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THE ROLE OF THE MEDICAL SOCIAL WORKER
ON A PEDIATRIC SERVICE

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

BY
MUSETTE MIDDLEBROOKS

SCHOOL OF SOCIAL WORK

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To her parents, for their inspiration and prayers, her sincerest gratitude and affection.
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CHAPTER I

INTRODUCTION

Significance of the Study

Professional work with many physically ill and handicapped children is increasingly being inspired by the concept that each child is a whole person, not an aggregation of well and sick parts, and that if his full recovery is to be accomplished, his total person must be treated. This concept is being reflected today in many hospitals and clinics where doctors and nurses have the help of social workers in understanding the social and emotional components of illness, and how the interaction of social, psychological, and physical factors affect the total functioning of the human organism.¹

In a medical setting, the social worker functions as a member of a team of specialists who serves the patient. This is what the authorities call "teamwork", and it has become an important factor in the practice of medical social work. Frances Upham defines medical teamwork as the co-ordination of services in the interest of the patient and his family and writes that it has come to be accepted as the only valid approach to the complex problem of maintaining and restoring health.²

Through this multi-discipline approach, the various professional disciplines cooperatively apply their knowledge, skills, and techniques toward the restoration and rehabilitation of the patient. Integration of the knowledge and services of the members of the team enables each of them to view the patient as an integrated whole which provides a basis for more effective


To appreciate the significance of the social worker's role in the total medical care of children, one must understand the various duties she performs as well as the many problems which confront her.

Because of the background of the various specialists on the medical team, they bring to the team a variety of feelings and attitudes and a difference in their knowledge of human behavior. Therefore, their focus of interest differs depending upon their broad basic knowledge of human behavior or the lack of it. Consequently, the role of the medical social worker requires that she utilize all of her basic knowledge and skills in working cooperatively with the members of the team as well as in rendering effective service to the child and his family.

There are certain social and emotional factors that predispose or interfere with the child's illness and prevent him from deriving maximum benefit from medical care. Many of these factors contribute to the recurrence of the child's illness and are important to the medical social worker from a preventative standpoint. Too, there are certain social implications specific to a particular disease which require interpretation to the child and his family as these may significantly affect the acceptance of a prescribed plan of treatment.

The medical social worker helps the child and his family to adjust to the child's illness and tries to allivate any fears or other harmful attitudes on their part which may have an adverse effect on the progress of the child. She interprets the reactions, feelings, and attitudes of the patient...

and members of his family to the physician and other team members in order that they may have a better understanding of the child and his situation. She has a broad knowledge of community resources and assists the child and his family to make constructive effort to utilize the available resources.

The primary function of the medical social worker is the practice of social work in collaboration with the medical care of the patient. Through a social study of the patient and his social situation, the medical social worker contributes to the physician and other members of the medical team an understanding of the social and emotional factors which are affecting or are affected by the patient's illness, and which contribute to his adjustment to illness or his fullest use of available medical social service.

The medical social worker has committed herself to the furthering of the fundamental purposes of the medical profession. It is a challenge to her skills to function as a member of a team of specialists who serve the patient and to be able to help the patient and his family understand the quality of her contribution. If the value of her contribution is to be recognized and accepted, she must continually strive to gain respect for her specific role and for the philosophy which she represents.

As a student worker at the City of Detroit Receiving Hospital, the writer had innumerable opportunities to observe and become familiar with many of the services rendered by the social worker on the Pediatric Service. It was her hope that this study would reveal some of the specific services offered by the medical social worker in assisting the child and his family to use their strengths and resources constructively for healthful living.

Purpose of the Study

The purpose of this study was to show the role of the medical social worker as a member of the Pediatric team in the treatment of children

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with social problems relating to their illness. It was an endeavor to show some of the specific services rendered by the social worker in carrying out her function within the framework of the total medical care of the child.

Method of Procedure

The case study method was used in studying and analyzing twenty cases chosen from the total number of patients referred to Social Service from the Pediatric Department at Receiving Hospital, from October 1, 1956 to January 1, 1957. The writer chose only twenty cases because she felt that they were representative of the major services offered by the medical social worker.

