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Medical social work with the age group from fifty to sixty-five at Boston City Hospital

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MEDICAL SOCIAL WORK WITH THE AGE GROUP FROM FIFTY TO SIXTY-FIVE AT BOSTON CITY HOSPITAL

A THESIS

Submitted by

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TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS (Cont'd)

TABLE OF CONTENTS (Cont'd)

LIST OF TABLES

LIST OF TABLES

CHAPTER I

INTRODUCTION

Purpose of the Study

The aim of this study is to obtain knowledge regarding some of the problems of medical-social planning among the age group from fifty to sixty-five years as seen in Boston City Hospital. The study seeks to analyze some of the medical social service given, as it is recorded, and to evaluate the availability and use of resources. It also seeks to find ways of alleviating unfavorable conditions and improving the quality or extending the service of the medical social worker to this age group. This thesis will aim to evaluate the emotional components of illness among the group studied to offer suggestions for better understanding of them by the medical social worker.

This age group was selected because the average duration of life has steadily increased due to advances in medical science. As a result, the period in which physical degeneration may be expected is longer and more significant.[1] Science enables more people to grow to older ages by giving them a healthier start in life. Yet little has been done to alleviate the problems of declining strength and capacity, although physicians recognize that somewhere during the epoch of

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1 "The Money Value of a Man", Metropolitan Life Insurance Company-Statistical Bulletin, August, 1946.

middle age specific disorders associated with the aging of a person begin.

There are indications of public consciousness of the increasing size of the old age group and that there are resultant social problems. Unfortunately, the method of attacking these problems has not maintained a proportionate tempo.

Extension of the life span has made it possible for man to remain relatively independent and socially productive for a longer period. This possibility has affected the social philosophy of the nation accordingly to make greater economic and social demands upon the aging individual.

Public awareness from widely publicized scientific articles concerning the decline of the functions of man's organs and faculties should have led to greater defense measures. Sensible reasoning indicates the need of helping the aging individual to properly adapt his mode of life to meet these changes rather than to wait for the period when human changes are more rapid and more traumatic.

Scope of the Study

This study is based upon an analysis of fifty-five recorded cases from the Department of Social Work at the Boston City Hospital. These cases were selected from the caseloads of two medical social workers. One worker covered surgical wards and the other covered medical wards. These caseloads are representative of the casework done by other medical social workers within the hospital.

All recorded cases belonging to patients within the age group from fifty to sixty-five years, who were on these services during the period from January 1, 1946 through December 31, 1946, were selected for study.

No additional data from medical records or other sources has been used in determining the problems of the patients and the services given.

Method of gathering data

The cases selected for study have been evaluated by means of a schedule which was drawn up to cover the points mentioned in the Purpose of the Study. From the information obtained tables were made giving statistical data useful in drawing conclusions. The schedule sought to indicate diagnoses, prognoses, degrees of disability, and the need, use, and adequacy of the resources used. Emotional factors affecting planning and final disposition were reviewed to the extent that they were recorded.

Consultation with administrative personnel, doctors from the medical staff, and other social workers at the Hospital has aided the study. Written material concerning the problems of the age group as seen in hospital settings has also added to the background of information needed for the study.

The monthly statistical sheets showing all recorded cases of the two medical social workers were checked to determine their total caseloads. These cases had been referred from Wards five and six of the II Medical Service and Wards

three and four of the III Medical Service. From the III Surgical Service (General Surgery) cases were selected from Wards five, six and seven. From the VI Surgical Service (Orthopedic Surgery) Wards one, two, and seven were used for the selection of cases.

Limitations of the Study

This study is limited by the inadequacy of the material in many records, the lack of information concerning follow-up service, and the paucity of full general social summary as routine procedure with each patient. The lack of reference material for additional information concerning the medical and concurrent social needs of this particular age group has also been a handicap.

Though these cases are representative of conditions found among patients at Boston City Hospital, it must be realized that the patient group at this hospital is in general prescribed by certain regulations regarding eligibility for admission.

CHAPTER II

THE HOSPITAL SETTING

To understand the patient group it is helpful to know something of the setting in which they are confined. Boston City Hospital is a large general hospital established to treat patients suffering from curable diseases.[1] It is located in a part of the city known as the South End. This has become, in general, a rooming house section populated by a low income group. The area has also become somewhat industrialized.

The Hospital is intended primarily to serve persons having a legal settlement in the City of Boston, regardless of their income. Legal settlement is obtained by persons over the age of twenty-one years who have been living five continuous years in the City without receiving aid. The same length of time is required to lose settlement. Policy regarding admission of patients states that the Hospital will admit persons nonresident and not settled in Boston only as private patients, i.e. paying patients in private rooms. Unsettled persons residing in Boston may also be admitted as paying patients. Yet "all accident or emergency cases shall be received at all hours, night or day, irrespective of settlement".[2] No person whose case is judged incurable shall be

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1 Directory of Social Resources of Greater Boston, 1946. Greater Boston Community Council.

2 The Sixty-seventh Annual Report of the Trustees of the Boston City Hospital, 1941.

admitted to the Hospital, unless there are urgent symptoms which appear capable of being relieved.

Since this hospital is a city institution it is impossible for it to be completely selective in the admission of patients as shown by the many accident cases for whom eligibility cannot be established for some time. As a civic hospital it bears the brunt of all such organizations in that undesired patients denied admissions to private institutions are automatically shunted to the Boston City Hospital. Therefore the patients in this study represent a good random selection of this age group.

Boston City Hospital is supported mainly by tax funds. Due to this fact, legally settled patients unable to pay for hospitalization are given free care on the wards. There was an income from paying patients of less than four per cent of the total operating cost in 1945. According to figures from the annual report for that year the total operating expense of the Hospital was $3,816,351.80 and the income from paying patients was $128,037.09. These statistics provide a clue to the general economic status of the patient group.[3]

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3 The Eighty-Second Annual Report of the Trustees of the Boston City Hospital, 1946.

CHAPTER III

DESCRIPTION OF THE PATIENT GROUP

General Discussion of the Age Group

The study of geriatrics, the care of the aged, has been extended and intensified during the past few years due to the problems that have presented themselves in an aging population. For the most part research was done with the age group that begins at sixty-five years. There is a dearth of information about the pre-geriatric group. Yet within this group are additional problems as well as many of the medical-social problems of the older age group which are more intensified. It is within the age group from fifty to sixty-five that a preventive approach to the problem of geriatrics is indicated. Such an approach would seek to prevent premature deterioration, with its subsequent actual organic disease, through constructive health programs which would attack disease in its incipient stages.

The emotional components of illness would be deeper in this age group which our society expects to be economically and socially productive. Fear of illness is always great. When it implies financial insecurity at a time when a man's prospective earning capacity and his work span is lessened there is tangible reason for such fear.

"Of the five leading causes of death in our country, four--heart disease, cancer, cerebral hemorrhage, and nephritis are diseases characteristic of middle life and old age.

In the same category are diabetes and arteriosclerosis which rank among the first ten causes of death...The National Health Survey indicates that seventy per cent of persons permanently disabled are at ages forty-five or higher."[1]

The daily impact of modern life is more detrimental to all men past fifty than to men of thirty years. "As life advances, the perfection of action of the inherent regulatory functions diminishes: people become more susceptible to heat and cold, and the capacity of the circulatory system to adapt itself grows less."[2]

Because Boston City Hospital functions primarily to meet the medical needs of Boston residents unable to obtain private or other hospital care it is of interest to obtain a general descriptive picture of the patient group. This should show more objectively the background factors which are affected by the patient's hospitalization. Examples of these are mode of living, number of dependents, and factors influencing the facility with which medical needs can be obtained, such as financial resources. In a later section the emotional component of disease as it affects the patient and the carrying out of medical recommendations will be presented. That material will show the subjective elements as recorded from interviews with the patients.

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1 "Health Problems of an Aging Population", Metropolitan Life Insurance Company--Statistical Bulletin, December, 1946.

2 George Lawton, editor, New Goals for Old Age, p.77.

Distribution of Patients by Sex

Among the fifty-five patients studied at the Boston City Hospital thirty-eight or seventy per cent were males and seventeen or thirty per cent were females. This is significant because it indicates that the medical social worker works with over twice as many men as women patients in this age group and the problems of each sex differ. In arranging for convalescent care of patients the matter of their sex can be a problem. Many nursing homes are limited to accepting only one sex. With the scarcity of nursing homes there may be delays in finding vacancies for either sex at the time they are ready for discharge. This means further delay on the ward for the patient.

In family groups the wage-earner is usually the man. The strain of loss of income during his illness may be far greater upon the entire unit than when the wife is ill. When she is ill the problem to the family generally concerns housekeeping matters.

It has been shown that the mortality rate of women is much lower than for men.[3] From this fact it might be assumed that women suffer to a lesser extent from degenerative diseases.

TABLE I

DISTRIBUTION BY SEX OF THE FIFTY-FIVE PATIENTS STUDIED

Sex	Medical	Surgical	Total
	28	27	55
Males	20	18	38
Females	8	9	17

3 Malford W. Thewlis, The Care of the Aged, (St. Louis: The C. V. Mosby Company, 1942.)

Sources of Income

The patients whose records were selected for study had been receiving ward service at Boston City Hospital. The wards in the Hospital are intended for use by patients unable to pay for private or other hospital care. For this reason the economic aspects of their hospitalization has great significance.

