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Some types of medical-social problems incident to hospital adjustment and discharge of twenty-one rheumatic fever patients

Joan B. McWilliams

ATLANTA UNIVERSITY

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SOME TYPES OF MEDICAL-SOCIAL PROBLEMS INCIDENT TO HOSPITAL ADJUSTMENT AND DISCHARGE OF TWENTY-ONE RHEUMATIC FEVER 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
JOAN BLONDELL MCVILLIAMS

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1955
ACKNOWLEDGMENTS

The writer wishes to acknowledge the Grace-New Haven Community Hospital, in New Haven, Connecticut for the use of their material and Miss Hortense Lilly, who was my thesis supervisor at the Atlanta University School of Social Work, for her invaluable assistance in facilitating the preparation of this thesis.
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CHAPTER I

INTRODUCTION

Significance of the Study

It is only within recent years that attention has been drawn to prolonged illness as a public health problem of the first magnitude. We are witnessing a growing concern about its extent and its implications for world progress and a beginning attempt to study the problem in all its aspects.

On the basis of the National Health Survey, 177 persons out of every 1,000 have a chronic disease. That's one out of every six of us — a total of more than 26,000,000. However, the figure includes people with relatively minor conditions, such as hemorrhoids, asthma, and the like and does not mean that all these people are disabled or sick. When the survey was made in 1935-36, about 6,000,000 of us laid up at least seven consecutive days a year because of chronic illness, recent studies indicate that the figure now would be even greater. A study undertaken for the National Conference on Care of the Long Term Patient Under the Auspices of The Commission on Chronic Illness presented findings indicating that almost 3.5 percent of the total population suffers from disabling long-term chronic disease or impairment.

Not only is the number of people with prolonged illness large, but available figures support the general impression that this number is

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1 Minna Field, Patients Are People (New York, 1953), p. 29.

constantly on the increase. This may be accounted for at least in part, as being due to (a) increased longevity, (b) our greater awareness of early manifestations, (c) the more intensive use of medical attention in the beginning stages, and (d) the more highly developed medical diagnostic skills.

As a consequence of this increase in the number of people suffering from prolonged or chronic illness there has been a growing change of attitude toward these sufferers in medical settings. Today, more than ever before emphasis is being placed on the treatment aspects of chronic illness. We are also beginning to see changes in concepts surrounding the illness. The nomenclature, as an example reflects the change. At one time these sufferers were referred to as "incurable" or "custodial". The shift has been from "incurable" to "chronic" to the present terminology of "prolonged". There is also a trend toward the building of special hospital wards or buildings for treatment and hospitalization of these patients.

These and other changes in attitude toward people with prolonged illnesses have brought about profound change in the concept of what constitutes an adequate program of medical care. The medical social worker being an established member of the hospital staff has also had to change her concepts and attitudes toward patients with prolonged illnesses. This change was necessary in order for her to be a functional member in medical institutions operating in a framework influenced by the current attitude toward chronic illness. No longer does the medical social worker seek primarily to render friendly services to make the patient's stay in the hospital more endurable and to bring some measure of cheer and comfort. She has now

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1 Minna Field, op. cit., p. 25.
become aware that these patients need help just as the acutely ill patients need help. Further, that their behavior is not merely an indication of a deliberate intent on the part of these patients to be contrary but rather is evidence of some inner or outer difficulty. These and other awarenesses on the part of the medical social worker has made her realize that her understanding and skill, developed in serving acutely ill patients, are equally applicable to the problems presented by chronic sufferers.

The writer while doing her block field work placement at the Grace-New Haven Community Hospital in New Haven, Connecticut became interested in the types of problems encountered by the patients on pediatric service which often required the help of the medical social worker. Also being interested in long-term illness, the writer decided to make a study on the activities of the medical social worker in assisting the patient with rheumatic fever in adjusting to hospitalization and discharge. Rheumatic fever, like other long-term illnesses, calls for an adjustment on the part of the sufferer to the illness. This adjustment is sometimes more difficult for children than for adults. This might partially be explained on the basis of the child's inability to understand and to accept the limitations the illness imposes on him and by which other children are not restricted.

Rheumatic fever, an illness of long-term duration, has been catapulted into prominence as the enemy of youth ever since some of the once-devastating scourges, such as diphtheria, dysenteries and other childhood infections, were reduced to relative insignificance. Although rheumatic fever and rheumatic heart disease alone cause more chronic disabling illness in

childhood than any other disease, it is not solely limited to childhood but is encountered in men and women of all ages.

As rheumatic fever is not a reportable disease in many areas of the country, there is still no accurate data on its general prevalence in urban and rural areas in the United States. Three crude methods for determining prevalence of the disease exist as a substitute for reporting, but none is adequate. These methods are: the collection of local hospital statistics on the annual number of admissions for rheumatic fever, the analysis of mortality rates from heart disease in the age group five to twenty-five, and the examination of representative population groups such as school children to determine the prevalence of heart disease. It is estimated that about a million Americans of all ages are affected either by the disease or the rheumatic heart condition that results from it.

Some statistics show that rheumatic fever including rheumatic heart disease: (1) ranks with tuberculosis and syphilis as a great disabling chronic disease; (2) except for accidents, is the commonest cause of disease among school children; (3) is the second commonest cause of death by disease in the twenty to the twenty-four age group; (4) causes much of the heart disease in later life; and (5) in the United States affects more than a million persons, young and old. Although these figures would

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2 T. Duckett Jones, M.D., op. cit., p. 94.

indicate a health program of major proportions, these facts are not as alarming as the incidence of the disease might indicate. More revealing is what happens to the rheumatic fever patient as they progress through life.

To learn what happens, 1,000 patients who had been treated for rheumatic fever at the House of Good Samaritan in Boston were checked for ten years. At the end of that time, fourteen had been lost sight of, but for the rest it was found:

439 were leading perfectly normal lives with no evidence of heart damage that could be detected by the usual means of examination.

209 had sufficient evidence of scarring in the heart tissues to impose slight—but only slight limitations on their normal activities.

135 had developed cardiac damage serious enough to limit their physical activities severely.

203 had died, chiefly from rheumatic fever, but 19 of them (or 9 percent of the deaths) from causes unrelated to rheumatic fever or any other heart disease.\(^1\)

Significant as the fore-mentioned facts might appear, it is perhaps even more significant to note that rheumatic fever is not yet widely handled throughout the nation as a problem of public health.

Purpose of the Study

The purpose of this study was (1) to indicate some of the social and medical aspects of rheumatic fever; (2) to show the nature of the problems accompanying the patient's adjustment to the hospital and to his discharge; and (3) to determine the activities of the medical social worker in dealing with these problems.

Method of Procedure

The writer surveyed the related literature in the field relative to chronic illness and rheumatic fever in order to gain a balanced perspective,

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\(^1\) T. Duckett Jones, M.D., *op. cit.*, pp. 94-95.
to gain some information about the subject and survey some of the methods used in the literature.

The case record material was obtained from the social service department of Grace-New Haven Community Hospital in New Haven, Connecticut. Twenty-one cases were included in the study covering a period from October 1, 1951 to June 30, 1954. Of the total number of cases closed on the pediatric service, the twenty-one cases included in the study comprised all of the closed cases of patients who presented problems around discharge planning during the above-mentioned period. Closed cases were used because the writer was interested in studying cases in which the services had already been rendered in order to determine all of the processes used in the cases from initial contact to termination. The period covered was used as the writer was desirous of securing the most current information.

A schedule was prepared in order to obtain information relative to the identification of the patient, the social and financial factors involved in the area of discharge planning and the patient's adjustment to illness, the relationship in the family situation and the attitude of the family and the patient to the illness and some of its aspects. The data was obtained from the face sheet of the case record, the written narrative record, and interviews with the case worker on pediatric service.

Scope and Limitations

This study was limited to twenty-one cases obtained from the social service department of the Grace-New Haven Community Hospital during the period from October 1, 1951 to June 30, 1954 as these were all of the patients known to the social service department with a diagnosis of rheumatic fever and who also had a problem around discharge planning and problems
affecting hospital adjustment. The cases studied included fourteen white females and seven white males ranging in age from three months to seventeen years. Of the twenty-one cases under study only one patient was a Negro. The study is not inclusive of all types of prolonged illnesses but is restricted to rheumatic fever and involves only the activities of the medical social worker in assisting the patient with his hospitalization and discharge. The availability of more case records from the pediatric service concerning the area under study serves as another limitation. The time span in which the study has to be completed coupled with the limited experience of the writer in compiling material for such a study further limits it.

The categorizations of the patients' attitudes included in the schedule were arrived at on the basis of the material in the case record. The objectivity of these categorizations is limited since there was no attempt to standardize these observations. These, therefore, represent the writer's judgment only.
CHAPTER II

MEDICAL AND SOCIAL ASPECTS OF RHEUMATIC FEVER

Effect of Rheumatic Fever and Its Treatment

Rheumatic fever is an acute disease that often runs a chronic course and attacks the connective tissue in widespread areas of the body and causes inflammation of the muscles, valves, and outer lining of the heart. The exact nature of the disease is not easily described as its effect. It has no one characteristic symptom. Pain in the joints and a continued fever are common - hence the name - but these may mark other ailments as well. Its overwhelming importance stems from the fact that the heart is frequently affected; it sometimes leaves the heart less efficient and permanently scarred. When this happens the child has chronic rheumatic heart disease. However, every child with rheumatic fever will not develop permanent rheumatic heart disease. The best statistics on the prospects of recovery are based on a study of rheumatic fever patients at a Boston hospital. According to this study two-fifths of the persons who had rheumatic fever had no evidence of heart disease and could have a life of normal activity; a third had to limit their activities but in most instances the limitations were slight - less than 15 per cent had to limit their activities drastically. The remainder - about 20 per cent died within ten years. Although the direct cause of the disease is not known, it is generally agreed that the disease almost always follows a hemolytic streptococcus infection. If rheumatic fever appears, it usually does so two or four weeks after the "strep"

\[1\]Ibid., pp. 94-95.
infection, although in relatively rare instances it may manifest itself in a few days or be delayed for weeks. The disease usually passes through two stages; active and inactive. While in the active stage, the acute symptoms usually last only for weeks or months. After the first attack wears off the patient may look almost well and be eager to get up. This, however, is the danger point, for the disease may still be active. Medical care for the rheumatic fever patient is characterized by the necessity for hospitalization, for prevention of recurrence through adequate convalescent care, for continued supervision, and for the protection of the patient's family.

