Medical social work in the clinic and ward settings of a general hospital: a study of the medical social problems and the related social services in twenty-five medical clinic cases as compared with twenty-five medical ward cases at the Beth Israel Hospital /

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MEDICAL SOCIAL WORK IN THE CLINIC AND WARD
SETTINGS OF A GENERAL HOSPITAL

A STUDY OF THE MEDICAL SOCIAL PROBLEMS
AND THE RELATED SOCIAL SERVICES IN
TWENTY-FIVE MEDICAL CLINIC CASES AS
COMPAARED WITH TWENTY-FIVE MEDICAL WARD
CASES AT THE BETH ISRAEL HOSPITAL

A Thesis

Submitted by
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PREFACE

The writers wish to acknowledge their appreciation to Mrs. Bess Dana, Director of the Social Service Department at the Beth Israel Hospital, for her help and encouragement in stimulating the research for this study.

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CHAPTER I

INTRODUCTION

In his discussion of "The Biodynamic Point of View in Medicine", Dr. H.M. Margolis describes disease as "...the reaction of the organism as a whole to external and internal energy impacts disturbing its equilibrium so seriously that the organism exhausts its capacity for adaptation."¹ Dr. Margolis offers the theory that

The inherent tendency of the individual, as of any living organism when under stress, is to move toward re-establishing a state of equilibrium and health. Naturally the ruggedness and capacity of different individuals to re-establish equilibrium vary. The patient's elasticity is determined by his heredity and his previous life experiences. It varies, too, with the force of the stress and the conditions under which he is exposed to it. And yet, the wonder, literally, is not that the human organism fails to rebound, but that, so often it does. The capacity for adaptation by the human organism seems almost infinite.²

Illness often constitutes a situation of severe stress for the individual. This stress may reflect itself in many or all of the patient's life adjustments. The patient may be striving, as Dr. Margolis suggests, towards a re-establishment of his capacities for maintaining himself as a self-sufficient individual, even in the face of physical and emotional obstacles encountered in illness. The medical social worker can provide invaluable assistance to the patient in his attempts to adjust to the situation of illness. The medical social worker then serves as an important helping link for the patient between the disabling experience of being ill

² Ibid., p. 6
and the process of his striving to regain his physical, emotional and social equilibrium.

**Purpose of the Study**

The purpose of this study is to examine and compare medical-social problems and related social casework services in the Medical Clinic and on the Medical Ward. The writers will attempt to answer the following questions:

1. Who are the patients coming to the Medical Clinic and the Medical Ward? How and for what reasons are they referred to the Social Service Department?

2. What principal medical-social problems do these patients present? How do the types of problems differ in the two settings?

3. Are there elements in each setting which influence the types of problems which come to the attention of the medical social worker?

4. What are the kinds of casework services offered the patients in each setting in relation to the principal medical-social problems? How do the clinic and ward groups studied compare in terms of the specific casework services?

5. How do the different settings influence the medical social worker's use of community resources to meet the patients' needs?

6. What kind of contact does the medical social worker have with the families of patients in each setting?

**Sources and Scope of Data**

This study is based on an analysis of fifty cases known to the social worker, twenty-five from the Medical Clinic and twenty-five from the Medi-
cal Ward of the Beth Israel Hospital. The period covered was the year 1950. The social workers' monthly statistics provided the names of patients referred to Social Service during this period. An attempt was made to use the records of the first twenty-five patients referred to the Social Service Department from each setting during the year 1950, but this was necessarily conditioned by the availability of the records and also by the suitability of the method of case recording for the purposes of research.

Method of Procedure

In order to analyze the cases, a schedule was devised. See Appendix for a copy of the schedule. Tables will be used for study of the statistical data of the total clinic and ward groups, which will prove helpful in drawing conclusions and making comparisons.

The cases in each group will then be categorized according to the principal medical-social problems as seen by the medical social worker with reference to the reason for referral and her diagnostic evaluation of the patient's total needs. Case studies and interpretations with relation to the questions raised in this study will be given for each category of principal medical-social problems in both the clinic and ward groups of cases.

Two writers have undertaken this study in order to examine a larger number of cases from the clinic and ward. Miss Dragon will present the data on the clinic study and Mrs. Berliner will present the data on the ward study. Conclusions and comparisons will be undertaken jointly.

Limitations

The conclusions drawn from this study will be conditioned by the lim-
ited number of cases used. This then presents only a fragmentary picture of social service in the clinic and on the ward of Beth Israel Hospital. Most of the records available for this study were recorded in summarized form, which necessitated some subjective interpretation on the part of the writers with regard to the questions raised in this study.
CHAPTER II
BACKGROUND OF STUDY

History of the Beth Israel Hospital

The Beth Israel is a voluntary, acute general hospital, with depart-
ments of general medicine, surgery, obstetrics, pediatrics, and psychiatry,
each service having its own ward beds, with the exception of psychiatry.
There is also an Out-Patient Department comprised of thirty-two different clinics.

The hospital had its start as the Mount Sinai Hospital Out-Patient Clinic, opened in 1902 in a converted five-room store on Chamber Street in the West End of Boston. This was the beginning of "a far-sighted dream and dedicated to the principle of service to the sick and the poor among us".5

One year later, because of the overcrowded conditions, the Mount Sinai Out-Patient Department was transferred from Chamber Street to 17 Staniford Street, and officially opened its doors at this new location on November 23, 1903. An important medical activity at Staniford Street, and first begun in 1908, was an obstetrical service under the direction of Dr. Alonzo K. Paine. A home delivery service, as part of the medical teaching program of Tufts College Medical School, was carried on by externs radiating out of the Mount Sinai Dispensary.


4 The Hospital Story. Unpublished mimeographed pamphlet, The Beth Israel Hospital.

5 Ibid., p. 1.
Both the increased use of the facilities of the Dispensary and the lack of room, as well as of equipment, served to emphasize the need for further expansion. Therefore, in 1915, an old estate at 45 Townsend Street, Roxbury, was purchased and converted into a forty-five bed hospital which included X-ray and laboratory facilities, operating rooms, etc. This location eventually became the site of the present Jewish Memorial Hospital for the chronically ill.

As it became apparent that the facilities at this hospital were too limited for the needs and the demands of the community, a group of public spirited citizens launched a campaign in 1923, setting a goal of one million dollars, to build a modern hospital, in order to provide more beds, as well as for the creation of teaching facilities. During the building process, the proposed buildings were enlarged, a large Out-Patient Department was constructed, and a Nursing Home was erected, the new Beth Israel Hospital being dedicated on August 1, 1928. Arrangements were immediately developed with both the Harvard and Tufts Medical Schools for important teaching affiliations. The original buildings housed the medical and surgical services and in 1950 new buildings were erected to house the obstetrical and pediatric services and a research unit.

The Beth Israel Hospital today is a member agency of the Associated Jewish Philanthropies from which it derives a large amount of financial support. Support is also gained from generous endowments and from the devoted volunteer work of the Beth Israel Hospital Ladies Auxiliary, which have made it possible for the hospital to continue to practice its belief in the principle of service to the sick and poor, as proven in the large amount of free care given both to clinic and ward patients. Of a total of
370 beds, 125 are ward beds. In the year 1950-51 almost two-thirds of all ward care was given free. In the Out-Patient Department during that year eighty-five per cent of the cost of clinic visits made by patients was borne by the hospital.

The Beth Israel Hospital engages in a broad general program of medical care to patients, research, teaching, and preventive medicine. In its teaching program the Beth Israel Hospital is affiliated with the Harvard and Tufts Medical Schools, as well as the Simmons, Boston College, and Boston University Schools of Social Work. Each year the hospital trains an average of one hundred student nurses, forty-eight internes and residents, eleven dietary students, twelve X-ray, laboratory and dental technicians, and five or six social service students. In addition to this work, full-time research in medicine, surgery and preventive medicine is carried on continuously. The Out-Patient Department serves as an important instrument of preventive medicine through its diagnostic facilities. It is felt that progress has been made in educating the public to the importance of prevention of disease. It is hoped that eventually the hospital will be able to sponsor a Home Care Program which will be particularly adapted to the needs of older people in coping with the problem of care for the chronically ill.

The Social Service Department

The Social Service Department of the Beth Israel Hospital originated

6 Orientation lecture to social work students by Mrs. Bess Dana, Director, Social Service Department, Sept. 1952.

7 Annual Report of the Social Service Department of the Beth Israel Hospital, October 1, 1950 - September 30, 1951.
with the establishment of the hospital on Brookline Avenue, in 1928. It was included in the original planning of the new hospital, in recognition of social service as a trained discipline in medical care. From the start it was required that personnel of the department be trained social workers.

Starting on a small scale, the Social Service Department has increased to meet the growing needs of the hospital. There are now the director, a full-time casework supervisor, a part-time supervisor, nine caseworkers, a case aide, and secretarial staff. A system of senior and junior workers was begun several years ago, as it became evident that certain complex situations in a medical setting required more experienced workers than did others. In addition to casework responsibilities, senior workers also supervise junior workers and students.

As with all disciplines within the hospital, the main focus of the Social Service Department is the care of the patient. In addition, it participates in the other functions of the hospital, of teaching and research. Social work students of Simmons and Boston University are trained in the Department, and staff members also participate in teaching the social components of medicine to students of medicine, nursing, dietetics, etc.

Since the Beth Israel Hospital is a member agency of the Associated Jewish Philanthropies, all referrals of Jewish Family and Children's Service (another member agency) clients are made through the Social Service Department. There is a close exchange of information between the agencies in these cooperative cases, and a medical-social evaluation is sent to the Jewish Family and Children's Service by the Social Service Department.

Since the Social Service Department has always been an important part of the hospital, the medical staff has, by experience, developed an under-
standing of the use of the social worker in a medical setting, and the caseworker functions as a respected member of the hospital team dedicated to the physical and emotional health of the patient. This cooperative endeavor has been inspired by the philosophy held by the staff of the hospital of treating the patient as a whole.

The medical staff at the Beth Israel Hospital recognizes the role of the social worker in treating the patient as a whole, by helping the patient to achieve a more satisfying adjustment to a situation in which the problem of illness is the paramount one.
CHAPTER III
THE SETTINGS

This chapter will be concerned with a discussion and comparison of the clinic and ward in terms of the meaning of the particular setting to the patient and the referral process to the Social Service Department in each setting. There will also be a discussion of the function and practice of the medical social worker, with some reference to the effects of the clinic and ward setting on the areas of the social worker's activity.

The Ward

What does it mean to be on a ward in a hospital?

"The patient is directly affected by the authority in the medical setting....Hospitalization is regimentation. The patient is expected to conform and even to relinquish control over his own destiny".8

When a patient is admitted to a hospital, his clothes are taken from him, he is placed in a bed, and becomes one of many patients. He is separated from his family and friends. His usual mode of life is interrupted. He is virtually denied his normal responsibilities, and comes to an almost child-like level of performance.

The emotional ingredients of fear, pain, anxiety, guilt, shame, and related feelings which form the variable emotional components in illness tend to isolate the sick person. His perceptions turn inward on his various ailing organs, and he feels others cannot understand or accept what he is experiencing.9


Hospitalization means placing oneself in the hands of others, being rather helpless and dependent. At the beginning of a period of hospitalization there is active interest in the patient. He is asked many questions, has multitudes of tests, X-rays, and the like. Many members of the hospital staff come to see him. Then this dies down. Consultations are held, his case is discussed; but in none of this can the patient participate.

...the patient is expected to acquiesce, not to offer suggestions or to ask questions. This is implied by the fact that he is not being consulted and by the evasive attitude maintained by the hospital staff. The patient has his own theories of what is the matter and what would help him. He is under acute stress of physical discomfort and anxiety. At the same time, he is aware of the requirement that he be a good patient. The amount of inner disturbance will depend upon the degree to which the patient's theories differ from the hospital's activities. His own theories which he cannot express may erect a wall that excludes a view of the usefulness to him of the hospital's activities.10

When the time comes for discharge, again it is the doctor who makes the decision, who indicates to the patient when he may leave. However, the patient may not feel ready to leave. He may feel he is being put out, is not worth helping. He has come to depend on the hospital, and may have fears that he is not well enough to leave, and that he cannot receive adequate care elsewhere. He may have fears of temporary or permanent disabilities, or changes in his former way of living. He may be torn between a desire to remain dependent on the hospital, and his eagerness to return to a more responsible, independent pattern of living.

The Clinic

What does it mean to attend a clinic? The patient coming to a clinic comes of his own choice. He may have symptoms such as headaches, backaches, or intestinal disorder, which have been troubling him and from which he seeks relief. The clinic is a diagnostic center. He hopes that he may only need some pills or simple remedy to relieve his discomfort. On the other hand, he may fear that something is seriously wrong with him, and hates to have to face this possibility. When he comes to the clinic for the first time, he has to be interviewed by the Admitting Officer to determine his eligibility for low cost clinic care.

The patient who must seek his medical care in a clinic is often apprehensive about the quality of what he is to receive. Part of this is due to a distrust of anything received free or for only a small fee. Often assurance that the best doctors in town are on the staff is not sufficient to allay his fears of being used for experimentation or as a subject for study. He must feel that there is concern for him as an individual and that his problems are recognized and accepted as important.11

After being accepted and given an appointment to Medical Clinic for a complete physical examination, he may have to wait in line at the cashier's window, and then has to wait sometimes for an hour or two before his turn comes to be seen by one of the clinic doctors. While waiting on the bench he may see patients in various stages of illness and disability, and he ponders the possibility that he, too, may be developing an illness such as one of these. Finally, when he is called into the clinic, he sees several curtained booths and the nurse directs him to one booth where a young doctor comes in to examine him and ask him all kinds of questions about his symptoms, illnesses in his family, what he does for a living, who are

in his family, etc. After examining him this young doctor may call in some of the other doctors to look at him, and he may become rather frightened at the thought that he has symptoms requiring so much attention. Perhaps he is seriously ill. He cannot understand what the doctors are saying, and he is searching their faces for their reactions.

