The role of the social worker in treatment of fifty long-term chronically ill patients

George Edward Pipkin
Atlanta University

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THE ROLE OF THE SOCIAL WORKER IN TREATMENT
OF FIFTY LONG-TERM CHRONICALLY ILL PATIENTS

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
GEORGE EDWARD PIPKIN

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1961
ACKNOWLEDGMENTS

The writer wishes to acknowledge with gratitude his appreciation to the Tuskegee Veterans Administration Hospital Social Service Department, and the faculty members of Atlanta University School of Social Work for their valuable assistance in preparing this study. Special thanks to Mrs. Genevieve T. Hill of the School of Social Work, Mrs. Vera Foster and Mrs. Laura Farley of Tuskegee Veterans Administration Hospital.
DEDICATION

To my wife who gave so much, so that I could accomplish so little, with all my love.

—George Pipkin
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INTRODUCTION

Significance of the Study

Chronic illness has now become the number one problem of medical care. With the control of epidemic diseases and the reduction of maternal deaths, the pendulum has swung away from an emphasis on acute conditions to that on chronic diseases.¹ Medicine has made great strides in the past fifty years, particularly since the advent of the sulfa preparations in 1936 and more recently the development of the antibiotics.²

Today, as a rule, people do not die of an acute illness, medical or surgical, but recover completely or proceed into a sub-acute stage with delayed recovery and find themselves afflicted with a chronic condition, which is, by its very definition, an illness persisting beyond three months.³

By solving one health problem we have created another. For example, in controlling epidemics and reducing infant mortality rates we have made it possible for people to live longer and thus become the victims of chronic diseases. Contrary to some beliefs, this problem is not a new one, nor has it developed suddenly. There have always been people ill with some chronic disease. What is new, is the increasing threat to our happiness and national security because of the magnitude of the problem. When

¹Theda L. Waterman, Valorus Lang, Chronic Illness (St. Louis, 1955), p. 7.
²Ibid.
³Ibid.
epidemics were killing thousands of our citizens we gave scant attention to the ravages of heart disease or cancer.¹ But today, with epidemics no longer occurring, chronic diseases consequently have become the leading causes of death and are the greatest threat.² Chronic illness is the nation's number one problem by virtue of the number of persons involved and the duration of the illness. Because of these factors many social and economic problems are created.

The problem has been intensified by a general shift of population from rural to urban living. The crowding of families into smaller spaces results in lack of room for the care of a chronic invalid. In the past, it was possible for most families living on farms or in single dwelling to care for members of the family who became ill. Such care is becoming increasingly difficult.³

Besides being the nation's greatest health killers, chronic diseases are also the leading causes of unemployment and poverty. We cannot allow this threat to our national security to go unchallenged. Now, at long last, we are beginning to take stock of the situation, to appraise our needs and to make plans toward the ultimate solution of this threat.⁴

Attitudes, warped for generations, are changing as the nature of long-term illness and the needs of its victims are better understood and as better treatment methods become known. Neglect and pessimism are being replaced by an aroused social conscience and by confidence in the value of treatment and rehabilitation. The change is not sufficiently rapid

¹Ibid., p. 18.
³Theda L. Waterman, and Valorus Lang, op. cit., p. 19.
⁴Ibid., p. 21
or extensive, of course, and paradoxically needs to be accelerated among persons in the health professions even more than among those persons in the general population. Only a few years ago chronic illness was commonly regarded as hopeless. Now it is well known that many persons who are seriously disabled can be restored to comfortable happy usefulness.

The chronic disease problem as a whole has looked so formidable that for years the nation was deferred from even starting to work out a solution. Twenty-eight million, the total of chronically ill, seemed an unmanageable problem. Now we know that some twenty-three million of this total are not in the problem group in that their diseases and impairments are so minor that they are amenable to the care and services which most communities offer. However, there remains about five million, where the disability is so great that some form of community organization needs to be brought to bear on the problem.

The range of services needed for persons disabled by chronic illness include: adequate diagnostic and medical services in a hospital or outpatient department; adequate medical services at home, including the coordinated services of a physician-led team of health personnel; rehabilitation services in hospitals, at home and in rehabilitation centers; care in nursing homes; selective job placement; sheltered workshops and

---


2 Ibid.

3 Ibid.
day care centers.¹

The service to chronically ill persons should provide the same fidelity and dignity of care now usually accorded the patient with acute illness. Needs of the chronically ill should be met in plans for general medical care, not in isolated programs. Services should be organized so that patients can move easily to and from home, hospital, and nursing home.²

The Veteran's Administration operates the world's largest system of hospitals, from which 500,000 veterans are discharged annually.³ Recognized as a leader in the field of medical rehabilitation, the agency seeks to restore each patient to the maximum physical, vocational, psychological, and social level of which he is capable. In fulfilling this mission it combines the efforts of the physician, dentist, nurse, pharmacist, laboratory technician, psychologist, dietitian, social worker, rehabilitation specialists, etc., into medical team work which provides the eligible patient with complete diagnosis, treatment, and rehabilitation.⁴

Social workers have been trained to study, assess, and treat social problems. All social workers are concerned with the problems of the individual person and of society, but medical social workers, through their

²Ibid.
association with diseases and hospitals are especially equipped to handle
the problems of the chronically ill. Medical social workers are part of
the medical team and are found in hospitals, both public and private as
well as in medical care programs and as consultants in health agencies
and in medical welfare programs.¹ The medical social worker works with
the patient, his family, and the medical team endeavoring to assist in
solving the many problems associated with illness.

The core of Medical Social Work is casework service to patients and
their families. Increasingly social workers are giving consultation to
other professional personnel on individual patients. At the same time
social workers are helping in the development of various programs with-
in their institutions, in some community planning, in teaching and in
research.² Social service is an integral part of medical care - and
the social worker is an important contribution to the medical treatment
team.

The Medical Social Worker considers the social and emotional status
of a patient as it affects or is affected by his medical problem, and
when needed, has concerned himself with the patient's life situation and
his adjustment which is so closely related and essential for help with
any medical plan.³ Today social work in the medical setting has embraced

¹Janet Thornton, Social Component in Medical Care (New York, 1937),
p. 6.

²Grace White, "The Distinguishing Characteristics of Medical Social
Work," Medical Social Work, I (September, 1951), 37.

³Ibid., p. 38.
this concept. Medicine has given many more years of life to man. Our task now is to help these years be richer, to help humanity use them more fully and more completely.¹ For many patients and their families, social treatment is the method of help required to insure not only better use of medical care, but better health and the achievement of social well-being. The social worker is seen as possessing expertness and special skills which are a direct contribution to patient care.²

Modern social work as an expert service is seen in many ways in the medical setting. In some instances social service makes it possible for medical care to begin. In others, it speeds recovery and may be helpful in preventing any further or additional deterioration or handicap. In still other situations, social service is what is needed by particular patients and their families and is the treatment of choice.³

The burden that chronic illness creates for any person can be substantially lightened by appropriate attention to the deep feelings and attitudes harbored by the patient toward his condition; also to the strain on personal relationships, and the financial and other insecurities associated with long-term illnesses. These social complications in illness, whether causal, concomitant, or resultant are the social workers' responsibility to recognize and either care, or, insofar as possible relieve, or assist the patient to endure.⁴

¹Claribel H. Moncure, op. cit., p. 178.
²Grace White, op. cit., p. 38.
³Ibid.
⁴Ibid., p. 39.
The writer became interested in chronic diseases after observing the number of veterans who were either disabled or handicapped by chronic diseases at Tuskegee Veterans Administration Hospital. According to the Annual Statistical Report for 1960, prepared by the Medical Record Library, four of the five major disease categories prevalent in the hospital were classified as chronic illness. Of the five major causes of death in the hospital, three were classified as chronic illnesses.

