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# A study of the referral process at the Boston Veterans Administration Hospital

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BOSTON UNIVERSITY  
SCHOOL OF SOCIAL WORK

A STUDY OF THE REFERRAL PROCESS  
AT THE  
BOSTON VETERANS ADMINISTRATION HOSPITAL

A Thesis

Submitted by

Nancy Lee Watkins

(B.S. Syracuse University, 1955)

In Partial Fulfillment of Requirements for  
the Degree of Master of Science in Social Service

1957

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## CHAPTER I

### INTRODUCTION

#### Purpose of the Study

This is a study to investigate the referral process to the Social Service Department at the Boston Veterans Administration Hospital. It is undertaken with the desire to be helpful to the individual worker and the whole department in its planning, so that it can be of better service to the patient. Also, since there is not a great amount of literature in the field, perhaps this study will add something to the knowledge of the referral process. The following aspects of referrals as they now come to the Social Service Department will be studied.

Pertinent descriptive information about the patient will be obtained to determine whether certain selective characteristics predominate in the persons referred. The source of referral will be considered in terms of the person, hospital service, or agency making the request. The understanding of Social Service function by the referring source will be studied by noting the reasons for referral. The method of referral used by various sources will also be of interest, especially the use of formal or informal channels in making the referral. The patient's preparation for referral by the referring source, his expectations from Social Service, and his attitude toward accepting help are to be included. The conception of the patient's problem as seen by the referring source is to be compared with the worker's evaluation of the problem.

From this study of the referral process, we hope to obtain some idea

of the factors which make for appropriate referrals. This descriptive study of the entire process of referral was undertaken to bring into clearer focus aspects of the referral process in order to identify common procedures. It is not the purpose of this thesis to decide on the effectiveness of these referral practices, as this would be a question for evaluative research. In order to improve their services, this is something that the staff might embark upon as a result of this study. Administrative plans or changes could be based on this study. Education as to the role of Social Service might be indicated for certain sources.

This project is being undertaken jointly by two Simmons students: Mary Herod and Marianne Sommerfeld; and two Boston University students: Faiga Connors and Nancy Watkins. Since a thesis has the primary purpose of providing an educational experience in a complete research process, each member of our group will be responsible for producing a complete thesis using her own sample of cases. The group met alone and collectively with Dr. Katherine Spencer of Boston University, Dr. Jennie Mohr of Simmons College and Mrs. Juanita Handy of the agency. Through these meetings, we collaborated on the formulation of the research questions and the evolving of the schedule. This schedule which is included in the Appendix has been used for all four parts of the study. It is the product of several revisions to make it more inclusive.

The following are the five general questions to be examined. Under each, sub-questions are listed.

1. What are the general social and medical characteristics of the patients referred?

Do patients of a certain age, marital status and occupation get referred? Are there any general characteristics of medical diagnosis and limitations in this group of patients?

Is our impression true that mostly older, chronically ill patients are referred? This may influence the type of casework, as working with older, unemployables affects the kind of casework that is possible. On the other hand, younger patients may have more potential for long term casework treatment.

Thus, we are interested in finding out if a certain type of patient ends up in Social Service and if so, what kind.

2. What are the sources, methods and circumstances of referral?

By examining the method of referral, it will be revealed whether the referral was planned as a result of a structured ward team conference or came about by informal communication such as a conversation with a social worker. Are certain methods of referral preferred by certain sources? We hope this will throw light on the appropriateness of formal or informal channels for referral.

The source of referral may be medical, as doctor or nurse, or non medical, as vocational counsellor or self, relatives, etc. Are there particular doctors, such as doctors on certain wards, who refer more than others? Do certain services such as medical and neuropsychiatric refer more often? Do some sources refer for certain reasons more than other sources?

The timing of referral can be very important and we want to know when, in his hospital stay, the patient is referred to Social Service. Are referrals made too late in the patient's treatment for effective social planning? It is anticipated that many are referred when discharge is due. Hopefully, the study may indicate to the hospital administration whether this is so.

3. What conceptions do the referring persons seem to have of the patients' problem and the social worker's role?

The type of referral made by the doctor in a hospital to the Social Service Department would seem to be greatly influenced by his conceptions of the role of the social worker and her function in the hospital and the usefulness of these functions in relation to a particular patient. By inference in the analysis and interpretation of the other questions, the role of the Social Service Department as seen by other hospital personnel should be seen more clearly.

By examining the referring person's participation in the referral, it may be found that the problem is not too well identified or described. Oftentimes, the doctor, as the referring person, may realize that there is a stress but may state that he is not certain what it is and the social worker is asked to explore. In other cases, there may be a definite statement.

4. How was the patient prepared for the referral and how does the patient participate in it?

We are interested in the nature of preparation as reported by the referring person and as reported by the patient himself. What was the patient told in preparation for referral and by whom? Was preparation effective in that the patient had the same understanding of the purpose of referral as the source? What was the patient's conception of his problem and did he feel he needed Social Service help? It might just be the referring person who feels he needs help.

5. To what extent does the problem as seen by the social worker coincide with the problem as seen by the patient and the referring person?

When Social Service evaluates, its identification of the problem may not be the same as what the referring sources state or what the patients see as problems. How does the general area of the problem, as presented by the doctor, compare with the general area of the problem as seen by the social worker?

#### Sources of Data and Method of Selecting Sample

The sources of data were primarily the social case work records. It was evident at the outset of this study that past cases now on record in the department would prove inadequate for the investigation in that they were recorded for treatment rather than research purposes. It was therefore necessary to turn to new cases in the collection of data, in order that proper attention could be paid to recording the details of the referral. Because of their interest, the staff workers agreed to record the process of referral and first interview material promptly and in a way that would give data covering the items in the schedule. A copy of

this recording was available to each student for each case in her own sample.

Social Service index cards supplied the following information: the patient's age, sex, marital status, last occupation, present date of admission to hospital, and date of referral to Social Service. These cards are filled out when the patient enters the hospital and a copy is filed in the Social Service office, whenever a case is opened. Certain data (previous hospitalization at Boston Veterans Administration Hospital; date of present admission to hospital; and date of discharge, if known) were obtained from files in the Registrar's Office. In addition, the hospital medical records provided information about diagnosis, record of treatment given, progress notes and other medical and psychiatric data. They also contained information about prior Boston Veterans Administration Hospital admissions.

When there were gaps in the factual material in the recording, these were supplemented by material gained from personal interviews with the social worker who had been active on the case.

The cases for this study include the first 160 cases referred to the Social Service Department after November 1, 1956, through December 20, 1956. Thus, this is the total population for the period studied. Each student studied a total of 40 cases, picking up every fourth case in rotation as they were referred to the department. The re-opened cases referred during this period were included but were noted on a separate list so that they could be evenly divided between the four study groups. Thus, each student had a random sample from the total population known to Social Service.

