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Medical social work with chronically ill patients on the home medical service of the Massachusetts Memorial Hospitals, November, 1949 to November, 1951

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MEDICAL SOCIAL WORK WITH CHRONICALLY ILL PATIENTS ON THE HOME MEDICAL SERVICE OF THE MASSACHUSETTS MEMORIAL HOSPITALS NOVEMBER, 1949 TO NOVEMBER, 1951

A Thesis

Submitted by

Ging-ru Dzo Loh

(B. A., Ginling College, 1932)

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CHAPTER I

INTRODUCTION

Purpose

> There are few things in this world which humiliate, depress and demoralize persons more, or make them more dependent on their relatives and friends, than prolonged illness which blights their lives and saps not only their physical vitality but also their spirit, if relief is not obtainable. It is the most formidable antagonist of social development. As a killer and a disabler of man, it is often excessively cruel because of the slowness and the relentlessness of its action.
>
> ----- E. M. Bluestone[1]

The prevalence of chronic illness is steadily increasing in this country. From the National Health Survey undertaken by the United States Public Health Service in 1935 among three million people in nineteen states, it was revealed that 18 per cent of the surveyed population, or almost one in every five persons had some chronic disease.[2] Dr. Henry J. Bakst in his lectures on medical information delivered at the Boston University School of Social Work during the academic year of 1951 - 1952, estimated that in

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1 E. M. Bluestone, "Long Term Illness in Modern Society," Journal of American Association, 33:1051, March, 1949.

2 Ernst P. Boas, The Unseen Plague: Chronic Disease, p. 7.

the United States approximately twenty-five million people had some chronic disease, and that in the age group of sixty-five years old and over, one out of every two persons had chronic disease. In 1870, chronic disease caused one fifteenth of all recorded deaths; today it is responsible for more than half of the total mortality.[3] Chronic disease is important not alone as a major cause of death, its social implications are of far greater significance. As Dr. Boas says:

> Chronic disease creates not only medical problems, they are a major cause of social insecurity; their malign influence permeates into all phases of our living, causing indigency and unemployment, disrupting families and jeopardizing the welfare of children.[4]

At the Home Medical Service of the Massachusetts Memorial Hospitals, where the writer did her second year field work, about six out of ten of all the cases referred to the social service department involved chronic illness situations.[5] Modern science and medicine have prolonged and are prolonging the span of human existence, but "if social and medical comfort does not accompany age, longevity proves to be a burden when it should be a

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3 Arthur Bachmeyer and Gerhard Hartman, The Hospital in Modern Society, p. 302.

4 Ernst P. Boas, op. cit., p. v.

5 Beatrice S. Stone and Henry J. Bakst, "Educational Experience in Social Work and Medicine on a Domiciliary Medical Care Service," Social Service Review, 26:49, March, 1952.

blessing.[6]

From the standpoint of a medical social work student, the writer is interested in knowing what medical social workers can do and should do in serving this group of patients. This thesis is an attempt to study some of the social services offered to a selected group of chronically ill patients at the Home Medical Service of the Massachusetts Memorial Hospitals with a view to obtaining some understanding of the social and emotional needs of chronically ill patients and of how medical social workers can best meet these needs.

In undertaking this study, the writer had several questions in mind: Who were the victims of chronic diseases? What were the prevalent chronic diseases among this group of patients? What were some of the social and emotional needs of the patients that arose from their chronic illness situations? How were these needs met by the medical social worker? And, lastly, what was the role of the medical social worker in working with the chronically ill patients?

Scope of Study

This study is based upon an analysis of seventeen recorded cases from the caseload of the social worker on the Home Medical Service of the Massachusetts Memorial Hospitals. They are all closed cases and cover a period of time from November, 1949 to November, 1951. The following criteria were used in the selection of these cases:

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6 E. M. Bluestone, op. cit., 33:1051.

1. that the cases include a varied group of medical diagnoses and related social problems which were thought to be fairly representative of chronic illness situations encountered on the Home Medical Service of the Massachusetts Memorial Hospitals

2. that they are closed cases as closed cases were thought to provide a better perspective of the role of the social worker and the problems involved

3. that the records which were selected contain comparatively comprehensive recording consistent with the purpose of research.

Checked with the monthly statistical sheets of the social worker on the Home Medical Service, these seventeen cases represent approximately 7 per cent of the total cases of chronic illness situations referred to her during those two years. The writer wished to use a larger sample but had to limit the cases to the present number in order to meet the criteria set down for the selection of the cases.

Method of Study

In order to analyze the cases, a schedule was devised covering the points mentioned in the purpose of the study. This schedule sought to indicate the description of the group of patients in regard to their race, age, sex, income, marital status, mode of living, medical diagnosis and physical limitations. Social problems of the patients at the time of referral were reviewed and further problems emerging at a later period were analyzed. A study of the social services offered the patients was made as to how

adequately they met the needs of the patients and what community resources were utilized. Tables are used to give statistical data which would prove helpful in drawing conclusions. Case studies are given to supplement the collected data in a descriptive way.

Consultation with the social worker on the Home Medical Service helped the writer to obtain the case records and statistical sheets for use. Literature on the problems of chronic illness and the aged group furnished much information as background for this study.

Limitations

A study of this type has certain limitations. In the first place, conclusions drawn from a study of a limited number of patients give only a fragmentary view of the total picture of the chronically ill patients in general. Secondly, conclusions drawn from this study represent conditions encountered on the Home Medical Service of the Massachusetts Memorial Hospitals which serves a specific group of patients only. Lastly, all the data were gathered from case records which in general lack definite statements as to what emotional problems the patients revealed, so conclusions on the patients' emotional problems had to be based upon the writer's own interpretation and diagnostic thinking in many instances.

CHAPTER II

THE HOSPITAL SETTING

Brief Survey of the Massachusetts Memorial Hospitals

The Massachusetts Memorial Hospitals is one of the largest and well-equipped medical and health centers in the Boston area. Founded in 1855, it is now a grade A hospital, approved by the American Hospital Association, the American College of Surgeons and the American Medical Association. It is a voluntary hospital, supported by private endowments, Community Fund, individual contributions and income from patients. The budget for 1950 was $2,741,176.00 and the hospital personnel for the same year numbered 1450.[1] The hospital consists of several units: the Evans Memorial for research as well as for private and ward patient care, the Talbot Memorial for outpatient care, the Robinson and the Collamore Memorials for ward and private bed care, the Haynes Memorial for infectious diseases, and the newly formed Medical Associates for group practice as well as for research and teaching. The hospital is fulfilling the major function of a modern hospital, that is, care for the sick, prevention of diseases, teaching and training of medical personnel, and research for the furtherance of medical science.

