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A STUDY OF TWENTY ADULT CARDIAC CASES AT RHODE ISLAND HOSPITAL TO SHOW THE FACTORS WHICH HAD BEARING ON THE PATIENTS' FOLLOWING OR NOT FOLLOWING THE MEDICAL RECOMMENDATIONS

A THESIS

Submitted by

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(A.B., Colby College, 1943)

In Partial Fulfillment of Requirements

for the Degree of Master of Science in Social Service

1949

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CHAPTER I

INTRODUCTION

PURPOSE OF THE STUDY

This study of twenty adult patients with arterio-sclerotic heart disease or hypertensive cardio-vascular disease was undertaken to find out some of the common factors which had bearing on the patients' following or not following the medical recommendations. Such a subject was selected because the significance of cardiac patients' adhering or not adhering to the necessary recommendations may well be spoken of in terms of life or death.

The study purports to determine what common areas are influential in affecting the patients' adjustment to their illnesses. Such areas may include lack, non-use or inadequacy of community resources, poor home conditions, poor social planning or the patients' own inability to accept their illness limitations. The positive aspects in the above areas may be influential in affecting adequate adjustment.

It is the writer's intention to break down these broad areas, wherever one is significant, to show the specific factors which influence presence or absence of adjustment. The over-all purpose of this thesis is to point up existing inadequacies so that they may be known

and so that steps may be taken to remedy or to eliminate them.

SCOPE OF THE STUDY

The material for this study was taken from the records of the Rhode Island Hospital in Providence, Rhode Island. These included the social service records, the medical records and the out-patient department records. Because the social service records in many cases were incomplete the material was supplemented by data from records of other agencies. In addition, the writer contacted various community resources to determine their adequacy and function in respect to the service offered and/or the amount and type of service given to a particular patient.

The writer was interested in studying the problems of adult patients with arteriosclerotic heart disease and hypertensive cardio-vascular disease. It is widely recognized that these two conditions are the major causes of cardiac deaths for the middle and old age groups.[1] The conditions may also be present in the younger adult age group but their incidence here is less frequent in proportion to other types of heart disease. The records were accordingly selected on the basis of diagnosis. The age range in these cases falls between forty and eighty.

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1 See Chapter II, page 8.

In the two year period from January, 1947 through December, 1948, 239 adult cardiac patients were known to social service.[2] One hundred and eighty-one of these had arteriosclerotic heart disease or hypertensive cardiovascular disease. One hundred of this number had some type of written material. Forty-two of the one hundred were written up in records. (The remainder were summarized briefly on short service cards.) The writer selected those twenty records which furnished the most information in respect to patients' adjustment to their illnesses.

It is obvious that the cases selected are not representative of a cross-section of cardiac patients inasmuch as they are only eleven per cent of the total hospital cardiac admissions for the two year period.[3] In addition, most cases known or referred to social service are ward patients. However, the writer is interested in the problem of patients' lack of adjustment. The cases known to social service fall largely into this category. Because such a small number of the total cases known have any written record it is difficult to state the social service representation in respect to the twenty cases used. The writer feels justified in concluding, however, in view of the inadequacy

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2 Information obtained from the medical worker's monthly statistical sheets.

3 Total cardiac admissions for 1947 and 1948 were 2,077.

of social service cardiac coverage, that these cases were ones which the worker chose to concentrate on and to write up in some detail out of the total number worked on, and in this respect the cases may be said to be representative of the total known.

The twenty patients were all hospitalized in Rhode Island Hospital sometime during the two year period (1947-1948) and then discharged into the community. The length of follow-up in the social service records varied according to the time the patient was admitted to the hospital and according to the type of service given. In addition, several of these patients were hospitalized more than once during the two year period or had been hospitalized before 1947, and referred to social service more than one time. The writer, therefore, in the cases of more than one admission or referral took a fixed time during the 1947-1948 interval in each individual case and studied the material during and following that particular hospitalization period. The periods of study for each patient vary, therefore, in respect to the particular time interval. The common element is the hospitalization and discharge into the community during the two year period. Where there is available information the case is used up to the point where another hospitalization occurs or the 1948 period ends. Where the material covers only a brief period and does not extend,

such information as is available is used, supplemented wherever possible by material from other sources.

Inasmuch as the scope of this study is broad, the worker has, of necessity, had to impose certain limitations in respect to analyzing the individual situations. It is to be remembered that the writer desires to find out common factors for all of the patients which had bearing on their following or not following the medical recommendations. The study, therefore, will not attempt to show all of the minute factors relative to a particular case situation (such as details regarding patients' relationships with their families, reasons for desertion, divorce or marital discord, descriptions of previous maladjustments, etc.) but only the most outstanding in regard to influencing the patients' adjustment to medical recommendations. These common factors (such as use of nursing homes, financial assistance, home conditions, patients' ability to recognize seriousness of their illnesses, etc.) will be broken down wherever possible to indicate how and/or why a particular item was effective.

In further clarifying the above the writer wishes to state that in cases of individual inability to accept illness limitations no attempt will be made to explore the deep-seated underlying emotional conflict which may be responsible, or to handle the material in terms of a per-

sonality analysis.

Finally the writer would like to point out that this study does not purport to show comprehensive social service function in these cases but only social service action as it is instrumental in affecting patients' adjustment to a particular medical recommendation.

The material obtained from the twenty cases is presented in statistical form. Following this two cases representative of the group are presented to illustrate the statistical data. On the basis of standard medical recommendations for cardiac patients a schedule was drawn up. The twenty cases plus information regarding patients obtained from other sources were applied to this schedule. The material abstracted was compiled to arrive at significant statistical results.

PLAN OF THE STUDY

The writer's plan for developing this thesis is as follows: Chapter I is an introduction to the study including the purpose, scope and the plan for development of the study. Chapter II will indicate the present day problem of arteriosclerotic heart disease and hypertensive cardiovascular disease, including national statistics, Rhode Island Hospital and social service statistics and the physical picture of both cardiac conditions. Chapter III will state and explain the medical recommendations for cardiac patients and

indicate the type of resource necessary to meet the need. Chapter IV will be a presentation of the descriptive data for the twenty patients studied in statistical form. Chapter V will include a presentation of two cases representative of the group. Chapter VI will consist of summary, conclusions and recommendations.

CHAPTER II

THE PRESENT DAY PROBLEM OF ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSIVE CARDIO-VASCULAR DISEASE

Heart disease is the nation's number one health problem. At the present time approximately 4,000,000 Americans have some kind of heart trouble.[1] One out of every twenty persons suffers from diseases of the heart and blood vessels; and one out of every three deaths is due to diseases of the heart and blood vessels.[2] It has been estimated that heart and blood vessel diseases account for one death a minute in the United States.[3]

Heart disease kills more people than the five other leading causes of death combined. In 1945 out of a thirteen and a half million population tuberculosis killed 53,000, pneumonia 68,000, nephritis 88,000, accidents 96,000, cancer 117,000 and heart disease 587,000.[4] The heart disease death figure in 1948 was close to 600,000.

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1 Howard Blakeslee, Know Your Heart, p. 3.

2 American Heart Association, One Out of Three, p. 1.

3 American Heart Association, What About Your Heart, p. 1.

4 Paul D. White, M.D., "Heart Disease: Twenty-Seven Questions Answered," Vogue, May, 1947, p. 14.

It has been estimated that by 1960 it will be 1,200,000.[5] The tremendous increase in heart disease deaths is attributed to the increase in total population as well as to the increase in the age span.[6]

It is to be noted that heart disease is not only a major cause of death but also of chronic disability. It causes a loss of 152,100,000 week days annually.[7] It is not only detrimental in terms of death and disability but also in terms of mental anxiety and loss of self-reliance.

There are three main causes of heart disease in the United States today: arteriosclerosis, hypertension and rheumatic fever. Arteriosclerotic heart disease is most common among the aged; hypertensive cardio-vascular disease is most common among the middle aged; and, although rheumatic heart disease is most common among children, it also appears in large numbers in the young adult, middle and old aged groups. In the middle and old age groups, alone, however, arteriosclerotic heart disease and hypertensive cardio-vascular disease are the most predominant.[8]

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5 Blakeslee, op. cit., p. 1.

6 Metropolitan Life Insurance Company, Studies in Heart Disease, p. 1.

7 American Heart Association, One Out of Three, p. 4.

8 American Heart Association, What About Your Heart, p. 2.

It is interesting to note the Rhode Island Hospital adult cardiac admissions during the 1947 and 1948 period to show the incidence of arteriosclerotic heart disease and hypertensive cardio-vascular disease in proportion to the other causes of heart disease. This data is presented in Table I.

It may be noted in Table I that arteriosclerotic heart disease and hypertensive cardio-vascular disease lead the list of heart disease causes, forty-three per cent and forty-two per cent, for the adult group. The combined figure is eighty-five per cent of the total.

A tabulation of these Rhode Island Hospital adult cardiac patients known to social service during the 1947 and 1948 period showing the high incidence of arteriosclerotic heart disease and hypertensive cardio-vascular disease repeated is presented in Table II.

It may be noted in Table II that arteriosclerotic heart disease and hypertensive cardio-vascular disease again lead the list of heart disease causes, although in different proportion, fifty-nine and twenty-four per cent respectively. The combined figure is eighty-three per cent of the total.

The prevalence, then of arteriosclerotic heart disease and hypertensive cardio-vascular disease in adults in terms of Rhode Island Hospital statistics is high. It can readily be seen that these two causes of heart disease far

TABLE I

INCIDENCE OF ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSIVE CARDIO-VASCULAR DISEASE IN PROPORTION TO OTHER CAUSES OF HEART DISEASE: RHODE ISLAND HOSPITAL ADULT CARDIAC ADMISSIONS, 1947 AND 1948

Type of Heart Disease	Number of Patients 1947	1948	Total Number	Total Per Cent
Arteriosclerotic Heart Disease	397	488	885	43
Hypertensive Cardio-Vascular Disease	418	455	873	42
Rheumatic Heart Disease	80	93	173	08
Arteriosclerotic and Hypertensive Heart Disease	36	70	106	05
Congenital Heart Disease	1	1	2	001
Syphilitic Heart Disease	1	8	9	004
Beri-beri Heart Disease	0	6	6	003
Heart Disease Undiagnosed	2	2	4	002
Hyperthyroid Heart Disease	1	1	2	001
Subacute Bacterial Endo-carditis	3	5	8	004
Tuberculosis Heart Disease	0	0	0	000
Heart Disease Due to Poison	6	2	8	004
Heart Disease Due to Tumors	0	1	1	001
Total	945	1,132	2,077	1000

TABLE II

INCIDENCE OF ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSIVE CARDIO-VASCULAR DISEASE IN PROPORTION TO OTHER CAUSES OF HEART DISEASE: ADULT CARDIACS KNOWN TO RHODE ISLAND HOSPITAL SOCIAL SERVICE OUT OF TOTAL HOSPITAL ADMISSIONS, 1947 AND 1948

Type of Heart Disease	Number of Patients 1947	1948	Total Number	Total Per Cent
Arteriosclerotic Heart Disease	68	73	141	59
Hypertensive Cardio-Vascular Disease	24	33	57	24
Rheumatic Heart Disease	14	14	28	12
Arteriosclerotic and Hypertensive Heart Disease	5	1	6	02
Congenital Heart Disease	1	1	2	01
Syphilitic Heart Disease	1	2	3	01
Beri-beri Heart Disease	0	1	1	005
Heart Disease Undiagnosed	0	1	1	005
Hyperthyroid Heart Disease	0	0	0	00
Subacute Bacterial Endo-carditis	0	0	0	00
Tuberculosis Heart Disease	0	0	0	00
Heart Disease Due to Poison	0	0	0	00
Heart Disease Due to Tumors	0	0	0	00
Total	113	126	239	1000

outweigh any others. The figures are in agreement with national figures in the respect that nationally the two diseases are predominant in the middle and old age groups.