As yet, there is no specific cure for rheumatic fever, although symptoms may be relieved through the use of hormone substances like ACTH and cortisone and salicylate drugs like aspirin until the rheumatic fever infection dies down. The only effective treatment for rheumatic fever is long rest in bed under good medical and nursing supervision. It has been agreed upon by most authorities that once an individual has had rheumatic fever his susceptibility to repeated attacks is that much greater. However, attacks of rheumatic fever are by no means limited to children. Adults may also be stricken, whether or not they have a record of previous attacks. During World War II, 40,000 persons in the armed forces were stricken. As far as any one could tell this was a first attack for many

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2Herbert Yahraes, Rheumatic Fever, op. cit., p. 9.
3What the Classroom Teacher Should Know and Do About Children with Heart Disease (American Heart Association Publication), American Heart Association, November, 1954, p. 6.
4Frances Upham, op. cit., p. 57.
Factors Influencing Prevalence of Rheumatic Fever

The families in which one or more members have had rheumatic heart disease or rheumatic fever, are sometimes referred to as "rheumatic families." This usually implies that members of this family are three times more susceptible to the disease than non-rheumatic families. Various readings indicate that studies have been made in an attempt to determine the relationship between heredity and rheumatic fever. Some doctors feel that heredity is the basis of susceptibility taking as evidence the preceding statement; others refute this theory on the basis that certain environmental conditions are responsible for the development of the first occurrence and that these same conditions make it more than likely that some other members of the family will be affected. The prevailing opinion is that a susceptibility to rheumatic fever can be inherited, as can a susceptibility to many other diseases. From a hereditary point, the family may be the source of infection and is the first line of defense against re-infection.

Some of the problems associated with tuberculosis are compared with this illness. In tuberculosis the family has to be protected from the patient; in rheumatic fever, the patient has to be protected from the family. For new attacks may be brought on by a hemolytic streptococcal infection and this may be carried to the patient by one who comes in contact with him. Unlike "strep", rheumatic fever itself is not contagious; one person with rheumatic fever does not pass it on to another.

1Herbert Yahraes, op. cit., p. 7.
The observation has been made that "poverty, malnutrition and unhygienic surroundings furnish the most favorable human soil for the development of this infection."

That rheumatic fever occurs most often among the underprivileged has been brought out in two similar studies made in England and the United States. In England where class distinction is much sharper it is easier for doctors to classify patients economically and socially. In the United States a study was made of college students among a higher-than-average economic level. Findings showed that the higher the economic level the students were from, the less rheumatic fever and rheumatic heart disease occurred than among those who did not attend college (and the wealthier students seem to have less than the others). The better the living conditions then the less prevalent is rheumatic fever and its sequela, rheumatic heart disease. As in the case of tuberculosis, a high prevalence is more or less a sign that the country or community has not yet risen to a high standard of living. Crowding, inadequate food, inadequate clothing, and lack of cleanliness probably all play a role in this important factor.

Several studies have been made to determine the relationship between crowded home conditions and heart disease. Such a study by Robert W. Quinn and his associates brings out the following facts:

2. O. F. Hedley, "Incidence of Rheumatic Heart Disease Among College Students in the United States," Public Health Report, LIV (August, 1938), 1635.
One of the features which did stand out was the effect of crowding within the home which was apparently an important factor influencing the prevalence of rheumatic heart disease; the rate in the crowded homes being almost twice that in non-crowded homes.

The other finding of the survey failed to show any significant differences with the exception of familial history of rheumatic fever or rheumatic heart disease which was significantly higher among rural children.¹

There also seems to be some relationship between rheumatic fever and geography and climate. Rheumatic fever is particularly prevalent in the colder, damper areas of the country, namely, New England, the Rocky Mountains section, and the Great Lakes section. The colder seasons favor hemolytic streptococcus infection, maybe, in part because people are crowded together indoors more. Thus, in the northern United States, the long winter and spring seem to be the likely seasons of the year for the occurrence of rheumatic fever. Rheumatic fever reaches its peak in April and its lowest point in November. Death rates from rheumatic heart disease are lower for the South as a whole than for any other section, and Southerners seem to be more free from hemolytic streptococcus infection and from rheumatic fever.

Social Implications of Rheumatic Fever

It is generally agreed that a social component exists in every illness in so far as the illness disturbs the usual normal activities of the patient. The extent of this interference may range all the way from a minor inconvenience to a major breakdown in an entire way of life. Illness thus influences the patient's environment, his relationship and his

feelings of adequacy and well-being. People differ from each other constitutionally and psychologically. Diseases affect the human organism variously. The development, progress, and final outcome of many illnesses are influenced by factors other than the disease itself. Reaction to a given illness in different individuals will be determined by their diverse constitutions and personality structures, and by their economic and social circumstances. The interplay of all these elements produces the individual illness situation for each person. Therefore, the care of the whole person, rather than the treatment of the disease only, becomes the aim of all the professional workers involved.

The social consequence of rheumatic fever or any chronic disease includes dependency, long periods of invalidism, and disruption of personal and economic family life. Boas states,

There is no organization during welfare work, be it family welfare, be it child welfare, medical social service or visiting nursing, no hospital, dispensary or home for the aged or chronic sick that is not called on daily to solve problems arising from the immediate effects and by products of chronic invalidism.

A chronic illness such as rheumatic fever may create debt, or budgetary deficits for which many people are unable to make adequate provisions. Very often the financial and economic cost of illness create natural anxiety in people. Sometimes referral to a public agency for financial assistance for the payment of hospitalization and convalescent care arouses


3 Frances Upham, op. cit., p. 19.
hostility toward the patient with which the family has to be helped. It may also intensify parental rejection because of expense and inconvenience. As rheumatic fever is an illness which usually takes the patient out of the home, at least temporarily, changes in family composition and status usually result. This sometimes accentuates a mother’s need for overprotecting her child and increases the child’s feeling of anxiety and dependence. Innumerable combinations of circumstances often arise and cause shifts in family relationships to which adjustments must be made.

The various problems which arise from the removal of the child from the home occur frequently and may become more serious if the home is inadequate. For if parents recognize that the home they have provided has contributed to the child’s illness, they may feel guilty and upset and consequently unable to give the child all the emotional support which he needs during hospitalization and convalescence.

For the hospital care to be effective, medical supervision for an extended period may be necessary. Convalescence is highly important at a time when these children are gradually returning to as normal a life as possible. One study shows that a group of patients treated in a convalescent home gained three times as much weight, had only one-fourth the incidence of upper respiratory infection, and after discharge had only one-half the number of recurrences as a group of patients who convalesced at home. Although the convalescent period is important to the health of the patient, it sometimes creates emotional problems in both patients and

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2 Herbert Yahraes, op. cit., p. 11.
parents. As parents and patients often see convalescent care away from home as a threat, they usually need help in following through on this recommendation.

Because of the chronicity of rheumatic fever, restrictions are often placed upon the activities of patients. Five classes prepared by the New York Heart Association show the limitations imposed upon persons with heart disease. These classes are:

A. Patients with heart disease whose physical activity need not be restricted.

B. Patients with heart disease whose ordinary physical activity need not be restricted but who should be advised against unusually severe or competitive efforts.

C. Patients with heart disease whose ordinary physical activities should be moderately restricted, and whose more strenuous habitual efforts should be discontinued.

D.Patients with heart disease whose ordinary physical activities should be markedly restricted.

E. Patients with heart disease who should be at complete rest, confined to bed or chair.¹

Interestingly enough, not all patients with rheumatic fever develop heart disease. Of those who do, only a small number fall into Class D or E. As a result they are able to lead a fairly active life. Medical authorities now feel that in the past too much emphasis was placed on the scar left on the heart by rheumatic fever and not enough attention to the danger of the rheumatic fever recurring. As a result, they formerly restricted the child's activities unnecessarily and even harmfully because of the anxiety these restrictions aroused in both the patient and his parents.

¹Criteria for the Classification and Diagnosis of Heart Disease, 3d ed. (New York Tuberculosis and Heart Association, 1932), quoted in May G. Wilson, Rheumatic Fever (New York, 1940), p. 567.
In current practice, children with rheumatic fever are permitted to engage in as many activities as their condition permits. Schooling at home and in the hospital is endorsed so that the child will not lose any time out of his classes. In some instances, special adjustments have to be made if the cardiac child is to return to the normal classroom.

Any chronic illness, such as rheumatic fever, often creates social and emotional problems of multifarious and multitudinous dimensions for the child and his family. As the medical, social, and economic elements are so closely interwoven and of as much significance for the welfare of the patient as medical treatment, the social problems in chronic illnesses invariably require intensive and long-term casework services.

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CHAPTER III
CHARACTERISTICS OF THE PATIENTS

Sex, Race and Age

Rheumatic fever is a children's disease. It usually comes first when the child is six or seven years of age, although it may come at any time during childhood. It kills more school age children in the United States than any other disease. Table 1 shows the sample study by sex and race of the twenty-one patients included in the study.

TABLE 1
STUDY SAMPLE BY SEX AND RACE

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

It is interesting to note, although the figures in the above table do not correspond with this point of view, that T. Duckett Jones suggests that rheumatic fever seems to maintain complete impartiality between boys and girls in the frequency and severity of its attacks. However, he further points out that in adults, women are more often affected than men. Wilson suggests that in various reported series there is a slightly

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2 T. Duckett Jones, op. cit., p. 98.
higher incidence of the disease among girls than among boys as indicated in this study.