### Limitations

There are certain limitations inherent in any study of social case records. In this study, even though a schedule was set up before the interviews were recorded, the worker did not record fully all the facts we were interested in. Where this seemed to occur, staff members were contacted to provide additional information and counteract the recording deficiencies. In doing this, it was found that the workers were often vague in recollection of specific points, although there was a high degree of cooperation. Therefore, limitations existed because of incomplete recording.

In dealing with human attitudes, it must be recognized that human bias may enter in. The factors of subjectivity and incomplete recall would naturally enter into any study of this type. Evaluation of information given as well as of situations where information was not given was done as objectively as possible by the writer.

It needs to be recognized that this study includes only patients referred to Social Service who are presumably not representative of the total hospital population. We can state the characteristics of patients referred to Social Service but we do not know in what ways they are different from the total hospital population.

Another limitation is the period of time studied, which included the Christmas season. At this time of the year there seems to be more pressure for discharge, and, therefore, a larger number of cases involving discharge planning and financial arrangements may be expected. Referrals in other parts of the year might be different but there is no other study to compare these with.

## CHAPTER II

BACKGROUNDThe Boston Veterans Administration Hospital<sup>1</sup>

The establishment of the Boston Veterans Administration Hospital was authorized in September, 1946, after a survey by the Veterans Administration indicated that additional hospital facilities for the care and treatment of veterans of all wars were needed in the Boston area to supplement the services provided by the West Roxbury Hospital and by the Cushing General Hospital in Framingham. The final selection of the site was made in March, 1948, by the Corps of Engineers, and construction was started soon afterwards on the six permanent structures. In June, 1952, the entire hospital was inspected by the Veterans Administration Engineers and turned over to the Manager of the hospital, and on July 10, 1952, the first patients from the West Roxbury Hospital, which was to be converted to a center for paraplegic patients, were transferred to Boston. On July 27, 1952, the hospital was formally dedicated.

Because of the closing of the West Roxbury Hospital preparatory to transfer of that unit from the Veterans Administration to the Department of Defense, it was necessary to put the Boston Veterans Administration Hospital in active use as rapidly as possible and to this end, the

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1. Sources of material used in this section are: The Minute Man, 9:28, July 27, 1952; and Boston Veterans Administration Hospital, Social Service Department, Social Service Manual.

majority of staff were drawn from West Roxbury and Cushing Hospitals and combined with other professional and lay personnel so that a larger number of patients could be adequately handled.

There are 1,200 employees of the Boston Veterans Administration Hospital, approximately 50 of whom are engaged in special medical research programs. The remainder are directly concerned with the care and treatment of patients and the administration of the services of the hospital. These are the following: the Medical Service, including a special Cardiac Section, and Allergy Clinic; Surgical Service, including Orthopedic, Neurosurgical, Ophthalmology, and Oto-Laryngology Sections; Neuropsychiatric Service, including one open and two closed wards, and the Neurology Section to which are attached the National Veterans Epilepsy Center, and the Aphasia Unit; the Physical Medical Rehabilitation Service, including Physical Therapy, Occupational Therapy, Correctional Therapy, Manual Arts Therapy, and Educational Therapy; the Radiological Service; the Nursing Service; the Laboratory Service; the Pharmacy Service; the Dietetic Service; the Dental Service; and Social Service. The Special Research Section includes a Radioisotope Laboratory, the National Veterans Epilepsy Center and the Tumor Clinic. In addition to its services as a treatment and research center, the hospital also maintains a training program for student doctors, psychologists, physical therapy trainees, social workers and others.

#### Function of the Social Service Department

The major focus of the social worker in the Boston Veterans Administration Hospital is helping the patient with those social and emotional problems which his illness creates for him and with obstacles which

prevent him from obtaining maximum help from medical treatment. This kind of responsibility often means that work is done not only with the patient and his family, but also with community resources whose help the sick person could utilize.

#### Referrals to the Social Service Department

In different hospitals, as in different family agencies, referral procedures may vary. These procedures are influenced by many factors including the physical setting, the size of the department in terms of the number of workers, the related services offered in the hospital, the social services cooperating within the community and the degree of education of the hospital professional personnel to the program of the Social Service Department.

Any patient who is in the Boston Veterans Administration Hospital is eligible for Social Service assistance, but not every patient is known to the department. In order to receive help, a patient must be referred.

Each member of the social work staff has specific assignments of teams of doctors or wards from which he assumes responsibility for all referrals. This includes the casework thinking and clarifications of function involved in accepting the referral for casework treatment.<sup>2</sup>

Referrals to Social Service are made in a variety of ways but primarily by doctors either individually or in designated conferences, such as formal ward conferences. Personal contact between social worker and physician may allow a verbal referral. Some referrals are made by telephone

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2. Boston Veterans Administration Hospital, Social Service Department, Social Service Manual, p. 2.

and others by written request in one form or another. The worker might be requested to assist the patient or his family at anytime.

Separation from the family, fear of any experiences involved in hospitalization, fear of an operation, renewal of anxiety regarding military and battle experiences, difficulty in interpersonal relationships may be causes of emotional disturbances that may retard medical treatment. The physician, recognizing that these deeper emotional disturbances cause anxiety, may ask the worker to see the patient to help him express some of his feelings about the problems with the ideas of reaching a better solution.<sup>3</sup>

Sometimes the doctor may desire background material to aid in diagnosis and thus asks the worker to talk with the patient, his family and other resources. The worker may be asked to evaluate family attitudes regarding the patient's illness, his discharge and other problems. "Effective discharge planning enables the Veteran to maintain the degree of help gained in the total hospital experience and allows early return home."<sup>4</sup>

Patients, once they learn that Social Service is available, may request help themselves. In this medical setting, this form of referral accounts for the second largest group of referrals. The patients may go to the social service office, place a request through some of the other hospital personnel, or meet a social worker on the ward.

In addition to these two main sources of referral, there are also the adjunct services in the hospital, such as nurses, contact officers, vocational counsellors, etc. Where there is a broad acceptance of Social

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3. The Minute Man, 9:28, July 27, 1952.

4. Ibid.

Service and some understanding of personal problems, the number of referrals from these sources may be considerable. Family who have had contact with social agencies or know of such service may seek help for themselves or the patient. Also there are the social agencies within the community which may be interested in the patient or his family and feel that the social worker can be of help to the patient.