Most of these veterans required the service of the social worker in helping to alleviate some of the social and emotional implications manifested by these diseases. Since social service was an integral part of the service provided for hospitalized patients with long-term chronic illnesses, the writer felt that a study to describe the role of the social worker would be of value in planning for and improving the "total care" of patients with long-term chronic diseases. The results of this study might be used administratively in planning for the distribution of manpower within the social service department.

Do the social workers apply the full casework approach including social study, assessment and treatment? It is hoped that the results of this understanding will show precisely what services were rendered by social workers and how often. How and to what extent were activities coordinated to help the patients and their families through intra-professional and inter-agency cooperation? It is also hoped that the results may contribute, not only to hospital social service departments, but to a wider understanding of the social components in medical care.

Definition of Terms

The significant terms to be used in this study were defined by the
Commission on Chronic Illness.\(^1\)

\textbf{A.} "Chronically ill, all impairments or deviations from normal, which have one or more of the following characteristics: are permanent; leave residual disability; caused by non-reversible pathological alterations; require special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation or care."

\textbf{B.} "Long-term includes only those persons suffering from chronic diseases or impairment, who require a continuous or prolonged period of care, that is, who are likely to need, or who have received care for a continuous period of at least thirty days in a general hospital; or care for a continuous period of more than three months in another institution or at home, such care to include medical supervision and/or assistance in achieving a higher level of self care and independence."

\textbf{Category of Chronic Illness As Classified by the Commission on Chronic Illness}\(^2\)

- Malignant Neoplasms
- Cardiovascular Diseases
- Respiratory Disorders

\(^1\)Commission on Chronic Illness, \textit{op. cit.}, p. 18.

\(^2\)A complete detail classification of chronic diseases by the Commission of Chronic Illness can be found in the Appendix.
Purpose of the Study

The purpose of this study was to describe the social worker's role in treatment of long-term chronically ill patients at Tuskegee Veterans Administration Hospital, Tuskegee, Alabama.

Method of Procedure

Fifty case records of patients with chronic diseases were selected from the inactive, alphabetical files of the social service department. The first case that conformed with the definition of a long-term chronic illness was selected and every third case thereafter until there was a total of fifty. The sample included cases who received services between January 1, 1960 and January 1, 1961.

A schedule was constructed for obtaining information from the records. Such information being classified by the writer as identifying information, medical information, social information and information about the role of the social worker in reference to; referrals, resources used in helping the patient, social worker's role in relation to other disciplines in treating the patients and the goals of the social worker in the case.

Pertinent literature was reviewed for additional general information and interviews held with social workers on the medical service added to
the writer's knowledge of direct service to the patients.

Scope and Limitations

This study was conducted during a six month block field work placement at the Veterans' Administration Hospital, Tuskegee, Alabama. It was limited to fifty cases involving males with a medical diagnosis of a "long-term chronic illness," to whom social service was rendered by a social worker between January 1, 1960 and January 1, 1961. The writer is cognizant of the fact that cases involving all of the chronic diseases were not included in the study. However, it was believed that a representative sample was obtained to describe the social worker's role in working with chronic diseases. Only the social workers on medical service were interviewed.
CHAPTER II

DESCRIPTION OF THE SETTING

Two miles northwest of Tuskegee, Alabama, and one and one-half mile from the campus of the famous Tuskegee Institute, lies the Tuskegee Veteran Administration Hospital, the eleventh largest in the nation. It is located on a 290 area tract of land which was donated to the government for the construction of the hospital by Tuskegee Institute in 1921. The hospital was dedicated in February, 1923, by the then Vice-President, Calvin Coolidge.

Originally, a six-hundred bed hospital, the capacity increased to a peak of 2204 in 1954, and later reduced to its present 1912 following a multi-million dollar modernization project. The quality of medical treatment has progressed under the guidance of seven different managers: Colonel Robert H. Stanley, Major Charles M. Griffith, Colonel J. H. Ward, Colonel Eugene H. Dibble, Dr. T. T. Tildon, Dr. Prince P. Barker, and Dr. H. W. Kenney, the present manager. ¹

Although this installation is considered a neuropsychiatric hospital with a bed capacity of 1912, 113 of these beds are designated for medical services, 159 for surgical service, 45 for physical medicine and rehabilitation service, 19 for neurology service, and the remaining 1276 for psychiatric service. Since the date of establishment of this hospital through July 1960, 90,355 patients have been admitted for treatment.

¹Physical Medicine and Rehabilitation Service, "History of Tuskegee Veterans Administration Hospital," Hospital Printing Shop, Veterans Administration Hospital, Tuskegee, Alabama, 1961.
The admissions averaged 192 per month during the fiscal year 1960, and the discharges averaged 213 per month. The bed capacity was nearly ninety-five per cent utilized during the fiscal year, 1960.1

The physical plant is comprised of fifty-eight permanent buildings, eighteen temporary buildings, and seventeen structures. The station owns and operates a laundry, centralized steam plant, raw water pump station and water filtration plant, sewage treatment and disposal plant, refrigeration, ice-making and air conditioning plants.2

Beginning in 1923 with 176 employees assigned, the hospital began its long journey towards the rehabilitation of the human mind and body. Since that beginning, the number of employees has increased to a total of 1,395 representing nearly 150 skills and professions. Operating on a budget of more than nine million dollars, the hospital has projected programs which will certainly make the installation one of the finest in the nation.3

The hospital personnel is divided into two sections, the administrative services and the professional services. The administrative section is divided into seven departments and has the responsibility of management maintenance, supplying equipment and distribution of operating expenses, for the hospital. The social service department works closely with contact service which establishes and maintains contact with veterans in respect to their rights and benefits; and with registrar division which coordinates and provides administrative services pertaining to the

1Ibid., p. 2.

2Ibid.

3Ibid., p. 4.
examination, admission, treatment, transfer and disposition of beneficiaries, including medical legal aspects. These departments support and facilitate the medical treatment program.¹

The professional services include: general medicine and surgical service, neuropsychiatric service, psychology service, dental service, nursing service, physical medicine and rehabilitation service, social service, laboratory and dietary service. These services are directly responsible for the treatment of the patient from the time of admission to discharge. In keeping with the inter-disciplinary approach to treatment, each one offers a specific service in terms of its function.²

The neuropsychiatric service consists of a team of highly qualified psychiatrists, psychologists, social workers, nursing personnel and therapist from physical medicine and rehabilitation who employ the latest techniques and procedures to effect the eventual return of the veteran to his home and community. There are three departments in this section. Acute treatment is for patients who can benefit from intensive short-term therapy. Continued treatment is for those patients who cannot be helped by short-term therapy, and whose condition is considered chronic. The neurological service deals with those patients whose illnesses have resulted from organic deterioration of the nervous system and brain damage. A large number of long-term patients are referred to social service from

¹Lynwood Dorsey, "Administrative Aspects of Patient Care" (Lecture during Student Orientation Program, Tuskegee, Veterans Administration Hospital, Tuskegee, Alabama, September 16, 1960).

