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The Services Rendered by the Medical Social Worker in the Area of Discharge Problems of the Chronically Ill Service Patients Hospitalized at Mount Sinai Hospital, Chicago, Illinois, for a Period of Four Weeks Or Longer During 1951

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THE SERVICES RENDERED BY THE MEDICAL SOCIAL WORKER IN THE AREA OF DISCHARGE PROBLEMS OF THE CHRONICALLY ILL SERVICE PATIENTS HOSPITALIZED AT MOUNT SINAI HOSPITAL, CHICAGO, ILLINOIS, FOR A PERIOD OF FOUR WEEKS OR LONGER DURING 1951

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TABLE OF CONTENTS

Chapter		Page
	LIST OF TABLES	iii
	INTRODUCTION	v
	Purpose of Study--Method of Study--Setting of Study	
I	CHRONIC ILLNESS AND ITS SOCIAL IMPLICATIONS	1
II	DESCRIPTION OF PATIENTS	19
III	THE MEDICAL SITUATION OF THE PATIENTS . . .	34
IV	ATTITUDES OF PATIENT AND RELATIVES TOWARD DISCHARGE AND SOCIAL SERVICE ACTIVITIES	50
	SUMMARY AND CONCLUSIONS	73
	BIBLIOGRAPHY	79
	APPENDIX	83

LIST OF TABLES

Table		Page
I.	CLASSIFICATION ACCORDING TO RACE	20
II.	CLASSIFICATION ACCORDING TO RELIGION . . .	22
III.	CLASSIFICATION ACCORDING TO SEX	23
IV.	CLASSIFICATION ACCORDING TO MARITAL STATUS	24
V.	CLASSIFICATION ACCORDING TO MARITAL STATUS IN RELATION TO LIVING ARRANGEMENTS	27
VI.	CLASSIFICATION ACCORDING TO SOURCE OF INCOME	28
VII.	CLASSIFICATION ACCORDING TO SOURCE OF REFERRAL	30
VIII.	CLASSIFICATION ACCORDING TO AGES OF PATIENTS	33
IX.	CLASSIFICATION ACCORDING TO AGE INCIDENCE AND DISEASE	43
X.	CLASSIFICATION ACCORDING TO DAYS HOSPITALIZED	47
XI.	CLASSIFICATION ACCORDING TO PREVIOUS HOSPITALIZATION DURING CALENDAR YEAR 1951	49
XII.	CLASSIFICATION ACCORDING TO MEDICAL RECOMMENDATIONS AND DISPOSITION BY MEDICAL SOCIAL WORKER	53
XIII.	CLASSIFICATION ACCORDING TO ATTITUDE OF PATIENTS IN RELATION TO ACCEPTANCE OF MEDICAL RECOMMENDATIONS	60

Table | Page

XIV. CLASSIFICATION ACCORDING TO DAYS BETWEEN MEDICAL DISCHARGE AND ACTUAL DISCHARGE OF PATIENTS 62

XV. CLASSIFICATION ACCORDING TO PRINCIPAL SERVICES RENDERED BY THE SOCIAL SERVICE WORKER 66

XVI. CLASSIFICATION OF COMMUNITY RESOURCES USED BY SOCIAL SERVICE IN DISCHARGE PLANS 68

XVII. CLASSIFICATION ACCORDING TO TYPES OF SERVICES REQUESTED BY SOCIAL SERVICE FROM COMMUNITY AGENCIES 71

INTRODUCTION

During the last twenty-five years we have recognized the fact that chronic diseases now constitute one of the major public health problems. They are responsible for far more illness and disability than are acute diseases and are the causes of more than half of all deaths. Today, in a period of full employment, the biggest single factor creating need for assistance is chronic invalidism.

With advances in the prevention and treatment of communicable disease and with the increasing number of aged persons, among whom chronic disease is most prevalent, we are confronted with an urgent need for taking stock of the adequacy of existing facilities to meet this problem.

This study is based on the analysis of the services rendered by the medical social worker in the area of discharge problems of the chronically ill service patients hospitalized at Mount Sinai Hospital, Chicago, Illinois, for a period of four weeks or longer during 1951. The minimum hospitalization period of four weeks has been selected in order to endeavor to separate the

acutely ill from the chronic sick and the year of 1951 has been selected since this will give us the most representative, current picture of the problem.

PURPOSE OF STUDY

The purpose of this study is: (1) to explore the problems created by chronic illness upon discharge from the Hospital; and (2) to describe and define the activities of the medical social worker in working out discharge plans with the service patients.

During this period, there was a total of 166 patients hospitalized for a period of four weeks or longer. Out of this group, eighteen were premature babies and twenty-one patients expired. Our study, therefore, is concerned with 127 patients. Approximately half of this number, namely, sixty-three, were referred from the Out-Patident Department, seventeen were referred from the Emergency Room of the Hospital, forty-one were referred from private doctors and six patients were referred by agencies in the community. These patients ranged in age from approximately one month to eighty-nine years of age.

The Mount Sinai Hospital is a 337 bed non-sectarian, voluntary hospital situated on the West side of the City of Chicago. It is affiliated with the Jewish Federation of Chicago and receives its funds from this source as well as from the Community Fund and affiliated auxiliaries. The Hospital is governed by a board of directors, who establish basic policies. It is the responsibility of the Director and Associate Director of the Hospital to see that these policies are adhered to. Each department head is responsible for the proper functioning of his department to the Director and Associate Director.

This Institution has been affiliated with The Chicago Medical School since 1947 and serves as a teaching institution for third and fourth year medical students. The School of Nursing is accredited for collegiate training.

The Hospital conducts monthly Public Health Forums which is open to the public. The purpose of these forums is educational. Current medical problems are presented to the public by outstanding doctors in the field of medicine and psychiatry.

This Hospital, staffed by approximately three

hundred doctors, serves both private and service (ward) patients in the community. Out of a total of 12,797 patients hospitalized in 1951, two thousand and twenty-four were service patients.[1]

The patient's eligibility for service hospital care is determined by a budget which is formulated by the Council of Social Agencies and by the extent of medical care the patient requires. Patients accepted for hospital care are assigned to the wards. The medical staff assigned to the wards assume responsibility for these patients. A service patient receives any auxiliary care which his medical condition requires and the medical staff recommends. For example, if his condition is such that he requires a private room, special nursing care, transfusions, expensive medications or appliances, the patient will secure these regardless as to whether he or his family can meet any part of the cost thereof. Service patients may receive totally free care or pay any amount up to $7.50 per day for complete medical care.

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1 Annual Report of the Director of Mount Sinai Hospital for 1951.

The Hospital administrators have been endeavoring to follow long range plans for expansion and research. In the last few years, they have added the tenth and eleventh floors to the main building; they have also erected a modern nurses' home and interns' quarters. At present, an eleven story building is being built for the purpose of housing research and laboratory facilities.

This Institution operates an out-patient department for the care of the medically indigent. This Department consists of sixty-nine specialty clinics, staffed by 260 doctors of whom the majority are on a voluntary basis. The responsibility for the operation of the Out-Patient Department is a dual one. The Medical Director is responsible for the direction and supervision of the medical staff and the medical care program. The Supervisor of the Out-Patident Department is responsible for the administrative functions. In 1951, six thousand and ninety-four indigent patients made 61,662 visits.[2]

The patient's eligibility for clinic admittance is set up by a budget which is formulated by the Council

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2 Ibid

of Social Agencies and used by the various, recognized clinics throughout the City.

Recognizing the ever-increasing number of aged patients and the problems which they present, the Out-Patient Department has established a Geriatric Clinic to deal more effectively with the medical and social problems which affect this group.

The Social Service Department consists of four professional workers and a supervisor. The workers are responsible for both hospital and clinic patients. The workers carry the same services in both the hospital and clinic. This serves a dual purpose, namely, continuity of service to the patients and medical follow-up of patients known to the individual worker. It is the goal of the Department to have 100 per cent coverage of all hospital service patients and clinic patients presenting serious diagnoses. Other patients who appear to have social or emotional problems hindering their response to medical treatment are referred by the medical staff for social evaluation in order that the information obtained may be used to assist the medical team in planning towards full recovery. Other referrals to Social Service are from patients and their families and from other

agencies in the community. The worker functions most successfully in the close working relationship of the medical team, namely, the doctor, the nurse and the social worker. In a medical setting, the social worker who endeavors to fulfill her case work goals must at the same time meet her responsibility towards the hospital and the medical staff.

In all general hospitals, there is a group of patients which is attracting the increased attention of administrators, medical staff and social workers. The large number of chronically ill persons in general hospitals who require long term care represents a serious problem.

Mount Sinai Hospital, which is the setting of this study, is a general hospital and has been set up for the care of the acutely ill. While the social worker's function is to meet the patient's needs, she also has a responsibility to help the Hospital fulfill its function of administering care to the acutely ill. In this area, her efforts must be directed towards discharging the chronic patients as quickly as possible after they have recovered from the acute exacerbation and have received maximum benefit from their Hospital stay.

CHAPTER I

CHRONIC ILLNESS AND ITS SOCIAL IMPLICATIONS

The word "chronic" comes from the Greek Chronikos, meaning time. "Chronic Disease has been defined for administrative purposes as a disease that may be expected to require an extended period of medical supervision or hospital, institutional, nursing or supervisory care."[1]

Chronic invalids have been defined as those "persons who have been or are likely to be, incapacitated by disease for a period of at least three months, that is, unable to follow the daily routine of the average, normal person, and whose incapacity will probably continue for an indefinite period."[2]

While chronicity is a relative concept, so that no classification of disease as acute or chronic can be

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1 Vlado A. Getting, "A Coordinated State Program for Chronic Illness", American Journal of Public Health, XL, October, 1950, 1251.