## CHAPTER III

SOCIAL SERVICE, TEAMWORK AND REFERRALS

This chapter will define some of the important purposes of the Social Service Department in a hospital. Harriet Bartlett says:

If Medical Social Casework has a valid place in the hospital structure, it must contribute something different from, and in addition to, the service offered by the doctor, nurse, and others within the hospital, and by other social workers in community agencies.<sup>1</sup>

The hospital setting is basically one of authority. This not only pervades the physicians' relationship with the nurses, but also the relationship of these people with the patients. In this authoritarian atmosphere, the social worker attempts to use a method which is different. The social worker is first concerned with the patient as a person and what his present experience means to him. The patient's response to this new experience depends on many previous experiences which the social worker may have to recognize before being able to understand what the meaning of illness is to the patient, what the specific situation means to him, and what problems are raised in his life by this illness. Harriet Bartlett goes on to say:

Another important feature of the social worker's approach is that suspended judgment which grows out of the recognition that persons facing any sort of difficulty may be, to a large extent, irrationally motivated and full of conflict.<sup>2</sup>

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1. Harriet Bartlett, Some Aspects of Social Casework in a Medical Setting, p. 19.

2. ~~Harriet Bartlett, op. cit.~~, <sup>Ibid.</sup> p. 20.

Very often, few others in the hospital have an understanding of this factor, are not interested enough in this aspect to give it much consideration or have the time or skill to deal properly with it.

The social worker in the medical setting attempts to meet the patient where he is, emotionally and intellectually. She tries to help him understand the situation in which he finds himself, and in addition tries to help him plan to make the best possible adjustment to his situation. If he has a choice of plans, she endeavors to help him think through these alternatives and come to a constructive decision. If there is no choice, it is the social worker's responsibility to help the patient accept and face the limitations imposed as best he can. As Harriet Bartlett says.... "the main objective in these situations is growth."<sup>3</sup> This means growth of the patient's personality in terms of maturity. It must be recognized, however, that the goal may not always be reached, but movement is growth in a smaller degree.

Several factors in a medical setting tend to differentiate medical social service from other types of social service. The main emphasis is, of course, on illness. This means that the social worker must have a special knowledge of medical terms, and treatment, in order to function effectively. She must also have a knowledge and understanding of purpose and function of the other hospital personnel. The medical social worker labors under pressure related to illness. When a person is acutely ill, there may be little time in which to effect an adjustment. A continual

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3. ~~Harriet Bartlett, op. cit., p. 20.~~ Ibid.

and large turnover of patients, with a constant demand for making way for new patients, adds to this pressure on the worker. The medical setting in itself, where the social worker is only part of a large group of people involved in returning the patient to health, lends a different atmosphere.

The term "teamwork" as used in medical social work refers to the co-operative action of various members of an inter-professional group, all of whom are striving toward the same goal. These people all have as their interest the return of the patient to optimum health and rehabilitation as soon as possible. More specifically, in the individual case in the hospital, the team usually consists of physician and nurse until other adjunct services such as social service, physical therapy, corrective therapy, etc., are added.

In relation to teamwork activity, Harriet Bartlett states:

Since coordination is essential, it is important to emphasize the point that the physician always remains the leader of the team ... the ultimate responsibility for medical diagnosis and treatment of each individual patient rests with the physician.<sup>4</sup>

This responsibility and leadership position of the physician does not preclude the active participation of the other team members in planning the course of treatment. The social worker is the expert on the social factors related to illness, and as these factors often have direct and considerable bearing upon the condition of the patient, a joint evaluation of them with the physician should be made in order to facilitate proper diagnosis and treatment. Similarly, as the physical condition

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4. Harriet Bartlett, Medical Social Work, p. 48.

influences and limits the type and success of social adjustment, joint evaluation of social treatment planning should be made. Caroline Elledge says: "... the worker does not offer service to the patient without first consulting the physician."<sup>5</sup>

According to the basic tenets of Social Service, the patient should have the opportunity to help plan for himself and those for whom he is responsible. Thus, a physician may refer a case to Social Service on the basis that the patient's wife needs financial assistance. This situation directly affects the patient, and our culture suggests that the patient may have conflict over this situation. If the patient has always planned for the family, what will it mean to him to have someone else do it without his cooperation? What degree of cooperation with the patient is necessary? It is often repeated that the way in which a person takes a step may, at times, be as important to the person's future well-being as the step itself.

Therefore, in modern medical care, where treatment is administered by a group of specialists, teamwork and understanding of each others roles among all the participating specialists are essential. In addition, as the patient is the focus of care, he should be actively included in the planning whenever he is physically and mentally capable of contributing to that planning.

There is not a lot written about the referral process itself but in social work literature some general information can be found. There seem

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5. Caroline Elledge, The Rehabilitation of the Patient, p. 94.

to be two prevailing methods by which patients are referred to Social Service in the hospital. One is the referral of an individual patient for service in relation to a specific problem. Most commonly these referrals come from the physician. This may be accomplished in various ways, as ward conference, personal contact with social worker, written request or telephone. Patients, once they learn that social service is available, often request help themselves. They may meet a social worker on the ward, place a request through some of the other hospital personnel, or go to the Social Service Office. Nurses, dieticians, librarians, occupational therapists, desk clerks and others may call to a social worker's attention a patient who in the course of their work they felt had a social problem. Social agencies within the community may be interested in the patient or his family and feel that the social worker could be of help to the patient and thus make a referral. Families who have had contact with social agencies or know of such service may seek help for the patient or themselves.

The other method is that of 100 per cent referrals. This system may include everyone coming to a given clinic or a given hospital to be interviewed at least once by a social worker, or it may include only patients in certain categories, e.g., all patients with cancer or all neuropsychiatric patients, etc., whose problems may be thought to be particularly significant.

One common approach is through medical diagnosis ... Another point of entry is through some social qualifications which suggests a potential medical social need ... Still another point of entry is at certain significant stages in the course

of the patient's medical care.<sup>6</sup>

There are many modifications of these types of categorical approach to the patient.

In the Boston Veterans Administration Hospital, we use the method where specific individuals are referred for specific services to meet their needs. More detailed discussion of this was given in the preceding chapter.

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6. Harriet Bartlett, Some Aspects of Social Case Work in a Medical Setting, p. 232.

## CHAPTER IV

DESCRIPTION OF THE PATIENTSAge, Sex and Marital Status

This chapter will give a description of the general social and medical characteristics of the referred patients. This presentation of data includes information relative to age and marital status, household in which the patient is living, diagnosis, type of service in hospital, occupation, the time within hospitalization at which the referral was made, and whether the case was known to Social Service before.

TABLE I  
AGE AND SEX

Age	Male	Female	Total
25 - 34	8	1	9
35 - 44	10	1	11
45 - 54	4	-	4
55 - 64	11	-	11
65 - 74	3	-	3
75 and over	2	-	2
Total	38	2	40

The sample of 40 patients consists of 38 males and 2 females. In this group, there are 2 male Negroes and 38 white patients. Table I indicates that 26 patients, or 65 per cent, fall in the middle age group between 35 and 64. However, there are two peaks in the groups 35 - 44 and

55 - 64 with 11 patients each. This is presumably related to the number of Veterans from the two World Wars.