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1 Massachusetts Memorial Hospitals, Annual Report, 1950.

The Massachusetts Memorial Hospitals is a general hospital. Medical services are provided by fifteen separate medical and surgical staffs, representing all the major divisions of medicine and most of the specialities. Besides internal medicine and general surgery, there are divisions of obstetrics and gynecology, dermatology, genito-infectious diseases, pediatrics, psychiatry and neurology, infectious diseases, orthopedics, otolaryngology, opthalmology, urology, dental surgery, radiology, anesthesiology, and pathology and immunology. Thirty-five clinics are held regularly in the Out Patient Department. Hospital care is available primarily for acute medical, surgical and obstetrical conditions, the present accommodation being available for three hundred and sixty adults and forty infants. The Haynes Department of Infectious Diseases has in addition a capacity of one hundred and twenty beds.

Although the Massachusetts Memorial Hospitals is to serve mainly the residents of Boston and Massachusetts, its service is extended to patients from all over the United States and foreign countries. Medical care is given to patients without regard to race, religion, or social and economic status. In 1950, 8177 patients received hospital care, 4612 patients attended clinics at the Out Patient Department, and 4534 patients were treated in their homes by the Home Medical Service.[2]

The Home Medical Service of the Massachusetts Memorial Hospitals

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2 Ibid.

The Home Medical Service of the Massachusetts Memorial Hospitals was started about 1875 when the hospital inaugurated a district program to provide medical care to the indigent sick living in the area around the hospital and the affiliated Boston University School of Medicine. The program was operated from the Out Patient Department and was then called the District Service. The annual report of the hospital for 1878 indicated that in the previous year 1,507 patients were treated at home and received 5,887 visits.[3]

In July, 1948, the District Service was reorganized as the Home Medical Service. A series of changes was introduced in terms of its organization, facilities, equipment and integration of the services of several departments of the hospital and the Medical School. Since then more emphasis has been put on the educational aspect and greater stress has been placed on preventive medicine at the level of the individual patient and his family. The function of the Home Medical Service today is twofold: to give direct service to the community and to teach the medical students to see the patient in his natural environment so that they can learn to approach the patient as a whole person in relation to his social environment.

The Home Medical Service serves an area about a square mile surrounding the hospital and the Medical School, which includes most of the South End of Boston and a portion of

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3 Henry J. Bakst, "Social and Environmental Medicine: The Home Medical Service," The Boston Medical Quarterly, 1:18, June, 1950.

Roxbury. The population is approximately 50,000, composed of a wide variety of racial groups. A large portion of the population are receiving some form of public assistance.

The regular staff on the Home Medical Service consists of a director, two residents, a full-time social worker and a full-time nurse secretary. Every month a group of from four to six fourth year students from the Medical School is assigned to practice on the Service. For the past few years, two social work students from the Boston University School of Social Work have been assigned to the Home Medical Service for field work placement under the supervision of the social worker covering the Service. The Service has access to laboratory and diagnostic facilities in the hospital. Consultation with other departments of the hospital is available when needed. The facilities of the Boston Health Department are utilized for the investigation of specific communicable diseases. Close cooperation is maintained with the Visiting Nursing Association. A weekly psychiatric consultation is held with the Department of Psychiatry in the hospital to help the medical students obtain some understanding of the psychic and emotional components of illness.

The Home Medical Service cares for patients with both acute and chronic illness and covers all age groups. During 1950, the total number of visits paid to patients was 14,735. Medical care is provided at no charge to the patients, but since October, 1950, the Service is being reimbursed by the Department of Public Welfare for each visit to its recipients at the rate of $2.12. The Home Medical Service is aided by a grant from the Commonwealth Fund.

The nurse secretary receives and screens calls from individuals, social agencies, or other hospitals. Emergency cases are referred directly to the hospital and ambulatory patients are advised to report to the Out Patient Department. The nurse secretary is also responsible for maintaining medical supplies and equipment and the filing of patient records. When a new group of medical students is assigned to the Service, the nurse secretary meets them to discuss with them the basic and practical procedures in home nursing.

The medical students, referred to as externs, have a conference with a medical instructor every morning to review all the cases they saw on the previous day. In the afternoon when they come back from home visits to patients, they meet the two residents to check up the diagnosis and treatment plan. When necessary, the residents go with the externs to visit the patients. When a patient becomes ambulatory, he is referred to an out patient clinic for follow-up; when a patient needs hospitalization, he is hospitalized at either the Massachusetts Memorial Hospitals or the Boston City Hospital.

The Social Worker on the Home Medical Service

The social worker participates in the teaching program as well as giving direct service to the patients referred to her by the externs. Every month when a new group of externs is assigned to the Home Medical Service, the social worker holds an orientation conference with them in order to help them understand the function of the medical social worker, the significance of team work, and the social

implication of illness. The social worker also participates in the weekly Social Service Conference led by the Director of the Home Medical Service and attended by all the externs, the social work students, and representatives of the Visiting Nursing Association and other social agencies which are interested in the patients discussed at the conference. This conference is devoted to reports and discussions of cases of individual patients who have been referred to the social worker. The discussion includes both medical and social problems of the patients and usually leads to further steps in the medical and social plan for the patients. The experience the social worker and the social work students bring to the conference often opens up some new vista to the externs in relation to the illness of the patients.

Another teaching function which the social worker performs is the supervision of two social work students who are assigned to the Home Medical Service each year as has been mentioned before.

In the calendar year of 1951, the total number of cases referred to the social worker was 209. The cases vary from relatively simple situations to more complex ones; some of the problems involved are placement for terminal care, obtaining temporary financial assistance, evaluation of clinical status of patients at the request of public relief agencies, placement of children whose parents needed hospitalization, development of proper family adjustment in illness situations, and family relationships, marital relationships or personality adjustment.

CHAPTER III

DESCRIPTION OF THE GROUP

Age, Sex and Race

Of the seventeen patients studied, three were men and fourteen were women. The racial distribution was ten white and seven Negro patients. Their age range is shown in Table I.

