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The Role of the Social Worker in the Home Medical Care Program at Mercy Free Dispensary

Mary Gwendoline Durkin
Loyola University Chicago

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THE ROLE OF THE SOCIAL WORKER IN THE
HOME MEDICAL CARE PROGRAM AT
MERCY FREE DISPENSARY

by

Sister Mary Gwendoline Durkin R.S.M.

A Thesis Submitted to the Faculty of the School of
Social Work of Loyola University in partial
Fulfillment of the Requirements for
the Degree of Master of
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CHAPTER I

INTRODUCTION

In 1952 a home medical program was organized at Mercy Free Dispensary in conjunction with and supplementary to the services of the Mercy Hospital and clinics. The social service department of Mercy Free Dispensary has participated actively in this new program since its inception and has been a major activating force.

Purpose and Scope

The purpose of this thesis, then, is to investigate, describe, and evaluate the role of the social worker in the Home Medical Care Program at Mercy Free Dispensary and include as well, a short history of the program. With this goal in mind, a thorough study was made of all active cases during the first year of the program's installation. Therefore, the study includes those patients accepted for home care from March, 1952, date of inception, to March, 1953, a period of one year.

Method

Compilation of the material for this study was achieved by utilization of a schedule. The study was made by

gathering material from the medical and social case records of all the patients accepted for home medical care during the period previously described. The material giving the history of the development of the program was secured from the minutes of the committee meetings held during the early organizational phases of the program and from letters of correspondence.

History of Program

In order to study and clarify more accurately the role of the worker in the Home Medical Care Program, it would be well to give a description of the program itself, reasons for its inception, and the type of services rendered.

Need

The number of patients attending Mercy Free Dispensary was increasing daily and, with this increase, the unmet needs of certain types of patients became startlingly apparent. First, referrals for hospitalization increased. The allotment of hospital beds was being occupied by patients who, with proper medical supervision, could actually make a more satisfactory adjustment in their own homes. Another group of clinic patients could not afford hospitalization and could, at less expense, be adequately cared for in their homes. Finally, the problem of the chronically ill patient also brought into focus the need for a program to help these patients who were no longer

physically able to attend the out-patient clinic.

Hence, the need for the establishment of a program was clearly and forcefully indicated and the medical and administrative staff of Mercy Hospital and Mercy Free Dispensary were interested in meeting this need. The Sisters, in their Holy Rule, have the obligation of visiting and caring for the sick in their homes. The Stritch School of Medicine of Loyola University wished to integrate more completely the social aspects of care of patients in their own home, along with medical practice. They recognized as well, the teaching possibilities of the program for their students, and in addition, St. Xavier School of Nursing wished to expand their teaching program in the field of health for their student nurses and a home medical care program was seen as providing facilities for home visiting under experienced, qualified supervision.

Community Interests

The need for home care naturally is not confined to Mercy Free Dispensary patients, but is a nationwide problem. Community interest in Chicago is very prominent and various community organizations have encouraged the development of home care programs. The Welfare Council of Metropolitan Chicago has requested clinics to develop such a program on the basis

of the need indicated by the Cook County Health Survey of 1947 and in view of the success of the Michael Reese Hospital plan.¹

At an executive committee meeting of the Welfare Council of Metropolitan Chicago on March 6, 1951, it was indicated that home medical care service, integrated with hospital and clinical care, should have a high priority at that time. It was further indicated that well-staffed hospital Social Service Departments were needed so that the already existing community services might be effectively mobilized in behalf of patients needing care in their own homes.²

The Visiting Nurses Association is also concerned with medical supervision of patients under their care, and in order to help in the financial needs of such a program, the Community Fund made available money to clinics to begin such programs. The American Cancer Society and the American Heart Association, as well as the Community Trust of Chicago have also recommended the organization of home care programs.

1. "Survey of the Health Field in Chicago and Cook County," (Prepared by the Welfare Council of Metropolitan Chicago, April 1947). p.2.

2. "Unmet Needs in the Health Field," (Prepared by the Welfare Council of Metropolitan Chicago, March, 1951).p.3. (Mimeographed.)

Recognizing the need for a home care program, the Executive Committee, composed of the Administrator of Mercy Hospital, Director of Mercy Free Dispensary, Dean of the Stritch School of Medicine of Loyola University, Medical Director of Mercy Free Dispensary and the Director of the Social Service Department of Mercy Hospital-Mercy Free Dispensary, organized a home care program which went into effect in March, 1952. The program was organized primarily to service those patients who could no longer attend the clinic but could be treated adequately in their own homes. A second aim of the program was to facilitate the availability of hospital beds, by allowing patients to be discharged with assurance that their convalescence at home might be completed under medical supervision and care.

Source of Referral and Procedure

Patient may be referred by any staff physician in the hospital or clinic. If at all possible, the patient is examined in the general medical department of the clinic before being accepted on the program.

The examination includes a complete physical work-up with chest X-ray, Kahn, C.B.C., and urinalysis.