²Willis Lewis, "Interdisciplinary Professional Services" (Lecture during Student Orientation Program, Tuskegee Veterans Administration Hospital, Tuskegee, Alabama, September 6, 1960).
The general medicine and surgical services provide treatment for the patients' physical illness. The surgical service is prepared for every kind of emergency and elective work and is staffed with six surgeons, six surgical residents and ten consultants. The medical service is dedicated to the treatment of heart disease, gastro-intestinal diseases, lung diseases, tuberculosis, allergies, diabetes, strokes, arthritis and other degenerative joint diseases. They have the latest equipment for diagnosis and treatment. The medical service is staffed by eleven physicians, four residents and two electrocardiogram technicians.

Although long-term chronically ill patients may be found on any ward in the hospital, there are four wards that are designated for housing of these patients. These wards are designated so these patients can be grouped together in order to receive the best medical and nursing care and in hope that anxieties created by these long-term illnesses will be lessened by associating with others who are experiencing similar illness.

The Social Service Department was organized in 1926 with one worker. The department now has ten workers and five clerical employees. The staff also supervises students from two schools of social work. More than eight hundred cases are handled each month.

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1E. T. Odom, "Medical Services" (Lecture during student orientation program, Tuskegee Veterans Administration Hospital, Tuskegee, Alabama, September 7, 1960).

2E. D. Taylor, "Long-term Medical Care" (Lecture during student orientation program, Tuskegee Veterans Administration Hospital, Tuskegee, Alabama, October 5, 1960).
Clinical social work is an integral part of medical care, treatment and rehabilitation. The social worker contributes a skilled appraisal of the source and significance of the social, emotional, and economical complication in which the patient has become involved. Social casework with individuals and families is a basic and continuing program.

The basic functions of clinical social worker consist of planning for and carrying out the following health-focused functions in close accord not only with the medical, paramedical and domiciliary staff within the department of medicine and surgery but with other veteran administration departments also.¹

A. Joint planning with administrative and professional staff; participation in administrative and medical policy formulation and program planning of services to disabled veterans collectively and singly.

B. The practice of social work with individuals and with groups.

C. Giving social work consultation with regard to individuals and groups.

D. Education of social work staff and students, and participation in the educational programs of the medical and paramedical professions and allied personnel.

E. Utilization of the resources within community health and welfare agencies and organization and the services of volunteer groups and individuals.

F. Identification of gaps in community coverage of social and health needs as they affect veterans' well-being and collaboration with community in

developing social health programs that will re-enforce the Veterans Administration Program.¹

G. Social work research.²

In this hospital social service conducts a pre-admission program for psychiatric patients who are on the waiting list for admission. They review all applicants to evaluate social conditions and advise the admitting physician of the degree of intrafamilial stress and acting out behavior. The social work service also conducts group therapy and resocialization projects. This service supervises all patients on trail visit and has pioneered in a foster home care program which has placed over three hundred patients in homes in the community and over an area including five counties.

¹Ibid.
²Ibid., p. 5.
CHAPTER III

CHARACTERISTIC OF THE PATIENTS

In order to understand some of the social and emotional implications of chronic diseases, it is necessary to know as much as possible about the patient, his physical condition and his environment. The following pages are designed to enlighten the reader on the fifty patients studied in this project.

Age

The problems of chronic illness and those of the aging are often confused, because many of the problems of older people become complicated by the presence of some form of chronic illness. Not all of the chronically ill are aged nor all of the aged chronically ill, but the percentage of incidence of chronic illness is higher among the older members of our population than it is in any other group.\(^1\) However, in this study only thirty-two per cent of the patients were "senior citizens" or sixty-five years and over. In fact the percentage of patients under forty years of age was the same as patients over sixty-five years of age. Thirty-two per cent of the patients were forty or under, thirty-six per cent were between the ages of forty-one and sixty-five, and thirty-two per cent were over sixty-five. Chronic illness increases with age but is not necessarily a problem of age.

\(^1\)Theda V. Waterman and Valorus L. Lang, *op. cit.*, p. 8.
TABLE 1

AGE OF PATIENTS

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<thead>
<tr>
<th>Age in Years</th>
<th>Number</th>
<th>Per Cent</th>
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<tr>
<td>40 or Under</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>41 to 65</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>65 and Over</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
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</table>

Diagnosis

While it was acknowledged that cases involving all of the chronic diseases would not be included in this study, there was a wide range of chronic illness representing the major disease categories. Some of these illnesses in the study differed in the severity of the disease. However, much as they differed in other respects, all of the chronic diseases had one characteristic in common; they were all diseases of long duration. Table 2 shows the major diagnosis of the patients in the study.

The major diagnosis of the fifty patients studied was shown in Table 2. However, twenty-two or forty-four per cent of the patients had a diagnosis including two or more chronic diseases.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
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<tbody>
<tr>
<td>Tuberculosis</td>
<td>5</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
<td>5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>4</td>
</tr>
<tr>
<td>Hypertension Cardiovascular Disease</td>
<td>5</td>
</tr>
<tr>
<td>Hemiplegia, Paraplegia</td>
<td>4</td>
</tr>
<tr>
<td>Degenerative Joint Disease, Unspecified</td>
<td>2</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2</td>
</tr>
<tr>
<td>Cerebral Thrombosis</td>
<td>2</td>
</tr>
<tr>
<td>Anemia</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Hepatitis</td>
<td>2</td>
</tr>
<tr>
<td>Sclerosis of the Liver</td>
<td>2</td>
</tr>
<tr>
<td>Arteriosclerotic Heart Disease</td>
<td>1</td>
</tr>
<tr>
<td>Intractable Asthma and Bronchitis</td>
<td>2</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>1</td>
</tr>
<tr>
<td>Rheumatic Heart Disease</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Genito-urinary Disease</td>
<td>1</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>1</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>1</td>
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<td>Acute Cholecystitic</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
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Date of Admission

Twenty-four of the patients were admitted to the hospital in 1960. One patient had been admitted in 1953 and three in 1954. Twenty-two patients were admitted between 1954 and 1960. Sufficient data was not obtained to determine if these patients were hospitalized continuously from date of admission to the time of the study.

Regional Location of Patients

Forty-five of the patients studied were from the Southeastern States of Alabama, Georgia, and Florida. Three were from Mississippi, one from Illinois and one from Arkansas. Thirty-five or seventy per cent of the patients were from the rural areas of those States.

Socio-economic Conditions

Only a limited amount of formal education had been received by most of the patients. Three had a college education and one had two years of college training. Nine of the patients had reached high school in their formal education, however, only three had finished. There was no information concerning the educational level of seven of the patients.

