The patient maintained that she was very content with her present situation and revealed a fear that a social worker could make plans for her against her will. The patient responded to the social worker's interpretation of her function, reassurance and interest by revealing her background and requested that the worker come to see her again.

In an evaluation of the situation in the Home Medical Social Service Conference, it was felt that patient's needs would be best met by remaining in her present environment. It was recommended that the doctor and the social worker continue to see the patient and motivate her toward coming to the Out Patient Department for an evaluation of her rheumatoid arthritis, for a maximum restoration of her mobility and her eyesight.

In her relationship with the social worker the patient demanded frequent visits. In the early interviews she revealed her distrust of medication,
fear of surgery and her hostility toward the medical profession. The social worker accepted patient's hostility and offered her support and understanding. When the patient revealed her concern about her failing eyesight, the social worker discussed with her the possibility of making an appointment in the Out Patient Clinic. The patient agreed to this plan and arrangements were made with the doctor to have patient seen in the Out Patient Clinic. When patient manifested a great deal of anxiety about keeping the appointment the social worker emphasized that the decision remained with her. The patient was not able to follow through with these recommendations. Both the doctor and the worker continued to see the patient. In the interviews with the worker the patient revealed increasing hostility toward the doctor and her disappointment that they were not able to help her. She continued to resist any plan which entailed any effort on her part, and her anxiety increased to the point where she denied the need of further medical treatment but requested that the social worker continue to visit her. The patient continued to deny the need for medical care and as she was no longer under the care of the Home Medical Service, the social worker discontinued her contact with the patient. She assured the patient of their continued interest and patient was relieved to know that medical care was available whenever she needed it.

This patient had never received adequate treatment for her rheumatoid arthritis. She had gradually succumbed to the crippling effects of her disease. Her resistance to taking help was expressed in the denial of her problem and in her hostility toward the doctors. Her hostility was the result of her despair and the feeling that nothing could be done to help.

She was more severely disabled than her actual physical symptoms would allow. The lack of treatment and exercise had resulted in severe immobilization of her joints
She was receiving good physical care in her environment and her friend was willing and able to continue her responsibility. However, she was alone during the day, was no longer able to read and her environment provided her with very few satisfactions.

The social worker accepted the patient's hostility and offered this patient reassurance and support. The patient formed a dependent relationship with the worker and was able to reveal her problems. The social worker understood that the patient could accept a minimum amount of change and would strongly resist a recommendation of nursing home care. An interpretation of the patient's needs to the doctor resulted in a more limited treatment goal, and the patient accepted medical care at home for a five month period. However, any attempt to motivate the patient toward helping herself and cooperating with the doctor's recommendations resulted in her denial of the need for further treatment.

The personality of this patient prevented her from receiving adequate medical care and was a handicap to any longterm treatment plan that was partially acceptable to the patient. When treatment was terminated the patient's anxiety was minimized by the knowledge that further service was available whenever she wished it.

The other case which was included in the first sub group of this category is similar to the case presented in that the
patient was a middle-aged woman who was discouraged and upset by the lack of improvement in her condition, and she was not cooperating in the recommendations made by the doctor. The patient lived alone and was separated from her husband. She had been an only child and her father had died when she was very young. She described her mother as a cold, domineering woman. The social worker helped the patient to understand the necessity for increasing her own efforts and motivated her toward actively cooperating in the therapeutic regime recommended by the doctor. Many of the patient's dependency needs were met in her relationship with the social worker. Her physical condition improved as did her outlook toward her situation.

In the two remaining cases included in the second sub group the patients showed an attitude of resistance to medical care which was similar to that of the patient described in Case V. One was an elderly woman who resided with her husband. She was completely dependent on him for her care and freely expressed her dissatisfaction with her situation to the doctor and the social worker. The doctor believed that the patient's symptoms were more severe than her actual physical condition would allow. The social worker discussed the possibility of nursing home care with the patient who decided against the plan. In the case work relationship the social worker attempted to motivate the patient to greater physical activity, but the latter continued to cling to her symptoms and ultimately refused medical care.
The last case included in this category was an elderly man who lived alone. During an acute attack of rheumatoid arthritis this patient cooperated with the treatment recommendations made by the doctor. He expressed an interest in nursing home care and worked closely with the social worker in following through with this plan. However, when the patient had some remission of the disease and became more active, he decided against custodial care, and refused to be seen by the doctor. The contact with social service was discontinued when the case was closed with Home Medical Service. The social worker assured all of these patients that further medical care would be available to them upon their request.

