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A study of continuity of medical care: a social worker's evaluation of sixteen patients discharged from the Boston City Hospital

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF CONTINUITY OF MEDICAL CARE
A SOCIAL WORKER'S EVALUATION OF SIXTEEN PATIENTS DISCHARGED FROM THE BOSTON CITY HOSPITAL

A Thesis

Submitted by

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TABLE OF CONTENTS

LIST OF TABLES

Preface

This thesis, part of a pilot study carried out under the auspices of the United Community Services, developed out of the need to know if patients who require long-term comprehensive care receive the services which will help them be as self-sufficient as they are capable of being after leaving the protection of the hospital. Because of increasing specialization and depersonalization of service, many patients do not receive continuity of care. This is a problem which concerns the physician, hospital administrator, social worker, in fact, all those interested in the welfare of people.

As the increase of chronic illness must be met in some way by the community, cooperative planning to take united action is required. To that end was this timely study initiated. Although the need to know how to assist those with chronic illnesses is with us now and will increase with each year, it is first necessary to become aware of the nature and extent of the problem before action based on understanding can be taken. Recognition of this problem will increase as more people face it in personal family crisis.

One of the purposes of the United Community Services is to gather facts about the health and welfare needs of

the people of the community to determine how effectively, efficiently, and economically they are being met.[1] As the fund-raising, budgeting and planning organization for Metropolitan Boston, United Community Services is interested in the total process of planning for healthier, happier communities. Supporting the tradition of voluntary service, numerous studies and activities are carried on for the community benefit.[2]

Focusing on the problem which is a community concern, this study was developed and directed by Dr. Leonard S. Rosenfeld, Director of the Medical Evaluation Studies, Dr. Avedis Donabedian, Medical Associate, and Mrs. Ruth Cowin, Social Work Consultant for this study. Four students from two Schools of Social Work collected data on a group of eighty-four patients who had been ward cases in three teaching hospitals in Boston. Miss Kaila Goldman from Simmons College, Mrs. Melanie Houchins, Miss Doris Kitt, and Mrs. Mary Joan McLellen from Boston University saw patients on follow-up visits approximately three months after they had left the hospital.

The writer found this research project to be a stimulating experience which greatly increased her perception of the problems the chronically ill patient and the community

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1 United Community Services, By-Laws, January 25, 1957.

2 United Community Services, Annual Report, April 1956.

must meet in a large urban region. The social and emotional factors which help or hinder in making adjustments were noted. Appreciation of those who assist the patient at the time of crisis and afterwards was increased as a result of contact with many agency representatives.

Casework skills were used in the interviewing process. The techniques used in a one visit situation left much to be desired, but the writer learned much in the practice.

Greater awareness of some of the problems confronting the individual with chronic illness was gained, but no final answers could be given as a result of this exploratory study.

CHAPTER I

INTRODUCTION

Chronic illness adds a burden to the community in loss of days from work and in social consequences which affect the patient and his family. Arthritis, heart disease, and diabetes, the three chronic illnesses discussed in this group study, are among the principal foes of health confronting people in the middle years of life. Sometimes these conditions may be fatal, but more often they become causes of disablement which requires long term care. It has been stated that chronic illness is the challenge of this era to hospital and public health officials as well as to the other professions concerned with sickness and disability.[1]

> In such an age illness, disability, and preventable deaths are problems the whole community must comprehend and help to solve. The time honored confidential relationship between the physician and his patient has limited value unless it is supported and enhanced by the presence in the community of adequate diagnostic and treatment facilities; and this is particularly true of the patient with long-term illness.[2]

The person with a chronic illness should be regarded and treated as a whole person. If this viewpoint is accepted, the services of several professions and disciplines will be needed for optimum rehabilitation. Although at

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1 National Health Council, Guides to Action on Chronic Illness, 1956, p. 10.

2 Ibid, p. 10.

present more emphasis is laid upon the knowledge and treatment of the physical aspects of chronic illness, it is recognized that the social and emotional factors involved also must be considered to assist in meeting the problem as effectively as possible.

> Recognition should be given to the importance of the emotional attitude of those who have a long term illness. Personnel in institutions and at home, including the patient's family, must constantly seek to help the patient to endure pain, delay, and disappointment, faithfully follow difficult treatment regimes, keep hope alive, maintain a "will to live" and develop a philosophy of acceptance as part of mature faith.[3]

It is believed that unless the basic needs of the individual are met, medical care in itself will be of little value. The team approach is necessary for assurance of coordination of services which will provide regular services of a physician, provision of drugs and medical equipment, full utilization of community resources and continuity of these services. Certainly the medical social worker can be a key member of the team working toward medical continuity of care. Through direct knowledge of the patient and families, the social worker can strengthen the positive values inherent in the patient's relationship with other members of the medical team at the same time encouraging team members to support the patient in his social as well as medical

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3 Ibid, p. 11.

adjustments.[4]

With knowledge of these problems that must be met, the Medical Care Evaluation Studies was established to examine the experiences of people who have continuing need for medical care after they leave the hospital to see if they received the services they need. For this study, continuity of care implied the availability of appropriate services and the effective coordination of services to assure continued responsibility for the welfare of the patient.

Purpose.-- Knowing that patients who are hospitalized often do not receive services that have been recommended, the purpose of this study was to explore the precise nature of what services are available to people who have continuing need for medical care after their period of hospitalization. It was hoped that practicable methods could be developed for measuring the effectiveness of medical follow-up after the patient leaves the hospital. If these procedures proved to be of practicable worth, methods to measure availability and continuity of medical and related services could be utilized at different times to measure the effectiveness of coordination within the community or to test the adequacy of an institution's program of

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4 Frances Upham, A Dynamic Approach to Illness, Family Service Association of America, New York, 1949, p. 39.

care.

Scope of Study. The sixteen patients described in this thesis, part of the group study of eighty-four cases, were from two catagories of chronic illness out of the three selected for the exploratory study. These sixteen cases are those with the diagnoses of arteriosclerotic heart disease and diabetes who were treated in the wards at Boston City Hospital. Every one in the group had been in the hospital for treatment sometime between July 1956 and December 1956. These cases were chosen by the medical house resident who selected them from the three categories of chronic illness chosen for the study and which met the following conditions:

(1) The illness was chronic requiring continuous medical care.

(2) They were types of illness in which social service, rehabilitation, and bedside nursing service are frequently required.

(3) The cases were sufficiently frequent so that a useful sample could be drawn in a reasonable period of time.

(4) All cases were ward cases who were more dependent on community facilities and resources.

(5) Only cases living in the Boston Metropolitan area served by the United Community Services were selected.

(6) Patients who were available for follow-up visits by social work students three months after discharge from the hospital were chosen.

Method of Study.-- The medical and social inventories which the house resident made at the time the patients left the hospital were used for each patient to compare the pattern of services received with the estimates of need made at the time of discharge in an effort to determine the adequacy of these services. Each patient was checked in the files of the Social Service Department to see if any were known or had been known to this service. The medical records of all the patients were obtained from the House Medical Records Library and from the Out-Patient Record Room. Using a schedule compiled by the study group, follow-up interviews with the patients or with those caring for the patients supplied current data. The Director of the Social Service Department reviewed the activities of the department to help the writer understand the function of the medical social workers in this particular institution.

The literature on chronic illness was examined as well as reading on the particular disease described in this thesis.

Limitations.-- Because of the attitudes of the informants toward the purpose of the interview, not all the

information gained could be judged as adequate or accurate. Nursing home personnel had to supply information when a patient had died or the aged patients were confused and incompetent to answer the questions concerning financial and medical facts. One patient who had moved to another state could not be visited so that limited information was gained from a member of her family. Material from medical records was used for the one patient who could not be traced.

The limited knowledge and experience of the writer in a research interview prevented her from obtaining fuller and more pertinent material.

Although some of the patients were known to medical social workers, there were but three patients on whom medical social summaries had been written. No Social Service notes were written in the medical records.