TABLE II  
MARITAL STATUS

Marital Status	Number of Patients
Single	7
Married	25
Widowed	3
Divorced	3
Separated	2
Total	40

Table II reveals that 25, or 62.5 per cent, of the referred patients are married. Further analysis reveals that prior to this hospitalization, 25 were living with spouse; 2 with their children; 5 with parents; 6 alone; and 2 with friends. This seems in agreement with the age distribution which shows fewer in the younger group. Most are in the middle age group and are married and living with spouse and family.

In this group, it was found that 17 patients (42.5 per cent) were referred from medical wards, 17 (42.5 per cent) from neuropsychiatric, and 6 from surgical. This is in keeping with statistics on source of referral kept by the Social Service Department. Surgical cases are not referred as frequently as medical and psychiatric cases. Also surgeons perform acute immediate operations and then transfer the patient back to a medical ward where certain problems around chronic illness may arise.

Occupation

The following Table presents the occupations of the patients:

TABLE III

OCCUPATION PRIOR TO PRESENT HOSPITAL ADMISSION

Occupation *	Number of Patients	Per cent
Professional	1	2.5
Clerical and kindred	3	7.5
Sales and kindred	1	2.5
Protective service	1	2.5
Domestic service	2	5.0
Skilled	3	7.5
Semi-skilled	4	10.0
Unskilled	10	25.0
Unemployed	10	25.0
Retired	3	7.5
Housewife	2	5.0
Total	40	100.0

\* Except for the last three categories, the patients' occupations were classified according to the system used in the Dictionary of Occupational Titles and Classifications, Federal Security Agency, Social Security Administration, second edition, 1949.

In this sample, there was just one patient who had a professional occupation -- that of a teacher. There were three clerical workers and one salesman. Three fell in the category of skilled workers, as foreman and mechanic. In the semi-skilled, there were a sandblaster, a boiler-maker, and two assembly machine operators. Three of the older patients were retired. The two women patients were housewives prior to admission.

Twenty-five per cent of the sample fell in the unskilled category. This group includes manual occupations that involve the performance of simple duties that may be learned within a short period of time and that require the exercise of little independent judgment, as truck driver, oiler, longshoreman. Twenty-five per cent of the sample were unemployed prior to admission. Thus, 50 per cent of the patients referred were either unemployed or in unskilled positions prior to hospitalization. With persons in these occupational categories, one may expect to find financial problems.

#### Hospital Service

As shown in the following table, there were 17 referrals from Medical Service, 17 from Neuropsychiatric and 6 from Surgical.

TABLE IV

#### AGE AND HOSPITAL SERVICE

Age	<u>Hospital Service</u>			Total
	Medical	Surgical	Neuropsychiatric	
25 - 34	1	-	8	9
35 - 44	5	-	6	11
45 - 54	2	-	2	4
55 - 64	7	3	1	11
65 - 74	1	2	-	3
75 and over	1	1	-	2
Total	17	6	17	40

Table IV shows that 14 of the 17 from Neuropsychiatric Service were between 25 and 44, whereas only 6 from the Medical Service fell in this range. The Surgical referrals were all 55 or over.

In this sample, it seems that the referrals from Neuropsychiatric Service are the younger patients.

### Diagnosis

The following table presents the diagnosis of the patients at the time of referral:

TABLE V  
DIAGNOSIS OF THE PATIENTS AT TIME OF REFERRAL

Diagnosis	Number of Patients	Per cent
Schizophrenic reaction, chronic undifferentiated type	1	2.5
Manic depressive reaction, manic type	1	2.5
Anxiety reaction	8	20.0
Conversion reaction	1	2.5
Multiple sclerosis	2	5.0
Epilepsy	1	2.5
Beriberi	1	2.5
Cataract	1	2.5
Cancer	5	12.5
Heart disease	3	7.5
Skin disease	2	5.0
Lymphonia	1	2.5
Peptic ulcer	2	5.0
Arteriosclerosis	2	5.0
Gastro-Intestinal pathology	2	5.0
Bronchial asthma	2	5.0
Rheumatoid arthritis	2	5.0
Not established	3	7.5
Total	40	100.0

Table V shows that the patients represented many types of illness. These were all chronic cases but represented for the most part an acute manifestation of the disease, or else the patient was obtaining some type of treatment for illness. The largest single category of patients referred was Anxiety Reaction (20 per cent); the next largest category was cancer with 12.5 per cent.

#### Timing of Referral

Table VI shows that 32 patients, or 80 per cent, were referred within the first 19 days of their current hospitalization and 8 patients, or 20 per cent, were referred after 20 days.

TABLE VI

LENGTH OF PRESENT HOSPITALIZATION  
UP TO THE TIME OF REFERRAL

Length of Hospitalization	Number of Patients	Per cent
More than 90 days	1	2.5
30 - 90 days	2	5.0
20 - 29 days	5	12.5
10 - 19 days	13	32.5
5 - 9 days	10	25.0
Under 5 days	9	22.5
Total	40	100.0

After referral was made to Social Service, most of the patients were seen by a social worker within 2 days of the time of referral. There were six patients who were not contacted for approximately a week, but it might

be significant to keep in mind that this occurred at Christmas holiday time.

In addition, it may be noted that of the 40 patients, 11 had been hospitalized in Boston Veterans Administration Hospital before, but only 6 had been known to Social Service.

TABLE VII

LENGTH OF TIME BETWEEN REFERRAL  
TO SOCIAL SERVICE AND DISCHARGE

Time between Referral and Discharge	Number of Patients	Per cent
1 - 7 days	16	40.0
8 - 15 days	2	5.0
16 - 30 days	4	10.0
Still Hospitalized	12	30.0
Died	5	12.5
Other	<u>1</u>	<u>2.5</u>
Total	40	100.0

Table VII reveals that 16, or 40 per cent, of the patients were discharged within one week after referral to Social Service, the majority coming from medical wards. The implication seems to be that discharge planning precipitated the referral and was stated as such in 10 cases. Eighteen, or 45 per cent, were discharged within two weeks, and 22 were discharged within a 30 day period. As of February 22, 1957, there were 12 patients or 30 per cent still hospitalized. Of these, 11 were from the Neuropsychiatric Service. There seems to be a relationship between

Neuropsychiatric Service referrals and longer periods of hospitalization. Five of the patients have subsequently died: 3 from Medical Service, 1 from Surgical Service and 1 from Neuropsychiatric Service. One Medical patient with cancer was transferred to another Veterans Administration Hospital.

In the majority of the 22 referrals made 30 days before discharge the social worker observed multiple problems, but because of the imminence of discharge, extensive casework was not possible. It seems that in some cases referrals are made too late in the patients' medical treatment for the most effective Social Service planning.