If the Medical Director believes the patient can use the facilities of the home care program, he requests the

Social Service Department to make a home visit to evaluate whether the social and physical set-up of the home is feasible for adequate care. A home visit is made by the social worker and a conference is held with the medical director of the program. At this time the worker presents her evaluation and after discussing the social and medical potentialities, a decision is made as to acceptability. After the case is approved, regular visits by the doctor are made. All medical care given is under the supervision of the Director of the Home Care Program. Each senior medical student avails himself of the opportunity of accompanying the doctor to the homes of the patients. Such medical and social care is continued as long as the patient requires it.

Presentation of the Study

Chapter II will present a description of the sixty-seven patients who constituted the principal source of the study. The problems and service rendered to these patients, while attending the out-patient department will be discussed in the third chapter. Chapter four will discuss the problems of the hospitalized patients. In the fifth chapter a description will be given of the role of the social worker in the home care program. The last chapter will contain a summary and some concluding comments.

CHAPTER II

DESCRIPTION OF THE PATIENTS

In order to make a more adequate study of the contributions made by the social service department in the home care program, it is necessary to have some insight as to the type of patient who seeks medical care through a clinic, and briefly indicate the procedure of registration. In addition, this chapter will describe the sixty-seven patients who constitute the source of this study. Identifying data, such as race, age, religion, marital status, members in the home, and financial situation, will be discussed.

The patients who seek medical care at Mercy Free Dispensary are those individuals who, for various reasons, cannot afford private care. The majority of them come voluntarily to clinic requesting medical help and usually are most hopeful that through medical aid, they can be rehabilitated sufficiently to continue a normal existence. In other words, the individual from the time he enters the clinic is presenting a need.

The patient is interviewed by the admitting clerk

who obtains from the patient routine information and evaluates the financial situation. The information as given by the patient is accepted, and it is the policy of the dispensary not to verify the amount of income or any other information secured from the one seeking admission to the clinic. The individual is given an appointment for a physical examination, which may be within a day or a week from date of registration. Clinical rates are also explained to the patient, with the understanding that if the charges become too difficult, the patient may request that his financial situation be reviewed and a more agreeable rate be decided which will enable the patient to make some contribution toward his medical expenses.

Patients are seen by senior medical students who take an extensive medical history and do the preliminary examination of the patient. The patient is then sent for examination to a senior physician who, paid by the university, supervises the student program. He checks the history and physical examination records, recommends any further tests, makes a tentative diagnosis, and refers the patient to the required specialized clinic. Here a plan for treatment is made and a definite diagnosis is given.

With this brief explanation of clinic registration

and initial physical work-up as a background, we can make a detailed study of the sixty-seven patients who have passed through various phases of the out-patient department and are now active on the home care program.

Race

The sixty-seven patients under study comprised fifty-two female and fifteen male patients, of whom four were colored male and fifteen were colored female.

Age

As the following table will indicate, the male patients represented the middle age and old age group. One male patient, age two, is an unusual case, and as can be seen by the table, deviated from the general norm. This patient was born with a malignant tumor, which was removed, and he is now being treated for nephritis.

The difference in the female grouping should be noted. Patients range from the young age group through the old age group, with the average mean falling in the middle age group.

TABLE 1

AGE

AGES	MALE	FEMALE	TOTAL
1-9	1	0	1
10-19	0	2	2
20-29	0	3	3
30-39	0	1	1
40-49	2	7	9
50-59	2	8	10
60-69	3	10	13
70-79	5	14	19
80-89	2	5	7
TOTAL	15	52	67

Marital Status

Inasmuch as a primary aim of this program is the maintaining of family unity, a study of the marital situation is highlighted. As the following tables indicate, there were

sixteen married patients. Ten of these were female and six were male patients. However, twenty-three of the patients were widows or widowers, and are residing with grown children. Therefore, it seems apparent that the children have accepted the responsibility of caring for their parents and home care is aiding them in this respect.

TABLE II

MARITAL STATUS

STATUS	MALE	FEMALE	TOTAL
Single	4	5	9
Married	6	10	16
Separated	1	10	11
Divorced	1	4	5
Widows or Widowers	3	23	26
TOTAL	15	52	67

Financial Situation

As the following table will indicate, the majority of patients on home care are receiving grants from the Chicago Welfare Department, and the old age pension recipients also number eighteen. Three families are being assisted through Aid to Dependent Children, four patients are receiving Disability Allowances and one is receiving a grant through Blind Assistance.

TABLE III

FINANCIAL STATUS

SOURCE	MALE	FEMALE	TOTAL
C.W.D.	2	16	18
O.A. P.	4	14	18
A.D.C.		3	3
D.A.	3	1	4
B.A.		1	1
Private Resources	6	16	22
TOTAL	15	52	67

Religion

Although Mercy Free Dispensary is under Catholic auspices, it has no religious restrictions. Religious affiliation of the patients is as follows: Catholic, thirty-five; Baptist, fifteen; Methodist, three; Episcopalian, one; Presbyterian, two; and remaining eleven were of undetermined Protestant denomination.

Summary

This chapter introduced the potential home care patients, giving some insight as to what types of patients are active in an out-patient clinic. The study illustrated that more women are recipients of home care, the majority of patients are supported through public assistance, age groups vary, and the majority of patients that ultimately become active on home care are of the white race which may be due to the fact that the housing facilities of the majority of colored patients are inadequate for the home care program.