The only related study, outside of generalizations made about the need for continuity of care for those with chronic illness, was a research study carried on in four hospitals in the west of Scotland. In the latter study of an unselected group of 705 men, it was found that social and environmental factors influenced the patients in accepting or refusing the required medical assistance offered by the health services. Those who had most frequently recurring

spells of hospital treatment were, in the main, drawn from the less privileged groups in the community. This study, carried out between the years 1950-1953, stressed the fact that many of the patients could have benefited from some form of social service.[5] The small group of sixteen patients investigated by this writer for this present thesis cannot be considered as representative of the entire study group, but can be regarded as representative of the patients who were ward cases in the Boston City Hospital which met the criteria of this study. The judgments made regarding medical continuity in this thesis are those of the writer.

In the following chapters the writer will attempt to find answers to the following questions: (1) How effective is the medical follow-up after the patient leaves the hospital? (2) Why do patients receive or not receive the care which they need? (3) Do the patients understand and follow the recommendations made by the doctor? (4) What has the social worker done or could do to aid in continuity of medical care?

The setting.--A description of Boston City Hospital and the Social Service Department is necessary in order to explain the treatment opportunities for those served in this setting.

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5 T. Ferguson and A.N.MacPhail, Hospital and Community, p. 45.

Boston City Hospital is a municipal, tax supported institution which receives no financial aid from the United Community Services. The Hospital, established in 1864, instituted services which have proved flexible in developing medical programs to adjust to the needs of the changing community. In keeping with its scientific spirit, Boston City Hospital is a center of treatment, teaching and research. The staff of over two hundred physicians is noted throughout the country. Students from every leading medical school come to Boston City Hospital for training. The Hospital is sixth in size and fourth in the number of patients treated in the United States. The facilities and services of this hospital are only available to residents of Boston who are unable to pay for private care.

From its beginning, Boston City Hospital recognized the need for medical social services. At first such services were unorganized and carried on by the nursing staff until, inspired by the development of Medical Social Work at Massachusetts General Hospital, the Medical Staff collaborated with a "Private Committee of Women" to organize a Social Service Department in 1914. The first Director, Miss Gertrude L. Farmer, headed a group of six workers and several volunteers who gave medical social treatment to 1,089 patients.

During the first two years of the department, the work was financed entirely by private funds. The first report of 1915 stated that a fund of $6,608 had been raised. At the end of this period the cost of this service was included in part in the general hospital budget.[6]

The Social Service Department has grown with the Hospital. Today the majority of workers are chosen from the Civil Service lists thus eliminating opportunities for political influence. In 1956 forty-six workers served a total number of 111,039 patients. Patients receiving services which were not recorded for the permanent social files numbered 109,232. More intensive social study and treatment were given to 1,807 patients. It is estimated that the total number of recorded cases was 5,034 which averaged 420 cases each month. Medical relief was given to 1,967 patients. There is no average case load per worker as services vary according to the area covered by the worker.

There is the Director of Social Service, Mrs. Sahra Rapp, seven supervisors of workers and students, twenty-five caseworkers, and five clerks all of whom are paid by the City of Boston. Non-city paid workers number two supervisors, two case workers and two research workers. Two

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6 Elena R. Porrata, "The Development of the Medical Social Service at Boston City Hospital," Simmons College, School of Social Work, May 1946. An unpublished thesis.

caseworkers are paid by the Cancer Fund.[7]

The Department of Social Work shares the teaching program of the hospital by teaching interns, third and fourth year medical students, and nurses the social aspects of illness. Students from the Schools of Social Work of Simmons College, Boston College, Boston University, and undergraduates from Regis College are given supervised field work experience at the Hospital. Eight students were supervised during 1956.

At present there is no direct research in the Department. The two workers doing research are affiliated with outside interests rather than being directly responsible to the Department.

Staff meetings, held once each month, provide an opportunity for speakers from various community agencies to give information to the workers about community resources and new aspects of Public Welfare. At times, doctors who appreciate the social implications of illness speak to the staff.

There is no psychiatric consultant available to the staff at this time. The one psychiatrist who is at Boston City Hospital works with the medical students to help them learn to treat the whole person. It is hoped that in time this specialist will be available for consultations by the

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7 Report for the Year 1956, Department of Social Work, Boston City Hospital.

staff members. In the meanwhile, the supervisor of the Psychiatric Unit is accessible to the workers when advice is needed.

Social work activities in the Department have been classified into two groups-recorded and unrecorded cases. The recorded cases are those on which valuable case work treatment is recorded and filed. The cases on which the worker keeps no permanent records in the Social Service Department files are brief services classified for statistical purposes into six different kinds: (1) interpretative service which requires case work techniques in interpretating medical diagnoses and medical recommendations to the patient, his relatives or other agencies; (2) cooperative service in which the worker gives information to other agencies concerning patients from whom case work responsibility is being carried; (3) Discharge services are given to patients in relation to leaving the Hospital; (4) medical follow-up facilitates the continuation of further medical treatment at the Hospital or in the community; (5) administrative services contribute to the smooth running of the Hospital and (6) social review to explore the patient's need for social assistance.

Although the majority of cases are referred to the medical social workers by the physicians in charge, relatives or anyone in the community may contact the workers in

regard to any patient.

The Social Service Department at Boston City Hospital is a well integrated member of the hospital team. Although understaffed, the workers in the department give services to as large a number of patients as is possible.

CHAPTER II

DIABETES

Of the three chronic illnesses discussed in the group study, diabetes will be described in detail in this chapter as illustrating the medical and social problems of chronic and recurrent illness in adults.[1] Six of the sixteen cases presented in this thesis had some degree of diabetes.

Diabetes mellitus-meaning a passing through of honey-is a disease of carbohydrate metabolism in which the body cannot make use of certain kinds of foods. The body of the diabetic is unable to change sugars and starches into energy or store them for future use to the extent that the average person's body does. Sugar accumulates in the blood stream raising the blood sugar levels above normal. When higher than normal levels are reached some of the excess sugar is excreted in the urine. The presence of sugar in the urine is the commonest sign of the disease.

Although the essential cause of diabetes is not known, it is believed that the lack of insulin, a substance produced by the islets of Langerhans in the pancreas, is mainly responsible for this inability to use carbohydrate

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1 For the study of heart disease see Melanie Houchins, "A Study of Continuity of Medical Care, A Social Worker's Evaluation of Nineteen Patients Discharged from Massachusetts General Hospital." Unpublished Social Study, Boston University School of Social Work, 1957.
For the study of arthritis see Mary Joan McLellen, "A Study of Continuity of Medical Care, A Social Worker's Evaluation of Fifteen Patients Discharged from Boston City Hospital."

foods to their fullest. Other organs of internal secretion such as the anterior pituitary, adrenal cortex and thyroid are also involved in the body's use of carbohydrates. Diabetes is a complex disease.

The most common symptoms of this chronic disease are thirst, hunger, the frequent passing of an increased quantity of urine, weight loss and marked fatigue. Characteristic signs may develop suddenly or gradually. In some cases there are no symptoms present and only when the blood and urine have been tested in the course of a routine physical examination has the disease been diagnosed.

Many diabetic patients are obese prior to the onset of diabetes.[2] Fat people are ten times more likely to develop the disease than thin people because fat people eat excessively and being fat increases the need of the body for insulin placing a strain on the islets of Langerhans.

Those who have a family history of diabetes are more likely to develop the disease, but it should be remembered that it is the tendency to diabetes and not the actual disease which is inherited.[3] Although diabetes is a common disease of the middle years of life and older people develop it more often than the younger person, in the young the

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2 Elliott P. Joslin, Diabetic Manual for the Doctor and Patient, p. 243.

3 Ibid, p. 227.

disease is likely to be more severe. "There are a million and a half known diabetics in the United States and another million unknown.[4] More women than men develop diabetes. Above the age of sixty-five years, one man in seventy will have it and one woman in forty-five. Diabetes is found as frequently in the Negroes and Indians as in the white population. If account were taken of both the unreported and the undiagnosed cases, the prevalence is considerably higher at the middle and older ages than actual figures show.