2 Dwight H. Green, "Nature of Chronic Disease", Interim Report to Sixty-Fourth General Assembly, Springfield, Illinois, June 7, 1945.

absolute, the following differentiations between acute and chronic diseases have been made by Dr. Haven Emerson:

> The first point in the differentiation between acute and chronic disease is duration of illness. Fundamentally, the chronic patient differs from the acute in that the former suffers from a disease which is of comparatively long duration, while the latter suffers from a disease, often the same disease, which is of comparatively short duration. One person may react acutely to a disease that might make another a chronic invalid. There is no sharp dividing line between the two.
>
> The second point in the differentiation between acute and chronic disease is curability, which has a subtle but potent influence on hospital policy. There was a time, not so long ago, when the mortality rate was taken as an index of the efficiency of a hospital. Unfortunately, a high percentage of cures is similarly considered in many quarters as an index of efficiency in a hospital. Obviously, institutions caring for chronic disease cannot show a low mortality rate or a high percentage of curability. The acutely sick patient is, in most instances, curable. His prognosis is good. The general mortality rate is relatively low among acutely ill hospital patients. Chronic disease, on the other hand, is not only long drawn out, but often incurable by any known methods of therapy. Chronic disease is almost never self-limited. The prognosis is not often good. The ultimate mortality rate is relatively high.
>
> The third point of differentiation between the two types of patients depends upon their emotional attitude. In the long-suffering patient, the emotional attitude is one of resignation (though he is not, of course, reconciled to his illness), while that of the acutely sick patient is one of aggression. In the acutely sick patient the battle rages fiercely, with all offensive and defensive weapons in play.

> In the long-term patient the time element, as well as the weapons, change the picture. His problem does not have a medically urgent character, the edge having been worn off his signs and symptoms. He, therefore, does not invite an immediate response by the community. Whatever urgency there may be to his problem is largely social. Provision for his care must, however be made, particularly in those instances where housing problems are involved.
>
> Another distinction refers to the age of the patient. The majority of acutely sick patients arein the younger decades of life, while the majority of chronically sick patients are in the older age groups. The younger are naturally better fitted to struggle with disease than their elders who have, in most instances, the handicap of an accumulated medical history as well as age.[3]

One of the principal causes of the increasing prevalence of chronic disease has been the advance in medical and surgical care which has prevented death and produced an aging population.

> Two thousand years ago, the average length of life was twenty-five years; at the turn of the century, it was forty-nine; today it is sixty-six.[4]

Over 1,500,000 people in the United States require long-term care because of chronic illness. In addition to this group, there are a great many people who

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3 Haven Emerson, Administrative Medicine, New York and Edinburgh, 1941, 97.

4 Howard A. Rusk, "Dynamic Therapeutics in Chronic Disease", Postgraduate Medicine, V, 4, April, 1949, 278.

require care because of other physical handicaps and impairments, such as blindness, deafness and orthopedic disabilities.[5]

Another important cause in the increase of the number of the chronically ill is the lack of attention given to chronic disease patients. In the past, control of the acute infectious diseases was emphasized. With victory over these diseases, scientific effort and research has been directed towards the chronic diseases. Today acute disease is still emphasized, and time and money is willingly spent for victims of emergencies. Long-term illness, in contrast, had been treated for a long time as the stepchild of modern medicine. From the viewpoint of the physician, the long-term patient represents a difficult problem in medical science, requiring skill, originality, sustained interest and great patience. In medical schools, teaching is still geared to acute conditions while chronic diseases are relegated

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5 Howard A. Rusk, "Dynamic Therapeutics in Chronic Disease", Postgraduate Medicine, V, 4, April, 1949, 278.

to the back wards.[6]

The health standards of a nation or a community can be measured only by the standards maintained by its people, and chronic diseases bring serious helplessness and suffering to individuals, thereby lowering the general health level of any community.

A basic change is required in society's traditional attitude towards chronic illness and its victims. One of the great needs is provision for total treatment of the chronically ill patient in terms of his whole problem. There must be a realization that much illness of this type can be prevented and that many persons heretofore regarded as inevitably disabled can be rehabilitated to lead useful, happy lives. This conviction is the starting point for any genuine program of chronic disease control.

In order to fully comprehend the magnitude of this problem, we should know something about the origin of chronic disease, what chronic diseases are, what proportions of the chronically ill become invalids, what

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6 Jurgen Ruesch, "Mastery of Long-Term Illness", Medical Clinics of North America, March, 1943, 435. (This book is still being used as a text book.)

effect it has on the patient, his family and the community.

Dr. Ernest P. Boas has described the origin and incapacitating nature of chronic diseases as follows:

> Chronic diseases are for the most part obscure in origin, although a number of the infectious diseases, in particular, tuberculosis, syphilis, and the several forms of rheumatism are responsible for much chronic disability. Among the many diseases of unknown origin the most important are diseases of the heart, arteries, kidneys and liver, organic affections of the nervous system, mental disorders, cancer, non-tuberulous diseases of the lungs, such as asthma, the various forms of rheumatism, diabetes mellitus and other disturbances of the glands of internal secretion or of metabolism.
>
> Physical incapacity arising from these diseases is at first insignificant but gradually assumes even greater proportions. In the earlier stages of his illness the subject of a chronic disease is ambulant and able to work, but gradually he becomes more and more disabled and eventually becomes an invalid.[7]

The Surgeon General of the United States Public Health Service has repeatedly referred to chronic illness as this country's "Number One Health Problem". There is hardly a family, one member of which is not stricken by some such illness as heart disease,

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7 Ernest P. Boas, The Unseen Plague Chronic Disease, New York, 1940, 4.

rheumatism, cancer or diabetes. This is partly borne out by the fact that there are approximately ten thousand people in Illinois alone who are invalids as a result of rheumatism or arthritis and almost that many that are incapacitated by heart disease.[8]

Affliction with a chronic disease is too often considered as a part of the penalty of growing old. Chronic illness covers a multitude of conditions, age groups and economic-social levels. A National Health Survey conducted in 1945 showed:

> The incidence per one thousand rises sharply from twenty to fifty years and much more sharply thereafter. For all ages, the incidence rate per thousand persons is 177, and for those in the age group sixty-five to seventy-four, it stands 467.1 per one thousand.[9]

The economic aspects of chronic illness is therefore emphasized. Prolonged illness produces serious problems both to the patient, the family and the community. When illness occurs, there is an immediate

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8 Ellen C. Potter, "Chronics Can Be Cared For Now", Hospitals, XVIII, No. 5, May, 1944, 33.

9 Howard A. Rusk, "Dynamic Therapeutics in Chronic Disease", Postgraduate Medicine, V, 4, April, 1949, 279.

disruption of the routine of family life, additional economic problems arise and must be met. Whatever funds may have been available at the onset of prolonged illness are seldom enough to carry a patient beyond the acute phase of his disease.

When the wage-earner himself is ill, the principal income is lost to the family, and if there are no savings, complete dependency soon follows. Relatives sometimes can help in emergencies, but cannot do so indefinitely. If the patient is the wife, the husband may be forced to work irregularly in order to stay with her, or he may have to employ someone to help in the home. It might even become necessary to board out his children. This puts an additional strain on his income, which in a large measure is being used to pay current medical expenses. Among the poorer classes these difficulties are accentuated and chronic illness leads to economic catastrophe. Even families of the so-called middle class experience great difficulty in financing the cost of chronic illness, and are gradually pushed to destitution by the continuous financial drain of chronic illness.

A short term illness may or may not be an

expense to the patient, but a long drawn out illness is almost always an expense to the community.

Today, in a period of full employment, the biggest single factor creating need for assistance among families throughout Illinois is chronic invalidism. A report given by Miss Edna Nicholson, Director of the Chicago Central Service for the Chronically Ill, on April 10th, 1945, estimates that there were twenty-five thousand to thirty thousand invalids in Illinois who were in need of financial help in meeting the cost of adequate medical care, or would be within the immediate future.[10]

A study made in 1947 by the office of the Executive Secretary of the Illinois Public Aid Commission revealed that twenty-three per cent of all public assistance recipients were chronic invalids and that this group accounted for over $25,000,000 of the State's annual expenditures of $105,000,000 for all types of

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10 Dwight H. Green, "Nature of Chronic Disease", Interim Report to Sixty-Fourth General Assembly, Springfield, Illinois, June 7, 1945, 8.

public assistance.[11]

It is quite evident from these figures that the entire community feels the impact of chronic illness both directly and indirectly. The loss of the productive capacity of any of its members is a serious loss to the community. Added to this is the ill-health, juvenile delinquency and other child-care problems arising from homes broken or disrupted by invalidism and death. We must realize the far-reaching effect of this problem as demonstrated by the heavy economic load which the community must bear in supporting families who have become dependent because of illness.