At the time of this study, only five or ten per cent of the patients had been working prior to their admission to the hospital. Two of the patients had been students. The remaining patients were either retired because of age or were physically unable to work. Most of the latter were farmers or unskilled laborers, and when confronted with physical limitations imposed by their illness were unable to find employment within their physical limitations because of limited educational background. There were only six, or twelve per cent of the patients who
were professionals or skilled laborers. The occupations of these six included a minister, school teacher, engineer, two bricklayers, and an insurance executive. The other eighty-eight per cent of the patients were farmers or unskilled laborers.

The income of these patients in most of these cases was from the government. At the time of this study thirty-one or sixty-two per cent of the patients had annual income of less than 1,200 dollars. The highest income received by any patient was by the retired engineer, two-hundred dollars a month. Ten or twenty per cent of the veterans received compensations for some type of service-connected disability. Three of the patients were receiving money from an insurance or some type of job compensation. Only four of the patients stated that they did not have any income.

Table 3 shows that thirty-six or seventy-two per cent of the patients in this study received their income from the federal government. Twenty-six of these patients received permanent and total disability benefits, the amount of these pensions ranged from sixty-six dollars to eighty-five dollars a month. Generally, the patients receiving service-connected compensation and those receiving insurance or unemployment compensation, retirement or social security benefits had a slightly higher income than patients receiving permanent and total disability benefits, and public welfare.

Married patients were predominant, numbering twenty-six or fifty-two per cent. Eight were separate from their wives, but not divorced. Three were divorced and four were single. One patient stated that he had a common law wife and seven were widowed. There was no information
Thirty-six or seventy-two per cent of the patients listed one or more persons as dependents. These dependents included wife, parents, children, step-and grandparents, in-laws and various other relatives. Twenty-three of the patients were living with their wives. Seven were living with their parents or in-laws, the same number was living with a brother or sister and one with an aunt. Four of the patients were living with a friend. Four were living alone and there was no information concerning living arrangements for four of the patients.

There seems to be general agreement that chronic illness is more prevalent in the lower income groups where housing, food, and environmental conditions are less conducive to good health. The same is true...
for groups who are not well informed in health practices and when medical, dental and nursing services are likely to be used on a more limited scale. In these groups there is not only an inability to pay for such services but there is also less appreciation of the value of good health supervision.¹

CHAPTER IV

ROLE OF THE SOCIAL WORKER

This chapter describes the role of the social worker in the treatment process of the fifty patients in the study. It describes the activity of the social worker from the referral to the collaborative role as a member of the medical team. To help the chronically ill patient, the focus for treatment must be on the whole individual and the correlated team approach is the best method to help rehabilitate the disabled patient to useful living in his home and community.¹ The efforts that the social workers at this hospital make toward the end of effective team functioning will be shown in this chapter.

Referrals

In the team approach the doctor is usually the leader of the team. He is the person who had the ultimate responsibility for the patient's life and health. The social worker comes into the situation, in the majority of cases, on referrals from the doctor, to explore the situation and to give services which the exploration with the patient reveals as pertinent to the medical care. Frequently, the physician refers those individual patients whom he believes have personal and environmental problems which are interfering with the total restoration of the patient.²

¹Theda L. Waterman and Valorus F. Lang, op. cit., p. 8.
²Grace White, op. cit., p. 38.
Other members of the team and representatives of outside agencies also refer individual patients to the social worker. The social worker, through her understanding of problems that are manifested by various illness, has the responsibility to open cases where she thinks her services might be of value to the patient. Some patients come on their own and others are referred from various health and social agencies.

In this study sixty-two per cent or thirty-one of the patients were referred to the social worker from the ward physicians. Most of these patients were referred during ward rounds or staff conferences. Twelve per cent or six of the patients were referred to the social worker from some other source within the hospital. This group included referrals from ward clerks, nurses and other departments within the hospital. Six, or twelve per cent of the patients were self-referrals. Four, or eight per cent of the patients were cases activated by the social worker and the remaining three or six per cent were referred from relatives or wives of the patients.

Table 4 shows the referral sources of the fifty patients studied. The primary source of referrals to the social worker was from the physician. This seems to reflect an understanding by the doctors of the function of the social worker and her inclusion in their concept of the medical team.

There is increasing recognition that man's social environment affects his mental and physical health and well-being and that it will either produce disease of itself or alter other diseases. Many physicians now realise and stress, the social aspect to almost every patient every illness and its treatment.¹

¹Dora Goldstine, Medical Social Work (Chicago, 1958), p. 5.
Table 4 shows that the social workers in this study had opened four cases where they felt their services may be of value. Other personnel in the hospital were also cognizant of the service that the social worker provided and the worker received a large number of referrals from these sources. Patients and their families feel a need to use the service that is rendered by the social worker, and do so, by asking for help through self-referrals. Eighteen per cent of the patients in this study were self or family referred.

The cases were studied according to the specific referral problems as seen by the individual who made the referral or the patient. Because of the strain on personal relations and the financial and other insecurities associated with chronic illness, many social and economic problems
were created. It was indicated that the social worker received a wide range of specific problems among his referrals.

**TABLE 5**

**ORIGINAL REFERRAL PROBLEMS OF PATIENTS STUDIED**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Evaluation</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Medical Treatment</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Hospital Adjustment</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other Social Problems</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 5 shows that sixteen or thirty-two per cent of the patients were referred for social evaluation to help facilitate medical diagnosis and treatment. Fifteen, or thirty per cent of the patients were referred for discharge planning. Eight, or sixteen per cent were referred for financial assistance. Five were referred for help in facilitating hospital adjustment and medical treatment. Six were referred for other social problems that included: establishing family ties, problems around patients.

funds, arranging for patient to go to church and arranging for patient to go on pass.

A scientific and humanitarian approach is required in the case of any patient with chronic illness; an exploration of the pertinent social and personal facts, with their accompanying emotional coloration—facts that complicate the onset of the patient's illness and his ability to fully collaborate in his treatment.¹

In the casework process, understanding and studying of the referral problem is often the first step. Social workers in these studied cases, in an effort to understand the referral problem, found that eight percent of the cases referred did not require social casework for the originally stated problem. Accordingly, in forty-four percent of the cases the social workers' exploration revealed the presence of problems in addition to those stated in the referral.

The social worker in the medical setting carries a role which demands subtle blending of sensitivity and objectivity. Patients need the help of a professional person who is both a part of the setting and yet sufficiently separate so that there is the objectivity which encourages trust and frankness. It must be clear to the patients and the professional associates that the worker is identified with and supportive of the recommendations of the medical team and the administration, but yet does not have to impose them on the patient and is not the carrier of medical or administrative authority.²

Direct Service to the Patient

In this study services related to discharge planning and social

¹Ibid., p. 3.

²Grace White, op. cit., p. 31.
evaluation led among the activities of the social workers. Eighteen, or thirty-six per cent of the patients received direct service related especially to discharge planning. The same number received service based on social evaluations. Of the eighteen cases referred for social evaluation, case work service was rendered to fourteen, or twenty-eight per cent of these for some additional problems that affected their hospital adjustment. Casework service related to admission, was rendered to one patient. Eight patients were helped especially with financial assistance. Five of the patients were helped with other social problems that included: help in establishing ties with family, and help in legalizing common law marriage. Services were given to thirty, or sixty per cent of the patients in two or more areas in an attempt to meet the totality of the patients' problems.