Before leaving the clinic perhaps he is given appointments for laboratory tests, chest X-ray, an electrocardiogram, a referral to another special clinic, a return appointment to Medical Clinic, and several prescriptions. He gazes upon this collection of slips of paper with bewilderment and concern. He has to go to each of these places in the Out-Patient Department and set the dates for the appointments. The doctor has assured him that these tests are important before they can tell for certain what is wrong with him and he can be helped. He wants to know, too, but it seems that he has to go to a great deal of trouble to find out. Will he have to wait all morning for each of these tests? However, he has been told that he must follow these recommendations if he wants to help himself.

The patient participates in planning to meet his medical needs. He is the one to take the initiative to come to clinic. He makes the effort to return to clinic, he makes his own appointments, and he takes the responsibility for following the doctor's instructions about diet, medicines, rest, etc., if he wants to feel better. Unlike the ward patient, who remains in bed and has everything done for him and brought to him by the nurses and doctors, the clinic patient must do much to help himself. The clinic patient is expected to assume this responsibility because he is still a self-maintaining individual. He may be holding a job, supporting
his family, and carrying on all his other customary activities. When he leaves the clinic he goes back to the community, to his home and family, and job. He has not had to separate himself from all these things as does the ward patient, who is made completely dependent upon the administrations of the doctors and nurses. For the clinic patient his medical care consumes only a portion of his time, and its implications may involve only partially other areas of his life activities. The clinic patient has the choice to return or not return to clinic, depending upon his desire to help himself, his own attitudes towards illness, and the feelings of confidence and interest in him which have been shown by the clinic personnel. He must feel that the doctors, nurses, and other clinic attendants are interested in him as an individual if he is to cooperate and take an active responsibility in following medical recommendations.

For the patient who is a frequent attender of clinics and who has a more disabling chronic illness which pervades and limits all his life activities, the clinic may be a source of encouragement and emotional support. The clinic personnel may become another family to him to which he turns with all his problems, be they medical or in some area of his social life. The clinic is prepared to offer him support and help in all of these problems because of the teamwork approach of the doctors, nurses, and social worker. The clinic social worker may get to know him over a long period of time when he attends clinic regularly, and he feels that she is someone who is his own special friend to whom he can turn with any problem which is troubling him.

The Referral Process

The customary pattern of relationship which is visualized in social
casework when intake is discussed is that by which the person in need himself makes application to the social worker for assistance. When social work is part of another institution, however, such as the school, court, or hospital, it more frequently happens that someone else who is in contact with the client observes his need, or has it called to his attention, and refers the client to the social worker.¹²

The Ward

Patients are referred to the Social Service Department from the ward in several ways. Most frequently it is through the medium of medical-social ward rounds. Patients may also be referred by the ward or consulting physician by contacting the social worker at her office. There are also referrals from outside community agencies requesting medical-social evaluations of their client, occasional requests for assistance from a patient or patient’s family.

Medical-social ward rounds are held weekly. Participating are the resident physician, the intern, and the social worker. The social worker is the constant figure in this medical team, since she is permanently attached to one ward, while the doctors rotate on different services every few months.

During medical-social ward rounds, each patient on the ward is reviewed briefly by the intern, who presents the medical situation, probable length of hospitalization, immediate and long-term outlook, probable ability to resume activity or necessary limitations, care which will be necessary after discharge, and what he knows of the patient’s social situation. Each case is then discussed, and decision made as to whether the patient should be referred to the social worker.

Rounds offer the opportunity for the worker to interpret the areas in which she can offer help, so that the doctors better understand the contribution of the Social Service Department. She also interprets social and emotional components of illness, thereby stressing the patient as a whole individual. In this way rounds are also a part of the teaching function of the social worker. In addition, problems come to be recognized earlier, since the worker is present when patients are discussed and also due to increased awareness on the part of the doctors.

Early identification and referral to the social worker of patients with problems gives the social worker the opportunity to work with the patient and his relatives to alleviate situations before they become critical. This preventive approach is generally more effective in eliminating crises...than help given once the situation has become critical. 13

Rounds are also the medium through which the social worker and doctors report progress, new thinking, and further planning regarding patients previously referred to the worker.

The Clinic

The referral process in the Medical Clinic follows no closely set pattern. Much depends upon the sensitivity of the clinic physician to social and emotional difficulties which the patient may bring to him. A proper understanding by the clinic doctor of the role of the medical social worker in helping the patient with problems related to his medical care, as well as problems in other areas of his adjustment, will do much to stimulate good referrals from the physician. Referrals to the Social Service Department from the clinic may also come from the nurse, the clinic

clerk, the Admitting Officer, from an outside social agency which has referred the patient to the clinic, or from the patient himself or a member of his family.

Referrals from Medical Clinic personnel are made by telephone to the casework supervisor who assigns a social worker who is on the clinic service. When the worker gets down to the clinic, she usually consults first with the doctor, also looking at the patient's medical record for further medical or social history which may be helpful to her in her understanding of the patient; and then either sees the patient in an interviewing room in the clinic, or on the bench, or takes him up to her office. She later provides the referring doctor with the results of her interview with the patient which may have bearing upon his medical situation, or which may contribute to the doctor's understanding of the patient.

The Medical Social Worker

Many professional persons in the medical setting individualize the patient but the medical social worker uses an approach and method which are distinct from that of the physician, nurse, and others. The social worker seeks first to understand the patient as a person and the implications which this particular experience of illness has for him. Where is he in the experience of being ill? What specific problems does it present to him? Starting always at the point where the patient is -- emotionally and intellectually -- she endeavors to aid him to understand the situation which he faces and do something constructive about it. If there is only one possible outcome, she endeavors to assist him to accept and face this, so far as he is able. Always she tries to help him to move as much as possible through his own initiative and in the manner which will be best for him, both as an individual and in terms of his social relationships. Seen in the perspective of the total personality, this means the objective of growth. Seen in the smaller segments of experience which actually represent social casework from day to day in a medical setting, it more often means some rather simple type of movement in relation to a difficult step in medical care or in adjustment to illness. We should realize that the humbler objective is not only appropri-
ate but essentially the same as the larger one, that is, that a constructive type of movement in relation to a specific problem contributes toward growth of personality.14

More and more the medical social worker is called upon by the doctor to help patients with special emotional or social problems related to their illnesses, due either to environmental difficulties, or more often to fears, rational and irrational. One of the important ways in which the medical social worker helps the patient is in enabling him to accept medical care in a way to meet his own particular needs.

Medical social work is wholly concerned with the problems of illness and operates as an integral part of the medical care being given. The medical social worker's interest in the patient's behavior as an ill person and in the meaning of the treatment to him will be more specific than will that of the caseworker outside the medical institution. The ways in which this understanding is used may seem to differ, but only in the details of the application of casework concepts and not in the basic concepts themselves.15

In a general hospital the specific problems which come to the attention of the social worker in the clinic setting, as compared with the ward setting, may differ somewhat in their nature; however, the generic casework skills with which the social worker approaches the problem, in helping the patient, are the constant factors in casework in both settings.

The sick person will often have a feeling of helplessness in regard to his medical situation. If he has some understanding of his treatment, why changes are made, and what treatment entails; if he has some chance to express a choice and to participate in medical care plans, he may feel somewhat less helpless, and so more able to benefit from treatment. Very

14 Bartlett, op. cit., pp. 19-20
often the medical social worker can help a patient by interpreting to him, and helping him to see what the hospital is trying to do for him and how he can be helped medically, in language that the patient can understand. She can also give him the opportunity to express his ideas about what is going on. Knowing more about the particular patient, in terms of his individual wants and needs, she can interpret this understanding to the other members of the medical team, who will then have a better picture of the patient as an individual, and may better meet his needs.

Since the patient is generally a part of a family group, he is none the less so by being sick.

To offset the sense of isolation and abandonment that patients are inclined to feel, the social worker should be aware of the value of the emotional support of family members.\textsuperscript{16}

The participation of the patient's family in planning is, therefore, of great value, to the patient and to the family as well, since the patient's illness affects not only him but those with whom he is in daily contact. The family member, too, is made to feel less helpless by being able to take a part in the patient's medical care planning.

Another casework function of major importance in the medical setting is that of cooperative work with community agencies.

\textit{...we see how the medical social worker's understanding of illness and of the hospital experience to the patient may enable her to aid community agencies and their clients toward a more effective use of medical facilities.\textsuperscript{16} Through presenting the medical plan with its social implications carefully to the agencies, she aids them to do better work for the patients in their own area at the same time that they further the medical care. When social problems are first discovered within the medical institution it will be the social worker who takes the initiative}

\textsuperscript{16} Upham, op. cit., p. 45.
in mobilizing community resources. 17

From this statement by Miss Harriet Bartlett it will be seen that the medical social worker must have a thorough knowledge and understanding of the policies and practices of the various social agencies in the community. Since she has a responsibility for referring patients to appropriate community resources and working cooperatively with interested agencies in their joint efforts to help the patient in his adjustment, she represents the link between the patient and the community resources.

Another skill of the medical social worker is that of working with patients who might not ordinarily turn to social agencies, but who will more readily accept casework service as a part of medical care. Having helped the patient to make use of casework services in the medical setting, the social worker may then be able to assist him to accept referral to another social agency in the community for continued casework help when this seems indicated. In this respect, she is enabling the patient to make use of social resources within the community which he might not have approached on his own initiative prior to seeking medical care.

Miss Harriet Bartlett has suggested that the patient's physical and emotional state affects the social worker's approach to him in offering him help. She states that

If the ward patient has been acutely ill, a slower tempo may be necessary than with the clinic patient who is less sick, and the temporarily increased dependency of the ward patient may require a supportive type of treatment until his physical and emotional improvement allows him to assume more active command of his situation. 18

17 Bartlett, op. cit., p. 218.
CHAPTER IV

DESCRIPTION OF THE TOTAL CLINIC AND WARD GROUPS

This chapter will be concerned with the description of the total clinic and ward groups of cases studied.

Sex and Age

Of the twenty-five patients in the clinic group studied, there were eleven men and fourteen women. Of the twenty-five patients in the ward group studied, there were fourteen men and eleven women.

The age range of the patients in the total clinic and ward groups is shown in Table I.
TABLE I

DISTRIBUTION BY AGE OF THE CLINIC AND
WARD PATIENTS

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 19</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>20-29</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50-59</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>60-69</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>70-79</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>80-89</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

It may be noted from the above table that the ages of the clinic patients showed a more even distribution, while the ages of the ward patients were more heavily weighted in the older age groups, in that there were nineteen patients who were fifty years or older.

Marital Status

The marital status of the patients is shown in Table II.
TABLE II
MARITAL STATUS OF THE CLINIC AND
WARD PATIENTS

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

It may be noted from the above table that the marital status of the patients in the two groups studied closely parallel each other.

Living Arrangements
The living arrangements of the patients are shown in Table III.
TABLE III
LIVING ARRANGEMENTS OF THE CLINIC AND
WARD PATIENTS

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with spouse</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Living with spouse and children</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Living with children</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Living with parents</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Living alone</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Medical Diagnosis

The medical diagnoses of the patients are shown in Table IV. Because many of the patients studied presented more than one diagnosis, the writers, for the purpose of clarity, have grouped the diagnoses in terms of their incidence occurring singly or in combination with other diagnoses.
### TABLE IV (a)

**DISEASES OF THE CLINIC PATIENTS**

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Incidence Occurring Singly</th>
<th>Incidence Occurring in Combination</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional symptoms</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety neurosis</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Internal hemorrhoids</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Duodenal ulcer</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gout</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pyelonephritis</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Benign prostatic hypertrophy</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Obesity</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Endocrine disorder</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>18</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>
### TABLE IV (b)

DISEASES OF THE WARD PATIENTS

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Incidence Occurring Singly</th>
<th>Incidence Occurring in Combination</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Anemia</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Homologous serum jaundice</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Duodenal ulcer</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Purpura</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Functional symptoms</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Barbituate poisoning</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reactive depression</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Thyrotoxicosis</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Aneurysm of the basilar artery</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Chronic lymphatic leukemia</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Cerebral vascular accident</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Gastro-intestinal malignancy</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Acute anxiety state</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Eosinophilia (blood disease)</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genito-urinary infection</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Asthmatic bronchitis</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>24</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>

It may be noted from Table IV (a) that the diagnosis accounting for the largest number of clinic patients was that of functional symptoms, in-
cluding nine out of the twenty-five clinic patients studied. The label of functional symptoms is used when the patient complains of vague, ill-defined aches, pains, and other symptoms for which no organic basis can be found. Since these symptoms usually have an emotional basis, the clinic physician very often refers the patient to Social Service for social review or medical-social evaluation. Taking the group of patients with functional complaints, and including the two patients with diagnoses of anxiety neurosis and anorexia nervosa, this study finds a group of ten patients with symptoms of emotional etiology and with no other demonstrable organic disease, and one patient having functional symptoms not related to her medical diagnosis, but occurring in combination with it.

The next largest category of diseases in the clinic group was that of heart disease, a chronic disabling illness commonly seen in medical clinics. Other diagnoses as shown in Table IV (a) showed no significant weighting in any one group but indicated a fairly representative range of medical problems as seen in medical clinic patients.

Seventeen patients had diagnoses occurring singly with no other organic disease and the remaining eight patients had a total of eighteen diseases occurring in combination with other diseases. It may be noted from this table that ten of the seventeen diagnoses occurring singly were related to emotional problems, there being only seven diagnoses of demonstrable organic disease occurring singly in contrast to seventeen of this type occurring in combination with other diseases.

In reference to Table IV (b) there is a wide range of medical problems in this group of patients, with heart disease occurring more frequently than any other. There are ten patients who have some form of heart
disease, either by itself or in combination with another medical problem.

Thirteen patients of the ward group had a single disease, while the remaining twelve had a total of twenty-four diseases occurring in combination with others.

In contrast with the clinic group there was only one patient with functional symptoms, and that was in combination with another medical problem. The diagnoses of re-active depression and acute anxiety state, indicating emotional problems, occurred in combination with medical problems, also. Since this is an acute general hospital, patients admitted to the ward usually have demonstrable organic disease, requiring hospitalization for adequate study and treatment.