Although several studies have been made to determine the susceptibility of various races to rheumatic fever, Paul states that with the possible exception of the two studies on the Negro and perhaps the Irish, there appears to be little evidence that any particular race is especially susceptible to rheumatic fever. Wilson agrees that there appears to be no conclusive evidence of a racial susceptibility. Hedley believes "that rheumatic fever and rheumatic heart disease are apt to be more fatal in the Negro than in the White, and that this is particularly true in the southern states, but in spite of this, the rate at which Negroes acquire rheumatic fever in New Haven seems to be lower than that of the general population."

In table 2 is shown the sample study by age and sex. Two patients included in the study were under one year of age. In spite of the fact that various authorities differ concerning age levels for the onset of the illness, it is commonly agreed that the average onset is about six years. Several investigators have, nevertheless, reported the occurrence of the disease in the first two years of life. Seven of the patients studied

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4Oswald F. Hedley, "Trends, Geographical and Racial Distribution of Mortality from Heart Disease Among Persons 5-24 Years of Age in the United States During Recent Years (1922-36)," *Public Health Report*, LIV, p. 2271.
5May G. Wilson, *op. cit.*, p. 18.
showed the onset of the disease to be under six years of age. Approximately nine of the female patients studied fell in the age-range 1 under 9 years. Four of the male patients studied fell in the age-range 9 under 17. It has been suggested from a reading that onset is about a year later for girls than for boys. This, however, was not indicated in the patients studied.

**TABLE 2**

**STUDY SAMPLE BY AGE AND SEX**

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Under 1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1, under 5</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>5, under 9</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>9, under 13</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13, under 17</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>17, under 21</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

**Place of Residence**

Rheumatic fever appears to be more prevalent in urban communities in temperate latitudes throughout the world. In a study done in New Haven, Connecticut on rheumatic fever, it was found that rheumatic heart disease had its highest prevalence among the poorest children living in an urban environment. Seventeen of the number of patients studied were from urban areas and four were from rural areas. The most economically deprived family was from a rural area.

The following is an example of economic deprivation in a rural family.

This patient was one of six children ranging in age from 10 to 2 years. Another baby was expected by the family in the fall of the year. The patient's family occupied a cabin in a rural area which
consisted of two rooms, 12' by 16'. There was no running water in the cabin and the bathroom was located out of doors. The father stated that his income was $24.00 to $30.00 weekly which he received from the television business he and a friend had opened a few months ago.

Living Arrangements

TABLE 3

STUDY SAMPLE BY NUMBER OF ROOMS AND NUMBER OF MEMBERS IN FAMILY*

<table>
<thead>
<tr>
<th>Number of Rooms</th>
<th>Number of Members in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
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</tr>
<tr>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

*One patient is not included, therefore, total is less than twenty-one.

Table 3 shows the number of family members in the dwelling in comparison with the number of rooms in the dwelling. One family was comprised of eight members and had only two rooms. Three of the families had three rooms. Of this number two families had four members, and one family had three members. Seven families had four rooms. Of these three families had six members, two families had five members, one family had four members and one family had nine members. Four families had five rooms. Of these, three families had six members, and one was comprised of four members. Two families had six rooms and each of these families had five and six members respectively. Only three families had seven rooms. Of this number, one family had nine members, one had seven members and one family had four members.
From the preceding statements it is obvious that crowding was evident in the majority of the patients' homes. Wilson, Paul and Yahraes suggest that crowding along with other factors such as low income, poor diet, and inadequate housing have some relationship to rheumatic fever. A study done in England by Perry and Roberts showed there was a great variation in the prevalence of rheumatic heart disease in the various wards of Bristol with a significant correlation between crowding and heart disease prevalence, for, as the number of persons per room increased, the case rate went up. Findings from the study done by Paul suggested that there was no indication that rheumatic fever was increased as excessive crowding increased among the families included in his study. Nor was there any indication that the rheumatic fever increased among the most poverty-stricken families.

Income of Families

Another measure of deficient living conditions which went hand in hand with crowding was the income of the family. The main source in most of these families was the father's income. The average weekly income of the families was sixty-six dollars and seventy-two cents.

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1 Ibid., p. 56.
3 Herbert Yahraes, Rheumatic Fever, op. cit., p. 6.
TABLE 4
STUDY SAMPLE BY FAMILY'S WEEKLY INCOME*

<table>
<thead>
<tr>
<th>Family Weekly Income</th>
<th>Number of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
</tr>
<tr>
<td>$10, under 30</td>
<td>2</td>
</tr>
<tr>
<td>30, under 50</td>
<td>0</td>
</tr>
<tr>
<td>50, under 70</td>
<td>8</td>
</tr>
<tr>
<td>70, under 90</td>
<td>7</td>
</tr>
<tr>
<td>90, under 110</td>
<td>3</td>
</tr>
</tbody>
</table>

*One family not included as patient was the ward of a county.

In three instances public assistance served as the families' source of income, supplemented by the father in one instance. Of the total number of families studied, only two mothers were gainfully employed and their incomes were used to supplement their husbands' earnings. The parents in those families receiving public assistance were separated because of marital problems or for other reasons. For the most part, the fathers were engaged in manual work, two, however, were self-employed. Taken separately, it was found that two families had weekly incomes of one-hundred dollars and each of these families included only four people which perhaps might indicate that all patients studied were not economically deprived.

Familial Incidence of Disease of the Patients

Most authorities on rheumatic fever agree that there is some relationship between rheumatic fever and familial susceptibility.}

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1 Herbert Yahraes, op. cit., p. 7.
### TABLE 5

**STUDY SAMPLE BY FAMILIAL INCIDENCE OF RHEUMATIC FEVER**

<table>
<thead>
<tr>
<th>Familial Incidence of Rheumatic Fever</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>21</td>
</tr>
<tr>
<td>Parent</td>
<td>1</td>
</tr>
<tr>
<td>Paternal uncle</td>
<td>1</td>
</tr>
<tr>
<td>Maternal uncle</td>
<td>1</td>
</tr>
<tr>
<td>Paternal and maternal aunt</td>
<td>3</td>
</tr>
<tr>
<td>None stated</td>
<td>15</td>
</tr>
</tbody>
</table>

As shown in Table 5, six of the patients had known histories of familial incidence of the disease. Of the total number of families, only one family revealed a parent as having had rheumatic fever. Those families that did have a familial incidence of rheumatic fever, for the most part, had occurred in either the paternal or maternal aunt or uncle of the patient. There were a brother and a sister in two of the families studied. Familial incidence of these siblings revealed rheumatic fever to have occurred in two paternal aunts and in one maternal aunt.

In a study of familial incidence of rheumatic fever, it was found that in about 72% of 112 families one or more of the near relatives of the rheumatic subject—parents, grandparents, aunts, uncles, or cousins—were rheumatic.

Although several studies have been made to examine the familial incidence of rheumatism in general genetic terms, no study has been able to prove conclusively that there is a hereditary basis for the illness or disease. It is believed, however, that hereditary influences serve as an important factor in the epidemiology of the disease.

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Siblings of Patients

The study sample of sibling distribution is shown in Table 6.

<table>
<thead>
<tr>
<th>Number of Siblings</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Fourteen of the patients had less than four siblings. The remaining seven patients had no more than six and no less than four siblings. Interestingly enough, one of the patients was an identical twin. Referring to Wilson's reference to the incidence of rheumatic fever among twins as an indication of the possible role of genetic factors in the familial incidence of the disease, to date, such is not evident in the case of the above twins. As pointed out previously, only two of the patients were related. These patients showed the onset of the disease to have been within three and a half months of one another. Yahraes points out that rheumatic fever rarely strikes all the children of a family at the same time. Not any of the other patients' siblings had rheumatic fever.

It has been established by many studies that rheumatic fever does not always result in rheumatic heart disease. Sixteen of the patients studied had cardiac damage. The remaining five patients who did not have cardiac

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1Ibid., p. 46.
2Herbert Yahraes, Rheumatic Fever, op. cit., p. 7.
damage were diagnosed as having acute rheumatic fever. Of the number of patients studied, five of them were having a recurrent attack of rheumatic fever. Each of these patients also had cardiac damage. This was not unusual as rheumatic fever has a tendency to strike again and again, and the extent of cardiac damage appears to increase with the number of recurrences.

Prognosis and Length of Hospitalization of Patients

In the instances where a long past history of the disease was known, the duration of the illness prior to hospitalization by days was not included. One patient had no evidence of rheumatic fever prior to hospitalization. Seven patients had evidences of illness one to three weeks prior to hospitalization. Four had symptoms less than one week before hospitalization and two had symptoms from three to five weeks. Only two patients had symptoms covering a range of five to nine weeks prior to hospitalization.

Data obtained from Table 11 revealed that the longest period of time spent in the hospital by any patient was forty-five weeks and the shortest period of time spent in the hospital by any patient was one week. The average number of weeks spent in the hospital by the patients was nine and one-half weeks.

Prognosis for most of the patients was favorable, and one patient's prognosis was given as excellent. Of the five patients with a long past

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1 What the Classroom Teacher Should Know and Do About Children With Heart Disease, op. cit., p. 6.

history of rheumatic fever, only one had a prognosis of poor.

Seasonal Admission of Patients

Various readings support the idea that there is a relationship between rheumatic fever and the seasons of the year. It is believed that rheumatic fever is least prevalent during the summer months. The seasonal trend of the disease by months is noted to be highest in the month of April and most prevalent during the months February, March and April.

Table 7 shows the study sample by month of admission. This table revealed that eleven of the total number of patients included in the study were admitted to the hospital during the months extending from February to April. The highest number of admissions was during the month of February.

