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A study of patients with carcinoma referred to social service on the Home Medical Service at the Massachusetts Memorial Hospital from 1949 through 1952

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A STUDY OF PATIENTS WITH CARCINOMA REFERRED TO SOCIAL SERVICE
ON THE HOME MEDICAL SERVICE AT THE MASSACHUSETTS
MEMORIAL HOSPITALS FROM 1949 THROUGH 1952

A thesis

Submitted by
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CHAPTER I
INTRODUCTION

Exposition and Purpose.

Carcinoma, or cancer, is a disease in which body cells behave abnormally, growing wildly and injuring normal cells. Unless alteration takes place, death is inevitable. So profound is the subject and so colored with fears that, until recently, few have had the courage to investigate it, and the funds available for research have been miniscule. Money on a large scale is now being provided, however, and many investigators are devoting their time to cancer research. The incidence of cancer is rising today, as the age of the population is increasing. Carcinoma is more likely to occur in middle or later life, and more people are living to be cancer victims.

The purpose of this study is to show the problems that patients with cancer have in relation to the illness, and how their needs are met through the activity of the social worker. An attempt will be made to answer the following questions:

1. What were the particular problems that were the basis for the referral of these patients to the social worker?
2. What were the additional problems these cancer patients and their families face?


3. How did the social worker try to aid the cancer patient in working through a satisfactory plan for medical care?

4. In what ways was the teamwork approach used in helping the patient in planning medical care?

Scope of Study, Sources of Data, and Methodology.

The twenty-two cases studied and reported in this thesis include all those patients with the designated diagnosis of cancer who were referred to the Home Medical Service, Social Service Department, of the Massachusetts Memorial Hospitals from the time the program was established in 1949 through 1952.

The sources of material used in this study were the records and copies of letters of the Social Service Department; the social consultation sheets, medical records, and referral forms of the hospital, Out-Patient Department, and Home Medical Service; and, in a few instances, verbal information given by members of the Social Service Department. As it is the practice of all social service departments to have complete case histories written only on comprehensive cases and those carried by students, the material for the majority of the cases studied could not be obtained exclusively from the Social Service Department. The records of other departments were used as a means of obtaining identifying factual material and information related to diagnosis and treatment.

The method of procedure used in this study is as follows: A survey of books, pamphlets and articles in
periodicals from the fields of medicine and social work in relation to carcinoma is presented. The organization and services of the Home Medical Service of the Massachusetts Memorial Hospitals are described. The records of the twenty-two patients are analyzed with reference to the thesis questions, and four typical cases presented in detail.

Limitations.

The outstanding limitations of the study lie in the selectivity of the group studied, and inadequacy of records. As many of the cases were referred by Boston University students of Medicine LV on the Home Medical Service, this apparently influences the nature of the group, as referrals seem to be of individuals with obvious problems, and those closely related to medical treatment and care. As to the inadequacy of the sources of data, the social service records were written to serve the practical purpose of that department, and were not comprehensive, as the patients were classified as limited cases. The medical records, also, were written by the physicians for their specific purposes. In many instances, therefore, details that would be useful in such a study as this could not be obtained. Conclusions are limited to the cases studied, and do not apply outside the scope of this study.
CHAPTER II

CARCINOMA--A MALIGNANT TUMOR

Historical.

Indications of knowledge of the disease of cancer date back many centuries. An Egyptian papyrus was found, copied from a surgical treatise originally written about 3000 to 2400 B.C. This described the examination, diagnosis and lack of treatment for the disease. In the Hippocratic Collection of the third century B.C. is found a description of two types of tumors--carcinos, which included all the non-malignant types, and carcinoma, malignant growths. Many more records of detailed clinical descriptions and operational procedures can be found, but it was not until the eighteenth century that there were many speculations as to the etiology of the disease. The invention of the achromatic microscope by Lamarch in 1824 made cellular investigation possible, and Virchow's work on cellular pathology (1858) contributed greatly to the knowledge of the disease. The first investigation into the genetics of cancer was done by Tyzzer in 1907, who produced strains of mice which developed cancer, and others that were resistant to it.

The history of treatment of cancer has kept pace with the expanding knowledge. Early treatment was actual cautery, in the last half of the nineteenth century the antiseptic
technique in surgery made more extreme treatment possible, and the discovery of anesthesia in 1905 led to our present-day radical surgery. In 1895, Roentgen discovered X-ray, which was used first for diagnostic purposes, then as a therapeutically. After the Curies discovered radium in 1898; it was found that radium therapy was sometimes better than X-ray or surgery, especially in cancer of the cervix.

Modern cancer research dates back to the first part of the twentieth century, the biological era. The areas of intensive investigation have been in the broad field of heredity, viruses, carcinogenic or chemical agents, hormones, chronic irritation, diet and metabolic considerations. The shift from normal physiological behavior to abnormal or pathological activity constitutes the crux of the cancer problem. Why should cells, which have acted in a normal fashion for a period of time, suddenly change their characteristics of growth and reproduction and invade surrounding tissue? This is the riddle to be solved.

Natures of Carcinomas.

Boyd defines Carcinoma as new cells which proliferate without control and which serve no useful function.\(^1\) A tumor cell originates from a normal cell in any tissue of the body and retains to a varying extent the normal characteristics with which it was once endowed. There are degrees of differentiation

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\(^1\) William Boyd, *Surgical Pathology*, p. 105.
which indicate the histological origin of the growth. As these neoplastic cells "mimic," microscopic examination is necessary to detect the "mother" cells and identify the various types of tumors. The general clinical course can then be predicted.

The classification of tumors may be subdivided into two broad groups; benign and malignant. The benign groups are innocent, remain encapsulated, and do not spread or metastasize. They grow rather slowly and represent a problem with reference to their size and location. A malignant tumor, on the other hand, will continue to grow and spread not only by contiguity and infiltration of the surrounding tissues, but also by the blood and lymph streams establishing new colonies far away from the original site. Each variety and type of malignancy has a distinct method of metastasis. Those of the gastro-intestinal tract will metastasize through the lymphatics to the liver. Cancer of the thyroid, prostate and breast usually metastasize to bone. Carcinomas of the lung usually metastasize to the brain.