The writer feels that a presentation of the physical picture of these two types of heart disease is helpful in understanding their nature and severity and why the need for following medical recommendations is so important.

Arteriosclerosis is a disease wherein changes take place in all of the blood vessels of the body.[9] Since the heart is a very important part of the blood vessel system it, too, is affected by arteriosclerosis. The importance of arteriosclerosis in the heart is considered a disease entity in itself. It is called arteriosclerotic heart disease.

The heart, although part of the blood vessel system, also has its own blood supply. This is comprised of vessels called the coronary arteries and veins. It is through these vessels that the heart muscle derives all its nourishment and oxygen; and if this blood supply is cut off the heart muscle cannot survive.

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9 Subsequent material presented in this chapter regarding the conditions of arteriosclerotic heart disease and hypertensive heart disease, unless otherwise designated, was obtained from Dr. George H. Huston, Surgeon, Middlesex County Hospital, Waltham, Massachusetts.

In arteriosclerotic heart disease coronary arteriosclerosis is a common complication. The coronary arteries become inefficient with respect to their chief duty of transporting blood. The walls of the vessels become thick and rough, thus jeopardizing the passage of blood through them. When a part of the heart muscle receives less nourishment than normal from the coronary blood vessels supplying it the patient often experiences pain commonly called angina pectoris. If this reduction in blood flow is only a temporary one the pain usually disappears on rest or by taking certain drugs and there is oftentimes no permanent damage to the heart muscle. However, if one of the coronary arteries becomes completely blocked by a blood clot (thrombus), by a particle of the arteriosclerotic vessel wall breaking off or by the gradual thickening of the walls themselves that part of the heart muscle supplied by the affected blood vessel can no longer function properly.

A new source of blood supply may become available to the heart muscle by a process which is known as collateral circulation, and if this develops adequately along with sclerosis of the arteries, heart disease does not develop. This is a process whereby branches of the coronary arteries become larger and carry more blood "to the extent that they supply enough blood to that part of the heart muscle which

was being deprived by the original hardened artery."[10]

It is hoped that an adequate collateral circulation will develop to take care of that part of the heart muscle being periodically deprived of blood after the angina attack.[11] Rest and relaxation are advised to help this collateral circulation develop. Death may occur with the first angina pectoris attack but more often patients have numerous attacks and live through them as the attacks last only a brief period of time and because collateral circulation eventually develops.

However, if collateral circulation does not develop and the pain does not subside as in the typical angina pectoris and the heart muscle continues to be deprived of its blood supply the disabled

> heart muscle keeps on with its regular contractions along with the rest of the heart for hours until the muscle fibers become swollen and defunct. When this occurs they cease to contract and the pain begins to subside.[12]

There remains a considerable bruise to the muscle and it is necessary for the patient to rest for several weeks in order that scar tissue may be formed in place of this bruise and in order that collateral circulation may develop.

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10 Paul D. White, M.D., Heart Disease Caused by Coronary Arteriosclerosis, p. 2.

11 Ibid., p. 4

12 Ibid.

> During the first week the heart wall at the point of injury is at its weakest so there is danger of rupture with hemorrhage into the pericardial sac and consequent death.[13]

There is likewise danger after coronary thrombosis of angina pectoris or cardiac enlargement. As in angina pectoris the initial attack may be fatal or the patient may recover and live for years. Cardiac Failure is the eventual outcome of such a condition.

In arteriosclerotic heart disease not only are the blood vessels of the heart involved to make the heart work less effectively but also there can be a very definite involvement of the heart valves. The two valves chiefly affected are the mitral valve which lies between the left ventricle and the left auricle and the aortic valve which lies between the left ventricle and the aorta. The changes in these structures are such that the flow of blood through the heart is not adequately controlled since the valve action has been interfered with. Because of this the heart is called upon to do additional work to keep the blood moving in the right direction which factor places an additional strain on the heart. Such a condition may cause a dilatation of the heart which may be compensated for by the heart muscle becoming stronger. This in itself, however, calls upon an increased blood supply and since, as has been

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13 Ibid., p. 4.

stated above, there is already arteriosclerosis of the arteries, the hypertrophy is usually inadequate. Cardiac failure is the eventual outcome of such a condition just as it is in coronary heart disease.

Hypertensive cardio-vascular disease develops as the result of high blood pressure over a long period of time.

> Blood pressure is the pressure under which the blood in the arteries is maintained. It is important because the blood can be made to flow only by maintaining pressure in the arteries just as water will flow through a hose only if it is under pressure. No one can live without blood pressure.[14]

High blood pressure is when the pressure within the arteries is greater than normal. Blood pressure is abnormal when it exceeds 140 systolic and 90 diastolic. (Systolic blood pressure is the pressure in the arteries just as the heart completes a contraction or beat and diastolic is the pressure in the arteries when the heart is temporarily at rest.)

"The heart acts as a pump which makes blood move through the body."[15] The arteries are the medium through which the blood is pumped. As the arteries lead out from the heart into the various sections of the body they end up in arterioles, tiny blood vessels which are the smallest branches of these arteries.[16] These arterioles are

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14 E. V. Allen, M.D., High Blood Pressure, p. 4.

15 Ibid.

16 Metropolitan Life Insurance Company, Your Heart, p. 8.

constricted less blood can get into them from the arteries, the heart is forced to pump harder against the increased resistance to keep the blood flowing at a near normal rate and so the pressure of blood in the arteries goes up. When the arterioles are dilated the reverse process takes place.[17]

Hypertension is present when these arterioles are in a constant constricted state thereby forcing the heart to work harder all of the time. The specific reason for the nerves causing this arteriole constriction is unknown. There have been many theories advanced but the exact reason has not been definitely proven as yet. When the blood pressure remains constantly high the heart muscle due to overwork is forced to enlarge. This is the first step in the development of hypertensive cardio-vascular disease.[18] Following this the heart eventually reaches a point where it cannot cope with the increasing blood pressure because the blood supply within the muscle cannot keep up with the increase in muscle size. When such a condition occurs there is dilatation of the heart (as seen also in arteriosclerotic heart disease) which leads to cardiac failure.

The prognosis for patients with hypertensive cardio-vascular disease varies. Some may succumb early; others

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17 Ibid.

18 Ibid.

live for several years. Regulated activity and avoidance of excitement are imperative.

It is to be noted that a patient may have either arteriosclerotic heart disease or hypertensive cardiovascular disease or both. If the latter is the case the complications are accordingly multiplied. However, as far as is known today hypertension does not cause arteriosclerosis nor does the latter cause the former.

This physical picture of the two cardiac conditions indicates the severity of the two diseases. Because of this and the fact that there are no known cures for the diseases it is doubly important for patients to adhere to the medical recommendations in order to prolong their lives. These medical recommendations will be discussed in detail in the following chapter.

CHAPTER III

AN EXPLANATION OF WHAT THE MEDICAL RECOMMENDATIONS FOR CARDIAC PATIENTS ARE AND AN INDICATION OF THE TYPE OF RESOURCE NECESSARY TO MEET THE NEED

By and large the medical recommendations for all cardiac conditions are the same. They vary, however, in proportion to the severity of the particular type of heart disease. The presence of the condition of arteriosclerotic heart disease or hypertensive cardio-vascular disease denotes in itself either actual heart change or damage or possible pending heart change or damage. Often either disease is detected only with the occurrence of the first heart attack. It follows, therefore, that these patients are severely incapacitated from the time that their illness is discovered. The degree of incapacitation depends (among other factors) upon the actual damage to the heart muscle. Those patients, who recover from the first heart attack, develop scar tissue and collateral circulation and are not in imminent danger of another attack (so far as is known), may return, after hospitalization and a period of temporary nursing care, to their former lives with restriction of activities. Those patients, on the other hand, whose heart conditions have become so acute that there is continual danger of another attack or cardiac failure should receive after hospitalization (in a general hospital) continuous

medical, nursing or custodial care or a combination of these.

One medical recommendation then for cardiac patients (arteriosclerotic heart disease or hypertensive cardiovascular disease) after hospitalization is either temporary care or chronic care.

Temporary care may be obtained in a private nursing home in the community, in a public nursing home designated for this purpose or in the patient's own home with the services of a trained nurse. A fourth alternative, usually less satisfactory, is care in the patient's home administered by relatives either with or without the frequent services of a district nurse.

Chronic care, depending on the particular type required, may be obtained in a chronic-care state hospital, in a private or public nursing home, in a boarding home or in the patient's own home.

A further medical recommendation for cardiac patients is restriction of physical activities. This includes restrictions in respect to returning to work as well as restriction of normal physical activities. The recommendation may be that the patient cease work entirely because the exertion required by such activity might be severe enough to bring on a heart attack. This recommendation obviously includes all of the chronic care patients.

The recommendation, on the other hand, may be that

the patient can return to work provided he takes a light job. A light job is one which requires little physical effort. The patient is not called upon to hurry, overwork or become fatigued.[1] It has been pointed out that "a great amount of physical effort can lead to the onset of chest pain and shortness of breath."[2] Such a recommendation as the above often requires that the patient change over to a new type of work. When this is the case vocational rehabilitation and job placement are often needed. This recommendation usually applies to the temporary care patients.

In conjunction with job restrictions there is the recommendation for some cardiac patients who have complicating physical disabilities aside from or in connection with those of the heart condition to have a period of occupational therapy before returning to their occupation. A program geared to service this need is accordingly necessary.

In addition to working restrictions there are restrictions in respect to normal physical activities. This includes, in the broad sense, some curtailment in almost every sphere of physical activity and elimination of some

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1 Community Service Society, Cardiac Conditions, p. 9.

2 Leonard J. Goldwater, M. D., "Heart Disease and Employment," Rhode Island Medical Journal, March, 1947, p. 14.

types altogether. The cardiac patient should avoid stair climbing, walking fast, walking in severe weather, swimming in cold water, doing strenuous housework, engaging in competetive athletics and the like.[3] The cardiac patient needs a great deal of physical rest and relaxation. He should go to bed early and take a nap during the day. This latter gives the heart an opportunity to rest.[4]

It has been stated that the patient with heart disease has to go against the American way of life. He is forbidden to gamble or take a chance as such a venture (in terms of physical action) might prove to be fatal. These risks denied the cardiac patient are the ones which add zest to the ordinary routine of living.[5] Many cardiac patients are obliged to alter their whole pattern of life and this is a difficult task to start upon at middle or old age. Because of the difficulty involved in readjustment and particularly in regard to the curtailment of physical activity, it has been suggested that compensatory substitutes be provided to take up the patients' time and interest. Such substitutes would include sedentary games of skill and chance and other appropriate recreational activities. In

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3 Community Service Society, op. cit., p. 8.

4 Metropolitan Life Insurance Company, Your Heart, p. 14.

5 Irving R. Roth, M. D., Problems in the Prevention and Relief of Diseases of the Heart, p. 13.

addition programs providing for the development of hobbies such as drawing, painting, sculpturing and the like would be helpful.[6] It is felt, therefore, that a facility designed to meet these needs would be of value.

A most important medical recommendation for cardiac patients is avoidance of emotional strain. "Worry and severe nervous shocks can aggravate a cardiac condition."[7]

> The heart beats faster under emotional stress and pumps out more blood. The faster it beats, the harder it works and the less time it has to rest.[8]

It has been pointed out that "alleviation or elimination of the causes of emotional disturbance may increase the patient's activity and ability to function better."[9]

The patient's emotional adjustment to his illness is dependent upon a gamut of factors: the patient's personality, his relationship to the people in his environment, his economic situation, the availability of community resources and the like.[10] The type of resource helpful in removing

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6 Community Service Society, op. cit., p. 8.