<table>
<thead>
<tr>
<th>Month of Admission</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>1</td>
</tr>
<tr>
<td>January</td>
<td>3</td>
</tr>
<tr>
<td>February</td>
<td>5</td>
</tr>
<tr>
<td>March</td>
<td>3</td>
</tr>
<tr>
<td>April</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>3</td>
</tr>
<tr>
<td>June</td>
<td>2</td>
</tr>
<tr>
<td>July</td>
<td>1</td>
</tr>
</tbody>
</table>

Educational Status

In spite of the fact that perhaps no conclusions can be drawn from this study in regard to the effect of illness on the school retardation of the patients studied, it is nevertheless interesting to note the school retardation shown in the patients presented herein as it is known that

1 Ibid., p. 14
illness like other factors does sometimes serve as a factor in retardation. Table 8 shows the age and educational status of the patients studied. It was found that nine of the fourteen patients studied in regard to retardation were retarded. Only six of the fifteen studied were in the proper grade. Seven of the total number of patients included in the study were not applicable for study as to educational status because of age limitations. Of the remaining five patients who were not retarded, it was interesting to note that in the case of one patient, in spite of having a long past history of rheumatic fever, no retardation was evident. One factor which might account for this is attendance at the hospital school in which the patient was hospitalized. It is believed by some authorities that children with heart trouble should not be made to feel "different" or unlike other children because of their illness. As this was the prevailing attitude at the hospital in which the patients in this study were hospitalized, all of the patients of school age and whose conditions permitted such were given supervised teaching experiences.

TABLE 8

STUDY SAMPLE BY AGE AND EDUCATIONAL STATUS*

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Elementary School</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>7 - 10</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>11 - 13</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>14 - 17</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

*Seven patients are not included due to age limitation.

Herbert Yahraes, Rheumatic Fever, op. cit., p. 18.
CHAPTER IV

SOME TYPES OF MEDICAL-SOCIAL PROBLEMS INCIDENT TO HOSPITAL ADJUSTMENT AND DISCHARGE OF TWENTY-ONE RHEUMATIC FEVER PATIENTS

Types of Problems Created by the Illness

The very concept of "discharge" from the hospital for prolonged illness is a comparatively new one. In the past the chronicity of the illness influenced the over-all thinking about the persons and, consequently, the provisions made for his medical care. Because of the shift in emphasis within recent years in concepts on care and treatment of chronic illness, provisions for the medical care and services rendered patients with chronic illnesses have also undergone changes.

Today, recognition is given to the fact that hospitalization for the acutely ill person and for the persons with a chronic illness have different meanings. Once the hospitalization for the acutely ill patient is over, he is usually ready to return to his normal way of living. Such is not the case with persons suffering from a chronic illness. The continuity of the disease means that at the end of his period of hospitalization, the patient is faced with a new set of problems. The end of the hospitalization represents but "one of the stages in a life which henceforth will be governed by the demands of an illness, which threatens to change the whole pattern of living." Thus, the patient may face increased problems in his adjustment.

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1Minna Field, op. cit., p. 92.
2Ibid.
Although having accepted the axioms "patients are people" and "patients have families", the implications inherent in the latter axiom is becoming more and more evident. It has been established that other than the patient, those most directly affected by the patient's illness are the members of his family, especially the immediate family. Cooley states that to the family of the patient, illness means problems and changes and consequent adjustments. The problems and changes seem to fall into four main classifications: economic problems, the physical set-up in the home, the status of various members of the family and composition of the group, and emotional tensions. This classification corresponds to those set forth in this study.

Medical Social Worker's Activities in Assisting With the Patient's Hospital Adjustment and Discharge

In modern hospitals the medical social worker's primary role is one in which she gives attention to the patient's social and emotional problems as an integral part of treatment. When children are removed from their accustomed surroundings, separated from their families and friends, thrown into a strange unfamiliar environment, subjected to procedures they do not understand, fearful of the outcome and deprived of the usual freedom to determine their way of living, they often feel helpless, frightened, and threatened with resultant detrimental effect on their physical conditions. Thus, it is the responsibility of the medical social worker to assist these patients with their hospital adjustment and subsequent discharge. This is the necessary role so that the social and emotional aspects

1 Carol H. Cooley, op. cit., p. 55
inherent in the illness do not hamper the patients' being restored to maximal functioning capacity. Further, the medical social worker renders services to the patient's family as the family frequently needs help in coping with the uncertainties, deprivations, and anxieties evoked by the illness.

One of the functions of the medical social worker in regard to discharge planning for patients with rheumatic fever was that of evaluating the home situation in relation to its suitability for convalescent care. Most of the twenty-one patients included in this study were referred to the worker by the doctor. Twenty of the patients were referred to the worker for home evaluation as it related to convalescent care. One of the patients was referred for the purpose of transferring the patient to a convalescent home as the patient had no home to return to for further care.

Following the referral of the patients, the parents of the patients were interviewed by the social worker at the hospital in an attempt to evaluate the entire social situation and to get some knowledge of the family's relationship to the patient and other aspects that might affect the patient's condition. Office interviews were held as circumstances sometimes prevented the worker from making home visits, however, in some instances home visits were made. Cannon states that a visit to a patient's home is often essential to a better understanding of the social and living conditions. Cohen feels that it is unfortunate, the practice of visiting patient's homes has declined greatly, although the value of a skilled office interview is valuable.

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Table 4 on page 22 shows the weekly income of the patients' families studied. From this it is obvious that most of the families were unable to bear expenses for hospital and convalescent care. It is fairly general knowledge that illness means additional expense for all families, and for the most of them it becomes a burden by creating burdensome indebtedness. The family is unusual which does not feel some strain where there is illness and many families require financial care. T. Duckett Jones states "The cost of the care and rehabilitation of a rheumatic fever patient is so great that few families can afford the expenses involved if the best possible treatment is employed, and this is doubly true when repeated attacks occur." Knowledge on the part of the family of their inability to pay for the medical care of their children often fosters anxiety.

The following excerpts from the case records of patient #4 and patient #10 give some indication of the anxiety created for several families because of finances.

In talking with the social worker, Mr. stated that his income was $65.00 a week but that this salary was affected by the weather as he did construction work. He also stated that they paid $18.00 a month for the apartment they lived in and that they paid monthly payments of $100.00 on a loan. The family also owed $63.00 on a previous hospital bill. Upon being told about the possibility of receiving some financial assistance by the worker, Mrs. expressed much interest. She stated how she and her husband had been worried as to how they would meet the cost of this hospitalization as their income did not leave much room for expense of this kind.

An interview with Mr. and Mrs. , parents of patient #10, revealed that although the family carried medical insurance it would not pay for more than half of the hospital bill. He had already spoken to his bank about the possibility of securing financial assistance when he knew the patient was coming to the hospital. He

1 Carol H. Cooley, op. cit., p. 56.

2 T. Duckett Jones, op. cit., p. 105.
thought that he could take a second mortgage on the house they owned, which was already mortgaged for $3,000.00. The family's present debts are $100.00.

Of the total number of patients studied, nineteen families were found to need financial assistance with hospital expenses and sixteen needed assistance with convalescent care expenses. Two of the families were already being assisted with expenses for hospitalization and convalescent care. One family insisted on paying for convalescent care and the remaining families did not require financial assistance with convalescent care as the patients did not require such care.

In helping to meet the financial expenses connected with the patient's hospitalization and convalescent care, the medical social worker referred the patient to the appropriate community resource. Nineteen of the families readily gave their consent for referral to the Division of Crippled Children for financial assistance, and another was referred to the Soldier, Sailor, and Marine Fund.

If the illness creates a financial problem, the patient and family should be helped to make constructive efforts to utilize available social resources. The caseworker should have a broad and thorough grasp of the various types of agencies and community resources and should help the patient and his family make selective use of them and exercise valid choice. Early clarification may avert the family piling up debts with consequent strain and worry. The family should also have timely assistance in considering their capacity to pay for medical care, to pay for various appliances, for special diet, extra household help, special equipment, and

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1 Frances Upham, *op. cit.*, p. 49.
other items. Preparation should also be given to the family for any new experience such as applications for various types of public assistance, institutional care and other services.

In view of all-pervading influences of prolonged illness, it is not surprising that discharge from the hospital poses problems for the patient and his family. Even when family members are eager to have the patient at home, they may find that the limitations imposed by the illness demands a permanent rearrangement in their living which is difficult to achieve. The home to which the patient must return from the hospital is often inadequate to meet his needs. Most families feel a compulsion to make the surroundings as satisfactory as possible. Frequently the whole group makes sacrifices in order that the patient may have the essentials of care. Sometimes because of lack of funds, they are unable to do anything about the situation. Even though the other members of the family group gladly sacrifice their own comfort for the patient, they will be unhappy if they are unable to provide the surroundings he needs. They will feel responsible for any regression or lack of gain on the part of the patient.

If there is a feeling of guilt, or hostility, the family cannot be a happy group.

Housing for some low income families, especially in more urban centers, is often most unsatisfactory. In many areas, buildings are in poor

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1 Ibid., p. 50.
2 Carol H. Cooley, op. cit., p. 57.
3 Ibid., p. 58.
4 Ibid., p. 59.
repair, with plaster falling, window panes gone, and inadequate heating facilities. Overcrowding is the usual, rather than the uncommon thing, and will have to be accepted by many.

The home of a patient suffering from rheumatic fever should be a clean, peaceful, pleasant place - free from crowdedness, dampness, drafts, and leaks - where he could have plenty of good food of the proper sort and complete rest. Ideally, the patient should have a bedroom of his own, but when such is not possible, he should sleep in a separate bed.

Table 3 (page 20) shows the size of the families studied in comparison with the number of rooms in the dwelling. Only four patients of the twenty-one studied showed the patient to sleep alone in a single room. Seven of the total number studied revealed the patient shared a room and sleeping in a single bed. Six instances revealed the patient to have shared a bed with one or more persons. From such information shown in Table 3 and information of the patients' sleeping arrangements it is obvious that in spite of the medical recommendation that the patient with rheumatic fever should sleep in a separate room, the provision of such for most of these families would be a luxury impossible for them to afford. Every child with rheumatic fever should have a bed to himself - preferably a room - which he needs not only for complete rest but for avoidance of "strep" infections from others. Findings from data studied show that only four patients slept alone before hospitalization. The need for the patient to sleep alone following hospitalization created the extra problem for both the patient and his family.