TABLE I

DISTRIBUTION BY AGE OF THE SEVENTEEN PATIENTS STUDIED

Age	35-44	45-54	55-64	65-74	75-84
Number	1	1	5	4	6

"The prevalence of chronic disease increases with age."[1] Among these seventeen patients studied, one patient was between the age of thirty-five and forty-four (specific age thirty-five), one between forty-five and fifty-four (specific age fifty), five between fifty-five and sixty-four, four between sixty-five and seventy-four, and six were over the age of seventy-five. There were no children or young adults in this group.

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1 Ernst P. Boas, The Unseen Plague: Chronic Disease, p. 7.

In this group of patients, the number of women was about 4.7 times of that of men. This incidence may be partly explained by the fact that women have a longer life span than men and therefore have more chronic diseases. In the National Health Survey and in the Massachusetts study conducted in 1929, 1930, and 1931, it was also revealed that the incidence of disabling chronic disease was higher among women than among men.[2]

Economic Status

TABLE II

SOURCE OF INCOME OF THE SEVENTEEN PATIENTS STUDIED

Source of Income	Male	Female	Total
Old Age Assistance	1	6	7
General Relief	-	5	5
Government Pension	1	-	1
Social Security Benefits	-	1	1
Own Resources	1	2	3
Total	3	14	17

2 Ibid., p. 8.

As the Home Medical Service of the Massachusetts Memorial Hospitals serves a district composed mainly of low income groups, it is not surprising that about 82 per cent of the patients included in this study were on some form of public assistance or other government subsidies and that only 18 per cent of the group were self-supporting. Of the three self-supporting patients, one lived on the rentals of a rooming house which was a very inadequate income, one was supported by her husband, and the other one was a wage earner who became unemployed because of his illness, One patient receiving Old Age Assistance and one receiving General Relief had some pension and Social Security benefits respectively to supplement their income. Another patient on General Relief received supplemental aid from the family society.

Chronic disease is closely linked with poverty.[3] On account of its insidious and slow-progressing nature, chronic disease lacks the fearsome qualities of an acute emergency and consequently tends to be overlooked and neglected during its early stages. This is particularly true with the poor as medical care is costly and frequently beyond their capacity. Neglected and uncared for, the disease develops unchecked to such an extent until it incapacitates the patient and may create poverty for himself and his family.

Marital Status and Mode of Living

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3 Ibid., p. 14.

TABLE III

MARITAL STATUS OF THE SEVENTEEN PATIENTS STUDIED

Marital Status	Male	Female	Total
Single	1	-	1
Married	1	2	3
Widowed	-	11	11
Separated	-	1	1
Divorced	1	-	1
Total	3	14	17

TABLE IV

MODE OF LIVING OF THE SEVENTEEN PATIENTS STUDIED

Mode of Living	Male	Female	Total
Alone	1	9	10
With Family	1	2	3
With Relative	1	3	4
Total	3	14	17

Among this group of patients, eleven were widowed, three were married, and the other three were either single or separated or divorced. As regards mode of living, ten out of the seventeen patients lived alone, three patients lived with husband or wife and children, and four lived with married children or other relatives.

It is significant that a very large number of the aged chronically ill patients live by themselves. Lack of proper care is usually a grave problem for them.

Medical Diagnosis

Of the seventeen patients included in this study, five alone had only one disease each; the other twelve patients all presented a combination of illnesses. Table V shows the illnesses that occurred singularly or in combination.

TABLE V

INCIDENCE OF DISEASES OF THE SEVENTEEN PATIENTS STUDIED

Diseases	Incidence Occuring Singularly	Incidence Occuring in Combination	Total
Heart Disease	1	8	9
Diabetes	2	2	4
Arteriosclerosis and Hypertension	-	4	4
Cancer and other Tumors	1	2	3
Anemia and Mal-nutrition	-	3	3
Arthritis	-	2	2
Asthma	-	2	2
Chronic Glaucoma and Blindness	-	2	2
Peripheral Neuritis	-	2	2
Hemiplegia	-	1	1
Infectious Hepatitis	1	-	1
Severe Angina	-	1	1
Duodenal Ulcer	-	1	1
Ulcer of Leg	-	1	1
Fractured Ribs and Hip	-	1	1
Total	5	32	37

Heart disease was the most prevalent chronic disease among this group of patients. Nine of the seventeen patients had some forms of heart disease. Heart disease is the leading cause of death in this country today. As a cause of disability it ranks third, preceded only by nervous and mental diseases and rheumatism.[4]

Diabetes mellitus, arteriosclerosis and hypertension were next common chronic diseases among this group of patients. Four patients had diabetes mellitus and four had arteriosclerosis and/or hypertension. Of the four diabetic patients, two had bilateral amputations and one had one leg amputated due to diabetic gangrene.

Two patients had cancer, which is the second killer of human life in this country today. Another patient had a questionable tumor, but the patient was not followed at the Home Medical Service and the case was closed before the disease showed further development.

Three patients had pernicious anemia and avitaminosis; two of them had five different diseases.

Physical Limitations

Ambulatory, bed-chair, and bed case are the general terms employed by physicians in classifying physical disability and in making medical recommendations for the convalescent care of the patient. These terms are used here with qualifications. An ambulatory patient is one who is able to walk around the house or up and down stairs

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4 Ibid., p. 8-9.

either independently or with the assistance of crutches or a cane. A bed-chair patient is able to sit up in a chair for several hours a day or even to move around in the room, but he is confined to the room all day. A bed patient needs complete bed rest and nursing care. Table VI shows the physical disability of the patients included in this study.

TABLE VI

PHYSICAL LIMITATIONS OF THE GROUP

Physical Limitations	Patients
Ambulatory	8
Bed and Chair	4
Bed-Rest	5
Total	17

Among these patients included in this study, five were completely bed-ridden, four were bed-chair patients, and eight were ambulatory. As some cases covered a considerable length of time. the degree of disability of some patients changed according to the progress or regression of their medical conditions. One bed-rest patient became ambulatory after one month's bed rest. One patient, who had been confined to her room for three years, became ambulatory several months after the social worker first saw her. A

few ambulatory patients became bed-ridden following the exacerbation or recurrence of their illness. Four patients died during the period covered by this study.