7 Paul D. White, M. D., "Heart Disease: Twenty-Seven Questions Answered," Vogue, May, 1947, p. 14.

8 Metropolitan Life Insurance Company, Your Heart, p. 4.

9 Ethel Cohen, "The Social Component in Heart Disease," American Heart Journal, October, 1938, p. 429.

10 Ibid., p. 428.

disturbing emotional factors varies in respect to the individual problem. If the problem is caused by environmental factors, alleviation or elimination of them is indicated. The medium for affecting this change is often social service help. If the problem is due to the patient's own emotional maladjustment intensive case work or psychotherapy may be indicated.

A common medical requirement for any incapacitated person is an adequate budget (income) to maintain a decent standard of living and to meet the medical needs. The budget for cardiac patients should include "special allowances for extra rent, blankets, beds, drugs and medical care,"[11] plus adequate amounts for fuel, food and special diets.

The obvious resource for meeting this need is one which can supplement inadequate private incomes in order to raise the individual to a decent standard of living level. In situations where the individual has no income the budget should be apportioned in the same manner.

A further medical recommendation for cardiac patients is "adequate, continuous medical supervision for an indefinite period of time."[12] Doctor's attention falls

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11 American Public Welfare Association, "Organized Care of Chronic Illness," p. 2.

12 Cohen, op. cit., p. 427.

within this category. Such a need is met by the services rendered by hospital clinics or by the services of local medical doctors in their offices or in the patients' homes. A second recommendation which falls within the medical follow-up category is that of home nursing care. This pertains to those patients who are not in nursing homes or chronic care hospitals. Such care is provided by a trained nurse in the home, by frequent services of a district nurse or by relatives with or without the services of a district nurse. In respect to the services of a district nurse it has been recommended that some nurses be especially trained in the field of heart disease in order to meet the cardiac requirements more adequately.[13]

In addition to the above medical recommendations for cardiac patients, special recommendations may be needed. This includes a special diet and/or special medicine. The diet is usually a low salt or protein one.[14] It is important for the patient to follow the diet, particularly in cases of hypertensive cardio-vascular disease, as it is felt that the presence of salt in the system may have a direct bearing on the arterioles. In addition, all obese

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13 Frank Cutts, M. D., "Needs in the Field of Adult Cardiac Difficulties," p. 4.

14 Allen, M.D., op. cit., p. 9.

patients with either type of the disease are advised to lose weight as overweight may put an added strain on the heart.[15] Accordingly there should be a resource available to furnish a copy of the diet and to assist the patients in planning it and budgeting their funds, if necessary.

The special medicine usually in the form of pills or injections is given to alleviate acute pain (as in angina pectoris), to maintain the proper heart rate or to provide other corrective measures in the heart. It is vitally important for cardiac patients to take the medicine prescribed as this can prevent the occurrence of a heart attack. It is recommended, therefore, that medication be readily available to cardiac patients and supplied at a minimum of cost. A resource to meet this need is often the hospital clinic.

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15 American Heart Association, What About Your Heart, p. 4.

CHAPTER IV

PRESENTATION OF THE DESCRIPTIVE DATE FOR TWENTY CASES

In this chapter it is the writer's purpose to show whether a group of twenty cardiac patients followed the medical recommendations or not and the common factors which had bearing on the patients' following these recommendations or not following them.

In order for the reader to have a more comprehensive picture of the patient group studied, the following data is presented even though it is not pertinent to the following or not following of medical recommendations in this study. Of the twenty patients studied five were in the forty to fifty age group, four in the fifty to sixty age group, seven in the sixty to seventy age group and four in the seventy to eighty age group. Ten of these patients were male and ten were female. Nineteen were white and one was colored. Twelve were Catholic, six Protestant and two Jewish. Five of the patients were single, six were married and living with their spouses, five were either separated from spouses or divorced and four were widowed. Eight patients had hypertensive cardio-vascular disease and twelve patients had arteriosclerotic heart disease.

The medical recommendations for the twenty patients are as follows: seventeen needed chronic care, three needed

temporary care. All of the patients needed restriction of physical activity in some area. Twenty were either not to work at all, had to take a lighter job or could return to work only after a period of occupational therapy. All of the patients had restriction of normal physical activity. All of the patients needed avoidance of emotional strain and an adequate income to maintain a decent standard of living and to meet the medical needs. All of the patients needed medical follow-up: twenty needed doctor's care and ten home nursing care. Within the category of special recommendations eighteen patients needed medicine and nine needed to follow a diet.

The procedure of presenting the descriptive data is outlined as follows: There are seven main categories designated as titles by a number and name. They are Chronic Care, Temporary Care, Restriction of Physical Activities, Avoidance of Emotional Strain, Adequate Budget (or Income) to Maintain A Decent Standard of Living and to Meet the Medical Needs, Medical Follow-Up and Special Recommendations. Three of these titles are subdivided to incorporate the necessary items pertaining to the title subject. Restriction of Physical Activities is subdivided to include Not Working at All, Necessity of Taking Light Job, Necessity of Having a Period of Occupational Therapy before Returning to Work and Restriction of Normal Physical Activity. Medical Follow-

Up is subdivided to include Doctor's Care and Home Nursing Care. Special Recommendations is subdivided to include Special Diet and Medicine. The other four titles are not subdivided and are considered as units in themselves. Under each title or item the writer will first indicate how the particular recommendation for the patients was determined. If the adequacy of following a recommendation is denoted by the patients' using a particular type or kind of service or community resource, in itself, such a criterion will then be indicated and the reasons for the adequacy pointed out before actual presentation of the material begins. The writer will then indicate in tabular form whether or not the patients adhered to the particular recommendation. The descriptive data expanding upon the items in the tables will follow indicating the principal reasons why patients followed or did not follow the recommendations. The common significant factors as shown by the detailed presentation of the descriptive data will then be pointed out at the end of each title or item.

TITLE I - CHRONIC CARE

The recommendation for patients to have chronic care was determined from the social service records where in most cases it was recorded that the doctor referred patients for this service. In many cases the particular type of chronic care was indicated such as State Infirmary or nursing home.

In those cases where the doctor did not recommend chronic care and/or where the special type of care was not indicated and the patients' condition and other factors in the situation indicated the need for it the writer placed the patient in the chronic care category and designated the special type of care.

For the purposes of this study four types of chronic care were set up as ideal criteria: institutional care, nursing home care, temporary nursing home care followed by chronic boarding home care and chronic boarding home care only. Where the patient did not accept one of these plans but returned to his own or relatives' home each home situation was evaluated and if it met the need for the most part was deemed satisfactory.

Instituional care, after hospitalization in a general hospital, is used here to designate care in a chronic hospital where doctors', nurses' and attendants' services are immediately and continuously available. Patients in this group are either in continual need of these services (bed cases) or in frequent need of these services but need continuous medical supervision. Their conditions are such that lack of availability of services at a particular moment might well result in heart attack and death. This group may lead a bed-chair existence or may be ambulatory at times. The patients usually fluctuate between a bed, bed-chair and

ambulatory existence, the amount of each or combination of one or all being unpredictable. The main factors which differentiate this type of care from all others are the immediate availability of doctors' attentions and the hospital setting.

Chronic nursing home care after hospitalization in a general hospital is used here to designate nursing care in a nursing home where a doctor's attention is needed only occasionally. The emphasis is on nursing care together with a well balanced routine of living. Such patients have doctors' attentions as needed either by services of a local medical doctor or by attending clinic. Most patients need bed nursing at first, then lead a bed-chair and partly ambulatory existence. Their condition requires, however, continuous nursing supervision and continuous availability of nursing care.

Temporary nursing home care followed by chronic boarding home care is used here to designate nursing home service for a period of time followed by custodial care where the patient is furnished with board and room and supervision of activities. By the time these patients go to a boarding home they are ambulatory and are able to provide their own personal care. Chronic boarding home care only, after hospitalization, falls within the same definition as given above.

It is to be noted here that under the first category (institutional care) chronic nursing home care is offered when the patient refuses a chronic hospital (namely the State Infirmary). Such an alternative in this study is considered adequate as it provides for the greater part of the needs.

Seventeen patients needed chronic care: seven needed institutional care, six needed chronic nursing home care and four needed temporary nursing home care and then chronic boarding home care. Table III shows the number of patients who received chronic care.

TABLE III

THE RECEIPT OF CHRONIC CARE

Type of Chronic Care	Number of Patients Who Receive Chronic Care	Number of Patients Who Do Not Receive Chronic Care	Total Number of Patients
Institution or Adequate Substitute	1	6	7
Nursing Home or Adequate Substitute	5	1	6
Temporary Nursing Home Followed by Boarding Home or Adequate Substitute	1	3	4
Total	7	10	17

Of the seven patients who were referred for institutional care six did not receive adequate chronic care. Five refused to go to the State Infirmary or a nursing home. Four of these patients could not accept the illness needs in terms of separating from their former way of living regardless of the type of chronic care offered. The fifth patient refused because he would only accept care in the Jewish Home for the Aged. Three of these five patients returned to their own homes and lived alone. These plans were inadequate because patients had to do their own work and care for themselves. Two of these five patients returned to their own families or went to relatives' homes. These plans were inadequate because one patient was left alone all day and the other patient did not receive continuous medical care in the home. One of the six patients was not referred to the State Infirmary or a nursing home by the doctor and did not have adequate care. In this instance the doctor refused to recognize social service interpretation of the home conditions. This patient returned to his own home where care was inadequate because he did not receive continuous medical attention. (This patient became worse and had to be readmitted to the hospital.) In five of these six cases social service interpretation of the chronic care need to the patients was not accepted by them.

The most common significant factors brought out by the above data are the inability of patients to accept their illness needs in terms of separating from their former way of living (in the home) regardless of the type of community resource offered and that patients' homes did not meet the need because the patients were alone, had to care for themselves, do their own work and did not receive continuous medical care.

Of the seven patients recommended for institutional care one received adequate chronic care. This patient refused the State Infirmary because she stated it was a place to die. The patient had previously been in a nursing home but this had not proved satisfactory. The patient returned to her own home where the family assisted and where district nurse and doctor's services were frequent and continuous.

The most common significant factor brought out by the above data is that the home is satisfactory for chronic care when relatives cooperate and district nurse and doctor's services are supplied and are continuous.

Six patients needed chronic nursing home care. Five of these patients did receive adequate care. Four accepted care in nursing homes. These patients recognized the need of chronic care, had previously lived alone and wanted chronic care. Care in these nursing homes is considered adequate as all the homes are licensed by the City of

Providence and are thereby obliged to adhere to certain standards. Social service arranged nursing home care in three cases, interpreted the need to relatives in two cases and the need to the Department of Public Welfare in three cases. The Department of Public Welfare paid for nursing home care in three cases. The fifth patient received adequate chronic care in her own home. This patient liked being independent and wanted people to help her. The home was adequate because a friend obtained medicine for patient and gave her injections and relatives did the housework and provided nursing care.

The most common significant factors brought out by the above data are patients' willingness to accept chronic care based on recognition of the need and fact that they had previously lived alone; the availability and use of nursing homes; the function of social service in arranging nursing home care and interpreting the need to the Department of Public Welfare and the service rendered by the Department of Public Welfare in paying for the care.

Of the six patients who needed nursing home care one did not receive adequate care. This patient went to a nursing home for a temporary period but left when she felt better as she no longer recognized the need for care. Patient returned to her own home which was dirty and crowded. Social service arranged nursing home care, interpreted the

need to relatives and made weekly payments to the nursing home with money deposited at social service by the patient's son.