It is estimated that in Chicago and Cook County, the annual cost of care for invalid persons during 1947 amounted to approximately fifty million dollars. Many of these persons were cared for in their own homes, others were scattered throughout the community in nursing homes, hospitals, homes for the aged, the Homes for Incurables, the County Infirmary at Oak Forest, and

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11 Raymond M. Hilliard, "Chronic Illness", Survey Midmonthly, November, 1949, 307.

elsewhere.[12]

Every individual is a potential factor in the community. He is either productive or non-productive, independent or dependent. Since ". . . the goal of medical care is to maintain and restore the chronically ill as independent and self-supporting members of the community,"[13] adoption of a new approach to chronic illness is essential. Such an approach should include appropriate emphasis on prevention of chronic illness; on continued study of its causation; on early detection, diagnosis, and treatment; and on planned convalescence and rehabilitation.

The aspect of rehabilitation cannot be overemphasized. In chronic disabilities in which complete restitution to normal can no longer be expected, medical treatment should be directed to arrest the progress of disease, and to enable the patient to maintain or resume

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12 Leo M. Lyons, "Resume of the Problems of Chronic Illness", Hospital Council Bulletin, Chicago, January, 1947, 13.

13 Joint Statement of Recommendations, "Planning for the Chronically Ill", Journal of the American Medical Association, 135, October 11, 1947, 344.

his accustomed place in society and in his family. The patient must be taught to regard his illness not as the focus of his life, but as a handicap to be overcome. Often a patient is advised to leave work and to devote his whole time to his cure, when it would be far better to keep him at his occupation, and to teach him how to adjust to his disabilities. If gainful work and independence are no longer possible, the attempt still must be made to preserve the patient's ego, by keeping him self-reliant. The arthritic or paralytic frequently derives more benefit from the use of his crippled limbs and stiffened joints in routine tasks and caring for his personal needs, than he does from the physiotherapy. With a non-sentimental optimism and a fixed determination, both on the part of the physician and the patient, the utmost in rehabilitation can be achieved.[14]

The psychological approach to the patient and his problems is particularly important in the management of long-term patients. Fundamental to all treatment is the basic realization that the patient must be treated as

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14 Ernest P. Boas, The Unseen Plague Chronic Illness, New York, 1940, 22.

an individual and treated as a whole. "Man is a unity of mind and body, and medicine must consider this unity."[15] Chronic illness has a prfound effect upon the patient's external life, on his occupation, his economic status, on his family relationships, on his daily habits and social intercourse. Often, the patient is overwhelmed by the necessary readjustment of his mode of living and becomes extremely insecure and anxious and needs reassurance.

Patients with disabilities and impairments tend to suffer from isolation and feelings of inferiority and need sympathetic understanding and help. This requires not only understanding and patience but also time.

The psychological management of anxiety is the most essential therapeutic step in any disease. While happiness and joy of living depend upon freedom from anxiety, the stresses and strains caused by anxiety have negative effects upon the physiological processes in the body. Every physician attending to chronic diseases has to be aware of and has to depend upon

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15 G. Ganby Robinson, The Patient As A Person, New York, 1939, 423.

management of anxiety for achieving results with his patients.[16] This presupposes a good doctor-patient relationship, which represents one of the principal tools to induce the patient to use his invalid body the best he can. This relationship was more easily achieved in the days of the family doctor, who knew much about the patient and his family, and often acted in the capacity of advisor. He treated both the disease and the patient. Traditionally, the physician has always had an interest in the social factors of the patient's illness, but his primary professional concern is the patient as a physical organism. Today, in an era of specialization, particularly in an urban community, the doctor's time is greatly utilized in the medical care of the patient. He devotes a great deal of his time to free clinics, to research and to his private practice. This leaves him little, if any, time to devote to the social and emotional problems of the patient.

The medical social worker of today has taken on some of the functions of the general practitioner,

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16 Jurgen Ruesch, "Mastery of Long-Term Illness", Medical Clinics of North America, March, 1943, 442.

supplementing the work of the doctor.

The needs of the sick are rarely simple; more often, they are complex and require several kinds of help at the same time. To help a person towards full recovery depends upon a number of things: the nature of the illness itself, the kind of person who is ill, the social setting of which he is a part, and the resources that are available to him.

The medical social worker discovers the social forces that modify disease in the individual sick and tries to mold the environment of the sick person to the end that it may favor a speedy and complete recovery. She also teaches the patient to adjust to his illness. Medical social work is the application of social case work to medical service.[17] The focus in social case work is on helping the individual make the best possible use of himself and his potentialities within the social world of which he is a part.[18]

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17 Ernest P. Boas, The Unseen Plague Chronic Illness, New York, 1940.

18 Harriett M. Bartlett, Some Aspects of Social Casework in a Medical Setting, Chicago, 1942, 263.

The medical social worker always starts with some understanding of the underlying medical problems secured from the doctor, but her primary professional concern is the person and the social factors in the patient's situation, particularly those factors that have some bearing on the illness. The implications are that there is something within the patient himself or within his environment that is contributing to his illness or that prevents him from traveling a smooth course from illness to physical recovery and from physical recovery to restoration to social functioning. There might be something in the nature of the illness itself that threatens serious and destructive consequences to the patient or the pattern of living he has established for himself. Thus we see that if treatment of a medical problem is to be successful in terms of the life career of the patient, it must frequently include consideration and treatment of the social factors interwoven with it.

The medical social worker functions as an integral part of the "medical team". Her contribution differs from the services offered by the doctor and the nurse, in that she approaches the patient and works with him as a person in a social situation. She includes his

family and the community implications of the problem in her consideration of the situation.

Another contribution by the medical social worker is that of interpreter. Within the hospital where she practices, she interprets the doctor's medical recommendations to the patient, and the patient and his social situation to the doctor and other hospital personnel. Outside of the hospital, she interprets medical recommendations, including restrictions and changes in living habits to the patient's family and to the community.

This role is exceedingly important in relation to chronic illness. The chronic sick demand much more time of the medical social worker than the acutely ill, because a larger proportion require assistance in becoming adjusted to their disabilities. A great deal of her time is spent in making adequate plans for the family during the patient's hospitalization. This is especially true if the patient is the wage earner or the mother in the family. With limited facilities for the care of the chronically ill, the medical social worker is often handicapped in making the best plan for the patient. This places a greater responsibility on the worker for

preparation and interpretation to the patient and the family. The medical social worker must then be able to help the patient accept separation from the hospital to a new environment. The chronically ill who have been hospitalized for a given period of time and have found a certain measure of security within this setting find it more difficult to make this move. They require patient understanding and support. It is clearly evident that the medical social worker has a definite area of function in a medical setting, particularly in relation to the problem of chronic illness.

CHAPTER II

DESCRIPTION OF PATIENTS

The patients included in this study have two things in common; they are medically indigent and they are considered chronically ill because of their period of hospitalization. There are, however, wide variances in this study group, particularly in relation to the ages of the patients, their medical conditions, and their attitudes in relation to discharge plans.

The statistical data secured from the medical and social service records of patients included in this study will give us a description of these patients. This will enable us to better understand the attitude of the patients and their families in relation to discharge plans.

This study includes 127 patients who were hospitalized for a period of four weeks or longer during 1951. Out of this group, fourteen were negro patients and 113 were white patients. This figure may be accounted for by the fact that negro patients with illness involving long periods of hospitalization are often initially referred to Cook County Hospital. While the

number of negro patients represents approximately eleven percent of the total study group, it is of particular significance to the medical social worker in relation to discharge plans. The facilities for post hospital care, such as convalescent homes and nursing homes, are extremely limited for the negro patient in Chicago. Another factor which complicated discharge plans was the poor and crowded housing of these patients, which was not conducive to either convalescence or nursing care in the home of the patients.

TABLE I

CLASSIFICATION ACCORDING TO RACE

Race	Frequency
White	113
Negro	14
Total	127

Another factor which had some bearing on discharge plans was the religion of the patients in the study group. Patients of different cultural and racial backgrounds feel insecure when placed in homes or

institutions foreign to that background.[1] Many patients of the Jewish faith would not accept care at any institution which did not maintain a Kosher dietary. This presented serious complications because of the limited convalescent and particularly nursing facilities which maintain such a dietary. Eighty-four patients, or approximately 66 percent were of the Jewish faith.

The religious factor was also a serious consideration in discharge plans for some of the twenty-five Catholic patients included in the group. Some of the patients, realizing the seriousness of their illness, were anxious to be placed in Catholic convalescent or nursing homes. The problem of limited Catholic facilities complicated discharge plans.

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1 Harriett M. Bartlett, Some Aspects of Social Casework in a Medical Setting, Chicago, 1949, 25.

TABLE II

CLASSIFICATION ACCORDING TO RELIGION

Religion	Frequency
Jewish	84
Catholic	25
Protestant	18
Total	127

Of the 127 patients studied, the female patients showed an increase over the male patients by seventeen. This seems to coincide with a report given by Miss Edna Nicholson, Director of the Central Service for the Chronically Ill of Chicago, in which she states that, "chronic illness tends to strike men and women equally, but that women outnumber men in the higher age group of the population where the incidence of chronic illness is highest."[2]

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2 Edna Nicholson, "Variables in Planning Long-Term Care", Hospitals, XX, February, 1948, 64.

TABLE III

CLASSIFICATION ACCORDING TO SEX

Sex	Frequency
Male	55
Female	72
Total	127

Table IV represents the marital status of the patients. In this group, forty-six patients, or approximately 36 percent, were married, thirty-seven patients or 29 percent were single, thirty-three patients were widowed, and eleven patients were separated.