Length of Time the Patients Were Known to the Social Service Department

TABLE VII

LENGTH OF TIME THE PATIENTS WERE KNOWN TO THE SOCIAL SERVICE DEPARTMENT

Length of Time	Patients
Less than One Month	2
From One to Three Months	5
From Three to Six Months	5
From Six to Nine Months	3
From Nine to Twelve Months	-
Over One Year (Less than Fifteen Months)	2
Total	17

The length of time the patients were known to the Social Service Department varied from sixteen days to fourteen months. Two cases covered a period of time less than one month; two other cases covered a period over a year; and thirteen cases covered a period between one to nine months.

Summary

This chapter provides descriptive data regarding the patients included in this study. The group included both white and Negro patients and more women than men. Ages ranged from thirty-five to eighty-four; over half of the group was above sixty-five years old. Economically this was a dependent group, as fourteen out of the seventeen patients lived on public assistance, other governmental subsidies or private relief, and the three self-supporting patients had inadequate incomes. As regards their marital status and mode of living, only three patients were married and lived with their spouses, the others were widowed, separated, divorced or single, and mostly lived alone in substandard rooming houses or apartments.

The most prevalent chronic diseases among the group were, according to their order: 1) heart disease, 2) diabetes mellitus, arteriosclerosis and hypertension, 3) cancer and malnutrition, 4) arthritis, asthma, diseases of the eye, and neuritis. Five patients were completely bed-ridden, four were confined to their rooms, and eight were ambulatory.

The length of time the patients were known to the Social Service Department was from sixteen days to fourteen months.

CHAPTER IV

ANALYSIS OF THE SOCIAL AND EMOTIONAL PROBLEMS OF THE GROUP

The social and emotional problems of these seventeen patients which arose from their illness situations were multiple and varied. In this chapter, all the problems revealed by the patients will be reviewed and analyzed, and a study will be made to see what problems and how many of them have been met by the medical social worker. An analysis will also be made of the types of services offered and the community resources utilized by the medical social worker in helping these patients to meet their needs.

Original Problems of Referral

Except for one patient who was referred to the social worker directly by her daughter for plans for care, all the other sixteen patients were referred by the externs. The problems at referral fell into five categories: plans for care, financial problems, medical appliances, housing and emotional support. Nine patients had problems of care, four patients had financial problems, two patients needed medical appliances, one patient had a housing problem, and one patient needed emotional support. The patient who needed emotional support had been confined to her room for three years because she had rheumatoid arthritis, but the physician thought she was physically fit to go out so he referred her to the social worker for support and encourage-

ment to take walks out-of-doors. This case was an emotional one. All the other four categories may be classified as social problems. Table VIII shows the various problems of the patients at the time of referral.

TABLE VIII

PROBLEMS OF PATIENTS AT TIME OF REFERRAL TO SOCIAL SERVICE

Problems	Patients	Total
Plans for Care		9
Nursing Home Care	3	
Plan for Discharge	2	
Plan for Terminal Care	1	
Social Evaluation	3	
Financial Problems		4
Help with Budget Planning	1	
Help to Apply for Public Assistance	1	
Help to Apply for Temporary Financial Assistance	1	
Other Financial Problems	1	
Need for Medical Appliances		2
Artificial Limb	1	
New Dentures	1	
Housing Problem	1	1
Emotional Support	1	1
Total	17	17

Additional Problems After Referral

The preceding table shows the original problems at referral. They were the problems of the patients as seen by the physicians. After they were referred to the social worker, fourteen patients disclosed additional problems, some arising from new medical developments and others being problems which the patients did not reveal to the physicians. Table IX shows these additional problems.

TABLE IX

ADDITIONAL PROBLEMS OF THE PATIENTS
AS SEEN BY THE SOCIAL WORKER

Problems	No. of Occurrence
Lack of Adequate Care	2
Need for Financial Assistance	6
Difficulty in Family and Social Relationships	8
Need for Better Living Arrangements	5
Need for Medical Appliances and Spplies	2
Problems Related to Hospitalization and Follow-Up at Clinics	10
Need for Emotional Support	8
Total	41

Forty-one problems of various categories, in addition to the original problems at referral, were revealed to the medical social worker by these patients. This means that the patients often had more than one problem. In fact, only one patient showed no other problem besides that of referral. The other sixteen patients had several problems, many of which were inter-related.

Two new categories of problems were disclosed here. They were those connected with hospitalization and follow-up at clinics and those related to family and social relationships. The need for better living arrangements can be combined with housing needs to form one category.

Comparing Table VIII with Table IX, we find that the number of patients who needed plans for care increased from nine to eleven, of those who needed financial aid increased from four to ten, and of those in need of medical appliances from two to four, better housing from one to six, and emotional support from one to nine.

It is understandable that more problems would be disclosed to the medical social worker. Patients often find it easier to talk to the social worker about their problems because of the casework relationship with the worker. Another reason was the time factor. The length of time the social worker carried on these cases varied from sixteen days to fourteen months. As time went on and as the illness of the patients progressed, additional problems arose from the newly developed medical situations.

Emotional Problems of the Group

From the above two sections, it was shown that some

patients needed emotional support to accept the medical plan. This generally meant that the patients had some emotional problems which had a negative effect upon their medical conditions. A close study of the conversations and behavior of the patients revealed that in most situations there were various kinds and degrees of emotional undercurrents. The emotional and the social problems were interwoven and cannot be segregated.

Only four patients among the group failed to show any negative feelings or emotional reactions. A diabetic patient with bilateral amputation adjusted well to her condition and was even optimistic and cheerful in her outlook. She was a married woman living with her husband in a comfortable home. Two other patients adjusted well to their situations; one was also a diabetic, bilateral amputee, receiving public assistance and living with a son and a granddaughter; the other was an aged widow, living alone who was receiving Old Age Assistance. Both were independent personalities with considerable ego strength. Another patient had only one interview with the social worker and failed to manifest any emotional reaction.

The remaining thirteen patients all disclosed various negative feelings. Fears of death, of hospitalization, of surgery, or of other things were fairly common. Anxiety over one's own physical condition, over the medical treatment plan, or over financial situations existed among most patients. Some patients showed symptoms of regression, being over-demanding, irritable, aggressive, or narcissistic; while others had feelings of rebellion against their dependency and helplessness. Most patients verbalized

feelings of loneliness and depression. A few manifested some guilt feelings and regarded their illness as punishment for unconscious guilt.