The most common significant factors brought out by the above data are that as the patient felt better she no longer saw the need for care in a nursing home and her own home was unsatisfactory because of dirty and crowded conditions.

Four patients needed temporary nursing home care followed by chronic boarding home care. Three of these patients did not receive adequate care. Two patients went to a nursing home for a temporary period but left before they should. Both returned to their former way of life, went to work and lived alone. Both stated that as they felt better they no longer saw the need for care. Social service made nursing home arrangements and paid a small weekly amount pending sick benefits for one patient. The fourth patient returned to his own home because he preferred to make his own plan. The home was inadequate because patient's wife was unable to provide the nursing care needed.

The most common significant factors brought out by the above data are that patients left nursing homes before they should and returned to their former way of living because as they felt better they no longer saw the need for care and that a patient refused nursing home care because

of his desire to make his own plan and returned to his home where nursing care was inadequate.

Of the four patients who needed temporary and boarding home care one did receive adequate care as far as is known. This patient gave up his own room and went into a nursing home. Patient liked being dependent. Social service interpreted the need to patient and the Department of Public Welfare and the latter paid the nursing home fee. As far as is known the patient remained in the nursing home and did not re-enter the community or have boarding home care.

The most common significant factors brought out by the above data are patient's accepting nursing home care because he liked being dependent; the availability and use of a nursing home; the function of social service in arranging care and interpreting the need to the Department of Public Welfare; and the service rendered by the Department of Public Welfare in paying for the care.

In reviewing the total chronic care data the writer will now sum up those factors which were most significant in all types of adequate and inadequate care. The most significant points pertaining to adequate care were the patients' desire for care based on recognition of the need and the fact that patients had previously lived alone; the availability and use of nursing homes; the function of social

service in arranging nursing home care and interpreting the need to the Department of Public Welfare; and the service rendered by the Department of Public Welfare in paying for the care.

The most significant points pertaining to inadequate care were the patients' refusal to accept care outside of the home based on their inability to separate from their former way of living and the patients' leaving nursing homes before they should based on the concept that, as they felt better, they no longer needed further care. In addition, patients' homes proved to be unsatisfactory because patients did not receive continual medical care; patients did not receive custodial care; and homes were dirty and crowded.

TITLE II - TEMPORARY CARE

The recommendation for patients to have temporary care was determined in the same manner as for those patients who needed chronic care.

Temporary care in this study is used to designate convalescent care in a nursing home after a period of hospitalization for a brief time only. The patient can then return to his own home and resume his previous activities with limitations. The nursing home is the ideal criterion set up by the writer. However, if a patient returned to his own home the individual situation was evaluated and if this

fulfilled the need, for the most part, it was deemed satisfactory.

Three patients needed temporary care. The doctor made the recommendation for two and the writer judged from the individual situation that the third patient needed this care. As only three patients needed temporary care and all did not receive it this information is not presented in tabular form.

All of the three patients did not have adequate temporary care. Two patients refused to go to nursing homes because they were unable to recognize the seriousness of their illness. One patient was not referred for care by the doctor who failed to accept social service interpretation of the patient's home conditions. The three patients returned to their own or relatives' homes. Three received no nursing care because relatives did not feel the patients were seriously ill or relatives were not concerned enough to provide care. In addition, one patient was subjected to continuous emotional friction in the home and another was in a dirty and crowded home. Social Service interpretation of the need was not accepted by these patients or their relatives.

The most common significant factors brought out by the above data are that patients refused nursing home care because they were unable to recognize the seriousness of their illness and that homes did not provide the nursing

care because relatives likewise were unable to recognize the seriousness of patients' illness or were not concerned enough in patients' welfare.

TITLE III - RESTRICTION OF PHYSICAL ACTIVITIES

ITEM A - PATIENT IS NOT TO WORK AT ALL

The recommendation for patients not to work at all was determined from doctors' statements recorded in the social service cases or from the doctors' designation of chronic care which category in itself excludes working.

Seventeen patients were not to work at all. Table IV shows the number of patients who accepted this recommendation.

TABLE IV

THE ACCEPTANCE OF NOT WORKING AT ALL

Whether or Not Patient Accepted Not Working At All	Number of Patients
Did not work	14
Did work	3
Total	17

Of the seventeen patients fourteen accepted the medical recommendation. Twelve of these patients had not worked before hospitalization so that the illness need did

not pose a new problem. In addition, these twelve patients were not obliged to work to supply their subsistance needs. Six patients had been receiving Department of Public Welfare assistance and continued. One patient had been receiving Red Cross assistance and continued to do so. Two others were previously housewives, had lived on allotments and husbands' earnings and continued in this way. One other had been living on savings and continued. The ninth patient lived on savings and then received Department of Public Welfare assistance. The source of income for the tenth patient is not known.

Two of the twelve patients had previously worked before hospitalization. These patients gave up work because they recognized the seriousness of their illness. Both patients accepted Department of Public Welfare assistance for the first time. Social service referred these patients to the Department of Public Welfare and interpreted the need to that agency.

The most common significant factors brought out by the above data are patients' previous acceptance of not working before hospitalization so that the illness did not pose a new problem and the availability and use of the Department of Public Welfare or private funds so that patients were not obliged to work to supply their subsistance needs.

Three of the seventeen patients did go to work. Two

stated that they were obliged to work because of lack of funds. Both refused Department of Public Welfare referral because it was charity. The third patient reported that, as he felt better, he believed his illness to be of a temporary nature and he could work with no harm to himself. This patient was not pressed for subsistance funds. All three took jobs requiring great expenditure of physical energy.

The most common significant factors brought out by the above data are that patients worked because of lack of funds and refused to accept a financial dependency status and that patients believed their illness was of a temporary nature and they could work with no harm to themselves.

ITEM B - PATIENT CAN WORK IF HE TAKES A LIGHT JOB

The recommendation for patients to take a light job was determined from doctors' statements recorded in the social service cases. These patients were not in need of chronic care.

Two patients could take light jobs. As only two patients fall within this recommendation the acceptance is not presented in tabular form. One patient did not take a light job; the other chose an adequate substitute and did not work at all.

One patient took the wrong type of job. He became

a dishwasher. This patient refused to consider social service referral for vocational rehabilitation, stated that he was capable of finding a job himself. The patient could not understand the meaning of light job in terms of the illness need.

The most common significant factors brought out by the above data are the patient's inability to understand the need of a light job in terms of his illness and his refusal of assistance based on his independent attitude.

One patient did not return to work at all. Inasmuch as this patient did not engage in physical activity on a job, this is judged by the writer as satisfactory for this category. The patient was not obliged to work because he had sufficient income from a veteran's pension and other sources to cover his subsistance needs. Patient wanted to return to his former job (fireman) but his employer would not rehire him due to the illness. Patient would not accept any other referral. Social service referred patient to the Veterans Administration to apply for the pension.

The most common significant factors brought out by the above data are that the patient had a private income so that he was not forced to work, that his former employer refused to rehire him due to the illness and that social service and the Veterans Administration helped patient to obtain this private income.

ITEM C - PATIENT CAN WORK IF HE HAS A PERIOD OF OCCUPATIONAL THERAPY

The recommendation for occupational therapy was determined on the basis of the doctor's statement and the social worker's interpretation of the need as recorded in the social service record. As only one patient needed a period of occupational therapy and received it, this information is not presented in tabular form.

In this particular case the occupational therapy was indicated for a condition other than the heart condition. The doctor stated that in terms of the cardiac condition patient could return to his own job. It was obvious, however, that patient could not work at all unless something was done to correct a nerve condition of his hands.

This patient returned to work after a period of occupational therapy. He accepted social service referral to Community Workshops, received training and improved sufficiently to take up his former job.

The most common significant factors brought out by the above data are the patient's willingness to accept occupational therapy; the availability, use and adequacy of Community Workshops and social service referral to that agency.

ITEM D - RESTRICTION OF NORMAL PHYSICAL ACTIVITY

The recommendation for restricting normal physical activity was determined from the social service cases where

the doctors' statements were recorded.

Twenty patients needed restriction of normal physical activities. Table V shows the acceptance of this recommendation.

TABLE V

THE ACCEPTANCE OF RESTRICTING NORMAL PHYSICAL ACTIVITY

Whether or Not Patient Restricted Normal Physical Activity	Number of Patients
Did restrict activity	8
Did not restrict activity	10
Not Known	2
Total	20

Eight of the twenty patients restricted their activities. Five of these patients were in nursing homes where they received the proper rest and were not allowed to overexert or engage in strenuous activity. The other three patients lived in their own or relatives' homes. In these cases patients were too ill to engage in much activity and relatives were available to do the heavy work, housework and cooking.

The most common significant factors brought out by the above data are the importance of the routine and

supervision of the nursing home in curtailing activity and the factor that patients at home were too ill to engage in activity and relatives did the necessary work.

Ten of the twenty patients did not restrict their physical activity. Five patients did not rest. Three of the five returned to their jobs against advice. Two of the five took long walks and two others chopped wood. These five patients stated they did not like to sit around, that it was difficult to do nothing, that there was no diversion to take up their time and energy.

Two of the ten patients left nursing homes before they should. One returned to a job and the other did strenuous housework. Both patients stated that, as they felt better, they believed their condition was not serious and saw no harm in resuming normal activities. Two others of the total ten patients lived alone and did all their own housework. Patients refused to go into any type of home for care and no one came to their homes to assist. The tenth patient was unable to rest due to noisy children in the neighborhood. This patient wanted to move but no other facility was available.

The most common significant factors brought out by the above data are that patients found it difficult to do nothing and there was no satisfactory diversion provided; that as patients felt better they believed their condition

was no longer serious and resumed normal activities; that when patients refused outside care no one came into their homes to assist.

The writer was unable to obtain information concerning the physical activities of the other two patients.

TITLE IV - AVOIDANCE OF EMOTIONAL STRAIN

The recommendation for avoidance of emotional strain was determined by the writer as a requisite for all of the patients as it is one of the standard criteria set up for all people with cardiac conditions.

Twenty patients needed avoidance of emotional strain. Table VI shows the acceptance of this recommendation.

TABLE VI

THE ACCEPTANCE OF AVOIDING EMOTIONAL STRAIN

Whether or Not Patient Avoided Emotional Strain	Number of Patients
Did avoid emotional strain	0
Did not avoid emotional strain	16
Not known	4
Total	20

Sixteen patients were unable to avoid emotional strain. Six patients had continuous upsets due to friction

or difficulty with family or relatives. Two of these patients continued with long term marital maladjustments which were accentuated by the patients' illness. One patient continued with a long term friction with his mother-in-law and another patient with her daughters. Both of these were also accentuated by the patients' illness. A fifth patient was upset because her children would not help her and a sixth felt neglected because her son would not help her. In the above six cases either patients' or relatives' personalities or attitudes were to blame.

Intensive case work or psychotherapy was indicated for these patients in order for them to adjust better. Rhode Island Hospital Social Service is too understaffed to provide adequate intensive coverage of cases. Supportive help was given but this was inadequate. (It is felt by the writer that these were medical social problems and therefore should have been handled by hospital social service, especially since a type of relationship was established during supportive case work.) Patients were not referred by doctors for psychotherapy. The community resources providing this service are so limited that there is not adequate coverage and so there is little point in referring patients for this type of help.