Carcinomas are classified on the basis of the types of tissue of the primary neoplasm. The two most common malignant growths are the carcinomas and the sarcomas. Carcinomas are tumors that arise from epithelial tissue and metastasize via the lymph channels. Sarcomas are tumors which arise from the connective or supportive tissue and metastasize via the blood stream. The latter occur in the young, are extremely hard to cure, and represent a discouraging picture as they are
unusually resistant to all types of therapy. As a general rule, the younger the individual with a malignancy the more malignant the lesion. Adenocarcinomas are malignancies of the glandular structure such as the breast, thyroid, intestines. Leukemias may be considered cancer of the blood in which the white blood cells increase in undue proportions. They are related to the various malignant lymphomas of which Hodgkins Disease, a malignancy of the lymph glands, is a type. There is no tissue in the body that may not be subject to malignant changes.²

**Etiology.**

The essential cause of cancer is unknown, but theories have been brought forth to explain the various phenomena. Potts, in 1777, was first to recognize the carcinogenic factor in soot. The skin cancer on the hands of fishermen from handling tar while mending their fish nets is an example of this. Another theoretical cause of cancer is that chronic irritation has a positive correlation with cancer of the lip and tongue.³ The cobbler who constantly fills his mouth with nails and withdraws them one at a time over his lips seems to be particularly vulnerable. Carcinoma of the cervix in multiparous women with untreated lacerated cervix also falls into this category of chronic irritations.

² Lauren Ackerman and Juan A. del Regato, Cancer..., Diagnosis, Treatment and Prognosis, pp. 76.

The hormonal theory is based upon the premise that the hormones influence the growth or recession of cancer cells. For example, a cancer of the breast in a pregnant woman has a more rapid growth rate. The rapidity of growth during pregnancy is attributed to the action of hormones. The prostatic cancer in males is accelerated by androgens, or male hormone, while as contrast estrogens, or female hormone, retard its growth.

The virus theory has been advanced by Bittner, who was able to breed mice with a predominance of breast cancer, the ratio remaining constant. The young mice of this constant strain are not allowed to nurse from their mothers, subsequently, the incidence of breast cancer was materially reduced, proving that something in the mother's milk produced a tendency to form breast cancer in the mice. This he called the "milk factor" and attributed it probably to a virus. Due to the difference in time from one generation to another between humans and mice, it is estimated that it will take about seventy-five years to prove this point in humans.

Genetic factors are being considered by Dr. Little and his group at Bar Harbor, Maine. He has studied families of mice that have a specific type of tumor in a specific organ with distinct characteristics. He believes the inheritance of tumors is caused by multi-genes. There is a great difference of opinion as to how far these results can be applied to man
because of the complexity of the genetic facts and the difficulty of getting statistics which are of any value. The meta-
volic theory is based upon the high incidence of malignancy during the menarch and the potential relationship to the well-known metabolic changes of this period.

As population which has the highest exposure to risk of cancer is increasing (over forty-five) it may be anticipated that cancer will increase as a primary cause of death in the overall mortality rates, but not necessarily in the age adjusted rate. (See Graft I.)

Cancer knows no barriers. It occurs among the young and old, the rich and poor, and among all races. Admittedly, death statistics are not very accurate, for the diagnosis on the death certificate is usually based on clinical assumption and seldom on confirmed pathological findings. In general, however, it is admitted that carcinoma is under-diagnosed rather than over-diagnosed.4

Diagnostic Methods.

The diagnosis of cancer depends upon the symptoms and necessarily depends upon the part of the body involved. The American Cancer Society, with its constant and repetitious emphasis on early diagnosis, has broadcast through the newspapers, radio, and television, the seven danger signals. They are as follows:

4 Lauren V. Ackerman and others, Cancer, Diagnosis, Treatment, and Prognosis, p. 18.
CANCER DEATH RATES BY AGE AND SEX
UNITED STATES - 1945

Vital Statistics of United States - 1945
Statistical Research Department, American Cancer Society
1. Any sore that does not heal.
2. A lump or thickening on the breast or elsewhere.
3. An unusual bleeding or discharge.
4. Any change in wart or mole.
5. Persistent indigestion or difficulty in swallowing.
6. Persistent hoarseness or cough.
7. Any change in normal bowel habits.

The specific diagnosis of malignant disease, however, is made by the pathologist in examining the tissue removed. The tissue in question is first grossly described, a section from the gross specimen is removed, stained and placed in paraffin. By means of a microtome it is cut up into very thin sections so that the individual cell may be seen through the microscope and thus diagnosed. The cancer cells retain some of their original characteristics. Therefore, it is possible for the pathologist to state the origin or primary site of the malignancy, whether it is a slow or fast-growing tumor, and whether the lymphatic or the blood stream has been infiltrated.

Early diagnosis may be determined by a papanicolaou smear, which takes advantage of the change in the size and shape of the nucleus of a cancer cell that has been shed off by its parent. It represents an early method of diagnosis and is extremely useful. Smears may be obtained from the genital tract and mouth, or by the stomach-washing examination of the gastro-intestinal tract. The examination of other body transudates and exudates, such as urine, sputum and abdominal ascites.
plural effusion or aspirations from the bronchi, may produce cells from existing cancer. Prompt fixation of the cell and staining gives ninety to ninety-five per cent accuracy of diagnosis.

X-ray constitutes the most important diagnostic procedure in the hidden organs. X-rays of the chest will disclose cancer of the lung long before it can be picked up by the stethoscope. It also constitutes the most valuable method of diagnosis in the upper and lower gastro-intestinal tract, and is often the only means of diagnosis. The lower gastro-intestinal tract, the last twelve inches of the rectum and sigmoid, is amiable to diagnosis by means of sigmoidoscopy.

Various types of instruments have been devised for diagnostic purposes which give the operator an opportunity of visualizing the tumor itself within the body cavities. These are usually called scopes, with a prefix depending upon the part involved. The cystoscope is used to examine the bladder, urethra and kidneys. The peritoneoscope allows one to view the general abdominal cavity. The bronchoscope is used to visualize the bronchi. The esophagoscope and gastroscope are used to visualize the esophagus and stomach. These also allow the diagnostician to take a biopsy for definitive diagnosis.

Treatment.

The most important treatment of cancer is its prevention. Prevention is best accomplished by the removal of pre-cancerous lesions such as ulcerations of the skin, lip,
mouth, anus and cervix by removing the source of chronic irritation.

Surgery is the oldest method of treatment and still holds the major place today. In operating on a malignant growth, the surgeon must make a wide, adequate excision which includes the accompanying lymphatics in an effort to completely eradicate the disease. Surgery is becoming more and more extensive so that some people call cancer surgery a mutilating surgery.

Recently, Brunschweig and his associates have become even more radical, and have devised his so-called eventration operation, or evisceration, in which not only the malignancy and its adjacent lymphatics are removed, but many organs in its immediate vicinity, in an effort to produce a higher percentage of cures. This has brought about a good deal of medical, moral and philosophical discussions as to whether this extremely extensive and devastating type of surgery is indicated or justified in relation to the so-called salvage value of the individual following it.

Electro-coagulation was the method used by the ancients in their so-called surgery. Today it plays an extremely important role in malignancies of the buccal cavity, including the tongue.

X-ray therapy is used both from a therapeutic and palliative standpoint. Certain malignancies are radiosensitive. These are usually the fast-growing variety, especially the
lymphomas. The slow-growing variety are less amenable to
radiation but, in the absence of better therapy, it is worth
consideration. X-ray therapy is often used as a palliative
procedure when a cure cannot be expected, but relief of pain
or partial regression of the tumor will bring comfort and
increase the life span of the patient.