\(^1\) What the Classroom Teacher Should Know and Do About Children With Heart Disease, op. cit., p. 7.
From the following example involving patient #20 perhaps one might get some idea of the problems created in the area of living arrangements:

Patient #20 was one of six children whose mother was expecting a baby in five months. The family occupied a cabin in the rural area which consisted of two rooms - 12' by 16'. Prior to hospitalization, the patient shared a bed with a sibling. Upon being informed of medical recommendations the family revealed they had wanted to build another room to the cabin for the patient but had not done so. The worker sensed that they really did not see how this could be accomplished, but rather that it was expected of them. Although the family was desirous of building a room for the patient, the family was financially unable to do so. Thus, the patient was unable to have a room of her own.

In some instances the family may recognize that the unhealthy conditions of the home have contributed to the child's illness and may feel guilty and upset about this. As a result they are unable to give the child all the emotional support he will need during his hospitalization.

The following excerpt shows the guilt created in the mother of patient #6 because of inadequate housing facilities and other problems:

Patient #6 was the baby in a family of six siblings. In discussing the home situation with the family it was found that the family occupied the first floor four room apartment in a six family house. The toilet was in the hall and was shared with other occupants. Mrs. ____ said the place was so damp and cold that the furniture had warped. In this discussion around housing, much guilt was evident on the part of Mrs. ____. She wondered if the family's housing facilities had contributed to the patient's illness. The mother's guilt was due to her feelings that she might be responsible for the patient's illness. She stated that the patient was the youngest in a multiple birth of three. The birth of these babies had received much publicity. At this time, the suggestion had been made to the family that perhaps the State Welfare Department could assume custody of the babies during their earlier years of life. This suggestion was made because the babies were very small and would need special care, and because the family's income was very marginal and their housing facilities inadequate. Both parents had refused the suggestion. They had felt that as the children were theirs, they should rear them. Since the patient's illness, the mother had had fears that people would feel she had been an inadequate mother.

As a result of obtaining information about the social situation existing in the homes of the families interviewed by the social worker, the
doctor was informed of the social situation by the social worker and this information was considered by him in making medical recommendations for discharge. If the doctor knows the patient's social situation, he can gear his recommendations accordingly. Both the social worker and doctor need always to keep in mind the human factors in the situation which limit treatment and which neither social worker nor doctor can solve. In a hospital setting the medical social worker is invariably drawn into a cooperative relationship with professional people of other disciplines. When the social worker obtains information from the patient concerning his social situation, she is in a position to confer with doctors, nurses and other staff members interested in the case, on significant matters that will greatly affect treatment. In sixteen of the cases, it was recommended that the patient receive convalescent care out of the home. The need of financial arrangements for this care has been mentioned in this chapter.

Timely help with the reality planning frequently enables the patient and family to handle their anxiety about the medical situation. Clarifying the problems involved provides them with a sound supporting basis for activities, freeing them from floundering about in a morass of questions and doubts.

Relationship of Patient with Family

If the discharge of the patient is to be facilitated with ease, the social worker must be aware of all the interrelations which exist among the

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1 Carol H. Cooley, op. cit., p. 35.


3 Frances Upham, op. cit., p. 50.
various aspects inherent in illness which affect the patient. One such aspect of which the worker should be cognizant is the relationship existing between the patient and his family. Recognizing that the attitude of family members is an important element, facilitating or retarding the patient’s progress, it necessitates those concerned with the patient’s care to help family members handle some of these problems so that they may find release and not be forced to vent their feelings upon the patient. Not often is the worker able to gain insight into this complicated aspect of the patient’s life in one or two interviews, but rather the summing-up of this information is an on-going process. In view of this, consideration was given to relationship of the family and patient throughout the hospitalization of the patient, as it was not only considered in regard to its effect upon the patient at the time of discharge. Ethel Cohen states that medical care alone is inadequate, and is economically wasteful unless at each step there is study and active planning to meet the child’s needs throughout the illness.

In regard to the patients’ relationships with their families it was noted that fourteen patients had positive relationships with their families prior to illness. Evidence of disturbed parental relationships were seen in seven of the families studied. Of these seven families, two mothers were rejecting of their particular child. In another instance, rivalry existed between the mother and the father for the patient’s affection. One patient had a positive relationship with only one parent, and the relationship between the three remaining patients and their families was

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1 Minna Fields, op. cit., p. 167.
2 Ethel Cohen, op. cit., p. 175.
unstable. One of the patients was not applicable in the consideration of family relationship as the patient had been residing with a foster mother who no longer desired his presence in her home. These relationships among the patient and his family remained the same, in most of the families at the time of discharge. During the patient's hospitalization the medical social worker tried, when possible, to assist the parents having an unstable relationship with their children gain some insight into the effect of this relationship on the patient in an attempt to foster or help develop more wholesome ones. To further assist the family in this area, the medical social worker forwarded very inclusive reports on the patients to the convalescent home when the patient was to receive convalescent care and case work help if needed. The social worker at the convalescent home continued to work with the parent and patient whenever necessary or indicated.

The following example illustrates a disturbed parental relationship as seen in the case record of patient #5.

The following information was known to the worker before her interview with the patients mother:

Patient #5 seemed to have a lot of "death wishes" or feelings that something harmful would happen to her family around which she was having guilt feelings. The doctor who gave the worker this information felt this was because her parents reprimanded her for going out with boys. She had run away from home several times but had always run to her grandmother's house. She admitted that she had taken money from her mother's pocketbook and lipstick from places where she baby sits.

The patient told the doctor that she had gone out on heavy petting parties with boys and that she frequently took rides with them. She said she knew this was wrong but that she could not help herself. She said she had learned the "facts of life" from her mother this year but was vague as to what her mother had told her. The same fear that something was going to happen to her relatives if she was not home continued throughout her interview with the doctor. She said that she liked her mother much better now because she had bought her some new clothes and had provided them with a better home. She stated that her mother wanted her to go to a Catholic school but she didn't want to go there as they did not permit the wearing of lipstick and
this was the reason her mother wanted her to go there.

In working with the mother, the medical social worker made use of the information given to her by the doctor. The worker's interview with the mother revealed the following:

Worker noted that the mother seemed to be mixed in her feelings about her daughter and her illness. It was also her impression that the mother related to the patient more as a sibling than as a maternal person and the mother seemed to always want special concessions for the patient. Early in the hospitalization the patient's mother began the habit of bringing very rich food to the patient as the patient complained of the hospital food. Instead of helping the patient to accept some of the limitations of the illness, the mother, by her overprotective attitude influenced the patient to fight against her limitations. The mother and daughter were receiving some secondary gains from the illness in the form of attention for the mother from relatives, and in the form of gifts for the patient. The mother made it very clear that if home bed rest were recommended for the patient she would not be able to stay home with her as her salary was needed in the home. This was stated before the possibility of her daughter's needing convalescent care was told to the patient or her mother. (This information was not obtained in the first interview with the mother but over a period of time).

In meeting the problem in the forementioned case, the worker felt it best to see only one member of the family for the purposes of treatment and to have someone else work with the other family members. A nurse during her post-graduate work period in mental hygiene agreed to see the patient (assisted by a psychiatrist).

The mother's relationship to the child prior to the hospitalization was considered important by the medical social worker as it was found to have many implications for the subsequent adjustment of the child and to the total situation. One instance cited on page 38 showed how a negative relationship of mother and child produced a disturbance in the handling of the illness for the child and mother. Instances studied where there existed some disturbance in the parental relationship for the most part, the mother or father, denied the negative factors in the relationships.
However, they were able to reveal that the same type of relationship had existed before the hospitalization after some type of relationship had been established with the medical social worker.

Disturbances in the parental relationship may serve as a contributing cause of the development of illness or of continued disability to the child. The child, caught in an atmosphere of emotional conflicts, sets up various mechanisms to handle the anxiety created by the family tensions. To understand parental attitudes, the social worker must come to know the parents and the patient, the family situation, and the interaction of the family members. A variety of causes may disturb family balance and affect the feelings of the parents toward the ill child. Because of guilt, parents may either reject or over-protect the child or may be unable to accept the diagnosis and treatment. Help given to both parent and child contributes to the child's development and improves family relationships. Such assistance requires the caseworker to identify not only with the child in his problems and feelings but also with the parents in theirs. The security the parents gain from a positive relationship helps them to participate in carrying out various aspects of the care necessary for the patient such as convalescence, schooling and recreation.

Attitude of Patient and Patient's Family

Whenever something happens to us for which we are unprepared, our inner security is disturbed and immediately the forces of mind and body work together to try and bring about the state of security that existed

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1Frances Upham, op. cit., p. 69.

2Ibid., p. 72.
previously. This is true for adults but it is particularly true for children. When a child becomes ill, regardless of whether the disease is simple measles or rheumatic fever, something new has happened to the individual and his security is threatened. This is especially true when the illness is painful, prolonged, and involves treatment that is strange, harsh and frightening. Since reaction of the individual to the experience of illness as well as the meaning it has for him depends on several factors, on their interaction, and on the relationship of these factors to the illness itself, each factor of itself may have a little or no meaning. However, considered in its relationship to other factors and to the illness situation, it may be significant. Emotional factors have long been considered to be of importance in chronic illness but the extent of this importance has been difficult to evaluate.

As the reaction or meaning of the illness to the patient is often an extension or resultant of the family's reaction, it is significant that the medical social worker sees the implications of the reactions of the family to the illness. Table 9 on page 42 shows the reactions of the families of the patients studied to the illness, to the hospitalization and to the discharge.

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2 Carol H. Cooley, op. cit., p. 16.