Four of the sixteen patients had upsets due to financial difficulties. Three patients were unable to live on

their incomes and had continuous trouble over lack of adequate funds. One of these three was ineligible for Department of Public Welfare assistance; a second refused to apply for Department of Public Welfare assistance because he would have to sell his car; a third was receiving Department of Public Welfare assistance but claimed the amount was insufficient. One of the four patients was disturbed because Red Cross would not pay for storage of her furniture. In one case social service referred the patient to Red Cross where patient filed for and obtained a higher serviceman's allotment. In another case social service interpreted the financial need to the Department of Public Welfare which agency raised the budget but not to a high enough level to satisfy patient. The adequacy of Department of Public Welfare budgets and patients' incomes will be discussed under Title V.

Six of the sixteen patients had upsets due to more diversified factors. One patient was upset because he could not move. There was no facility available. A second was upset because she was not admitted to St. Elizabeth's Home.[1] This home had a long waiting list and could not service patient.

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1 A private nursing home for chronically ill patients where a $1,000. fee is required on entrance and patient may remain for life.

A third was upset because she was not admitted to the Home for Aged Women. Patient was refused admittance because she did not pass the physical examination. A fourth patient feared that her child would be sent back to Exeter[2] and she wanted him in the home. Social service arranged for the Department of Public Welfare worker to discuss this with patient and child remained in the home. The fifth patient feared going to the State Infirmary because she thought it was a place in which to die. Relatives allayed patient's fears by refusing to send her there. The sixth patient was upset because his employer would not rehire him and patient felt, therefore, that he was no longer any good. Social service attempts to refer this patient for rehabilitation were not accepted by him. In five of the above cases the primary disturbing factor was in regard to a condition other than the patients' own emotional maladjustment.

The most common significant factors brought out by the above data are emotional strain due to friction or difficulty with family or relatives and emotional strain due to lack of adequate finances. (The writer feels that the other disturbing factors are so diversified that no general conclusions can be drawn.) In regard to the former cause

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2 Home for the feeble-minded.

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of emotional strain the writer feels that intensive case work or psychotherapy was indicated. Neither was provided because Rhode Island Hospital is too understaffed to provide adequate intensive coverage of cases and patients were not referred for psychotherapy because there are not enough adequate community resources to provide this service.[3]

It is not known whether the other four patients avoided emotional strain or not.

TITLE V - ADEQUATE BUDGET (OR INCOME) TO MAINTAIN A DECENT STANDARD OF LIVING AND TO MEET THE MEDICAL NEEDS

This recommendation was judged by the writer as necessary for all of the patients, as it is a standard requirement for all cardiac patients as well as for all incapacitated people.

The writer would first like to define the term "decent standard of living" as it is used in this study. It is based on the definition given in "Family Incomes and Cost of Family Budgets."[4] This is not a minimal standard of living, nor is it a standard of living far above the reach of the great majority of families. It is, instead, a standard which falls between these two extremes; a normal, average standard

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3 See pages 92 and 93.

4 Hurwitz, Abner, "Family Incomes and Cost of Family Budgets," Monthly Labor Review, U. S. Department of Labor, Bureau of Labor Statistics, 66:2, 176, February, 1948.

of living. It is a standard which has been chosen because it reflects a level of living which is common to the majority of families whose needs are adequately supplied. It is a reflection of community experience.[5]

It may be mentioned here that the writer had some difficulty in locating a standardized budget on a decent standard of living level (as defined above), which would have some validity and would include itemized expenditures as well as yearly total budgets (from which weekly budgets could be computed) for average families of one, two, three, four and five persons. The above specifications were necessary (for purposes of comparison) because information pertaining to all the itemized expenditures of the twenty patients was not available although, in most cases, the weekly incomes or budgets could be obtained. In further clarifying this it may be pointed out that itemized medical expenditures for the twenty patients and their resources to meet same were available. However, figures regarding food, clothing, rent and the like for all of the twenty patients were not available. Therefore, the writer has separated medical expenses from all the others and has set these expenses up as one category for comparison. In respect to the other items (food, etc.),

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5 Ibid.

because itemized figures for the twenty patients were not available, the writer had to group all of these into another category and compare them as a whole with a certain fixed criterion, which is a standard budget set up to include the average funds necessary to cover these expenditures. (This standard budget is entitled, "The City Worker's Family Budget."[6] In this study, the section pertaining to Indianapolis, Indiana families by 1945 income and family size in relation to the "City Worker's Family Budget" for March, 1946[7] is used because expenses for families of various sizes are given.[8]) This second category (a composite of food, clothing, etc. and excluding the medical expenditures) is designated as decent standard of living in this study. (The first category is medical expenditures.) Therefore, the basis of comparison will be on two levels: decent standard of living and medical expenditures.

The determination of using these two levels of comparison (one, a decent standard of living, to be compared to a certain fixed figure and the other, medical expenditures, to be compared item by item with other criteria) presents

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6 Kellog, Lester S., and Brady, Dorothy S., "The City Worker's Family Budget," Monthly Labor Review, U. S. Department of Labor, Bureau of Labor Statistics, 66:2, 133-170, February, 1948.

7 Hurwitz, op. cit., p. 177.

8 Ibid., p. 176.

several complications. The "City Worker's Family Budget" (which approximates the requirements of the twenty patients as nearly as possible) gives, naturally, yearly and itemized budgets which include the medical expenses. Furthermore, the itemized medical expenses in this budget do not conform to those of the twenty patients. The "City Worker's Family Budget" is set up to include the normal expectancy of periodic illness, not chronic illness, which latter requires abnormal and continuous medical expense. In addition, the "City Worker's Family Budget" includes pre-paid group health insurance plans, whereas only three of the twenty patients had any type of medical insurance, and this was only for hospitalization.

Therefore, the writer does not intend to use the "City Worker's Family Budget" as a criterion for medical expenses at all. Because, as previously mentioned, itemized medical expenditures and resources to meet same are available in most of the twenty cases, the criteria will be based on the need in the individual case. Such needs include, in general, payment for hospitalization, nursing home care, doctor's, clinic and medical fees. Thus, this medical category is entirely separated from the decent standard of living category which latter is further amplified below.

With the medical criteria and expenditure category thus disposed of, the writer was still faced with the decent

standard of living level category and the "City Worker's Family Budget" which met the patients' needs in areas other than the medical but which, as set up, included in its total figure both the decent standard of living and medical funds. It was necessary to delete the medical allocation before the remaining figure could be validly used. The "City Worker's Family Budget" states that seven per cent of the yearly total is used for medical expenses.[9] This per cent was accordingly deleted from the "City Worker's Family Budget" yearly figures. The remaining figures were used as the criteria for the decent standard of living level.

The original "City Worker's Family Budget" yearly figures were (before deductions) $1,170. for a single man or woman; $1,660. for a family of two; $2,140 for a family of three; $2,552 for a family of four; and $3,110. for a family of five.[10] Seven per cent was deducted from the above amounts and the balance divided by fifty-two to furnish the weekly figure. The criteria used in this study are, therefore: $20.92 weekly for a single person; $29.75 weekly for a family of two; $38.27 weekly for a family of three; $45.64 weekly for a family of four; and $55.62 weekly for a family of five.

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9 Kellog and Brady, op. cit., p. 156.

10 Hurwitz, op. cit., p. 177.

If the patient's weekly income (budget) meets one of the above criteria (determined by the number of persons in his family) he will be considered as having a decent standard of living level. (It is to be noted that the "City Worker's Family Budget" pertains to the 1946 period when prices were lower than in 1947 and 1948. For reasons stated above this budget was used, however, in spite of this obvious limitation. Where the figures of a particular budget or income approximate the "City Worker's Family Budget" on the lower end of the scale and, as such, are deemed adequate, a reservation may be made in terms of the higher prices of the later years.) Finally, in regard to this criterion, the writer wishes to indicate that living in a nursing home, although a medical expense, is considered a decent standard of living level, inasmuch as board and room and living essentials (aside from nursing care) are furnished. The nursing homes in this study are all licensed by the City of Providence and are obliged to live up to certain standards.

If the patient's income (budget) meets the medical criteria (differing in each case) he will be considered as having adequate funds for medical expenses. If his income (budget) meets both criteria it will be considered adequate. If, however, the income (budget) fails to meet one or both criteria it will be considered inadequate.

The writer would like to here indicate that in those

cases where the Department of Public Welfare carries the entire financial responsibility for all expenditures from the beginning of hospitalization on, adequacy is based on the amounts given for subsistance in terms of the criteria given above and whether the necessary medical expenditures are met. In those cases where the patient maintains himself on a private income and the illness forces him to turn to other resources to finance some of his needs, the private income will be deemed inadequate. Savings or flat sums of money are considered part of the weekly incomes in this study, as patients were using these funds to live on at the time of the study. The period of adequacy or inadequacy of funds is for the time of this study only. The writer does not purport to indicate whether or not patients' funds will continue to be adequate or inadequate.

The plan for presentation of the data is first to indicate those patients who had adequate funds to meet both levels and then those patients whose funds were inadequate in meeting one or both levels.

Twenty patients needed adequate funds. Table VII shows the number of patients who had adequate funds.

TABLE VII

PROVISION OF ADEQUATE BUDGET (INCOME) TO MAINTAIN A DECENT STANDARD OF LIVING AND TO MEET THE MEDICAL NEEDS

Whether or Not Patient Had Adequate Funds and Wherein Funds Inadequate		Number of Patients
Did have adequate funds		7
Did not have adequate funds		12
Adequate funds for medical needs but not for decent standard of living	5	
Adequate funds for decent standard of living but not for medical needs	3	
Inadequate to meet decent standard of living and medical needs	4	
Not known		1
Total		20

Seven patients had adequate funds. Four of these patients were in nursing homes for chronic care. The Department of Public Welfare paid the necessary nursing home fee plus small amounts for incidental expenses. Two other patients lived alone and had incomes exceeding $20.92 per week. One of these patients had $4,000. savings plus sick benefits of $18. per week. Patient later returned to work; the amount

of wages is unknown. The other patient had a monthly veteran's pension of $72, veteran's bonus of $200, savings of $200 - $300, bonds (amount unknown) and was eligible for the $20 weekly veteran's benefits. The seventh patient lived with his wife and one child. His weekly income exceeded $38.27. This patient earned $20 per week and his wife earned $20 per week.

In regard to medical expenses the Department of Public Welfare paid all the fees for four of the seven patients. This included hospital bill, nursing home fee, medicine and clinic or doctors' fees. The amounts given were in addition to the patients' regular budget allowance. In one case social service interpreted the higher medical expense need and the Department of Public Welfare gave additional funds.

Three other patients took care of their medical expenses with their own insurance or funds. In all three cases Blue Cross paid for the hospital bill; three patients paid clinic fees and two paid for medicine. (The other did not need it.) In addition, one of these patients paid his own nursing home fee.

The most common significant factors brought out by the above data are the availability and adequacy of the Department of Public Welfare in meeting the living and medical needs when a patient is in a nursing home and the importance of Blue Cross in meeting the hospital bill. (Because the

sources of private income are so diversified the writer feels that they cannot be compiled here to indicate any one significant item.)

Twelve patients did not have adequate funds. Five of these patients had adequate funds for medical expenses but not for a decent standard of living. Three of these five patients were living in their own homes alone and received Department of Public Welfare assistance which was less than $20.92 per week. One received $13.61, the second $10.85 and the third $16.11. A fourth patient was living with one other and received less than $29.75 per week. The Department of Public Welfare allowance was $22.56 per week. A fifth patient lived with two others and received less than $38.27 per week. The Department of Public Welfare allowance was $25.38.

The Department of Public Welfare paid the hospital bill, clinic or doctors' and medical fee in all five cases. The money was given in addition to the regular budget. In one of these cases social service interpreted the need for higher medical funds and these were supplied. In one case patient's son paid the nursing home fee.

The most common significant factors brought out by the above data is that the Department of Public Welfare supplies adequate funds for medical expenses but not for a decent

standard of living[11] when the patient is living in his own home.