Radium, with its Gamma ray, is similar to X-ray. Its
primary use is in carcinoma of the cervix and uterus, as well
as superficial cancers of the skin.

Radioactive elements are available to certain hospitals
from the government laboratory at Oak Ridge, Tennessee. These
substances are playing a gradually increasing role in the
treatment of cancer. The following elements have been tried.

Radioactive iodine: This is primarily used in cancer
of the thyroid and is especially effective with metastatic
lesions, usually found in the bones. A certain amount of the
isotopes dissolved in water is consumed, and by means of a
Geiger counter, the concentration of the radioactive iodine
may be determined in the various parts of the organs of the
body.

Radioactive phosphorus, used in the treatment of
leukemias, is largely in the experimental stage and has not
proved too effective.

Radioactive cobalt is used like radium in the treatment
of carcinoma of the cervix.
Chemotherapy has been predominately identified with Dr. Farber and his group at the Children's Medical Center in Boston. They have used the anti-folic acid group of drugs, such as aminopterin; the nitrogen mustard group, and more recently a drug called Tem. These chemical compounds influence, at least for a time, the growth of certain malignancies, although no permanent cure has taken place. For the first time, growths such as the leukemias have been influenced. This represents at least a step in the effort to control the growth of tissue by means of chemical compounds, and has great promise for the future.

Palliative Treatment.

In cases where there is no further hope for cure, the question of terminal care arises in the relief of the pain and an effort to make the remaining days of the patient's life as comfortable as possible. One method, of course, is large doses of drugs such as morphine, the sedatives and snake venom. These are usually taken in quantities large enough to produce relief, and no effort is usually made to retard their use for fear of developing the habit. Usually, drugs such as aspirin and codine are tried first, and the drugs are gradually increased in dosage and strength as the disease progresses.

In lesions from the pelvis down, the injection of about one cubic centimeter of absolute alcohol in the spinal canal is effective. Here the alcohol, being lighter than the spinal fluid, floats to the top and paralyzes the sensory nerves for
a period of about three to six months. In the event that the pain runs down both extremities, the procedure is repeated a few days later and the affected extremity is relieved.

Chondotomy by means of surgery interrupts the sensory nerve pathway, and the patient is relieved of his pain although the malignancy has continued to grow. This is a highly technical operation performed by only neuro-surgeons.
CHAPTER III

EMOTIONAL AND SOCIAL ASPECTS OF CARCINOMA

The problems of long term illness have been a source of increasing concern to the professional group caring for the sick. While this century has witnessed a dramatic reduction in the incidence and intensity of acute illness, there has been no comparable victory in chronic disease. Long-term illness implies a continuity of the disease but not a static condition. According to Minna Field and Bessie Schless, chronic illness involves a three stage process:

1. The acute phase, when active medical care is necessary.

2. The chronic stage, in which the patient can function in his normal environment provided he recognizes his limitations and receives continued medical and nursing supervision.

3. The custodial stage, in which the patient requires physical care with a minimal of medical attention.¹

Before further discussing the implications of the above stages of chronic disease, it is important to consider what this particular diagnosis means to this particular person at this particular time during his life. The recent trend in medicine is pointing away from the treatment of a disease and

and towards the treatment of the individual with the disease (that is, the consideration of man in his totality) and gives recognition to the interrelationship between the emotional, physical and social adjustment of the individual.

Elizabeth Rice states that social casework in a medical setting is based on sound, generic casework principles, supplemented by the additional knowledge and skills essential to the setting. The focus and tempo of medical casework are geared to the total plan for the patient in relation to the medical diagnosis and needs as indicated by the physician. The normal individual will find in illness a threatening situation and usually reacts accordingly.

The idea of disease and the individual interpretation of disease create anxiety in a person whether he is free of disease or not. People in all societies are apt to attribute the onset of disease to some higher power, such as punishment by God, or unresolved guilt feelings. In a recent study, it was noted that most patients expressed feelings of guilt with reference to cancer. "It is my fault that I have cancer, I must have done something wrong--I am ashamed to talk about it." At first, they deny their symptoms and hesitate to seek


medical attention as early as it is indicated. This feeling is peculiarly intensified in patients whose symptoms are those of cancer. 4

The Acute Stage.

The diagnosis of cancer is as difficult for the doctor to handle as it is threatening for the patient. This is because the patient looks to the medical doctor for help as a final authority, and the doctor often feels keenly his own helplessness as a medical man. This feeling of insecurity is transmitted to the patient, no matter how skillfully the doctor may handle the situation. 5

"In a state of relative health, each individual has a more or less stable system of relationships through which he depends upon certain individuals, and, in turn, lends support to certain others." 6 The patient finds himself dependent upon strangers, in a sense, for a dependent relationship must, out of necessity, be set up between the sick individual and the doctors, nurses, social worker and other medical personnel with whom he comes into contact. The placing of trust and confidence is in itself an ambivalent emotional experience, for one usually tries to consider oneself independent. Thus,

4 M. S. Rubenstein, "Do Cancer Detection Programs Cause Cancerphobia?" Current Medical Digest, Vol. XX, No. 4, April, 1953.


the occurrence of a serious illness disrupts the entire system of established relationships.

Hospitalization isolates the patient from his family, and, if it is an insecure family situation, this may set up a fear mechanism which the patient has been contemplating for some time. Separation fears, real and potential, have now become a reality to the patient and have to be handled in some way. If he is a dependent type, he may transfer his dependence from the family to the hospital staff, or he may move his interest from his family circle to the hospital family and become extremely concerned about the other patients in the ward. If a person is of an aggressive nature, he may become very demanding in the hospital situation.

It is important for the medical social worker to understand the reactions of the sick person who becomes very dependent during the acute stage, and then moves gradually back towards his normal degree of self-sufficiency. The social worker must adjust her treatment to his changing needs, and interpret his behavior to the nursing staff and to the patient's family so that they may understand his apparent passivity or hostility. It is during the acute stage that the social worker plans to observe the patient's behavior recurrently over a fairly extended period before making any judgments as to what his long-term pattern may be.

The role of the physician is a difficult one to define, for, while the patient is hospitalized, his role is not so
much that of the family friend, but rather that of the
threatening authoritative figure who makes demands on the
patient and the patient's family. The patient sees the doctor
as one who orders clinical tests that are painful and uncom-
fortable, and who may ultimately recommend an operation. At
this time, the patient may undergo castration fears. As it
is the doctor who is actually "castrating," a relationship
with the patient is set up for which he is not prepared. As
the doctor's hurried explanations and non-committal answers
sometimes confuse the patient, the social worker must often
further interpret to the patient the implications of his
disease. He needs someone with whom to discuss his future
plans. The social worker helps the patient to accept his
disease with its limitations, and encourages him to express
his feelings about his illness and the recommendations made
by the physician.