TABLE 9
SAMPLE STUDY OF FAMILY’S ATTITUDE TOWARD ILLNESS, HOSPITALIZATION AND DISCHARGE*

<table>
<thead>
<tr>
<th>Family Attitude</th>
<th>Total Number</th>
<th>Patient Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10 11 12 13 14 15 16 17 18 19 20 21</td>
</tr>
<tr>
<td>Toward Illness**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calm</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Anxious</td>
<td>17</td>
<td>x x x x x x x x</td>
</tr>
<tr>
<td>Overprotective</td>
<td>2</td>
<td>x x x x x x x x x x</td>
</tr>
<tr>
<td>Acceptant</td>
<td>18</td>
<td>x x x x x x x x x x x x</td>
</tr>
<tr>
<td>Indifferent</td>
<td>2</td>
<td>x x</td>
</tr>
<tr>
<td>Uninformed About Illness</td>
<td>9</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td></td>
<td>x x x x x x x x x x x x</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16 x x x x</td>
</tr>
<tr>
<td>Toward Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperative</td>
<td>4</td>
<td>x</td>
</tr>
<tr>
<td>Uncooperative</td>
<td></td>
<td>x x x x</td>
</tr>
</tbody>
</table>

* Numbers indicate the frequency or occurrence of each attitude towards illness, hospitalization, and discharge for different patient numbers.
### TABLE 9 -- Continued

<table>
<thead>
<tr>
<th>Family Attitude</th>
<th>Total Number</th>
<th>Patient Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Toward Medical Recommendation</td>
<td>13</td>
<td>x</td>
</tr>
<tr>
<td>Cooperative ..</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncooperative ..</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toward Discharge</td>
<td>7</td>
<td>x</td>
</tr>
<tr>
<td>Accepting Non-accepting</td>
<td>11</td>
<td>x</td>
</tr>
</tbody>
</table>

*One family is not included as the patient was the ward of a county.

**Some families had more than one attitude, therefore, the total exceeds twenty-one.*
It was interesting to note that of the two families whose reactions to the illness was calm, this was a recurrent attack of rheumatic fever for one patient. Also interesting was the fact that although only two of the total number of families were calm in their attitude toward the illness, only three patients showed anxiety around their illness. This, however, does not infer that anxieties did not exist for the other patients. Each of the mothers whose reaction to the illness was indifferent rejected their respective child. Fourteen of the families were anxious in regards to the illness and eighteen of these families were accepting of it. Nine of the families were uninformed about the illness and needed much interpretation about the illness and its limitations. Such interpretation and clarification were given the parent and child by the doctor and the social worker.

Fear, due to illness, as exhibited by the patient is illustrated in the following excerpts taken from the case records of patient #14 and patient #3 respectively.

The patient (#14) was a 15 year old male who was quite withdrawn upon admission into the hospital and found it difficult to talk with members of the hospital staff. He seemed to be very fearful of hospital procedure and had a particular aversion to needles. He showed much fear and anxiety around being in the oxygen tent, and had voiced fears of dying. He also worried about the cost of his hospitalization to his family.

Patient #3 was a seven year old male who was a very active child and had been a little hard to manage on the ward. He seemed to want to do what he was told, but hopped out of bed often and had to be reminded that he was on bed rest. In talking to the medical social worker, it was discovered that there was some underlying reason for the behavior. He had noticed that the nurses had to help another patient when she got out of bed. He had reasoned that this was because her legs were weak due to the length of time she had stayed in bed. In an effort to safe-guard himself against a similar state, he was determined that he would keep his legs in good condition. He had noticed that his legs did not seem quite as strong as
when he first became ill. He seemed to have had a great deal of fear around his illness.

1 Betty Huse states that the usual reaction of the parent and the child to a diagnosis of rheumatic fever is undue anxiety. According to Deutsch, cardiac children may suffer especially from anxiety. Upham also agrees on the point that a serious illness or handicap involving long-time hospitalization or convalescent care may provoke anxiety in the patient and in other family members. Unless timely and appropriate help is extended on a family-focused basis, not only is the patient's recovery placed in jeopardy but the danger of destructive reactive patterns within the family are increased.

Helping these patients and their families around these anxieties and fears was the function of the medical social worker. First, the worker attempted to reduce some of the anxiety by evaluating its source and extent. In many instances the families were concerned about the child and the threat the illness presented to the child. Their concern was also in the area of finances. In dealing with the practical problem in the reality situation some relief was afforded the families in this area. Next, the worker tried to evaluate the amount of knowledge the parents had in regard to the illness and how well they understood the doctor's interpretation of the illness.

4 Upham feels that anxious parents, unfamiliar with the intricacies of

1 Betty Huse, "If a Child Has Heart Disease or Rheumatic Fever," Reprinted for The Children's Bureau, from The Child, VIII (May, 1944), 163.
4 Ibid., p. 72.
modern medicine, fail to grasp the doctor's explanation. Frequently they misunderstand or misinterpret technical terms and, through fear, misconstrue what the doctors tell them. This was evident in some of the families of the patients studied. In working with these families the worker was continually interpreting the illness and some of its ramifications to the families. When it was necessary the worker arranged to have the parents talk with the doctor, first helping them to define what knowledge they desired to know. Since the parents are the ones who are going to have to help the patient regain his sense of security and confidence, parents should be given a complete understanding of what the illness is, what the dangers are, what to expect in the course of illness, the types of convalescence that is to be expected, and what will be expected of them.

In instances where the families were uninformed about the illness, they were encouraged and helped to talk about their anxieties and fears so that any misconceptions could be cleared up. They were given friendly reassurance and support to help them meet the situation so that they could mobilize themselves both physically and emotionally to meet the emotional demands of the patient.

The medical social worker encouraged the families and the patients to participate actively in the medical plans for the patients where healthy family relationships existed. Families were encouraged to visit regularly and to keep the patient abreast of what was happening in the home situation so that the patient would not feel the loss of status in the family. To further alleviate anxiety in the patients, they were visited frequently by

1Ibid., p. 57.
the worker in an attempt to establish a relationship with them so that they would feel free to discuss their fears, anxieties, and general problems with her.

Patient # 17 is illustrative of some of the above mentioned facts:

The patient was a 12 year old female who in talking with the social worker seemed to know why she was in the hospital and was able to give her diagnosis as rheumatic fever. She expressed to the social worker some fear about the possibility of heart damage. As the worker explored this further with her, she learned that the patient had picked up her information from hearing her mother talk about the four children who lived next door to her and who also had rheumatic fever. She also told the worker that she didn't like the doctors to examine her. She said she had noted that the times they did a physical examination they had paid particular attention to her heart. The worker felt that some of this dislike of the examination by the doctors had some of its basis on the fact that she was beginning to mature a little and was embarrassed by having the young interns examine her. In the patient's own mind she had thought they were looking for signs of heart damage, although she had never mentioned this to the doctors, however, it was in her mind whenever she saw one of them.

As a means of helping to reduce the fear in the patient, the medical social worker discussed the above information with the doctors in medical ward rounds. She was able to interpret the fears of the patient to the doctors. As a result they were careful in their handling of her.

1 Jetter and Huse suggest that the patient should be given every opportunity to talk about his feelings, particularly about what he thinks it means to him so that any misinformation he had might be cleared up. It is important that the child have a constant person in the hospital to whom he can ventilate his grievances, fears and fantasies. This will make the child feel that he is not deserted.

1 Lucille Jetter, op. cit., p. 258.
2 Betty Huse, op. cit., p. 358.
3 Betty Huse, op. cit., p. 357.
Table 9 also shows the attitude of the families toward the hospital. Sixteen of the families were cooperative toward the hospital and thirteen were cooperative with the medical recommendation. Four of these families were uncooperative with the medical recommendations. Four of the families who were uncooperative with the hospital were the same families who were uncooperative with the medical staff in carrying out recommendations.

The patient presented on pages 38 and 39 illustrated uncooperativeness on the part of the family also. The following, patient # 4 and patient # 13 also illustrate uncooperativeness on the part of the family in regard to medical recommendations for convalescent care:

Patient # 4, a five year old female, had been recommended for convalescent care out of the home. The mother found this difficult to accept although she had been told medically the child needed this convalescent care. It was noted that when she visited the patient, she would tell the patient she would be coming home in a few days and that she would not have to stay in the hospital much longer. This was not done in an aggressive way but seemed to be almost a quiet insistence that the child return home. It was the social worker's impression that Mrs. ____ was unable to accept the recommendation because she was lonesome for the child. Only after the social worker had helped Mrs. ____ accept the recommendation was she able to give her consent for the patient to have convalescent care away from home.

Patient # 13 was a six year old female whose mother was having a difficult time accepting the hospitalization and medical recommendations. She was very critical of the general method used by the hospital in the patient's hospitalization. She insisted that the child was not happy there and that the patient had told her the hospital was like a prison. Without being told medically, the mother was continually telling the patient she would be going home in a few days or weeks and as a result the patient became very hard to manage. Each time the mother came to visit the patient there would be a scene upon her departure.

It was interesting to note of the four families who were uncooperative with the patient's being in the hospital and in carrying out medical recommendations, three had poor relationships with the patients and one mother had the need to feel the patient was utterly dependent on her.
By showing the families understanding, offering them reassurance and interpretation, the medical social worker was able to help some of these families with their problem in this area. To be able to support the child throughout his illness and medical care experience, parents themselves must have security and confidence. Parents should receive from the physician a simple explanation of the child's condition, the proposed treatment and its effect on the child's future functioning, possible alternatives, and requirements for after care. Usually when people are informed and have some understanding of the situation in which they find themselves, they are more accepting of it.

The patient's reaction to and acceptance of medical recommendations are determined by many factors and are not dependent alone on the care prescribed. The following table gives the frequency of the patients attitude toward the illness, hospitalization and discharge.