CHAPTER III

PROBLEMS AND SERVICES RENDERED TO OUT-PATIENT

In the preceding chapter we have seen the type of patients who were active in the out-patient clinic and who eventually became active in the home care program. The purpose of this chapter is to make a study of the diagnosis of these patients, pointing up some background material of the illnesses in general, number of visits with the social worker, the presenting problems and the services rendered by the social service department. In order to clarify more completely the problem and the service rendered a few excerpts from the case record of patients on the home care program will be presented.

Following the patient's physical examination, he is referred to the specialized clinic for diagnostic discussion. The majority of patients on home care were initially seen in the out-patient clinic and the following table will indicate the final diagnosis. The result of the study points up the fact that the majority of patients on home care are suffering from what is called a prolonged or

chronic illness. It would seem advisable therefore, to consider chronic illness and its presenting problems in general before studying the concrete problems of the patients on home care.

TABLE IV
DIAGNOSIS

DISEASE	MEN	WOMEN	TOTAL
Arthritis and Rheumatism		5	5
Cancer	3	20	23
Cardiovascular diseases	10	13	23
Cirrhosis of Liver		2	2
Diabetes Mellitus	2	7	9
Epilepsy		3	3
Poliomyelitis		2	2
TOTAL	15	52	67

Chronic Illness

What is chronic illness? According to the book entitled Patients are People, chronic illness is that which

should be viewed for all practical purposes as an extension of an acute disease over a long period of time.³ Chronic illness includes many illnesses with different effects on each patient and requiring different treatment both medically and emotionally. In such patients, there are changes which often occur and simultaneously with these changes are problems characteristic of the particular stage. These changes are related to the four phases of the disease: the acute phase, in which active medical care within a hospital is imperative; the convalescent stage, in which the patient prepares for a return to normal or near normal health, the chronic stage, in which the patient can function in his normal environment, providing he recognizes his limitations and receives continued medical care, and lastly the custodial stage, in which the patient requires care with a minimum of medical attention. Each phase of the illness comes with its special interpretation, presents particular problems, and calls for special ways of meeting them. Since prolonged illness presents many a concomitant problem, it is obvious that the social implications of prolonged illness cannot be separated from their medical implications and the problems which they jointly present seriously effect the patient, his

3. Minna Field - Patients are People (New York's Columbia University Press, 1953) p.8

family, the professional groups, and the community of which they are a part. Furthermore, illness affects not only the the ordinary pattern of living; it affects the patient's feelings about himself. In fact, something happens to the ego of the person who feels his customary way of coping with life slipping away from him. Fortunately, the profession of social work has come to realize and is aware of these changes and individual differences.

Problems of Out-Patients

Having established the fact that the patients we are about to study, have many problems that are interrelated with their illness, we shall proceed to study the individual problems of the patients and the role of the social worker in assisting them.

In each of the specialized clinics at Mercy Free Dispensary, a qualified social worker is assigned to give service when needed. The tumor and cardiac clinics have a social worker in the clinic at the time the patient is seen by the doctor. It is at this time that the social worker initiates her contact with the patient. For example, let us review the program of an ordinary tumor clinic day at the Mercy Free Dispensary. The presiding doctor and his attending men may see on an average of seventy patients in one

clinic session. It is obvious that the doctor is pressed for time and cannot give adequate explanation, interpretation, and reassurance to the patient. During the examination, the worker observes the patient and attempts to recognize the feelings of the patient and is formulating a plan of approach to this particular individual. After the doctor has completed his examination, the worker discusses the illness with the patient and explains the treatment plans recommended by the physician. From this first contact with the patient, the worker gains some insight into the present problems and usually can foresee some future problems that will undoubtedly arise as a result of the patient's illness.

All the patients on home care were known to social service while in the out-patient clinic, with the exception of six patients who were referred by private doctors before their discharge from the hospital. The patients were seen each time they made their clinic visit by their social worker and were encouraged to contact them whenever needed. The worker held regular conferences with the patients and frequently discussed their cases with the physician. The following table will indicate the most numerous problems facing the patients while attending clinic as an out-patient.

TABLE V

PROBLEMS OF THE OUT-PATIENT

PROBLEMS	MALE	FEMALE
Domestic Difficulties		13
Finance	4	13
Housing	1	4
Transportation	1	6
Adjustment to Illness	15	52
TOTAL	21	84

In order to clarify the type of domestic difficulty that may be encountered and the service rendered by the social worker, it would be well to present an excerpt from one of the home care records.

Patient was a forty-five year old mother of five children with cancer of the breast with metastasis. With the help of the social worker, she was able to make an adequate adjustment to illness but was very upset over her marital difficulties.

Patient indicated she married her husband, realizing he was an alcoholic, hoping to change

his ways. Following their marriage, he continued drinking and left the family destitute on many occasions. She continued to live with her husband because of her children. The father was not interested in them and they often were obliged to go outdoors so as not to bother him. A few months ago, he became abusive and severely beat his wife and she had him arrested and requested a psychiatric evaluation. Patient was informed by the psychiatrist that her husband was not committable but that he was very emotionally upset. After that event, the husband threatened the patient continually for trying to have him committed to an institution. Worker contacted the husband who kept his first appointment. She allowed him to express his feelings and his ideas of being misunderstood, indicating he was a sick man and had a bad case of nerves.