**Sources of Referral**

The sources of referral to the Social Service Department are shown in Table V.

**TABLE V**

**SOURCES OF SOCIAL SERVICE REFERRAL OF THE CLINIC AND WARD PATIENTS**

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic doctor</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Ward doctor</td>
<td>-</td>
<td>22</td>
</tr>
<tr>
<td>Outside social agency</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Patient</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Patient's family</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
The foregoing table shows that the most frequent source of referral to the Social Service Department in both settings, is the doctor, there being eighteen clinic patients and twenty-two ward patients so referred. Outside social agencies referred four clinic patients and two ward patients. The only other referral in the group of ward patients studied was by the staff psychiatrist. Of the remaining three clinic patients, two referred themselves to Social Service and one was referred by a member of the patient's family.

Reasons for Referral

The reasons for referral to the Social Service Department are shown in Table VI.
TABLE VI
REASONS FOR SOCIAL SERVICE REFERRAL OF THE
CLINIC AND WARD PATIENTS

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arranging for chronic care</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Medical-social evaluation</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Medical-social evaluation for outside agency</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Arranging for convalescent care</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Help in vocational adjustment</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Review of financial situation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Arranging for sanatorium care</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Obtaining social history from patient's family</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Alleviation of home situation</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Help in engaging in recreational activities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Information regarding nursing home resources</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Transportation arrangements</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Help regarding another family member's medical situation</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clarification of medical recommendation for hospitalization, to patient and family</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

In the clinic group the largest number of referrals to the Social Service Department was for medical-social evaluation, five at the request of the clinic doctor and five for outside social agencies. As may be seen
from the table, the remaining fifteen patients were referred for a varied number of reasons. Of the six referred for problems closely related to planning in regard to the medical situation, one patient was referred for arrangements for chronic hospital care, one for convalescent care, one for sanatorium care, one for information regarding nursing home resources, one for transportation arrangements to clinic, and one for clarification of medical recommendation for hospital admission to the patient and his family. Referrals for the nine patients presenting social problems less directly related to the medical situation included three patients referred for help in vocational adjustment, two for review of the financial situation, two for help in engaging in recreational activities, one for alleviation of the home situation, and one for help in regard to another family member's medical problem.

In contrast to the clinic group, the largest number of referrals from the ward was for specific arrangements for further medical care. Of the fifteen so referred there were ten patients referred for chronic care arrangements, three for convalescent care arrangements, and two for sanatorium care arrangements. The next largest group was of eight referrals for medical-social evaluation, six at the request of the ward doctor, and two for outside social agencies. In addition, there was one referral for help in vocational adjustment, and one for obtaining a social history from the patient's family for the psychiatrist.

Contact with Patients' Families

The social worker's contacts with families of the patients are shown in Table VII.
### TABLE VII
SOCIAL WORKER'S CONTACTS WITH FAMILIES OF THE CLINIC AND WARD PATIENTS

<table>
<thead>
<tr>
<th></th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases in which there was family contact</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Number of cases in which there was no family contact</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

It may be noted from the above table that in the clinic group studied only seven cases involved contact with the patient's family. This represented twenty-eight per cent of the total clinic group. However, in the ward group nineteen cases involved contact with the patient's family. This represented seventy-six per cent of the total group.

Contact with Outside Agencies

In meeting the needs of the patients, the social worker had contact with or worked in collaboration with various outside agencies. Table VIII lists all the agencies involved.

In all these cases where there was a referral to another hospital, the patient was also referred to the Social Service Department of that hospital.
### TABLE VIII
OUTSIDE AGENCIES USED IN HELPING PATIENTS MEET THEIR NEEDS

<table>
<thead>
<tr>
<th>Agency</th>
<th>Clinic</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jewish Memorial Hospital</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Boston City Hospital</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Jewish Tuberculosis Sanatorium of New England</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Convalescent or nursing homes</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Public agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division of Old Age Assistance</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Division of Aid to Dependent Children</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Division of General Relief</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Division of Vocational Rehabilitation</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Soldiers' Relief</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Veterans' Administration Mental Hygiene Unit</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Jewish Family and Children's Services</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Jewish Vocational Service</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Hecht House</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Greater Boston Aid and Fuel Society</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Red Cross Motor Corps</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>19</td>
</tr>
</tbody>
</table>
It may be seen from Table VIII that the clinic social worker had contacts with Jewish Family and Children's Services in regard to seven patients. This was the outside agency most frequently used. This figure may serve partly to point up the close working relationship operating between the Jewish Family and Children's Services and the Beth Israel Hospital Social Service Department. There were two contacts with other medical care resources, the remaining nine contacts being with various public and private social agencies.

In the ward group the agencies most frequently used in helping the patient to meet his needs were other medical care resources in the community, seven patients requiring the use of Jewish Memorial Hospital and two requiring the use of the Jewish Tuberculosis Sanatorium of New England. Closely related to these were four more cases in which convalescent or nursing home resources were used. There were two cases where there was contact with the Division of Old Age Assistance, three with Jewish Family and Children's Services, and one with the Greater Boston Aid and Fuel Society.

**Principal Medical-Social Problems**

In studying the cases, it became evident that they fell into several categories which may be best described as the principal medical-social problem, i.e., the patient seen as a whole, considering his social and emotional problems as related directly or indirectly to his medical situation.

The principal medical-social problems of the patients in the total clinic and ward groups studied are shown in Table IX.
TABLE IX (a)
PRINCIPAL MEDICAL-SOCIAL PROBLEMS OF CLINIC PATIENTS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential medical social problem</td>
<td>6</td>
</tr>
<tr>
<td>Personality maladjustment</td>
<td>3</td>
</tr>
<tr>
<td>Disturbed social relationships</td>
<td>2</td>
</tr>
<tr>
<td>Medical-social evaluation for community agency</td>
<td>5</td>
</tr>
<tr>
<td>Vocational adjustment</td>
<td>2</td>
</tr>
<tr>
<td>Need for financial assistance</td>
<td>2</td>
</tr>
<tr>
<td>Need for help in medical or nursing care planning</td>
<td>5</td>
</tr>
<tr>
<td>Convalescent care</td>
<td>1</td>
</tr>
<tr>
<td>Chronic care</td>
<td>2</td>
</tr>
<tr>
<td>Transportation arrangements</td>
<td>1</td>
</tr>
<tr>
<td>Hospitalization planning</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
TABLE IX (b)
PRINCIPAL MEDICAL SOCIAL PROBLEMS OF
WARD PATIENTS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic care</td>
<td>11</td>
</tr>
<tr>
<td>Potential medical-social problem</td>
<td>7</td>
</tr>
<tr>
<td>Convalescent care</td>
<td>5</td>
</tr>
<tr>
<td>Medical-social evaluation for community agency</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

It may be noted from Table IX (a) that only five clinic patients presented principal medical-social problems directly related to the need for medical or nursing care. Of the remaining twenty cases, six patients presented potential medical-social problems, three had problems of personality maladjustment, two had problems of disturbed social relationships, five patients needed a medical-social evaluation for a community agency, two presented major problems of financial assistance, and two needed help in vocational adjustment.

It may be noted from Table IX (b) that the largest number of cases in the ward group fell into the two categories in which the principal medical-social problem was that of arranging for other medical care. There were sixteen cases in this group, in eleven the problem being that of chronic care, and in five that of convalescent care. Of the remaining nine, seven cases were considered potential medical-social problems and two were
evaluations for an outside community agency.

These categories of principal medical-social problems will form the basis for the next chapter, where they will be defined, and the groups presented and discussed.
CHAPTER V

PRINCIPAL MEDICAL-SOCIAL PROBLEMS OF
THE CLINIC PATIENTS

The principal medical-social problems of the clinic patients, as indicated in the preceding chapter, are: potential medical social problem, personality maladjustment, disturbed social relationships, medical-social evaluation for a community social agency, vocational adjustment, need for financial assistance, and need for help in medical or nursing home planning. One case illustration will be presented for each of the categories with the exception of the potential medical-social problem group for which two cases will be presented.

Potential Medical-Social Problem

The six cases falling into this category were designated as potential medical-social problems either because the diagnosis connoted serious social and emotional implications or because the symptoms which the patient presented did not appear to be on an organic basis, but rather a somatic expression of social or emotional problems. In the latter case the clinic physician may call upon the social worker to provide aid in medical diagnosis by her exploration of the patient's social situation which may explain the basis for his symptoms. In the process of securing this information for the doctor the social worker uses her diagnostic skills to determine the needs and possibilities for casework treatment for the patient.

Ages: The patients in this category represented a fairly young age group, as follows: 17, 22, 30, 32, 38, and 43.

Marital Status: In this group three patients were married, two were single, and one was separated.
Living Arrangements: Of these patients two were living with spouse, one was living with spouse and children, one was living with children, and two were living with parents.

Diagnoses: Four patients presented functional complaints with no organic disease, one patient had anorexia nervosa, and one had pulmonary tuberculosis.

Source of Referral: All six patients were referred by the clinic doctor.

Reason for Referral: Two patients were referred for medical-social evaluation, one for alleviation of the home situation, one for help in accepting her illness and following medical recommendations, one for help in obtaining part-time employment, and one for help in engaging in outside activities as a treatment plan preliminary to psychiatric referral.

Casework Services to the Patient: In one case an interview offered the patient release of emotional tension and an opportunity to focus on her problem and a plan of action. The case of the patient with pulmonary tuberculosis required interpretation of medical recommendations for sanatorium care, helping the patient to accept her illness and the need for treatment, and some environmental manipulation in the way of arranging for care of the patient's children. Another patient was given a supportive relationship in seeking help for problems of personal and social adjustment, the worker also referring the patient to group work resources, and eventually preparing him for referral to psychiatry. Another patient was given a supportive relationship in the area of meeting her own medical needs and using hospital resources. Another patient was given support and recognition in his efforts to handle his wife, who was suffering from a reactive depression. The last patient was offered casework help in work-
ing through conflicts about his mother and his girlfriend, since he was expressing these through functional symptoms.

Contact with Patient's Family: In two of these cases the social worker had some contact with members of the patients' families. One case required enlisting the help of the patient's sister in making arrangements for transfer to another hospital for medical care for tuberculosis, having the patient's children X-rayed, and arranging for care of the children during the patient's absence from the home. The other case involved exploration of a marital situation because the patient was showing somatic symptoms of tension. In this situation contact with the patient's wife resulted in intensive casework with her. In the other four cases in this group there was no direct Social Service contact with patients' families.

Contact with Outside Agencies: In two of the six cases in this group, medical and social resources in the community were utilized on behalf of the patient. One patient was referred to a settlement house for group activities as part of the treatment plan, and one patient was referred to the Social Service Department at another hospital when she was transferred there for treatment for tuberculosis and for sanatorium arrangements.

Case 1

This patient was a thirty-eight year old, married, living with his wife and mother-in-law, who was referred by the doctor in Medical Clinic for help in alleviating the home situation. The patient had come to the clinic complaining of a pain in his left chest and fatigue during the past few weeks, which he thought was due to insufficient sleep and nervous strain. It was the doctor's impression that the patient was suffering from a fatigue and tension state due to difficulties in the home.

In the interview with the social worker the patient explained that he worked on a night job from eleven to
six. He tried to sleep mornings but was awakened constantly by his wife who wished to talk with him. His wife had had a hysterectomy three months ago, from which she was recovering slowly, but which had left her very nervous. The patient was very concerned about his wife. He tried to be sympathetic with her about her condition but at the same time he felt very much under a strain to maintain his sympathetic attitude and still get his needed sleep. Since the patient's wife attended the Diabetic Clinic at this hospital, the social worker suggested that she see his wife when she came to clinic. It was planned to interpret to her the patient's need for rest and also to get acquainted with her and try to interest her in some leisure-time activities to occupy her time.

In interviews with the patient's wife the worker found her to be suffering from a depression reaction to the hysterectomy in addition to other life experiences. The wife's mother lived with them in the home and the patient's wife had regressed to the point of being extremely dependent upon her mother, allowing the mother to take over complete management of the household. The patient's wife did little during her waking hours but sit and daydream about the past. In relation to the patient's needs, the worker interpreted to the patient's wife the importance of helping her husband to get his rest in view of his symptoms and the doctor's feeling that he was not getting enough sleep. The patient's wife was able to accept this quite readily and to cooperate. She also wished to discuss her own medical situation and her feeling of depression. For more intensive casework with the patient's wife, the worker arranged future appointments.

The worker found in subsequent interviews that the patient's symptoms had begun to disappear as some of his wife's demands upon him were lessened and his wife was receiving attention and help. This improvement in the patient was noted by the clinic doctor. The worker continued to give the patient a great deal of emotional support in his efforts to maintain his sympathetic attitude toward his wife, in his praising her for very small things, and encouraging her to do things. It was the worker's impression that the patient was a relatively stable person who was able, with support, to understand his wife and to meet her needs.

Case 1 illustrates the type of social problem which may serve as a background for the functional complaints with which so many patients come
to the Medical Clinic. In this situation the patient might have continued
to develop physical symptoms had not an exploration of his social situ-
tion been undertaken.

The social worker's contact with the patient's family was essential;
when intensive casework was offered to his wife, the patient's symptoms
began to disappear and he began to make a healthier adjustment to meeting
his wife's emotional needs. Interpretation to the patient's wife of his
need for adequate rest also helped her to understand better her husband's
realistic needs.

In this case the social worker functioned in relation to helping pre-
vent further physical and emotional breakdown in this family through offer-
ing support to the patient and more intensive casework to the patient's
wife.