A study of the sources of income of each patient shows that only one patient was living on his savings alone. None of the patients had steady independent income. Ten patients were receiving some form of public aid. Five patients received pensions, and five were being supported by relatives. The remaining thirty-four, sixty-one per cent of the group studied, relied upon their employment for income. Four of this last group had to supplement their earnings by using their savings.

The availability of funds to meet an individual's needs is always a major factor in planning. In the event of hospitalization, the average patient is deprived of his income for the duration of his illness and his convalescence. If the patient does not have funds available for his care, it becomes the responsibility of the medical social worker to seek resources which will provide for the patient's needs. "Convalescent care is both a social and an economic problem."[4]

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4 Proceedings of the Conference Held Under the Auspices of the Committee on Public Health Relations of the New York Academy of Medicine, Convalescent care, 1940.

From the statistics in Table II it can be seen that the need is great for financial help for the patients in the age group studied at Boston City Hospital.

In cases of chronic illness wherein the period of incapacity is of long duration, perhaps permanent, the need for financial assistance is greatly extended. In the National Health Survey, thirty-three per cent of persons with chronic disease were between the ages of forty-five and sixty-five years of age. This problem is most serious in the productive years of life. "The incidence of chronic disability as well as the need for medical aid, that is medical care without payment or with part payment, is much more serious among the low income groups."[5]

The philosophy of the American people has helped to establish through legislation and general policy the age of retirement at sixty-five years. This is seen in the Federal Social Security Act under the Old Age and Survivors Insurance and the Old Age Assistance programs. The average man or woman who relies upon his employment for his source of income is therefore expected to be economically productive during the years from fifty to sixty-five.

In studying the number of patients with savings it appears that only six male patients of the fifty-five patients studied had any savings. Five of these had less than thirty

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5 Mary C. Jarrett,"Care of the Chronically Ill of Cleveland and Cuyahoga County," Cleveland: The Benjamin Rose Institute, May 20, 1944, p. 5.

TABLE II

SOURCES OF INCOME OF

THE FIFTY-FIVE PATIENTS STUDIED

Source of Income	Males 38	Females 17	Total 55
Employment	22	7	30
Employment plus Savings	4		4
Savings	1		1
Family			
Spouse	1	3	4
Children	1		1
Pensions			
Veteran's	1		1
Veteran's Widow		1	1
Veteran's plus Soldier's Welfare	1	1	2
City	1		1
Welfare			
Dependent Aid	4	4	8
Aid to the Blind		1	1
Aid for Dependent Children	1		1

dollars apiece. The sixth patient had been forced by illness to retire to his own business. Though the amount of his savings is not mentioned in the record, the recorded information concerning planning for future needs after discharge indicated that he would be forced to apportion this amount frugally to have it meet his needs at home for many months. Only one female patient had any savings. These were in the form of war bonds having a total face value of $200. This sum would be easily absorbed by her needs before she could return to work, as she required many months of convalescence after discharge.

"Illness and disability constitute the greatest single cause of economic insecurity and dependency today."[6] It is an acknowledged fact that there is a close link between poverty and illness. Meeting current consumption needs is only part of a wage earner's responsibility. In addition he has the obligation to make provision for himself and his dependents for the time when he cannot earn.[7] To "Save for a rainy day" is a basic American tenet which implies protection during a period of loss of income.

The facts learned from reviewing the availability of savings as a resource at the time of illness is significant. This study shows that not one patient had sufficient savings

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6 Massachusetts Central Health Council, Should Social Security be Extended Further into the Fields of Medical Care and Hospital Service? 1944.

7 "Measuring Family Responsibility", Metropolitan Life Insurance Company--Statistical Bulletin, May, 1946.

to meet his total needs for the duration of his incapacity. Each was forced to rely upon help from outside sources such as special funds, public assistance, and private agency grants. Although the nation had endeavored to provide security for its citizens through the Social Security Act of 1935 and various workmen's compensation programs, it had not substantially dealt with the problem of insecurity caused by sickness.[8]

TABLE III

AMOUNTS OF SAVINGS
OF THE
FIFTY-FIVE PATIENTS STUDIED

Savings	Male	Female	Total
No Savings	32	16	48
Under $50	5		5
$51-$100			
$101-$150		1	1
Limited	1		1

Marital Status and Dependents

The marital status of a patient helps to determine planning for his care upon discharge. In several cases, among the married patients, the medical recommendation for nursing home care which could not be adequately provided at home created great emotional disturbance in the patient and his family.

8 Arthur C. Bachmeyer, M.D., and Gerhard Hartman, PhD. editors, Hospital in Modern Society, pp. 703-709

This involved further delay on the ward. In one case a patient was living in a two room apartment with his married daughter before he was admitted to the Hospital. Rest and very limited activity were recommended by the doctor for his care. The daughter could not provide him with this care, nor with adequate environmental conditions, due to their cramped quarters. It was necessary for the patient to go to Tewksbury for institutional care. In another case, the wife feared the disease and the type of care it necessitated. The patient was unwilling to go elsewhere for care. Much interpretation concerning the nature of the disease and what was involved in its care had to be given before the wife agreed to have the patient return to his home. Her negative attitude caused much delay in meeting the needs of the patient.

Among some of the single patients it was necessary to arrange for nursing home care despite the fact that the patient merely needed to have his meals prepared for him. This was due to the fact that most of the single patients lived alone in rooming houses.

In the group of fifty-five patients studied, the single patient comprised the largest group; (See Table IV). There were twenty-three single patients, over forty per cent of the entire group. Of these, eleven were males and twelve were females. There were eleven, or twenty per cent, who were married. Eight of these were males. Of the twelve who were widowed five were males. Two males and five females were

separated; and two patients were divorced, both males.

In many instances the husband or wife can offer great assistance in planning for the patient. An example of this fact is the case of a man for whom terminal care in a cancer hospital was recommended. He was eager to return to his home. This was not possible because his wife had to work to support herself and she could not give him care. It was only from her that he could accept the interpretation of the need for such care.

TABLE IV

MARITAL STATUS
of the
FIFTY-FIVE PATIENTS STUDIED

Marital Status	Males	Females	Total
Total	38	17	55
Single	11	1[illegible]	2[illegible]
Married	8	[illegible]	11
Widowed	5	7	12
Separated	[illegible]	5	7
Divorced	2		2

From these figures it can be seen that the medical social worker could not count on the assistance of a spouse in planning for patients in more than twenty per cent of the cases that fall within the age group studied.

Seven of the eleven married patients had dependents. One

patient had seven, two had one each, two had two each; and the remaining two married patients had four and five respectively. One single patient had two dependents, his unmarried, elderly sisters. The other patient with dependents was a widower, who had been supporting his widowed daughter and her young child.

There are many emotional factors involved in planning for the care of patients with dependents. The figures in Table V indicate that this problem is most frequently met in work with married patients. In families of low economic status, in addition to frequently having to provide financial help for the patient, it is often necessary to work out plans for the care of his dependents. Such planning involved time in interpreting resources to both patient and family, making referral to specific agencies, and time in preparing social summaries to facilitate referral.

TABLE V

NUMBER OF DEPENDENTS AMONG
THE FIFTY-FIVE PATIENTS STUDIED

# of Dependents	0	1	2	3	4	5	6	7
Marital Status								
Single	28		1					
Married	4	2	2		1	1		1
Widowed	11		1					
Separated	7							
Divorced	2							
	46	2	4		1	1		1

In the case of the man with seven dependents it was necessary to refer the family for Aid to Dependent Children. To prove their eligibility for such assistance a summary proving the patient's inability to support them due to physical incapacity had to be prepared by the medical social worker. In addition, arrangements had to be made to provide care in a chronic hospital for the patient and the means of transportation for the family to visit the patient. The matter of visiting was vital to the emotional welfare of both the patient and the family.

Mode of Living

Illness fosters dependency and the mode of living of the patient therefor affects the carrying out of medical recommendations following discharge. The patient who lives alone in a rooming house generally has to meet his own needs. Reliance upon well-intentioned friends and relatives living apart from him does not offer much security. Within a home where there are relatives or friends the personal emotional relationships and attitudes toward the illness must be evaluated in making plans. Chronic illness is another factor that can affect home care. It involves much strain because of the prolonged need of the patient.

In one case the wife had been caring for the patient who had been suffering for several years from a chronic disease. The strain of waiting upon him and of working as a seamstress to supplement their meager income from Dependent Aid caused

her to have a physical breakdown. By nature of the course of the disease, the patient could do less and less for himself and institutional care had to be arranged by the medical social worker. A long delay was involved in making these arrangements, during which time the wife and a niece also presented information concerning the patient's need to the institution in which admission was sought.