After allowing the patient to ventilate considerably, he was asked about his wife's illness. He appeared to be oblivious of the fact that she was ill. Worker explained to him his wife's condition and the prognosis. Husband showed some feelings and admitted he was not a good husband and that he had made his family miserable. He asked the worker to help and requested an appointment for an allergy clinic to see if his asthmatic condition could be relieved. Patient's husband attended allergy clinic regularly, and held weekly visits with the social worker. Through the supportive help of the social worker and the medical treatment in allergy clinic, the husband did strive toward being more understanding and helpful in the home, to the extent at least, the family did remain together until the death of the mother.

Finances

Of the sixty-seven cases studied on home care,

thirteen patients had financial difficulties over and above those usually encountered when illness strikes a family. The following case will demonstrate the problems of family and how the social worker was able to help them.

This is a case of a forty-three year old man, married and has two children. Patient attends cardiac clinic and is being treated for a severe rheumatic heart condition with chronic decompensation. Prior to his illness patient was employed by a meat packing firm and had an excellent work record. Following his termination of employment because of illness, the firm paid his full salary for six months, and gave him half pay for another six months. The income the last six months was inadequate and the patient refused to apply for assistance.

Worker attempted through interpretation to aid him in realizing that he was entitled to assistance inasmuch as the patient had such a deeply rooted antipathy against relief from experiences he had in his youth when his family were on relief. The family was in debt, owed back rent, bills for furniture, food and clothing. The anxieties and worries over finances were having an adverse effect on the patient.

Worker wrote a lengthy letter to the Reade Industrial Fund, explaining the problems of this family. Worker included an itemized listing of all bills which amounted to \$500.00. Worker requested that the Fund consider giving this family a grant which would enable them to meet some of these expenses. Within three days, the worker received a check for \$500.00 from the Reade Industrial Fund, indicating that in view of the circumstances, they felt this to be a worthy case and wanted the family to have a new start as far as finances were concerned. The patient's wife was able to secure dentures and the necessary clothing, became employed part-time to

support the family.

Housing

The patients on home care, as a rule, do not have a housing problem because in the worker's evaluation, housing must be adequate before home care is approved. However, of the sixty-seven active cases, five patients were found to have poor housing. These cases were approved on an emergency basis because of immediate medical need for treatment.

The problem of housing can be most serious and yet the worker is limited in resources to write a letter of recommendation to the Chicago Housing Authority requesting better housing for the home care patient.

Transportation

Ten of the patients that became active on home care were unable to come to the clinic on public conveyances. In such cases, the worker had the medical director evaluate whether or not the patient was able to come to the clinic on the street car. If the doctor recommended cab facilities, the worker contacted the public agency to relay this recommendation. The agency then accepted the recommendation and provided a cab for the patient.

Adjustment to Illness

All patients, in varying degrees, have a period of

adjustment to their illness. In the case of the home care patient, indication of possible adjustment in the home must be shown before the patient is eligible for the program. The medical director of home care and the social worker, both agree that adjustment to the illness is necessary before home care can be of value to the patient.

Conclusion

In this chapter, illnesses of the home care patients have been highlighted, the general effects of a prolonged illness considered, and the presenting problems of the home care patient while in attendance in the out-patient clinic studied. The role of the worker became apparent: the social worker is always available to assist the patient, offers sustained supportive help and interpretation and assists the patient to utilize the many services that are available to him.

CHAPTER IV

PROBLEMS OF HOSPITALIZED PATIENTS

In the previous chapter a study was made of the home care patients during their attendance to the out-patient clinic. In this chapter, another phase that the majority of home care patients had to undergo will be studied; namely, the period of hospitalization. This part of the study will indicate the number of home care patients who were hospitalized, the number of visits by the social worker, and the problems of the patients in this setting with illustrations of the services rendered by Social Service Department.

In view of the diagnoses of the home care patients, it is quite evident that irrespective of the extensiveness of medical attention received, hospitalization ultimately becomes necessary in a large portion of cases. When this recommendation is made to the patient, a new series of problems generally becomes apparent; however, in the case of the home care patient, discussion of these problems is facilitated inasmuch as the groundwork of a case work relationship has already been laid.

Fears of Hospitalized Patients

The patient is concerned with the strangeness of the hospital, which to him is frightening. As a result, the worker is usually asked what will hospitalization be like, how long will it last, and what can the patient expect from it. In most cases, the patient is actually expressing fear, anxiety and hopelessness, in addition to a practical consideration of the cost of hospital care. Furthermore, there is the dilemma facing the breadwinner whose family is left without means of support or that confronting the mother who feels she cannot enter the hospital because she does not know what plans can be made for the care of the small children.

Before the patient can benefit fully from medical service, there is usually a need of assistance in coping with these problems.

Because of the patient's experience as an outpatient, he realizes he is not facing these difficulties alone and can count on the social worker for understanding and assistance.