Case 2

This was the case of a sixteen year old boy referred
by the doctor in Medical Clinic in February because of
symptoms of anxiety and nervousness which the doctor felt
were hysterical in origin. Last year the patient claimed
to have had anemia which forced him to stay home from
school. The patient was not treated medically at this
hospital at that time, but at the time of this clinic
visit his hemoglobin was at a normal level and the doctor
could find no organic basis for his complaints. The pa-
tient had many complaints about his home life, many of
them centering around the fact that he did not like his
mother's cooking, which he seemed to feel had something
to do with his being anemic. He had few outside activi-
ties and was failing in his junior year at high school,
primarily due to having missed so much school. The pa-
tient had been known in the past at a neighborhood set-
tlement house and the doctor felt that if he could have
more outside activity it would be of help to him. The
patient was to return to the Medical Clinic in two months
to see if this regimen had helped. At that time the doc-
tor would evaluate the possibility of the need for refer-
ral to Psychiatry.
When seen by the social worker the patient stated at once that his parents must not know that he was coming to the hospital because they would not understand or approve and they were very punishing. The worker complied with this request at his insistence. He brought out resentment against his mother's overprotectiveness, describing her as a very nervous woman who could not let go of him because he was an only child and who would not let him make up his own mind about anything. The patient told about his frustrations in finding satisfactions in his social life, school, or with his family. With help from the worker he associated the beginning of his anemia with his decision to give up his ambition to become a meteorologist and instead to go into his father's business, which his father had been insisting upon. He related that he had once been very active at the settlement house, having been president of various clubs, but lately he had drawn away from outside activities, feeling that he should spend all his time on his schoolwork. The social worker helped him to consider the advisability of returning to the settlement house as a specific medical recommendation, also interpreting that it would help his school work for him to get into more social activities and steering him away from his introspective tendencies. The patient agreed to try this and the worker contacted the settlement house and the boy's worker there, who arranged an appointment to see the patient and help him to enroll in some groups.

The worker continued to give the patient support and encouragement around his plan of self-help through contacts over the telephone and during visits at the hospital when he came in expressing concern around not letting his parents know about his plans. He then confessed that he had told his father that the doctor said that he (the father) was the cause of the patient's illness.

The worker also consulted regularly with the settlement house caseworker on the patient's progress there and at the end of a month, the caseworker there reported that the patient was unable to benefit from group activities because of his anxiety. This was reported to the doctor in Medical Clinic, who saw the patient at that time and recommended referral to the Department of Psychiatry. The social worker prepared the patient for referral to Psychiatry by helping him to work through his resistances, which were expressed around his feeling that "psychiatry is a new science", that "other people get along without it", and that he could "bury" his problem. The worker appealed to his pride in his intelligence, and his desire to help himself, also interpreting that burying problems
does not solve them. With encouragement from the worker the patient kept two appointments with the psychiatrist, but then began missing appointments, also failing to get in touch with the worker. Appointments were sent, to which he did not respond. Although the worker recognised that the patient had quite a lot of anxiety and resistance around accepting psychiatric treatment, she felt that he at least intellectually accepted the fact that it could be of benefit to him and it was there if he wanted it. Also it was felt that the pressure on him had been lessened in that he had transferred to a school with less demanding standards and the summer vacation was at hand. In addition, the worker felt that the patient had used a good bit of his contact with the hospital in bettering his relationship with his parents. He tended to assert himself a little more instead of withdrawing into illness.

Case 2 illustrates another situation in which the patient presented functional complaints to the clinic doctor which were actually symptomatic of personal and social problems with which the patient felt unable to cope. In this case the social worker cooperated with the clinic doctor in evaluating the patient's social and emotional needs behind his physical complaints and in working out a treatment plan to meet these needs.

Casework with the patient involved giving him support and encouragement around his expressed desire to help himself in finding a more satisfactory adjustment to his social and emotional problems.

Contact with the boy's family was not attempted as the worker respected the patient's request that this not be done, and the patient seemed anxious to seek help and work out his problems by himself.

In regard to utilization of outside social resources, the hospital social worker was able to cooperate with the boys' caseworker at the settlement house in offering group activities to the patient as a possible solution to his problems of social adjustment. The worker was then able to interpret the results of this joint treatment program to the clinic doc-
tor, who on the basis of this, decided to refer the patient to Psychiatry for more intensive treatment, using the worker to help prepare the patient for this move.

Personality Maladjustment and Disturbed Social Relationships

Although Personality Maladjustment and Disturbed Social Relationships were designated in Table IX (a) in the preceding chapter as separate principal medical-social problems, they will be grouped together for the purpose of this discussion inasmuch as they seemed to be closely related to each other and separate from the other categories of problems presented in this study. In all five cases in this group the medical problem seemed secondary to the more basic problems of serious and long-term personal or social maladjustment. Of these five cases three presented problems of personality maladjustment and the other two presented problems of disturbed social relationships.

Ages: The ages of these patients covered a wide range; as follows: 27, 36, 57, 70, and 85.

Marital Status: All of these patients were married.

Living Arrangements: One patient was living only with spouse and the other four were living with spouse and children.

Diagnoses: Two patients presented functional complaints, one had an anxiety neurosis, one had a duodenal ulcer and was obese, and the fifth patient had general and cerebral arteriosclerosis and bilateral deafness. (This last patient was eighty-five years old).

Source of Referral: Four patients were referred to the social worker by the clinic doctor and one patient referred herself.
Reason for Referral: Three patients were referred for medical-social evaluation and treatment, one patient was referred for help in finding outside activities to occupy his time, and one patient requested help in regard to a family member's medical situation.

Casework Services to the Patient: In the first case the patient was offered a supportive relationship as a collaborative treatment plan with a psychiatric therapy class for obese women and the patient was enabled to obtain some catharsis and also insight into her behavior. In the second case the worker offered a supportive "mothering" relationship, explored family relationship problems, and helped the patient to accept referral to Psychiatry. In the third case the worker did a social review of the patient's home situation for the doctor in the clinic and referred the patient to his Old Age Assistance worker and family physician. In the fourth case the patient was given an opportunity to express her feelings of rejection of her mother and offered help in planning living arrangements for her mother outside of the home. In the fifth case the patient was offered a casework plan to work out her compulsiveness and anxiety about environmental problems and to focus on her need for help.

Contact with Patient's Family: In this group there was direct casework contact with one patient's family, involving helping the patient's daughter to plan for activities to occupy the patient's time and allowing her to express her feelings of concern about long term, poor parental relationships; and offering her further casework help in working out her own anxiety. In the other four cases there was no direct contact with the families of the patients although the families were served indirectly in several instances through individual casework with the patient.
Contact with Outside Agencies: In two cases there was no contact with outside agencies. Of the three cases in which there was, one case required referral of the patient to Jewish Family and Children's Services for help with financial problems and children's camp plans, since the patient had been known to this agency in the past. The family agency worker and the hospital worker shared information over a long period of time when the hospital worker continued to work with the patient around planning for medical needs. In another case the Jewish Family and Children's Services worker referred the patient's daughter to the hospital social worker since the daughter had come to them for help around planning activities for the patient in regard to his medical needs. In the last case, which was a brief contact, the hospital social worker contacted the patient's Old Age Assistance worker for information about the patient's wife's apparently psychotic behavior, the situation being referred back to the Old Age Assistance worker and the patient's family physician for continued supervision.

Case 3
(Personality Maladjustment)

This was the case of a thirty-six year old, married woman, living with her husband and four children, ages 4, 10, 12, and 14. Another son, aged nineteen, was with the Air Force in Germany. The patient referred herself to Social Service for help in sending her fourteen year old son to Orthopedic Clinic for evaluation of his hip pain. At the same time the patient complained of her own illness, not having been out of the house for almost a year, and finding it difficult to get around because of an ulcer condition. The patient had previously been followed in Medical Clinic for a duodenal ulcer but had not come to clinic for over a year. As the patient seemed to have so many complaints herself, the worker gave her support in coming in to Medical Clinic for evaluation of her own condition.
Because of the emotional component in her ulcer condition and her obesity the clinic doctor referred her to the Psychiatry Department for group therapy classes for obese women. The worker gave the patient a great deal of support and encouragement about accepting psychiatric referral, the patient recognizing that she needed help because of her moodiness, her inability to sleep and crying spells.

During the interval while the patient was waiting for her name to come up on the waiting list for an appointment to the group therapy class, the worker continued to offer her a great deal of warmth and attention, from which the patient was deriving considerable satisfaction. She needed emotional support in relation to her concern about her fourteen year old son, who was admitted to the hospital for surgery for a slipped epiphysis, and also in relation to her husband's hospitalization for a hernia operation and her concern about not hearing from her son in Germany.

Four months later when the patient began attending the group therapy class, the worker attempted to decrease her interest in her, allowing the patient to use her on a catharsis and supportive basis. The worker's role was primarily a supporting one, encouraging the patient, being warm, and making up in terms of the relationship with a mother which the patient had missed in her childhood. In relation to the patient's doubts about the efficacy of the group therapy class, the worker kept encouraging her to continue therapy.

In conjunction with the psychiatric treatment and casework the patient was able to develop some intellectual insight into her great need to control, especially her eldest son, and make many attempts to avoid this pattern with some of the other children. The patient brought to the social worker her problems in handling her children. Her twelve year old son stuttered and the Jewish Family and Children's Services had provided him with a Big Brother. A Sea Scout leader was also being helpful with her fourteen year old son. However, the patient had many complaints about the help her children were getting, stemming from her own need to control them and her own unsolved problems of childhood rejection by her parents, and hostility towards her own children. The worker gave her support in her efforts to help her children, encouraging her to accept the help they were getting from other interested persons also. The worker contacted the caseworker at the Jewish Family and Children's Services in order to review their contact with the family, which was mostly in relation to the provision of a Big Brother for the twelve year
old boy, and to inform them of the patient's contact with the Social Service Department at the hospital.

The patient continued to call upon the worker at irregular intervals during the course of group therapy when she became anxious about some family crisis, such as her eldest son's discharge from the Air Force, his difficulties in adjusting to civilian life, and her own need to direct him. Although the patient had displayed some movement at first in gaining insight into her difficulties, the resistance towards taking really constructive help was enormous and she began breaking appointments at her group therapy class. She was unable to use the worker further than on a catharsis basis although the worker attempted to help her focus on working on a difficulty together. Finally she became angry with the psychiatrist, after some incident about an appointment which had made her feel rejected, and terminated contact with the worker, as well as with the group therapy class. The worker consulted the psychiatrist who felt that little more could be done to help the patient.

The patient later went to the Jewish Family and Children's Services Agency for some financial help and for camp plans for the children. The caseworker at that agency became interested in the family, contacting the hospital worker who gave her a report on the patient's contact with the departments of Social Service and Psychiatry at the hospital and the outside agency continued to follow the patient.

Case 3 illustrates the type of social problem which a patient may bring to the clinic in relation to medical needs. This patient had social and emotional problems of long duration which pervaded her family relationships. Intensive treatment was indicated because the patient's problems went back to early childhood conflicts and were affecting her ability to find satisfactions in life, as well as expressing themselves through emotionally charged illnesses, such as ulcers and obesity. The social worker in this situation was able to cooperate with the psychiatrically sponsored group therapy class for obese women by offering the patient a warm and supportive relationship. The worker also attempted to help the patient to
gain some insight into how her own personality needs were affecting her ability to cope with family problems, particularly her handling of her children. Although the patient's problems were closely related to personal and social maladjustment and difficult family relationships, the social worker, was able to cooperate with other members of the medical team in helping this patient to meet her medical, social, and emotional problems in a coordinated approach.

When medical treatment was no longer the focus in this case, as the patient terminated the contact with the hospital, the medical social worker was able to provide the family agency with a report of the patient's progress in the hospital.

The patient had been known to the family agency in the past and while she was being treated at the hospital, there had been some sharing of information between the two agencies, the patient finally being steered back to the family agency for help with financial and environmental problems. Patients in this category of Personality Maladjustment or Disturbed Social Relationships, because of the long term nature of their problems, may have been known previously to other social agencies, or may require referral to outside social agencies for continued help when the focus ceases to be on a medical-social problem and the patient is no longer attending clinic.

**Medical Social Evaluation for Community Agencies**

Cases were designated as falling into this category when the patients were referred to the medical social worker by an outside social agency for medical-social evaluation of the patient, with particular reference to the planning of that agency with the patient. In these cases the major case-
work responsibility was left with the outside agency and the medical so-
cial worker functioned in the sphere of help related to the patient's med-
ical needs. Periodic reports were also given to the caseworker in the out-
side agency. This service to interested social agencies in the community
represents an important aspect of the medical social worker's job because
of her close relationship to the medical resource utilized by the patient
and the frequency with which medical problems appear in a configuration of
other social problems.

Of the five cases in this group, two required only a brief contact,
the worker providing the outside social agency with a medical-social re-
port on the patient. The other three cases required long-term collabora-
tion with the outside agency.

_Ages:_ Ages of patients in this group were as follows: 16, 23, 38, 43,
and 70.

_Marital Status:_ One patient was single, two were married, one was sepa-
rated, and one was widowed.

_Living Arrangements:_ Two patients were living with spouse and children,
one was living only with spouse, one was living alone, and one (the six-
teen year old boy) was living with his grandmother.

_Diagnosis:_ Diagnoses in this group were as follows: rheumatic heart dis-
ease; arteriosclerotic heart disease with congestive failure; gout, diabe-
tes, and hypertension; functional complaints; and question of endocrine
disturbance, also with functional complaints.

_Source of Referral:_ Three of these cases were referred by the Jewish Fam-
ily and Children's Services (two from the Family Division and one from the
Foster Home Department), one patient was referred by the Veterans' Admin-
istration Mental Hygiene Unit, and the last patient was referred indirectly from Soldiers' Relief through the patient's daughter.

Reason for Referral: All five patients were referred for medical-social evaluation.