Three of the twelve patients had adequate funds for a decent standard of living but not adequate funds to cover medical expenses. One patient had over $500 savings and paid the nursing home fee himself. The second patient lived alone and had an income exceeding $20.92 per week. This income consisted of $18 per week sick benefits, $600 savings and a private insurance from patient's place of work (amount unknown). The patient later returned to work; the amount of wages is not known. The third patient in a family of three had an income exceeding $38.27 per week. This patient received $18 per week sick benefits, $27 in boards and a pension from his place of work (amount unknown). This patient later returned to work; the amount of wages is not known.

Three patients were unable to pay all of their medical expenses out of their own funds. One patient's sister paid the hospital bill and doctor's fee. Another patient paid part of the hospital bill himself and social service cancelled the balance. In addition, social service paid part of the nursing home fee until sick benefits came through for this patient. The third patient was unable to pay for special clinic

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11 The Department of Public Welfare does not meet the criteria figures for a decent standard of living set up in this study.

treatments. Social service made these free.

The most common significant factors brought out by the above data are that funds adequate to maintain a normal decent standard of living level do not cover all of the medical expenses when illness occurs; and the function of social service in making financial adjustments for these patients.

Four of the twelve patients had inadequate funds to meet both the living and medical levels. Two of these patients lived alone and had incomes of less than $20.92 per week. One received unemployment compensation in the amount of $16 per week. The other received $68 serviceman's allotment, $15.69 per week.[12] A third patient in a family of two received less than $29.75 per week. This income was derived from $68 monthly serviceman's allotment and $15 monthly rents, $19.15 per week. The fourth patient in a family of five received less than $55.62 per week. The income consisted of husband's $40 weekly earnings. All of these patients were ineligible for Department of Public Welfare assistance for additional amounts for living expenses because, according to Department of Public Welfare budget, the incomes were adequate.

All four of these patients were unable to pay their hospital bills. Two accepted Department of Public Welfare

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12 Weekly figure derived by dividing monthly figure by four and one third.

referral and that agency paid the fees. Two others refused to apply to the Department of Public Welfare and social service cancelled the bills. One patient was unable to pay her doctor's bills. Red Cross paid for two visits and the remainder were left unpaid. Three of these patients paid for medicine out of their own inadequate weekly incomes. (One patient did not need medicine.)

The most common significant factor brought out by the above data is that patients with inadequate living funds were ineligible for Department of Public Welfare assistance because patients' funds exceeded the Department of Public Welfare's living allowance. In addition, when medical expenses were superimposed upon the regular expenses, patients were unable to pay for most of the medical needs; Department of Public Welfare assistance was available to pay hospital fees.

The writer would like to here indicate the most important data drawn from the significant factors given under each of the above sections. Under the adequate column they are availability and use of the Department of Public Welfare; adequacy of the Department of Public Welfare in meeting both needs when patient lives in a nursing home; the use of Blue Cross in meeting the hospital bill.

Under the inadequate column they are inadequacy of Department of Public Welfare funds in meeting a decent standard of living level when patient lives in his own home; the

patients' ineligibility for Department of Public Welfare assistance except for hospital bills when his income is insufficient to meet a decent standard of living level but only meets a minimum standard of living level; and that the private incomes of some patients which meet the decent standard of living level do not cover the medical expenses when these are added.

TITLE VI - MEDICAL FOLLOW-UP

ITEM A - DOCTOR'S CARE

The recommendation for this service was judged necessary for all of the patients by the writer for obvious reasons. Medical follow-up in this section pertains to whether doctors' care was available or not, what helped the patients to use it or why they did not use it. It does not attempt to show whether one type of care (doctor visiting the home) was more suitable in a particular case than another type of care (leaving the home to go to clinic).

The criteria deemed satisfactory are the Rhode Island Hospital Out Patient Department where the services of the best medical doctors in the state are available and the services of local medical doctors.

Twenty patients needed doctors' care. Table VIII shows the number of patients who received this care.

TABLE VIII

THE RECEIPT OF DOCTOR'S CARE

Whether or Not Patient Received Doctor's Care	Number of Patients
Did receive doctor's care	18
Did not receive doctor's care	2
Total	20

Eighteen of the patients received adequate doctor's care. Twelve of these went to Rhode Island Hospital Out Patient Department. In five of these cases social service arranged ambulance transportation for patients. In three other cases relatives or friends provided transportation. In one of the above cases social service made special treatments free of charge. The factors which motivated three other patients in coming to clinic are not known.

Six of the eighteen patients had the services of local medical doctors. Two of these patients managed to pay doctor's fees themselves although they did not have adequate budgets. In two other cases the Department of Public Welfare paid the fee. In one other case relatives paid the fee, and what helped in the sixth case is not known.

The most common significant factors brought out by the above data are the availability and use of Rhode Island Hospital Out Patient Department and local medical doctors; the factor that patients were assisted in getting to clinic by relatives or by hospital ambulance arranged by social service.

Two of the twenty patients received inadequate care. These patients did not keep clinic appointments because, as their conditions improved, they did not feel further treatment was necessary.

The most common significant factor brought out by the above data is the patients' inability to recognize the seriousness of the illness in respect to the need of long term doctor's care.

ITEM B - HOME NURSING CARE

The recommendation for patients to have home nursing care was determined from the social service records where the recommendation was stated or by the writer who judged there was a home nursing need on the basis of the individual situation. The home nursing need corresponds for the most part to the chronic and temporary care needs. In two cases, however, where institutional care was indicated and patients returned home, home nursing service in itself was not needed at the time of discharge although other benefits of institutional life were necessary. Eight patients were in nursing homes.

Ten other patients needed home nursing care. Of these, six needed continuous nursing care in the home because they were so ill and four needed home nursing care for a temporary period.

Ten patients needed home nursing care. Table IX shows the number of patients who received home nursing care.

TABLE IX

THE RECEIPT OF HOME NURSING CARE

Whether or Not Patient Received Home Nursing Care	Number of Patients
Did receive home nursing care	5
Did not receive home nursing care	5
Total	10

Five patients had adequate care. In all of these cases the relatives in the home recognized the seriousness of the illness. Three were capable of administering home nursing care alone and two gave it with the help of the district nurse. In all five cases doctors' and social service's interpretation of the type of care needed was accepted. In addition, social service referred the district nurse in two cases.

The most common significant factors brought out by

the above data are that relatives recognized the seriousness of the illness and were capable of providing the necessary care; the availability and use of the district nurse in assisting; and interpretation to relatives of the type of care needed (by doctors and social service).

Five patients had inadequate care. In three cases the relatives did not recognize the seriousness of the illness and did not provide care. Relatives refused to cooperate in doctors' or social worker's planning. It is not known whether district nurse referral was suggested. It is probable that in these cases it would have been rejected. Two of the five patients did have frequent services of a district nurse but other factors in the home situation made the total home nursing care inadequate. One patient lived alone and needed continuous nursing care. The other patient also needed continuous nursing care and lived with his wife who was incapable of providing it even with the assistance of a district nurse.

The most common significant factors brought out by the above data are that relatives did not recognize the seriousness of the illness and refused to cooperate in doctors' or social worker's plan and that frequent district nurse services were not enough to counterbalance other factors in the total home nursing needs.

TITLE VII - SPECIAL RECOMMENDATIONS

ITEM A - SPECIAL DIET

The recommendation for patients to go on a diet was determined from the medical records.

Nine patients needed a special diet. Table X shows the number of patients who went on a special diet.

TABLE X

THE ACCEPTANCE OF FOLLOWING A SPECIAL DIET

Whether or Not Patient Followed Diet	Number of Patients
Did follow diet	7
Did not follow diet	2
Total	9

Seven of these patients went on the diet. In five cases the hospital furnished nursing homes with a copy of the diet and it was followed there. In two other cases the hospital gave patients a copy of the diet when they were discharged home. In one of these cases social service interpreted the need of an increased food allowance to the Department of Public Welfare.

The most common significant factors brought out by the above data are the furnishing of the diet by the hospital

and the importance of the nursing homes in supplying the diet.

Two patients did not follow the diet. Both were furnished with copies by the hospital. One refused to follow it because he could not recognize the seriousness of the illness and the other gave up the diet as his condition improved because he no longer saw the need of continuing.

The most common significant factor brought out by the above data is the patients' inability to recognize the seriousness of his illness in terms of following the diet.

ITEM B - MEDICINE

The recommendation for patients to take medicine was determined from the medical and Out Patient Department records.

Eighteen patients needed medicine. Table XI shows the number of patients who followed this recommendation.

TABLE XI

THE ACCEPTANCE OF TAKING MEDICINE

Whether or Not Patient Took Medicine	Number of Patients
Did take medicine	14
Did not take medicine	3
Not Known	1
Total	18

Fourteen patients took the medicine prescribed. Eight of these patients got medicine at the Rhode Island Hospital Out Patient Department at a minimum cost. In five cases the Department of Public Welfare paid and in three cases patients paid themselves. In two of these cases social service got the Department of Public Welfare to increase the patients' funds for special medicine. One other patient was given injections at home by a friend. Of two of the three patients who paid themselves both had inadequate budgets.

Three of the fourteen patients were in nursing homes where medicine was supplied on recommendation of the doctor. Injections and pills were given at the nursing homes. The Department of Public Welfare paid the necessary fee for two patients and the other had an adequate budget and paid himself.

Three other of the fourteen patients who did not attend the Out Patient Department obtained medicine from other sources. In one case the patient's children obtained and paid for the medicine. One other patient obtained and paid for the medicine himself in spite of the fact that he had an inadequate budget. The Department of Public Welfare paid for the third patient's medicine.

The most common significant factors brought out by the above data are the availability of medicine at Rhode Island Hospital Out Patient Department at a minimum cost and the use

of this service; the importance of the nursing homes in supplying and administering the medicine on the recommendation of doctors; and the factor that patients obtained medicine even though they had inadequate budgets to pay, indicating that some other necessary item was sacrificed.

Three of the patients did not take the medicine prescribed. One patient refused to take anything but aspirin, another refused medicine because he said it made him sick and a third did not bother to continue taking medicine as he felt better. In the first case the patient had an inadequate income. The other two had adequate funds.

Inasmuch as the above factors are all different the writer feels that no common significant factors can be pointed out here.

In one other case it is not known whether the patient took the prescribed medicine or not. The other two patients did not need medicine.

CHAPTER V

PRESENTATION OF TWO CASES ILLUSTRATIVE OF THE GROUP

The two cases presented below are illustrative of the two types in the group of twenty patients. In general the patients fell into two categories: those who did not follow the majority of medical recommendations and those who did follow the majority of medical recommendations. The first group tended to disregard all but one or two of the recommendations. These patients either entirely rejected chronic or temporary care or accepted it only for an inadequate period. Once out of the hospital or nursing home they tended to resume a normal routine of living, returned to work, engaged in strenuous physical activities and the like. These patients were unable to avoid emotional strain and tended to have inadequate incomes or budgets. If home nursing care was indicated it usually was not given or, if so, was inadequate. However, most of these patients did obtain doctor's care, did follow a diet (if ordered) and did obtain and take the necessary medicine.

The second group tended to accept all but one or two of the medical recommendations. Most of these patients fell into the chronic care category. Their ability to accept chronic care seemed to pave the way for their acceptance of other recommendations. Desire and need for dependency plus

recognition of the illness needs seemed to be governing factors here. These patients usually went into chronic nursing homes or had adequate care in their own homes. They did not work and tended not to engage in strenuous physical activity. As in the above group, however, these patients were unable to avoid emotional strain. This group tended to have adequate budgets or incomes. If home nursing care was needed, relatives cooperated in providing this service. Most of these patients, as did the first group, obtained doctor's care, followed the diet and took the necessary medicine.