TABLE VI

MODE OF LIVING OF THE

FIFTY-FIVE PATIENTS STUDIED

Mode of Living	Males	Females	Total
Alone	23	13	36
Family	12	3	15
Friends	3		3
Nursing Home		1	1

Thirty-six, or sixty-five per cent, of the patients studied lived alone. Fifteen lived with their families. Three shared the homes of friends and one was admitted to the Hospital from a nursing home. From these figures it is apparent that in a major proportion of referrals to social service the social worker must work alone to find adequate resources for care of patients at the time of discharge. Although many patients had received adequate interpretation of the need for nursing home care, they were most eager to return

to the normalcy of familiar surroundings, whether a small room in a rooming house or better. It is not uncommon to have the patient express the idea that in so doing he will feel independent again. Learning to be dependent when the physical condition of a person demands it can be difficult. It offends an individual's self-esteem to have to rely upon others. Helping the patient to more easily accept this need is important. It is generally recognized that a sick person living alone suffers through lack of service. Fear and depression occur when the patient lacks understanding companionship.[9] In many instances faulty environment was the causative factor of illness. It is the responsibility of the social worker to appraise the patient's facilities for care to carry out the medical recommendations of the physician.[10] At times the physician is aware of the environmental inadequacies and they are mentioned by him among his reasons for referring the patient to social service.

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9 Janet Thornton and Marjorie S. Knauth, The Social Component in Medical Care, pp. 188-189.

10 Ernst P. Boas, The Unseen Plague Chronic Disease, pp. 66-72.

CHAPTER IV

MEDICAL FINDINGS

Definition of Terms

At the beginning of any discussion concerning degrees of disability it is necessary to clarify terms. The average person has some idea that a chronic illness lasts longer than an acute one, but thoughts vary widely concerning any dividing line between the two. For the purposes of analysis and evaluation of degrees of disability of the fifty-five patients in the age group studied, it has been necessary to arbitrarily set a definite standard of delimitation. The definitions of acute and chronic diseases as set up by Dean Anderson of the Boston University School of Medicine will be used. They are as follows: An acute disease is one in which the patient recovers completely in six to eight weeks, or the disease process becomes inactive in that time. A chronic disease is one in which the disease process remains active for more than six to eight weeks, or it tends to recur, or to produce lasting disability.[1]

Three other terms used in classifying disability which must be defined are ambulatory, bed-chair, and bed cases. These terms are generally used by the physician in making his medical recommendations for the convalescent care of the patient. An ambulatory patient is able to walk around a house

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1 Mrs. Selma Bridges, Lecturer, Social Implications of Some Medical Diseases, Boston University School of Social Work, January, 1947.

although he may be unable to climb stairs. In this study those patients from the orthopedic surgical services who could walk about on crutches, although not allowed weight bearing, are described as ambulatory. Bed-chair patients are those who can spend several hours a day seated on a chair, even if it is necessary for them to be assisted from the bed to the chair. In some instances these patients can walk for brief distances and are allowed bathroom privileges. Bed patients require complete nursing care in bed.

These terms are also significant in making financial arrangements for nursing care as rates for care are based upon the varying needs for nursing service as indicated by these definitions of disability.

Degrees of Disability

TABLE VII

DEGREES OF DISABILITY

OF THE FIFTY-FIVE PATIENTS STUDIED

Degree of Disability	Medical	Surgical	Total
Acute		1	1
Chronic	28	26	54
Ambulatory	8	10	18
Bed-chair	12	11	23
Bed	8	6	14

The social and medical implications of chronic disease

are countless because the prevalence of chronic disease increases with age. The problem is one of the productive years of life. Nationwide Public Health surveys have shown that thirty-three per cent of the persons with chronic illness were in the age group between forty-five and sixty-four years.[2] Aside from the emotional and mental maladjustments of chronic illness are the great problems of personal and financial dependency. There is a close link between poverty and chronic illness. The chronically ill patient can seldom pay for his hospital care. More than fifty per cent of the hospital beds in the United States are occupied by patients suffering from chronic physical and mental disorders.[3] This would indicate that the chronically ill place a heavy burden upon the community.

The most significant point shown by Table VII is the fact that only one patient in the group studied had an acute illness. An eight weeks period has been used in tabulating the statistics in this table. Although it was necessary to use this arbitrary figure for computation purposes, note should be made of the fact that the treatment period in some fracture cases is longer and generally such cases are not considered chronic when they go on to union in the prescribed period of treatment.

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2 Ernst P. Boas, The Unseen Plague Chronic Disease, pp. 8-9.

3 Arthur C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. editors, The Hospital in Modern Society, pp. 602-605.

The statistics also show that about one-third of the group were ambulatory at time of discharge. This information is important in its relationship to adequate planning for convalescent care. At the present time nursing home rates are rising rapidly. In past years most of the nursing homes accepted standards set up by Old Age Assistance policy allowing payment of forty-eight dollars per month for ambulatory patients, sixty-five dollars per month for bed-chair patients, and seventy-eight dollars per month for full bed care of patients. This set of rates was used also for patients requiring financial assistance from other public agencies and assistance funds. Because of the increasing costs involved in running nursing homes and the scarcity of them they have become more demanding in their rates. It is now almost impossible to obtain a vacancy in one for an ambulatory patient, and it is difficult to find one for a bed-chair patient because of these rates. Most of the homes which are recognized as being emotionally and medically best equipped are demanding rates ranging from $25 to $35 per week. Among the patient group studied only twenty-five per cent were full bed patients. As the degree of care needed by patients who were restricted by their need to adhere to assistance standards affected the availability of nursing home vacancies it also affected length of hospitalization.

Table II shows that ten patients received welfare assistance prior to hospitalization and thirty-four were reliant upon

employment to meet current needs. This means that eighty per cent of the group studied required financial aid to meet nursing home needs. Under the section dealing with adequacy of resources the problems involved in obtaining such assistance to meet nursing home rates will be discussed.

Length of Hospitalization

The Boston City Hospital is a general hospital intended primarily for the treatment of acute illness. Patients with chronic disease generally go first to a general hospital for diagnosis and some treatment. Ideally, the general hospital which must keep its wards clear to meet the immediate demands of the acutely ill, should then be able to quickly transfer chronic patients requiring prolonged treatment to hospitals equipped to meet such need.[4] Circumstances are such, at the present time, that this does not occur. Some of the reasons for this are due to lack of resources and long waiting periods for admission to other institutions. These problems and others are enlarged upon in the section on resources.

The per capita cost per ward patient for the year 1945 in the Boston City Hospital was $6.34 per day.[5] The average cost of care for a convalescent patient in a private home, a convalescent home, or in a hospital for chronic care is less.

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4. Arthur C. Bachmeyer, M. D., and Gerhard Hartman, Ph. D., editors, The Hospital in Modern Society, p. 367.

5. Eighty-second Annual Report of the Trustees of the Boston City Hospital, 1946.

Consequently, the sooner a patient can be moved from an acute general hospital, the greater the gain to the community. From the standpoint of hospital administration the length of stay of the patient on the ward is of great concern. Doctors and social workers are also harassed by this problem.

From the standpoint of the patient, who is the prime consideration of the medical social worker and the hospital in general, length of hospitalization is a most important factor. One of his deepest concerns about his illness is in terms of when he will get back to his routine duties. As has been shown under the section on Source of Income, illness to the greatest number of patients in the age group studied at Boston City Hospital means total loss of income. Worry concerning his financial insecurity has direct bearing upon his illness. Knowledge of this effect of worry is important to those who plan to help the patient.[6]

The figures shown in Table VIII indicate the length of time spent on the wards by the patients. This table was divided into two sections; one presenting the patients on the medical wards, and the other, those patients studied who were on the surgical wards. This division was made because the methods of treatment involved in the field of orthopedic surgery demand that the patient remain in the hospital, on the average, for a longer period of time than the acutely ill

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6 Arthur C. Bachmeyer, M. D., and Gerhard Hartman, Ph. D., editors, The Hospital in Modern Society, pp.360-367.

TABLE VIII

NUMBER OF DAYS SPENT ON WARD

BY THE

FIFTY FIVE PATIENTS STUDIED

Number of Days	Medical	Surgical	Total
1-10	0	2	2
11-20	3	2	5
21-30	5	6	11
31-40	3	1	4
41-50	8	1	9
51-60	1	1	2
61-70	2	3	5
71-80	2	1	3
81-90	0	1	1
91-100	1	1	1
101-110	1	2	3
111-120	1	0	1
121-130	0	2	2
181-190	1	1	2
191-200	0	1	1
211-220	0	1	1
431-440	0	1	1

medical patient. Some examples of average periods of fixation for fractures, taken from a standardized Fracture Fixation chart, set up by some of the doctors on the orthopedic surgical services, to be used as a general guide demonstrate this fact. Low leg fractures average twelve weeks. Fractures of bones of the forearm have an average fixation period from six to eight weeks. This chart also mentions that in adults fixation is generally maintained on the average two weeks longer than in the young.