The Chronic Stage.

We find a different set of factors operating in the
next step after hospitalization, when the patient returns to
the family. The family has difficulty in adjusting to the
situation, particularly if the disease is diagnosed as
carcinoma. Each individual in the family has his own associa-
tions with the diagnosis and is threatened by its implications.
The problem of accepting the patient back into the family
group is complicated by the probability that the family cannot
accept the patient wholeheartedly because of various feelings
of guilt.

The patient is further isolated from the family by its preparation for his home care, such as a special room, special hospital bed, special medical care, or special privileges in terms of the radio and television set being placed in his room. These may be presented to the patient as a gesture on the part of the family to break the isolation of the hospitalization and open up the previous family circle for the patient. However, it is sometimes possible that these represent a way of the family's handling their guilt feelings. It is difficult for the patient, particularly the chronically ill cancer patient, to gain from the family and the original social structure the status he once had.

During this period, it is not uncommon for the physician to pay the minimal number of visits. The patient feels that he is being avoided at this time when he has a need to seek advice. Although perhaps able to be up and to participate in limited activity, he is not getting better. The doctor has only prescribed symptomatic treatment, and the patient feels he is being neglected as no active treatment is being given.

It is during this chronic stage that the medical social worker works with the members of the family group. At first, she helps familiarize them with the community resources that will lighten the medical and physical care of the patient, such as the Visiting Nurse Association, or daily
housekeeping services. Later, the social worker guides the future planning for the patient's care, which is built on the positive strengths within the family.

The Custodial Stage.

As the patient and family come to an awareness of the inevitable result of the course of the disease, the problems of "grief work" become eminent. Before this, however, the patient is faced with the desertion of the physician, who, for various reasons—time, the nature of the disease, and an inner sense of helplessness—is not constantly in attendance. There are also the overall problems associated with terminal cancer. A family with a cancer patient in residence has the strain of the physical care that the patient requires, which is often beyond the capabilities of the average family. The family, as well as the patient, undergoes grave emotional stress. Sympathy from neighbors may be antagonizing if the patient is hostile and aggressive and may intensify the family's struggle towards balance. If the patient is passive and accepting, while family members may be gratefully, they may wonder and resent the patient's apparent acquiescence.

During this stage the physician often recommends that the patient be placed in a chronic disease hospital, or in a nursing home. Although the family welcomes the recommendation, they realize that the patient will never return home, and it

is with misgivings that they let him be transferred. The social worker is often called upon to help the patient and his family in the "grief process" that precedes or follows death. As the family members reminisce about the dying or deceased person, there seems to be a rapid relief of tension. During the animated conversation in which the sick or deceased is idealized, misgivings about future adjustments are worked through.
CHAPTER IV

HOME MEDICAL SERVICE OF MASSACHUSETTS MEMORIAL HOSPITALS

General Procedure.

The Massachusetts Memorial Hospitals consist of a group of five units—for research and ward care, the Evans Memorial; for out-patient care, the Talbot Memorial; for general hospitalization, the Robinson and Collamore Memorials; and for contagious diseases, the Haynes Memorial. The original building, or the Talbot Memorial, was erected in 1876 by the Homeopathic Medical Society. It was about this time the Boston University School of Medicine was opened under the auspices of the Homeopathic physicians, and the hospital has maintained its close association with the school since. In 1885 a Nurses Training School was founded, and in 1920 the Social Service Department was established.

The need for organized social work first arose in the Eye and Orthopedic Clinics. The social worker helped the patients in obtaining material needs, such as eye glasses and braces. The dilemma of the unwed mother who came to the Pre-Natal Clinic, was the first social problem to come to the attention of the social worker, and social case work as we know it today was then initiated. Today, twelve social workers constitute the Social Service Department at the Massachusetts
Memorial Hospitals.

The Home Medical Service operates from the Out-Patient Department of the Hospital, and is a joint service offered to the community by the Hospital and Boston University School of Medicine. Calls received from persons living within a designated geographical area represent the main source of requests for medical care. Patients are also referred by social agencies and by hospitals that desire further follow-up in the homes of patients who have been discharged. These calls are received by a registered nurse who makes a preliminary evaluation of the case for the eligibility requirements.

Fourth year medical students are assigned to this service in groups of from four to six for a period of one month. These fourth year medical students, more often referred to as externs, make the first personal visit to the patient to determine the nature of the complaint, and provide medical care under the supervision of two resident physicians. Two practicing physicians who are on the medical staff of the hospital serve as preceptors. The relationship between extern and preceptor is essentially that of physician and consultant, insofar as the patient is concerned. This year, student nurses have been added to the service. They undertake nursing service to the patients as ordered by the extern, and work in cooperation with the visiting nurses, who also provide nursing services for the Home Medical Service.
Role of the Medical Social Worker.

The Home Medical Service deals with a medically indigent population, and their demands on public and private resources are a problem of considerable proportion. When an extern encounters a case in his 'practice' where a social problem interferes with the patient's medical problem, he refers it to social service. Many of these patients are referred because of the presence of multiple problems of a social, environmental, or emotional nature complicating physical illness.

Every Thursday morning there is a social service conference which all Home Medical Service personnel attend. The extern presents the medical information and the social worker the social background. The patient is then discussed from both the medical and social aspects, and suggestions are made to help in the better medical and social management of the patient.

The extern's referral of a cancer patient to social service is of utmost importance, particularly if the patient has had no previous contact with the social worker. His referral can be the first constructive step towards on-going relationships among the patient, his family and the social worker during this period of strain. If the extern is aware of the services the medical social worker is equipped to offer, he will naturally be able to make a referral that will include some interpretation to the patient of the assistance the worker can give. Thus, the medical social worker will not be
confronted with a sick person who has no idea of her function. The skillful handling of the referral will also serve as an added reassurance to the patient that the doctor and social worker are combining their efforts in his interest.

After referral, the medical social worker visits the patient in his home and evaluates the situation. Through her case work skill and knowledge of community resources, the social worker is able to help the patient. The medical doctor's recommendations for care form the basis for realistic planning with the cancer patient and his family. This medical social practice is now referred to as the teamwork approach to the patient. The social worker also recognizes the father-like role the medical doctor assumes in the eyes of many patients and the reassurance and comfort which can come from confidence that the doctor is doing all that can be done to help. Whenever possible, she fosters a good relationship between the patient, the patient's family, and the medical doctor by encouraging them to seek his advice whenever necessary. Thus, through a series of conferences, formal or informal, the social worker and the doctor in the Home Medical Service attempt to formulate satisfactory plans for the medical-social needs of the patient.