The study of these cases indicated that the patients included in this category had emotional problems that were affecting their adjustment to their illness and their response to treatment. The personality problems of these patients contributed to their resistance to treatment and their attitude toward their illness. In working with the patients included in this category the social worker recognized that if these patients were to be helped to adjust to their illness they needed greater self-awareness, a change in their attitude, and a greater understanding of the total situation. Thus, the problems of these patients and the focus of the social worker's activity indicated that they be included in the same category.
DISABILITY

In this third category are included those cases where the patient was severely disabled, and his activity severely limited by the disease. The pain and deprivation which resulted from their illness is the outstanding problem these patients had to face. The following presentation is the case which gives the clearest example of the patient's needs and the activity of the social worker.

CASE VI

The patient, a 61 year old woman, was severely crippled with advanced rheumatoid arthritis, from which condition she had suffered for twenty years. She now has severe involvement of her knee joints. A diagnosis of pulmonary emphysema, arteriosclerotic heart disease and malnutrition was also made. She suffered from severe joint pains and shortness of breath. Patient lived alone in a small, poorly heated room. She was able to walk only with difficulty and was dependent on her friends to bring her food. Patient needed immediate hospitalization for treatment of her pulmonary disease and upon discharge from the hospital would need nursing home care. Patient was an alert, intelligent woman who was separated from her husband who contributed nine dollars a week toward her support. This income was supplemented by Disability Assistance. She had never had any children and although she had seven living siblings she did not have a close relationship with any of them. At one time before her marriage she had worked as a waitress but gave this work up to take care of an invalided mother. When patient was first seen by the extern of Home Medical Service she had signed out three days before from B Hospital. The extern thought patient should be readmitted to the hospital immediately, but as she refused to return to B Hospital, the case was referred to the social worker for help in arranging for patient's admission to the hospital.
When seen by the social worker the patient was pleasant and cooperative and readily expressed her dissatisfaction with her present situation. She readily agreed to go to H Hospital and arrangements were made by the doctor for her admission. The case was then closed by social service. Two months later the case was reopened. Patient had been discharged from H Hospital to a boarding home where she had remained for three days, and then she had returned to her former residence. She was being seen again by the extern on Home Medical Service, who felt that patient needed nursing home care. In the interviews with the social worker, patient complained of her increasing disability from arthritis, her inability to get enough food for herself. She was concerned also about the lack of heat in the room. She complained that she was being neglected by her friends and family. Despite her extreme dissatisfaction she was not able to make any definite decision about her future plans. The social worker discussed three possible plans with patient: moving to a better room; admission to a chronic hospital; admission to a nursing home. As patient did not come any nearer to a solution to her problem, the social worker told her that the decision was up to her and requested that she contact worker when she had made her decision. The doctor continued to see patient regularly. One month later patient telephoned to the social worker and requested that arrangements be made for her admission to a nursing home. The social worker initiated the help of patient's sister in selecting a nursing home suitable for patient's needs. Patient was transferred to a nursing home, and as she adjusted very well the case was closed.

This patient was severely disabled by rheumatoid arthritis. The disease had progressed to such a point that little could be done to bring back any mobility to her joints. She could not use her hands and walked with difficulty, and she was not able to care for herself. The pain she suffered in her joints and the chronic chest condition contributed to her ever increasing disability. She was becoming more and
more handicapped by her disease and needed custodial care and nursing supervision.

Patient's needs were not being met in her environment. There was not anyone on whom she could depend for continued care. Her room was poorly located and it was becoming more and more difficult for her to get out.

An alert intelligent woman, she realized that she was becoming more and more handicapped and that her needs were not being met in her environment. She realized that to accept institutional care meant a permanent change in her way of life. She had struggled to maintain her independence and had previously shown a strong resistance to accepting hospitalization or nursing home care. Now she was faced with the reality of her illness and the need for a decision regarding her future plans.

She related easily and well to the social worker, and in their first contact with the patient, the social worker found her ready and willing to accept hospitalization, and her acute pulmonary condition necessitated that immediate arrangements be made. When patient was again referred to social service, her need for medical attention and nursing supervision was not as acute but both patient and social worker, however, were aware that some change must be made in patient's environment, and the social worker's role was to give the patient support in order to help her make her own decisions as to her future plans. In the casework relationship three
possible plans were discussed and carefully considered. The patient was assured of worker's interest in her problem, but if she was to follow through on any plan the worker felt the patient must take the responsibility for making her own decisions. When the worker became less active, and the patient was relieved of the pressure of making an immediate decision, she was able to decide to accept nursing home care and to ask for worker's help in making definite arrangements.