"In the orthopedic field the greatest difficulty exists for adults and adolescents who are discharged in plaster casts or on crutches and who are not able to move freely, or to go up and down stairs. Many convalescent homes refuse to accept them."[7]

The figures shown in Table VIII indicate the length of time the patients spent on the wards. From them it is learned that the modal group is forty-one to fifty days. The median number of days is forty-six days, which means that the average patient remained on the ward that length of time. On the surgical wards the greatest number of patients stayed from three to four weeks. On the medical wards the greatest number remained approximately seven weeks. All the medical patients remained more than one week, but two of the surgical patients remained less than one week. Thirteen patients, nine of whom were surgical patients, remained over three months. One

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7 Proceedings of the Conference Held Under the Auspices of the Committee on Public Health Relations of the New York Academy of Medicine, Convalescent Care, 1940

surgical patient remained on the ward over fifteen months. This long stay was due to inadequacy of resources for convalescent institutional care. The patient finally died while still in the Hospital. He had been ready for discharge one month after his admission to the Hospital.

Information concerning lengths of stay of patients in the Hospital is significant because it indicates, in general, how long the social worker will have to make plans for the care of the patient upon discharge. There must be an awareness of the meaning of delayed discharge to the patient. The financial strain can be intense for the patient at such times. In the case of orthopedic impairment, while waiting for the fixation of a fracture, the patient may become bored and restless because he is as mentally alert and interested in things outside himself as when he is physically sound. He may not feel ill, despite some discomfort from the immobilization of the injured limb. Nursing care rather than treatment by the doctor is generally all that is needed after a certain point and when the patient is not discharged at the time there is waste of service from the doctors. These problems are but a few of the many complex problems involved.

Major Diagnoses

Most patients had more than one diagnosis but only the major one was considered in classifying the type of disease. The standards formulated by the National Conference on Nomenclature of Disease were used. They have been approved by all

the leading national medical, surgical, hospital, and public health associations and societies.

Over sixty per cent of all deaths now occur after the age of forty-five and of this total nearly two-thirds are accounted for by chronic diseases. "The leading chronic diseases in their order as causes of death are: heart diseases, cancer, arteriosclerosis, high blood pressure and nephritis."[8] Tuberculosis, although only fifteenth in prevalence, is a major cause of disability and death in the United States.

> Two out of every hundred persons in the United States have a permanent orthopedic impairment of such a serious nature that they are partially or completely crippled, deformed, or paralyzed...Incapacity from these conditions is two and a half times as great in low income groups as among the highest income groups ($3000 and over). Almost one-third of these impairments are due to accidents occurring while their victims were engaged in gainful occupations.[9]

Among the patient group studied, ten patients had a diagnosis showing cardiac involvement, seven suffered from cancer, four had tuberculosis, one had diabetes, and one had chronic bronchial asthma. There were twenty-two patients with orthopedic impairments. Of this group, approximately half had good prognoses. Among the twelve with good prognoses for their fractures there were four patients who had other chronic disabilities such as: arthritis, radial palsy, chronic alcoholism, and old poliomyelitis impairment.

In reviewing the prognoses for the total patient group

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8 Ernst P. Boas, The Unseen Plague Chronic Disease, p. 8.

9 Ibid, p. 13

TABLE IX

MAJOR DIAGNOSES AND PROGNOSES

OF THE

FIFTY-FIVE PATIENTS STUDIED

Case #	Diagnoses	Prognoses
Diseases of the Musculo-skeletal system		
Diseases due to trauma		
1	Fractured left femoral neck, non-union	Fair
2	Fractured dorsal lumbar vertebrae	Good
3	Intracondylar fracture, right femur	Good
4	Fracture both bones right lower leg	Good
5	Fractured dorsal vertebra	Fair
6	Fractured oscalsis, right	Good
7	Fractured intertrochanteric, left hip; foot drop	Fair
8	Chip fracture, left lateral malleolus Right radial palsy	Good
9	Bilateral fracture, os calsis	Good
10	Fractured left tibia, Charcot joint (right)	Good
11	Fractured left tibial table	Fair
12	Compound fracture lower tibia and fibula; partial left foot amputation with subcutaneous emphysema	Fair
13	Fractured pelvis	Fair
14	Fracture and impacted neck of left humerus	Good
15	Ruptured quadriceps, right patella attachment; old poliomyelitis	Good

DIAGNOSES AND PROGNOSES (Cont')

Case #	Diagnoses	Prognoses
16	Oblique Fracture of right tibia, chronic alcoholic	Good
17	Arthritis, arteriosclerotic heart disease, compensated	Fair
18	Gout, left glass eye, 10% vision of right eye.	Fair
19	Intertrochanteric fracture, left femur; arthritis	Good
20	Fractured patella, lues, old mid-thigh amputation	Poor
21	Compound comminuted fracture of left tibia; questioned Korsakoff Syndrome	Fair
22	Fractured right ankle and closed reduction	Good
Diseases of the Respiratory System		
23	Pulmonary tuberculosis, X-ray positive	Poor
24	Pulmonary tuberculosis, moderately advanced	Favorable
25	Pulmonary tuberculosis, moderately advanced	Favorable
26	Pulmonary tubertulosis, Inactive later	Fair
27	Chronic bronchial asthma	Good
Diseases of the Cardicvascular System		
28	Rheumatic Heart Disease	Fair
29	Arteriosclerotic heart disease, decompensated	Good
30	Arteriosclerotic heart disease; old cerebral thrombosis	Fair

DIAGNOSES AND PROGNOSES (Cont'd)

Case #	Diagnoses	Prognoses
31	Essential hypertension; cerebral thrombosis with left hemiplegia	Fair
32	Luetic heart disease	Fair
33	Arteriosclerotic heart disease, moderate decompensation, auricular fibrillation; late lues	Poor
34	Arteriosclerotic heart disease with auricular fibrillation	Fair
35	Cerebral thrombosis with left hemiplegia, hypertensive heart disease	Fair
36	Hypertensive heart disease, bronchitis, barbiturate addiction	Fair
Diseases of the Digestive System		
37	Gastro-intestinal bleeding; coronary thrombosis with left hemiplegia	Guarded
38	Chronic duodenal ulcer; optic atrophy	Fair
39	Double inguinal hernia, right and left	None
Diseases of the Endocrine System		
40	Diabetes mellitus, amputation of gangrenous toes, both feet	Good
Diseases of the Nervous System		
41	Multiple sclerosis, pediculosis	Poor
42	Parkinsonism	Poor
43	Epilepsy	Fair
44	Paralysis agitans; glaucoma OS and OD	Poor

DIAGNOSES AND PROGNOSES (Cont'd)

Case #	Diagnoses	Prognoses
45	Cerebral and general arterio-sclerosis aphakia, malnourishment	Fair
46	Acute urinary retention with fecal impaction, old cerebrovascular accident with some paralysis	Fair
	Diseases due to Infection	
47	Cellulitis of right hand, old cerebro-vascular accident, hypertensive heart disease, bronchial asthma	Fair
48	Cellulitis of Scrotum	Good
	Diseases due to New Growths	
49	Carcinoma of rectum with colostomy and metastases	Bad
50	Metastatic Carcinoma	Poor
51	Metastatic Melanotic carcinoma with paraplegia	Poor
52	Carcinoma of Prostate with advanced metastasis	Poor
53	Carcinoma of prostate with advanced metastasis	Poor
54	Carcinoma of bladder with metastasis	Poor
55	Carcinoma of pelvis and left hip	Poor

selected for study, it is shown that only sixteen or a little over one-fourth of the group had good prognoses. Fourteen had prognoses of poor or worse. One patient's prognosis was not given in the social case record. He had a diagnosis of double inguinal hernia. There is no prognosis for such a condition in itself. It depends on the amount of discomfort and incapacity involved by his way of life and his personal care.

The diagnoses in themselves greatly affected discharge planning in many cases. The seven patients with cancer were in need of terminal care. Most patients in the last stages of cancer require nursing and some medical attention. Unless the home conditions are exceptionally favorable the patient with advanced cancer is better off in a hospital. Rose Hawthorne Lathrop Cancer Hospital is the main institutional resource used by Boston City Hospital for terminal cancer care. It is used not only because the care given there is satisfactory but because it is privately endowed and free care is given.

One patient with tuberculosis had great difficulty in accepting her diagnosis. She refused sanatorium care in the beginning. Fortunately, toward the end of her hospitalization, the disease was diagnosed as inactive and she was allowed to convalesce in the home of her brother. In general, due to the awareness of the public of the need for institutional care for those suffering from this disease, patients will accept the recommendation for sanatorium care and once the decision has been made they are very restless until transferred. This is

clearly seen in two of the four patients with tuberculosis. One became so impatient that he left and went by himself rather than waiting another day for the transportation that had been arranged.

Among the diseases of the nervous system presented by the group, three patients had diseases which indicated the need for more intensive nursing service as the disease progressed. These were the patients with a diagnosis of multiple sclerosis, of Parkinsonism, and of paralysis agitans. Institutional care is usually advisable in these cases, unless a family can afford the very long term emotional and financial drain of their care.

Heart disease, arthritis, diabetes, cancer, and diseases of the nervous system occur, for the most part, in middle and later life. Very little investigation has centered on the diseases from which people of middle age suffer. Yet it is generally conceded by those persons interested in the problems of the chronically ill that they are not necessarily incapacitated for active useful lives or for employment.