It will be noted that the two illustrations given below do not fit into all the categories outlined in the preceding chapter. Such a coverage would demand presentation of the entire twenty cases. The writer feels, however, that these case situations are illustrative of enough of the major topics to show the general trend of all the patients studied.

Case A is typical of those patients who did not accept the majority of the medical recommendations.

CASE A

Mr. W., age 52 was white and of the Catholic faith. He was admitted to the hospital with arterioscierotic heart disease manifested in the stage of cardiac decompensation. He remained in the hospital four weeks after which time it was recommended that he have a period of temporary nursing home care followed by chronic boarding home care.

Mr. W. was divorced from his wife and lived alone. He was not working at the time that he entered the hospital due to a leg accident. He had been steadily employed previously, however, as a bus driver for the United Electric Railways Company. Patient accepted the nursing home interpretation and social service made arrangements for him to go to a private nursing home in the community. As patient's funds had been somewhat depleted during hospitalization social service paid five dollars weekly for the nursing home until patient's sick benefits came through. This patient remained at the nursing home for a brief period and then left. He returned to his own room and to his former job. He stated that as he felt better he felt he could increase his activities with no harm to himself. Patient in spite of social service interpretation believed his illness to be of a temporary nature. He said also that his funds were depleted and he had to return to work. Patient flatly refused a Department of Public Welfare referral stating that he would not accept charity.

In regard to the danger of physical exertion patient stated that he did not like to sit around and do nothing and that it made him feel better to do something. He resumed a normal routine of living. Mr. W. had continuous friction with his former wife and two children. Although he had never contributed to his children's support he expected them to help him during his illness. He wanted to go to his daughter's home where his former wife was also living. His daughter could not take him because of lack of space and felt it would be a bad situation with her mother in the home. Patient had continuous arguments with his family regarding this situation. His was a case of chronic maladjustment in regard to his family life. Social service gave supportive help but the patient's emotional maladjustment remained unchanged.

Mr. W. had an income exceeding $20.92 per week during hospitalization and while he received sick benefits. He had, before hospitalization, $600. savings and while in the hospital and nursing home a United Electric Railways pension (amount unknown). Sick benefits supplemented this later, (in nursing home). Patient's wages when he returned to work are unknown. Mr. W., although he had adequate funds for a decent standard of living could not meet all his medical expenses. As indicated social service paid five dollars weekly to the nursing home until sick benefits came through. In addition this patient was unable to pay his total hospital bill and social service

had to cancel the remainder as patient refused Department of Public Welfare assistance.

Mr. W. obtained doctor's care at the Rhode Island Hospital Out Patient Department. Social service arranged ambulance transportation from the nursing home for him. Patient obtained his medicine at the out patient department at a minimum of cost and paid for this himself. Mr. W. was not required to follow a diet.

It may be seen from the above illustration that this patient actually only conformed to two of the medical recommendations (doctor's care and the taking of medicine). He was totally unable to recognize his illness needs in regard to the other recommendations.

Case B is typical of those patients who did accept the majority of medical recommendations.

CASE B

Mrs. C., age 60, was white and of the Catholic faith. She was admitted to the hospital with hypertensive cardiovascular disease manifested by a cerebral vascular accident and cardiac decompensation. Patient remained in the hospital four weeks after which time it was recommended that she have chronic nursing home care.

Mrs. C's. husband had deserted her some years ago and patient had been living alone. She accepted the nursing home recommendation because she wanted to be taken care of (wanted dependency) and also recognized the seriousness of her illness. Patient liked the nursing home life and remained there. Social service made arrangements for the nursing home and interpreted the need to the Department of Public Welfare which agency paid the fee. Mrs. C. had been working steadily prior to her illness as a bookkeeper. When the illness occurred, however, she was without funds. Patient recognized that she could not return to work and accepted the Department of Public Welfare referral (financial dependency status) easily. This agency made it possible for patient to obtain subsistance funds without working and also provided the nursing home care needed.

Mrs. C. was restricted in her activities at the nursing home where she stayed. She was not called upon to do heavy work, housework, climb stairs and the like. This patient did not avoid emotional disturbance. Her one son refused to help or have anything to do with patient and this was a continual source of distress to patient. This is an instance where the relative is the cause of the emotional upset. Social service interpretation to the patient's son was of no help. For reasons unknown he refused to assist his mother financially or otherwise.

Mrs. C. had adequate funds to meet her living and medical needs. The Department of Public Welfare, as previously stated, paid the nursing home fee and likewise supplied additional amounts for patient's incidentals. This agency also paid for patient's hospital bill and assumed the responsibility for payment of medicine and doctor's fees. (It was necessary to have a local medical doctor come to the nursing home to attend to Mrs. C..)

Mrs. C. received the necessary injections and medication at the nursing home where these were given on recommendation of the doctor. This patient needed to follow a salt free diet. Instructions regarding the diet were supplied to the nursing home by the hospital and the nursing home gave patient the necessary foods.

It may be seen from the above illustration that this patient conformed to most of the medical recommendations. Her willingness to accept a dependency status and the part played by the nursing home and the Department of Public Welfare (together with the services of other community resources) were instrumental in affecting this adjustment.

CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

It is the writer's purpose in this chapter to summarize the common significant factors brought out in the foregoing material, rearrange them into meaningful categories and made recommendations for some of the more significant lacks and inadequacies.

The writer feels because of the variety of topics and the diversity of material, that a tabular presentation of the summarized significant factors is easier for the reader to understand. The data are, therefore, presented in this manner. Table XII shows only those common significant factors which had bearing on the patients' following the medical recommendations.

The writer has regrouped the items given in Table XII and placed them in five main categories: community resources, patients' attitude, patients' particular situation, relatives' attitude or help and other factors. This was done in order to point out more clearly what types of conditions were pertinent to the following of a particular recommendation. Community resources includes those agencies and/or services which helped the patients in meeting one or more of the recommendations. Patients' attitude includes how the patients felt about their illness, how they accepted it, the way they

TABLE XII

COMMON SIGNIFICANT FACTORS WHICH HAD BEARING ON THE PATIENTS' FOLLOWING THE MEDICAL RECOMMENDATIONS

Recommendation	Significant Factors
Chronic Care	1. Patient recognizes seriousness of illness need 2. Patient previously had lived alone 3. Availability of nursing homes 4. Use of nursing homes 5. Function of social service in arranging care 6. Function of social service in interpreting need to DPW[1] 7. DPW pays for nursing home care
Temporary Care	1. None
Not Work at All	1. Previous acceptance of not working before hospitalization so illness does not pose new problem 2. Availability and use of DPW funds or private funds so patients not obliged to work to supply their subsistance needs
Take Light Job	1. Patient has private income so not forced to work 2. Social service and VA[2] helped patient obtain income 3. Former employer refused to rehire because of illness
Period of Occupational Therapy	1. Patient willing to accept training 2. Availability, use and adequacy of Community Workshops 3. Social service referral to Community Workshops

TABLE XII (Cont'd.)

Recommendation	Significant Factors
Restriction of Normal Physical Activity	1. Importance of routine and supervision of nursing home in curtailing it 2. Patients too ill to engage in 3. Relatives did necessary work
Avoidance of Emotional Strain	1. None
Adequate Budget (Income) to Meet Living and Medical Expenses	1. Availability and use of DPW 2. Adequate DPW budget (medical and living) when patient in nursing home 3. Adequate DPW medical expenses when patient on regular DPW assistance and living at home 4. Use of Blue Cross in meeting hospital bill
Doctor's Care	1. Availability and use of RIHOPD[3] and local medical doctors 2. Patients assisted in getting to clinic by relatives or by social service arranging ambulance transportation
Home Nursing Care	1. Relatives recognize seriousness of illness and capable of providing necessary care 2. Availability and use of district nurse in assisting 3. Interpretation of type of care needed by doctors and social service (to relatives)
Medicine	1. Availability of at RIHOPD at minimum cost and use of this service

TABLE XII (Cont'd.)

Recommendation	Significant Factors
Medicine (Cont'd.)	2. Importance of nursing homes in administering and supplying on recommendation of doctor 3. Patients obtain it even though had inadequate budget (income) indicating sacrifice of some other item
Diet	1. Furnishing of copy by hospital 2. Importance of nursing homes in supplying it

1 Department of Public Welfare
2 Veterans Administration
3 Rhode Island Hospital Out Patient Department

dealt with their dependency situation and how they were able to use offers of assistance. Patients' particular situation pertains to certain special features of their condition or environment. Relatives' attitude or help is used to designate various ways in which they (relatives) assisted patients in meeting particular recommendations. Other factors include any miscellaneous items which do not fall into the above categories.

COMMUNITY RESOURCES

Nursing homes were an important community resource in this study. They were prominent in supplying chronic care, restricting physical activity, supplying and administering medicine on recommendation of the doctor and supplying patients with the correct diet.

The Department of Public Welfare was of significance in this study. It was important in paying the nursing home fee for chronic care patients; in supplying funds to other patients so that they were not obliged to work to subsist; in providing adequate funds for a decent standard of living and medical expenses when patients lived in a nursing home; and in supplying adequate funds for medical expenses when patients were receiving regular weekly assistance and living in their own homes.

The Rhode Island Hospital Social Service was of significance in this study. It was important in arranging

nursing home care; interpreting the nursing home need to the Department of Public Welfare; arranging ambulance transportation to clinic; interpreting the type of home nursing care needed to relatives and in making referrals for occupational therapy and for pension application.

The Rhode Island Hospital was of significance in this study. The out patient department was important in providing doctors' care and supplying medicine at a minimum cost. The hospital was important in furnishing copies of the diets. The doctors were important in interpreting the type of home nursing care needed to relatives.

Local medical doctors were important in this study in providing doctors' care (outside of the clinic). The District Nurse Association was important in assisting in the home nursing need. Community Workshops was important in supplying adequate occupational therapy and the Veterans Administration was important in assisting with pension applications so that subsistance funds were provided.

PATIENTS' ATTITUDE

The patients' own attitude had bearing on their following certain of the recommendations. The patients' ability to understand the seriousness of their illness helped them to accept chronic care; the patients' previous acceptance of financial dependency before hospitalization helped them to accept the fact that they could not work again; the patients'

sacrificing some other item (even though they had inadequate funds) helped them to purchase the necessary medicine; and the patients' accepting the fact that occupational therapy was necessary before they could return to work helped in their taking advantage of Community Workshops and improving so that they could return to work.

PATIENTS' PARTICULAR SITUATION:

The patients' particular situation had bearing on their following certain of the recommendations. The factor that patients lived alone was important in prompting them to accept chronic care in a nursing home; the factor that patients were too ill prevented them from engaging in physical activity; and the factor that some patients had private incomes had bearing on their not returning to work.

RELATIVES' ATTITUDE OR HELP

Relatives' attitude or help was of significance in this study. Relatives were of importance in doing housework so that patients were not obliged to and this restricted their physical activity. Relatives assisted in providing patients' transportation to clinic; they were important in recognizing the seriousness of patients' illness, being capable of administering home nursing care and providing it.

OTHER FACTORS

Two other factors were of significance in helping

patients to follow medical recommendations. Blue Cross was important in meeting medical expenses by providing payment of hospital bills and an employer was helpful in preventing patient's return to work because he would not rehire him due to the illness.

Continuing with tabular presentation of the material Table XIII shows those common significant factors which had bearing on the patients' not following the medical recommendations.

The writer has regrouped the items given in Table XIII and placed them in six main categories: patients' attitude, relatives' attitude, home conditions, inadequacy of community resources, lack of community resources and other factors. This was done in order to point out more clearly what types of conditions were pertinent to patients' not following a particular recommendation.