The patient at Mercy Free Dispensary who is hospitalized, knows the availability of social service assistance. The social worker visits the wards daily and sees

each clinic patient with brief or prolonged discussion related to his specific problems and emotional needs.

The clinic patients are hospitalized at Mercy Hospital in a nineteen-bed ward. The wards are bright, cheerful, clean, and staffed as adequately as possible. In spite of this, the surroundings are entirely new to the patient and often-times he has many questions and fears about the routine. Actually, the ward staff is entirely too busy to discuss these anxieties with the patient and at times may not be understanding of the conflicting emotional problems of the patient.

Once again the medical social worker may be helpful to the patient. In the case of the home care patients, forty were hospitalized before they became active on home care program. Of the forty patients hospitalized, twenty-three had anxieties about hospital routine. These patients told of disturbances related to treatment procedures since they were not familiar with specific procedures and consequently, each new procedure constituted an additional emotional threat to the patient. In such cases, the worker, if at all possible, explained the procedure to the patient and continually rendered supportive help.

Another difficulty that was generally presented

to the worker was the fact that the doctor in the busy ward could not take time to explain to the patient the reasons for or results of various tests. The effect of this lack of sharing and the help which the social worker gave in such a situation is illustrated in the following case:

Patient was a fifty-five year old woman, hospitalized for surgery of the right arm. Worker visited patient regularly and noticed she was becoming very depressed and withdrawn since admission. Upon questioning, she expressed her anxiety over her doctor indicating she had been hospitalized two weeks and no mention of surgery or plans were discussed with her. Worker discussed case with doctor who frankly admitted he was afraid to discuss the case with the patient because he feared surgery which in her case may result in an amputation. Worker informed the doctor that she knew the strength of the patient and that he could talk freely to her. Doctor began talking to the patient and within a short time once again she became a happy well-adjusted patient.

Frightening as were the medical procedures, the prospect of surgery was far more disturbing. Of the forty patients hospitalized, thirty-one had to undergo surgery. The decision as to whether to submit to surgery is often a difficult one for the patient to make, and he is afraid to risk the consequence of not having it. In each case the worker was able to help these patients by assisting them to resolve this conflict by enabling them to verbalize their fears and to weigh as objectively as possible, the advantages

and disadvantages. In the following case, the worker had to continue to help the patient work through her fear of surgery for three months before patient consented to this procedure:

Patient was a seventy year old woman with carcinoma of the breast who refused surgery on several counts. Namely, she was too old, fear of treatment as a clinic patient, no one to care for her after dismissal from the hospital, and could not afford the hospital bill. Worker told the patient that she could not be forced into the hospital, however, informed her that her condition would become worse and surgery at this time could prolong her life. Worker tried to convince patient that clinic patients were treated like private patients in the hospital and as far as hospital bills were concerned, worker would see to it that she would be hospitalized on a Community Fund bed. Patient was also encouraged by telling her that upon dismissal from the hospital, house-keeping services could be secured for the patient. Finally, the patient was hospitalized and after two weeks, related to the worker how sorry she was for not consenting to surgery upon the first recommendation.

Four of the hospitalized home care patients had small children about whom they were concerned. In these cases the worker was able to secure housekeeping facilities from private or public agencies to care for the children during the day and made plans with relatives to care for the children in the evenings.

Hospital Bills

The problem of finance was not too apparent, as far as the home care patients were concerned. Thirty-four of the

hospitalized patients were receiving public assistance benefits and these agencies paid for the recipients' expenditures while hospitalized. The hospital, however, has an agreement with the agencies, whereby the hospital charges such patients a much lower rate than the ordinary private patients pay for the same service. The remaining six patients, who were not recipients of public grants were placed on a community fund bed if not financially able to pay for their own hospitalization.

Future Adjustments

The patients on home care, all had anxieties over future adjustment following their discharge from the hospital. In an acute illness, once the patient is discharged from the hospital, the patient is usually ready to resume normal living. Not so the patients who are on home care. Even though the acute episode has subsided and the progress of the illness has been temporarily arrested, the illness may continue as long as the patient lives and gradual deterioration or an acute flare-up can be expected. The patients who eventually became active on home care had such worries as to where they would go after being discharged, and where they could obtain the medical care they needed. This par-

ticular problem was a rather difficult situation since most of the patients had families and the social worker was anxious to have them return to their own home, recognizing that a period of adjustment would be necessary. However, meeting the social needs of the patients was not sufficient since the patients would need follow-up medical care. Since the patients are active in the clinic, it is obvious that they could not afford private care. It was because of the recognition of these needs and the fact that hospital beds were being occupied for long periods of time that the home care program was organized. Therefore, the social worker was instrumental in meeting the future needs of these patients by contributing to the Administrative Committee of Mercy Free Dispensary the knowledge she had concerning a most important factor, namely, the social, medical, emotional needs of the patients.

Conclusion

In this chapter, the problems confronting the patient while hospitalized were considered and the contribution of the social worker has been pointed out. Furthermore, the importance and the responsibility of the professional team, namely, doctor, nurse, social worker, working closely together for the welfare of the patient was also clarified.