Since most diagnoses impose specific limitations as part of treatment, examples have been selected of several typical cases. These illustrations were selected to show how medical recommendations necessitated change, at least for a short time, in the patient's mode of living, some of the services required to arrange for the meeting of these needs, and the concurrent emotional factors in the specific cases.

Case #3 was a sixty year old man with a wife and three children. He had been supporting them by working as a steel-loader in a foundry prior to an accident on the Boston Elevated Railroad. The diagnosis upon admission to the hospital was intracondylar fracture of the right femur. Treatment demanded that his leg be placed in traction for at least six weeks, following which he would be given a knock knee brace. Even with this he would be allowed no weight bearing for another six weeks.

The patient had no savings and the family was forced to turn to public assistance for help during the patient's unremunerative recuperation period. An accident claim had been filed but adjustment could not be expected for many months. The family was forced to apply for Aid to Dependent Children. Hospital funds had to be provided for the patient's brace.

Fortunately the home was adequate for the convalescent care of the patient following his traction treatment. Despite the initial recommendation for only six weeks in traction the patient had to remain in the hospital for eight weeks. Upon his return home he had to undergo a period of further unemployment during which he learned to adjust the brace.

Case #18 was a fifty-five year old widow, who had been supporting herself by doing part-time housework. Her diagnosis upon admission to the hospital was compound fracture of lower tibia and fibula with partial traumatic amputation of the left foot and subcutaneous emphysema. Although she had a fair prognosis, treatment was long and she was hospitalized six months. At the end of three months she had a second operation, and then a third at the end of the fourth month, because she was not healing properly.

The patient had been self-sufficient, independent in spirit and filled with pride. During her period of hospitalization she became sorry for herself and deeply worried that she would not be able to support herself in the future. She also feared inability to get about, even with the aid of a brace. The patient was suffering much pain during treatment which naturally affected her state of mind.

Following discharge from the hospital, it was necessary for the patient to move in to her daughter's home because she lacked income and physical ability to manage alone. She was still wearing a cast at that time. One month later a second cast was applied and the patient was still confined to a bed-chair existence. For many more months she was followed clinically until she was discharged.

Case #32 was a fifty-eight year old man who was admitted to the Hospital with an acute exacerbation of his arteriosclerotic heart condition. According to the diagnosis and recommendations he had auricular fibrillation and would need some convalescent care upon discharge, then restricted activity, help in finding work suitable to his physical limitations, and follow-up care in the Out-Patient Department. The patient, who was single, had been supporting himself as a dishwasher. He had been living alone in a single room on the third floor of a rooming house. The doctor warned that the patient must move to first floor quarters as he would never again be able to climb many stairs. His only relative, a half sister, did not have adequate facilities to offer him a home or funds for nursing care. Despite much medical interpretation by the doctor and the medical social worker concerning his chronic need to restrain from physical exertion, the patient still expected complete cure, yet was fearful of ending his days in a hospital for the chronically ill. The patient finally had to go to a nursing home, the cost of which had to be met by the hospital because of lack of other resources. Shortly after discharge to this home the patient had to be readmitted to the Hospital and he died.

Case #42 was a sixty-two year old man with a diagnosis of paralysis agitans and glaucoma of both eyes. His prognosis was poor. He had been ill for many years but had not been too great a burden upon his wife as far as the demands of nursing care were concerned. He had been receiving seven dollars a week, the maximum assistance grant of Dependent Aid. In order to maintain their home his wife worked as a seamstress.

Beside medication prescribed, it was recommended that the patient continue activity to the extent of his physical capacity and that he receive supportive nursing care. Chronic nursing care in an institution was indicated for the remainder of the patient's life.

CHAPTER V

SOCIAL FINDINGS

Emotional Factors Involved in Planning

The effect of the emotions of a patient in regard to the nature of his disease, the course of treatment, and the effects of the disease upon his normal mode of living play a vital part in medical-social planning. Illness is primarily a medical problem, but it is also a social and an economic one. No two patients have identical reactions to the same disease. The understanding by the doctor and medical social worker of the significance of the disease to the patient is derived from trained observation of personality reactions and careful consideration of the case history.

It is impossible to categorize the emotional factors in order to evaluate them. By presenting summaries of some of the social case records of the group studied some insight into the complicated ramifications of planning should be given. The patient must be seen in the total environmental picture. First, he is a patient in the hospital; second, he is a member of a family or intimate social group; third, he is a member of the community. The influence of each circle of his contact reacts upon him and he in turn leaves an impression upon it.

In the sections on Sources of Income, on Savings, on the Length of Hospitalization, and on Degrees of Disability mention was made of some of the broader economic aspects of hospitalization as they affect the patient. In the sections on

Marital Status and Dependents and on Mode of Living some of the difficulties of planning are shown as they affect the patient within his circle of family and friends. In the section on Degrees of Disability some of the differing effects of acute and chronic disease are presented as they relate to the emotional equilibrium of the patient. It is the pressures from all these forces as they interact that will be shown in the case summaries presented for illustration.

> Case #1 was a sixty-four year old, unmarried woman who had been working as a dishwasher in a hotel to support herself. She was suffering from a fractured hip. The patient had many good friends who visited her but only one relative, a niece. They were unable to assist the patient financially or to offer a home for her convalescence. The patient had no savings and was only eligible for Dependent Aid. The maximum grant available from that agency was not sufficient to pay for private nursing home care. She had been hospitalized for four months, then required several months of nursing care before the nail used in treatment could be removed from her hip. Following the second operation she would require further convalescent care before she could return to her routine way of life. It was determined that the patient had a Lynn settlement and therefor it was necessary to arrange for institutional nursing care in Lynn. The patient was upset about being sent to another city for her care and also by the long period of incapacity.

> Case #2 was a sixty-one year old widow. She had been living alone with her dog for many years, supported by a Veteran's Pension. This patient's increasing weakness following admission to the hospital with acute urinary retention and fecal impaction complicated by an old cerebro-vascular accident which had left slight paralysis and her subsequent dependency forced her to accept nursing home arrangements despite the fact that her greatest desire was to retain her home furnishings and her dog.

The permanent relinquishing of familiar and cherished possessions is one of the most traumatic experiences of pa-

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Case #2 was a sixty-one year old widow. She had been living alone with her dog for many years, supported by a Veteran's Pension. This patient's increasing weakness following admission to the hospital with acute urinary retention and fecal impaction complicated by an old cerebro-vascular accident which had left slight paralysis and her subsequent dependency forced her to accept nursing home arrangements despite the fact that her main desire was to retain her home furnishings and her dog.

The permanent relinquishing of familiar and cherished possessions is one of the most traumatic experiences of re-

tients who require chronic care.

In many cases single patients without close ties of family or friends who have undergone long periods of institutional nursing care become very dependent upon the protection of such custodial care when they are subsequently discharged. In later illnesses they are usually eager to return to such care.

> Case #7 is such an example. He had been at the State Infirmary at Tewksbury for many years suffering from asthma. Upon discharge from that institution he had been attempting to maintain himself as a bar porter. When hospitalized with a fractured hip he was eager to return again to Tewksbury.

The feeling of dependency caused by illness is irritating to some patients but to others it offers satisfaction and they dread being discharged because of the threat of being forced to maintain their own needs. Some, when finally discharged, seek employment in any capacity at the Hospital.

> Case #8 was a fifty-eight year old single man who had been employed as an accountant at a shipyard. He became so dependent that he sought to enlist political aid in remaining in the Hospital following the acute stage of treatment for his fractured ankle. He was unsuccessful.

Patients frequently suffer from the fear that their jobs will not be held for them. In such instances the social worker can often be of some help in establishing the understanding and the cooperation of the employer in relieving this fear. Lack of security is an important factor in the cause and course of disease. Worry and fear are probably more harmful than disease. It has often been said that the industrial convalescent tends to return to work too soon just because of his

increasing dread of insecurity.

Case #15 was a fifty-eight year old single man who had been supporting himself as an elevator operator before he was hospitalized with ruptured quadriceps. The treatment necessitated no weight bearing for six weeks. His prognosis was good. The patient was referred to social service for temporary aid. The patient, who had been lame for many years due to an old poliomyelitis disability was cooperative and optimistic. The worker was able to arrange that his job be held. At the end of the first month the patient was discharged with the recommendation that he receive physio-therapy treatment several times a week. At about this time the patient began to worry again about his job. The social worker again obtained reassurance from the employer that it would be held. The patient was most eager to keep this job to which he had so well adjusted with his former disability. After another month the patient was allowed to return to work. At the end of three days his legs began to swell and the doctor ordered that he give up his job and obtain sedentary work. This meant a retraining process and new adjustment, a physically and emotionally difficult task despite the aid of social service agencies.

Case #16 was a similar problem. The patient, a fifty year old widower had been supporting his widowed daughter and grandchild. For fifteen years he had worn a prosthesis because of an old mid thigh amputation. He had obtained a job as a night cleaner at one of the colleges and made adequate adjustment to the work. The new injury diagnosed as fracture of right tibia and fibula required three months hospitalization. This accident completely disabled the patient. Attempts to help him to walk with the aid of a brace were unsuccessful. The social worker sought to alleviate his intense depression by referring him for service from rehabilitation and home work agencies. Long delay due to inadequate resources added to the patient's dejection.