Dietetic management is always essential in the treatment of illness. This is especially true of chronic disease. Many of the patients included in this study were particularly restricted to special diets. It is of significance to the social worker that patients living with their families are better able to adhere to dietary regulations. Patients living alone have greater difficulty in adhering to diets since these patients usually maintain a sleeping room and eat their meals out. In assisting the patient in making discharge plans, consideration must be given by the medical social

worker to this particular aspect of the patient's medical follow-up.

TABLE IV

CLASSIFICATION ACCORDING TO MARITAL STATUS

Marital Status	Frequency
Married	46
Single	37
Widowed	33
Divorced or Separated	11
Total	127

Another important factor to be considered in relation to discharge plans was the living arrangement of the patients, prior to their admission. Did they have families? Did they live with their families prior to admission, and if so, could they return to them? If not, where could they hope to go when they left the hospital?

"The patient does not exist by himself but as a member of a family . . . The family is the unit of illness, because it is the unit of living."[3] It became

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3 Henry B. Richardson, Patients Have Families, New York, 1945, 94.

important, therefore, to consider the patients as members of family units in relation to discharge plans.

The largest number of this group, namely, forty-six patients, were married and lived with their spouses. They had definite family responsibilities and their illness was a serious factor in the economic and social security of the family unit. The next largest group numbered forty-one patients, and these lived with relatives.

Fourteen of this group were children, eleven of whom returned to their homes. Discharge plans for the remaining three included foster home placement and further hospitalization for a specialized type of surgery. The remaining twenty-seven patients living with relatives included single adults, patients who were widowed, divorced or separated. In this group were included patients who were living with children, both married and single. These people were also part of a family unit and were linked together by residence or kinship.

There was a total of twenty-nine patients living alone, ranging in age from thirty to eighty-nine years. All but four patients were elderly, ranging in

age from fifty to eighty-nine years. This age factor was of particular significance to the social worker in regard to discharge plans. Some of these patients could not return to their former mode of living. Some of these patients did not have any relatives or close friends, and this further complicated discharge plans. With community facilities as limited as they were, the chronically aged presented even more complications in relation to adequate discharge plans.

Six were placed in the category of "Other". These patients had lived in old peoples' homes prior to their admission, five of whom were able to return to these homes. The sixth patient was not accepted by the home after discharge, and it became necessary to make other plans.

Five patients, classified as living with friends, had no family ties.

Summarizing, a total of eighty-seven patients patients or 68 percent of this group were living with their families and had some family responsibilities.

TABLE V

CLASSIFICATION ACCORDING TO
MARITAL STATUS IN RELATION TO LIVING ARRANGEMENTS

Status in Household	Total	MARITAL				
		Single	Married	Widowed	Divorced	Separated
Total	127	37	46	33	8	3
Living with Spouse	46	0	46	0	0	0
Living with Relatives	41	22	0	15	4	0
Living with Friends	5	3	0	0	2	0
Living alone	29	9	0	15	2	3
Other	6	3	0	3	0	0

The ability of the patients to meet any or all of their financial needs after discharge from the hospital must be considered at the time of discharge planning. Table VI indicates that fifty-one patients had already exhausted their resources and were being subsidized by agencies in the community. Fifty-two patients were also being assisted financially by relatives and friends. Only twenty-four patients had private income, including old age and survivors' insurance benefits.

As pointed out in the previous chapter, the

continuous financial drain of chronic illness inevitably leads to destitution. This table bears out these findings, in that a total of one hundred and three patients or 80 percent were completely dependent financially.

TABLE VI

CLASSIFICATION ACCORDING TO SOURCE OF INCOME

Source of Income	Frequency
Private Income	24
Agency	51
Family or Friends	52
Total	127

One of the important aspects in discharge planning is medical follow-up. The basic characteristic of chronic diseases is their long duration. While symptoms may be continuous or remittant, all chronic diseases require medical supervision or care, lasting over a period of months, years or an entire lifetime. It is, therefore, of significance to the social worker to know the sources of referral of the patient to the hospital.

In the following table, the largest group of

patients, numbering sixty-three, were known and referred to the Hospital from the Clinic. These patients presented no particular problem in the area of medical follow-up. All patients who were ambulant were followed up in the Clinic, and those who were not ambulant for a specified period of time were seen in their homes by one of the doctors in the Home Medical Service, available to service patients of the Hospital.

The forty-one patients referred by private doctors were referred back to their doctor for medical follow-up. The seventeen patients who were hospitalized as emergencies directly from the Emergency Room of the Hospital presented problems in medical follow-up.

It was necessary for the medical social worker to explore the source of previous medical care of these patients to ascertain where to refer them for medical follow-up. Contacts had to be made with either the clinic or the private doctor who had previously known these patients to insure continuity of medical care.

The six patients referred by agencies presented no particular problem in relation to medical follow-up. These patients were referred from the Home for Aged Jews which has its own staff physicians.

TABLE VII

CLASSIFICATION ACCORDING TO SOURCE OF REFERRAL

Source of Referral	Frequency
Clinic	63
Emergency Room	17
Private Doctor	41
Agency	6
Total	127

Chronic disease has often been considered synonymous with old age. While many of the degenerative diseases are part of and associated with the aging process, it is an error to consider that chronic disease is merely a problem of old age. According to Milton Terris:

> It was discovered in the National Health Survey that more than three-fourths of the persons with chronic disease and two thirds of the invalids were in the fifteen to sixty-four year age group. More than one-half of the persons with chronic disease and one-third of the invalids were under the age of forty-five, while 16 per cent of the persons with chronic disease and 13 per cent of the invalids were under twenty-five years of age.[4]

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4 Milton Terris, "Chronic Illness", Social Work Yearbook, 1949, 111.

Table VIII gives the ages of the patients in ten-year periods. The number of patients is too small to be statistically significant, since the age distribution in any general hospital follows that of the general population. However, the study group bears out the fact that chronic disease is not exclusively one of old age. Sixteen children under the age of twenty years were included in our group. This is of particular social significance to the social worker. Discharge plans involved consideration of patients' needs, medical follow-up, including serious consideration in relation to rehabilitation and restraining. It was also necessary for the social worker to give interpretation, assurance and support to the parents. The needs of this group of patients is more aptly pointed out by W. Palmer Dearing:

> Many of these young people can be treated successfully, but often at considerable expense to their families and to the community. Others, less fortunate, require special educational programs and placement services if they are to lead adjusted, useful lives. Each time the community allows one of these young people to spend his entire life in inactivity, it sacrifices nearly fifty man-years of productive effort and contented living.[5]

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5 W. Palmer Dearing, "Chronic Illness - The Nation's Number One Health Problem", National Conference of Social Work, New York, 1950, 142.

Thirty-one patients, ranging in age from twenty to fifty years, represented patients chronically ill in the most productive phase of their lives. The age factor is important to social workers in regard to family responsibilities. Chronic illness in the bread-winner or homemaker may not be completely disabling. However, it frequently does cause loss of earnings and requires expensive treatment at the period of life when family financial burdens are greatest. Serious chronic disease often reduces the economic status of the family and disrupts family organization.

Eighty patients, approximately 63 per cent of the total study group, were elderly, ranging in age from fifty to eighty-nine years. The age factor presented serious discharge problems in relation to financing convalescent or nursing care. Chronic disease among the older population comes at a time when their incomes are reduced, and the vast majority do not have the resources to obtain the treatment and the related services they need. Frequently they become economic burdens on children who are trying to provide for their own families.[6]

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6 Ibid., 143.

TABLE VIII

CLASSIFICATION ACCORDING TO AGES OF PATIENTS

No. of Patients	Ages
14	1 month - 10 years
2	10 - 20 years
9	20 - 30 years
9	30 - 40 years
13	40 - 50 years
17	50 - 60 years
31	60 - 70 years
29	70 - 80 years
3	80 - 89 years
127	Total No. of Patients

CHAPTER III

THE MEDICAL SITUATION OF THE PATIENTS

The modern practice of medicine is characterized by the exercise of teamwork in which the doctor assumes leadership and the other professional personnel in the medical organization accept direction and supervision from him.

The special contribution of the medical social worker in this area lies in the relating of medical and social problems connected with the medical care of the patients. The worker explores the situation with the patient and brings pertinent social and emotional factors complicating the illness to the doctor so that the total patient may be treated, not the disease alone. In order for the worker to make this contribution effectively, she must have some basic knowledge regarding health and disease, medical practice, understanding the factor of the emotions and the meaning of behavior in illness.

Before the social worker can explore the social situation, it is necessary for her to know as much as

possible about the patient's medical condition.

We are concerned particularly in knowing about the medical conditions of the patients in the study group. What exactly were the medical problems presented by the group? What relationship did the age incidence have to the disease, if any?

The following classification is not intended to be a complete classification of medical diseases. It is an attempt to list the cases selected for this study in general categories of medical conditions.

Health is a condition in which the organism is in complete adaptation to its surroundings.[1] This definition was adhered to in the designation of these cases as diseases; surgical problems and injuries were also included. A disease is that condition as a result of which the organism suffers from discomfort.[2]

Infectious Diseases include a single case of each of the following: Tuberculosis of the Hip, Rheumatic Fever, Acute Myelitis, Meningo-Encephalitis and

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1 William Boyd, Textbook of Pathology, 5th Edition, Philadelphia, 1947.

2 Ibid., 13.

Chronic Pelvic Inflammatory Disease.

Diseases due to Physical and Chemical Agents: Included are three cases of burns and one case of frost bite, resulting in bilateral amputation of both legs, below the knees.