Casework Services to the Patient: The patient referred by the Veterans' Administration Mental Hygiene Unit was given support in utilizing medical resources in the hospital, allowing him to express resentment towards the doctors which he felt during the lengthy diagnostic period, and also preparing him for recommended psychiatric treatment. In another case the worker explored with the patient her feelings about going to a nursing home before sending a report to Soldiers' Relief. The young patient referred by the Jewish Family and Children's Services Foster Home Department was seen briefly during his clinic visits in order to determine his attitude towards his illness (rheumatic heart disease) and towards physical limitations of activity, before the medical-social report was sent to the outside agency. One patient referred by the Jewish Family and Children's Services was a New American and was given a dependent relationship during the frightening experiences of being in a new country and needing medical care. The worker offered interpretation of medical recommendations and emotional support in helping the patient to utilize hospital resources and accept treatment, gradually encouraging the patient to become more independent in this area. The other patient referred by the family agency was given a great deal of support in accepting medical recommendations, facing his illness, and utilizing resources which would enable him to continue to carry his responsibilities as a father and wage earner insofar as possible.
Contact with Patient's Family: In two out of the five cases in this group there was some direct contact with members of the patient's families. In the first case, the contact with the patient's wife was of a fairly superficial nature in which the worker made a home visit and discussed planning with both the patient and his wife; however, continued planning was done directly with the patient when he came to clinic. In the other case the worker had contact with both the patient's daughter and son in exploring the patient's home situation and his need for nursing home care, also helping the patient's daughter to make financial arrangements for this care through Soldiers' Relief.

Contact with Outside Agencies: As would be expected, contact with community agencies was the distinguishing feature of this group of cases. All five cases required varying numbers of telephone contacts and letters to the outside agency, depending upon the length of contact between the patient and the medical social worker and the complications in the patient's medical situation. Three cases required fairly routine medical-social reports of the doctor's recommendations and the hospital social worker's observations. The other two cases required more involved collaborative treatment plans for the patients as worked out between the hospital social worker and the caseworker in the outside social agency.

Case 1

This was the case of a twenty-three year old, married, New American woman referred to the Social Service Department by Jewish Family and Children's Services requesting medical-social interpretation of the patient's physical condition and need for dental treatment. The patient complained of various aches and pains. She also had diarrhea with abdominal pains. It was the doctor's impression that the patient was suffering from enteritis and that her pains
were either rheumatoid or neuritic. It was also felt that many of her complaints were on a psychoneurotic basis.

The patient, her husband, and their two year old son arrived in this country several months prior to referral. The patient was born in Russia and left there during the war. She had since lost track of her family. She and her husband met in a Displaced Persons Camp in Italy, where they had remained until coming to this country. The patient's husband was steadily employed in a factory at the time of referral.

The patient's intestinal condition improved readily, and her only remaining complaint was of rheumatoid pains. Dental X-rays indicated necessary dental work, which she planned to have done. This was postponed because of hospitalization of the patient's son for extractions. She visited her son daily, seeing the worker before and after seeing her son, looking to the worker for sympathy and support. She also shared with the worker some concern about her marital difficulties, indicating that her husband complained about her housekeeping and care of the child. She also could not make friends with people her husband wanted her to and felt unable to please him. The nurses complained that she did not follow ward regulations and brought food to her son, although she had been asked not to. The worker interpreted medical recommendations to the patient who then planned to bring a toy, instead of food, to her son. She did not follow through, though, and continued to bring food for the boy.

The patient did not follow up on her own medical care, and the worker informed the family agency of this. They then requested psychiatric evaluation for the patient, in terms of her marital problems, in addition to further medical care. The worker urged the patient to return for her medical care, but although the patient made several appointments, she did not keep these until several months later. She was then complaining of tiredness and pains all over her body and study was initiated for the question of endocrine disturbance. She continued to attend various clinics and for several months depended on the worker considerably, coming to her office before examination to make sure that the worker would be present during her clinic visit. She expressed the need for the worker's presence in terms of helping the doctor to understand her better. The worker also frequently arranged appointments for the patient, allowing her to be dependent.

Later the patient expressed some understanding of her
emotional problems, recognizing that she often laughed inappropriately and that she did not handle her child well. She asked to see a specialist and the worker offered to arrange for psychiatric referral. Although the patient was interested, she wanted to delay this until her medical needs were taken care of and she did not have so many other clinic appointments. The worker encouraged her to make her own appointment for clinics, at times, and gradually the patient did take over this responsibility. She also began coming to see the worker after her clinic visit, instead of before, to report what had transpired during the clinic visit.

During the worker's contact with the patient she kept the worker at the family agency informed of the patient's treatment progress. Since case work was being carried on at the family agency and the patient had become more independent in her ability to utilize hospital resources, the medical social worker was able gradually to withdraw from the situation.

Since casework with the patient was being carried on by the family agency, the hospital social worker focused on helping the patient in regard to her medical needs. She also assisted the family agency by keeping them informed of the patient's medical studies and treatment and her reactions to a new setting. The worker helped the patient, who was in the process of adjusting to a new country and a new way of life, to adjust to the new and threatening situation of a hospital. She interpreted hospital regulations to the patient in regard to the patient's son; however, the patient, because of her own needs, was unable to follow them. The worker allowed the patient to lean on her and be dependent for a time. She then gradually encouraged the patient's independence. However, although the patient did realize intellectually the need for psychiatric evaluation, she was not ready to accept it yet, although the worker offered her help and support in taking this big step. This information also was shared with the family agency which planned to steer the patient back to the hospital for psychi-
Of the twenty-five cases used in this study, two presented problems of vocational adjustment as the principal medical-social problem. This necessitated a medical-social evaluation of the patient's employment capacities and interests, and referral to appropriate community resources.

**Ages:** One patient was fifty years old and one was sixty-eight years old.

**Marital Status:** One patient was married and the other was widowed.

**Living Arrangements:** One patient was living with spouse and children and one patient was living with children.

**Diagnosis:** One patient had internal hemorrhoids, and the other patient had arteriosclerotic heart disease with angina pectoris.

**Source of Referral:** Both patients were referred by the clinic doctors.

**Reason for Referral:** One patient was referred for help in finding part-time employment and the other patient for help in his vocational adjustment.

**Casework Services to the Patient:** Interview with the first patient revealed that she really did not want to work and the patient was helped to see that her adjustment to Old Age Assistance was the best possible one for her. The other patient was given considerable support and help around finding a job, through encouragement from the worker and use of the Jewish Vocational Service.

**Contact with Patient's Family:** None.

**Contact with Outside Agencies:** In the first case there was no contact with employment resources in the community since the part-time employment requested for the patient by the doctor was considered inadvisable from a standpoint of social adjustment for the patient. In the second case there
was contact by the social worker with the Division of Vocational Rehabilitation regarding their previous contact with the patient, and referral of the patient to the Jewish Vocational Service in helping him to find a job. A medical-social report on the patient's medical situation and job-finding progress was also sent to the Division of Aid to Dependent Children.

Case 5

This was the case of a fifty year old, married man, living with his wife and three children; a daughter aged twenty-two, and two sons, aged nineteen and thirteen. The patient was referred by the doctor in Cardiac Clinic for help in his vocational adjustment. The doctor said that the patient's arteriosclerotic heart disease with angina pectoris would not allow work such as driving a truck, which would exert him to any extent. He should be employed at a clerical job, preferable sedentary. However, he could do a full eight hours work a day. The doctor also pointed out to the social worker that the patient's wife had had a manic depressive psychosis which had been treated, apparently successfully, and that a brother died recently from a cardiac condition.

The worker explored with the patient his feelings about seeking vocational help, speaking to him of the doctor's interest and his conviction that the patient was physically able to make some sort of vocational adjustment. Despite the background of difficulties with his wife, the patient did not speak particularly of feelings or emotional difficulties. He took a very practical approach to his problem. He told the worker of his unsuccessful contacts in the past with the Division of Vocational Rehabilitation and the Jewish Vocational Service. The patient and his family were then receiving $40.00 a week from Aid to Dependent Children. He wanted to find a job that would pay at least this much, but had been unable to find anything in the newspapers that seemed suitable for him. The patient appeared to be a well-integrated and intelligent person and showed some interest in obtaining a selling type of job. The worker offered to contact the Division of Vocational Rehabilitation and also the Jewish Vocational Service to see what they might be able to offer him, the patient being agreeable to this plan.

The worker contacted the Division of Vocational Rehabilitation, where she was told that they had been un-
able to find anything for the patient. It was felt that he was too old to be retrainable. However, it was suggested that the patient get in touch with them again.

The worker also contacted the Jewish Vocational Service, the worker there agreeing to resume interest in the case upon a referral letter from the hospital social worker. The doctor was consulted again about limitations on the patient's activities and a letter was sent to the Jewish Vocational Service. The patient was contacted again and encouraged to re-apply at both of these agencies.

The patient stopped by to see the worker a month later to ask for help regarding his difficulties with Aid to Dependent Children related to ownership of his car, which he felt necessary from the point of view of future vocational adjustment when he might need it. At this time the patient spoke favorably of his contact with the Jewish Vocational Service, feeling that since referral from the hospital more had been done for him than had ever been attempted before. He had a lead on a job obtained through the Jewish Vocational Service and had made an appointment to see a prospective employer. The worker gave him support in his job finding efforts and agreed to send a letter to the Division of Aid to Dependent Children, giving a medical-social report on the patient and including a summary of his progress in finding a job. The worker continued to keep in touch with the Jewish Vocational Service, steering the patient back to that agency when he became discouraged after one job had not worked out well. The patient had expressed some feeling around accepting Aid to Dependent Children but his need to remain dependent upon this source of security seemed to be an important factor impeding his efforts to make a vocational adjustment.

However, he presented himself in a very matter of fact manner to the worker, which actually prevented working with him on his real difficulties around securing a job, the patient resisting any interpretation of how his own feelings might be influencing his ability to find a job. Accordingly, the worker continued to give him reassurance about his medical condition and the doctor's recommendations, understanding of the difficulties involved in finding a job within these limitations, and support in making use of employment resources.

Eventually the worker at Jewish Vocational Service contacted the hospital social worker to report that the patient had secured a job selling insurance and was quite happy. The patient's son had also been given help in securing a job.
Case 5 illustrates a medical-social problem of vocational adjustment influenced by the physical limitations imposed by the patient's illness. In this case the social worker was able to give the patient reassurance about medical restrictions on his activities. She explored with him his feelings about returning to work, encouraged him to make use of employment resources in the community, and offered him support in his efforts along these lines when he came to the clinic. Although the social worker attempted a more intensive casework approach in helping him to understand his resistances to finding a job, the patient could not accept any interpretation of this.

The social worker had a cooperative relationship with the worker at the Jewish Vocational Service, providing that agency with medical-social recommendations. There was sharing of information on the patient's progress between the two agencies. A medical-social report was also given to the Division of Aid to Dependent Children. This case, then, illustrates the effectiveness of cooperative relationships between the hospital Social Service Department and other social agencies in the community in developing a coordinated approach to planning with a patient.

**Need for Financial Assistance**

In the two cases which fell within this category, financial need was the principal medical-social problem; however, financial problems may also appear during casework contact as secondary problems. In these two cases the patients' financial problems were directly influencing their medical conditions.

*Ages:* One patient was sixty-four years old and the other patient was seventy years old.
Marital Status: One patient was widowed and the other was separated.

Living Arrangements: The widowed patient was living with her children and the patient who was separated from her husband was living with a single brother.

Diagnosis: One patient had rheumatoid arthritis and the other patient was suffering from signs of malnutrition due to inadequate food intake.

Source of Referral: Both patients were referred by the clinic doctor.

Reason for Referral: Both patients were referred for financial review since the financial problems appeared to have bearing upon the patients' food intake and resultant symptomatology.

Casework Services to the Patient: In the first case the social worker helped the patient to overcome her resistance to accepting financial help and gave her support in making application for Public Assistance. In the other case the worker helped the patient to secure diet instruction from the dietician in Food Clinic, explored with the patient her financial circumstances, and gave the patient information about using Public Assistance as a resource.

Contact with Patient's Family: In neither case did the social worker have direct contact with the patient's family.

Contact with Outside Agencies: In neither case did the social worker have direct contact with the community resource offering financial assistance. However, both patients were encouraged to make use of this resource on their own initiative.

Case 6

This was the case of a sixty-four year old woman, separated from her husband, who was referred to Social
Service by the doctor in Medical Clinic for help with her financial situation. The patient suffered from rheumatoid arthritis and hypertension and it was felt by the doctor that her medical condition was being activated by poor diet, due to economic stresses.

The patient had been separated from her husband for seventeen years and was living with her sixty-one year old, single brother whom she described as being "odd" and whom she had always had to care for. The patient had a forty-one year old, unmarried daughter who worked and lived out of the home.

The social worker's investigation of the patient's financial situation revealed that she had worked as an organist in theaters until about ten years ago, having to give this up because of arthritis in her fingers. For the last two years she had rented her two extra rooms, bringing in an income of $64.00 per month. Up until recently she had been able to manage and had had a comfortable income from money left to her by her father and money from insurance policies. However, this had all been used up, one of her boarders had left her, and the rent had gone up to $58.00 a month. The patient claimed that she did not have enough money with which to eat and would have to ask her daughter for help to pay her next month's rent, although her daughter had been unaware of the patient's desperate financial circumstances and did not earn much money herself.

The worker offered to the patient understanding of the difficult situation she was facing and suggested the possibility of her applying for Public Assistance. The patient made a definite distinction between Old Age Assistance and General Relief in terms of acceptability to her. She was eagerly looking forward to the day when she would be sixty-five and would be eligible for Old Age Assistance but expressed a good deal of feeling around making application for General Relief, bringing out her feelings of pride and independence, and fear and shame that her neighbors would know if she were receiving General Relief. She feared primarily a visit from the Public Assistance visitor to her home because then the neighbors would learn of her plight. For the same reason she also feared going to the Public Assistance office. The worker was able to offer her reassurance about the confidentiality of Public Assistance records and confidential contacts. The patient was also offered assurance that this was her right and that it was of real importance that she eat properly and have some money to do so.

The patient was still reluctant to make this move and
continued to exert efforts to secure another roomer as a solution to her financial problem. The worker went along with the patient's decision by suggesting various places where she could place her name on a room registry, such as schools, the Y.M.C.A., and Traveler's Aid. The patient preferred to try this before applying for relief. She did not keep clinic appointments and the case was closed at this point, a month after referral, because the patient was not attending clinic and was working on her own plan to arrive at a solution of her financial problems.