## CHAPTER V

CHARACTERISTICS OF THE REFERRAL PROCESS

This chapter will deal with the method, circumstances of referral, and the reason for referral as stated by the referring sources, as well as the referring person's participation, the action taken, and the patient's attitude toward help.

Source of Referral

Of the 40 cases under study, 23 were referrals from the doctor, 15 were self referrals, 1 was from a social worker from another Veterans' Administration station, and 1 was from a wife.

TABLE VIII

SOURCE OF REFERRAL AND SERVICE

Service	Doctor	Source Self	Other	Total
Medical	10	6	1	17
Neuropsychiatric	8	9	-	17
Surgical	5	-	1	6
	—	—	—	—
Total	23	15	2	40

From Table VIII, it may be noted that, in regard to self referrals, over one-third, or 35 per cent, of the patients on medical service referred themselves. Over one-half, however, of the psychiatric patients, or 53 per cent, were self referrals. It might be speculated that the

psychiatrists suggest contacting a social worker but there is no evidence in the recording to substantiate this.

TABLE IX

AGE AND SOURCE OF REFERRAL

Age Group	Source			Total
	Doctor	Self	Other	
25 - 34	3	6	-	9
35 - 44	5	6	-	11
45 - 54	3	1	-	4
55 - 64	8	2	1	11
65 - 74	2	-	1	3
75 and over	2	-	-	2
	—	—	—	—
Total	23	15	2	40

Table IX reveals a tendency for the older patients to be referred by the doctor. There is a definite grouping of the self referrals in the younger groups. Twelve, or 80 per cent, of the self referrals fell between the ages of 25 and 44. From Tables VIII and IX, it appears that the majority of self referrals were among the younger patients on psychiatric wards.

Method of Referral

Table X presents material on the method of referral in the 40 cases.

TABLE X

METHOD OF REFERRAL

Method	Number of Cases	Per cent
Ward conference	11	27.5
Telephone call to office	10	25.0
Office visit	9	22.5
Conversation with social worker	8	20.0
Memo	1	2.5
Letter	1	2.5
	40	100.0

Table X reveals that only 11 cases, or 27.5 per cent of the total, were referred in ward conferences. Ten referrals, or 25 per cent, were made by telephone calls to the office; this was closely followed by office visits and conversations with the social worker. There was one formal letter from a wife of one of the patients and one memo from a ward nurse who was approached by a patient.

Certain methods were utilized more by certain sources, as can be noted from Table XI.

TABLE XI

SOURCE OF REFERRAL AND METHOD

Method	Doctor	Source Self	Other
Ward conference	11	-	-
Telephone call to office	5	4	1
Conversation with social worker	7	2	-
Office visit	-	8	-
Memo	-	1	-
Letter	-	-	1
	23	15	2

The 11 cases referred in formal ward conference were referred by the doctor. The remaining 12 cases referred by the doctor were by the informal methods of conversation with the social worker and telephone calls to the office. It is obvious that the importance of these informal methods of referral should not be underestimated. Although not so many doctor referrals were made in ward conference as would be expected, it can definitely be noted that when this method was used, the doctor was more explicit in defining the problem.

Eight of the 15 self referrals were made by the patients' coming to the office. Telephone calls followed second with 4 cases. Two of the patients met a social worker on the ward and expressed a desire to talk to her; they defined their problems at that time. As noted above, in four self referrals, the patients called the office directly and asked for Social Service assistance. Since this seemed to be an unusual situation,

further investigation revealed that it had been suggested by an adjunct service in the hospital that they contact Social Service. One patient asked a nurse to contact Social Service who relayed a memo to that department.

### Reason for Referral

Table XII gives the reason for referral as reported by the referring person. The reasons are listed according to their frequency. The largest category was financial planning with 37.5 per cent of the total number. Second was disposition planning with 25 per cent, followed by arrangements for further treatment with 15 per cent.

TABLE XII

#### REASON FOR REFERRAL AS SEEN BY REFERRAL SOURCE

Reason	Number of Cases	Per Cent
Financial planning	15	37.5
Disposition planning	10	25.0
Arrangements for further treatment	6	15.0
Attitude and adjustment to illness	2	5.0
Employment	2	5.0
Living arrangements	2	5.0
Personal and family relations	1	2.5
Social diagnostic study	1	2.5
Transportation	1	2.5
Total	40	100.0

It was noted earlier that 10 patients were unemployed at the time of their admission. Only 3 of these were among the 15 cases referred for financial planning. Further analysis reveals that the remainder of the patients referred in this category had financial problems brought about because of their illness. Thus, there was not much relationship between unemployment prior to hospitalization and financial problems, while the medical condition did seem to cause financial difficulties for the family while the patient was hospitalized. In addition, since many of the patients either had to convalesce or could not return to their former occupations, financial planning was necessary in view of imminent discharge. It was also found that because of their being in unskilled and semi-skilled positions, many patients received few company benefits during their illnesses.

TABLE XIII

REASON AND SOURCE OF REFERRAL

Reason	Source		
	Doctor	Self	Other
Financial planning	5	9	1
Disposition planning	10	-	-
Arrangements for further treatment	5	1	-
Attitude and adjustment to illness	1	-	1
Employment	-	2	-
Living arrangements	-	2	-
Personal and family relations	-	1	-
Social diagnostic study	1	-	-
Transportation	1	-	-
Totals	23	15	2

Table XIII gives the breakdown of reasons for referral, according to the source of referral. It may be seen that some patterns do exist. Of the 23 cases referred by the doctors, 10, or 44 per cent, were for disposition planning. This may be somewhat misleading for this group includes almost any problem which might be seen as a hindrance to the veteran's return to the community and his adjustment there. Although the patient was referred by the physician for disposition planning, there was no indication of what he felt the specific problem to be. Job planning, financial problems, post-discharge care, living arrangements, and emotional adjustment are all included in this category.

It may be significant to note that nine of the ten referrals made by the doctor for disposition planning were made by some informal method. There was just one case of disposition planning referral in a ward conference where the social worker was just asked to investigate. Therefore, it seems that the doctor defines and discusses the problem more in a formal team meeting.

There is no substitute for regular ward conferences, which provide the means for review of those patients' situations where a combination of medical and social needs require thoughtful consideration from a long-range point of view.<sup>1</sup>

A ward conference under the leadership of the physician enables each member of the team to make his particular contribution in developing the plan for the individual patient.

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1. Caroline Elledge, The Rehabilitation of the Patient: Social Casework in Medicine, p. 94.

Among those cases referred by the physician, referral for financial planning and arrangements for further treatment share second place with five cases each, or 12.5 per cent of the total cases referred.

In the group of self referred cases, the greatest number was for financial planning with nine cases, or 22.5 per cent of the total cases.