In an article on "The Money Value of a Man" put out by the Metropolitan Life Insurance Company the problem of physical incapacity is discussed from the standpoint of age and earning ability. This article speaks of the grave difficulty of readjusting to new employment conditions when a man becomes middle age or older. One of the reasons given is that the wage earner

has the responsibility of supporting a family, the consumption costs of which increase until the wage earner is in his sixties. At that time the average family usually again consists of only husband and wife as it was in the beginning before children were added to the unit. During the earlier years the current needs of his family are only part of a man's moral family obligation. In addition, he has the responsibility of making provisions for his dependents in case of his untimely death. Among the lower income groups there is usually no opportunity to establish this reserve protection. Therefor such a m an disabled in his productive years is economically worse off than the family of the man old enough to receive retirement income or Old Age Assistance. It must be remembered that it is mainly this lower income group that is seen at the Boston City Hospital.

The problem of finding adequate nursing home or institutional care facilities to meet individual needs will be discussed with specific reference to cases under the sections on Resources and Disposition of Patients. Sectarian preference, transportation problems of patient and visitors, and delays in obtaining adequate disposition of case needs all have a deeply emotional effect upon patients. Some patients do not make adequate personality adjustments when settled in nursing homes equipped to meet their specific medical needs. In some instances it is necessary to transfer such patients two or three times.

Among the patients who had relatives with homes having adequate care facilities, such resources could not be used in several cases because of family tension. Frequently, although relatives had given care to patients during the early stages of illness the strain became too great when it was determined that the disease was chronic and such service was then withdrawn. The patient usually indicated through depression his feeling of rejection and much tactful interpretation was needed to obtain any acceptance of a secondary plan. In a few cases wherein families first refused to give home care to the patient, when the substitute plan had been made, their guilt reactions forced them to insist upon assuming the burden. Such unwilling care cannot give much satisfaction to the patient. Recognition of this fact by the doctors and social workers led to delay in discharge from the Hospital of several patients to such home situations.

> Case #54 was a fifty-nine year old housewife admitted with a diagnosis of hypertension, bronchitis, hypertensive heart disease, neuritis, and barbiturate addiction. She was given symptomatic treatment and was ready for discharge in one month. Her married daughter indicating friction between herself and the patient suggested chronic hospital care for her. The patient's husband, a chronic alcoholic and the daughter agreed that Long Island Hospital was suitable. The husband in the past had not been dependable or cooperative with the patient according to the social history. At the last minute he changed his mind and professing to make amends took her home.

> Case #47 was a sixty year old carpenter who had a diagnosis of cancer of the rectum with colostomy and metasteses. His prognosis was bad. Permanent nursing care was recommended. The home consisted of his wife, his mother, his two sisters, and a son who was in the

Army. The wife expressed resentment of the inadequate income the patient had been providing during the past few years since the onset of his illness. She agreed to his going to the Rose Hawthorne Lathrop Cancer Hospital as she felt she could not carry through the chores necessitated by home care. The patient was most eager to go home and refused to consider the plan for hospitalization. Finally the wife agreed to let him come home if the Visiting Nurse would do the nursing. Because of her negative attitude and the patient's intense emotional dissatisfaction the doctor and social worker planned to keep the patient on the ward for a longer period. At the end of three months he died in the Hospital.

These various problems are not exceptions. They are routinely familiar to the social worker and are but a few of the many that are presented.

Disposition of Patients

The final disposition of the fifty-five patients studied is presented in Table X. This table was set up according to sex so that it might be possible to note the proportion of male patients who were able to return to the community in self-sustaining capacity. Men in this age group are expected to be employable according to the present philosophy of the nation.

It appears that less than one fourth, or twenty-three per cent, of the male patients were able to be discharged to their own care. Slightly more than one third, or thirty-five per cent, of the female patients were left in their own care. Only one female patient was transferred to another institution, whereas over one third of the male patients required longer hospitalization.

TABLE X

DISPOSITION OF THE

FIFTY-FIVE PATIENTS STUDIED

Status	Males	Females	Total
Total	38	17	55
Own Care	7	6	13
Care of Relatives	2	1	3
Institution	19	1	20
Public Agency	3	7	10
Private Agency	2		2
Lost	2	1	3
Died	3	1	4

According to an evaluation of these hospital transfers all were for long term care if not terminal care. The female patient was transferred to the Rose Hawthorne Lathrop Cancer Hospital for terminal care. Five male and seven female patients were transferred to the care of other social agencies. This means that they were back in the community but unable to manage without some form of assistance, mainly financial. Several patients in this group were convalescing in nursing homes, funds for which were provided by these agencies. The patients who are categorized as lost were discharged and left

the Hospital before the social worker was informed of their discharge plans or they left against the advice with the expressed statement that they did not wish further assistance. Follow-up visits were not made by the social worker to the latter group. Of the former group follow-up visits to the addresses given by the patient for the Hospital records showed that the patient was no longer living there and his new address was unknown.

Of the twenty patients requiring chronic institutional care twenty were from the medical services. This was undoubtedly due to the fact that the majority of patients suffering from the degenerative diseases were medical rather than surgical cases. The surgical cases were mainly accident cases involving orthopedic treatment. Probably half of those patients sent to other hospitals could have received adequate nursing care in private homes of relatives or friends if such were available or in nursing homes if they could have afforded it. The implication appears to be that all required custodial care in a hospital set-up. In the chapter on the Emotional Factors Involved in Planning, reference is made and examples shown of patients physically able to manage in the community if they could have received adequate boarding care supplemented by periodic medical follow-up in clinics and from the Visiting Nurse Association.

Use of resources plays a prominent part in the final disposition of patients. It is from an evaluation of the adequacies of resources used that we get a more realistic picture of

the significance of disease in its effect upon the mode of living of the patient.

Resources

Existing facilities for the care of the sick, particularly the chronic sick, present a most disturbing picture. This is especially true for those patients who are too old to be cared for under existing child care programs and are not old enough to meet the requirements for old age programs. In general, most social agencies are reluctant to work with patients requiring long term or terminal care. The reason is partly economic. Voluntary agencies, for example, cannot carry a long term burden and serve as many persons as well, or as widely, as their policy demands. The high cost of equipment, labor, and general living costs have made the running of nursing homes appear to be a most unprofitable and an aggravating business. The lack of emotional satisfactions attendant upon care of a physically degenerating patient are a minor but an existing factor. Agencies tend to juggle the responsibility for them.

Table XI presents a list of all the resources used by the medical social workers in planning to meet the needs of each of the fifty-five patients. In many cases, several resources were used for one patient. These resources will be designated as adequate or inadequate in some of the case examples presented in this chapter. The use of the term adequate merely signifies that by use of this resource the more pressing social

TABLE XI

RESOURCES USED FOR THE

FIFTY-FIVE PATIENTS STUDIED

Resources	Medical	Surgical	Total
Rose Hawthorne Lathrop Cancer Hospital	4	2	6
Jewish Memorial Hospital	1		1
Middlesex Sanitorium	1		1
Worcester Sanitorium	1		1
Rutland Sanitorium	1		1
State Infirmary (Tewksbury)	4	2	6
Lynn Infirmary		1	1
West Roxbury Veteran's Hospital	2		2
Kehoughton Virginia Veterans' Hospital		1	1
Veterans' Administration	1		1
Soldiers' Relief	3	1	4
Bureau for the Blind	2		2
Dependent Aid	4	7	11
Aid to Dependent Children		1	1
Catholic Charitable Bureau	1	1	1
Industrial Aid Society	2		2
Lend-A-Hand Society	1	4	5
Vocational Rehabilitation		1	1

RESOURCES (Cont'd)

Resources	Medical	Surgical	Total
United States Employment Service		1	1
Visiting Nurse Association		1	1
Red Cross Transportation		2	2
Cooperative Workshop		1	1
Shuman Fund	4	2	6
Community Federation Allotment Fund		8	8
Boston Dispensary		1	1
Friends		3	3
Relatives	3	3	6

and the medical problems were met to an extent compatible with the health and emotional satisfaction of the individual patient. The term inadequate, for the purpose of this study, signifies that the total need of the moment could not be met or that there was dissatisfaction on the part of the patient.

Rose Hawthorne Lathrop Cancer Hospital was used for the terminal care of six of the seven patients suffering from cancer. The seventh patient died in the hospital. This voluntary hospital offered excellent medical care at no cost to the patient. The major drawback to the use of this facility was its distance from the City of Boston. It is located in

Fall River. Four of the six patients transferred there expressed deep concern about the difficulty relatives and their friends would have in visiting. One patient, a fifty-five year old single man, despite anticipating that his death would occur shortly, refused to go there until one family, his only close friends, agreed to visit frequently. Another patient and his seven dependents were deeply disturbed about the cost of traveling that distance as they were being supported by Aid to Dependent Children since the patient's onset of illness. Another problem met in obtaining care for cancer patients is the fact that there is a long waiting list for admission to the Hospital. It is not unusual to have the delay last several months. As most patients suffering from cancer are not aware of their diagnosis they become very restless awaiting transfer or discharge. This occurred in the case of a fifty-two year old unmarried clockmaker. He was willing to go to another hospital for further treatment but grew listless and dejected during the two month waiting period.