It will be noted that these categories are in a different order than the foregoing ones and that some new categories have been added. The rearrangement was used in order that the recommendations given might follow more closely after those categories which had previously been discussed. Patients' attitude falls within the same definition as under the foregoing group. Relatives' attitudes includes various ways in which they (relatives) did not assist in helping patients to meet a particular recommendation. Home conditions

TABLE XIII

COMMON SIGNIFICANT FACTORS WHICH HAD BEARING ON THE PATIENTS' NOT FOLLOWING THE MEDICAL RECOMMENDATIONS

Recommendation	Significant Factors
Chronic Care	1. Returns home - inability to separate from former way of living 2. Leaves nursing home prematurely - as feels better does not feel further care needed 3. Homes Patient had to care for self Patient had to do own work Patient did not receive continuous medical care Patient did not have custodial care Crowded and dirty
Temporary Care	1. Refuse nursing home - unable to recognize seriousness of illness 2. Homes not provide it Relatives not give care - unable recognize seriousness of illness Relatives not concerned enough in patients' welfare
Not Work At All	1. Lack of funds and refusal to accept financial dependency status 2. Thinks illness of temporary nature and can return to work with no harm to self
Light Job	1. Unable to understand need in terms of illness 2. Refusal of assistance (referral) based on independent attitude

TABLE XIII (Cont'd.)

Recommendation	Significant Factors
Period of Occupational Therapy	1. None
Restriction of Normal Physical Activity	1. Patients found it difficult to do nothing - no satisfactory diversion provided 2. As felt better believed condition no longer serious and all right to resume activities again 3. Patients who refused outside care - no one came into home to assist
Avoidance of Emotional Strain	1. Due friction or difficulty with family or relatives Needed intensive case work or psychotherapy Social service not provide intensive case work because too understaffed to provide intensive coverage Doctors not refer for psychotherapy because of inadequacy of existing community resources in providing help 2. Due lack of adequate finances (see below)
Adequate Budget (Income) To Meet Living and Medical Expenses	1. Inadequate DPW[1] decent standard of living budget when patient lives in own home 2. Patient ineligible DPW (except for hospital bills) when own income insufficient to meet needs and meets only minimum standard of living level

TABLE XIII (Cont'd.)

Recommendation	Significant Factors
Adequate Budget (Income) To Meet Living and Medical Expenses (Cont'd.)	3. Private incomes of some patients which meet decent standard of living level not cover medical when added
Doctor's Care	1. Inability recognize seriousness of illness
Home Nursing Care	1. Relatives not recognize seriousness of illness and refuse to cooperate in doctor or social worker plan 2. Frequent services of district nurse not enough to offset other factors in total home nursing need
Medicine	1. None (too diversified)
Diet	1. Inability recognize seriousness of illness

1 Department of Public Welfare

includes the particular set-up of the home and the facilities lacking in the home which would have helped patients in meeting a particular recommendation. Inadequacy of community resources pertains to certain agencies whose services are incapable of meeting the need and lack of community resources pertains to absence of an agency needed to provide a necessary service. Other factors has been defined above.

PATIENTS' ATTITUDE

The patients' own attitude was one of the principal reasons why they failed to follow some of the medical recommendations. The patients' inability to separate from their former way of living was instrumental in their rejecting chronic care in a community resource; the patients' assumption that, as their condition improved their illness had terminated, caused them to leave nursing homes prematurely, return to work and resume normal physical activity; the patients' complete inability to recognize the seriousness of their illness in almost every sphere resulted in their refusing nursing home care, taking heavy jobs, not following their diets and not bothering to obtain doctors' care; the patients' inability to adjust to a sedentary life because they could not sit around and do nothing resulted in their resuming normal physical activity; the patients' own personality pattern was instrumental in causing friction in the family or difficulty with relatives resulting in emotional

strain.

RELATIVES' ATTITUDE

The attitude of relatives was of significance in preventing the patients from following some of the medical recommendations. Relatives were unable to recognize the seriousness of patients' illness or were not concerned enough about patients' welfare and did not provide home nursing care; relatives refused to cooperate with doctor or social worker plans in providing home nursing care; relatives' own personalities helped cause family friction and difficulty resulting in emotional strain for patients.

HOME CONDITIONS

Home conditions were of significance in the patients' not following medical recommendations. This pertains to those patients who refused outside care. Patients who lived alone and needed chronic care did their own housework because no one came into the home to assist. In addition, they did not receive continuous medical care because they did not have the frequent services of a doctor. Dirty and crowded homes were also instrumental in preventing patients from having the type of environment needed.

INADEQUACY OF COMMUNITY RESOURCES

The inadequacy of some community resources was of significance in this study. The Department of Public Welfare

did not provide a decent standard of lving budget and was unable to help those patients who had a minimum income because such income was too high for Department of Public Welfare eligibility standards. The Department of Public Welfare in Rhode Island has standard budget figures which are minimal or below, which it is obliged to adhere to because of lack of more adequate funds to work with.[1]

The fact that Rhode Island Hospital Social Service did not provide intensive case work in cases where it might have been helpful is significant in this study. Such a lack is due to the fact that the department is understaffed in respect to cardiac coverage. There is one social worker who covers the entire medical service (patients in the hospital). This includes cardiac as well as all the other medical conditions. Social service obtains cases by doctors' referrals or by choosing the cases itself on the basis of the need or problem. It will be recalled that the writer indicated in Chapter I that only eleven per cent of the total hospital cardiac admissions were known to social service. Complete coverage of cardiac patients is obviously lacking. Even with the exclusion of the private patients the coverage for ward patients is insufficient. In the two year period the social

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1 Information obtained from Department of Public Welfare, Providence, Rhode Island.

worker was able to work on 239 cardiac cases.[2] Because of the number of cases to be covered the social worker, in regard to cases which needed intensive case work of the twenty cases studied, was unable to supply other than supportive case work. This was obviously due to the worker's lack of time and the need to cover as many cases as possible in some manner (supportive) rather than concentrate on only a few and give intensive case work.

There is, in addition, a case worker in cardiac clinic. Although the case load there is less than the above, the number still exceeds the worker's ability to provide adequate coverage, especially on an intensive level.

The inadequacy of existing community resources in providing psychotherapy is an important factor in this study. Patients were not referred for service by the doctors because hospital clinics in the community are incapable of handling a large group of patients and giving intensive therapy due to lack of trained psychiatrists (in the community) and the consequent lack of their services on hospital staffs.[3]

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2 Many of these patients were readmitted to the hospital during the two year period. When a readmission of one of the 239 patients occurred the writer did not count this as another case.

3 Information obtained from a community resource which prefers to remain anonymous.

LACK OF COMMUNITY RESOURCES

The lack of a community resource to provide sedentary recreational diversion, development of hobbies and group activities for chronically ill patients is a factor which has bearing on the patients' not restricting their physical activity. There was no suitable diversion offered in the home or in the community for these patients who complained of having nothing to do.

OTHER FACTORS

A final item falls within the category of other factors. Some patients whose previous income was sufficient to maintain a decent standard of living under ordinary conditions found it insufficient to cover medical expenses once illness occurred.

RECOMMENDATIONS

The writer would like to make the following recommendations for several of the inadequacies noted above. It is felt that housekeeper service might assist those patients who refused to leave their own homes and lived alone. Such a service for adults is not readily available in the community. Family Service offers housekeeper service only in those homes where there are children.[4]

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4 Information obtained from the Family Service Society, Providence, Rhode Island.

International Institute offers housekeeper service only in cases where there is a language handicap; the service is limited and it pertains only to individuals of foreign extraction.[5] The writer, therefore, feels that a housekeeper service for incapacitated adult individuals who refuse to leave their own homes should be made available.

The financial situation in which the Department of Public Welfare plays the leading role leaves much to be desired. Lack of funds (derived from city, town, state and federal taxes) to provide for higher budget standards is responsible for the low figures. The writer feels that a solution to this problem is difficult to devise. Ideally a raise in general taxes would answer the problem. Otherwise the writer feels that a re-evaluation of total tax funds allotted for the various projects in each city or town might be helpful in realloting lesser amounts for some programs and larger amounts for the Department of Public Welfare program. Finally the passage of a state law requiring the cities and towns to set aside a certain minimum amount for assistance might serve to partially answer the need.

The inadequacy of Rhode Island Hospital Social Service in providing intensive case work because of heavy case load

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5 Information obtained from the International Institute, Providence, Rhode Island.

can only be remedied by providing better social service coverage of the total number of patients needing assistance. The shortage of trained workers is a national problem and the community problem can only be alleviated satisfactorily when the national need is remedied. However, the writer feels that for the present a social worker covering only adult cardiac patients (those in the hospital) would help in providing some of the case work indicated for this group.

The inadequacy of existing community resources in providing psychiatric service due to lack of trained psychiatrists is also a national problem and is not easily remedied. The writer feels, however, that some incentive measures might be instigated to encourage more trained psychiatrists to enter the community. A clinic set up solely for the purpose of providing psychotherapy (apart from neurology as is the case at Rhode Island Hospital and Charles V. Chapin Hospital)[6] and available to all patients referred at a fee suitable to their income might serve as a drawing card for psychiatrists and thereby help patients in meeting the necessary need.

The lack of a community resource for recreational diversion is an important one. The chronically ill cardiac

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6 A City Hospital for short term psychiatric care before patient is sent to State Hospital for Mental Diseases for chronic care.

is forbidden so many things that he has to look to new outlets to take up his time and interest. Community Workshops has a home program which occasionally provides the patients with knitting, sewing and other projects (which later may be sold) but there is no special emphasis on recreation or hobbies and no type of group participation in sedentary activities. Community Workshops, as a matter of fact, is specifically geared toward earning a living and wherever possible toward job placement.[7] The writer feels, therefore, that a community resource devoted solely to a program of group and individual recreation and the development of interests and hobbies would benefit the cardiac group as well as many other chronically ill patients.

The problems, then, of the cardiac patient in meeting the various medical recommendations are numerous. In terms of this study, the writer feels that much remains to be done at the community level as well as with the problem of the patient in his particular personality setting in order to affect the necessary adjustment. Certain recommendations in this connection have been outlined above. With the problem of heart disease on the increase it is to be hoped that the community will become more cognizant of its inadequacies and

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7 Information obtained from Community Workshops, Providence, Rhode Island.

will endeavor to take some of these necessary steps to eliminate them.

Approved,

Richard K. Conant

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APPENDIX

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SCHEDULE

HOW ARE THE MEDICAL RECOMMENDATIONS FOLLOWED OR NOT FOLLOWED

1. Chronic Care

Type - institution, nursing home, boarding home, other

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

2. Temporary Care

Type - nursing home, boarding home, other

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

3. Restriction of Physical Activities

A. Working Restrictions

1. Not supposed to work at all

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

2. Patient has to change job to lighter one

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

3. Patient can go back to job but needs occupational therapy first

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

B. Restriction of normal physical activity

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

SCHEDULE (Cont'd.)

4. Avoidance of Emotional Strain

Patient accepts	Does not accept
Why	Why not
Who or what helped	
How	

5. Adequate Budget (Income) to Maintain a Decent Standard of Living and to Meet the Medical Needs

Patient receives	Does not receive
Why	Why not
Who or what helped	
How	

6. Medical Follow-Up

A. Doctor's Care

Patient accepts	Does not accept
Who or what helped	Why not
How	

B. Home nursing care

Patient accepts	Does not accept
Who or what helped	Why not
How	

7. Special Recommendations

A. Diet

Patient accepts	Does not accept
Who or what helped	Why not
How	

B. Medicine

Patient accepts	Does not accept
Who or what helped	Why not
How	