The particular period of study was chosen because approximately two or three months prior to the study, full social service coverage of Pediatrics was not available due to the resignation of the regular worker, and it was not until October, 1956 that full coverage was again extended to this service.

A schedule was used in assembling and analyzing data from the social service records and hospital and clinic charts. Interviews were held with the social worker covering the Pediatric Service and with the Director of Social Service. All available literature pertinent to the study was read and studied.

Scope and Limitations

This case study included twenty cases referred to Social Service from the Pediatric Department at the City of Detroit Receiving Hospital from October 1, 1956 to January 1, 1957.

Data relative to the study were limited because no formal Social Service records were kept. Because of the pressure of the work, Social Service recording was brief and pertinent and did not always show the coordinated
procedure as a certain amount of routine was generic to the setting. The Director of Social Service felt that in an ideal situation, recording would be more complete. However, because of the nature of the setting, an increase in material recorded could mean a sacrifice of services to the child and his family. Consequently, confronted with the alternative of sacrificing the recording for the patient and vice versa, the Director of Social Service believed that the decision should be in favor of the patient.

This procedure is not unusual to a medical setting and Harriett Bartlett explains that

...because of the large number of patients, the brief case is likely to predominate in the average case load. The medical social worker cannot, except in a research setup, expect to have a protected job in which she concentrates upon intensive service to a few highly selected patients.... It is in the nature of the medical setting that there will be many persons with acute and urgent needs and that rapid action is necessary. It is the ability to integrate casework with this reality that is essential to the building up and maintenance of a sound medical social case load.\(^1\)

The study was not concerned with the quality or the effectiveness of service. It was rather an endeavor to show some of the particular services rendered by the medical social worker in carrying out her function as a member of the Pediatric team.

CHAPTER II

SETTING OF THE STUDY

Description of Receiving Hospital

The City of Detroit Receiving Hospital is a municipally owned and operated hospital whose primary function is to provide medical care for the emergency and/or indigent cases of Detroit residents. The Hospital was authorized by City Charter in 1913 under the auspices of the Detroit Department of Public Welfare. As the result of a charter amendment, approved by the City's electorate, administration and control of the hospital was assumed by the Detroit Board of Health in January, 1950.

The first unit of the hospital was opened October 12, 1915. Because of the rapid increase in population, additions to the original structure were made in 1921 and in 1927. The most recent addition, the Farwell Annex, which houses the out-patient clinics as well as the laboratories for cardiac and cancer research, was officially dedicated in December, 1952.

For administrative purposes, the hospital is divided into three units: Administration, Medical Care of Patients and Plant Operation. Under the Division of Administration is the Admitting Office, Ambulance Division, Business Office, Communications, Dietary Department, Medical Records and Stenographic Pool, Personnel, Storekeeping and Timekeeping. Under Professional Care of Patients are Medical Activities and Nursing Activities. Medical Activities include: Pathology, Medicine, Surgery, Radiology, Psychiatry, Anesthesiology, Pediatrics, Dermatology, Urology, Ophthalmology, Gynecology, Orthopedics, Oral Surgery, Otolaryngology, Dental Clinic, Intern Training, Pharmacy, and Social Service. The Nursing Department comprises the Registered Nurses, Practical Nurses, Medical Attendants, and Physiotherapists.
Under the Division of Plant Operation are the maintenance and Housekeeping Departments.

Receiving Hospital has a bed capacity of 789. Of this number, 75 beds are allocated to Pediatric patients and "boarders." Boarders are well babies, who by reason of neglect or desertion, are accepted for boarding care when referred by the police department. They are kept until plans are made for their care. The remainder of the beds are distributed on the medical, surgical, and psychiatric wards.

There are thirty-nine clinics operating within the hospital, one of which is the Pediatric clinic, which is held twice weekly.

Initial treatment at Receiving Hospital is given in the emergency wards to ambulatory and first aid cases without regard to the patients' financial status or legal settlement. All patients are billed for services rendered. After admission, the patients who have been hospitalized over seventy-two hours are referred to the Wayne County Department of Social Welfare where arrangements for payment or decisions relative to free care are made. All patients with a minimum income are required to pay according to a budget employed by the hospital investigators. Free out-patient clinic care is provided through the City Physicians' Division to those patients found eligible by the Hospital Investigation Bureau.