The worker made use of social resources to affect a transfer to a nursing home and initiated a close relationship between patient and her family by asking patient's sister to help select a nursing home suitable for patient's needs.

The activity of the social worker helped the patient adjust to her disability and accept the long term care that she needed. Frequent hospitalizations were thereby avoided and the problem of obtaining adequate medical and nursing care for patient was solved.

All of the patients in this group were in need of hospitalization or nursing home care.

One elderly woman lived alone in the fourth floor of a rooming house and was completely dependent upon her landlady to bring her food. She had continually resisted the suggestion that she consider going to a nursing home which had been made by the social worker at C Hospital. She was referred to the Home Medical Service when she was no longer able to be seen in
the clinic. The refusal of her landlady to continue to take the responsibility for her care forced her into accepting care in a nursing home. The activity of the social worker centered around obtaining the approval of Old Age Assistance for placing patient in a nursing home and arranging for the financial responsibility to be taken by that agency. The patient was transferred to a nursing home, and the patient's son was encouraged to take an interest in the plan and to make arrangements for her personal possessions.

Another similar case was that of an elderly woman who resided with her daughter. The patient's condition was such that this plan was no longer satisfactory. The social worker arranged for patient's transfer to a nursing home, and interpreted the patient's needs to the public assistance agency that assumed the responsibility for the payment of patient's care in a nursing home.

The final case included in this group is that of an elderly man who lived alone in a rooming house. He was referred to the social worker because he had resisted hospitalization, although he was suffering from a severe attack of the disease. In this case the social worker was successful in helping the patient accept hospitalization at a general hospital. During remissions of the acute attacks this patient insisted upon returning to his room. The social worker recognized this patient's need to maintain his independence
and in the case work relationship offered the patient the support he needed, and he came to worker for assistance whenever he had a problem he could not meet himself.

In this group of cases all of the patients were brought face to face with the reality of their physical handicap. Despite the fact that they had other problems which contributed to their difficulties the incapacitating affect of the disease motivated them toward seeking assistance and created an unsatisfactory social situation. Thus, the activity of the social worker was focused on helping these patients adjust to their illness and accept the changes their physical condition demanded.

The study of this patient group revealed that they had three outstanding problems arising out of the illness situation, and that these problems affected the role that the social worker played in treatment. By her individual approach and the use of the basic concepts of social case work, the social worker aimed at understanding the patient and his problem. When she gained a clearer picture of the situation she formed a treatment plan that would meet the patient's particular needs. If the patient appeared to be discontent with his environmental situation, but supporting the positive aspects of his present situation seemed to be the best plan, the social worker focused her activity on minimizing the environmental pressures. In those cases where the patient's
personality was the outstanding problem, the social worker focused on offering these patients the support and understanding they needed if they were to be able to accept the demands of treatment. The role of the social worker was also affected by the severity of the patient's illness. In those cases where the patient's illness was so severe that their needs could only be met by a change in the environment, the social worker necessarily focused on helping these patients accept the fact that some change in their living arrangement had to be made. It is important to note here that although the problem the patient faced in relation to his illness had a marked influence on the activity of the social worker and the framework within which she formed a treatment plan, her role was affected not only by the patient's problem but also by the person who had the problem, thus by total picture the patient presented.
CHAPTER VI

GENERAL SUMMARY AND CONCLUSIONS

In this study the writer has attempted to determine some of the problems that face the patient with rheumatoid arthritis who is receiving medical care at home, and the type of service offered to these patients through the medical social worker.

In a medical setting the social worker focuses on those problems which have arisen out of the illness situation. A study of these cases showed that three outstanding problems that these patients had in relation to their illness fell under three general categories; emotional, physical, and environmental. These problems had a significant affect on the role that the social worker played in treatment of these patients, and all of the cases were discussed in the light of the patient's needs in all three areas. The physical problems that these patients had were the disabling affects of the disease which interfered with their daily routine of living and prevented normal activity. The influence of the emotions on the disease process made the personality of these patients and their reaction to their illness an important factor for the medical social worker to consider when formulating a treatment plan. To be successful, a home care
program should be carried on in an environment where the patient's total needs are met, thus the disturbing elements in the environment had an important affect on the patient's adjustment to his illness and the following of treatment recommendations.

The length of time necessary for adequate treatment of the arthritics and the time consuming permanent nature of the care needed to effect partial rehabilitation of those in the advanced stages of the disease created a need for prolonged social treatment to help the arthritic adjust to his illness and to the recommendations of the doctor.