In all of the cases, counseling and interpreting services were the leading specific casework service to the patients. In forty-two, or eighty-four per cent of the patients, the primary focus of counseling was interpreting hospital procedures and medical regime, and helping the patient to understand and accept the reality of his illness. This maladjustment showed itself primarily by the patient not conforming to his medical regime or presenting behavior disturbances on the ward.

Case 1 illustrates a case where the patient presented some behavior problems on the ward.

Case 1

Mr. C., seventy-four years old, married, veteran with silicosis and tuberculosis, hospitalized since March 21, 1959, was referred because of apparent maladjustment and
refusal to cooperate with hospital personnel. Veteran had become hostile to hospitalization and medical personnel. He had found little relief for his situation which is now long chronic.

The worker in this case saw the patient five times in an effort to offer supportive treatment to the veteran and help him adjust to his illness. In these interviews, she accepted the hostility of the patient and helped him to talk through his problems concerning other hospital personnel. The worker allowed the patient an opportunity to talk about family problems that were created by his hospitalization. These problems included discussing plans for the patient's sixty-four year old wife who was disabled by arthritis and had no one to help her with household duties. The worker stated in her assessment of this patient that he was attempting to be self-sufficient and rejecting of any interest, whereas in reality he probably felt helpless and insecure. This patient was helped to release anxieties and hostilities created by long hospitalization, which helped the patient adjust or alleviate problems related to his illness.

Case 2 shows a portion of a recorded interview in which the patient requested a talk with the worker about problems related to his illness.

Case 2

Mr. W., thirty-two years old, married, veteran with a diagnosis of cardiovascular disease and acute bronchitis was a self-referral who "wanted to talk about my condition."

This patient who had been unemployed for six months before coming into the hospital, left his wife after arguing over his stepson's using the car without permission. During the argument, the wife stated that "he (the son) is mine, the car is mine and you are mine."
Veteran admitted this statement made him feel he had completely lost his independence and admitted coming
to the hospital in an effort to escape. During the interview, the patient repeatedly expressed the importance of his being able to himself maintain the family's standard of living.

In this case the worker was confronted with problems that were created by the patient's not being able to adjust to his illness and the limitations that his illness imposed on him. This veteran's problem was further complicated by his family's reactions. The worker's activity in this case was focused around helping the patient to accept his illness and the realization that he alone would not be able to maintain the family's standard of living because his physical condition would not enable him to work regularly as a laborer. The worker helped the patient to see that part of his problem was trying to maintain high living standards, and that part of the source of the difficulty in the marital conflict was the patient's feeling that he was losing his independence and masculinity.

The worker helped this patient to alleviate some of his anxiety by explaining, after a conference with the doctor for clarification of veteran's working status and physical condition, the degree of disability of the veteran. Together they discussed some type of employment that the patient could do with minimum strain and the worker referred the patient to the counseling psychologist for testing for job level.

Social treatment may be total or partial rehabilitation, prevention of deterioration, or merely enabling the patient to deal with some special aspect of his life so he can give best cooperation with his care, keep alive hope and confidence and reduce his disablement.¹

¹Department of Medicine and Surgery, Information Bulletin, op. cit., p. 5.
It is the social workers responsibility to alleviate problems within the patient's attitude toward the people around him, the care given him, the enormousness of his health problem from his viewpoint, or possibly some carried over cultural or emotional objections to some feature of the total hospital regime or method of treatment.¹

Before the patient is ready to leave the hospital, hopefully, the social worker has been alerted and has established a supportive relationship with the patient. The social worker should be aware of the factors that are confronted by chronically ill patients in his life situation and illness. She has a picture of his family, community and cultural background. The worker is concerned with the type of home the veteran has and who is there to care for him. She also takes under careful consideration the patient's feeling about returning to his home and the image he has of himself in terms of his place in the family and the family's feeling about the patient's returning. The answer to these questions play an important part in planning for the patient's future.²

The team works toward the best plan for the patient with each member making his own contribution to the patient's adjustment and outlook. The social worker advises on the social situation, the doctor evaluates the medical prognoses and needs of the patient and other members share and contribute to the decision.³

In this study there were many and varied aspects of discharge planning, among them were: employment possibilities for the patient, vocational

¹Ibid.
²Grace White, op. cit., p. 32.
³Ibid.
and educational facilities for the patient, finding a home for patient, adjustment of the patient's attitudes so that he would be able to live within the limitations of his illness, locating members of the family, evaluating home situations and help in financial arrangements for after-care and out-patient care. In fifteen of the eighteen cases where casework focus was primarily on discharge planning the worker offered service in two or more of the above areas. High on the list for discharge planning was casework service to the families of the patients. (This will be discussed later in this chapter.) Case No. 3 shows the multiplicity of problems confronted by workers in planning for de-hospitalization of the patients.

Case 3

Mr. J., seventy-one years old, World War I Veteran, married with a diagnosis of cardiovascular accident and diabetes mellitus was referred by the ward physician for discharge planning. This patient had been hospitalized three times since 1956.

Prior to his admission to the hospital the patient had lived with his sixty-eight year old wife in a small resort city in Southeastern Florida. The veteran had been confined to a wheelchair since 1957. The family's only income was a permanent and total disability pension of $66.15.

When first approached about the possibility of leaving the hospital, veteran expressed a fear of going home because he did not feel that his wife could care for him. It was his contention that his wife did not understand the nature of his illness and could not fix his diabetic diet.

Worker referred the case to the regional office near the veteran for a home evaluation. The regional worker reported that the sixty-eight year old wife had refused to accept the veteran because of severe financial difficulties and her failing health. Worker referred the patient's wife to the local Department of Public Welfare who helped her in obtaining medical care for her heart condition and transportation to and from the health
center. Worker, from regional office, helped the wife to understand the problems of her husband's illness and how to prepare for after-care for the veteran. Hospital worker referred veteran to contact for aid and attendance fee which he received and was able to pay a distant cousin to come daily and help the wife care for the patient.

In the above illustration the worker was confronted with several problems in trying to plan for the de-hospitalization of the veteran. First the veteran had anxiety about leaving the hospital because he feared he would not get the proper post-hospital care. Secondly, the wife refused to accept the veteran because she was not able to care for him financially or physically. The worker helped to alleviate these problems by referring the wife to the proper community resource for medical care and by helping to modify her attitudes toward her husband. The worker also helped the veteran to realize that he could obtain the proper nursing care at home with the help of Aid and Attendance Benefits.

The medical social worker serves both the patient and the hospital; her's is a two-fold loyalty. For the hospital she helps to keep the flow of patients so that there are beds available when needed.

She assists the patients who are ready for discharge in making plans for their continued care when such is needed. All too often, patients continue to stay on in badly needed hospital beds simply because there seems to be no other place where they can receive needed care. The social worker can assist the patient in finding suitable care elsewhere thus benefiting both the patient and the hospital.¹

This does not mean that patients should be transferred from the hospital before they are physically and emotionally ready to go; it merely means

¹ Theda L. Waterman and Valorus F. Lang, op. cit., p. 53.
that there is more efficient use of limited facilities. If this was the only function of the social worker she would be performing a valuable service to society, but her services are far more extensive. Of the fifty cases studied twenty-seven, or forty-four per cent of these patients could be discharged from the hospital if plans could be developed for after-care.