The social worker on the Home Medical Service also functions in a teaching capacity both in interpreting to the

1 Henry B. Richards, Patients Have Families, (1945), p. 212.
medical student the role of the social worker in a medical care program and in supervision of two social work students from the Boston University School of Social Work.
CHAPTER V
THE PATIENT GROUP

The following tables are presented in order to give a clearer picture of the patients included in this study. Such factors as the reason for referrals, the problems these patients present, and the general picture of the social situation indicate the type of situation in which the services of the social worker are needed.

Age and Sex.

Of the twenty-two cases studied, nine were male and thirteen were female. The number of cases examined is limited, but the findings agree with other studies that indicate that in the general population carcinoma is most often found in women.

Table I also shows the wide range in the ages of the group of patients under consideration. They range from the young adult of thirty to the eldest patient who was eighty-four. The highest incidence of the disease occurred between the ages of fifty and fifty-nine. The age of the patients had little relation to the severity of the symptoms, and the youngest patient in the group had the same prognosis as the oldest one.
TABLE I

AGE AND SEX DISTRIBUTION OF PATIENT GROUP

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 - 39</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>40 - 49</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>50 - 59</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>60 - 69</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>70 - 79</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>80 - 89</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>13</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Marital Status and Mode of Living.

The patient's marital status and his mode of living prior to the onset of carcinoma has a profound effect upon the medical social plan. As seen in Table II, the majority of these patients were living with their respective husbands or wives.

TABLE II

MODE OF LIVING

<table>
<thead>
<tr>
<th>Mode of Living</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Spouse and Children</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Alone</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>13</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
Two-thirds of the male patients and all but one of the female patients were married. The one exception was a widow. It is interesting to note that none of the patients were separated or divorced.

Source of Income.

Sixteen of the patients included in this study were receiving public assistance. The incapacitating effect of the disease and the fact that the patients served by the Home Medical Service are of the low marginal income group would account for the fact that the majority of these patients were receiving public assistance. The income of those patients who were self-supporting was barely sufficient to meet their needs, so the threat of illness was a definite threat to their financial security.

TABLE III

SOURCE OF INCOME OF PATIENTS

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Supporting</td>
<td>6</td>
</tr>
<tr>
<td>Old Age Assistance</td>
<td>9</td>
</tr>
<tr>
<td>Aid to Dependent Children</td>
<td>2</td>
</tr>
<tr>
<td>General Relief</td>
<td>4</td>
</tr>
<tr>
<td>Disability Assistance</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
Sources of Referral.

Twenty-one of the twenty-two patients were referred by a medical source.

TABLE IV

SOURCES OF REFERRAL OF PATIENTS TO SOCIAL SERVICE

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Medical Service Physician</td>
<td>16</td>
</tr>
<tr>
<td>Visiting Nurse Association</td>
<td>2</td>
</tr>
<tr>
<td>Family Society</td>
<td>1</td>
</tr>
<tr>
<td>Massachusetts Memorial Hospital Tumor Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Boston City Hospital, Social Service</td>
<td>1</td>
</tr>
<tr>
<td>Massachusetts Memorial Hospital Chaplain</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

The majority of these patients were referred by the externs on the Home Medical Service who, in the course of medical treatment, were aware of the social and emotional implications of this disease. Other departments of the hospital were responsible for two referrals.
Eight of the twenty-two cases were referred to social service for social examination. The term "social examination" indicates a social and medical evaluation of the present situation. Five of the eight were referred by outside social agencies for information, two by the externs, as help was needed to plan for those in the home. One was referred by the hospital minister, as he knew the other members of the family.

Of the three referred for nursing home care, only one was admitted to a nursing home. The others were admitted to a general hospital in acute distress, or died at home before plans could be arranged. The same situation occurred in four of the six referred for chronic hospitalization. One patient referred for chronic hospitalization went to a nursing home at her request instead of a chronic hospital.
One of the four referred because of resistance to medical care failed to follow the doctor's recommendation; the other three received medical care and the diagnosis was confirmed.

### TABLE VI

**AGENCIES CONTACTED DURING STUDY**

<table>
<thead>
<tr>
<th>Agencies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Welfare</td>
<td>12</td>
</tr>
<tr>
<td>Medical Agencies</td>
<td>19</td>
</tr>
<tr>
<td>Family Agencies</td>
<td>3</td>
</tr>
<tr>
<td>Church</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

Several outside agencies were contacted by the social worker. The medically indigent population served by the Home Medical Service would account for the close working relationship between the medical social worker and the social workers from the Public Welfare Departments.

Table VII illustrates at which stage of cancer the patient was referred to the Home Medical Service, and at which stage the patient was referred to social service.

In every case, the patient in the acute stage was referred immediately to social service. Only one half of the
TABLE VII

STAGE OF REFERRAL

<table>
<thead>
<tr>
<th>Stage of Referral</th>
<th>Home Medical Service</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Chronic</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Custodial</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

cases seen by the Home Medical Service in the chronic stage were referred to social service. Once the patient reached the custodial stage, the referral to social service appeared to be automatic. Thirteen of the cases referred were known to social service for the short period of one month. Only three cases were known over a six month period.

The services rendered to the medical social needs of the patient group fall into four areas: physical care, financial matters, emotional needs of the patient, and support given to the patient's family. Although the reason for referral was usually a specific need, the problems revealed to the social worker in a casework relationship indicated that the patient could benefit from other services. A total of fifty-six services were offered by social service
TABLE VIII

SERVICES RENDERED TO THE MEDICAL SOCIAL NEEDS OF THE PATIENT GROUP

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to Physical Care</td>
<td></td>
</tr>
<tr>
<td>Medical Follow-Up</td>
<td>10</td>
</tr>
<tr>
<td>Nursing Home Placement</td>
<td></td>
</tr>
<tr>
<td>Chronic Hospitalization</td>
<td></td>
</tr>
<tr>
<td>Transportation Arrangements</td>
<td></td>
</tr>
<tr>
<td>Related to Financial Matters</td>
<td>7</td>
</tr>
<tr>
<td>Referral to Public Welfare</td>
<td></td>
</tr>
<tr>
<td>Social Service Relief Fund</td>
<td></td>
</tr>
<tr>
<td>Related to Emotional Needs</td>
<td>19</td>
</tr>
<tr>
<td>Interpretation to Patient Regarding Their Medical Condition</td>
<td>4</td>
</tr>
<tr>
<td>Supportive Casework Therapy</td>
<td></td>
</tr>
<tr>
<td>Related to the Needs of the Patient's Family</td>
<td>20</td>
</tr>
<tr>
<td>Aid in Planning</td>
<td></td>
</tr>
<tr>
<td>Supportive Casework Therapy</td>
<td></td>
</tr>
<tr>
<td>Interpretation Re: Medical Condition</td>
<td></td>
</tr>
<tr>
<td>Referral to an Outside Agency</td>
<td></td>
</tr>
<tr>
<td>Total Services</td>
<td>56</td>
</tr>
</tbody>
</table>

to the patients; ten to help arrange for physical care; seven to help in financial problems, five referred to Public Welfare and two to the Social Service Relief Fund; nineteen to help with emotional problems of the patient; and twenty to help the family care and plan for the patient.
CHAPTER VI

CASE PRESENTATIONS

A study of the patient group revealed that the cases fell into two groups, those in which the prognosis was good and those in which the prognosis was poor. The following case presentations show the problems these patients had in relation to their illness and how their needs were met through the activity of the social worker. The cases selected for presentation are representative of the group. The first case is one in which the prognosis was good, and four other patients fall into this category. The other three cases represent the remainder of the cases, in which the prognosis was unfavorable.