CHAPTER V

ROLE OF SOCIAL WORKER IN THE HOME CARE PROGRAM

This chapter will be concerned with the role of the social worker in the home care program. The presenting problems of the patients will be discussed, services rendered and case illustrations will be presented. In order to have a better understanding of what the program has attained, the present disposition of the patients, at the time the study was made, will also be given.

Before describing the actual role of the worker, it seems advisable to indicate the plans made by the executive committee of Mercy Free Dispensary for the role of the worker.

After thoughtful consideration and planning, it was decided by the executive committee that the role of the social worker was to be confined to four areas: namely, case selection, preparation of the patient and family, and rendering social service to the patient in the home.

Decision as to which patients might most effectively use home medical care in relation to their needs was placed with the director of the home care program. Once the

patient has been approved medically for the home care program, he is then referred to the medical social worker for an evaluation of the social situation. Before initiating this service, the committee also felt there would be a more effective working relationship between the medical staff and social service if the caseworker would secure from the doctor some understanding of the care program. He is then referred to the medical social worker for an evaluation of the social situation. Before initiating this service, the committee felt there would be a more effective working relationship between the medical staff and social service if the worker would secure from the doctor some understanding of the patient's exact medical needs, what might be expected in the way of change in the patient's medical needs, how much medical and nursing supervision would be necessary, what the patient could be expected to do for himself and what the doctor felt needed to be done

Hence, the social worker assumed the responsibility of gathering data in relation to all of these points, as well as data relating to the physical set-up of the home, financial situation, patient's attitude toward himself and his illness, the family's attitude toward the patient and what his illness meant to them. Because of the extensive work with

the patient through the various phases of his illness, it is felt that the worker in the home care program has good insight into the patient's feelings and also knows what can be expected from his family.

Home Evaluation

Since the home care program was new and the visiting of homes could be considered a new experience, the executive committee compiled the following form listing suggestions for the social worker to use as a guide in making a home evaluation.



SUGGESTIONS FOR SOCIAL WORKERS MAKING HOME VISITS⁴

1. Identifying Data
2. Type of home
Floor, number of rooms, heat, water, bathroom, entrance to home.
3. Patient's sleeping arrangements. Needs of particular diseases including: bed pan, heating pad, hospital bed, wheel chair, any other appliances. Is bedding adequate?
4. Makeup of family. Membership, employment, relationship to patient. Who is responsible for the care of this patient? His attitude, Patient's reaction to this person
5. Family's knowledge of disease and acceptance of it and the patient
How did patient react in previous life?
How did he meet his problems?
6. Evaluate functional component. If there is a strong functional element, give a more complete social history
7. Social worker's evaluation of the goals for home care

Home Evaluation of the Sixty-Seven Cases Studied

Using the foregoing suggestions, the worker evaluated the homes of the cases studied in this project. With the exception of five cases, all of the homes were considered adequate. These five cases were mutually accepted by the medical doctor and worker until some plan for nursing home care could be made. However, in considering the economic standards of these patients, it is rather obvious that few

⁴ Minutes of the Executive Committee Meeting on Home Care Program at Meroy Free Dispensary, January, 1952.

of the homes were outstanding as far as physical comforts. However, the worker found that even though the physical condition of the home and the economic status of the family may not have measured up to what might be considered satisfactory, that a favorable home atmosphere, a stable social situation, strong family ties, a basic acceptance of the patient can outweigh and overcome physical inadequacies.

Conference with the Doctor

After making the home visit, the worker has a conference with the doctor within a day or two following the home visit. At this time the worker presents a summary of her evaluation and makes her recommendation as to the suitability of the home and the family to the home care program. In discussing the sixty-seven cases with the doctor, both the medical director of the home care program and the social worker mutually agreed that these patients could be accepted for the program.

Planning with the Patient and Family

Once the patient has been accepted as a suitable candidate for home care, the patient is brought into the actual planning. The doctor has the responsibility of informing the patient that he is medically ready to leave the

hospital or that his condition is such that continued out-patient visits are no longer advisable. The sixty-seven patients constituting this study were all acceptable of the program after discussing their feeling with the doctor and the social worker.

Number of Visits

In addition to the home visit that is made in evaluating potentialities of meeting the requirements or standards for the home care program, there is no set pattern as to the regularity of visits. In the case of the patient being dismissed from the hospital, however, the worker attempts to visit within a few days from the date of discharge in order to assure the patient of the Dispensary's continued interest. Further visits are dependent upon and related to the adjustment the patient is making in the home.

Presenting Problems of Home Care Patients

Once the patient becomes active on the home care program, there are new problems and adjustments to be made. The sixty-seven patients constituting this study presented the following difficulties: Adjustment in the home, conflicts over patient's dependency, need for homemaker service, occupational therapy, nursing service and religious difficulties.

Twenty of the patients on home care had difficulty in making an adequate adjustment in their homes. Eight of the patients became so accustomed to dependency in the hospital they feared the return of self responsibility which home care implies. These patients expressed to the caseworker their anxieties and fears over the lack of medical facilities they might need in their own homes. The worker was able to allay their fears thru interpretation of the aims and purposes of the program. Furthermore, patients were given the assurance that if they needed hospitalization, the Dispensary would make every attempt to hospitalize them. The remaining twelve patients found it difficult to accept the limitations placed on them because of their illnesses. One of the most difficult problems confronting these patients was that of adjustment to their new status in the family. Confronted by their weakness, dependence, and inability to resume their accustomed roles, some of the patients questioned whether or not their families would retain the respect and love for them. The following case will illustrate the difficulties encountered by such patients.