Total Problems of the Group

TABLE X

TOTAL PROBLEMS OF THE SEVENTEEN PATIENTS

Problems	No.of Problems at Referral	No.of Problems after Referral	Total
Lack of Adequate Care	9	2	11
Need of Financial Assistance	4	6	10
Problems Related to Hospitalization and Follow-Up at Clinics		10	10
Need for Emotional Support	1	8	9
Difficulty in Family and Social Relationships		8	8
Need for Better Housing and Living Arrangements	1	5	6
Need for Medical Appliances and Supplies	2	2	4
Total	17	41	58

The total number of problems revealed by the patients was fifty-eight. They fell into seven categories. Most of them were inter-related. For example, one patient had need for adequate care and her problem was related to her financial problem. When the financial problem was solved, her problem of care was also solved. Another patient had problems in living arrangements which resulted from difficulties in her relationship with her daughter with whom she was living. When a problem presented various facets, all of them were counted as separate problems in Table X.

As has been mentioned in the preceding section, most patients had emotional problems of various kinds related to their social problems. The nine patients who are listed in Table X as needing emotional support had such serious problems that they needed considerable supportive case-work help.

Analysis of Services Offered by the Medical Social Worker

What types of services did the medical social worker offer to help the patients solve their problems? What community resources did she utilize in helping the patients meet their needs? In what areas was she successful and in what areas was she less able to help? What were some of the reasons for her failure to meet adequately some of the patients' needs? These are the questions raised in this section.

Table XI on page 31 shows to what extent the patients'

needs were met through the help of the social worker. A problem was considered adequately solved when the solution was satisfactory to the patient and was in keeping with his or her medical need. A problem was considered partially solved when its solution was not entirely satisfactory to the patient but was in accordance with the medical plan for the patient or when its solution met only part of his or her medical need. A problem was not met when no solution was worked out.

Of the fifty-eight problems revealed by the patients, forty were adequately met, seven were partially met, and eleven were not met to any degree.

The areas in which the medical social worker was most able to help were need for emotional support and difficulty in family and social relationships. The areas in which the medical social worker encountered difficulties were in financial problems and plans for adequate care for the patients. The chief difficulties she encountered were opposition of the patients, opposition of the family, and lack of community resources.

Opposition of patients or family were largely due to emotional or psychological reasons. Most patients in the group were aged people who resisted change. One patient refused to move from her unhealthy substandard apartment because she had stayed there for over twenty years. Another patient needed to move to a lower floor because of her heart condition, but she resisted the medical plan for the same reason. Most patients resisted nursing home care though they were badly in need of some one to take care of them. Opposition to hospitalization was mostly due to

fear of death or surgery.

Lack of resources was another difficulty in meeting the patients' needs. The chief source utilized for providing care for the patients was nursing home care, but most patients did not welcome such care. Of the eleven patients who needed adequate care, only five were able to accept nursing homes, and one of the five finally left the home where he had been placed for some time.

Financial aid and the service of the visiting nurse were the other sources utilized in meeting the patients' need for care. Financial assistance obtained from the Department of Public Welfare enabled the daughter of one patient to stay at home to care for her and solved her problem adequately. Small financial assistance was offered to some patients to enable them to hire neighbors to run errands for them and thus solved their problems partially. The service of the visiting nurse was successfully utilized. Such service, however, met the patients' problem only partially when the living arrangement of the patient was itself most unsatisfactory.

Public assistance was the chief resource utilized to meet the patients' financial needs. Four patients had their needs met adequately by public assistance. Six patients did not have their needs fully met because either they were not eligible or the public relief agencies thought that they had adequate incomes.

Table XII on page 32 shows the reasons for which the social worker failed to help the patients meet their needs adequately.

TABLE XI

ANALYSIS OF DEGREE TO WHICH PATIENTS' PROBLEMS WERE MET

Problems	Problems Adequately Met	Problems Partially Met	Problems Not Met	Total
Lack of Care	5	5	1	11
Financial Problems	4	2	4	10
Problems Related to Hospitalization and Follow-Up at Clinics	7	-	3	10
Difficulty in Family and Social Relationships	8	-	-	8
Need for Emotional Support	9	-	-	9
Housing Problem and Living Arrangements	4	-	2	6
Need for Medical Appliances and Supplies	3	-	1	4
Total	40	7	11	58

TABLE XII

ANALYSIS OF REASONS FOR INADEQUATE SOLUTION OF PROBLEMS

Problems	Opposition of Patients	Opposition of Family	Lack of Resources	Total
Lack of Care	4	2	-	6
Financial Problems	-	-	6	6
Problems Related to Hospitalization and Follow-Up at Clinics	3	-	-	3
Housing Problem and Living Arrangements	2	-	-	2
Need for Medical Appliances and Supplies	1	-	-	1
Total	10	2	6	18

TABLE XIII

ANALYSIS OF SERVICES OFFERED BY THE SOCIAL WORKER TO MEET PATIENTS' PROBLEMS

Problems	No. of Problems	Types of Services		
		Interpretation	Supportive Casework	Environmental Manipulation
Lack of Care	11	10	8	9
Financial Problem	10	10	-	6
Problems Related to Hospitalization	10	4	7	4
Need for Emotional Support	9	-	9	-
Difficulty in Family and Social Relationships	8	8	8	-
Housing and Living Arrangements	6	6	-	4
Need for Medical Appliances	4	4	-	3
Total	58	42	32	26

Table XIII on page 33 shows the types of services offered by the medical social worker to help the patients meet their needs. They were interpretation, supportive casework and environmental manipulation.

Interpretation was needed in most cases. Interpretation of the patients' needs was frequently made to the public relief agencies, family, landladies, or other agencies involved in order to obtain their cooperation in helping the patients. Sometimes it was necessary to clarify with the patients some confusions they had regarding their medical treatment or other problems that worried them. In many cases it was necessary to interpret to the physicians the social problems and feelings of the patients. In planning for the care of patients, the physician usually recommended nursing home care without considering their feelings, and the social worker had to interpret for these patients when such plans were not acceptable to them.

Supportive casework helped many patients accept the medical plan, smooth their relationship with their family or landladies, or function better within their physical limitations. One patient was badly in need of care but she resisted nursing home care which was the only facility available for her. Through the sustaining casework relationship with the social worker, the patient finally was able to accept the plan and had her need met.