CASE I

Mrs. X was referred to social service in June, 1950, by a physician, as she was resisting medical care and needed assistance in planning hospital admission.

The patient was a sixty-five year old, married woman who was seen regularly at the Massachusetts Memorial Hospitals Out-Patient Clinics. Her main complaint was bleeding post-menopause. In June, the doctors in the Gynecology Clinic recommended minor surgery and it was performed in July. At this time the diagnosis of adenocarcinoma of the endometrium was made. In September of the same year, the patient had a total hysterectomy. The patient's husband is carcinomatosis, primary site unknown, in
the advanced terminal stage. To date the patient is living and symptom free.

Mr. and Mrs. X live alone in a three room, second floor apartment. Both are supported by Public Welfare. Mr. X, seventy-nine years old, is receiving Old Age Assistance and Mrs. X is on General Relief. They have been married over forty years, but have no children. Mr. X had been a copper finisher most of his working life; however, it was often necessary for Mrs. X to work to supplement his income. Mrs. X appeared to be the more dominant figure in the marriage.

At the time of the referral Mrs. X was resistant to the medical care recommended by the doctor because of her husband’s serious medical condition. The patient gave him the constant nursing care he required. She was especially upset about Mr. X’s condition, as a neighbor had recently told her that she heard from a doctor that Mr. X would die any minute. The social worker pointed out that it is not customary for a doctor to discuss a patient with anyone except the next of kin. At this time, the worker learned that Mr. X was not receiving active medical care and that Mrs. X thought his diagnosis was a serious heart condition. The worker referred the patient’s husband to the Home Medical Service after which Mrs. X was able to discuss tentative plans for hospitalization. Before leaving, she agreed to talk her situation over with her husband and to phone the worker when she decided to come into the hospital. A home visit was made and Mr. X attempted to block and resist the tentative plans, until the social worker explained the need for them. He then insisted that Mrs. X come into the hospital, even when the patient tried to postpone the date because her symptoms had disappeared. Arrangements were made for Mrs. X’s sister to care for Mr. X, and the worker agreed to phone each day via a neighbor to learn how Mr. X was getting along.

While Mrs. X was in the hospital for surgery, Mr. X took a turn for the worse and the Home Medical Service doctor recommended hospitalization in a general hospital. This upset Mrs. X, who wanted to leave immediately. The social worker visited Mr. X and learned that his condition had improved, so she was able to reassure Mrs. X. At this time the patient was referred for Disability Assistance.
In September, extensive surgery was recommended for the patient, who was again faced with the same problem of care for her husband. The Home Medical Service referred Mr. X for nursing home care during Mrs. X's hospitalization. In cooperation with Mrs. X and the Old Age Assistance worker, Mr. X was placed in a nursing home. Mrs. X, when confronted with the plans, seemed to meet the situation extremely well, though understandably upset. Her chief concern upon her hospitalization was that she be kept informed about her husband's condition. She confided to the worker that she had planned her husband's burial should he die while she was in the hospital. She seemed completely aware of the terminal nature of his illness. Mr. X died during the patient's hospitalization, and supportive help was given at this time. After the patient's discharge, the case was followed by the gynecology clinic.

Interpretation. This case is unusual as both the husband and wife had cancer. The wife required immediate medical attention if the natural progress of the disease was to be prevented, while the husband's need could only be met by palliative medical treatment.

The social worker allowed the patient to discuss her problems freely by developing a relationship with a warm, sustaining interest. At times, she helped Mrs. X focus her attention on pertinent topics relating to her illness and the problem of her husband's care. Mr. X's manner indicated that he might prove difficult to handle and that he might block plans for Mrs. X's treatment. The social worker, therefore, focused her attention on him in order to gain his confidence and cooperation. After Mrs. X's need for medical treatment had been fully explained, he readily insisted that she be cared for immediately.
It was difficult for Mrs. X to accept the seriousness of her own condition, as she worried about her husband's health and care. Her concern resulted in a denial of her symptoms. With the help of the social worker, the patient was able to follow through a plan which involved separation from the patient upon whom he was very dependent. The social worker, besides giving support to both Mr. and Mrs. X, contacted agencies and other resources in making the physical arrangements necessary for treatment to take place.

The following cases are representative of situations in which the social worker helped the patient and the family face and solve the problems of terminal care and the adjustments that follow.

CASE II

Mrs. B was a forty year old woman who was referred to social service in January, 1952, by the extern on the Home Medical Service. The patient's condition was diagnosed as carcinoma of the right breast. The patient had had a radical mastectomy in October, 1950, with no immediate follow-up treatment. The patient stated that she felt reasonably well until December, 1951, when she telephoned the Home Medical Service. At this time she complained of knife-like shooting pains which began in her left shoulder and radiated down her arm to her left hip. X-rays revealed that the patient had metastasis of the cervical spine and lungs. Symptomatic treatment was offered by the Home Medical Service.

Mrs. B was referred to social service for assistance in planning for terminal care in a chronic hospital. Mrs. B had been married for about ten years, and had a seven year old daughter to whom
both Mr. and Mrs. B were very devoted. Mr. B was not well, and had remained at home to care for his wife and daughter. The family was supported by irregular contributions from Mr. B's mother. He had previously been employed as a laborer, but his workmen's compensation had recently stopped. The patient's sister, Mrs. F, was interested in the family, but, due to her own family problems, did not want to become too involved. Mrs. F had contacted a private family agency, which had referred Mrs. B to the Home Medical Service. A case worker from that agency continued to see the patient, and worked with the social worker on the Home Medical Service in formulating a plan for the patient's care in a chronic hospital.

The social worker from the Home Medical Service found the patient an emaciated woman in great distress. She did not know her diagnosis or prognosis, and referred to her illness as a nervous breakdown. She expressed concern about her financial status and her husband's medical condition, which she understood was cancer. The social worker arranged for the family's application to be taken for Aid to Dependent Children, and in February the family received some help. A referral was made to the Visiting Nurses Association to help Mr. B to care for the patient, and housekeeping services were provided when necessary.