Mrs. Z, a self-reliant, active woman was confined to the hospital for several months. The prospect of returning home a semi-invalid and dependent upon her grown children filled her with fear and

apprehension. During her period of convalescence in the hospital, the worker discussed plans for her return home. In the beginning the patient could not be reached but through the supportive help of the worker, she consented to the plan of home care.

Upon her return home, the patient's reaction was one of utter discouragement and she requested being placed in a convalescent home. The worker visited Mrs. Z. frequently and gave her continued encouragement. Gradually the patient began to see some progress in her limitations and began to assume some of the responsibilities she had before her illness. Although the patient did not take on her former role in the home, she did make an adequate adjustment to the program and realized how much she was needed and wanted by her family.

Homemaker Service

Four of the patients on home care were in need of homemaker service. These patients were suffering from cancer, were confined to bed and their prognoses became progressively worse. Two of these patients had small children and their anxieties were most severe because of the fear about future plans for their children following death. The following case will clarify the problem and the service rendered by the social worker.

Patient was forty-five years old, a widow having four small children. The diagnosis was cancer of the cervix. Patient accepted her illness and took care of her home until her condition warranted complete bed rest. Patient was continually worried about the welfare of her children.

Worker arranged for a housekeeper through the Catholic Charities to be with the family during the day. The worker contacted her relatives and they took turns staying with the patient after the housekeeper went home.

Worker held frequent interviews with the relatives and discussed plans for the children. Two of the patient's married sisters were anxious to take the children into their homes. Worker knowing the stability of the patient, was able to discuss these plans with her and the patient was most pleased to learn that her relatives were going to care for her children. Patient died within a short time and the children went to the relatives' homes and have made a good adjustment.

Occupational Therapy

One of the patients on home care was in need of occupational therapy. This patient is a sixteen year old girl who had rheumatic fever when eight years old. A year ago she had a circular vascular attack and her right side is paralyzed. The worker was able to arrange an occupational program through the Illinois Association for the Crippled. At the time the study was made, patient was making link belts, weaving place mats and rugs. Because of this program the patient is a much happier and better adjusted individual.

Nursing Service

Thirty of the patients on home care were in need of nursing service. Where such service is indicated, the pro-

blem was discussed with the medical director of home care, who, in turn, filled out the form for the Visiting Nurses Association. The worker then sent this recommendation to the Central Office of the association and usually, the nurse made her first home visit within a week.

Religion

One patient suffered anxieties and guilt related to religious conflict. The patient, a Catholic, married his wife outside the church and discontinued his religious practices. Patient had cancer of the lung and was aware of his prognosis. He expressed the desire of wanting to come back to the church but did not want to hurt his wife's feelings. Patient was most devoted to his wife and the most intensive interpretation and encouragement to contact a priest was completely rejected by the patient. Worker, through her many home visits, had established a good working relationship with the patient's wife and on one of these visits indirectly introduced the subject of religion. The wife immediately took up the suggestion and discussed her husband's religion with the worker. Actually, the wife was worried about the situation but hesitated discussing it with her husband since it seemed to be a closed subject. Worker encouraged her to talk to him about it, stating that the worker felt that the patient

was very much concerned. As a result, the patient returned to the Church and received the last rites a few days before his death

Patient's Adjustment To Home Care

Sixty-seven patients apparently made a satisfactory adjustment to the program. However, the type of patient on the home care program, because of his financial dependency, is usually most accepting of the medical services rendered him. The case records, however, have direct statements made either to the doctors on home care or to the social worker indicating that the patients are being benefited and making good adjustment in their homes with the assistance of the home care program.

Families' Attitude to Home Care Program

The families of patients on home care were most appreciative of the services rendered to their loved ones. Case records point out the fact that home care allowed for excellent care at a minimum expense and gave the patients a feeling of support and security.

Present Disposition

At the time this study was made, two years after the program began to function, the present disposition of the sixty-seven cases studied is as follows: Twenty-six of the

patients are still active on the home medical care program. Twelve of the patients were rehabilitated through the care received at home to the degree that they were able to return for continued treatment in the out-patient clinic. In one case, due to the illness of a daughter who was caring for her mother, it was necessary to make arrangements for a nursing home for this patient. Twenty-four of the patients died (Seven of these died at home and four were hospitalized and died at Mercy Hospital). The remaining thirteen patients died at Cook County Hospital. It was necessary to refer these patients to Cook County Hospital because there were no clinic beds available at Mercy Hospital.

Conclusion

The activities or role of the social worker in the home care program have been discussed and illustrated in this chapter. In addition, problems encountered and services rendered to meet these problems have been highlighted in an effort to illustrate the complete picture of physicians, social workers and patients working together toward the patient's maximum adjustment through the effective use of the home care program.

CHAPTER VI

CONCLUSION

This study has been concerned primarily with the role of the social worker in the home medical care program. In order to facilitate the analysis, description and evaluation of the role of the worker more accurately and completely, the worker's activity and service have been considered.