Diseases of Metabolism: Diabetes Mellitus was the major diagnosis in each of these cases. One of these cases was complicated by Hypertensive Heart Disease and an Infection of a Toe. Another of these cases had the multiple diagnoses of Diabetes Mellitus, Multiple Sclerosis and Rheumatic Heart Disease.

Diseases of the Digestive Tract: Included are two cases of Bowel Obstruction, four cases of Peptic Ulcer, two cases of Ulcerative Colitis and two cases of Gall Bladder Disease.

Respiratory Diseases: Included are three cases of Chronic Bronchitis and one case of fungus disease of the lung, known as Moniliasis. One of the cases of Chronic Bronchitis is complicated by a Lung Abscess.

Genito-Urinary: Included are two cases of infection of the kidney called Pyelonephritis. Calculi of the Urinary Bladder and of the Ureter comprise two other cases. Benign Prostatic Hypertrophy is the fifth case.

The case of Bladder Calculi had an Adenoma of the Prostate Gland as an accompanying diagnosis.

Diseases of the Blood: Included are two cases of Hemolytic Anemia. The third case is a case of Erythroblastosis Fetalis, a disease involving the incompatibility of blood factors between the newborn child and his mother. Hemolytic Anemia is of two types, Acquired and Congenital, and in this table we have an example of each type.

Cardio-Vascular System: Included are ten cases of Organic Heart Disease with some degree of Congestive Heart Failure. There are ten cases of Coronary Heart Disease with Myocardial Infarction, four cases are Cerebral Vascular Accidents, either hemorrhage into the brain tissue or emboli to the vessels of the brain. One case is diagnosed as Luetic Heart Disease. There are six cases of Peripheral Vascular Disease, either arterial or venous insufficiencies. The final case of Polyserositis, a generalized disease which involves effusions of fluid into the serous cavities of the body, namely, the Pericardium.

Endocrine: Included are cases of Thyrotoxicosis, a very serious condition of the thyroid gland in

which a toxic product is eliminated into the blood stream to exert a severe effect upon the metabolism and of the Cardio-Vascular System of the individual. One of these cases was complicated by pregnancy.

Locomotor System: These include problems of muscles, bones and joints. Included are two cases of Arthritis, one case of Chronic Bone Disease and fifteen fractures. Five of this group were Fracture of the Hip, a condition which occurs frequently in the aged group. One of this group is a Post Poliomyelitis.

Nervous: One of these cases is Psychoneurosis and the other is Encephalomalacia, a condition of softening of a portion of the brain in a sixty-eight year old, secondary to a poor vascular supply to that area.

Malignancies: Included are six cases of Carcinoma of the lower portion of the colon, including the rectum. One of the cases is one in which there is also a malignancy of the ovary. There are two cases of Carcinoma of the Stomach; one case of Carcinoma of the Esophagus; one case of Carcinoma of the Cervix, one case of Carcinoma of the Breast; one case of Carcinoma of the Pharynx; one case of Carcinoma of the Lung; one case

of Carcinoma of the Bladder; one case of Carcinoma of the Kidney and a single case of Lymphosarcoma.

Newborn: Included are one case of Congenital Megacolon and one case of Mongolism. Erythroblastosis Fetalis mentioned as a Disease of the Blood, is also one of the diseases of the newborn.

Eye: Included are two cases of Cataracts in the aged group past the sixth decade.

Skin: Among these cases is a single case of Exfoliative Dermatitis, a single case of Neurodermatitis and two cases of Pemphigus.

Others: Included are three cases of Diaphragmatic Hernias and one case of Strangulated Inguinal Hernia. There are two cases of Benign Tumors of the Breast and of the Stomach, respectively. The remaining three cases are undiagnosed.

Surveying the classifications, we find three categories outstanding in incidence. They are Diseases of the Cardio-Vascular System, Diseases of the Locomotor System and Malignancies. Diseases of the Cardio-Vascular System include mainly the Cerebral Vascular Accidents (Strokes), Arteriosclerotic Heart Disease, and Hypertensive Heart Disease, accounting for thirty-two

patients. In addition to the above classification, nine of these patients also were sufferers of Diabetes Mellitus which complicated and aggravated their cardiac condition.

Diseases of the Locomotor System accounted for seventeen patients and included problems of muscles, bones and joints. The cases in this category included two cases of Arthritis, one case of Chronic Bone Disease and fifteen fractures. Five of this group were cases of Fracture of the Hip, a condition which occurs frequently in the aged group.

Sixteen patients in this group were suffering from Malignancies, as more specifically defined in the preceding classifications. These categories partly coincide with the findings of Dr. Edward J. Stieglitz who states that:

> The most common and significant of the long-term illnesses are those commonly designated by the term, "degernative diseases", These include four major groups: Circulatory Disorders, Metabolic Disorders, Malignant Tumors, and the Arthrides.[3]

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3 Edward J. Stieglitz, "Medicine in an Aging Population", Medical Clinics of North America, Philadelphia and London, 1949, 300.

The three large categories of the study group, namely, Diseases of the Cardio-Vascular System, Diseases of the Locomotor System and Malignancies, accounted for sixty-five patients, or 51 per cent, of the total number of patients studied.

The medical diagnoses and disabilities of the patient are of particular importance to the social worker in discharge planning. With this in mind, ideally she should then explore community resources to meet the patient's particular needs. However, with the limited convalescent and nursing facilities, this goal is not always obtainable. From the disease classification of our study group, many serious complications arose in discharge planning.

To cite a few examples, the patient who had bilateral amputation of both legs required nursing care facilities which had a retraining and rehabilitation program.

Some of the patients who had suffered from cerebral vascular accidents presented the same type of problem complicated by the fact that some of these patients were incontinent for urinary and bladder control. One patient was an extremely obese woman and moving or

lifting her out of bed presented an additional problem in finding an adequate nursing home.

Some of the patients suffering from fractures were elderly. These patients heal slowly and are disabled for long periods of time. Discharge planning for these patients, in addition to convalescent care, included training in learning to use crutches without bearing weight on the fractured limb.

Some of the patients suffering from cardiac conditions and malignancies also presented serious discharge problems.

Summarizing, discharge plans were complicated by the fact that these patients required a specialized type of service in a convalescent or nursing home. Furthermore, convalescent or nursing home facilities with specialized programs were exceedingly limited and expensive.

TABLE IX

CLASSIFICATION ACCORDING TO AGE INCIDENCE AND DISEASE

DIAGNOSIS	AGES OF PATIENTS					NO. OF PTS.
	0-25	25-50	50-65	65-75	75	
Infectious Diseases	3	2				5
Diseases Due to Physical and Chemical Agents		2	2			4
Diseases of Metabolism		2	2	3		7
Diseases of the Digestive System	1	5	1	2	1	10
Diseases of the Respiratory System			2	1	1	4
Diseases of the Genito-Urinary System		2	1	2		5
Diseases of the Blood	2		1			3
Diseases of the Cardio-Vascular System		2	8	19	3	32
Diseases of the Endocrine Glands	1	4				5
Diseases of the Locomotor System	8	1	3	4	1	17
Diseases of the Nervous System			1	1		2
Malignancies	1	2	1	8	4	16
Diseases of the Newborn	2					2
Diseases of the Eyes			1	1		2
Diseases of the Skin	1	2			1	4
Others: Hernias, Benign Tumors and Undiagnosed Cases		3	4	1	1	9
TOTALS	19	27	27	42	12	127

Hospital care for the chronic sick is one of the most urgent problems of medical organization today.

There are two schools of thought in regard to the type of hospital care deemed necessary for the chronically ill. Dr. E. M. Bluestone states:

> The hospital bed, which is one of the most precious resources at our disposal for the care of the sick, may be used or misused, depending upon whether or not the patient who occupies it requires intensive scientific care in a hospital. Hospital care is, moreover, an expensive type of medical care and should therefore be limited to the sick who cannot obtain it otherwise. If they can obtain good medical care in any other way, they have no place in a hospital. The indiscriminate assignment of hospital beds regardless of actual need is based on a misunderstanding as to the other possibilities for medical care which can be made available in a community. If the use of hospital facilities is restricted to those who require intensive scientific care, we shall find that more hospital beds are available for more people.
>
> The place of the long-term patient, hitherto known as the chronic patient, in the modern hospital will be more secure in our planning if we restrict the use of hospital facilities to those who need them. The time has come when the hospitalization of the short-term and the long-term patient no longer depend on the duration of illness. Both types of patients must be integrated in the general hospital on a continuing basis, so long as the need for active hospitalization can be proved.[4]

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4 E. M. Bluestone, "The Place of the Long-Term Patient in the Modern Hospital", Bulletin, American College of Surgeons, Chicago, June, 1946, 7.

According to Mary C. Jarrett, who made a survey of the problem of chronic illness in New York City, patients requiring treatment for many months cannot be cared for advantageously in the same hospital wards with the acutely ill. It is also her opinion that patients, who remain in a hospital for months and for the most part are not suffering acutely, should be in a different atmosphere from those who are extremely ill.[5]

This opinion is shared by many hospital administrators and is particularly stressed today because of the acute shortage of hospital beds to care for the acutely ill. However, there is agreement in the thinking that patients afflicted with long-term illness who need intensive medical care for an acute exacerbation of the chronic illness should be cared for in general hospitals. There is also agreement and much feeling on the part of the hospital administrators that these patients should not remain indefinitely in general hospitals, and that planning for prolonged illness beyond the acute phase must be made available to these patients

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5 Mary C. Jarrett, Chronic Illness in New York City, 11, New York, 1933, 1.

elsewhere in the community.