Feelings of hopelessness which have sometimes been called "institutional apathy" are frequently found among the chronically ill. The feeling of helplessness which can stem from any actual experience of extended illness can create in the chronically ill a deep fear that nothing can be done to help him. With patients who want to leave but are physically unable to do so, the service that is offered is of supportive nature. As long as they feel that someone, and frequently it must be the social worker because there is no one else, is interested in them, they are unlikely to lapse into institution apathy. Lacks in community resources makes it impossible for some patients to leave even when they are physically able and some patients even prefer to remain in the hospital because the protected environment has met their dependence needs.

In this hospital patients who are diagnosed as long-term illness receive supportive case work as far as the limited manpower will reach.

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2 Ibid.
Of the fifty cases studied forty, or eighty per cent received some type of supportive case work. The focus of these treatments was usually centered around the area of the patient's interest or areas in which the social worker felt that the patient needed assistance in adjusting.

The nature of this service could be brought out in the case of a twenty-eight year old paraplegia patient who had been hospitalized for eighteen months at this hospital. Since the patient's admission to the hospital his wife had left him, carrying his three children with her. Veteran had not heard from his family or friends since hospitalization. His condition was caused by an automobile accident and only a limited amount of improvement could be expected.

In this case the worker made weekly visits (sometime more) to talk with the patient. The patient looked forward to these visits and often talked with the worker about problems that were causing him some anxiety, regardless of their nature. She helped the patient to feel that someone was still interested in him and was concerned about his welfare, without offering any false assurance in terms of the improvement in his illness or discharge from the hospital.

Anxiety in the chronically ill patient may come from such causes as the longing to be taken care of, and the dread of rejection, fear of separation from others, the fear of loss of links and feeling of guilt. The anxiety of the chronically ill patient may interfere with rest and prevent him from cooperating freely in treatment. The social worker who can gain the patient's confidence through the strength of her relationship encourages him to be more independent. This can be done through first helping him to meet his minimum dependency needs. What you need most in providing care for the chronically ill, is to be able to see what is in their
hearts and to help them achieve this.¹

Financial Help

In the past it was thought that only the indigent patients needed the services of the social worker, that financial problems were the chief difficulty of the chronically ill. Now we know that financial worries are only one of the many problems that beset sick people.² However, as medical and nursing care becomes more and more technical, the cost increase until very few people can meet the expense incurred in a long-term illness, and what about the families of these patients. Who will take care of the children? In this study only eight, or sixteen per cent of the patients received casework service primarily for financial assistance. This might be contributed to the fact that in this institution all patients are allowed to file a claim for compensation or pension from the U. S. Government. Of the fifty cases studied, forty-six were receiving Permanent and Total disability pensions, compensation or social security, or retirement benefits. Only four patients did not have an income (see Table 3).

Other assistance for the patients were arrangements for transportation to and from the hospital, arrangements for burial expenses, Chaplin Fund for transportation of patient's families from the hospital after

¹Mildred Hedberg, "Some Needs and Attitudes which must be Understood in Providing care for the Chronically Ill," (Lecture during conference on Hospital and After-care of the Chronically Ill, Tuskegee Veterans Administration Hospital, Tuskegee, Alabama, June 11, 1959).

²Theda L. Waterman and Valorus F. Lang, op. cit., p. 7.
visits, referral of veterans to National Epileptic League to obtain anti-convulsants at minimal cost.

Casework with Families of the Chronically Ill

The impact and shock of a diagnosis of one of the chronic illnesses is felt by patient and then by the family. Most of the emotional problems that beset the patient with a long-term illness involve his relationship with others. His acceptance of the diagnosis and any possible restrictions or limitations which it may cause may be influenced by the reaction of others. It is in this area that the medical social worker can make his most valuable contribution.\(^1\)

An important part of the social worker's treatment of the patient is to reduce the anxieties of the family. Families also become deeply anxious about the prognosis and outcome of the disease and treatment not only in terms of life expectancy but also of the patient's disability or helplessness, with support from the social worker most families can accept the reality of the illness and face even a hopeless prognosis with courage and strength to give the patient the supporting help he needs.

The social worker helps the family and friends in their adjustment to the new situation and assist them, not only in accepting the patient with his limitations but also in conveying to the patient the feeling he is still loved and needed.\(^2\)

In this study casework service was provided for twenty-seven, or forty-four per cent of the families of these veterans. These services

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\(^1\)Theda L. Waterman and Valorus F. Lang, *op. cit.*, p. 53

\(^2\)Ibid.
were either rendered by the clinical social worker in the hospital, Veterans Administration Regional Office, or a worker from social or health agencies.

Casework service with the focus on discharge planning was the primary reason for contact with the families. In eighteen of the twenty-seven cases where the family was seen in reference to discharge planning casework was centered around the family’s ability to care for the patient, this included the counseling of members of the family in post-hospital care and frequently, advising the family on problems in properly handling their situation. There were many problems that confronted these families. Among them were management of the household by the wife or mother, understanding the medical regime of the patients, inability to care for patient because of limited space in the home, inability to care for patient because of limited financial income, adjustment of children or spouse to the needs or attitudes of the patient returning home. Supportive casework was rendered to the families of these chronically ill patients just as it was to the patients.

Apart from counseling service, factual information was given to a considerable number of relatives. Matters dealt with included: purpose of treatment plan, procedure for obtaining public assistance and resources for after-care. Table 6 shows the purpose of contacts with the families of these chronically ill patients.
TABLE 6
PURPOSE OF WORKERS' CONTACTS WITH FAMILIES

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Number Contacted</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Planning</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>(Counseling attitudes of patients and family, Supportive casework, management of household, Post-hospitalization care).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishing Family Ties</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Procedure for Obtaining Public Assistance</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Purpose of Treatment Plan</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>54</td>
</tr>
</tbody>
</table>

An example of the social worker's activity with patients' families can be seen in the following case.

Case 4

A seventy-two year old World War I, white, married veteran was referred by the ward nurse because the veteran's family wanted to take this seriously ill veteran home for the week-end. Veteran had a diagnosis that included terminal cancer, cerebral arteriosclerosis and diabetes.

In the interview the wife of the veteran expressed a desire for the veteran to return home for "he looks as if he is better." The veteran's daughter in-law expressed concern about the type of service that her father in-law was receiving at this hospital. Further clarification of this revealed that the family had some anxiety around the veteran being in a hospital with a predominantly Negro staff. Further explorations with this family revealed that they had no idea as to the seriousness of the veteran's condition.

In working with this family the worker was confronted with the difficult task of helping them accept the severity of this patient's illness.
The family had to be helped to understand that the patient's condition was terminal and that he needed continuous medical supervision. This was important in this case because this family was financially able to care for the veteran. The family was relieved of some of their anxiety about the racial barrier after talking with the social worker and the doctor. The family was greatly relieved when the patient stated that he was being treated well. Here the social worker helped this family to talk through their anxieties and used the collaborative resource of the doctor, to help facilitate this process.

Use of Hospital Resources

Each member of the medical team's contribution is focused toward the primary purpose, which is better service to the patient. Each member of the team should think in terms of how his individual contribution may be related to the function of other individual members of the group. Each member also considers what he can learn from the other members of the team to improve and supplement his own particular service to the patient. We thus find the group working together with the goal of seeing that the patient gets the best service available to evaluate his problem.  