The medical social worker focused her attention on helping the patient's husband plan for the future. At first, he resisted any suggestion that his wife be hospitalized. As her condition grew more serious, however, and the burden of care increased, he was able to request the social worker's assistance in arranging for the patient's admission to a chronic hospital. She died there in March, one month after her admission.

After Mrs. B died, Mr. B did not visit the social worker, as he feared she would take his child away from him. Mrs. F, his sister-in-law, finally requested that the social worker contact him, as she was worried about his physical condition. Mr. B and his daughter were temporarily residing in Beverly, an outlying town, with his family, and he requested help in planning for the care of his daughter. Summer camp for a two week period was arranged. He expressed his fear of diagnostic tests to the social worker, but was able to continue
visits to a clinic of the Massachusetts Memorial Hospitals. His condition was diagnosed as seminoma of the right testical. In September, his physical condition had improved, and Mr. B requested permission to return to work. Permission was granted.

Interpretation.

The interagency cooperation involved in this case demonstrates the advantages of teamwork. One agency called in another when it could no longer meet the need, and yet continued to take an active interest and shared the responsibility in areas where it could help.

The reactions that the patient displayed during her terminal illness are of particular interest. She spoke of being rejected by the doctors, which is a common feeling of a cancer patient, as the doctor's visits are limited and no actual treatment is given. Throughout the initial interview she referred to her illness as a "nervous breakdown," denying any cancer, although she was able to refer to her husband's condition as cancer. The worker did not try to break down the patient's defenses because of her poor prognosis.

As the worker from the original agency continued to see Mrs. B, it was possible for the Home Medical Service worker to concentrate on the family. The social worker first focused on alleviating the immediate reality problems, then gave the immediate family and relatives support during a trying period for them. She clarified medical information, interpreted the need for Mrs. B's hospitalization, and
helped Mr. B work through his feelings about Mrs. B's leaving home. Then, through her relationship with Mr. B, the social worker was able to help him accept medical care for himself by letting him express his fears regarding diagnostic studies, and interpreting the need for them. In this case, both Mr. and Mrs. B had strength that seemed to rally at the time of a crisis and they were able to participate in plans that were recommended by the medical profession.

It is important to note that the worker initiated further contact with Mr. B after the patient's death. A stigma commonly attached to the social worker, namely that of removing children from the home, threatened Mr. B's relationship with the worker. The worker encouraged Mr. B to seek further medical attention, and together they worked out a summer camp arrangement for his daughter. The worker in this case seemed very much aware of the help she could give in preventing further social breakdown by constructive use of social agencies in the community.

CASE III

Mrs. W was referred to the Home Medical Service by The Family Society and to Social Service by the extern visiting her in December, 1949. The doctor recommended terminal care in an institution.

The patient was a fifty year old, married woman whose medical condition was diagnosed as carcinoma of the cervix in April, 1948, at which time she received thirty radium treatments at a general hospital. In November, 1948, a colostomy
was performed. The following May the patient went to a chronic disease home, presumably for terminal care, but returned home in the fall. The patient, who was in the terminal stages of the disease, received symptomatic treatment by the Home Medical Service and it was necessary to prescribe narcotic medication. She was not ambulatory and did not know her diagnosis.

Mr. and Mrs. W were married over thirty years and were the parents of two daughters. In 1940, the youngest and favorite daughter was killed in an automobile accident; following this, the patient suffered a seven year period of mental depression. The other daughter had married and was in contact with the family. The W's lived in a two room apartment on the fourth floor, but the bathroom facilities were on the floor below. Mr. W had been able to support his family adequately until Mrs. W's illness, when he stopped working to care for her. At the time of the referral, the W's were receiving General Relief, supplemented by five dollars a week from the Family Society. The W's were first known to the Family Society when Mr. W requested help in securing a housekeeper to help him care for his wife following her hospitalization at a general hospital. In the spring of 1949, the patient was sent to a chronic disease home, where Mr. W secured employment as he wanted to be near to his wife. The husband-wife relationship was one of unusual devotion. The patient left the home as her husband did not think that she was getting treatment there. From the medical viewpoint, chronic hospitalization was a necessity; however, there were obstacles in the way of this plan. The patient's husband felt that his wife would not go to a hospital unless he could work there and be with her more or less continuously. A chronic disease hospital was suggested to Mr. W as a possible placement, but he objected because Mrs. W did not know her diagnosis but did know the nature of this hospital. The social worker felt that the patient did know the nature of her disease. The social worker arranged a conference with Mr. W with the doctor in charge of the Home Medical Service to explain further the implications of cancer. Through a series of interviews with the patient's husband, he was able to express more and more freely the difficulties he was having caring for the patient. A nursing home was found that was acceptable to Mr. W, and he requested that the patient be moved there.
immediately (January 4, 1950). She remained there until she died on April 10, 1950. From the time she was admitted, Mr. W continued to see the social worker for supportive help while he was separated from the patient. Eventually, he was able, with the help of the worker, to secure a job.

**Interpretation.**

This case illustrates the joint planning of two social agencies for the benefit of the patient. The problem of financial insecurity was alleviated by referral to Public Assistance and bedside nursing care was arranged through the Visiting Nurses Association. The Family Society social worker helped the patient accept the limitations of her illness, while the medical social worker worked with the patient's husband in the area of medical planning for the terminal care of his wife. The social worker did not push the patient's husband to accept chronic hospital care, but rather gave him a realistic picture of what resources were available, based on the doctor's recommendations, and the assurance that she was interested in helping him carry through whatever plan he deemed acceptable. The difficulty in finding terminal care placement was complicated by Mr. W's insistence that Mrs. W did not know her diagnosis and his objection to chronic hospitalization. Mr. W was not threatened by the physical aspects of the disease (exposure to unpleasant sights, sounds, and odors and the intimate awareness of another's pain), as is clearly shown by his desire to work and be near his wife continuously until her eventual death.
However, this desire may also be interpreted as a strong dependent need, as the fear of separation appeared to be too threatening for him to face. At that time, the social worker endeavored to assure Mr. W of her continued interest and support, and arranged a conference with the doctor, who helped him accept and view his wife's condition realistically. The social worker helped Mr. W work through his feelings in regard to separation from his wife, so that eventually he was able to do some constructive planning regarding his own future.

CASE IV

Mrs. A, a sixty-year old married woman, was referred to social service in March, 1952, by a physician in the tumor clinic, for assistance in planning for terminal care. Until admission to another hospital could be arranged, the patient was seen by the Home Medical Service.

Mrs. A had been admitted to a general hospital in January, 1951, where a simple mastectomy was performed the next day for adenocarcinoma of the breast. Fourteen months later the patient was seen at a Massachusetts Memorial Hospitals clinic for symptoms of advanced carcinoma, complicated by the accumulation of fluid in the chest. At this time, the disease was presumed to be incurable, and symptomatic treatment and chronic hospitalization were advised.