Through the years, Receiving Hospital has maintained an invaluable affiliation with the Wayne State University College of Medicine. It is a teaching hospital for third and fourth year students from the College and graduate students in psychology from the University. It also provides placements for students in Social Work from various colleges and universities, among which is the Atlanta University School of Social Work.
The Pediatric Department

The Pediatric Department at Receiving Hospital was established during the early part of 1954 when a chief of Pediatrics was added to the hospital staff. Prior to this time, only a few children were admitted as emergency and surgical cases, and the children's ward was only part of the assignment of one worker. A small number of "well babies" or "boarders" was accepted and kept until plans were completed for their care in cooperation with other agencies. The expanded service added two more wards and a clinic.

In February, 1954, we (Social Service Department) received a request for social service coverage of the expanded Pediatric Service. Prior to this time, Pediatrics had been a specialty under Medicine, and was covered by the workers carrying medical wards. Under the new plan, the request was for one social worker to be assigned to Pediatrics with complete integration of the in-patient and out-patient services. It was possible to fulfill this request and an assignment was defined and worked out between the Director of Pediatrics and the Director of Social Service.  

Several conferences were held between the Chief of Pediatrics and the Director of Social Service in defining the areas of service, extent of service, clarification of function, location of office space, and selection of a worker to cover the service. When a worker was chosen, the Director worked closely with her in defining the assignment, extent of coverage, and social service recording.

In this department, cases are referred from the doctors and nurses assigned to Pediatrics, other hospitals and clinics, nursing services, social agencies and schools, parents and relatives, and social service review.

The most recent development in the Pediatric Department is the establishment of a Psychiatric Consultation Service. The social worker secures

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1 "Narrative Report" (Social Service Department, Receiving Hospital, Detroit, Michigan, 1954).
social histories on cases that are being studied intensively or presented for teaching purposes. Members of the Pediatric Department, including the social worker, and members of the Department of Neuropsychiatry meet and discuss the physical, social, and emotional factors in the cases presented in an effort to more adequately meet the needs of the patients.

The Social Service Department

The Social Service Department at Receiving Hospital was established in 1916

...as a service to the patient, the physician, the hospital administration, and to the community. It is designed to help meet the problem of the patient whose medical need may be aggravated by social factors and who, therefore, may require social treatment based on his medical condition and care.¹

Its development has more or less paralleled the history in the field of Medical Social Work. During the first ten years of operation, the social workers were assigned to the hospital at large with no apparent attempt to employ the services of certain workers on specific wards, services or functions.² The present positions within the Department have been defined by the administration and each worker has an individual assignment and specific duties.

The Social Service Department is under Medical Activities. Its members are recruited, promoted, transferred, discharged or retired through the Detroit Civil Service Commission, however, they are responsible, through administrative channels, to the Chief Personnel Officer of the Department of Health.

¹"Manual of Policy and Procedure" (City of Detroit, Department of Public Welfare, Bureau of Social Service) Item 213. (Mimeographed).

The Director is responsible jointly to the Business Manager and the Medical Superintendent. In addition to the Director, there is an Assistant Director, five psychiatric caseworkers, six medical caseworkers, two court workers, and three clerical workers.

There is one-hundred per cent coverage by Social Service of the psychiatric wards and clinic. The workers on the medical and surgical wards and clinics accept cases by referral.

Recording is brief and pertinent as it is a part of the unit record. It may be incorporated in hospital and clinic charts in chronological order and signed by the social worker. However, the process varies with the reason for the referral, purpose of the social service contact and the problems presented or identified. Much of the social worker's contribution is made on ward rounds and in clinics where information is exchanged and reports are made verbally.¹ A record of contacts with the patients and their families is kept in the Social Service office.