The Jewish Memorial Hospital, a private institution for chronically ill Hebrew men and women was used for the transfer of one patient. This hospital has one social worker who does mainly recreational service for the patients. The waiting list is long as this is the only Hebrew hospital for chronic diseases in the City and its bed capacity is still small although it is being enlarged.

Case #42 was the sixty-two year old Jewish patient suffering from paralysis agitans and glaucoma referred

to in the chapter on Diagnoses. The greatest factor involved in meeting his social need was a religious one. He understood and accepted the fact that his wife did not have the strength to continue to care for him at home and was willing to go to a hospital or a nursing home if it met the dietary laws of his religion and he could be with patients of his own faith. The nursing homes fulfilling these requirements were more costly than non-sectarian homes. The family was being supported by public funds with a maximum grant of seven dollars per week allowed the patient. This was approximately one-fifth the amount needed for the nursing home care. There was a delay of more than a month before the patient was accepted by the hospital. Although this period was fraught with tension and fears, the patient and his family were satisfied when he was admitted. This resource therefor proved adequate.

The Rutland, Middlesex County, and the Worcester Sanitoriums were used for three patients suffering from pulmonary tuberculosis. Settlement requirements were the bases for selection of them. In two of these cases the problem of delay in transfer was the major cause of inadequacy from the standpoint of the patients. One patient remained six months awaiting admission and the other patient waited one month. The latter was so seriously disturbed by this fact that when he received word of his acceptance he insisted upon going alone by bus rather than waiting until the next day for a relative to drive him there as was arranged by the social worker. This patient had good insight into his illness and was resigned to the situation. The distance from Boston was not a problem in any of these cases because two of the patients were more accessible to their friends and relatives by this move and the third had dissolved his family connections many years before.

Delay in transfer is also an administrative problem of major concern to the hospital. A general hospital must be equipped to handle the demand for beds. Chronically ill patients hamper the flexibility required to do this. Boas states that in general hospitals the chronic sick are regarded as intruders who divert the activities of the institution from its proper purpose. Facilities are not adapted to their needs in general hospitals and it is unnecessarily expensive to keep them there.[1] Particularly in cases of contagious diseases such as tuberculosis, the hospital is handicapped as it is necessary to isolate such patients. This results in a lessening of space and a curtailment of activity on the part of the medical and nursing staff.

Of the six patients transferred to the State Infirmary at Tewksbury, only one patient was eager to go. He had been there before and at the time of planning was greatly discouraged about his poor recuperative powers. The other five patients, their families and friends needed much interpretation of the need of the use of this plan before it was acceptable.

At the State Infirmary care is provided to "indigent and sick persons not chargeable for support to any city or town".[2] The institution has resident and visiting medical staffs,

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1 Ernst P. Boas, The Unseen Plague Chronic Disease, p. 34

2 Annual Report of the Massachusetts Department of Public Welfare, 1934, p. 41

nursing and social work service. Overcrowding is a frequent problem. Because of this there is often long delay in gaining admission there. The feeling involved regarding original dissatisfaction with plans for use of this hospital appear to be emotional. As originally this institution was an almshouse it seems to connote some social stigmata to patients who have been financially independent prior to illness or where family pride is injured when chronic need forces the family to relinquish its care of the patient.

Medically, service is adequate at this institution, although less crowded conditions would make for less strain. Often patients are sent there because of lack of resources, generally financial, to send them to more emotionally satisfying places. The long waiting periods indicate the need for more institutions set up to meet the needs of this economically dependent group. The waiting periods here as in all cases of chronic need, badly affect the proper administration of a general hospital.

Three patients were sent to Veterans' Administration hospitals. Adequate medical care was provided in each case. Two of the veterans were emotionally dependent upon the Administration as well as financially, and were eager to go. The third patient, who was psychotic but not committable, refused at first to sign papers for admission but eventually did. The delay of all three in gaining admission was difficult for the patients and the Hospital administration.

Fortunately, one man was able to pay for nursing home care between discharge and transfer. A second one required supplementation from Soldiers' Relief to do the same. The third was kept at the Hospital until transfer.

Soldiers' Relief was used in four cases to supply supplementation of pensions and the contributions of relatives to meet nursing home costs. Assistance from this agency was prompt and adequate for those who were eligible. It was denied to one patient because of the incligibility of his status.

The services of the Bureau for the Blind were used for two patients. In both cases this agency assumed full financial obligation as well as supervision of all social and medical-social planning and casework service. It was a most adequate resource from all standpoints.

Dependent Aid was used as a resource for eleven patients. Some difficulty was found in the adequacy of this resource. In one instance, it was necessary for the patient to deplete his savings of twenty-five dollars before he was eligible. This requirement leaves the patient with a feeling of great insecurity. The budgetary standards were based upon a maximum grant of seven dollars per week. This is rarely sufficient to adequately provide for the physical welfare of patients lacking other income. It did suit the need of one patient. That was for payment of nursing home care at one of the very few excellent nursing homes charging minimal rates.

The Industrial Aid Society had to supplement the Dependent Aid grant of one patient to meet nursing home costs pending his admission to the Rose Hawthorne Lathrop Cancer Hospital. Referral to Dependent Aid was made in five cases at final disposition by the Hospital Social Service Department. The low budgetary standards which precluded planning on an individual basis as is done for the Old Age Assistance recipient made this resource generally inadequate for planning to meet the needs of this age group.

Lend-A-Hand Society was an excellent resource in meeting the small cost of specific appliances used at medical recommendation. They supplied funds for an eighteen dollar brace for one surgical patient and a ten dollar cost for another. For two patients they paid for several weeks of nursing care. In one case for which aid was sought it was refused temporarily because the agency funds were depleted. In each case wherein they granted assistance they were prompt to make the decision and in paying.

The use of special funds available to Boston City Hospital Social Service Department, such as the Shuman Fund and the allotment from the Community Fund, was of great help in meeting emergency needs for medical appliances and nursing home care for patients requiring this service for a brief time. Such funds were used for fourteen of the total patient group.

Relatives offered resources such as funds and their homes

for convalescent care in only six cases. Friends contributed similarly in only three cases.

The most significant factors gained from this survey of resources appears to be the lack of institutional facilities for the care of those patients requiring chronic care. This lack is seen in the long delay involved in transferring those patients who were accepted eventually. Repeated throughout many of the case records of these patients is the problem of distance from their recent homes. Being uprooted from familiar surroundings is always upsetting to a patient. It is even more depressing when the patient is aware that such a move will last a long time. Overcrowding of the few available institutions for chronic care was so bad during the period studied that the Long Island Hospital and Infirmary, a public institution for long term care for the City of Boston, was not available. Its waiting list was so long that new applications were not accepted although in one case an attempt was made to use it. The patient's name remained on the waiting list for fifteen months. At the end of that time the patient died in the Hospital.

The second most serious problem presented was the inadequacy of financial grants from Dependent Aid, the only form of assistance for which many of the patients studied were eligible. The maximum grant has been raised three dollars per week within recent months. From the medical needs presented by several of the patients it is apparent that this increase

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would not have been adequate.

Private social agencies refuse to accept a case that indicates a long term need and little hope for improvement. They will also not take a discharged patient requiring only financial help. The public agency, Dependent Aid, cannot, according to their present budgetary standards, adequately support an ailing person in the community unless that patient is fortunate enough to be admitted to the one qualified low cost nursing home in Boston.

The need for shortterm grants averaging one hundred dollars for a few weeks appears to be significant. Special private funds to provide this will be necessary until the public recognizes that assuming the responsibility for expending greater amounts for rehabilitative short term nursing care is as worthy as barely sustaining an individual for the remainder of his life.

would not have been complete.

Private social agencies refuse to accept a case that indicates a long term rose with little hope for improvement. They will also not keep a discharged patient requiring only financial help. The public agency, hampered, according to their present budgetary structure, reluctantly supports an ailing person in the community rather than permit an unfortunate enough to be confined to the one institution for most mentally sick in Boston.

The need for short-time private sanitarium care has existed for a few years appears to be significant. Several private homes in Brookline this will be necessary until the public recognizes their responsibility for supplying adequate accommodations for treatment other than during one of the periods of mental illness.