Manipulative service was an important service in solving social problems and removing external pressures. Other agencies were often involved and on account of lack of community resources, the social worker sometimes encountered difficulties in this area. Other environmental

services consisted of arranging for appointments at clinics, arranging for transportation, contacting relatives for patients, giving collateral information, etc. Such services formed an important and necessary part of the social worker's job and had great significance for the patients.

In meeting the needs of the patients, the social worker worked in collaboration with various agencies. Table XIV lists all the agencies involved.

TABLE XIV

OTHER AGENCIES INVOLVED IN HELPING THE PATIENTS MEET THEIR NEEDS

Agencies		Cases
Other Hospitals		3
Visiting Nursing Association		5
Department of Public Welfare		14
Other Public Agencies		4
Boston Housing Authority	1	
Division of Vocational Rehabilitation	1	
Social Security Administration Office	1	
American Red Cross	1	
Boston Provident Association		1
Family Society of Great Boston		1
Other Private Agencies		4
Total		32

CHAPTER V

CASE STUDIES

In the preceding chapter, the social and emotional problems of these seventeen patients were analyzed and the services which the medical social worker offered to help them solve the problems were briefly discussed. In this chapter some individual cases will be presented to illustrate the nature of the problems and how they were met.

As shown in Table X on page 27, the problems of the group fell into seven categories. They were: 1) lack of adequate care, 2) need for financial assistance, 3) problems related to hospitalization and follow-up at clinics, 4) need for emotional support, 5) difficulty in family and social relationships, 6) need for better housing and better living arrangements, and 7) need for medical appliances and supplies.

1. Lack of Adequate Care

Eleven patients lacked adequate care. How they were helped to solve their problems was mentioned in the previous chapter. Here are two cases in which the patients all lacked care, but they presented two different situations. In the first case, the patient had a daughter who was willing to care for her at home but who had a financial problem to solve before she could take the responsibility. In the second case, the patient realized that she needed nursing home care and was able to do some planning but she

needed help to carry out her plan.

Case 1

> Patient was a sixty-two year old, colored widow with diabetes and arteriosclerotic heart disease. She had ulcer of the leg and was completely bed-ridden. She was on General Relief and lived with a daughter who worked as a housemaid. The daughter who had previous contact with the social worker requested the social worker to help her make plans for the care of the patient since she had to go to work.
>
> The patient had no other sources of income or other relative who could take care of her. While exploring with the daughter possible plans for the patient, the social worker found that the daughter would be willing to give up her work in order to stay at home to care for the patient, if her financial need could be met through other means. As this seemed to be the best plan for the patient, the social worker helped the daughter to apply for General Relief. The daughter's application for this aid was granted, and she gave up her work to care for the patient. The arrangement proved satisfactory to both the patient and the daughter.
>
> Realizing that it was a heavy responsibility for the daughter to care for the patient, the social worker continued her supportive visits to the family. The patient was hospitalized twice and had one leg amputated. Further financial problems arose as the patient needed special medication and surgical dressings. Efforts were made to secure aid from the Department of Public Welfare to no avail. Special funds in the hospital were finally utilized to meet the patient's needs.

In this case the problem of care for the patient was related to financial need. The patient's daughter was able

and willing to care for her but she had to work to support herself. Nursing home care for the patient was not considered since the patient had no funds to meet the cost and furthermore she did not want it. After exploring with the daughter all the possible plans for the patient, the best plan seemed to be for the former to stay at home to care for her mother. The services offered by the social worker helped to solve the patient's problem to the satisfaction of both the patient and her daughter and in keeping with the patient's medical need.

The patient had other financial problems arising from her illness. These needs were met by utilization of special funds in the hospital.

Planning for this patient was made mainly with the daughter. Supportive casework was offered to the daughter to reinforce her strength in caring for the patient.

Case 2

Patient was an eighty year old widow of Syrian origin living alone on Old Age Assistance. Her medical diagnoses were severe angina and hypertensive arteriosclerotic heart disease. She was unable to care for herself and asked the physician to find a nursing home for her.

The patient could not speak English freely, so a friend of hers acted as interpreter during the social worker's initial visit. However, after a few interviews the social worker and the patient were able to understand each other without the interpreter.

The social worker found out the kind of nursing home the patient would go to and recommended two homes for her to choose from.

> The patient selected one home which she had visited and liked. She went there and settled down.
>
> In helping the patient to plan for nursing home care, the social worker had to interpret the patient's need to a friend of hers and also to her priest. Both doubted that the patient could settle down in any nursing home and thought that a home for Syrian people would be more suitable for her. The social worker felt that the patient could decide for herself and invited her to participate in all the planning and to make all the decisions herself.

This patient was the only one among the group who asked for a nursing home. She showed considerable ego strength in making plans for herself and she participated actively in all the planning. The service she needed from the social worker was in making practical arrangements to carry out her plan. Such service was offered her by the social worker and met her needs adequately.

Interpretation of the patient's needs to her friend and priest was necessary because their understanding and cooperation were required in helping the patient to carry out her plan.

2. Need of Financial Assistance

Ten patients had need for financial assistance. Some needed some extra money to meet their medical needs, such as special diet, special medication, or medical appliances. One patient's difficulty was due to his lack of budget planning; another had difficulty because her Social Security check had been stolen. In the case presented below, the

patient's illness created for his family a grave financial problem which was adequately met by the medical social worker.

Case 3

Patient was a thirty-five year old, white wage earner. His diagnosis was acute infectious hepatitis and he was hospitalized from the Home Medical Service.

As the patient would need considerable period of hospitalization and convalescent care, he was in need of financial aid to support his family, which consisted of a wife and three young children. He was referred to the Social Service Department for help.

When the social worker visited the home of the patient, she found the wife unaware of the patient's condition. The social worker interpreted to her the implications of the patient's illness and helped her to explore possibilities of sources of income during her husband's non-remunerative recuperative period. As the family had no other source of income, the availability of General Relief and Aid to Dependent Children was explained to her. The wife showed some reluctance in applying for public assistance since the family had never been on relief before. The social worker accepted her feelings but pointed out the reality situation to her. She also arranged for a housekeeper to take care of the children for one day so that the wife could go to the relief agency to make the application. The wife was finally able to accept the plan and received Aid to Dependent Children.