The therapeutic regime recommended for these patients was often a long painful process, and they required from the physician careful painstaking treatment. The study of the social work done with this patient group showed that all of these patients required a great deal of reassurance and support from the social worker, and in all of the cases where intensive medical care was being carried on at home, the patient's contact with social service continued over a long period of time, and the social worker was a necessary member of the medical team.

This study revealed that all of the patients were disabled by the disease, some more seriously than others. Two were disabled during an acute attack only, but the remaining thirteen were permanently crippled in varying degrees. There
was some variety in the amount of activity within their capabilities, but these thirteen patients were all limited to some degree in the amount of activity they could carry on themselves.

There were varying reactions to the crippling effects of the disease among the patient group. For these patients suffering from an acute attack, the disease caused a great deal of anxiety. It resulted in a severe interruption of their daily routine, caused them to become dependent and their financial security was greatly threatened by the period of rest demanded for proper treatment.

Although there was a great variety in the number of years that these patients had suffered from the disease, all had seen themselves become progressively worse. These patients who were being treated intensively and encouraged to increase their activity, lacked the motivation to cooperate with the doctors by doing the painful tiresome exercises necessary to effect partial rehabilitation of their crippled joints. For those whose disability had reached the point where hospitalization or nursing home care was the only satisfactory plan, the complete surrender of their independence was an anxiety provoking event which they reacted to with a great deal of emotion. For some of the patients the medical recommendations made by the doctor only served to increase their anxiety about their illness and resulted in
their resistance to further treatment. A fear of the future, anxiety and a feeling of hopelessness were emotions common to these patients, and in all the cases where nursing home or hospital care was recommended, the patients showed a lot of resistance to such a step.

Financial stress, conflict in interpersonal relationships, and the lack of adequate care were the disturbing influences in the cases which were causing environmental pressure and making the social situation less conducive to medical treatment.

The medical social worker's understanding of the emotional component of illness and the dynamics of human behavior was a vital contribution in the treatment of these patients.

The small number of patients studied, and the fact that in only nine of the cases a full social history was recorded made it difficult to make any conclusive statements regarding the relationship of emotional trauma and the exacerbation of rheumatoid arthritis. However, there were found to be certain similarities in the backgrounds and life situations of the patient group which would suggest some relationship between traumatic events, the patient group and the disease process. In all nine cases where full family histories were recorded, the patient revealed some traumatic event in childhood or adolescence. This was either the loss of one or both parents
or an unhappy marital situation in their home. In two of the cases the first symptoms of rheumatoid arthritis appeared at the time of marital friction and the birth of their children. Death of a beloved relative was closely related to the onset and exacerbations of the disease in two cases.

The use of the basic concepts of social case work by the medical social worker enabled her to provide the patients with a definite useful service.

The social worker offered these patients many services.

1. With the use of environmental manipulation many of their material needs were met.

2. Through referrals to public agencies the patients were helped to obtain greater financial security, and private funds were made available to enable them to follow the recommendations made by the doctor.

3. The social worker made use of community resources to help these patients with their problems which included arranging for nursing home care and hospital admission, the temporary placement of children, and problems where legal advice was needed.

4. Through the case work relationship these patients were given support and acceptance which enabled them to reveal their problems and to discuss their feelings. This support and understanding given to these patients by the social worker, in many cases, satisfied their need enough so that the
problems that were blocking their response to treatment were minimized, and they became more cooperative in following treatment recommendations.

5. The interpretation of the patient's social and emotional needs by the social worker to the doctor helped the medical team plan a treatment program suitable to the patient's needs.

In preparing for this study the writer has noted that there is not a great deal of written material on the specific subject of the role of the social worker in the treatment of the patient with rheumatoid arthritis. Considering the prevalence and the severe consequences of this disease, and the need many of these patients have for the services the social worker can offer them, there seems to be a great need for more intensive research in this area. Further study of the patient with rheumatoid arthritis, his problems and the way the social worker can meet them would increase our ability to serve these patients in the best possible way.
APPENDIX I

OUTLINE FOR OBTAINING CASE DATA

I. Social Data
   Name
   Age
   Sex
   Marital Status
   Mode of Living
   Occupation
   Family Status
   Family History

II. Medical Situation
   Degree of Disability
   Complicating Diseases
   Treatment
   History of Illness

III. Referral to Social Service
   1. Source of Referral
   2. Reason for Referral
   3. Length of Contact

IV. Problems Presented by Patient

V. Services Rendered by Social Worker
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