Two months later the patient returned to Medical Clinic complaining of difficulty with her stomach, pains, etc. The doctor felt that her only difficulty was financial and emotional and referred her to Social Service. She was discouraged at being in this position again. She related that her daughter had been helping her with $25.00 a month, but she still did not have another roomer. At this point she was more willing to discuss referral to Public Welfare, having exhausted all other resources. The worker gave her much encouragement and support around applying for Public Assistance, detailing a great deal of what she might expect in making application, and offering understanding of what it meant to her to take this step.

The patient was finally able to make this move two months later and notified the worker by telephone, indicating that she was asking for support in this move, but not wishing the worker to contact the Department of Public Welfare or to intercede in any way. Nothing further was heard from the patient after this date and the worker telephoned her two months later to learn that she was then receiving Public Assistance, although she still hoped to find roomers. The worker reported to the clinic doctor that the patient's financial situation was then adequate to meet her medical needs.

Case 6 illustrates a situation in which the patient's financial problems and poor diet were activating her disease. The problem of financial need, therefore, had direct bearing upon the patient's medical situation.

In this case the social worker's first aim was to help the patient in alleviating the financial stress, the worker encountering extreme resistance on the part of the patient to applying for relief. The worker met the patient's fears around accepting Public Assistance and gave her sup-
port in making application for this aid, enabling her to make this move when she felt ready to do so. The worker had contact with the patient over a period of several months.

Need for Help in Medical or Nursing Care Planning

Of the twenty-five clinic patients studied, five presented problems related to medical or nursing care. Of these, two patients needed help in arranging for chronic care, one in arranging for convalescent care, one in making transportation arrangements to attend clinic, and one for planning for hospitalization.

Ages: Patients in this category were mostly in the older age group, as follows: 55, 58, 63, 65, and 85.

Marital Status: Two patients were married and three were widowed.

Living Arrangements: Two patients were living with spouse and children, two patients were living with children, and one patient was living alone.

Diagnosis: The patient requiring hospitalization suffered from generalized arteriosclerosis, hypertension, hypertensive and arteriosclerotic heart disease, epigastric hernia, myocardial infarctions, and angina pectoris. The patient needing transportation arrangements had diabetes, hypertensive heart disease, vascular disease, cerebral arteriosclerosis, and pyelonephritis. One patient needing chronic care had hypertension, arteriosclerosis, hypertensive and arteriosclerotic heart disease, and congestive failure. The other patient needing chronic care had severe hypertension, hypertensive heart disease, cardio-vascular accident, spastic left hemiparesis, hysteria (right side), and thalamic pain. The fifth patient, referred for convalescent care, was diagnosed as psychoneurotic and had complaints of headaches and fatigue.
**Source of Referral**: Four patients were referred by the clinic doctor and one patient referred himself.

**Reason for Referral**: One patient was referred for transportation arrangements for clinic visits; another patient for short-term convalescent care; another for clarification of medical recommendations for hospitalization to the patient and his family; another for arrangements for immediate admission to the Jewish Memorial Hospital for chronic care; and the last patient referred himself for information about nursing home resources.

**Casework Services to the Patient**: In the case requiring transportation arrangements, this service was provided. The interviews also provided the patient with an opportunity to express her hostility towards her husband and her adopted son and her resistance against taking help of any kind. In the case requiring convalescent care, it was found that there were no medical indications for this plan but that the patient requested it. Therefore, the worker helped the patient to accept a vacation plan as a satisfactory substitute. In the case of the patient who referred himself for information about nursing homes, the worker recognized the patient's desire to remain independent, giving him information on available nursing homes, and leaving it to him to decide when he would be ready to make this move. In the case of the patient requiring immediate admission to Jewish Memorial Hospital, most of the planning was done with the patient's daughter, although the social worker obtained the patient's acceptance of this plan. In the case of the patient requiring hospitalization, the social worker offered interpretation of medical recommendations to the patient.

**Contact with Patient's Family**: In two out of the five cases in this group, contact with family members was necessary to help the patient to follow
medical recommendations. In one case the patient's married daughter needed help in arranging for admission of the patient to Jewish Memorial Hospital. In the other case, which involved interpretation of medical recommendations for hospitalization to the patient and his family, the worker encountered resistance on the part of the patient and his family to such a plan. Although respecting the patient's right to self-determination, the social worker had to interpret to the family their responsibility for the patient's care, since they had preferred to abide by the patient's decision.

Contact with Outside Agencies: In three out of these five cases there was direct contact by the social worker with an outside social agency. One of these patients was referred to the Jewish Family and Children's Services, where she had been known in the past, for a vacation plan as a substitute for a convalescent home plan. Another patient was referred to Jewish Memorial Hospital, his daughter being referred to the social worker there for further casework. In the third case, Red Cross Motor Corps was contacted to provide transportation for the patient for clinic visits.

Case 7

This was the case of a sixty-five year old man, referred to Social Service by the doctor in Cardiac Clinic (which is part of the Medical Clinic Service) for clarification of medical recommendations to the patient and his family and for transportation arrangements home from clinic.

The patient was a married man, living with his wife and one son. A married son was living in his own home. Until recently the patient had been in the junk business and was very proud of his contribution to the war effort. But now he and his wife were supported by Old Age Assistance. The patient's medical diagnoses included generalized arteriosclerosis, hypertension, hypertensive and
arteriosclerotic heart disease, epigastric hernia, and anterior and posterior myocardial infarctions. He was also known to have had angina pectoris for fifteen years. Hospitalization was recommended on the day of the patient's referral to Social Service. However he could not be admitted on that day, as there were no beds available.

The worker spoke with the patient, interpreting the medical recommendations for hospitalization and exploring with the patient the possibilities for his receiving adequate care at home until hospitalization could be arranged. At the doctor's request, the worker spoke with the patient's son by telephone, interpreting the need for hospitalization, and adequate bed care for the patient at home until the admission date could be set. Both the patient and his family felt that he could be cared for at home in the interim period. The patient's son had some questions about hospitalization as related to finances and the worker interpreted that Old Age Assistance assumed responsibility for payment of medical expenses.

The worker kept in contact with the patient's family while he was at home, providing understanding of the difficulties entailed in caring for the patient at home. It was arranged that the patient's son would bring his father in when the admission appointment was sent. However, at that time the patient refused hospitalization, saying that he was feeling better. The worker spoke with the patient's son, who said that the family went along with the patient's decision, and that things were being managed satisfactorily at home. The family agreed to take responsibility for the patient's care. Admission was cancelled.

Case 7 illustrates a medical-social problem peculiar to the clinic setting, that of helping an ambulatory patient to accept the need for hospitalization. The social worker in this case interpreted medical recommendations to the patient and his family at the doctor's request. Since satisfactory temporary arrangements were available for the patient's care at home, the social worker provided taxi transportation home for the patient. She also confirmed medical plans with the patient's family, interpreting further to the patient's son the responsibility of Old Age Assistance for medical expenses. In these services the social worker was at-
empting to facilitate medical care of the patient. The patient's decision to remain at home was his own. The worker respected his right to self-determination. At the same time, since a medical problem was involved, she did confirm with the family his decision and their responsibility for supervising his care.
CHAPTER VI
PRINCIPAL MEDICAL-SOCIAL PROBLEMS OF
THE WARD PATIENTS

The principal medical-social problems of the ward patients studied are: chronic care, potential medical-social problem, convalescent care, medical-social evaluation for community agency. Two case illustrations will be presented for each of the chronic care and potential medical-social problem categories, and one case for each of the other two categories.

Chronic Care

There were eleven cases in which the principal medical-social problem was chronic care. This included hospital care and care at home - care which would involve considerable, and often permanent limitation of the patient's activities.

Ages: The ages of the patients in this group were as follows: 47, 53, 56, 58, 63, 65, 70, 72, 75, 78, and 79 years.

Marital Status: In this group two patients were single, six were married, two were widowed, and one was divorced.

Living Arrangements: In this group one patient lived alone, one patient lived with a parent, one with a cousin, one with a sister, two with spouse and children, two with children, and three with spouse.

Diagnosis: Diagnoses in this group included: aneurysm of the basilar artery; active duodenal ulcer; acute rheumatoid arthritis, asthmatic bronchitis, arteriosclerotic heart disease, active duodenal ulcer; arteriosclerotic heart disease with angina pectoris, congestive heart failure with pleural effusion; chronic lymphatic leukemia (two patients); cerebral vascular accident; gastro-intestinal malignancy, acute anxiety state; conges-
tive failure; severe essential hypertension, malignant hypertension, hypertensive retinopathy, hypertensive encephalopathy, and hypertensive heart disease; rheumatoid arthritis, arteriosclerotic heart disease, and angina pectoris.

Source of Referral: All eleven patients were referred by the doctor on the ward.

Reason for Referral: Of the eleven patients, ten were referred for chronic care, and one for medical-social evaluation.

Casework Services to the Patient: In seven of these cases the worker arranged for the patient's care at the Jewish Memorial Hospital. The worker had no contact with one patient in this group, as he was too ill; all work was therefore with the patient's wife. In three cases the patients were helped to express their feelings regarding chronic care, and required intensive interpretation, reassurance, and support around their feelings of hopelessness associated with chronic hospital care; one of these patients was also helped with his feelings of being rejected by his family, the worker, in addition, interpreting this to the patient's family.

Two of the patients in this group were going to homes of relatives for chronic care. In one case the worker interpreted to the doctor the patient's religious beliefs which made hospital care difficult, so that home care was arranged for, although chronic hospital care had seemed indicated. In the second case, the worker evaluated with the patient the various resources for his care on discharge.

Two patients were returning to their own homes for chronic care. In one situation, the patient was refusing to accept the limitations imposed by his illness, and required considerable support and interpretation around
this. Convalescent care was provided for this patient, being paid for by the Social Service Department. With the other patient in this group the worker evaluated the various possible resources for her care, helping her to come to a decision.

Contact with Patient's Family: In ten of these eleven cases the worker had some contact with the patient's family. (The other patient had no close family or friends.) All of these required interpretation of the medical recommendations for chronic care to a family member. In four of these cases there was intensive work in helping a family member to accept the need for chronic hospital care. Two of these needed reassurance that they were not rejecting the patients, since this care was medically recommended, and necessary. A third was enabled to express feelings of hostility towards the patient (her husband) who had been extremely demanding and dependent on her during his illness. In the fourth case, the worker involved the wife actively in exploration of resources for the patient's care, and also helped her to express her fears around her husband's condition, providing emotional support during a difficult period.

Contact with Outside Agencies: Seven of these patients were referred to the Jewish Memorial Hospital, at the same time being routinely referred to the Social Service Department at that hospital. The worker also contacted the Division of Old Age Assistance in regard to referral of one of these patients for aid. The worker had one contact with the Greater Boston Aid and Fuel Society, obtaining aid for a patient who was not eligible for public assistance. The worker also arranged for convalescent home care for this same patient.
Case 8

This patient was a 70 year old, married, Protestant man, living with his wife, who was referred to the social worker on medical-social ward rounds for help in planning for chronic hospital care.

The patient had been admitted to the hospital because of a cerebral vascular accident. He had responded somewhat to treatment, but was still a problem in medical and nursing care. He was incontinent, needed to be fed, required intravenous feedings, and was running a low grade fever of unknown etiology. His future outlook was extremely uncertain.

The worker had no contact with the patient, because his condition was such that he responded very poorly to conversation, and his intellectual understanding was greatly impaired. It was the feeling of the doctor and the patient's wife that no attempt be made to interpret to the patient the reason for his transfer to a chronic hospital.

The patient's wife was referred to the worker, by the doctor, to discuss plans for her husband's future care. It was her desire to take her husband home, should his condition make this feasible. This had worked out successfully following a previous cerebral vascular accident. She also felt that if her husband did not have long to live, she would prefer to have him come home, so he might die in his own bed. The worker interpreted to her the doctor's feeling that the patient required constant medical and nursing supervision at this time, which it would be impossible for her to supply, assuring her that when and if his condition improved to the extent where she would be able to care for him at home, this could be arranged. The worker also interpreted the uncertainty of the patient's illness, and the fact that no one could judge at that time what the patient's recovery might entail.

The patient's wife and the worker explored together the various resources for chronic care. There was also a financial problem. The patient had been active in a fraternal organization and his wife investigated the possibility of their assistance. The worker gave her information about Jewish Memorial Hospital, Holy Ghost Hospital, and the State Infirmary at Tewksbury. At the request of the patient's wife, the worker investigated financial resources, and learned that the patient might be eligible for Old Age Assistance, and application pro-
ceedings were begun. The patient's wife preferred that her husband go to Jewish Memorial Hospital, at which hospital his application was accepted.

The worker spoke with the patient's wife several times, chiefly around her fears concerning her husband's transfer to a chronic hospital, and fears that he would die. She appeared to have feelings about his going to a hospital which, although non-sectarian, was sponsored by a religious order other than their own. However, she denied this, expressing her concern as being around his receiving adequate care at any other hospital.

Included in the referral to Social Service at Jewish Memorial Hospital was information regarding the need for financial aid, and the fact that application proceedings had been started. That department was to continue the work in that area.

In this case, all the case work was done with the patient's wife, as the patient was too ill. Here was a completely dependent patient, unable to become involved at all in planning for his future care. The worker encouraged active participation in planning, on the part of the patient's wife, exploring with her various community resources for chronic care and financial aid, so that she was very much a part of planning for the medical care program for her husband. The worker also helped her to express her fears around her husband's condition and his further care, providing support during this period of distress.

Case 9

This patient was a 58 year old, single man, living with a cousin and her husband, referred to the social worker on medical-social ward rounds for help in arranging for chronic hospital care. The patient had been hospitalized four times within the year for treatment of chronic lymphatic leukemia. Treatment consisting of repeated blood transfusions had provided only temporary improvement, and other treatment had been unsuccessful. Chronic hospital care was recommended because the patient needed constant medical supervision, as he was unable to get along for any length of time without transfusions,
and because of a tendency toward frequent hemorrhages. This recommendation had been discussed with the patient by the doctor, and his cousin had been referred to the worker for discussion of the patient's transfer to Jewish Memorial Hospital.