¹ "An Experience in Setting up Social Service Coverage of an Expanding Service in a Hospital" (Social Service Department, Receiving Hospital, Detroit, Michigan, July 12, 1954), pp. 1-5.
CHAPTER III

THE TEAMWORK CONCEPT

Definition

The social worker in a medical setting functions as a member of a team of specialists who have as their main objective the preservation of health. The team is a unit, usually headed by the physician, which brings into focus the unique and overlapping skills, knowledge, and techniques of each discipline represented for diagnosis and treatment of the individual patient. 1 Consequently, through the interplay of diversely trained minds, a breadth of views is made possible in understanding the interrelationship of psychological and social factors in the treatment and prevention of illness. In a close, cooperative, multiprofessional union, each member pools his unique services toward a common purpose designed to meet the fundamental needs of the patient.

Philosophy

The human organism is a physiological, psychological, and social being and its totality is the product of the interaction of its three components. 2 This implies that the human being is an interacting whole and that in the application of all treatment, his total person must be considered. Commenting on the philosophy of teamwork, Frances Upham writes that


...the various professions have come to recognize the principle of interaction in the functioning of the human being. His needs—whether medical, economic, or social—are viewed, not as a series of separate entities that can be treated separately by a group of specialists but as a unit.

The basic philosophy underlying the teamwork concept recognizes the subordination of personal prominence to the efficiency of the whole.

...Here we take into consideration the fact that each member's contribution is focused toward the primary purpose, which is better service to the patient and the patient group. In subordinating personal prominence, each member of the group thinks in terms of how his individual contribution may be related to the function of other individual members of the team. Each member also considers what he can learn from the other members of the team to improve and supplement his own particular service to the patient. We thus find the group working together with the goal of seeing that the patient gets the best service available to evaluate his problem.

Therefore, in order for teamwork to be effective, the services of the various disciplines must be utilized within the framework of a co-ordinated interprofessional approach to the individual.

Relationship

The relationship among the members of the team is of primary importance if the achievement of their goal is to be accomplished. Effective teamwork is dependent largely upon the members' attitudes and feelings toward each other.

Miss Stein points out again that

...inherent in any teamwork relationship is a respect for every member's contribution, an awareness of one's own role, an understanding of how to use the other members of the team, and an opportunity for each member to indicate what his role will be in the individual case. Mutual agree-

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2 Stein, op. cit., p. 287.
ment is reached on the respective responsibility of each team member.¹

This implies that, in an atmosphere of positive relationships, the quality of service to the patient and his family will be enhanced by a more valuable interchange of knowledge.

Within the framework of a comprehensive service, the contributions of the various disciplines may be pictured as a series of overlapping circles. However, each of them makes a unique contribution to the team. On the Pediatric Service at Receiving Hospital, the doctor, nurse, and social worker comprise the team, with the thinking of other disciplines called into play when the situation warrants it. What, then, is the unique contribution of these three disciplines?

In the medical setting, the doctor is considered as head of the team. Miss Stein states that he brings to the team

...a body of medical knowledge which enables him to diagnose the particular illness and to make recommendations for the ongoing care of the patient commensurate with the restrictions growing out of the medical needs. In addition to his specific body of knowledge, the doctor comes with an understanding of and a sensitivity to people's feelings, based on his own personal relationships with people and on the formal teaching that he may have received in this area.²

Traditionally, the nurse has occupied a prominent place as an adjunct to the doctor. Because of her knowledge of the emotional and social aspects of illness, her services have extended beyond the primary role of giving bedside care. Miss Stein also explains that the nurse

...sees the patient for concentrated periods of time in a controlled environment. She sees the patient\'s reactions on the ward, sees whether or not there are visitors, and

¹Ibid., p. 287.

²Ibid., p. 287.
sees the reaction of the patient to his family and the family to the patient during these visiting sessions. The nurse also sees the patient's reaction to medical treatment and may see the family's reaction to the patient's hospitalization. She thus has much to bring to the group's better understanding of the individual patient and his family.¹

The medical social worker has a disciplined awareness of the psychosocial aspects of illness of the individual patient. Through her understanding of the meaning of illness for the patient and his family, she helps the patient and his family to participate in a plan of treatment consistent with the patient's medical needs and recommendations. The medical social worker's unique contribution to the team will be explored more fully in the following chapter.