As noted earlier in this chapter, a large number of self referrals were in the younger age group and from neuropsychiatric wards. Nine of the self referrals were for financial planning with eight of these from neuropsychiatric wards. Although most of them had been employed prior to their hospitalization, their present primary concern was for the financial welfare of wives and families. There was not only concern as to whether they would be able to return to work but also concern about adequacy of family finances during their hospitalizations. Again, it was found that in addition to this primary problem, the social worker uncovered further problems relative to personal and family relations in these cases.

#### Referring Person's Participation in Referral<sup>2</sup>

As shown in Table XIII, 23 of the cases were referred by the physician. In 10 of these cases, the reason that was given was disposition planning, and the doctor gave no specific indication of the problem but rather asked the social worker to explore or investigate the situation because of the difficulties connected with the illness. The physician

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2. The material called for by the schedule on this topic was not available in the case records. Item 15 B in the schedule has been eliminated, as it coincided with Item 16.

did not seem to indicate his expectations of Social Service in these cases. At least, all that was recorded was that the patient was near discharge and it was thought to be desirable to check to see if his affairs were in order. Analysis of the category disposition planning shows that 9 of the 10 referrals were by doctors on medical wards. Thus, the medical referrals tended to be for planning in relation to discharge, whereas psychiatric referrals tended to express underlying emotional problems in more specific terms than was customary in medical referrals.

In the remaining 13 referrals, the doctor defined the problem more specifically as financial arrangements or arrangements for further treatment and stated what the social worker was expected to do. The doctor's definition of expectations of the social worker was, for the most part, related to the patient's physical condition or difficulty because of the illness: for example, the referrals for follow-up treatment and for financial planning were related to physical limitations.

The doctor referral for attitude and adjustment to illness was the only one that did not appear to be described or defined but the doctor did state that the patient seemed depressed and fearful about the illness and seemed unwilling to remain in the hospital.

The self referrals were much more explicit in stating their problems and their expectations of Social Service; this could be seen more clearly in the recording. Nine of the self referrals came because of financial need and stated what they expected Social Service to do in this respect. All of these patients cooperated with the exception of one who became enraged when the social worker focused on the reality that the department could not give direct financial aid.

The telephone referral from the other Veterans Administration station was from a social worker and she defined the problem explicitly. The patient seemed to have a definite social and emotional problem as a result of a skin disease. She had been working with the patient in relation to this and, with her knowledge of the social worker's role, she supplied the essential information and enabled the department to work with him more effectively. She not only gave background by telephone but also sent a summary of background information and her activity with him.

One formal letter was received from a patient's wife who previously had had contact with a family agency and had a knowledge of the function of the social worker. The referral was regarding financial planning in relation to her husband's illness and she expected Social Service to help their family coordinate the available resources. She said they felt lost in the midst of his illness and felt that this was the place to turn. Needless to say the social worker found additional problems during the first interview but it seemed that the referral was appropriate.

### Patient's Preparation<sup>3</sup>

In most of the doctor referred cases, the patient seemed vague and hesitant and did not know who the social worker was or why she was there. The records showed that the social worker often introduced herself by

- 
3. There was a lack of recorded data for filling out the schedule Item 17. In regard to Item 17 A, no information was reported by the referring person as to whether the patient was prepared for the referral or what he was told. Where there were gaps, the individual social workers were contacted but for the most part they were vague and did not remember the transaction.

stating interest in planning with the patient. The lack of data in this area could have been due to lack in recording, so the writer contacted the workers and found that in most cases the patients were not prepared.

There was only one case where the patient stated that the doctor had told him a social worker was coming to explore the financial and home situation and to make arrangements, for he lived alone and was unable to work.

It was, therefore, not a common procedure with the patient, and the following statement seems very appropriate:

As social workers have contributed to the hospital personnel's greater understanding of individual patient needs, more patients are referred for social services. Ideally, the referring person should prepare the patient for the service that will be offered by another department of the hospital. Ideals, however, represent the distant goals toward which we work, knowing full well that they cannot be reached. The medical social worker may, therefore, simultaneously interpret and offer a service to the patients.<sup>4</sup>

#### Action Taken

As an outcome of the referral and first interview, none of the patients were referred to other sources. All the cases were accepted for continued care with the exception of four individuals. These four were offered brief service: two for follow-up treatment, one for financial assistance and one for transportation.

#### Patient's Attitude toward Help

Although some of the patients focused on their areas of concern faster than others, there was only one who did not have a positive

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4. Juliette Lipeles, "Teaching Social Work in a Medical Setting," Social Casework Journal, 37:452, November, 1956.

attitude toward the social worker's offer of assistance. This self referred person was very hostile when the social worker was unable to provide tangible financial assistance. Although two patients denied the problems for which the doctor referred them, they accepted Social Service interest.

It should be noted that this is the writer's estimate, as the records did not all state the patient's attitude specifically.

## CHAPTER VI

THE PROBLEM AS SEEN BY REFERRAL SOURCE,  
PATIENT AND SOCIAL WORKER

This chapter will compare the problem as seen by the referral source, the patient, and the social worker in order to obtain a better idea of how each views the situation. For clarity of presentation, we will first analyze the 23 doctor referrals. The type of referral made by the doctor in a hospital to the Social Service Department would seem to be greatly influenced by his conception of the role of the social worker and her functions in the hospital, and by the usefulness and relevance of these functions in relation to a particular patient.

TABLE XIV

DOCTOR'S REASON FOR REFERRAL

Reason	Number of Cases
Disposition planning	10
Financial planning	5
Arrangements for further treatment	5
Attitude and adjustment to illness	1
Social history	1
Transportation	1
Total	23

Comparison of the Problem as seen by Doctor and Social Worker

Of the 10 referrals the doctor made for disposition planning, the social worker found that the actual situation coincided with his reason

for referral, that is, the patient was going to be discharged soon and specific plans were necessary in regard to this. However, each of these cases were broken down into planning in regard to finances, employment or living arrangements, such as nursing home. It is interesting to note that the doctor made no referrals specifically for the last two reasons, but in seven cases the social worker saw these two problems as well as emotional adjustments. To better clarify the range of problems included under disposition planning, the writer is presenting the following case illustrations:

In the case of Mr. A., the worker, upon investigation of the situation, found that this 29 year old laborer had received his final week's pay three weeks before hospitalization and was concerned about how his family would manage in the event that his hospitalization extended for a long period of time or that he would not be able to work immediately upon his return home. The worker referred him to the Veteran's Services representative for financial help. Mr. A., was also interested in talking further to the social worker about his difficulties.

Mr. B., a 77 year old retired patient who was unable to care for himself, was referred for discharge planning. Although he was married and had been living with his wife, he realized that he could not return home, as he would need nursing home care. At his request, the social worker referred him to the Veteran's Service Agent who arranged for him to go to the Chelsea Soldier's Home.

Mr. C., a 52 year old single truck driver, was referred for preparation for discharge. In the first interview, Mr. C. expressed concern about not being able to return to his brother's home and not having enough money. He responded positively to the worker's suggestion of Veteran's Service Aid and of contacting his brother to make arrangements to return to his home later.