**TABLE 10**

**STUDY SAMPLE BY ATTITUDE TOWARD ILLNESS, HOSPITALIZATION AND DISCHARGE**

<table>
<thead>
<tr>
<th>Patient's attitude to illness</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calm</td>
<td>15</td>
</tr>
<tr>
<td>Anxious</td>
<td>3</td>
</tr>
<tr>
<td>Denying</td>
<td>-</td>
</tr>
<tr>
<td>Indifferent</td>
<td>-</td>
</tr>
<tr>
<td>Patient's attitude toward hospital</td>
<td></td>
</tr>
<tr>
<td>Accepting</td>
<td>14</td>
</tr>
<tr>
<td>Non-accepting</td>
<td>4</td>
</tr>
<tr>
<td>Patient's attitude toward medical recommendation</td>
<td></td>
</tr>
<tr>
<td>Accepting</td>
<td>14</td>
</tr>
<tr>
<td>Non-accepting</td>
<td>4</td>
</tr>
<tr>
<td>Patient's attitude toward discharge</td>
<td></td>
</tr>
<tr>
<td>Accepting</td>
<td>13</td>
</tr>
<tr>
<td>Non-accepting</td>
<td>5</td>
</tr>
</tbody>
</table>

*Three patients are not included because of age limitations.*
Three patients are not included in the table as their ages (3 months, 4 months and 2 years respectively) prevented the securing of the information in reference to the above. It was interesting that three of the patients who were non-accepting of the hospitalization and medical recommendations were the offspring of the parents exhibiting the same behavior and with whom these patients had disturbed parental relationships.

By visiting these patients the medical social worker attempted to form some type of relationship with the patients in an effort to assist the parents in the handling of this problem. She encouraged the families to interpret as much to the child about his illness as was feasible. If a child realizes that members of the hospital personnel know his parents and that his parents are aware and approve of what is going on, the child gains assurance that he too can trust these strangers. \(^1\) The social worker also offered interpretation and clarification to the patient when such was needed as it was realized that the child should be given an explanation about the things that are being done to him and planned for him. Moreover, the worker should provide the opportunity for the child to participate directly in the plans for him. \(^2\) With the sympathetic support of their families, children ordinarily can meet the threat of illness and handicap with a minimum of emotional disturbance and damage. \(^3\)

Table 11 shows that only three of the nineteen patients studied made poor adjustments to the hospital. There did not seem to be any significant

\(^1\) Ibid., p. 66.
\(^2\) Ibid., p. 61.
\(^3\) Ibid., p. 60.
relationship between the length of the patients' hospitalization and the adjustment made by them. The fact that one patient stayed in the hospital forty-five weeks and apparently made a very poor adjustment can not be attributed solely to his length of hospitalization. Other factors such as, first, rejection by his foster mother and, second, his lack of visitors might have been contributory. The worker being aware of the meaning of hospitalization for children and of some of the problems inherent in making this adjustment, attempted to offer the patients reassurance and comfort. For the most part, the medical social worker assisted the parents in helping them to help their child make the necessary adjustment. Most of the patients did not have too much difficulty adjusting to the hospitalization aided by support from their parents and from staff personnel. Parents seemed to have the most difficulty in adjusting to the hospitalization than the patients. Patient # 5 on page 38 illustrates the above statement.

TABLE II

SAMPLE STUDY BY LENGTH OF HOSPITALIZATION AND ADJUSTMENT*

<table>
<thead>
<tr>
<th>Length of Hospitalization in Weeks</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 4</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>5 - 8</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9 - 12</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13 - 16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17 - 20</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>21 - 24</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

*One patient was in hospital for 45 weeks and made a very poor adjustment. Two patients are not included because of age limitations. Therefore, the total is less than twenty-one.
In spite of the fact that medical recommendations for sixteen of the twenty-one patients discharged from the hospital recommended convalescent home placement, seven of the patients' families were non-accepting of the recommendations. This non-acceptance was not on the basis of rejection of the patient but was an outgrowth of the desire to have the patient back in the home. Four of the families shown in the eleven families in Table 10 who were non-accepting of the discharge of the patient were those in which disturbed parental relationships existed. The mothers in three of these families were requesting that the patients be placed in a convalescent home before the discharge medical recommendations were given by the doctor. The seven families accepting the recommendation for convalescent home placement did so on the basis of their reality situation in regard to living arrangements and their insight into the value of such care.

Preparation of Patient and Family for Discharge

After being told of the possibility of the patient's requiring convalescent care outside of the home, the medical social worker began preparing the families for such placement when it was necessary that she do so. This was done after the families had been told the need for convalescent care by the doctor. In three of the cases, because of certain circumstances in the situation, the worker had the doctor discuss convalescent home placement with the family. This was done as the worker was aware that the family would not be able to accept the recommendation unless it was put on a strong medical basis. Much interpretation had to be given the families whose children were not going to the convalescent home. Such interpretation centered around the needs of the patient as to adequate living arrangements, diet, medications, good health habits, supervision in order to maintain
general health at the highest level. The parents were encouraged not to be overprotective and over-conscientious of the patient in order to prevent the child from feeling "different" from the rest of the children. This feeling of difference is often the beginning of serious emotional problems and should be avoided if possible.

Preparation of the child and the parents for discharge to the convalescent home was considered to be very important by the worker as this was an area around which much feeling was exhibited by parents and children. Parents sometimes become alarmed lest the child think they are rejecting him. Patient # 13 illustrated this very clearly.

In discussing the care of the patient with the mother, the worker suggested that the child might be on bed rest several weeks before she left the hospital. In discussing the discharge of the patient, the worker mentioned that the patient would require a room to herself. At first the mother admitted that the patient would not be able to have a room to herself but then withdrew saying that she would "fix up" a room for her to have all to herself. She was not clear as to how this would be done and obviously would present an unsurmountable problem with five children and two bedrooms. The worker discussed this with her and she vacillated a great deal about it. After discussing the convalescent home with the mother, we suggested that she not mention this to the patient as it might be better if one of our doctors told her. The mother really led into this discussion by saying that she was afraid the patient would think she did not want her if she made her go to the convalescent home. The mother feared that the child was interpreting this hospitalization in that light.

The next day the mother called the worker and informed her that she did not want the patient to go to the convalescent home. She again repeated that she would "fix up" a room for the patient and that she saw no reason why the child couldn't get the rest at home. The worker thought that she seemed to be oblivious to the fact that the housing quarters were crowded and that the child would find it hard to stay in bed when her brothers and sisters were able to be up and around.

Realizing the difficulty the mother was having in accepting the recommendation, the medical social worker felt the mother had need for further

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1Lucille E. Jetter, op. cit., p. 259.
interpretation of the illness and arranged to have a doctor talk to her. Following this talk with the doctor the mother was more receptive of the idea. However, the worker recognized that in spite of the mother's receptiveness, she was still resistive to the idea and worked with her in an effort to make her acceptance of the transfer a more whole-hearted one. The worker believed that the mother was interpreting this recommendation as failure on her part as a mother rather than a medical feasibility.

To further facilitate the families acceptance of the convalescent plan, arrangements were made by the worker to have each of the families visit the convalescent home to which the child would be sent. This served to ease some of the doubts in the parents' minds about the feasibility of the plan. The worker encouraged the parents to participate in preparing the child for the transfer. All of the families who had been non-accepting of the recommendation for convalescent care, out of the home, were able to accept the plan on a medical basis after being helped by the medical social worker.

After the doctor told the patient about the transfer with the assistance of the parents, the medical social worker also helped to facilitate the transfer by discussing with the patient the things that concerned him about the convalescent home. Patient # 21 illustrates this:

In talking with the worker, the patient showed some understanding that the reason she was going to the convalescent home was because the doctor felt it was necessary. The patient's mother had made it clear that they wanted her home but that they also wanted her to get well. The patient seemed to have accepted this and also the fact that she would go to the convalescent home. She asked the worker many questions about the home such as what kind of children would she meet there, what they ate, what they did, and what the home was like.

The following shows the careful preparation that was involved in preparing patient # 8 for transfer to a convalescent home.
Patient # 8, a nine year old boy, was referred to the Social Service department at medical ward rounds for preparation for discharge.

The worker already had some knowledge of the patient's social background which served her as a frame of reference in the handling of the transfer. The patient had been deserted by both his mother and father and had lived from time to time with various relatives. He had become a ward of the county in which he lived and had been placed in a foster home. He had been considered a "problem" child by the foster mother, and during his hospitalization, it was discovered that she did not want him back in her home. This was the first knowledge that the welfare department had that the strong attachment the patient had for the foster mother was not returned.

During his hospitalization the patient was reported to be very hard to manage on the ward and various methods of attempting to handle him had failed.

The worker wrote two persons associated with the county of which he was a ward to arrange a conference in regard to the transfer. At this conference, it was decided that the patient would convalesce at a certain home.

The patient was told of the transfer by the doctor. The doctor explained that the patient needed a lot more rest even though he was greatly improved. He talked to him about the place pointing out similarities and telling him about activities there. The patient seemed to accept this and talked about it with enthusiasm. The social worker had already become acquainted with the patient on the ward. The worker continued to visit him and they played games about what the convalescent home would look like. Gradually the worker was able to learn just what the transfer meant to him. He once asked the worker if the transfer meant he would never go home. He seemed to accept the transfer and yet was torturing himself that he would never go back to his foster mother. The worker encouraged him to talk about the advantages of the convalescent home. The worker did not explore the patient's feelings around his rejection by his foster mother as she did not feel he was ready for this and that it would best be handled later at an appropriate time.

On the date of the patient's discharge, he packed all of his toys in a box to take with him. The worker suggested that she would ride out to the home with him. This seemed to have pleased him. Enroute to the home, the worker permitted him to choose the flavor of ice cream he wanted. This delighted him. Upon arriving at the home, he was greeted by a nurse who had been informed of his arrival by the social worker who had given pertinent information to the home about the patient. The nurse introduced him to some of the other children there and he became so engrossed in his activity with them he scarcely knew when the worker departed.