Although there is no known cure for diabetes, great strides have been made in the treatment of the disease. "Effective treatment has been available for over thirty years and constant research has improved both the methods of treatment and the understanding of the disease."[5] Today diabetics, with proper care, can live as normally and, on the average, almost as long as do people without diabetes. Diabetic coma, which once accounted for the majority of deaths a half century ago, now causes less than two per cent of the fatalities. Hardening of the arteries with its manifestations in different parts of the body is now the leading cause of death. The average diabetic, at this time, does not die of diabetes but with it.

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4 Joslin, op. cit., p. 9.

5 Groff and Lucy Conklin, Good News About Diabetes, p. 4.

Treatment objectives aim at relief of the symptoms, maintainance of normal nutrition, maintaining the insulin producing capacity of the pancreas, and prevention of complications. Diet, insulin and exercise are the three main elements in the treatment and management of the diabetic condition. All patients are assessed as to their individual needs and helped to regulate their diets accordingly. Such diets are similar to a normal diet except that there must be more restriction on foods containing sugars and starches. It has been estimated that twenty-five to fifty per cent of the people with diabetes are controlled by a balanced diet which is combined with adequate exercise. If a regulated diet is not enough to keep the blood sugar normal, injections of insulin necessary to supply the body's deficient amount can be added to the regulated diet and exercise to control diabetes. In severe cases, insulin is needed if a patient is to remain sugar-free and fit for work.

Several types of insulin, a preparation made from the pancreas of animals, are in use today. Regular insulin takes effect quickly lasting six-eight hours; protamine zinc insulin is slower in action, but extends over a twenty-four to forty-eight hour period; globin insulin falls between regular and protamine zinc insulin in action lasting from twelve to as long as twenty-four hours. Many diabetics find that the NPH insulin, which is one part regular insulin

Arteriosclerosis, a chief cause of gangrene, is likely to develop earlier in the diabetic. It has been stated that the main problem in diabetes today is to prevent premature hardening of the arteries. Research into the relationship between diabetes and hardening of the arteries is now under way.[6]

As in other chronic diseases, diabetes presents many psychological problems in addition to the physical ones. The necessity for accepting limitations, of adhering to a certain regimen affects the social living of the patient and his family.[7] Fear and resistance by both the patient and his family may be centered around the administration of insulin. If possible, every family should gain an understanding of the patient's medical and social needs to enable them to give the patient help in planning and carrying out the doctor's recommendations. Knowledge of how to regulate the diet, the use of right activity, how to administer the insulin and make urine tests should be known by both the patient and his family.

"A family's feelings about each of its members, and the individual's feelings about the family as well as their

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6 Conklin, op. cit., p. 16.

7 Upham, op. cit., p. 88.

interrelationships, affect the meaning of all experiences including illness."[8] Diabetic patients especially need to feel that someone in their immediate environment "cares" for him and will be there to support and aid him as he takes the responsibility of watching all the demanding precautions necessary to adequate care. Feelings and attitudes of the patient have a definite bearing on how the patient follows recommendations made by the doctor. Always the aim in working with the diabetic patient is to motivate him to help himself.

Dunbar states that in some cases of diabetes mellitus it is more important to follow the emotions than the blood sugar curve for the degree of diabetes exhibited by the diabetic patients is proven to vary in response to nervous and emotional influences.[9]

It is known that emotional factors influence the patient's physical state and although the normal functioning of the pancreas cannot be restored, the application of psychosomatic techniques can reduce invalidism. "The chronic disability which is often attributed to diabetes can more properly be laid at the door of the emotional con-

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8 Carol H. Cooley, Social Aspects of Illness, W.B. Saunders Company, Philadelphia, 1951, p. 21.

9 Flander Dunbar, Emotions and Bodily Changes, Columbia University Press, New York, 1954, p. 293.

sequences of the disease, and therefore can be obviated by helping the patient achieve emotional stability."[10]

No one personality pattern can fit all diabetic patients, but it is thought that many of the patients feel deep emotional conflicts regarding parental authority. Many diabetics are observed to have markedly infantile personalities. Avoiding responsibilities, the majority of patients enjoy being dependent on others. Overeating, which leads to obesity and strain on the pancreas, often is the greatest pleasure such a patient knows.[11] Feelings of deprivation, loneliness, and depression are common reactions of the diabetic who felt that he was deprived of the love and attention of the mother during childhood. There seems to be a strong relation between food and mother love in this disease.[12]

Internal and external factors must be considered in treating the diabetic patient so that the total person is considered. The social setting and personality of the patient must be weighed before setting up a plan for him. A regimen could not be followed by a patient who would feel that it would not be possible for him to meet the adverse

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10 Dunbar, op. cit., p. 206.

11 Ibid., pp.207-208.

12 Ibid., p. 328.

elements within himself or his environment. Medical care is important but cannot be utilized to the greatest degree unless the patient is helped in his general life adjustment. Both the physical and emotional aspects of diabetes must be considered in helping the patient understand himself so that he can lead a normal life.[13]

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13 Frances Upham, op. cit., p. 92.

CHAPTER III

THE GROUP OF PATIENTS STUDIED

During the months of July 1956 to December 1956 the sixteen patients in this study were hospitalized for various lengths of time as ward cases at Boston City Hospital. In this chapter a description of the group of patients will be presented according to their ages, sex and marital status, diagnoses, prognoses, degree of illness, degree of disability, length of hospitalization, living arrangements after hospitalization, and financial status. This was a socio-economic group for whom there were many deprivations.

Age and sex.-- The ages of the patients at the time of this study ranged from 32 to 88. As can be seen in Table I, seven of the patients were between the ages of 52 and 62, the complicated middle years of life.[1]

Table I

Age Distribution, According to Sex

Age		Female	Male	Total
32-41		3		3
42-51			1	1
52-61		2	5	7
62-71			1	1
72-81		2		2
82-88	total	2		2
		9	7	16

1 W.W. Bauer, Foes After Forty, John Hancock, 1950, p.1.

As can be seen from the chart, seven of the patients were male and nine were female. With the exception of two Negro females, all of the patients studied were white.

Marital Status.-- Table II shows the marital status of the sixteen patients.

Table II Marital Status

Marital Status	Female	Male	Total
Married	3	4	7
Widowed	5	1	6
Single		2	2
Unknown	1		1
TOTAL	9	7	16

In the group studied three women and four men were married at the time of the follow-up interview. Five women were widows and one man was a widower. There were two single men in the group. The marital status of one woman was unknown.

Diagnosis.-- The diagnoses of the sixteen patients are listed under the two main headings of arteriosclerotic heart disease and diabetes in addition to which many of the sixteen patients had other disabling illnesses.

Table III

Diagnoses of Sixteen Patients

Diagnoses	Number of Patients
Arteriosclerosis	9
Arteriosclerosis and Parkinson	1
Diabetes	1
Diabetes and Epilepsy	1
Diabetes and Psychoneurosis	1
Diabetes and Arteriosclerosis	3
TOTAL	16

It will be noted that there were nine patients who had arteriosclerotic heart disease; one patient was ill with arteriosclerosis and Parkinson's disease, and three patients suffered from arteriosclerosis and diabetes.

One patient had diabetes with no complications. One patient had the diagnoses of diabetes and epilepsy; another patient had diabetes and psychoneurosis.

Prognoses.-- At the time the patient left the hospital, the house resident estimated the life expectancy for most of the patients in the study.

Table IV

Prognoses of the Sixteen Patients

Prognoses	Number of Patients
Over one year	2
One year	3
Fair: six months to one year	5
Guarded: six months to one year	3
Poor: six months	2
No prognosis given	1
TOTAL	16

The prognosis of over one year was given to two diabetic patients. These two patients were the two youngest people in the study.

Three patients were given a prognosis of one year. One was diabetic, one had arteriosclerosis, and the third had both diabetes and arteriosclerosis.

Five people in the study were estimated to have a"fair" life expectancy of between six months to one year. Four of these patients had arteriosclerotic heart disease and one had both heart disease and diabetes.

Two patients with arteriosclerotic heart disease were given a "guarded" prognosis.

Of the two patients with the prognoses of "poor", one died in the nursing home soon after he left the hospital. This patient suffered from arteriosclerotic heart disease and Parkinson's disease. The other patient in this category, and the oldest patient in the study, suffered from arteriosclerotic heart disease to the extent that she was bedfast.