Mr. D., a 65 year old retired machinist, was referred for discharge planning. The patient expressed financial concern. There was no hope of working out employment because of his age. The patient had been receiving a non-service-connected disability pension while in the hospital, but with pending discharge

he had real areas of concern in regard to finances and living arrangements.

The five cases referred for financial planning were all found to have financial difficulties but in every case other social problems were also uncovered. In each of these cases, the patient's physical condition tended to limit the type of social adjustment after hospitalization. It was difficult for four of these patients to accept the fact that they might have to limit their activity and change vocations. It was difficult for them to accept limitations because apparently they had always planned for their families. The social workers recognized the necessity to show the patients that they could still, despite and within certain limitations, plan for themselves and be responsible for their families. In the fifth case, family problems were present and it was planned to see the wife also.

In the cases referred for arrangements for further treatment, the social worker agreed with the doctor's identification of the problem. In two of these cases, the social worker worked with the patients in regard to attitude and adjustment to illness as both had had their larynges removed. In another of these cases, the social worker found personal and family relationship problems and began work in these areas but was limited by the patient's discharge two days after the first contact.

The patient referred because of his attitude and adjustment to illness was found by the social worker to be non-accepting of his diagnosis of cancer. She also found a family problem in that the wife had an attitude of repugnance toward cancer and as a consequence had rejected him completely and was seeing other men during his hospitalization. When the

social worker took the social history from a psychiatrist, many problems related to the patient's social, emotional and physical life were uncovered, as would be expected. In both of these cases the patients denied problems and the worker had difficulty in forming a relationship. Also in both of these cases the doctor felt the emotional problems were hindering treatment.

In the doctor referral for transportation, no underlying problems needing further attention were uncovered because the patient was discharged that very day and it was necessary to arrange for his means of travel.

The range of problems as seen by the doctor in these 23 cases included social, economic and emotional ones. They ranged from more tangible problems of financial need to problems in the patient's attitude and adjustment to illness. The physician, in keeping with his role, definitely placed his emphasis on the actual medical situation in relation to these problems.

In almost every case, the main area on which the worker focused her assistance included the problem or problems stated in the referral. In every case but two, the worker also offered help in other areas. This evidence suggests that the worker did find the reasons for referral quite pertinent, but that she also had to use her own diagnostic skills to clarify the total psycho-social diagnosis.

#### Statement of Problem by Patient in Doctor Referred Cases

In the doctor referred cases, the patient's statement of his problem was much more vague and patients seemed uncertain as to what to expect.

This may be because of lack of understanding of the role and function of the social worker since these patients had never had any previous contact with Social Service.

It was noted that the six patients who had been known to Social Service previously were aware of the scope of the service and stated their expectations.

In 15 cases, the patient cited the same reason as the doctor and six more cited the same problem but identified another one also. There were only two doctor referrals in which the patient's view disagreed entirely with the stated reason for referral. One of these stated he really did not have a financial problem because his wife now had a part time job which brought sufficient income so that the family could survive adequately. The other was in regard to attitude and adjustment to illness where the patient denied any problems involved with his hospitalization although he accepted Social Service interest.

It must be taken into consideration, however, that these data are not as revealing as one might think. Since 10 of the doctor referrals were for disposition planning, the whole gamut of areas is left in which the patient could have problems and still be in agreement with the referring source.

#### Comparison of Problem as Seen by Patient and Social Worker in Self Referred Cases

In the 15 self referrals, it was noted that the patient's statement of his own problem was very well defined, and for the most part the presenting problem seen by the social worker was the same as that seen by the patient. Each case problem was appropriate inasmuch as it was something

with which the social worker could deal and with which she tried to help. Because of their involvement, the patients were very emotional and had difficulty in coordinating resources. Many clearances had to be made and it can be understood how a patient and his family can feel "lost" in the midst of "red tape". In the majority of these cases, the social worker uncovered problems in other areas of personal and family relations and attitude and adjustment to illness.

There was only one case, mentioned previously, where the social worker and patient disagreed. In this case there was no actual financial problem but the patient, who was on a neuropsychiatric ward, was obsessed with the importance of and need for money. This was the case where the social worker could not give any direct financial assistance. The social worker could see other underlying implications in the patient's situation.

Thus, the main situational problem seen by the social worker and patient were the same in 14 of the 15 cases. However, in over half of these cases, the social worker saw the patients' problems stemming primarily from emotional factors and difficulties in adjusting to the illness or disability. Emotional difficulties were evidenced by the worker's noting obvious depression, unrealistic planning, or denial of any other existing problem.

As was noted earlier, all of the six re-opened cases were self referrals and these patients showed understanding of the social worker's role and the potentialities of Social Service for helping them.

#### Comparison of the Problem as seen by Other Referring Sources, Social Worker and Patient

A social worker from another Veterans Administration station

telephoned and referred a patient for help in relation to accepting and adjusting to a skin disease. The social worker found that the referral was appropriate in that the patient did not accept his disability and would not move ahead with treatment, and work in this area was required. As mentioned in the previous chapter, she defined the problem explicitly and a summary was sent so that our department had a substantial idea of his problem and could therefore focus faster.

The other referral from other sources was a letter received from a patient's wife. The referral was regarding financial difficulties of five children and herself while her husband was in the hospital. This had a realistic basis and the worker told her about applying for Veteran's Services. The woman was lost not knowing where to turn to get financial aid as her husband had always provided for her. As a result of the first interview the social worker indicated that there seemed to be some marital conflict, as well as the financial problem.

In summary, for the most part the patient's statement of his problem, except in self referred cases, was vague and his expectations of Social Service uncertain; the doctor placed emphasis on problems related to the patient's physical condition and the social worker attempted to view the situation from the standpoint of the "total person" including the effect on the person and his family. The doctor's conception of the role and function of the social worker in this hospital seems to be appropriate, as the same reality problems were seen in most cases. The social worker, however, goes further and sees social and emotional implications. In all of these cases we find that the social worker made an evaluation of the patient's personal and social adjustment and attempted to help the patients

in those areas where she saw the patient's need.

## CHAPTER VII

SUMMARY AND CONCLUSIONS

Through a study of the referral process in 40 cases, the writer proposed to find significant material to answer several questions related to these referrals. The data were drawn from a sample as described in Chapter I. These questions were proposed:

1. What are the general social and medical characteristics of the patients referred?
2. What are the sources, methods, and circumstances of referral?
3. What conceptions do the referring persons seem to have of the patient's problem and the social worker's role?
4. How was the patient prepared for the referral and how does the patient participate in it?
5. To what extent does the problem as seen by the social worker coincide with the problem as seen by the patient and the referring person?