Mrs. A and her husband had been living in a six-room apartment in the South End for three years. Prior to this they lived about thirty miles outside of Boston. Mr. A had been unemployed for thirty years because of his severe asthma condition; consequently, the patient had supported them on her weekly salary as a bookkeeper until her retirement in 1949. At one time, Mr. A fixed electrical appliances in his own shop, but for thirty years had devoted his
time to his hobby, photography, with no effort to make it financially profitable. Occasionally, Mr. A's eighty-nine year old mother would send him a little money. Mrs. A. is an Old Age Recipient, but claims her husband is too proud to apply for General Relief. The patient appears to be the dominant, responsible person in the marriage.

The patient did not know her diagnosis, but worried about the physical manifestations of the disease, loss of weight, cough, and so forth; however, she optimistically believed that she would "trip the light fantastic" soon. The patient and patient's husband participated in the original planning for hospitalization, but Mr. A heard from an outside source that the hospital was a place for "incurables." He resented the implication of the plan, and requested admission to a general hospital. It appeared at this time that Mr. A was in doubt as to the condition of his wife, so a conference was arranged between him and the doctor at the tumor clinic. The patient was willing to go to the chronic hospital, as she was very uncomfortable at home, and was admitted there on March 31, 1952.

After the patient was admitted to the hospital, the social worker continued to see Mr. A. She helped him apply for General Relief when his funds were gone, and supported him in his decision to move as the apartment was too expensive for him. Mr. A insisted on obtaining an apartment large enough for the two of them, even though it was financially impractical, as he felt that Mrs. A. would return in spite of the conferences with the doctors in which they indicated she would not be well enough to return home. As the social worker was leaving she referred the case to the social worker at the hospital where patient was, as she felt that Mr. A would need help at the time of Mrs. A's death.

Interpretation.

Despite the patient's outer appearance of optimism, the medical social worker recognized that the patient might be finding it difficult to face re-hospitalization, and offered the support, warmth and encouragement she needed. Because of
the patient's poor condition, she welcomed chronic hospitalization despite her husband's objection to the implications.

Throughout the case, the worker's role with the patient's husband was one of encouragement and support. She recognized that this man had a great need to lean on someone during a time of stress, and the worker managed to fulfill this need. She helped him handle his anxiety about accepting financial assistance. Later, the worker encouraged him to see the doctor, despite his fear regarding the news.

After Mrs. A was transferred to a chronic disease hospital, the worker maintained her supportive role with Mr. A. At this time, she handled some of Mr. A's anticipated grief feelings. Mr. A had the opportunity to discuss his future plans with her and to talk about his feelings in regard to his wife's illness. The social worker supported his plan for a larger apartment than necessary, even though she knew it was impractical. This was a further indication to him of her continued interest in his situation.

It is interesting to note in these cases that, although the social worker helped formulate plans, she did not urge or push when the patient or family was reluctant, but rather accepted and respected their feelings about chronic care and hospitalization.
CHAPTER VII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary.

This study has been directed towards an understanding of the patient with carcinoma and how it affects his family. The problems that both the patient and his family encounter after the diagnosis has been made form the crux of this study. Twenty-two medical and social service records of the Home Medical Service at the Massachusetts Memorial Hospitals were studied. The study of these cases was guided by an attempt to answer the questions posed in the introductory chapter.

1. What were the particular problems that were the basis for the referral of these patients to the social worker?

2. What were the additional problems these cancer patients and their families faced?

3. How did the social worker try to aid the cancer patient in working through a plan for medical care?

4. In what ways was the teamwork approach used in helping the patient in planning medical care?

This study disclosed that the referrals to social service were made by people in a medical setting in all but one of the twenty-two cases. Most of the referrals were made with recommendations concerning specific arrangements deemed
necessary to facilitate the patient's following medical recommendations. The physical set-up of the Home Medical Service is unique in that the doctors and social workers have their offices next to each other, thus making it easier to work as a team in planning medical care for the patient. The recommendations of the physician are discussed in conferences with him before medical care for the patient materializes.

A study of the recorded material regarding the twenty-two patients reveals the presence of medical social problems. There are evidences of problems relating to physical care, financial assistance, emotional problems of the patient and those of the patient's family. The general nature of the problems around physical care are related to convalescent, nursing, or terminal care. Although the brevity of the available records does not permit a complete evaluation of the emotional problems of the patient, the recurrent problems seem to be desertion by the doctor, fears regarding the course of his disease, and the family interpersonal relationships. The family problems generally center around separation from their loved ones as they plan for terminal care placement and death.

Conclusions.

The consideration of the social and emotional implications of carcinoma and a study of the social service records on twenty-two carcinoma patients reveal that patients with this disease are frequently subject to many physical,
environmental, and emotional stresses during the course of their illness. The nature of the disease and the radical procedures usually involved in adequate treatment contribute to the many and varied social and emotional needs of patients with cancer.

Patients with cancer need adequate facilities for diagnosis, treatment and care. Frequently, they need hospitalization for the purpose of early diagnosis, as well as active and palliative treatment. In all cases, medical supervision and follow-up care are indicated which involve plans for special care at home or in a nursing home following discharge from the hospital. The needs for physical attention of those patients whose condition is untreatable range from nursing care in the home to placement in a chronic disease hospital.

Carcinoma is an incapacitating disease and one whose treatment and care are very expensive. Therefore, it is not surprising that carcinoma patients are confronted with financial problems.

A multitude of emotions are precipitated by any illness and treatment procedure. Like patients with other chronic diseases, carcinoma patients may have anxieties about subsistence for themselves and their dependents. In addition, the patient with cancer faces other threatening possibilities. To the patient an abrupt and painful death is a real possibility, and the patient frequently is besieged by many fears (some rooted in reality factors of the nature of the disease...
and of its treatment, and others partially rooted in ignorance of the nature and treatability of the disease) is faced with the necessity for making many personal adjustments.

Adequate treatment and care for a carcinoma patient can be effected by the patient's family responsibilities and by attitudes of members of the family towards him and his illness and their understanding of the illness. Just as carcinoma frequently presents many threatening aspects for the patient and at the same time requires his making many personal adjustments, the patient's family is undergoing a similar situation and at the same time the need arises for them to assume additional responsibilities and make certain adjustments.

The social worker in a medical setting employs generic casework principles, and meets the patient and his family where they are in regards to future medical care planning. The social worker did not force her plans on the patient or his family, but supported their suggestions and encouraged them to take the initiative whenever possible. This study points out that the environmental problems were the predominate pressing ones and that the emotional problems were the underlying ones. Recommendations.

The problems revealed by this study indicate that the problems do not terminate when the patient dies. This writer recommends that the social worker be aware of this fact and makes some provisions for the patient's family to get continued
case work service until they have fully adjusted to the loss of their loved one.

Approved:

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Dean
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