No prognosis was given for one patient who had diabetes.

Degree of Illness.-- Table V shows the degree of illness each patient had. The patients in this study are described as having a"mild," "moderate," or"severe"type of illness.

Illness with slight or no disabling symptoms in which there would ordinarily be little danger to life or competence

should reasonably good medical care be available is termed as "mild". "Mild"diabetes means that cases can be controlled by diet alone and no serious complications of the disease are present.

"Moderate" illness is characterized by moderately disabling symptoms which interfere with pursuit of normal occupation or activity appropriate to the age of the patient or constitutes a long-range danger to life or competence. Diabetes cases receiving less than thirty units of insulin a day, but having no severe complications are in this division.

"Severe" illness describes severely disabling symptoms with immediate danger to life or serious threat to long-range competence. A case of severe diabetes would need more than thirty units of insulin daily and severe vascular disease or other pathology might be present.

Table V

Degree of Illness

Degree of Illness	Number of Patients
mild	1
moderate	7
severe	8
TOTAL	16

Four of the patients were classified as "severe" diabetics, four had "severe" heart disease, seven patients

had arteriosclerotic heart disease which was "moderate", and one patient was classed as a "mild" diabetic.

Since half of the group had a "severe" degree of illness and seven others were classed as "moderate", it will be recognized that these illnesses had been of long duration for many of the sixteen patients.

Degree of Disability.-- The degree of disability was difficult to determine. In order to give a general picture of the amount of disability, the group has been divided into four categories based on information gained from the medical inventories and from the follow-up interview.

Table VI

Degree of Disability

Degree of Disability	Number of Patients
Limited work	9
Takes care of most activities of daily living	1
Limited activities of daily living-ambulatory	3
Bedfast	3
TOTAL	16

The three bedfast patients were unable to get out of bed and required nursing care for treatment, bathing, and eating.

Although limited in the activities of daily living, the three ambulatory patients could sit up in a chair and

take some care of their personal needs even though assistance with bathing and dressing was required.

The nine patients, who had capacity for limited work, could be retrained or could do work which would not require strenuous physical effort.

Length of Hospitalization.-- Ten of the patients had one to three previous hospitalizations with the same illness which required this last hospitalization. One patient, a forty-two year old Negro woman with the diagnoses of diabetes, epilepsy, and chronic alcoholism, had thirty-nine previous hospitalizations and had just returned home from the fortieth hospital admittance at the time of the interview.

Table VII shows the length of time the sixteen patients were in the hospital for this particular study.

Table VII

Length of Hospitalization

Days	Number of Patients
4-12	5
13-20	1
21-28	1
29-36	5
37-44	2
3 months or more	2
Total	16

Five patients were hospitalized from between four to twelve days and another group of five were in the hospital between twenty-nine and thirty-six days. Only two patients stayed three months or more.

Living Arrangements.-- Table VIII presents the living arrangements of the sixteen patients after leaving the hospital.

Table VIII

Living Arrangements After Leaving the Hospital

Live at home with Spouse	Live with relatives or others	Live Alone	Nursing Home	At home, outside nursing care	Total
7	1	2	5	1	16*

* One patient died in the nursing home.

Five of the patients required nursing home placement and one patient received medical home care. This last patient later returned to the hospital where he was seen following an operation which resulted in the amputation of a leg. The five patients in the nursing homes, one of whom died a short time after leaving the hospital, were elderly and unable to care for themselves.

Although the physical arrangements of eight homes were inadequate, the patients who lived with their spouse and family made no changes in housing with the exception of one patient who moved and could not be traced.

Weekly Income.-- All the patients in this study were unskilled or semiskilled workers twelve of whom had been unable to work or worked only irregularly before this hospitalization. Four patients were advised to change their occupations and seven patients, because of physical incapacities and age will never be employable. If suitable employment could be found, five patients might be able to do limited or part time work.

The weekly income of these patients ranged from $13 to $75 per week. The majority lived on very low incomes.

Table IX

Weekly Income of the Patients

Income	Number of Patients
$13-19	3
20-26	3
27-33	1
34-40	3
41-47	0
48-54	1
55-61	1
:: ::	
$75	1
Unknown	3
TOTAL	16

Two patients received financial asstance from Public Welfare, two received Disability Assistance, and four were supported by Old Age Assistance.

The husband's of two patients and the wife of another supported the families without any additional financial

assistance.

Insurance and savings were giving temporary financial support to one patient at the time of the interview. One seventy-three year old female patient who had been taken to another state to be near her son's family, was being given financial assistance by the members of the family supplementing her small income from insurance.

The financial income of three patients was unknown.

The following chapter will attempt to evaluate the medical continuity for these sixteen patients just described.

CHAPTER IV

CONTINUITY OF MEDICAL CARE

In this study it has been possible to study the community resources which were available to the patient on leaving the hospital. Since social and emotional factors influence the patient's attitude toward treatment reccommendations, it appears that the home and family of each patient would be the most important community resource to be studied and used in comprehensive medical care. Few families in the cases studied understood the emotional or physical needs of the patient in their midst with the result that indifference and friction in the family unit added to the patient's existing anxiety.

According to the author's judgment, continuity of medical care was evaluated and described as being "good", "fair," or "poor."

"Good" continuity will describe a patient who kept nearly every appointment and carried out medical recommendations. When frequent appointments were missed and medical advice was only partially carried out, the patient will be said to be an example of "fair" continuity. "Poor" continuity is characterized by extremely irregular clinic attendance and medical recommendations were poorly or not carried out.

Table X

Medical Treatment Recommendations

Case No.	Treatment Recommended	Type of Continuity	How Treatment was carried out	Reason
1	Return to Diabetic Clinic Psychiatric Clinic Diabetic Regimen	Poor	Attended Diabetic Clinic twice	Personality difficulties
2	Diabetic and Neurology Clinic Diabetic Regimen Abstain from Alcohol	Poor	No record of patient ever attending any clinic	Personality difficulties
3	Return to Diabetic and Medical Clinics Diabetic Regimen	Poor	Refused to attend clinic Regimen not followed	Personality difficulties
4	Return to Diabetic Clinic Diabetic Regimen Abstain from Alcohol	Poor	Attended clinic one time-Did not follow regimen or abstain from alcohol	Personality difficulties
5	Return to Diabetic Clinic Diabetic Regimen	Fair	Clinic Attended Diabetic Regimen not followed	Unable intellectually to comprehend Good staff-patient relationship
6	Return to Med. Clinic Regimen for Heart Disease	Good	Attended clinic one time then had LMD	Better financial status and fear of death
7	Return to Med. Clinic Heart Disease Regimen	Good	Recommendations carried out	Good doctor-patient relationship

8	Return to Diabetic Clinic Diabetic Regimen	Fair	Clinics and insulin followed Diet disregarded	Dependent Personality
9	Home Care Heart Disease Regimen	Good	Recommendations Followed	Supervised Medical Care
10	Return to Med. Clinic Heart Disease Regimen	Fair	Attended Clinic Did not follow Regimen	Personality Difficulties
11	Return to Med. Clinic Heart Disease Regimen	Fair	Clinics attended Regimen hard to follow	Denies condition and anxious so cannot be quiet
12	Nursing Home Care Heart Disease Regimen	Good	Recommendations Followed	Supervised Medical Care
13	Medical Clinic Heart Disease Regimen	Fair to Good	Moved to another State on leaving Hospital Now in Nursing Home	Was confused and refused to follow directions Now has supervised care
14	Medical Clinic Heart Disease Regimen	Good	Recommendations Followed	Supervised Care
15	Nursing Home Care Heart Disease Regimen	Good	Recommendations Followed	Supervised Care
16	Chronic Hospital Care Heart Disease Regimen	Good	Recommendations Followed	Supervised Care

Seven of the patients studied received "good" continuity of care; "fair" continuity was seen in four cases while one patient changed from "fair" to "good" continuity. "Poor" continuity was noted in four cases.

Treatment recommendations were given to the patients before they left the hospital by brief verbal instruction. Several patients were given written instructions to take to clinic doctors while recommendations for those who entered nursing homes or received home care were sent on forms by the social worker.