The social worker continued her supportive visits to the family. The wife managed well with the assistance she received and the

husband improved as anticipated. Three months after the onset of his illness, he recovered and went back to work.

This patient had a serious financial problem. His family needed temporary help for maintenance during the period of his illness. In addition, anxiety and worry over the situation he could have might complicate his illness. Timely assistance solved not only the problem of the patient and his family but also the problem for the community.

For an independent personality with self-respect, it is frequently difficult to accept help, especially financial help, from other people. This case was handled skillfully and the aid the family received was used in a healthy way.

Case 4

Patient was blind and had left hemiplegia. She was seventy-seven years old and lived alone. She complained to the physician about financial difficulties saying that she used to receive Aid to the Blind but it had been discontinued lately.

The patient lived in a substandard house. According to her story, her aid was discontinued because the authorities thought that she had some source of income. Actually she only owned the house which she inhabited, and the rental she received from some rooms in the house was very inadequate.

Contact was made with Aid to the Blind. Interpretation of the patient's medical condition and need was given to that agency. The patient's eligibility was re-established and she was informed to make re-application.

The discontinuation of the patient's aid was partly due

to the fact that she was reluctant to give information and was so inconsistent in her conversations that the relief agency believed she had other sources of income. Interpretation from the medical social worker gave that agency a better understanding of the patient and helped to re-establish her eligibility.

3. Problems Related to Hospitalization and Follow-Up at Clinics

While the patients were under the care of the Home Medical Service, six needed hospitalization and four had to come to different clinics for medical evaluation or follow-up. One patient had three hospitalizations and two other patients had two each. When the problem of hospitalization or attending clinics arose, it was generally necessary for the social worker to make all the practical arrangements for the patients. Transportation usually had to be provided through the service of Red Cross or by the Social Service Department. In some cases the social worker had to accompany the patients to the hospital or clinic. During the patients' hospitalization it was sometimes necessary for the social worker to arrange with Old Age Assistance or the landlady to retain the patient's room for him.

With some patients, supportive casework was needed in helping them accept hospitalization or attend clinics. The patient mentioned in Case 1 under the section, Lack of Adequate Care, page 37, had resistance to hospitalization because of fear of surgery. One patient with rheumatoid arthritis and another with a question of tumor had to come to the clinics for evaluation, but their fear and anxiety

prevented them from following the medical recommendation.

In some cases, practical limited service such as arranging transportation for them helped the patients accept the plan. Accompanying the patients to the clinics was also a great support.

No case illustration will be given here, as this problem can be seen in several cases mentioned under other problems in this chapter.

4. Need for Emotional Support

Nine patients had need for emotional support to accept the medical plans or to face the various problems arising from their illness. The following case will be illustrative.

Case 5

> This patient was a sixty-six year old widow with arteriosclerosis, heart disease, diabetes mellitus, peripheral neuritis and arthritis. She lived alone and was bedridden. The physician found that she had no one to take care of her and recommended nursing home care.
>
> The patient showed a great deal of anxiety when the social worker paid her initial visit. She introduced the subject of nursing home care and told the social worker that she did not want to be put in "those homes" or to be moved away from her room. She wanted to know what the social worker had to say to her.
>
> During the interview the patient apologized about the condition of her room. When talking about her relatives, she said that she would be ashamed to have them visit her in her condition.

> A working relationship was established with the patient. During subsequent interviews, the patient talked much about having terrible dreams which she described vividly to the social worker. She also expressed her fear of dying from her coughing spells which she frequently had.
>
> The patient could not even get up for her meals and had to depend upon her neighbors. Once the physician found her without any meal for two days. However, she still rejected nursing home care.
>
> The social worker made regular supportive visits to the patient, offering her practical services, clarifying some of her confusions regarding the medical plan for her, and helping her verbalize her ambivalent feelings. After several weeks, the patient accepted the medical recommendation and was placed in a nursing home where she was thought to be able to get the best care possible for her.

One important function of the medical social worker is to help the patient implement the medical recommendations. In this case, the patient could not accept the medical recommendations because of emotional reasons and the social worker's service proved helpful. From the remarks which the patient made about the condition of her room and about her relatives, we could sense the resentment and rebellion which she felt toward her illness and the feeling of desperation and helplessness accompanying it. To a patient who felt rebellious toward her illness, the medical recommendation would carry with it implication of authority and stir up feelings of resentment. This was probably one of the reasons why this patient found it so hard to accept a plan which seemed best for her.

The service offered to this patient by the social worker was mainly supportive. It was largely through the sustaining casework relationship that the patient was able to accept the reality and make the necessary adjustment to it.

5. Difficulty in Family and Social Relationships

Eight patients had some problems with their families, relatives or landladies. Most situations arose from the patients' need for care. One landlady complained to the physician that a patient who was her tenant was too great a burden to her that she requested nursing home for the patient. Another landlady refused to take a patient back after his discharge from the hospital. One patient wanted to live with a daughter who was unwilling and unable to take care of her. Three patients had a daughter, a husband or a sister who were devoted to them and willing to care for them, yet there was ambivalent feeling and difficulty in their relationships. One patient wanted a relative to take care of her, but the relative never answered her letter. Another patient had friction with a son and a teen-aged granddaughter with whom she was living.

In such situations the social worker generally took a supportive role. On one hand she tried to help the family or landlady develop some understanding of and sympathy with the patients, and on the other hand she tried to help the patients increase their ego strength to achieve more realistic and satisfying relationships with other people.

Below is a case showing this problem and the help

offered by the social worker.

Case 6

This was a colored widow sixty-four years old with dupdenal ulcer and hypertension. After discharge from the hospital, she went to live with a daughter. The daughter had three children and only three rooms. She complained that she could not keep the patient because of over-crowding living conditions, because she was not a nurse, and because she had three young children to take care of. Nursing home care was recommended to the patient but was rejected by her.

After a few interviews with the social worker, who tried to give support to both the daughter and the patient, the patient went back to her own apartment. During the six months when the social worker continued to see the patient, the patient had a number of clinic appointments and two hospitalizations. The social worker showed her interest in the patient through concrete services such as giving her taxi slips for transportation, accompanying her to clinics, and the like. After her second hospitalization, the condition of the patient was such that she could not possibly care for herself. The daughter's attitude toward the patient had become warmer and more sympathetic, but her circumstances made it difficult for her to take the patient under her care. The problem was solved when another daughter, who lived in another city, offered her home to the patient.