The patient brought out the feeling that Jewish Memorial Hospital connoted hopelessness. The worker discussed with him what he knew about that hospital, and he indicated that he had known people who had gone there to die, and felt that this was the case with him, too. He understood the need for treatment, but did not know why he could not remain where he was, since he felt so close to this hospital. The worker interpreted to him the function of Jewish Memorial Hospital, indicating that its aim is toward treatment of chronic illness, rather than exclusively terminal care. The patient seemed to accept this intellectually, but continued to express concern about the outcome of his condition, desiring to return to his cousin's home if there were no hope for him. In addition, he had some feeling that his cousin was rejecting him. The worker explained to the patient his right to make his own decision, recognizing his independent needs, but did stress that continued hospitalization was the best plan.

It was the patient's cousin's feeling that she could care for him at home as long as he did not require bed care, and wondered if he could not stay with her as long as that was possible. She indicated that the patient was very much a part of her family, and they all wanted to do everything possible to make him comfortable and happy. It was also apparent that she had many guilty feelings about transferring him to Jewish Memorial Hospital.

In view of the desire of the patient and his cousin for the patient to return to his home, the worker discussed this with the doctors during rounds. It was their feeling that any plan other than hospitalization would not be adequate or satisfactory.

The patient's application was accepted immediately by Jewish Memorial Hospital. Both the doctor and the worker spoke with the patient's cousin, assuring her that the transfer was a medical necessity, and did not imply her rejection of him. In speaking to the patient, it was interpreted that continued hospitalization was medically important, with the doctor assuming somewhat of an authoritative role. This was a doctor in whom the patient had great faith. He was also reassured about
being able to return to this hospital, should he so choose, the patient having raised this question. He accepted transfer to Jewish Memorial Hospital on those grounds.

In this case the social worker helped a patient to accept an inevitable plan for further care. The patient seemed to be aware of his prognosis, and the worker offered support in terms of interpreting to him the varied functions of the chronic hospital, which include treatment. She stressed the need for continued care (a medical necessity), but recognized with the patient his right to his own decision, reinforcing his independent strivings, which are so important to many persons placed in such a dependent role in the hospital. The worker also shared recommendations with the patient's cousin, involving her in planning for the patient. She, too, needed support around the recommendations. The worker helped her to express her guilt feelings, reassuring her and helping her to see the reality of the situation, i.e., the medical necessity.

In view of the patient's limited acceptance of his need for chronic care, the worker involved the doctor, in whom the patient had much confidence, as an authority figure.

**Potential Medical-Social Problem**

There were seven cases designated as potential medical-social problems. These were so classified either because the diagnosis was one which is generally accepted as having many social and emotional implications or because the expected length of hospitalization was so extended as to create problems of adjustment for the patient.

**Ages:** The ages of the patients in this group were as follows: 26, 33, 34, 41, 42, 52, and 65 years.

**Marital Status:** In this group one patient was single, four were married,
and two were separated.

Living Arrangements: In this group two patients lived alone, two lived with spouse; two lived with spouse and children, and one lived with parent and siblings.

Diagnosis: Diagnoses in this group included: homologous serum jaundice; duodenal ulcer with recent hematemesis; recurrent painful purpura of unknown etiology, weakness of the right knee preventing the patient from walking; barbiturate poisoning, reactive depression; thyrotoxicosis; and pulmonary tuberculosis (two patients).

Source of Referral: Six of the patients in this group were referred by the ward doctor. One patient was referred by the staff psychiatrist.

Reason for Referral: Three patients were referred for medical-social evaluation, two for help in arranging sanatorium care, one for vocational planning, and one to obtain a social history from the patient’s family, in order that psychiatric treatment might proceed.

Casework Services to the Patient: In three of these cases the social worker provided emotional support during prolonged hospitalizations. In one of these the worker helped the patient with planning to change his job, since it had aggravated his medical situation. The second patient also required intensive reassurance and interpretation around the nature of his illness and the outcome in terms of his ability to return to work. The social worker contacted the patient’s employer regarding the patient’s fear of losing his job. In the third case the patient leaned heavily on the social worker during hospitalization, ventilating her concerns regarding her family’s care during absence, and her fears about her illness. Social Service paid for housekeeping services during this patient’s convalescence.
The fourth case involved discharge planning with the patient, evaluating with her the various possible plans, and enabling the patient to come to her own decision.

In the fifth case, the worker collaborated with the psychiatrist around supporting and encouraging the patient's objective of returning to work.

Both patients who needed sanatorium care required considerable support and interpretation around the acceptance of such a plan. One patient was quite depressed, requiring psychiatric support as well. The other patient wished to be cared for at home, but after evaluation with the patient's family this was found not feasible.

Contact with Patient's Family: The worker had some contact with the families of four patients in this group. In the first case, the worker obtained a social history from the family. She also interpreted the patient's illness and the need for psychiatric treatment, and how they could help the patient continue treatment. The family also took part in discharge planning for the patient. In the second case, the patient's husband, a rather dependent man, was given intensive support and encouragement during the patient's prolonged hospitalization. He was also helped to accept referral for housekeeping assistance. In the third and fourth cases the family members were involved in planning for the patients' sanatorium care. In one of these, the worker evaluated with the family the possibility of home care, since the patient desired this. She also involved this patient's family in interpreting to him the need for sanatorium care.

Contact with Outside Agencies: One patient was offered the resource of the Division of Vocational Rehabilitation, and he then carried through the
referral on his own. The worker referred one patient's husband to Jewish Family and Children's Service for housekeeping service and interpreted the medical situation to that agency. The two patients with tuberculosis were referred to the Jewish Tuberculosis Sanatorium of New England for further care.

Case 10

This patient was a 65 year old man, separated from his wife, living alone in a three-room apartment, referred to Social Service by the Assistant Resident on the Medical Ward, for help in arranging sanatorium care, as a diagnosis of pulmonary tuberculosis had been made. The patient's closest relatives were a son-in-law and grandson, with whom the worker had contact.

The patient was at first extremely resistant to sanatorium care, insisting on returning to his own home. The worker evaluated with the patient's family the feasibility of such a plan, and learned that his home was very inadequate, being cold and unsuitable for him even when he was feeling well. Both the patient's son and grandson felt they could not take the patient into their own homes because of crowded conditions and the danger of contagion.

The worker assisted the doctor and the patient's family in interpreting to him his need for continued care in a sanatorium, as a result of which the patient finally accepted the medical recommendation.

This is the case of a patient referred for help around accepting a diagnosis and recommendation for further care which had many social and emotional implications. The patient was being required virtually to change his complete way of living for a period of time which was uncertain. The worker recognized the patient's resistance to sanatorium care, and explored with his family the possibility of home care, which the patient was insisting on. However, since his preferred plan was not feasible, the worker involved the patient's doctor and family in helping the patient to accept the medical recommendation. Here the patient and his family were partici-
pating in planning, and the family was involved in helping the patient to follow recommendations.

Case ll

This patient was a forty-one year old, married housewife, living with her husband, two children, aged three and ten, her mother, and sister-in-law, referred during medical-social ward rounds for medical-social evaluation because of diagnosis of homologous serum jaundice and the prospect of a long hospitalization.

Finances were a problem not in regard to daily management of the patient's home, but insofar as there were no extras for providing help in the home during the patient's absence. There was a small savings which the family was reluctant to use, since it did not appear likely that it could be replaced in view of limited income.

The patient was particularly concerned about the effect on her mother of taking on additional responsibilities during the patient's absence, since her mother had hypertension and was under medical supervision. The patient's concern seemed exaggerated in view of constant reassurance from her husband and mother that things were going well. This seemed related to the patient's being the managing and controlling member of the household, in contrast to the dependent and passive nature of her husband; and also her pattern of protection of her mother.

The worker discussed with the patient her anxiety about her home, the patient recognizing that part of this was her own desire to protect her husband. In view of the patient's concern and the doctor's report of her mother's physical condition, community resources for housekeeping services were explained by the worker. However, although she was willing, her husband was resistant to applying to a family agency, this connoting charity to him. The patient convinced her husband to see the worker. He indicated that the home situation was a strain on everyone, but felt he could not bring himself to apply for aid. Later, however, shortly before the patient's discharge, their son became ill, and her husband did ask for help in arranging for household help. Referral was made to a family agency, but was denied in view of the family's savings. Therefore, hospital funds were made available for part-time housekeeping help for three months, during the patient's convalescence. It was left to the family to interview and choose the most suitable person. The worker and the pa-
tient also worked out plans for the care of the house during the time the housekeeper would not be there.

During hospitalization it was decided that surgery was indicated. The worker saw the patient daily the few days preceding operation, helping her to ventilate feelings about surgery, fears of death. The patient's husband required considerable support and encouragement, as he seemed to be reacting to the absence of his wife's direction and management. He felt the doctors might be "experimenting" on her.

Following the operation the patient showed steady improvement, and her thoughts turned towards convalescent care. Various plans were discussed, as convalescent home and home care, with the patient and her husband, the worker offering assistance in any plan they would choose. The worker helped the patient to anticipate the slow progress of recovery, so that she was prepared for the changes from bed rest to beginning ambulation. She became more confident, as she took on increasing activity. The worker also recognized with the patient her mixed feelings about leaving the support and care of the hospital, and her eagerness to return home, where she went for her convalescent care.

The patient kept in contact with the worker for several months, by telephone and letter, giving weekly reports of her progress. As she was at home, the patient seemed to have been reassured about her family's ability to manage without her physical help, since she could supervise them. Provision of the cleaning woman apparently allevied her guilt about not being able to participate more actively. When the patient was discharged from medical care, she seemed no longer to need the worker's support, and discontinued contact.

In this case the worker provided a long-term supportive relationship during a lengthy hospitalization and convalescence. Many of the patient's concerns were related to the fact that she could not continue in her role as the active, aggressive member of her family. The worker helped the patient to obtain some insight into the fact that some of her concerns were exaggerated. However, the worker helped the patient, also, with practical planning for her home in her absence and during her convalescence.
Here a relatively adequate person was helped to accept a dependent role for a period of time, through a supportive relationship with the worker, and provision of resources which relieved the patient of her responsibilities, thus relieving her of guilt.

The patient's husband was directly affected by his wife's absence, missing her direction and management. The worker helped him and the rest of the family, as well as the patient, through the provision of housekeeping services, as well as continued reassurance and encouragement. The choice of housekeeper was left to the patient and her family, so that in this situation they functioned much as any normal family would. This was also an opportunity for the patient to participate in planning for herself and her family, maintaining her role of wife and mother.

Convalescent Care

There were five cases in which the principal medical-social problem was convalescent care. This category included patients who needed to have temporary limitation of activity and care, following hospital discharge, either at home or in convalescent or nursing home.

Ages: The ages of the patients in this group were as follows: 63, 66, 67, 69, and 85 years.

Marital Status: In this group four patients were widowed, and one was married.

Living Arrangements: In this group two patients lived alone, one with spouse, and two with children.

Diagnosis: Diagnoses in this group included: myocardial and pulmonary infarction; secondary anemia, generalized arteriosclerosis; hypertension, arteriosclerotic heart disease, acute myocardial infarction; pneumonia,
malnutrition; hypertensive heart disease.

Sources of Referral: All five patients in this group were referred by the ward doctor.

Reason for Referral: Two patients were referred for medical-social evaluation and three for help in arranging convalescent care.

Casework Services to the Patient: In all cases in this group there was planning with the patient for care on discharge, evaluating possible resources. One patient required authoritative interpretation on the part of the doctor in order to accept convalescent care. In this same case the Social Service Department assumed financial responsibility for two weeks of convalescent care. One patient required constant interpretation and reassurance from the worker about her husband's medical status, about which she was very concerned. The worker obtained this information from the patient's sister-in-law through frequent contact. In another case the worker helped the patient, a very independent person, to accept the limitations of her illness and need for assistance, both in regard to Old Age Assistance and convalescent home care. She helped the patient to express her fears about her illness, instead of denying them, helping her to accept her limitations.

Contact with Patient's Family: The worker had contact with the families of three of these patients. The other two patients had no family. In all three cases there was planning for the patient's care following discharge from the hospital. In addition, in one case, the worker kept in constant touch with the patient's sister-in-law, who informed the patient, through the worker, of the status of the patient's husband, who was hospitalized elsewhere. In another, the worker provided the opportunity for the child-
dren of a patient to express their feelings about their responsibility to their father, thus relieving them of some tension, so that they were able to plan more thoughtfully.

Contact with Outside Agencies: In this group the worker had contact with two convalescent homes and one nursing home, in arranging for three patients' care following discharge. She also explained the resource of Old Age Assistance to one of these patients, who later made application on her own.

Case 12

This patient was a sixty-three year old widowed man, living with his four unmarried children, ranging in age from nineteen to thirty-three years, referred to Social Service by the ward doctor for help in arranging convalescent care following hospitalization for repeated myocardial and pulmonary infarction. Medical recommendations were that the patient have two or three weeks of convalescent care, following which he could return home, on a limited regime, for three months. The patient was to return to the care of his private physician on discharge.

The patient was a dependent, passive, individual, feeling lonely and helpless since the death of his wife two years previous, and he was somewhat demanding of his children, feeling rejected by them. It was his plan to return home to convalesce, and to obtain housekeeping service. However, when the worker discussed this with his children, they objected to this plan. They expressed complaints about the patient, saying he was a cruel father, demanding and miserly. They also reported that the patient was meticulous about housekeeping arrangements, and overly active and exacting in regard to the cleanliness of the home. When this was discussed with the patient, he agreed that he became very upset when work was not done the way he preferred and that he probably would not be able to rest at home if the housekeeper did not meet his standards. However, he was fearful of going to a nursing home, because he had found it difficult to adjust to the ward situation and group living. Accordingly, arrangements were made for him to have a small private room at a nursing home, which his children had inspected, and which they had selected from several others.
In this case there was work with the patient and his family, involving the entire family group in a plan for the patient. Both the patient's personality and the feasibility of various possibilities for care on discharge were evaluated. Feelings of both the patient and his family were involved, in terms of the patient's compulsive cleanliness and the family's inability to meet these needs. The patient's children were helped to verbalize their negative feelings towards their father, and were able then to plan constructively, choosing a nursing home for the patient. The patient was helped to see that his standards were high, that it would be difficult to obtain a person who would satisfy him. He recognized the value of going to a nursing home, and accepted this plan. The worker met the patient's fears of inability to adjust by arranging for a private room. In this case the entire family was involved in planning and working through to an acceptable solution for all, since some choice was possible on a medical basis.