CHAPTER VI

THE ROLE OF THE MEDICAL SOCIAL WORKER

Recognition of the grave importance of peace of mind or emotional security to the welfare of the patient has created the need for casework service in hospitals. The doctor does not have the time, and in some instances the training to ferret out the fears and lacks of the individual patient. It is the medical social worker who finds them, and seeks and finds suitable ways of meeting them. She serves as a liason person between doctor and patient, patient and his family, and the patient and community. One of her major functions is interpretation. She helps to make the patient understand the medical recommendations and she follows the patient as long as necessary to help him to continue them. She also interprets his needs to other social agencies to obtain their resources when needed. She can contribute through her knowledge of the emotional factors affecting the patient to the doctor's fuller understanding. Boas says that the function of the medical social worker is to aid the physician in the treatment of the ill. She does not treat the diseases; she treats the patient. She discovers and interprets the social and economic factors involved in the sickness and tries to regulate them, so that they will favorably influence the outcome of the illness. Equally important, she instructs the patient and leads him to an adjustment of his illness and to his environment. The social factors in the care of chronic patients should be dealt

CHAPTER VI

The Role of the Medical Social Worker

with as definitely and systematically as medical factors.[1]

Ward patients in Boston City Hospital generally present financial need based upon their physical incapacity. Whether the patient needs an appliance, nursing care upon discharge or maintenance of himself or his family during his incapacity he is generally without resources to supply it. In many cities throughout the United States non-profit plans for hospital care insurance have been established. Although plans may vary in scope and nature of benefits, in general, they provide from three to four weeks of hospital service each year. Benefits do not cover fees to private physicians or nurses. These plans do not provide care for the indigent or unemployed, although ideally through such plans employed groups can finance medical care themselves. Such short term programs do not greatly benefit those who suffer from chronic diseases, which require prolonged treatment. This was most apparent among the group studied. Even if they had been covered by those existing hospital insurance programs they would not have met what proved to be the greatest need, funds for nursing or for chronic care.

The medical social worker in helping the patient to follow recommendations made by the doctor often has to do intensive interpretation to his family. Their attitudes toward

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1 Arthur C. Bachmeyer, M. D., and Gerhard Hartman, Ph. D., editors, The Hospital in Modern Society, pp. 699-703.

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1 Arthur G. Buchmyer, R. N., and Dorothy Jeffries, R. N., editors, The Hospital in Modern Society, p. 109-110.

the illness as well as toward the patient often greatly affects their cooperation. When the family feels they cannot provide nursing service in their homes they are often left with strong feelings of guilt. The medical social worker can often help them to work this out while helping the patient to understand the situation.

In many cases one of the most important roles of the medical social worker was to provide supportive casework during long periods of hospitalization of patients. This was particularly necessary since a large number of the group studied were without relatives or close friends who could be counted on to give the patient the emotional satisfaction of feeling someone had interest in him.

CHAPTER VII

SUMMARY AND CONCLUSIONS

This study of the medical-social problems of patients in the age group from fifty to sixty-five as seen at the Boston City Hospital has presented certain findings. Although the scope of the study is not of sufficient magnitude to have statistical validity, I believe that the basic conclusions to be drawn have sufficient merit to warrant suggestions for some changes, extensions, and additions of service to this age group.

It is apparent that this patient group at the Hospital is almost completely dependent upon its weekly or even day to day wage income. There are relatively no preparations for a "rainy day" through savings or some type of health insurance plan. Illness in almost every case made the patient economically dependent, at least for the duration of hospitalization, upon the public. Among those patients, approximately two-thirds of the total group, suffering from long term or terminal chronic diseases, the public was bearing the burden indefinitely. There is general acceptance of the fact that chronic disease incapacitating a man from gainful employment is a major problem of the aged. The physical deterioration of the old is considered a natural phenomenon. Arbitrarily, the demarcation line, at which time this may be expected to appear, has been set by Federal legislation at sixty-five

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years. There is little recognition that a vast number of persons in a younger age group might be manifesting these same illnesses.

Only one public institution, badly overcrowded, was available for patients suffering from general organic degeneration. There were chronic hospitals for specific ailments such as cancer and tuberculosis but they, too, were overcrowded as well as too distant for convenience. Institutions, programs or special services for less than complete long term custodial care were not available in sufficient quantity or quality.

General recognition of the emotional component of illness in this age group is almost completely lacking. A glance at the available resources indicates this fact. It appears to be the headache of each city or town or state to handle it as it can or will to meet the needs of this age group. They just do not fit. They do not have the sympathy that goes out to the ailing aged or the sick child. And this group has reached the stage in life where they cannot expect to have the recuperative powers of the young. Although few persons are willing to admit deterioration, it is medically recognized that responsibilities should be lessened after the age of fifty. Yet economic factors keep people straining at their work. Worry and fear of insecurity become more rampant with awareness of lessening physical ability and capacity and the knowledge that adequate social protection cannot be count-

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the reconstructive powers of the young. Although the records
are filling to their capacity, it is seriously recog-
nized that professionalized enough be learned either by the
of life. The economic factors keep people attending at
their work. Early are few is immediately decided more family
with success of receiving dignified ability to collect the
the knowledge that endowments society systemic course to com-

ed on before a man is sixty-five.

This group appears to be a lonely group. Family ties and friendship bonds are few and where they exist are often loose. Yet the sick patient is a dependent person. The doctor and the social worker can give him emotional supportive help for a brief time only. The medical social worker can recognize the social and economic factors involved in his illness and can try to regulate them favorably. When he is finally discharged from medical treatment she can offer no more than the services of the available agencies for the further protection and guidance of the patient.

In evaluating the final disposition of patients, one of the most unfortunate situations that is forced by lack of resources is the placing in an institution of a patient who merely needs boarding home care, rather than nursing care. Such patients cannot afford care in licensed nursing homes at their present high rates and they do not really need such intensive care. Housekeeping service, which is what they really need cannot be provided for the person who lives alone in a room as the majority of patients did.

Nursing homes in seeking sufficient profit are reluctant to admit any patient not requiring at least bed-chair care because the standard rate for ambulatory patients, as set by the Public Welfare Department is too low. It has been necessary at times for the medical worker to request bed-chair rate assistance for a patient who actually requires ambulatory

or on before a man is forty-five.

This group appears to be a costly group. Family type and frequently nurse are involved when caring for older people at home. Yet the sick patient is a responsible person. The doctor and the social worker can give his emotional problems help for a brief time only. The medical social worker can psychotize the doctor and occasionally relieve by his illness and can try to regulate them temporarily. When he is finally discharge from medical treatment she can offer no more than the services of the available agencies for the further protection and guidance of the patient.

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Nursing homes in evening sufficient profit are motivated to admit any patient not requiring at least semi-skilled care because the standard rate for ambulatory patients, as set by the Public Welfare Department is too low. It has been necessary at times for the medical worker to request hospitalization for a patient who actually requires convalescent

care, merely to obtain a place in a nursing home where he would be happy and well cared for. At other times sufficient funds to carry through such a plan have had to be garnered from several sources. As all agencies obtain their funds from the public either through taxation or directly intended contribution obtained from the Community Fund drives, it seems unrealistic and foolish for such a situation to exist.

The problem of long hospitalization because of inadequacy of resources to which to transfer a patient when he is ready is particularly serious in a general public hospital. It is a professional drain upon the medical, nursing, administrative, and social work staffs and an economic drain upon the community. Boston City Hospital is a general hospital established to care for the acutely ill. It cannot accept the responsibility for those who suffer from chronic disease. The chronic sick need special help to adapt themselves to living as full lives as possible. This help cannot be given in a general hospital. The patient therefor suffers by remaining.

Society has a moral obligation, as well as the need to protect itself, in seeking to prevent, delay, and to ameliorate the degenerative diseases through control measures. Much medical and social research and planning has been done for children and the aged. Little has been done for this age group which so greatly needs it. Early diagnosis and treatment available to all persons regardless of economic status is most important. A program to achieve this requires much

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public education and subsequent extension of public facilities. The eventual saving will be worth the investment.

With the financial drain of illness upon this age group being so great and the demand for free care so apparent, realizing that the funds used to pay for such care at the present are divided, though stemming from the one source, the community, it does seem that greater integration should be obtained. Voluntary or compulsary health care programs can not handle this problem of the patient who financially lives from week to week.

The medical social worker too often accepts the problem of inadequacy of resources as being irremediable at the time she is working with cases and therefor does not help to point out need for change through her recording of the problems met. By presenting them through staff conferences, and the like, some pressure may be brought to bear by her agency upon those in the community who are in a position to influence public thinking and public action.

First steps must come first. It seems indicated that the order of stepping is first toward public understanding by means of public education, then integration of agency resources to allow for greater facility of service, then expansion of facilities toward the goal of enriching the lives of the medically needy, and last, the organization of a program of preventive medicine that the life our culture has lengthened may be more satisfying to the individual.

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First steps must come first. It seems in Boston that the order of stepping is first toward public understanding by means of public education, then integration of agency resources to allow the greater facility of service, then expansion of facilities toward the goal of sustaining the lives of the medically needy, and last, the organization of a program of preventive medicine that the life our culture has lengthened may be made more satisfying to the individual.

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APPENDIX

Sample of Schedule Used in the Study

Record #_____Age_____Sex_____# of Dependents_____

Marital Status, Single____M____W____Sep____Div_____

Date Admitted_____Date Discharged_____

Medical Diagnosis_____

Medical Prognosis_____

Medical Recommendation_____

_____

Degree of Disability: Acute_____Chronic_____

Ambulatory_____Bed-Chair_____Bed_____

Reason for Referral to Social Service_____

_____

Occupation_____Savings_____

Source of Income_____

Need for Financial Help_____

_____

Resources of Relatives or Friends_____

_____

Emotional Factors Involved in Making a Social Plan_____

_____

_____

Adequacy of Resources in Making Plan_____

_____

_____

(over)

Final Disposition_____

Additional Comments_____