Family members of three patients were with the patient when the doctor gave final recommendations. The other thirteen patients were alone with the doctor at the end of hospitalization when treatment recommendations to be followed were given out.

The patients ill with arteriosclerotic heart disease were the seven who received "good" continuity of care when placed in nursing homes or received home care. Medical recommendations were carried out under the supervision of trained personnel who encouraged these patients to accept the limitations of the prescribed regimen.

In Case 6, "good" continuity can be attributed to a better financial status and to the fear of heart disease. This fifty-four year old married man, the only one of the sixteen patients who lived in a comfortable, single family home, attended clinic once after leaving the hospital. Impatient at having to wait in clinic, the patient transferred his care to a local medical doctor who lived near the patient.

A good patient-doctor relationship is the reason for "good" continuity of care in Case 7. On leaving the hospital this fifty-four year old Negro woman was given a summary letter containing recommendations which she took the next day to the doctor of an out-patient clinic where she had received care previous to her hospitalization. This patient spoke with trust and confidence of the doctor who she felt had all her interests in mind.

Case 13, a seventy-three year old widow with the diagnosis of heart disease, had lived alone before entering the hospital. She was discharged in care of a son in another state so that she did not attend the recommended clinics at the hospital although the family with whom she lived tried to help her follow the regimen. As the patient was confused and did not follow recommendations, the family placed her in a nursing home where she received supervised care. Continuity in this case changed from "fair" to "good."

"Fair" continuity is seen in Case 11, a fifty-nine year old married man who was hospitalized for the first time with arteriosclerotic heart disease. Discharged with the diagnosis and treatment recommendations, the patient went home to try to follow the regimen to which he could not adjust. Confident that the doctors were giving him good medical treatment in the clinic, this patient was

faithful in keeping clinic appointments.

Another example of "fair" continuity is seen in Case 10, a fifty-six year old married man who lost the sight in one eye two weeks after leaving the hospital. Frightened by his illness and discouraged by his loss of sight, this patient denied the need to restrict his activity even though he knew that he might experience a more severe or fatal re-currance of his illness. The family of this patient had little understanding of his condition thus depriving him of much needed emotional support. The patient attended many out-patient clinics but was not well enough adjusted to follow recommendations.

Four of the diabetic patients had "poor" continuity of care. One patient, who came from an extremely deprived home where she was unhappy in her marital relationship, had spontaneous obortions the last two times she was hospital-ized. This diabetic woman, the youngest of the sixteen patients, was seen to be depressed and in need of psychiatric attention. Diabetic clinic was attended twice after the patient left the hospital after which there was no record for her in any of the recommended clinics. The patient had moved from her home at the time of the follow-up interview and could not be traced.

"Poor" continuity is seen in Case 4, a fifty year old

single man who was given the diagnoses of diabetes melletus, arteriosclerotic heart disease, recurrent pancreatites and chronic alcoholism. He worked infrequently as an odd-job man and lived with a sister and her family who took care of him. Diabetic since 1955, this patient took no responsibility for his care disregarding the diabetic regimen. Personality difficulties seemed to hinder the following of medical recommendations in this case.

Two patients had attended no out-patient clinics; neither had they followed the diabetic regimen. Case 3, one of the two patients who follow no recommendations, was a forty-one year old married woman who had "mild" diabetes. She was afraid that she would die of heart disease as did her father and brothers. The patient refused to return to the clinics saying that she would die just as she is. When notified of the writer's coming visit, this patient left home telling her husband that the social worker was probably coming to tell her that she had some other terrible disease. Fear of her illness and poor personality adjustment blocked treatment recommendations given by the doctor.

Two of the six diabetic patients had "fair" continuity. These two patients returned to clinics but did not follow the diabetic regimen.

Case 8, an example of "fair" continuity, a fifty-four

year old married man who had severe diabetes returned regularly to clinic because of his dependent relationship with the hospital doctors who praised him because he could be trusted to remember his insulin. Confident that he knew what to do for himself, this patient disregarded the diabetic diet when at home.

Although intellectually incompetent to understand the need to watch her diet, Case 5, a fifty-three year old widow who lived alone, attended clinics because of a good patient-staff relationship which helped her receive "fair" continuity of care.

Those older patients in the group who were in nursing homes to receive nursing care because of arteriosclerotic heart disease were given supervised medical attention which contributed to "good" continuity of care.

None of the diabetic patients received supervised medical care after leaving the hospital.

The agencies of the community recommended by the doctor to give the patient comprehensive care are shown in Table XI.

Table XI

Agencies Recommended and Services Offered

Case No.	Agencies Recommended	Services Offered	Services Accepted
1	Out Patient Clinics	Medical Care	no
2	Out Patient Clinic	Medical Care	no
	Welfare	Financial	yes
	Social Service	Casework	no

3	Out Patient Clinic	Medical Care	no
4	Out Patient Clinic	Medical Care	no
	Alcoholics Anonymous	Supportive	no
	Public Welfare	Financial	yes
5	Out Patient Clinic	Medical Care	yes
6	Out Patient Clinic	Medical Care	yes
7	Out Patient Clinic	Medical Care	yes
8	Out Patient Clinic	Medical Care	yes
	Social Service	Referral	yes
	Vocational Rehab.	Employment	no
	Sheltered Workshop	Employment	no
9	Public Welfare	Financial	yes
	Social Service	Home Care Arrangements	yes
10	Out Patient Clinic	Medical Care	yes
	Cardiac Rehab.	Employment	yes
	Vocational Counselor	same	
11	Out Patient Clinic	Medical Care	yes
12	Out Patient Clinic	Medical Care	yes
	Cardiac Rehabilitation	Employment	no
	Public Welfare	Financial	yes
13	Out Patient Clinic	Medical Care	no
14	Public Welfare	Financial	yes
	Nursing Home	Nursing Care	yes
	Social Service	Interpretation & Placement	yes
15	Nursing Home	Nursing Care	yes
	Public Welfare	Financial	yes
	Social Service	Home Placement	yes
16	Chronic Hospital	Nursing Care	yes
	Social Service	Placement	yes
	Public Welfare	Financial	yes

From the foregoing table it can be noted that medical care was recommended for all the sixteen patients. All except four diabetic patients accepted medical care in some form.

The Department of Public Welfare, the next most recommended agency, gave financial assistance to seven patients referred for aid.

On the recommendation of the doctor, the medical social

worker planned to place patients in four nursing homes, one chronic hospital, and arranged home care for another patient who soon returned to the hospital for a leg amputation. Out-patient clinics had been recommended for Case 13 who is now in a nursing home in another state.

The services of Rehabilitation counselors were suggested to three patients. One patient had been recommended for retraining and job placement several years ago, but this was not followed through so that the patient felt all effort to find work was in vain. Case 10 had been referred to Cardiac Rehabilitation and, at the time of the interview, had seen the counselor to inquire about retraining and employment. Although referred by the doctor on the medical inventory, Case 11 had no knowledge that he was to use the services of Cardiac Rehabilitation. No referral to social service had been made to help this patient establish contact with this agency.

For two patients, both chronic alcoholics, casework services and Alcoholics Anonymous were advised. As far as the interviewer could tell, neither of these patients had participated in the planning for these services, so that the referrals were not accepted.

Seven of the sixteen patients were referred by the house resident to Social Service and, of the seven cases,

only three were recorded in the Social Service files. Table XII will show the referrals to Social Service and the reason for referrals.

Table XII

Social Service Referral

Case No.	Referred to Social Service	Reason for Referral	Need for Social Services Noted by the Interviewer
1	no		Casework to help with emotional problems
2	yes	Casework Treatment	
3	no		Casework and Interpretation
4	no		Casework for Emotional Problems
5	no		
6	no		Supportive Casework
7	no		
8	yes	Refer to Voc. Rehab.	
9	yes	Home Care Arrangements	Supportive Casework
10	no		Supportive Casework
11	no		Supportive Casework
12	yes	Nursing Home Placement	
13	no		Interpretation to Family
14	yes	Interpretation Nursing Home Placement	
15	yes	Nursing Home Placement	
16	yes	Chronic Hospital Placement	

All the referrals were made by the house resident and two of the cases who were placed in nursing homes had been referred at the previous hospitalization of the patients. One case was referred to social service two weeks before the patient was to leave the hospital.