Medical-Social Evaluation for Community Agencies

These were patients referred to the medical social worker by an outside social agency for medical-social evaluation with reference to the planning of that agency with the patient. In these cases the major casework responsibility was left with the outside agency. The medical social worker functioned in the sphere of help related to the patient's medical needs. She also gave periodic reports to the caseworker in the outside agency. This service to interested social agencies in the community represents an important aspect of the medical social worker's job because of her close relationship to the medical resource utilized by the patient and the frequency with which medical problems appear in a configuration of other
social problems.

There were two patients in this group on the ward.

**Ages:** One patient was fifty-six years old and the other was fifty-three years old.

**Marital Status:** Both of these patients were married.

**Living Arrangements:** One patient lived with spouse, the other lived with children.

**Diagnosis:** One patient had acute myocardial infarction and genito-urinary infection; the other had arteriosclerotic heart disease, mild angina pectoris, and eosinophilia (blood disease) of unknown origin.

**Source of Referral:** Both patients were referred by the Jewish Family and Children's Service.

**Reason for Referral:** Both patients were referred for medical-social evaluation.

**Casework Services to the Patient:** One patient was helped to accept the limitation of activity imposed by his illness. He was able to ventilate his feelings around this, and was then more able to move ahead to plan for necessary changes in his routine. At the patient's request the worker also contacted his landlord, regarding help in obtaining a more suitable apartment, in view of the patient's illness. The worker and the patient planned together for the patient's discharge. The second patient, a New American, was fearful of the unfamiliar environment of the hospital, afraid of medical procedures, and needed much interpretation and reassurance regarding the reasons for them, particularly a reducing diet and tuberculosis precautions.

**Contact with the Patient's Family:** The worker saw the families of both of
these patients. In the first case, the patient's wife required considerable interpretation and support around the medical recommendations, limitation of the patient's activity, and her fears in this regard. In the second case, the worker had contact with the patient's son, who at first identified with his mother's fears and hostility towards the hospital. The worker interpreted to him the need for tests, precautions, etc., which he easily accepted, and then cooperated with the worker in further explaining to his mother these procedures.

Contact with Outside Agencies: There was continued contact and sharing of information between the medical social worker and Jewish Family and Children's Service worker in both of these cases. Reports of the patient's medical status were sent to Jewish Family and Children's Service. These included the implications of the patient's illness for future planning by the family agency and some information as to the patient's adjustment in the hospital, thus providing a picture of the patient's reaction to a new situation, and an indication of future needs. Since the family agency was following the patient's social situation, the case was closed when there appeared to be no further medical problem, with the plan that it could be reopened should a new medical problem arise.

Case 13

This patient was a 58-year-old, married man, living with his wife, referred by the worker at Jewish Family and Children's Service for medical-social interpretation of the patient's illness and recommendations for his care. The patient had been known to Jewish Family and Children's Service as a New American, and this agency had been assisting him financially. The patient had been working as an independent agent selling household articles door to door, and his wife worked part-time as a cook and waitress.
The patient was hospitalized because of a myocardial infarction. He was acutely ill on admission, and on the danger list for a time. It was advised by the doctors that following convalescence the patient would need to change his occupation, since it involved more physical activity than he should be allowed.

The worker saw the patient and his wife frequently during the patient's hospitalization. For the first two weeks the patient's condition was such that it was not easy for him to talk, as he was having frequent attacks of chest pain and dyspnea, and the worker's activity during that time was on a friendly basis, conveying to him the interest of the hospital and of Jewish Family and Children's Service.

The patient's wife was very anxious and worried, at first fearful that her husband might not live, and then concerned with their future as she became aware of the limitations to be imposed by his illness. The worker listened to the patient's wife express these feelings, which helped to relieve some of her anxiety.

The patient was quite disturbed by the doctor's interpretation of the need for him to restrict his activity, to change his job for a more sedentary one, and if possible, to move to a first floor apartment. It became evident that the patient's fears were related to the fact that his father had died of heart and kidney trouble (which the patient also developed while in the hospital), at the age of forty-seven. He felt also that physical restrictions would prevent him from obtaining work that would be at all remunerative, in terms of his experience. The worker felt that the patient's pessimism about his vocational outlook was realistic, in view of the employment situation at the time, but encouraged him to avail himself of the Jewish Vocational Service with which he had already had experience. In addition, she pointed up to the patient his strengths in surviving past traumatic experiences, as the loss of his family and business in Germany, his having to reestablish himself in China and then again in this country. It was suggested, also, that the patient could take this up further with the worker at Jewish Family and Children's Service, when the doctors felt he was ready to consider employment.

During the patient's hospitalization his wife was active in trying to obtain a first floor apartment, but was unsuccessful. At the patient's request the worker phoned their landlord, to inquire whether the family
might exchange apartments with another tenant, in view of the medical situation, but this, too, was unsuccessful.

The patient became more optimistic as he improved physically. When he was ready to leave the hospital, discharge planning was worked out with him. In view of the fact that his wife worked, and was away most of the day, and because of the severity of his illness, it was agreed that the patient go to a convalescent home for two weeks. He accepted this readily, feeling he needed the additional supervised care before returning to his home, where he would be alone a good deal. Arrangements were made with the Jewish Family and Children's Service for the patient to have two weeks of convalescent care at a convalescent home. Since the patient had questions about his medical care in the interim period before returning to clinic, the worker arranged with the family agency worker for their doctor to be available for the patient. Ambulance service was also to be provided for the patient from the convalescent home to his home, as he had been advised against walking stairs for a month.

During the worker's contact with the patient and his wife, she kept the worker at the family agency informed of the patient's medical status, recommendations of limitation of activity, and the patient's reactions to these.

In this case the worker was helping the patient to accept a diagnosis and its implications. The worker offered emotional support and encouragement during a difficult and dependent period, to a patient who found it hard to accept recommended limitations, this seeming to be related to fears of not being able to survive. More intensive work in this area and around his future employment was to be carried out by the family agency which maintained major casework responsibility for the patient. The worker helped in practical planning, assisting in attempts to obtain a more suitable apartment. She also planned with the patient and the family agency for his care on discharge, the family agency being involved since major responsibility for the patient rested with them. The worker's contact with the
patient's wife was also supportive, during a period of stress, providing someone within the medical setting to whom she could verbalize her fears and concerns about her husband's condition.
CHAPTER VII
SUMMARY AND CONCLUSIONS

The purpose of this study was to examine and compare medical-social problems and related social casework services in the Medical Clinic and on the Medical Ward. The questions the writers have attempted to answer are the following:

1. Who are the patients coming to the Medical Clinic and the Medical Ward? How and for what reasons are they referred to the Social Service Department?

2. What principal medical-social problems do these patients present? How do the types of problems differ in the two settings?

3. Are there elements in each setting which influence the types of problems which come to the attention of the medical social worker?

4. What are the kinds of casework services offered the patients in each setting in relation to the principal medical-social problem? How do the clinic and ward groups studied compare in terms of the specific casework services?

5. How do the different settings influence the medical social worker's use of community resources to meet the patients' needs?

6. What kind of contact does the medical social worker have with the families of patients in each setting?

This study was based on an examination of fifty cases, twenty-five each from the Medical Clinic and the Medical Ward. A schedule was used for analysis of the individual cases with regard to the above questions.

There was a relatively even distribution of men and women in each
group studied. It was found that the ages of the clinic patients showed a more even distribution, while the ages of the ward patients were more heavily weighted in the older age groups. Marital status of the patients in both groups closely paralleled each other, the majority of the patients being married persons. With regard to living arrangements, the majority of the patients in both settings were members of family groups. However, there were only two patients in the clinic group living alone, while there were five patients in this classification in the ward group.

The diagnosis accounting for the largest number of clinic patients was that of functional symptoms, there being nine patients in this group who presented physical complaints for which no organic basis could be demonstrated. Two other patients presented emotional disturbances diagnosed as anxiety neurosis and anorexia nervosa. The next largest diagnostic group was that of heart disease, there being seven patients in this group.

There was a wide range of medical problems in the ward group, with heart disease occurring most frequently, i.e., in ten cases. There were two patients with diagnoses of emotional disturbances, both of these occurring with another medical problem for which the patient was being treated. In comparison with the clinic group, only one patient on the ward presented functional complaints, and these again occurred with another medical problem.

This comparison demonstrates the fact that in the clinic the social worker is more often called upon to help patients with whom physical complaints are symptomatic of poor emotional adjustment than on the ward, where she helps more patients with serious or acute physical illness.

In both settings the most frequent source of referral to the Social
Service Department was the doctor, there being eighteen clinic patients and twenty-two ward patients so referred. Social agencies in the community referred four clinic patients and two ward patients.

The most frequent reason for referral in the clinic group was for medical-social evaluation, as an aid either to the doctor or the social agency in the community, in helping better to understand and meet the patients' needs. There were ten patients in this group. Nine patients in the clinic group were referred for social problems less directly related to the medical situation, while six were referred for help around further medical planning.

In comparison to the clinic, there were fifteen ward patients referred for specific arrangements for further medical or nursing care planning. There were eight requests for medical-social evaluation, one for vocational planning, and one requested a social history from the patient's family in order that psychiatric treatment might proceed.

In examining the community resources used by the social worker in helping patients, it was seen that a more varied group of social agencies was utilized by the worker in the clinic, while, because of the nature of the patients' medical needs, emphasis with the ward group was upon other medical and nursing care resources.

Since most of the patients in the groups studied were a part of a family unit, the impact of illness on both the patient and his family must be taken into consideration by the medical team. In the groups studied the medical social worker had contact with the families of seven clinic patients, and nineteen ward patients, demonstrating that the implications of hospitalization tend to involve more active family participation in
planning to meet medical-social needs. Also, many families of ward patients required casework help in regard to their own feelings of anxiety, guilt, or helplessness around the implications for them of the patients' illness and hospitalization. Of the families seen in the clinic group, the most frequent reason for such contact was in regard to helping the patient and his family make some specific medical or nursing care arrangements.

It was found that the principal medical-social problems were somewhat different in the clinic and ward groups. Of the categories related to further medical or nursing care planning, the clinic presented only five cases in which this was the major problem needing casework services, whereas the ward group presented sixteen cases. There appeared to be more of an emphasis on problems in which physical symptoms were strongly influenced by basic social or emotional maladjustment, in the clinic. This is not to deny the existence of such maladjustment in the ward patient group. The social worker on the ward may often recognize that these problems need attention, but because of the patient's anxiety and preoccupation with his current, acute medical situation, he is often not ready or able to use casework services with problems other than what he sees as his major area of concern, i.e., his present illness.

It can be seen that the diagnostic skill of the medical social worker is important here in evaluating whether this anxiety, regression, or dependence which the patient shows in regard to his medical situation is primarily a temporary problem created by the urgency of this experience, or whether it is a manifestation of chronic social or emotional maladjustment requiring more intensive help.
In the majority of clinic patients categorized as potential medical-social problems the patients were helped to focus on recognizing the need for help in regard to personal problems related to physical symptoms, and were offered emotional support in working out and following a plan for medical or social casework treatment. Two patients required interpretation of the need for psychiatric treatment. Several of these patients required intensive casework treatment by the social worker; some were not ready to recognize the need for the help which was offered.

In the group of clinic patients being evaluated for community agencies, casework services were around interpretation of medical recommendations, exploration of the patients' feelings and attitudes around illness, and help and support in utilizing hospital facilities.

With the clinic patients whose principal problem was that of vocational adjustment, the worker explored their capacities and interests with them with regard to vocational adjustment within physical limitations.

The patients in the clinic group requiring financial assistance were given interpretation about utilizing Public Assistance as a resource, help and understanding around their resistance to accepting relief, and support and encouragement enabling them to make application for Public Assistance.

With the clinic patients requiring further medical care, the worker interpreted medical recommendations, and helped the patients in working out satisfactory plans suited to their individual needs and preferences.

The ward patients whose principal medical-social problem was that of chronic care required primarily interpretation of their need for this care, support around feelings of hopelessness, rejection, and anxiety, and in several cases, some evaluation of resources for continued care.
The largest number of the ward patients classified as potential medical-social problems were offered interpretation and emotional support regarding their medical situation, either in terms of extended hospitalization, or around planning for further medical care elsewhere. There was also support, encouragement, and practical planning with some of these patients in relation to their concerns and fears about jobs and families which were affected by the patient's illness and hospitalization.

The primary casework service with the ward patients requiring convalescent care was planning with the patients for their care on discharge, evaluating with them the various resources, and helping them to arrive at a satisfactory decision best to meet their needs.

The ward patients referred from outside agencies for medical-social evaluation were offered support and interpretation of medical recommendations.

In summary it may be said that supportive casework, interpretation of medical recommendations, environmental manipulation and referral to appropriate medical and social resources were necessary in both the clinic and ward settings. Although help given by the social worker was based on diagnostic evaluation of the patient's individual personality needs and strengths, the problems presented by the patients in the different settings varied in nature, as being either more or less closely related to the medical situation. It was seen that the types of problems which the clinic patients presented as compared with the ward patients were more varied and involved social and emotional difficulties in more extensive areas of adjustment as well as those related to physical problems. On the ward, because of the urgency and trauma involved in the very meaning of hospital-
ization and the acute stage of illness, there was a closer casework focus on the hospitalization and acute illness, and their meanings and implications for the patient and his family. This closer focus on the illness situation is also conditioned by the usually short duration of hospitalization in an acute general hospital, and the patient's inability to use help with problems less closely related to this current overwhelming experience. In the clinic the social worker has the opportunity, generally over a longer period of time, to help the patient with other problems of personal and social adjustment in the absence of the traumatic effects of acute illness seen on the ward setting.

Approved:

[Signature]

Richard K. Conant
**APPENDIX**

**SCHEDULE**

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