Another very important consideration, in relation to the length of hospitalization of the study group, is the cost of this type of medical care. Hospitalization is very costly as evidenced by per diem cost. In 1951, the per diem cost at Mount Sinai Hospital was $18.88. In 1952, it is has increased to $21.53. From this figure and from the following table, it is of particular significance to the social worker that this type of care is extremely costly to patients, their relatives and to the community.

Twenty-eight patients, or approximately 22 per cent, of the total study group were hospitalized from sixty to 203 days. The remaining ninety-nine patients were hospitalized from thirty to sixty days. Aside from the cost, another significant factor of long periods of hospitalization is that it tends to fixate the patient. This has special meaning to the social worker in discharge plans, as she must help the patient accept separation from the hospital.

TABLE X

CLASSIFICATION ACCORDING TO DAYS HOSPITALIZED

No. of Patients	Days Hospitalized
57	30 - 40
24	40 - 50
18	50 - 60
12	60 - 70
5	70 - 80
5	80 - 90
2	90 - 100
1	118
1	172
1	182
1	203
127	TOTAL

We have already noted the length of hospitalization spent by the group as a whole.

The following table indicates the previous hospitalization periods during the year of 1951 of the patients studied. Since the table only covers the same year in which the study was conducted, it is not intended to be representative of the duration of the chronicity

of the illnesses suffered by the patients in this study group. It is felt, however, that this table does throw some light on the recurrence of chronic illness, particularly with reference to the patients included in this study. There is also some indication in relation to the frequency of recurrent illness of the patients, which may be due to lack of medical supervision while the patients are out of the hospital. This emphasizes the importance of medical follow-up and the role of the medical social worker in arranging for this type of service for the patient upon discharge from the hospital.

Five patients of the total study group were hospitalized twice in addition to the hospitalization period considered in this study and thirteen patients had each been previously hospitalized once in addition to the hospitalization period considered in this study.

TABLE XI

CLASSIFICATION ACCORDING TO
PREVIOUS HOSPITALIZATION DURING CALENDAR YEAR 1951

Number of Previous Hospitalizations	No. of Patients
2	2
1	13
0	109
Total	127

CHAPTER IV

ATTITUDES OF PATIENT AND RELATIVES TOWARD DISCHARGE AND SOCIAL SERVICE ACTIVITIES

It has been previously pointed out that the doctor assumes leadership and authority in the medical care of the patient. It is, therefore, his responsibility to diagnose the patient's disease, prescribe the necessary treatment and to make medical recommendations for post-hospital care, which will enable the patient to retain the gains in health achieved from his hospitalization period.

> The trend of modern medicine is more and more towards the conception that the physician treats not merely a diseased section of the body but the whole person. Greater emphasis is being placed on the study of the patient as a whole, in which factors of emotional life, conditions of employment, habits of living, family life, and other human factors are considered in arriving at a diagnosis or in outlining treatment. . . . the doctor must view man as body and mind inseparable and must know him in his human surroundings as well as his physical world if he is to render service of the highest type.[1]

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1 Mary C. Jarrett, Chronic Illness in New York City, New York, 1933, 68.

For a satisfactory after-care plan to be made, the medical social worker informed the doctor of the social situation of the patients in relation to their medical needs. The social investigation was made by the worker who was familiar with the medical findings and progress of the patients during their hospital stay.

The medical recommendations for post-hospital care for the 127 patients in the study group were, therefore, based upon the medical and social needs of the patients. The recommendations specified the type of after-care necessary for the welfare of the patients prior to the consideration of the availability of facilities. It then became the responsibility of the medical social worker to implement these recommendations and to explore the community resources available to meet the individual needs of the patients.

The study group, as indicated previously, presented serious medical problems and many of the patients were totally or partially disabled. In order for the worker to implement the medical recommendations for post-hospital care, it was necessary for her to consider the patients' individual needs. In addition to this, knowledge of community resources was essential. The

ability to interpret the patients' needs to the community and to interpret the community facilities to the patients and their families was also one of the worker's functions.

In Chicago, the facilities for the chronically ill are very limited. These facilities were even more limited to our study group, because many of the patients or their relatives could not meet the cost of this type of care. This further complicated discharge plans.

The following table points out the gap between the medical recommendations as made by the medical staff and the final disposition made by the social worker. The medical recommendations were grouped into four classifications: (1) patients referred to their own homes included patients who were totally or partially ambulatory, but who had some special needs; (2) patients referred for convalescent care included patients who were ambulatory, but who needed further supervision and some nursing care; (3) patients referred for institutional care included patients who required custodial or terminal care; and (4) patients referred to nursing home care included patients who were totally bedridden and needed general nursing care. This group also included

senile and terminal cases.

It is of importance to note that the medical recommendations for convalescent, nursing and institutional care could not be met for twelve patients in the study group. These patients, therefore, returned home although this plan did not adequately meet their needs.

TABLE XII

CLASSIFICATION ACCORDING TO MEDICAL RECOMMENDATIONS AND DISPOSITION BY MEDICAL SOCIAL WORKER

MEDICAL RECOMMENDATIONS	No. of Patients	DISPOSITION BY MEDICAL SOCIAL WORKER	No. of Patients
Own Home	63	Own Home	75
Convalescent Care	31	Convalescent Care	26
Institution	6	Institution	5
Nursing	27	Nursing	21
Total	127	Total	127

Much emphasis has been placed on the concept of treating "the patient as a person", and the "individualness" characteristic of each human being. The medical social worker sees the patient first of all as a person who is sick and as an individual who has his

own unique personality. The personality distinguishes him from every other human being.[2]

Accepting the concept of individual differences, the medical social worker must be aware of the difference in attitudes and reactions of the patient in the process of separating from the hospital. In order to understand the individual attitudes and reactions in this area, the medical social worker must attempt to understand what discharge means to the patient.

Some patients react with hostility and aggression, some with anxiety and fear, and others simply accept the situation, either freely or because they are pressured into acceptance. These attitudes and reactions are often based on the patient's own personality needs and by the expectations of secondary gains. The patient who does not feel ready to leave the hospital because of his helplessness looks upon any other plan as unsatisfactory.

In working with the study group towards acceptance of the medical recommendations, the medical social worker attempted to understand what meaning the

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2 Arthur E. Fink, The Field of Social Work, New York, 1942, 278.

separation experience may have had for the patient and his family. The patients, as well as their families, were given careful interpretation of the medical recommendations for post-hospital care, by both the physician and the worker.

The attitudes and reactions of the patient's family in regard to the medical recommendations are equally important.

As stated by Henry B. Richardson:

> The family maintains an equilibrium within itself and towards the environment which is comparable with homeostasis, the mechanism by which the individual organism maintains itself in a state of balance. The members of the family may be compared to the organs of the body in spite of obvious differences. . . The welfare of the family depends not only on the characteristics of the individual, but also on the capacity of the family to maintain a stable equilibrium internally and with reference to the environment. . . The balance which is reached, favorable or otherwise, involves not only health and illness, but also social relationships, economic support, education, and other contacts with the outside world.[3]

Prolonged illness usually involves the entire family and places a great strain on the varied human relationships comprised in a family.

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3 Henry B. Richardson, Patients Have Families, New York, 1945, 95.

It was extremely important, therefore, for the medical social worker to understand and consider the feelings, attitudes and reactions of the patient's family towards his discharge from the hospital. She needed to know how the family felt about accepting the patient home and what responsibility they would or could accept for the patient. With this added knowledge, a more complete picture of the situation in relation to the patient's acceptance of the medical recommendations was had.

The attitude of the patients in relation to acceptance of medical recommendations in the study group has been classified under three headings, namely: patients who accepted the medical recommendations freely; patients who accepted the medical recommendations under pressure; and patients who rejected the medical recommendations.

Although these terms in themselves are self-explanatory, it was felt that case illustrations would better define these classifications.

(1) Patients who accepted medical recommendations freely:

A 35 year old white, Protestant woman was hospitalized for a period of sixty-six days for Carcinoma of the Rectum. She was widowed and lived with her twelve-year old daughter prior to her admission. Patient's sisters were intensely interested in her and were caring for her daughter during the patient's hospital stay. Medical recommendations were for patient to return home. The patient was well-adjusted to her hospital stay and comparatively free from worry regarding the care of her child. She made a real effort to get well as she was eager to return home. The sisters were eager for patient to come and planned to take turns in helping to care for the household until the patient regained her strength. The relatives came to the hospital to take the patient home on the day that she was medically discharged.

A sixty-two year old white, Catholic woman had been hospitalized for a period of thirty-four days for Arteriosclerotic Heart Disease. She was a widow and had been living with her brothers and keeping house for them prior to her hospitalization. Her only child, a married daughter, was living in Gary, Indiana. There was a very good relationship between the patient and her family and the patient was very anxious to go home as soon as she was medically discharged. Medical recommendations were for patient to return home. Although her brothers were very anxious to have her return to them, the patient accepted her daughter's home as a more adequate place for convalescence. The daughter and her husband both were eager for patient to come to their home. They took the patient home two days after her medical discharge. There was a slight delay as they had to make plans to come to Chicago.