The varying problems of the patients were manifest from the time they became active in the dispensary as out-patients. The problems of the out-patient were chiefly domestic disturbances, financial, housing, transportation, and adjustment to illness. Immediate services when possible, were proffered toward alleviation of these difficulties.

As the patient passed into the second phase of illness, namely that of hospitalization, different problems, having a new and frightening effect, faced the patient. These patients manifested fear and anxiety over hospital experience, hospital routine, concern about children left at home, and future adjustment. It has become apparent that a patient in relationship with a social worker is better able to

discuss these problems and the worker, through conference with the doctors and nursing staff, may then be able to contribute sufficient support to see the patient through his hospital experience.

The acceptance by the patient of the fact that his activity must be curtailed indefinitely or for a period of time, proved a problem area of considerable magnitude.

Through the organization of the home care program, a definite plan and procedure was established which enabled the patient to accept his illness more realistically and with greater security and hope for the future.

The process of establishing patient eligibility for the home care program is instituted by the social worker in her early service of home evaluation. At this time, family cooperation and activity is also initiated by the worker toward the patient's adjustment at home in mutual discussion and planning with them. As this study would seem to indicate, social service was able to alleviate in varying degrees, problems of patient dependency, domestic and religious conflict, disturbance in family relationships, and was instrumental in securing housekeeping and nursing service.

The necessity for seeing the patient in his social

setting has heightened the medical social worker's understanding of generic casework principles and also helps her to clarify the essential function of medical social work as it is related to ill people. Furthermore, the program is instrumental in enabling the medical social worker to interpret the intrinsic nature and function of social work to the hospital administration, the medical staff and the community.

The program has also offered the medical students the opportunity of working with the patient in his natural environment, which affords the student the opportunity of understanding the interplay between personality, social factors and disease.

The program is also helpful to the patient. The term "chronic disease" and its implications to the patient, and their families lose much of their threat. Seeing the patient in his own home emphasizes that the illness, disabling as it might be, does not rob him of his place as a person in the family and the community, or of his dignity as a human being and his right to live a full life.

As a result of this study, question has arisen with regard to several points which may be of interest for

future study. It will be noted that the number of patients attending Mercy Free Dispensary are predominantly negro; yet the number of negro patients on the home care program is a minority of nineteen. Secondly, it has been observed that thirteen of the home care patients died at Cook County Hospital for lack of clinic beds at Mercy Hospital, while one of the purposes of the program has been to make clinic beds available for the patients. While no conclusion can be drawn from these observations, it is hoped that further attention and study may be initiated in the future and that, if such problems actually exist, they may be alleviated.

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SCHEDULE

SOCIAL HISTORY

- | | | |
|---------------------|------------------------|----------|
| 1. Sex | 2. Race | 3. Birth |
| 4. Marital Status | 3. Religion | 6. Rent |
| 7. Number of Rooms | 8. Members in the home | |
| 9. Financial Status | | |

MEDICAL SOCIAL BACKGROUND

- | | |
|---|-----------------------|
| 1. Date of Admission to clinic | |
| 2. Clinics Attended | |
| 3. Diagnostic Evaluation | |
| 4. Number of Visits with Social Worker | |
| 5. Presenting Problems | 6. Services Rendered |
| Domestic Difficulties | Supportive Therapy |
| Finance | Financial Aid |
| Housing | Interpretation |
| Transportation | Caf Facilities |
| Adjustment Illness | |
| 7. Date of Hospitalization | |
| 8. Medical Therapy Rendered | |
| 9. Number of Hospital Visits by the Social Worker | |
| 10. Presenting Problems | 11. Services Rendered |
| Anxieties over children at home | Housekeeping Service |
| Hospital Expenses | Financial Aid |
| Problems of adjusting to hospital routine | Interpretation |
| Anxieties over future adjustments | Supportive Help |
| 12 Date of Referral to Home Medical Care | |

13. Reason for Referral to Home Medical Care
14. Preparation of the Patient
15. Planning with the family
 - Needs of the patient
 - Interpretation
 - Prognosis
20. Number of Interviews with family members
21. Presenting Problems
 - Adjusting in the home
 - Conflicts about patient's dependency
 - Homemaker's Service
 - Occupational Therapy
 - Nursing Service
22. Services Rendered
 - Casework service with patient and family for better understanding
 - Securing occupational therapy
 - Arranging for the Visiting Nurses Services
 - Medication
 - Discussing case with the Doctor
 - Interpretation and supportive help given to the patient
23. Patient's adjustment to Home Medical Care
 - Patient's statements to the doctor
 - Patient's statements to the worker
 - Patient's statements to the family
24. Family's attitudes to the Home Medical Care Program
 - Negative
 - Positive
25. Present Disposition
 - Case still active with Home Medical Care
 - Case referred back to the Out-patient Clinic
 - Case referred to a Convalescent Home Reason
 - Patient deceased
 - Date

Where

Home

Mercy Hospital

Cook County

Elsewhere

26. Reason for Referral to Cook County Hospital

Patient's Request

Financial Problems

No clinic beds available at Mercy Hospital