Five of the patients were referred for nursing care either in institutions or at home. In only one case did the doctor suggest that interpretation be given to the patient before nursing home placement was arranged. One case was referred to Social Service to help the patient contact the vocational rehabilitation counselor. One patient, a chronic alcoholic, was referred for casework treatment.

Personality difficulties were outstanding in the diabetic patients. Repressed hostility toward authoritative figures and dependency needs which had never been met in a satisfactory manner prevented these patients from using constructive measures to lessen their disabilities. Three of the patients had long histories of alcoholism.

Three of the patients referred to the medical social worker for nursing home placement had records in the Social Service files. In each case the social worker helped in coordination of medical care.

Case 14, a seventy-eight year old widow with the diagnosis of arteriosclerotic heart disease, had worked as a waitress until her retirement ten years ago. She lived alone in a small rented apartment receiving $57 per month from Social Security. When the patient was referred to Social Service by the house resident, the medical social worker tried to help the patient understand the need for nursing home placement. Not willing to accept such planning, the patient returned to her home before readmittance to the hospital eight days later. Learning that it was impossible for the patient to remain at home alone, the social worker again tried to help the patient accept and understand the doctor's medical recommendations. Arrangements were made with Public Welfare to finance nursing home care, and, although the worker hoped that the patient had been prepared for nursing home placement, on entering the nursing home the patient became confused and rapidly deteriorated.

In this case, the patient's needs, as far as medical care was concerned, were recognized by the physician in charge so that a medical social worker was called to help the patient. The worker found a nursing home and arranged for financial assistance to cover the cost of such care. Although the patient was helped to use available resources, she did not comprehend the recommendations made by the

doctor. Treatment recommendations were given to the nursing home personnel by the social worker that instructions might be followed. This is an example of where existing agencies cooperated in comprehensive care, but without the full co-operation of the patient whose feelings were not dealt with adequately even though the social worker had interpreted the need for such care to the patient.

Case 16, the oldest patient in this group of sixteen, was an eighty-eight year old widow who lived alone in her own house before hospitalization. Recipient of Old Age Assistance, this patient had been in an automobile accident and had been hospitalized in Maine before being transferred to Boston City Hospital where she received the diagnoses of arteriosclerotic heart disease with congestive failure and subacute bacterial endocarditus. The social worker was called in to speak with the patient regarding plans for care after leaving the hospital. The patient first felt that she was too sick to be discharged and then declared that she wanted to stay in the hospital until she was well enough to go home.

A daughter-in-law of the patient assisted the social worker in discussing with the patient plans for chronic hospital care. The worker wrote to Public Welfare stating medical recommendations, and financial assistance at the

rate of $10 per day was given to cover the cost of chronic hospital care. When seen at the time of the follow-up visit, this patient was bedfast. All the medical recommendations were being followed.

The third case in which the medical social worker helped arrange nursing home care was for Case 12. This sixty-seven year old widower with the diagnoses of arteriosclerotic heart disease and Parkinson's disease, had lived alone in a small two room apartment before hospitalization. Wanting to live in his own home as long as possible, the patient was helped by his landlord when unable to leave his apartment to do errands. The patient received $30 per month from Social Security which was supplemented by Old Age Assistance. Admitted to a nursing home, the patient was hospitalized after which he was readmitted to the medical ward and again discharged to the same nursing home. As the personnel of the institution found the patient difficult to care for and would not accept him after a further hospitalization, the social worker helped with nursing home placement. The patient died shortly after placement at the last nursing home.

The environmental modification used by the caseworker in the three recorded cases was important in helping these elderly and very ill patients receive the medical recom-

mendations which would give them the care each needed to make him as comfortable as was possible.

The patient who had been referred to Social Service for casework treatment did not know if she had seen a social worker, but believed that the person who came to talk with her one day must have been a social worker as he tried to help her to feel better. There is no recording on this patient.

As far as could be determined, the referral to Social Service to help in contacting the Department of Vocational Rehabilitation in the behalf of one patient was never received. Although this patient stated that he knew many social workers, there was no recording of any service that had been given.

Case 15, an eighty-six year old widow with the diagnosis of arteriosclerotic heart disease, received the services of a social worker in an agency outside the hospital who worked cooperatively with the hospital social service workers each time the patient was hospitalized. Understanding that the goal was to work for the benefit of the patient, the two workers combined efforts to help the patient receive "good" continuity of care.

In the opinion of the writer, there was a definite need for supportive casework with eight patients not referred to Social Service. In seven cases the patient's

problems were intensified because of personality difficulties. Two patients were especially unhappy in their family relationships. Emotional difficulties were evidenced by the patients' inability to talk about his problems, withdrawal from contacts with others, obvious depression, unrealistic planning, and anxiety state.

One patient expressed concern to the writer at the follow-up interview regarding his physical condition and prognosis as relating to his ability to gain employment. This man had been referred by the doctor for Cardiac Rehabilitation although the referral went no further than the medical inventory. At the time of discharge from the hospital, the patient waited an hour to see a social worker who he was told to expect. Becoming impatient, the patient went home without receiving help in his new adjustments. The writer felt that this patient could have benefited from supportive casework treatment and realistic assistance in helping him understand his regimen.

Those patients who had personality difficulties needed much support and encouragement which might have helped them to carry out medical recommendations to some extent. Supportive casework in which much encouragement and reassurance would have been given could have perhaps met many dependency needs of patients who felt inadequate to meet their personal

health crisis. Many of the patients expressed resentment that they should suffer from fearful, long-term illness. The defense mechanisms of denial, rationalization, and repression were observed by the writer.

In this particular study, the social worker was able to help the patients by her knowledge of community resources and ability to arrange practical services.

CHAPTER V

SUMMARY

This study of sixteen patients, part of a group research study directed by research workers of the Medical Care Evaluation Study at the United Community Services, proposed to discover the community services which were available to these patients after they left the hospital. Knowing that those who require long term care are given medical treatment recommendations, it was of decided interest to discover if the patient followed the recommendations made by the doctor and to find out why they were or were not observed.

Four students from two Schools of Social Work carried out exploratory research on eighty-four ward patients from three teaching hospitals in Boston. The patients were chosen by the house residents from three categories of chronic illness.

The sixteen patients described in this study came from the Greater Boston area and had been hospitalized in wards at the Boston City Hospital with arteriosclerotic heart disease and diabetes which were two of the three chronic illnesses chosen for this study. The ages in the group ranged from thirty-two to eighty-eight years. Each case was chosen by the medical house resident who made a

medical-social inventory of each patient before hospital discharge. Using the inventories as a basis, all the medical records of the patients were looked up and the Social Service files were checked before the interviewer went on a follow-up visit which was made approximately three months after the patient had left the hospital.

There were nine females and seven males in the group studied. Ten patients had a diagnosis of arteriosclerotic heart disease, three had diabetes with complications, and three had both arteriosclerotic heart disease and diabetes. The degree of illness each patient had was classified as being "mild", "moderate", or "severe." In eight of the patients the illness was considered to be "severe"; seven were classified as "moderate"; one patient had a "mild" degree of illness. Eight patients had a life expectancy of from six months to one year; three were expected to live one year and two over one year. Of the two patients who had been expected to live six months, one died before the follow-up visit.

Length of hospitalization ranged from four days to three months or more with ten patients having been in the hospital for treatment one to three times with the same illness. One patient had been hospitalized thirty-nine times.

On leaving the hospital, seven patients returned home

to live with their spouse, five entered nursing homes, two lived alone, and one received nursing care at home until he was again hospitalized. One patient went to live with relatives.

Although weekly incomes ranged from $13 to $75 a week for those patients whose incomes were known, ten of the thirteen patients received between $13 and $40 a week which did not cover the cost of living adequately. Nine of the patients received some kind of public assistance.

One house resident made all medical treatment recommendations as well as referrals to different agencies. Each one of the patients received recommendations for some kind of medical care and was instructed in the regimen to be followed. Medical care was made available to the patients by out-patient clinics, local medical doctors and nursing home personal.