6. Need for Better Housing and Living Arrangements

Six patients had problems connected with housing or living arrangements. Except for two patients who refused to move from their inadequate lodgings for emotional

reasons, all the others had their problems satisfactorily solved. Here is a case which was satisfactorily solved.

Case 7

> This diabetic patient had bilateral amputation because of gangrenes. She had applied for an apartment in a housing project but her application had not been granted. With the help of the social worker, who informed the housing authorities of the patient's physical conditions and needs, the patient was able to move into an apartment that was more suited to her medical needs.
>
> The patient also had financial problems which arose from her illness. She lived on some pension supplemented by Old Age Assistance, but she needed extra money to pay for insulin syringes, needles and the like. Her needs were met by the public assistance agency through the help of the social worker.

7. Need for Medical Appliances

Four patients needed medical appliances and supplies. One of them needed new dentures but hesitated to come to the clinic for evaluation. Before her problem was solved, she was hospitalized at another hospital and her case was transferred. The other three patients all had their needs met.

Case 8

> Patient was a fifty-five year old married woman who had both legs amputated because of diabetic gangrene. She was referred to the social worker because she needed help in obtaining a prosthesis.

In helping the patient to obtain the prothesis, the social worker conferred with the Division of Vocational Rehabilitation and the Bay State Society for the Crippled and Handicapped before she referred the patient to the Amputee Clinic at the Massachusetts General Hospital where the patient secured what she needed.

The family was self-supporting but was unable to meet the cost of the prosthesis. This need was met by the Bay State Society for the Crippled and Handicapped.

CHAPTER VI

SUMMARY AND CONCLUSIONS

This thesis is a study of seventeen chronically ill patients receiving care from the Home Medical Service of the Massachusetts Memorial Hospitals during November, 1949 to November, 1951. The questions which the writer raised in this study were: 1) Who were the patients with chronic disease? 2) What were the prevalent chronic diseases among this group of patients? 3) What were some of the social and emotional needs of the patients that arose from their chronic illness? 4) How were these needs met by the medical social worker? and 5) What was the role of the medical social worker in working with this group of patients?

As this study was limited to a small number of chronically ill patients, the conclusions drawn from this study can be applied only to this group.

This group included both white and Negro patients with the percentage for the white a little higher. It was composed largely of aged females and recipients of public assistance. The majority of the group were widows and lived alone with few family ties or friendly bonds.

The most prevalent chronic disease among this group was heart disease, nine patients out of the seventeen having some forms of cardiac illness. After heart disease came, according to their incidence, 1) diabetes mellitus, arteriosclerosis and hypertension, 2) cancer and malnutrition, and 3) arthritis, asthma, diseases of the eye and neuritis. As to the degree of physical disability caused by the

chronic illnesses, five patients were completely bed-ridden, four were confined to their rooms spending the day partly in bed and partly in the chair, and eight were ambulatory. Four patients succumbed to their illnesses during the casework contact.

This group of patients had various social and emotional problems which arose from their illness situations and complicated their medical problems. Their problems may be roughly classified into seven groups: 1) lack of adequate care, 2) need of financial assistance, 3) problems related to hospitalization and follow-up at clinics, 4) need for emotional support, 5) difficulty in family and social relationships, 6) need for better housing and better living arrangements, and 7) need for medical appliances and supplies.

The emotional problems revealed by these patients were closely related to their social problems. In most situations there were various kinds and degrees of emotional undercurrents. Most patients disclosed emotional disturbances which could be harmful to their recuperation. Fears of death, hospitalization or surgery, and feelings of loneliness and despair were common. Anxiety over various problems, particularly over financial conditions, existed among most patients. Some patients showed a considerable amount of regression and were demanding, irritable, complaining or narcissistic. A few patients had ambivalent feelings regarding their illness or seemed to have found secondary gains in their physical ailments.

The total number of problems revealed by the group was fifty-eight; most being inter-related and being various phases of some major problems. Of these fifty-eight

problems, forty were adequately met, seven were partially met, and eleven were not met.

The social worker was most able to help in cases in which the patients needed emotional support or had difficulty in family and social relationships. She was less able to help in financial problems and problems of care for the patients.

The reasons that some problems of the patients were not adequately met by the social worker were: 1) opposition of patients or family due to emotional problems and 2) lack of community resources.

The types of services offered by the social worker to help the patients meet their needs were mainly interpretation, supportive casework and environmental manipulation.

Interpretation was need in most cases. The most frequent interpretations were made to other agencies involved of the needs of the patients. This was important in helping the other agencies acquire a better understanding of the patients and become interested in them so that they would be ready to offer the needed assistance. Interpretations to the family or landlady were often needed in order that they could plan intelligently and participate responsibly in the care of the patients. For five patients, planning was done mainly through interviews with the family because the patients were senile, disoriented, or too ill. For some patients who could not grasp the medical recommendations given them by the doctor or who had confusion about certain problems, the social worker had to make interpretations to them. Helping the patients understand the medical recommendation was one of the social worker's chief tasks.

Lastly, interpretation to the doctor was necessary in many cases when the doctor did not have a good understanding of the patient's social environment or feelings that conditioned his or her illness. One of the medical social worker's functions was to bring to the doctor her individualized knowledge of the patient in the social, economic and emotional areas to help him to employ such information in working out an adequate medical plan for the patient.

Supportive casework was significant with these patients since this was an unhappy, lonely aging group. Supportive casework helped several patients accept the medical plan, achieve a more realistic and satisfying relationship with family or landlady, and develop more ego strength to function better within their physical limitations. Supportive casework was needed for families in some cases. This often helped the family to become more sympathetic and understanding and more willing to attend to the patient's medical needs.

Environmental manipulative services were important in meeting the patients' practical problems, such as lack of care, financial difficulty, housing problem, need for medical appliances, and the like. Such reality problems exerted harmful influence upon the patients and made their physical discomfort more unbearable. Removal or alleviation of environmental pressures was important for the patients' rehabilitation. Even for those patients with poor medical prognoses, these services made their life situations more comfortable during their last days.

Approved:
Richard K. Conant
Richard K. Conant
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