In this study there was evidence of cooperation between the social workers and other hospital personnel. Formal or informal discussions with the attending physician were reported for forty-four, or eighty-eight per cent of the cases studied. Although there was evidence of collaboration between the physician and the social worker, this study did not have access to the involvement or degree of interaction between the two in most cases. Thirty-three, or sixty-six per cent of the patients

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had the benefit of conferences that involved more than five members of the hospital staff. In addition to social workers, the participants usually included staff physicians, residents, interns, nurses, therapists, and dietitians.

The social worker has the responsibility to collaborate and utilize all available resource within the hospital. This involves not only the medical team but all possible resources within the hospital. The contact representative was used by the worker in ten or twenty per cent of the cases in this study. These services varied from helping to legalize common law marriages to filing claims for financial assistance. Other resources utilized by the worker in these cases were: psychology, dietician service, physical medicine and rehabilitation service, registrar division, travel service, burial clerk, chaplin and the blind center. Table 7 shows the para-medical services utilized by the workers.

Use of Community Resources

The impact of chronic illness is felt, either directly or indirectly, by the whole community. Because of the excessive burden of chronic illness, many families become impoverished and are forced into dependency. Family life is disrupted and all too often children become delinquent. There is a vicious circle of illness, poverty, and unhappiness which, if allowed to go unchecked, could undermine the moral fiber of the community.¹

¹Theda L. Waterman and Valorus F. Lang, op. cit., p. 35.
problems that are created by chronic illness. The social worker should have an awareness of the availability of community resources and their services. It is often through other agencies' service that she is able to accomplish a major part of her treatment goal. She is often the link between the hospital and other agencies that provide services for the chronically ill.¹

**TABLE 7**

**PARA-MEDICAL RESOURCES UTILIZED**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Number of Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blind Center</td>
<td>1</td>
</tr>
<tr>
<td>Burial Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Contact Representative</td>
<td>10</td>
</tr>
<tr>
<td>Dietitian Service</td>
<td>3</td>
</tr>
<tr>
<td>Director of Professional Service</td>
<td>2</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>9</td>
</tr>
<tr>
<td>Psychology Service</td>
<td>5</td>
</tr>
<tr>
<td>Travel Service</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

In this study, Department of Public Welfare was the most frequently used community resource. Eight cases were referred for financial assistance. In three of the eight cases referred, the worker requested

¹Ibid.
that the welfare worker assist in helping the patient or his family adjust to or utilize post-hospital care.

Other community resources utilized by the social worker in these cases were Social Security Board, Veterans Administration Regional Office, Public Health Agencies, American Red Cross, State Rehabilitation Boards, Police Department and the National Epileptic League. The workers in these cases used Veterans Administration Regional Office five times in helping these patients. (Use of Veterans Administration Regional Office can be seen in Case 3, page 33.) Public health departments were used three times, state vocational rehabilitation was used two times, and the National Epileptic League was used twice. The Social Security Board, Police Department and a minister was used one time each. Table 8 shows the community resources utilized by workers in this study.

TABLE 8
COMMUNITY RESOURCES UTILIZED

<table>
<thead>
<tr>
<th>Resources</th>
<th>Number of Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Public Welfare</td>
<td>8</td>
</tr>
<tr>
<td>Veterans Administration Regional Office</td>
<td>5</td>
</tr>
<tr>
<td>Public Health Department</td>
<td>3</td>
</tr>
<tr>
<td>State Vocational Rehabilitation Board</td>
<td>2</td>
</tr>
<tr>
<td>National Epileptic League</td>
<td>2</td>
</tr>
<tr>
<td>Social Security Board</td>
<td>1</td>
</tr>
<tr>
<td>Police Department</td>
<td>1</td>
</tr>
<tr>
<td>Minister</td>
<td>1</td>
</tr>
<tr>
<td>Red Cross</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
Case 5 shows the reason for use of community resources in helping the patient.

Case 5

Mr. G., sixty-eight years old, separated, World War I veteran, requested help in locating his daughters so they could help take care of him when he is discharged. Veteran had been hospitalized for five months with intractable asthma.

In this case the veteran had left his family (a wife and two daughters), twenty-eight years ago. Worker utilized the Veterans Administration Regional Office nearest the veteran's home to locate the daughters. One daughter had moved and had to be located through another regional office. These women had not seen their father in twenty-eight years and had mixed feelings about him.

After the daughters had been located, the one who expressed a desire to visit her father was orientated to his condition and to the fact that she would need emotional control in meeting him. She was alerted to the emotional aspects of asthma and the possibility that if her father became upset an asthma attack might result. This service was provided by the Veterans Administration Regional Office Worker.

This veteran decided that he would not live with either of his daughters and returned to his previous home. The worker, realizing that the patient would need some help with his health if he was to remain out of the hospital, referred him to the Public Health Department for medical supervision. He also received a portable oxygen tent to be kept in his home and was taught how to use it.

In this case the worker utilized several community resources, in
helping the veteran to achieve his desire of seeing his daughters and of acquiring much needed medical supervision. In this case the worker's service would not have been complete without providing after-care for this chronically ill patient.

Although the Red Cross is a national organization with agencies in all parts of the country, the workers in this study only used this organization one time. Is this an indication that the Red Cross is not actively participating, or sharing, in the alleviation of the problems of the chronically ill? Table 8 (page 44) reveals that no patients were referred to convalescent homes or institutions for long-term care. This is particularly important in view of the fact that twenty-seven of these patients could be discharged from the hospital if plans could be developed for after care. Nursing homes are a very real, new part of any program for the care of the chronically ill and disabled.\(^1\) Table 8 (page 44) also shows that the social workers in this study used only two private agencies in helping these patients. A fact that might interfere with the utilization of private agencies, nursing homes, in particular, might be the small income of these patients. However, the writer is cognizant of the fact that resources in this small rural community are limited.

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\(^1\) Theda L. Waterman and Valorus F. Lang, *op. cit.*, p. 53.
CHAPTER V

SUMMARY AND CONCLUSIONS

This study was an attempt to show the results of fifty cases that were studied for the activity of the social worker in the treatment process of long-term chronically ill patients. The study was descriptive and the primary focus was on the role of the social worker in helping these chronically ill patients to alleviate some of the social and emotional problems in relation to their illnesses. The study considered the background and scope of the problems of chronic diseases and a few characteristics of the patients studied. There was also a brief description of the Veterans Administration Hospital, Tuskegee, Alabama.

Fifty cases were selected from the inactive, alphabetical files of the Social Service Department. The sample included only cases who received services between January 1, 1960 and January 1, 1961, and involved males with a medical diagnosis of a long-term chronic illness.

It was mentioned in the study that the chronically ill is the number one problem of medical care. Not only is chronic illness the number one problem in terms of medical care but it is also the number one problem in terms of people involved. Besides being the nation's greatest health killers, chronic diseases are also the leading causes of unemployment and poverty. Although we know that as people survive childhood diseases and live into the old age they fall victims of the so-called degenerative diseases and other chronic ailments, it was brought out in this study that chronic illness is not necessarily a problem of the aged.
Sixty-eight per cent of the patients in this study were under sixty-five years of age.