Eight patients with heart disease received "good" continuity and two were classified as "fair." Two diabetic patients achieved "fair" continuity while four were categorized as "poor."

The fear of death, adequate finances, nursing supervision, and a trusting doctor-patient relationship were factors which helped the patients with heart disease follow medical recommendations.

Social and emotional deprivations which resulted in personality difficulties hindered diabetic patients from accepting the services offered to them and in following recommendations. Emotional dependency and feelings of hostility toward authoritative figures were inner personality factors which impeded the diabetic patients' ability to meet reality problems.

The house resident classed medical care and financial assistance as the two most necessary services required by the patients. Vocational Rehabilitation was suggested for three patients so that they might be retrained for employment.

Seven referrals were made to the Social Service Department for nursing home or chronic hospital placement and for home care arrangements. Casework treatment was recommended for one patient and it was recommended that another patient be given interpretation before nursing home placement.

It was noted in the medical records, as well as in the medical-social inventory, that the doctors were aware of many of the psycho-social problems presented by these patients. In the three cases in which there was recorded information regarding the medical social worker's activity, the doctor called the worker in to meet immediate problems which required the knowledge of community resources.

Eight of the patients not referred to the medical

social worker might have been helped to understand their problems and to have followed recommendations to a greater extent if interpretation and supportive casework treatment could have been given to them.

In the light of the foregoing facts, there are several recommendations that could be made which might prove to be of value for both the physician and social worker.

It would seem that a greater understanding of what each member of the medical team contributes and how each can work together to coordinate services in the interest of the patient would improve the process of making referrals thus "making it possible for the physician and the therapeutic team to operate from the hospital base and to extend their united services into the home."[1]

Medical treatment itself can do little when patients return to adverse social and economic conditions at home. To foster understanding of the patient's condition it would seem that more effort be made to see family members to share the medical recommendations with them so that the patient can know that he will have others to help him bear the responsibility for carrying out the advised regimen. After

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1 Francis Upham, op. cit., p. 27.

the talks with the physician, the family could be directed to the social caseworker for assistance with both practical services and psychological treatment to help the patient and his family in making new adjustments in the community.

As the patient is the most important member of the team, it could be suggested that the patient be brought into the planning for his future adjustments to a greater extent, The cooperation of the patient is needed to prevent relapse requiring frequent hospitalization. It seems that supervision by some member of the medical team, perhaps the medical social worker who could act as a liaison between the hospital where the patient felt safe and cared for and the community where he must adjust to his limitations, would be helpful in supporting the patient to follow medical treatment recommendations. It was noted in the cases of "good" continuity that the patient had a trusting relationship with some one person on the hospital staff. If the physician could not see the patient regularly it would appear that the medical social worker would be in a position to establish a relationship which might motivate the patient to face the reality of his illness so that he could deal with it more effectively. In this study, those patients discharged and left to their own devices did not follow treatment recommendations as did those who received supervised nursing care.

Since the personality patterns of the patients seemed to be a factor which influenced continuity of medical care, this would indicate that perhaps many of the patients might be helped if members of the staff could recognize when the services of the psychiatrist or social worker are required. Many times a referral comes too late to help the patient achieve good continuity of care. Those patients with a long history of illness should perhaps be referred to the social worker immediately on admission to the hospital.

In a further study it would seem that a better picture of what continuity of care could do to prevent the many hospitalizations the majority of these patients in this study had experienced could be gained from patients in a younger age group with an illness in a less severe stage. The patients described in this thesis were in the older age group with illnesses which were advanced so that there was little prospect of their being restored to health or of becoming fit for work.

The goal of helping the individual to help himself by following treatment recommendations will be realized more fully when the whole person and his environment are considered by the medical team. Only by the united action of the patient, medical team, and community can continuity of medical care be established.

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Time for Completion
of Schedule _____

SCHEDULE A3

MEDICAL CARE EVALUATION STUDIES

Study of Continuity of Medical Care

Discharge Medical Inventory

Hospital _____ Service _____ Ward _____

I. Identifying, Social and Demographic Data:

Name: _____ Hospital No. _____

Address: _____ Phone No. _____

_____

Age: _____ Sex: _____ Marital Status: _____

Years of School Completed: _____ Race: _____ Birthplace: _____

Family Income: (Estimate, if necessary)

Less than $1,000	_____	$3,000-$3,999	_____
$1,000-$1,999	_____	$4,000-$4,999	_____
$2,000-$2,999	_____	$5,000-and over	_____

Number in Family: _____ Number Working: _____

Date Admitted: _____ Date Discharged: _____

Previous Admission to This Hospital: (in past 5 year period)*

	Date Admitted	Date Discharged	Principal Diagnosis
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

* Note Additional Admissions on Reverse Side

Occupation:

Usual Job: _____ Industry: _____ Until When: _____

Most recent Job: _____ Industry: _____ Until When: _____

Living Arrangements:

A. Household:

1. Living with Family:

Relationship	Sex	Age

2. Living with Unrelated Persons. Number: _____

3. Living Alone: _____

B. Help Available:

1. Person available at home for needed housekeeping and bedside care? _____

Relationship: _____

a. Full-time daily _____

b. Part-time daily _____

c. Occasionally _____

Discharged to:

1. Residence:

Name of household head: _____

Address: _____

Town: _____

2. Institution:

Name: _____

Location: _____

II. Medical Status:

Diagnosis: List all conditions that interfere with or limit patient's activities, or which are likely to do so in the future (in advance of limitations which may normally accompany the aging process), or conditions that might require medical or nursing care, rehabilitation or other services. Include psychiatric conditions.

	Condition	Severity 1/	Stage 1/	Remarks
1.				
2.				
3.				
4.				
5.				
6.				
7.				

(List any additional conditions on reverse side)

1/ See attached instructions for definition of terms and classificati...

Estimate of Capacity:

(Circle numbers which most clearly characterize patient)

Current Status	Estimated Capacity (3 months)	
1	1	Unlimited ability to work at usual occupation (including school and housework).
2	2	Limited ability to work at usual occupation or changed occupation.
3	3	Able to carry out activities of daily livi... but unable to work or adjust independently

Current Status	Estimated Capacity (3 months)	
4	4	Limited ability for activities of daily living.
5	5	Complete dependence - unable to carry out any activities of daily living.

Describe cause and nature of disability:

Summary of course in hospital (current admission):

Prognosis for life (in months - up to 1 year):

Estimate of Medical Services Required: (3 months)

Enter estimate of medical care required for all conditions from which patient was suffering at the time of discharge from the hospital, to keep the patient as well as possible, and to help him achieve his maximum potential capacities.

Type Service	Purpose	Frequency or Amount
Medical Supervision		
Home visits		
Office or Clinic		
Specialist Care (Specify Type)		
X-Ray Therapy		
Rehabilitation Service (specify type, i.e. physical therapy, occupational therapy, prevocational training, vocational counselling, speech therapy, job placement, sheltered work, prosthetics, other).		
Dental Service (Specify Type)		
Other Medical Service (Specify Type)		
Regimen to be carried out by patient (specify - i.e. diet, medication, oral, or parenteral, exercise, other).		

REMARKS: _____

_____

_____

IV. Estimate of Nursing Services Required: (3 months)

(Bedside care, observation, injection, dressing, demonstration and instruction exercise, including supervision of graded activity, other.)

Type Service	Frequency or Amount	Skill(RN-PN-Untrained)

V. Estimate of Institutional Care Required:

(Specify type and amount - i.e. hospital, mental hospital, nursing home, other institutions) - in next 3 months.

Type	Period

I. Other Services:

(i.e. - Social Service; Housekeeping Service) - 3 months.

Type Service	Frequency or Amount

II. What is the patient's attitude toward indicated care?

_____

_____

_____

VIII. What recommendations were made to patient at time of discharge?

IX. What referrals were made? To what Agencies?

Signature

-6-56
0-26-56

MEDICAL CARE EVALUATION STUDIES

Study of Continuity of Medical Care

Followup Interview

INTERVIEWER _____ Time for Completion of interview _____

Affiliation _____

Date of interview _____ Hospital _____

I. Identifying Data:

Name: _____ Age: _____ Sex: _____

Address: _____

Phone Number: _____ Marital Status: _____

Hospital No.: _____

Date Admitted: _____ Date Discharged: _____

Call	Date	Time	Place	Interviewer Remarks*
1.				
2.				
3.				
4.				