(2) Patients who accepted medical recommendations under pressure:

(a) Pressure exerted by Relatives:

A seventy-eight year old, Jewish woman had been hospitalized for a period of thirty days for Coronary Heart Disease. She was a widow and made her home with a married daughter and her family. The patient also had three sons. During patient's hospitalization stay, she was anxious and continually asked the doctors and the worker when she would be going home. Medical recommendations were for patient to have a period of convalescent care. The patient was quite resistive about accepting this care and anxious to go back home. The married daughter urged the mother to go to a convalescent home, pointing out the advantages of this type of after-care and stressing the crowded conditions of her home. The patient accepted this recommendation, stating that she felt she should do what "my daughter tells me, even though I am very lonesome for home and the grandchildren." After final arrangements were made for the patient at the convalescent home, the patient rejected this plan and was reluctantly taken home by her daughter.

(b) Pressure exerted by the Hospital:

A seventy-seven year old, Jewish man who had been hospitalized for a period of thirty days for Arteriosclerotic Heart Disease with Angina Pectoris was discharged to his home. He and his second wife lived together in a one-room apartment. The patient was not ready emotionally to leave the protected environment of a hospital. During this period, there was an acute shortage of beds and many seriously ill patients were waiting to be hospitalized. Both the doctor and the social worker attempted to assure the patient of the improvement of his physical condition. The social worker also gave the patient and his wife careful interpretation as to his post-hospital regime. Although the worker spent considerable time in helping them accept the separation from the Hospital, both the patient and his wife felt that the Hospital "was pushing me out because they are

no longer interested in me.* The wife took the patient home two days after he had been medically discharged.

(3) Patients who rejected medical recommendations:

A fifty-nine year old Jewish woman had been hospitalized for a period of thirty-eight days for an Ulcer of the Stomach, complicated by Cardiac Decompensation and Left Heart Failure. She was living with her second husband prior to her admission to the Hospital. Their relationship was poor, and patient felt that her husband was not interested in her. Patient's only child, a married daughter, was living in New York City. She came to Chicago and visited the patient regularly during her hospital stay. The patient and her daughter were very close and the patient was very dependent upon the daughter. During the patient's hospital stay, she was very apprehensive, fearful and depressed. She needed continuous reassurance and support. The medical recommendations were for the patient to return home, but she refused to accept them. She insisted that she must go to a convalescent home. Although the daughter volunteered to remain in Chicago and help the mother in the home, the patient still persisted in going to a convalescent home. The daughter then took the initiative for securing convalescent care for the patient. The patient left the Hospital seven days after she was medically discharged to go to a convalescent home.

A seventy-year old Jewish woman was hospitalized for a period of forty-four days for Hypertensive Heart Disease, Cerebral Embolism, and Hemiplegia. The patient and her seventy-eight year old husband and a single daughter lived together prior to her admission. The daughter was employed during the day. In addition to the single daughter, there

were three other children, all married. The children were overly protective of the patient and there was evidence of guilt feelings on their part over patient's illness and ensuing paralysis. The medical recommendations were for nursing care, but the family had some difficulty in accepting these recommendations. After intensive casework services, the family was able to accept these recommendations and take initiative in the referral for nursing care. The patient, however, seemed too threatened by this separation from her family. Although the worker spent considerable time in helping the patient in this area, at point of completion of nursing care arrangements, the patient rejected these recommendations and insisted that the family take her home. There was a seventeen day delay between medical discharge and the time the patient left the Hospital.

Four patients in this group refused to complete their medical treatment and left the Hospital prior to their medical discharge.

TABLE XIII

CLASSIFICATION ACCORDING TO ATTITUDE OF PATIENTS IN RELATION TO ACCEPTANCE OF MEDICAL RECOMMENDATIONS

Attitudes of Patients	Frequency
Freely	88
Under Pressure	26
Pressure exerted by Family	15
Pressure exerted by Hospital	11
Patients who Rejected Medical Recommendations	13
Total	127

It has been established that hospital care today is costly and that there is a great demand for this type of care. This is particularly true of the patients who have exhausted their resources in securing medical care and as a result have become medically indigent.

Table XIV has great significance in pointing out that the study group as a whole spent from one to sixty-one days in the Hospital after their medical treatment had been completed or no further medical treatment was available. Some of the major factors for this delay were: (1) lack of family interest and participation in discharge plans; (2) the long interval between referral and disposition of hospital patients referred to other agencies for assistance in discharge plans; (3) the need to wait for beds in convalescent, nursing and institutional facilities; and (4) time spent by the medical social worker in exploration of facilities best equipped to meet the needs of the individual patient.

TABLE XIV

CLASSIFICATION ACCORDING TO DAYS BETWEEN MEDICAL DISCHARGE AND ACTUAL DISCHARGE OF PATIENTS

Days	No. of Patients
0	32
1 - 5	41
5 - 10	23
10 - 15	10
15 - 20	7
20 - 25	4
25 - 30	3
30 - 35	3
35 - 40	0
40 - 45	0
45 - 50	1
50 - 55	1
55	1
61	1
Total	127

"Medical social work is the application of social case work to medical service."[4] Medical social

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4 Ernest P. Boas, The Unseen Plague Chronic Illness, New York, 1940, 22.

work must include, therefore, not only sound generic case work, but also special knowledge and skills applicable to the medical setting in order that the medical social worker may function in an integrated way within the total services of medical care.[5]

The primary function of the medical social worker has been defined and accepted by the American Association of Medical Social Workers as the "practice of social case work in a hospital or clinic, which is concerned with helping the patient with personal or environmental difficulties which predispose towards illness or interfere with obtaining maximum benefits from medical care".[6]

In order for the medical social worker to function effectively, there is need to individualize the various aspects of the patient's situation and to work in close cooperation with the other members of the

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5 Elizabeth P. Rice, "The Generic and Specific in Medical Social Work", Journal of Social Casework, XIII, April, 1949, 135-136.

6 American Association of Medical Social Workers, A Statement of Standards to be Met by Medical Social Work Departments in Hospitals and Clinics, 1949, 3.

medical team interested in the total medical care of the patient. The importance of the consideration of the patient in relation to his family has also been discussed. In the formulation of a plan for post-hospital care, the medical social worker must also plan with the family and the community agencies. She must also permit the patient to make his own decisions and to live his own life according to his needs. The worker may assist and support the patient to participate in the discharge plan, but the patient should never be pushed or pressured.

The services which the medical social worker rendered to the 127 patients in the study group were varied and numerous, but adhered to the basic principles of social case work, namely:

(1) Individualization of the patient.

(2) Interpersonal relationship between patient and worker.

(3) Total acceptance of the patient.

(4) Right of patient's self-determination.

(5) Skill and uses of community resources within the patient, within the community and within the social worker.

Table XV indicates the principal services rendered by the medical social worker to the 127 patients studied. An interpretation of the social situation of each patient was given to the medical staff by the medical social worker. In some cases, several conferences with the medical staff were necessary because of difficulties involved in the discharge plan. Support and reassurance was given to eighty-three patients. One hundred and seven patients were given interpretation of their medical conditions, and post-hospital needs. Six of the patients in the study group were too ill to speak and fourteen patients were too young to understand, being under the age of ten years. Twelve patients were assisted in accepting an alternative plan since facilities in the community were not available to meet their particular needs. Five patients were assisted in thinking through vocational plans and accepted referrals to agencies in the community for this type of service.

The medical social worker found it necessary to give support and reassurance to seventy-one relatives. More frequent, discussion was necessary with some of the relatives who were ambivalent or rejected the patient.

Eleven patients completely rejected casework service.

TABLE XV

CLASSIFICATION OF PRINCIPAL SERVICES RENDERED BY THE SOCIAL SERVICE WORKER

Total Number of Patients 127

Total Number of Services 727

Services	No. of Patients
Support and Reassurance to the Patient	83
Interpretation to the Patient of His Condition and Needs	107
Help to the Patient in Accepting an Alternative Plan	12
Help to the Patient in Thinking Through Vocational Plans	5
Support and Reassurance to Relatives	71
Interpretation of Patient's Needs to Relatives	83
Patient not Accepting of Case Work Service	11
Interpretation to the Medical Staff	127
Interpretation of Patient's Needs to Community Agencies	114
Referral to Community Agency to Assist in Discharge Plans	114

Chronic diseases are in themselves more complicated to deal with than are acute diseases. A great

variety of services and facilities were necessary to meet the needs of the patients in the study group. Since the community lacked a well-planned and integrated service for the chronically ill, the discharge planning for some of the patients became more complex and time-consuming for the medical social worker. In order for the medical social worker to effect discharge plans in accordance with the needs of the patients, she referred 114 patients to eighteen agencies in the community for assistance in these plans. It was also essential that interpretation of the patients' needs be given to these community agencies. Table XVI reveals that seventy-nine patients were accepted and thirty-five patients were rejected for a particular kind of service.