In this study, twenty-six, or fifty-two per cent of the patients were married, four were single, one was involved in a common law marriage and there was no information about one. The remaining eighteen were divorced, widowed, or separated. Thirty-five, or seventy per cent of the patients had an income of less than one thousand two hundred dollars a year. With a large percentage of these patients being married and having families to support, one can see the financial problems that confronted many of these patients. Seventy per cent of these patients were from the rural areas where preventive health measures were not widely used. In general, the patients in this study conformed to the general agreement that chronic illness is more prevalent in the lower income group.

The diagnoses of these patients did not include all of the chronic illnesses, nor did they all have the same degree of severity. However, all of these illnesses were of long-term duration and they all presented some problem to the patient that motivated him to seek or accept help from the Medical and Social Service Department.

Social service is essential as a part of the total treatment of individuals who have been hospitalized with chronic illness. It was stated that the burden of chronic illness could be lightened by appropriate attention to the feelings and attitudes of the patients with chronic illness, the strains on personal relationships and the financial and other insecurities associated with long-term chronic illness.

It was stated in this study that the team approach is the best method to help the chronically ill patients, since the focus for treatment must
be on the whole individual to help rehabilitate him to useful living in his home and community.

The Clinical Social Worker's functioning as a member of the team dealt with a multiplicity of social and personal problems which interfered with or blocked the results the team desired to achieve. In general, the social worker rendered casework service to patients for problems that involved: helping the patient to deal with emotional reactions created by his illness as many times these reactions hinder recovery, helping the patient to make a satisfactory adjustment within the limitations of his illness and alleviate the anxieties created by the loss of income or financial strain by assisting these patients to obtain material help when necessary. Although only eight patients in this study were referred specifically for financial assistance, the writer feels that this occurred because all the patients in this study were veterans, who, if disabled by any other reason than misconduct, were eligible for compensation or permanent and total disability benefits.

The social workers in this study involved themselves in the process of supportive casework in an attempt to prevent these long-term chronically ill patients from lapsing into institutional apathy. This involved helping the patient to accept and adjust to long periods of hospitalization and trying to prevent the patient from obtaining that feeling of hopelessness and helplessness.

From this study there was evidence of the social worker helping these patients by rendering casework service to their families. This involved: interpretation to the family of the nature of the patient's
illness and the feelings and limitations that it imposes on the patient, the motivation of the families toward formulating plans for the patient's post-hospital care and rehabilitation.

The social workers also used available resources within the hospital to help alleviate the many problems created by chronic illness. Many para-medical and administrative services were utilized to help the patient with problems that were out of range of the services provided by social workers.

In this study, the social workers utilized various community resources. The most frequently used were public welfares, veterans administration regional offices, and health agencies. Collaboration in planning and providing for suitable after-care played a dominant role in the use of community resources. This study revealed that none of the fifty cases were referred to convalescent homes or institutions for long-term care. The writer does not feel that this reflects a lack of understanding or inconsistence in the use of community resources by the workers, but an absence of these resources in the community.

From this study, it was concluded that:

A. The Clinical Social Workers in this setting apply the casework process of study, assessment and treatment individually in working with the chronically ill.

B. Social service is involved in team functioning and makes a contribution to the treatment of the total person.

C. The Clinical Social Worker in this setting utilizes available resources in helping the chronically ill.

D. Clinical Social Workers are handicapped in working with the chronically ill in providing medical and nursing after-care because of lack of facilities in the community.
The writer feels that if more casework service could be provided for medical patients on admission, the multiplicity of problems that are created by long hospitalization would be alleviated before they become acute. This would necessitate the enlargement of the social service staff, but the hospital adjustment of the patients would be far smoother and the transition from hospital to home or other institution could be more rapid.
APPENDIXES

A. SCHEDULE FOR OBTAINING INFORMATION FROM RECORDS FOR THE ROLE OF THE SOCIAL WORKER IN TREATMENT OF FIFTY LONG-TERM CHRONICALLY ILL PATIENTS.

B. DIAGNOSES CLASSIFIED AS CHRONIC DISEASES BY THE COMMISSION ON CHRONIC ILLNESS.
APPENDIX A

SCHEDULE FOR OBTAINING INFORMATION FROM RECORDS
FOR THE ROLE OF THE SOCIAL WORKER IN TREATMENT OF
FIFTY LONG-TERM CHRONICALLY ILL PATIENTS

Identifying Data:
Patient's Name ___________________________ Age _________
Home Address: City ___________________________ State ________
Admission Date: ___________________________

Medical Information:
Major Diagnosis ___________________________ Other Diagnosis _________
Medical Regime: on Medication _________ Special Diet ______________
Others __________________________________________
What is the reason for continued hospital care: Medical _____________
No Home ___________________________ Lack of Funds ______________
Inadequate out-patient Facilities: ______________ Others _____________

Social Information:
Education ___________________________ Occupation ___________ Retired _________
Marital Status ______________ Number of Dependents ______________
With whom was patient living before hospitalization? ______________
Could he return to this home: __________, if not, Why? ______________
Patient's Income: ________________________ Source ______________________
Frequency of Family Contacts ____________________________

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Role of Social Worker:

Source of Referral: ________________________ Reason for Referral ________________________

Was the referral problem the reason for casework service to the Patient?
Yes _____ No ___________

If not, what was the focus of casework services ________________________________

Resources utilized by the social worker in helping the patient?

Medical Social Collaboration: ____________________________________________

Other Para-medical: ____________________________________________________

Community: __________________________________________________________

Family: ______________________________________________________________

What were the goals of the patient-worker in the case? _________________________

Were Goals accomplished? _____________________________

Describe the social worker's focus in rendering service to the patient. ____________
APPENDIX B

DIAGNOSES CLASSIFIED AS CHRONIC DISEASES
BY THE COMMISSION OF CHRONIC ILLNESS

Cancer, all sites
Normalignant tumors and tumors, nature unspecified.
Acute rheumatic fever.
Chronic rheumatism, arthritis, and gout.
Diabetes Mellitus.
Disease of the thyroid gland, including all types of goiter and parathyroid diseases.
Anemia, all forms.
Other general diseases.
Cerebral hemorrhage (apoplexy), embolism, thrombosis.
Other paralysis.
Chorea.
Neuralgia and neuritis.
Diseases of the eye and blindness.
Diseases of the ear and deafness.
Diseases of the heart and coronary arteries.
Arteriosclerosis and high blood pressure.
Tuberculosis (all forms).
Hemorrhoids.
Varicose veins or ulcer, varicocele.
Sinusitis.
Asthma.

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Hay fever.

Ulcer of the stomach or duodenum.

Hernia.

Diseases of the gall bladder and liver.

Nephritis and other diseases of the kidney, including kidney, unspecified.

Diseases of the bladder, urethra, and urinary passages.

Nonvenereal disease of the male genital organs.

Cysts of the ovaries, uterus, and tubes.

Eczema.

Diseases of the bones and joints, except tuberculosis and rheumatism.

Lumbago, myalgia, myositis, stiff neck and other muscular pains.

Other disease of the organs of locomotion.

Congenital malformations and other diseases of early infancy.

Other and ill-defined causes, including senility.

Psoriasis.
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