5. Specify persons giving information: _____

_____

* Use this column for appointment time or for recording information as to when and where respondent can be found.

II. Summary of Events Since Discharge:

III. Living Arrangements. (Current)

A. Households:

1. Living with spouse and other family members:

Relationship to patient	Sex	Age

2. Living with unrelated persons: (Specify)

3. Living alone:

4. Living in an institution: (Specify)

B. Changes in household since discharge. (Reasons for any change)

C. Help available: (Current) (Family, Neighbors, Friends.)

Frequency	Time	Person giving help and kind of help
1. Daily	_____	_____
2. Less than daily but more than once weekly.	_____	_____
3. Less than once weekly.	_____	_____
4. No help.	_____	_____

D. Help available since discharge. (Describe any changes.) - (Periods, frequency, time, person, reasons for changes.)

_____

_____

_____

_____

_____

E. Housing: (Current)

1. Accessibility:

Floor. _____

Elevator. _____

Public transportation. _____

2. Unmet needs in housing:

a) Space (specify) _____

_____

b) Facilities (specify) _____

_____

c) Accessibility (work, medical care) _____

_____

_____

[illegible]

[illegible]

[illegible]

[illegible]

	Amount
1. Patient.	
2. Member(s) of household (specify).	
3. Relief program (specify).	
4. Other - e.g. Social Security, etc. (specify).	
5. Other pertinent data.	

C. Changes due to patient's illness since admission to hospital.

V. Current Patient Activities: (Circle one.)

A. Work capacity unlimited.

B. Limited work.

C. Takes care of most activities of daily living.

D. Limited activities of daily living - ambulatory.

E. Bedfast.

VI. Occupational Adjustment:

A. Weeks since discharge: _____

B. Weeks not working: _____ Reasons: _____

C. Worked since discharge.

1. Full-time - weeks _____

2. Part-time - weeks _____

3. Occupation (specify and describe - industry, physical activity, hours, days per week, time).

_____

_____

4. Occupation before hospitalization. (specify) _____

_____

5. Reason for change of occupation, if any. _____

_____

VII: A. What did physician recommended at time of discharge? _____

_____

_____

_____

_____

_____

_____

B. Who was present at interview with physician? _____

_____

_____

C. Patient's attitude towards recommendations: _____

_____

_____

_____

VIII. Services recommended and received:

	Services Recommended			
Service (1)	Recommended (2)	When and By Whom Recommended (Date) (3)	Frequency or Amount (4)	By Whom To Be Given (Agency) (5)
Medical				
1. Medical Supervision				
a. Home visit				
b. Clinic visit				
c. Office visit				
2. X-ray therapy				
3. Other (specify)				
Rehabilitation				
1. Physical therapy				
2. Occupational "				
3. Prevocational "				
4. Vocational couns.				
5. Speech therapy				
6. Job placement				
7. Sheltered work				
8. Prosthetics				
Dental				

	Services Recommended			
Service (1)	Recommended (2)	By Whom Recommended (3)	Frequency or Amount (4)	By Whom To Be Given (Agency) (5)
Regimen				
1. Diet				
2. Rest & Exercise				
3. Oral Medication				
4. Parenteral med.				
5. Other (specify)				
Nursing				
1. Bedside care				
2. Observation				
3. Injection				
4. Dressing				
5. Demonst.-Instruc.				
6. Exercise, activity				
7. Other (specify)				
Institutional				
(Specify)				
Social Services				
1. Specific need (specify)				
2. Casework treatment				

Services Received

Service (6)	Dates or Frequency (7)	By Whom Given (8)	Describe departure from recommendations, reasons for not receiving recommended service or for receiving additional service (9)	Score (10)

IX. Additional Services Considered Necessary by Patient, But Not Obtained: (Specify type service, why needed, reason not obtained.)

X. Coordination of Services:

Person or agency Providing service or to which referral was made or recommended	By whom referred	Type of Service	How contact was initiated or why it was not established

XI. Attitude of Patient and Accuracy of Data:

A. Attitude of patient or person giving information toward interview.

B. Estimate of adequacy and accuracy of data.

Interviewer

DORIS KITT

THESIS ABSTRACT

A STUDY OF CONTINUITY OF MEDICAL CARE
A SOCIAL WORKER'S EVALUATION OF SIXTEEN PATIENTS DISCHARGED FROM THE BOSTON CITY HOSPITAL

The purpose of this study, part of a group study of eighty-four cases carried out under the auspices of the United Community Services of Metropolitan Boston, was to explore what services were available to patients who have continuing need for medical care after leaving the hospital. To discover whether patients understood and followed recommendations, if patients received the care they needed, and what part the social worker had or could have had in promoting continuity of medical care was the purpose of this follow-up study.

Little information on continuity of medical care could be found in the literature with the exception of a research study carried out in the west of Scotland. The conclusions drawn from that study indicated that social and environmental factors influenced the patient in accepting or refusing the medical assistance offered by the health services. The fact was stressed that many of the patients could have benefited from some form of social service.

The sixteen patients described in this thesis were those with the diagnoses of arteriosclerotic heart disease and diabetes. Each one of these patients had been hospitalized in the wards of the Boston City Hospital sometime between July 1956 and December 1956. All the cases were chosen by the medical house resident so that follow-up visits by the student social worker could be made approximately three months after the patient was discharged from the hospital. A schedule formulated by the group was used to structure the follow-up interview which added current data to that gained by the house resident who had made a medical-social inventory for each patient at the time of discharge..

The group of sixteen patients investigated by this writer could be considered as representative of the ward cases at Boston City Hospital which met the criteria of this study. All patients came from a socio-economic group for whom there were many deprivations. Although the ages of the patients ranged from thirty-two to eighty-eight, half of the patients were between fifty-two and sixty-two. The life expectancy for ten patients was estimated to be from six months to one year. Illness was "advanced" in all cases except one which was classified as "mild" The majority of these patients had been hospitalized many times with the same illness so that few were capable of being restored to health or of becoming

fit for work. Five of the patients required nursing home placement or home care. The income for these patients was low; the majority received some kind of public assistance.

After studying the treatment recommendations and how they were carried out, each patient was catagorized as having "good", "fair", or "poor" continuity of care. Eight patients with heart disease received "good" continuity; two were classified as "fair". Two diabetic patient achieved "fair" continuity while four were catagorized as "poor." It was found that those patients with the diagnosis of arteriosclerotic heart disease had "good" or "fair" continuity due to supervised nursing care, fear of death, or good doctor-patient relationships. "Poor" or "fair" continuity was observed in the diabetic patients who had no supervised care and who appeared to have many personality difficulties which hindered their carrying out treatment recommendations.

The house resident recommended medical care services for all sixteen patients. The Department of Public Welfare, the next most recommended agency, was contacted to give financial aid to seven patients. Nursing home placements and home care were arranged for elderly patients and those with advanced arteriosclerotic heart disease. The Department of Vocational Rehabilitation was recommended for three patients who might become employable after retraining. Alcoholics Anonymous and the services of a sheltered workshop were also recommended.

In this particular study the caseworker in the hospital setting was called upon mainly to assist the patients in using community resources and in arranging practical services. Had there been an opportunity for the caseworker to have been called in earlier, supportive casework treatmentmight have helped many of the patients to understand treatment recommendations so that they could have been carried out more fully.

This writer felt that patients might be helped to a greater extent if the home and family of the patient were studied so that some effort might be made to alter adverse social and economic problems. Personality characteristics of the patients should be recognized in making referrals and in presenting recommendations. It would be important to bring the patient into the planning for his future care to a greater extent for the goal of the medical team is to help the patient to help himself.. By establishing a good relationship with the patient, the social worker could do much to assist the patient as he makes new adjustments in the community after leaving the hospital.

Doris Kitt

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