TABLE XVI

CLASSIFICATION OF COMMUNITY RESOURCES USED BY SOCIAL SERVICE IN DISCHARGE PLANS

Agency	Number of Patients Accepted	Number of Patients Rejected
Catholic Home Bureau	3	5
Chicago Housing Authority	1	0
Chicago Home for the Friendless	2	3
Chicago Welfare Department	4	5
Cook County Department of Welfare, Oak Forest Service	2	0
Cook County Hospital	2	0
Dixon State Hospital	1	0
Jewish Children's Bureau	1	0
Jewish Family Community Service	8	3
Jewish People's Convalescent Home	7	2
Jewish Vocational Service	2	0
Psychopathic Hospital	1	0
Public Assistance Division Old Age Pension	8	5
Resthaven Convalescent Home (Including the Chronic Unit)	24	10
Salvation Army	0	1

(Continued)

Agency	Number of Patients Accepted	Number of Patients Rejected
State Division of Rehabilitation	3	0
United Charities	0	1
Visting Nurse Association	10	0
Total	79	35
Total number of patients referred to 18 agencies 114		
Total number of patients not referred to these agencies 13		
Total number of patients 127		

Some of the patients were referred for several types of services to various community agencies simultaneously, such as referral for convalescent care to one agency and referral for financial assistance to another agency. Out of the 114 patients referred, twenty-eight patients were referred to two or more agencies.

It also became necessary to refer patients who had been rejected by a community agency for a particular kind of service to other agencies in the community. As

has been pointed out previously, this caused an additional delay in discharge plans. It is highly significant that discharge plans for four patients in the study group were delayed, therefore, from twenty-eight to sixty-one days.

Table XVII reveals the types of services requested by the social worker for the 114 patients referred to the eighteen community agencies for assistance in discharge plans.

TABLE XVII

CLASSIFICATION ACCORDING TO TYPES OF SERVICES REQUESTED BY SOCIAL SERVICE FROM COMMUNITY AGENCIES

Type of Service	Total number of patients referred	Number of Patients Accepted	Number of Patients Rejected
Casework	7	4	3
Convalescent Care	39	24	15
Financial Assistance	4	3	1
Foster Home Placement	2	2	0
Hospitalization	2	2	0
Housekeeping Service	6	5	1
Housing	1	1	0
Institutional Service	5	5	0
Nursing Care	34	19	15
Visiting Nurse	9	9	0
Vocational Rehabilitation	5	5	0
Total number of patients referred for services	114	79	35
Total number of patients not referred for services	13		
Total number of patients	127		

Close cooperation of both private and public agencies in the community made possible the attainment of financial assistance, case work services, convalescent care, nursing care, institutional care, housing, vocational rehabilitation and retraining, housekeeping service and visiting nurse services. These agencies greatly facilitated discharge plans for some of the patients in the study group.

SUMMARY AND CONCLUSIONS

In summary, the activities of the medical social worker in the discharge planning for 127 chronically ill patients during 1951 was more intensive and involved than they were for the acutely ill patients. The problems of discharge, what discharge means to the patient, his family and the community were examined in this study. An attempt was made to show the problems with which the social worker must cope in the area of discharge of chronically ill patients. In addition, an effort was made to learn how she integrates the attitude of the patient, the family, and the community in the formulation of adequate discharge plans to meet the individual needs of the patients.

The 127 patients in the study group presented serious medical conditions and disabilities. Some of the patients were totally or partially ambulatory and others were totally bedridden, terminal and senile, requiring medical supervision, convalescent, nursing and institutional care. Sixty-five patients or 51 per cent of the study group had been hospitalized for either

Diseases of the Cardio-Vascular System, Diseases of the Locomotor System and Malignancies.

Consideration must also be given to the effect of their prolonged periods of hospitalization, both current and previous. The duration of their hospital stay during this admission ranged from thirty to 203 days. In addition, five patients had two previous hospital periods and thirteen patients had each one previous hospital period, during 1951, the year in which the study was conducted. The majority of the patients were white females of the Jewish religion, and eighty patients, representing 63 per cent of the total group, ranged in ages from fifty to eighty-nine years. Eighty-seven patients or 68 per cent were living with their families and had some family responsibility. Twenty-nine patients who lived alone ranged in ages from thirty to eighty-nine years. The close connection between prolonged illness and financial dependence was revealed by the fact that 102 patients or 80 per cent were completely dependent financially.

In addition to the difficulties encountered in securing adequate resources which would conform to the medical recommendations of the medical staff, the

worker was confronted with the various attitudes of the patients and their relatives towards separation from the hospital. Of the eighty-eight patients who accepted the recommendations freely, the majority were patients whose families actively participated in the discharge plans. Twenty-six patients accepted the medical recommendations for their discharge under pressure by both their relatives and the Hospital. The majority of these patients had already established deeply rooted patterns of dependency and were unwilling to leave the security and protection afforded by the Hospital. These patients and their relatives were unable to accept the fact that care in a hospital designed for treatment of acute conditions became unnecessary after the acute phase of their illness had subsided. Thirteen patients completely rejected the recommendations. Case material was presented to illustrate the attitude of the patients and their relatives in relation to medical recommendations for their discharge.

This study also revealed that the medical social worker spent a great deal of time in helping the patients accept separation from the Hospital. Serious difficulties were encountered in conforming with the

medical recommendations which caused great delay between the date of medical discharge and actual discharge from the Hospital. The study group spent from one to sixty-one days in the Hospital after being medically discharged. The reasons for this delay were lack of family interest and participation; long interval between referral and disposition of patients referred to other community agencies; waiting for beds in convalescent, nursing and institutional facilities; and time spent by the medical social worker in exploration of adequate facilities to meet the individual needs of the patients.

The social service activities were many and diversified. The patients and relatives were given interpretation of the patients' medical condition and their needs for after-care. Support and reassurance were given to the patients and their relatives to help them in accepting separation from the Hospital. Interpretation was given to the medical staff, and they were kept informed of the progress made and what plans might eventually be evolved. Because the medical social worker is an integral part of the hospital, she has a definite responsibility to the hospital, as well as to the patient. She must facilitate discharge plans as

quickly as possible.

The adequacy with which the social worker met the patients' needs and facilitated discharge plans depended to a great extent upon the community facilities available and the cooperation of community agencies approached for assistance in discharge planning. One hundred and fourteen patients were referred to eighteen agencies in the community. Some of these patients were referred for several types of service to various agencies simultaneously, such as referral to a convalescent home for convalescent care and to a public agency for financial assistance. Of the 114 patients referred for service, it became necessary to refer twenty-eight patients to two or more agencies. The medical social worker was unable to conform to the medical recommendations for twelve patients and found it necessary to make an alternative plan, which did not fully meet the individual needs of the patients.

Although these agencies greatly facilitated the discharge plans for some of the patients, the community must face the reality that it lacks a well-planned and integrated service for the indigent chronically ill.

Resources for convalescent and nursing care

for the indigent patients are very limited. This is particularly true for the Negro patients. There is also a very limited number of convalescent or nursing homes maintaining a Kosher dietary to meet the needs of the Orthodox Jewish patients. There is a long waiting period for beds in convalescent homes. There is an even greater waiting period for beds in nursing homes and institutional facilities, vacancies being dependent upon the death of their inmates. Very few convalescent or nursing homes have facilities to provide special diets, recreational facilities, occupational therapy or rehabilitation programs.

Continuity of medical supervision for patients returned to their homes is of great importance to help the patients retain the benefits gained during their hospital stay. In addition, home medical care would greatly decrease readmissions to the hospital.

A well-integrated program for the chronically ill should emphasize prevention and control of the chronic diseases, early diagnosis, rehabilitation, adequate and continued medical treatment, as well as adequate social services.

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C. UNPUBLISHED MATERIAL

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SCHEDULE

I. Identifying Information
   A. Code No._____ B. Age_____ C. Religion_____
   D. Race_____ E. Sex_____ F. Marital Status____
   G. Known to Clinic_____

II. Referral
   A. Referred by whom_____
   B. Recommendations on Referral_____

III. Patient's Status in Household Prior to Hospitalization
   A. Living with Spouse_____
   B. Living with Spouse and Children_____
   C. Living with Children but without Spouse_____
      1. Married Children_____
      2. Unmarried Children_____
   D. Living with Parent or Parents_____
   E. Living with Other Relatives (specify)_____
   F. Living Alone_____
   G. Other_____
   H. Does Patient have a Family_____

IV. Economic Status of Patient
   A. OASI or Private Pension_____
   B. Public Assistance_____
   C. Private Agency_____
   D. Dependent on Family Assistance_____

V. Medical History
   A. Diagnosis_____
   B. Date of Admission_____
   C. Previous Hospitalization for this Illness - Give Dates
      1._____
      2._____
      3._____
      4._____

VI. Medical Recommendations for Discharge Plans
Date Medically Discharged_____
A. Patient's Own Home___ B. Medical Follow-Up___
C. Housekeeping Service_ 1. Own Home_____
D. Visiting Nurse_____ 2. Clinic_____
E. Convalescent Care____
F. Nursing Care_____
G. Institutional Care___

VII. Patient's Attitude Regarding Medical Recommendations

A. Accepted _____ B. Rejected_____
1. Freely_____ a. Reason for Rejection
2. Under Pressure____ 1. Religion_____
3. Who is Applying 2. Economic_____
Pressure_____ 3. Home Inadequate for Patient's Needs_____
4. Personal and Emotional Reasons_____

VIII. Problems Involved in Final Discharge Plans
A. Referrals at Time of Discharge

	Referred To	For What	Accepted/Rejected
1.			
2.			
3.			
4.			

B. Final Discharge Plans_____
C. Medical Recommendations which could not be met_____
D. Resources not Available_____
E. Participation of Family in Discharge Plans
1. Acitve_____ 2. Passive_____
F. Did the Family of Patient come in to see Social Worker regarding Discharge Plans_____
1. How soon after called_____
G. Date of Discharge from Hospital:_____
1. Was there a delay from date Patient Medically Discharged?_____
2. How long_____
3. Reason for Delay _____