This information was obtained by the writer in an interview with the worker on pediatric service:

Upon his re-entrance into the hospital in 1955, the patient did not present a disciplinary problem on the ward but instead was
well-mannered. It was noticed by the worker that he had learned instead how to manipulate people to get what he wanted instead of screaming as he had done previously. During his stay at the convalescent home, he was given a great deal of attention by one of the nurses who served as a "mother figure" for him. This had a noticeable effect on his behavior and after a period of time he did not present behavioral problems on the ward.

The medical social worker learned from the county welfare worker of which the patient was a ward, that she had located two of the sisters who were living with a foster mother in a nearby city. The welfare worker arranged to have the patient's sisters and their foster mother visit him. Upon meeting the patient, the foster mother expressed interest in taking him into her home. As this plan was not definite, the patient was not told that he would be placed in another foster home. It was felt by the medical social worker that this information should be kept from him until the results of a planned operation were known. The purpose of this operation was to try and improve the patient's condition to the point where he could be medically supervised in a foster home. Following this operation it was planned that the patient would return to the convalescent home from which he had come prior to his readmission to the hospital. The medical social worker felt if the operation was successful, the patient should be prepared for foster home placement by the nurse at the convalescent home who had served as a "mother figure" for him.

Upham made the following statements:

In planning convalescent care, emphasis should be placed on enabling the family, if possible to give the child the kind of care he needs. If convalescent care away from home is necessary, parents and child should be prepared for the experience as carefully as possible. The child should be helped to feel that the convalescent care is temporary and part of a plan that includes his return to his home in a better condition to be part of the family. If it is apparent that the child will sustain emotional damage as a result of the separation, convalescent care will defeat its own ends.1

Brief Summary of Medical Social Worker's Activities

Briefly, the functions of the medical social worker may be summarized as follows:

1. Assisting the family with problems arising from the patient's admission to the hospital, amelioration of the family's anxieties due to having the patient institutionalized if need be.

1 Frances Upham, op. cit., p. 74.
2. Assisting in the interpretation of the hospital facilities and program to the patient and his family.

3. Formulating plans, with the assistance of other community resources.

4. Establishing a relationship with the family which will encourage them to maintain a positive attitude throughout the period of care or ultimately helping them to receive the returning patient with a fuller understanding and acceptance.¹

5. Assisting in the interpretation of the total needs of the patient to the doctor, other professional members of the team, to the patient's family and others who influence the patient's condition.

6. Helping to create an awareness by the hospital personnel of the social and emotional factors in illness.

¹Group for the Advancement of Psychiatry, "The Psychiatric Social Worker in a Mental Hospital," (Minnesota, 1947), p. 3.
CHAPTER V

SUMMARY AND CONCLUSIONS

Due to the number of persons suffering from chronic illness, much attention is being given to its extent, its implications and the problems associated with it. As a consequence of this increase in the number of persons suffering from prolonged or chronic illness, there has been a growing change of attitude toward these sufferers in medical settings. This change of attitude has not only been on the part of doctors and other professional personnel but also on the public at large.

The purpose of this study was (1) to indicate some of the social and medical aspects of rheumatic fever, (2) to show the nature of the problems accompanying the patient's adjustment to the hospital and to his discharge, and (3) to determine the activities of the medical social worker in dealing with these problems.

The literature suggested that rheumatic fever is considered to be childhood's greatest enemy. Also suggested was the fact that rheumatic fever and rheumatic heart disease alone caused more chronic disabling illness in children than any other single disease. The prevalence of rheumatic fever has been thought to be influenced by such factors as family susceptibility, crowding in the home, inadequate food, inadequate clothing, and lack of cleanliness, climate, geography of the country, and the season of the year. Although studies have not proven conclusively that these factors are a direct cause of rheumatic fever, the literature suggested that there is some relationship between these factors and rheumatic fever.
The social consequences of rheumatic fever, like other chronic illnesses, include dependency, long periods of invalidism, and disruption of personal and economic family life. This study points out that chronic illness, such as rheumatic fever, creates social and emotional problems of multifarious and multitudinous dimensions.

Of the twenty-one patients studied, seven were white males who ranged in age from one through fifteen years, thirteen were white females who ranged in age from three months through seventeen years and one Negro female, age eight. Data in regard to the patient's hospital adjustment and subsequent discharge revealed:

1. The reaction and subsequent adjustment of the patient to his illness was directly influenced by the reaction and adjustment of his family to the illness.

2. Families who were given some interpretation of the illness and some of its implications and who were able to comprehend the information given them were able to adjust to the illness and changes that it necessitated with less difficulty than those who had difficulty understanding and accepting the interpretation.

3. Illness helped create more anxiety in those parents who had had disturbed relationships with their child prior to hospitalization than those parents who had had positive relationships with their child.

4. The anxiety and fears expressed in all of the families were not solely related to the threat the illness presented to the child but also was related to their inability to pay expenses for medical and convalescent care.

5. Patients who had a disturbed relationship with their parents prior
to hospitalization had more difficulty adjusting to the illness than those who had had a positive parental relationship.

6. Parents who because of their own needs were unable to accept the hospitalization of the patient, created more anxiety in the patient than was evident in those patients whose families accepted the need for the hospitalization.

7. The families who were able to participate in the medical plans for the patients were more accepting of the medical and convalescent care recommendations than those who were unable to participate.

8. The adjustment to and acceptance of the hospitalization and medical recommendations on the part of the patient was better facilitated when the family was able to give their child support, reassurance and encouragement.

9. In most instances, parents seemed to have had more difficulty adjusting to the child's hospitalization than did the patient.

10. Separation for convalescent care required careful preparation of both the patient and his family because of the emotional components involved.

It was the writer's conclusion that illness does not exist in a vacuum for the patient, affecting him alone, but that it also has implications for the patient's family. Realizing the interrelationship between the patient and his family, it becomes obvious that treatment of the patient alone cannot hope to have significant and permanent results if the family which serves as a source of security and support for the patient is not treated also in regard to the medical-social problems which often result because of the patient's illness and hence interfere with his recovery.

Briefly, the activities of the medical social worker in assisting the patient and his family in adjusting to the problems inherent in the illness
may be summarized as follows:

1. Evaluating the patient's home situation in regard to convalescent care.

2. Referring the families who required financial assistance to community agencies for assistance with hospital and convalescent care.

3. Interpreting the illness and its various aspects and the patient's needs to both family and patient.

4. Interpreting to doctors and staff personnel the total needs of the patients as they relate to his social situation and family relationship.

5. Visiting the patients frequently in an attempt to establish a relationship that will encourage the patients to express their fears and anxieties.

6. Showing the patient and his family understanding and reassurance, and the giving of psychological support in an attempt to alleviate fears, and helping alleviate anxieties and help both patient and family understand and function within the limits of the patient's illness and consequent needs.

7. Arranging interviews for the patient's family with the doctor to facilitate greater understanding of the illness.

8. Preparing the patient and his family for discharge to the convalescent home.

9. Facilitating transportation for patients to the convalescent home.

Although there is no cure for rheumatic fever, persons suffering from the disease have a very favorable chance for complete recovery from the illness. This is possible as a result of the most effective treatment of the disease known today - long periods of bed rest under adequate medical supervision, followed by regular medical examinations for early diagnosis of
recurrent attacks. Thus, much emphasis is placed on long-term preventive measures for those who have had rheumatic fever. If parents and school personnel, health department, heart association, and family physician work together on a well organized prevention program, the results may make rheumatic fever a rarity instead of the threat that it is at present.
I. Identifying Data

Age ______

Sex ______

Place of residence

Urban ______ Rural ______

School History

Grade ______

Attended school in hospital ______

Family

Father ______

Mother ______

Number of siblings ______

Incidence of illness in family ______

Approximately the weekly income ______

Source ______

II. Medical Situation

Diagnosis ____________________________

Duration of illness prior to hospitalization _____________

Length of hospitalization

Date of Admission ________

Date of Discharge ________

Reaction to length of time in hospital ____________

Medical Plan _____________

Prognosis ____________

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III. Social Factors

Physical Environment

<table>
<thead>
<tr>
<th>Number of family members in dwelling</th>
<th>Number of rooms in dwelling</th>
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</table>

Sleeping arrangement of patient

<table>
<thead>
<tr>
<th>Before hospitalization</th>
<th>After hospitalization</th>
</tr>
</thead>
</table>

The Family Relationship of Patient Prior to Hospitalization

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
<th>Disturbed</th>
<th>After hospitalization</th>
</tr>
</thead>
</table>

Problems created for patient as a result

IV. Psychological Factors

Family Attitude Toward Illness

<table>
<thead>
<tr>
<th>Calm</th>
<th>Anxious</th>
<th>Overprotective</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indifferent</th>
<th>Acceptant</th>
<th>Uninformed about illness</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Family Attitude Toward Hospitalization

<table>
<thead>
<tr>
<th>Cooperative</th>
<th>Medical Recommendations</th>
<th>Discharge</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Uncooperative</th>
<th>Medical Recommendations</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient's Attitude Toward Illness

Calm
Anxious
Denying
Indifferent

Patient's Attitude Toward Hospitalization and Medical Discharge Recommendation

<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>Medical Recommendation</th>
<th>Discharge</th>
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</thead>
<tbody>
<tr>
<td>Accepting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Accepting</td>
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</tbody>
</table>

V. Problems Presented by Patient and/or Patient's Family Requiring Medical Social Worker's Assistance

- Assistance in feelings around and adjusting to illness
- Assistance in regard to family problems
- Assistance in regard to personal or behavior problems
- Facilitating institutional convalescence or chronic care
- Facilitating financial assistance

VI. Activities of Medical Social Worker in Handling Problems

- Interpretation of various aspects of illness
- Assistance in helping parents understand and accept patient's illness, limitations and medical recommendation
- Facilitating transfer of patient to convalescent home
- Coordinating interview of doctor with family
- Referral to community agencies
- Social histories and home evaluation
- Personal services such as letters, errands and so forth.
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