The writer first studied the general social and medical characteristics of the referred patients. In these cases Social Service gave assistance to patients ranging between the ages of 25 to 75. The majority of the patients, however, referred to the social worker were in the middle age group between 35 and 64 and were living with spouse and family as would be expected in this range.

The referrals were as follows: 17 from the medical service, 17 from neuropsychiatric and 6 from surgical. It was found that the younger

referrals were from the neuropsychiatric service and were mainly self referrals. The doctor referrals were made mostly for older, medical, chronically ill patients for the purpose of discharge planning and problems in relation to this.

Fifty per cent of the patients referred were either unemployed or in unskilled occupations prior to hospitalization. Further analysis revealed that there was little correlation between unemployment and referral for financial problems. Of the ten patients who were unemployed prior to hospitalization, only three were referred for financial planning. However, the remainder of the 15 referred for this problem were in semi-skilled or unskilled occupations prior to their hospitalization. It was speculated that in these types of occupations, few benefits are received during hospitalization and the patient has little opportunity for advance saving. In all of the 15 cases referred for financial problems, the financial difficulty seemed to be associated with the medical condition.

The diagnosis of the patients represented a variety that might be expected in a general medical hospital. Most of the patients were undergoing an acute manifestation of a chronic illness. The largest single category of patients referred had anxiety reaction; these were mainly self referrals. The next largest category was cancer patients who were all doctor referred cases.

Twenty-three of the referrals were made by doctors, 15 were self referrals, one was by a wife and one from a social worker at another Veterans Administration station.

Certain methods of referral were utilized more by certain sources. The doctors referred 11 of the cases in ward conferences and by this

method defined the reason for referral rather explicitly. The remaining 12 cases, however, were referred by informal methods such as conversation with the social worker or by telephone. The self referrals were mainly by office visit. The data did not throw light on the appropriateness of formal or informal channels for referral. It could be seen that in this particular hospital setting, a fairly informal, flexible system of referrals exists.

The most frequent problem, as seen by the referring person, was financial planning with 37.5 per cent of the total. This was closely followed by disposition planning with 25 per cent. This latter category, however, included many specific problems such as job planning, living arrangements, post-discharge care, financial problems and emotional adjustment. In comparing the problems as seen by the doctor, patient, and social worker, it was found that in most cases, the main presenting problem was seen as the same by each. For example, with regard to financial planning, the physician placed the emphasis on the planning as related to the patient's physical condition, the patient viewed it more subjectively and the social worker attempted to view it as it affected the patient and his family. Although the areas of the presenting problems were seen similarly by those involved, in almost every case the social worker saw social and emotional implications beyond this, for example, problems in family and personal relations or in attitude and adjustment to illness.

The role of the Social Service Department in this hospital appears to be seen more clearly from this study. The referrals were appropriate inasmuch as they were problems which could be handled by the department.

Analysis revealed that 45 per cent of the patients were referred within two weeks of discharge. This may mean that referrals are made too late in the patient's medical treatment for effective Social Service planning. This is particularly important since in the majority of cases the worker found additional social and emotional problems which in themselves required more time for casework. Hopefully, this study may indicate that earlier referrals would improve the patient's treatment.

In addition, education of hospital personnel as to the role of Social Service beyond service for immediate presenting problems might be advisable. As mentioned in Chapter III, the social worker is the expert on the social factors related to illness. These factors often have direct and considerable bearing upon the condition of the patient and by allowing enough time to have a joint evaluation of these factors with the physician, proper diagnosis and treatment of the patient might be facilitated. Likewise, because the physical condition of the patient influences and limits the type and success of social adjustment, time for joint evaluation of social treatment planning might prove most beneficial.

There was lack of recorded material in filling out the schedule in regard to the referring person's participation. However, it was found that in the doctor referrals, most of the patients were not specifically prepared for the referral. When the social worker came they were somewhat confused in that they did not seem to understand the reason for her entrance and as a result of this situation their response to the worker was rather vague. It seems likely that the patients might participate more effectively if they were prepared in advance of the referral. This seems to be best illustrated by the fact that in the six re-opened cases

and the self referrals the patients were more explicit in defining their problems and their expectations because they were familiar with the social worker's functions.

It would also appear that there is a greater need for more specific definition of the patient's problem in referring the case to the social worker. If the patients' problems were clarified at the time of referral, it would form a basis for more accurate and more speedy diagnosis on the part of the social worker.

To sum up, it has been noted throughout that an important contribution of the social worker is her interpretation of socio-economic and emotional factors involved in the patient's total situation. Interpretation of some of these factors to the doctor frequently facilitates the medical treatment of the patient. Although it is recognized that considerable effort has been made in this direction, the writer feels that greater emphasis upon the education of all members of the team to develop in them a better appreciation of the emotional and social factors in illness could be helpful. There may be many appropriate referrals that are not getting to Social Service because of lack of understanding.

When the various professions work together in the interest of the patient, the patient comes closer to being seen as a total individual and as a result receives more help. It is to be hoped that as the knowledge of the various specialists increases, as well as their knowledge of the process of teamwork, the team will be better able to achieve its aim of seeing and so treating the individual as a whole.

As a result of this study, the writer feels that more standardization of referral procedures seems indicated for staff consideration. This

would seem particularly desirable in relation to definition of problem, timing and whether or not the doctor discusses the referral with those referred.

Accepted  
Katherine Spencer  
5-14-57

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**APPENDIX**

## SCHEDULE

1. Name
2. Age
3. Marital Status
4. Sex
5. With whom living
6. Last occupation
7. Previous hospitalization  
at Boston Veterans Administration  
Hospital:
  - Dates:
  - Service:
  - Known to Social Service:
8. Date of present admission to hospital:
9. Date of referral to Social Service:
10. Date of first Social Service contact:
11. Date of discharge (if known)
12. Hospital service:
  - Medical
  - Surgical
  - Neuropsychiatric
13. Diagnosis at time of Social Service referral:
14. Source of Referral:
  - Name of referrer:
  - Position:
  - (If non-hospital, specify agency and position  
in agency).

15. A. Circumstances and Method of Referral

1. informal conversation with Social Worker
2. planned interview
3. letter
4. memo.
5. telephone
6. other

B. Topics covered in discussion with referring person

16. Referring person's participation in referral

A. Problem as identified and described by referring person

B. Expectations of Social Service

C. Precipitating circumstances (why referred as problem  
at this time)

17. Patient Participation

A. Reported by referring person

1. Was patient prepared for referral?
2. What was patient told about referral?

B. Reported by patient in interview

1. Was patient prepared for referral? By whom?
2. What was patient told about referral?

C. Patient's statement of his problem:

D. Patient's expectation of Social Service

18. Social Service evaluation

A. Social Service conception of problem

B. Patient's attitude toward accepting help:

19. Outcome of referral

A. immediate

B. continued

C. referred to other resource