Techniques

Consultation is the chief tool of communication and operation in teamwork; it is the coordinating and integrating force that runs through the entire process of treatment. It is through this means that the patient and members of the team relate themselves to one another, and it enables the team members to redefine their roles in carrying out their total treatment responsibilities. Furthermore, when differences of opinion arise in the course of treatment, consultation can often be the means of resolving these questions.²

The team employs various methods of communication and exchange of information in co-operating with one another. The methods employed may vary from hospital to hospital and from service to service within the same hospital. However, the more common ones employed are the use of the medical

¹ Ibid., p. 288.
² Lesser, op. cit., p. 125.
chart, day-by-day interpretation, formal lectures, post-clinic conferences, and ward rounds. All methods may be used in developing the teamwork relationship according to the interest and wishes of the various services and their usual methods of meeting the needs of the patient.

The professional fields of medicine and social work seem destined to be drawn closer together as we share, to an increasing degree, the responsibility for helping individuals who are ill to utilize more effectively their own adaptive resources and for helping to create the optimal environmental opportunity for the recovery and maintenance of ease. The separate and different professional services made available by the disciplines of medicine and social work are achieving relatedness within a vastly broadened framework of understanding about human capacities and human needs.1

CHAPTER IV

THE ROLE OF THE MEDICAL SOCIAL WORKER

The Generic Approach

Although all members of the health team appropriately are concerned with the nature of man's environment—social, physical, cultural, and ideational, and the influence of environment upon health—the social worker's focus is upon the relationship of the individual to the different parts of his environment and the furtherance of his adjustment to all or any part of it.¹

The medical social worker's contribution to the team is based on her special knowledge of the dynamics of human behavior embracing all of the skills and techniques of her profession as well as the philosophy of the profession which she represents. This emerges from her generic training in social work based on the assumptions that

...the individual and society are interdependent; social forces influence behavior and attitudes, affording opportunity for self-development and contribution to the world in which we live; not only are all problems psychosocial—inner and outer—but most casework problems are interpersonal, that is, more than one person is likely to be involved in the treatment of the individual, and particularly in casework is the family unit involved; the client is a responsible participant at every step in the solution of his problems.²

The implication here is that the social worker is skilled in human relationships and in helping the individual toward better social functioning through the use of his own strengths and society's resources. Because of her deep respect for the personality, worth and dignity, and right of self-

¹Eleanor Cockerill, "The Contribution of Medical Social Work to the Team of the Health Professions," Medical Social Work (September, 1951), p. 27.

determination of the individual, she attempts to see the individual's problem as he sees it, to allow him to move at his own pace, and to make his own decisions toward a goal that he is helped to set for himself.

Therefore, the medical social worker, in carrying out the full range of her functions, shares the common purposes, goals and philosophy of all social workers.

The Distinguishing Characteristics of Her Role

There are certain distinguishing features of medical social work which need to be stressed. It is supplementary to medicine which means that the process is one of teamwork with the physician and frequently with other professional persons, such as the nurse and dietitian. The hospital is a complex institution, the administration of which has many social aspects. Illness means fear, pain, disability, sometimes stigma for the patient and creates many problems for his family.

While the medical social worker employs all of the skills and techniques that constitute the generic approach in social work, she must supplement these with additional knowledge and skills essential to the medical setting.

In the performance of her role, Eleanor Cockerill writes that the medical social worker

...must not only describe the relevant factors within the total environment and identify those which are stressful in nature, but, more importantly, he must identify the problem of the individual in relation to a situation of stress. The meaning and significance for a particular individual of those stressful relationships and experiences which are revealed through the process of social study, and the relatedness of the various problems which are located, should be clearly established by the social worker, since this is the specific contribution he makes to the development of comprehensive understanding of the patient and his problems.

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Thus, we find here the recognition that the medical social worker is not only concerned with specific problems of medical care but that she must be equally alert to other problems in the patient's environment and evaluate these as they relate to the patient's illness. The pulling together and the relating of the problems identified reveal the meaning of illness to the patient.

The medical social worker has a broad knowledge of community resources and serves as a liaison in coordinating the medical and social resources in a community. She knows how to work with the resources in terms of their intake procedures, policies and services. Too, it is her responsibility to bring to the attention of the patient and his family the resources available to meet the patient's needs and to assist them to make constructive use of them.

Role of Consultant and Therapist

Mary Hemmy states that the role of the social worker may be classified as a consultant and as a therapist and that

...these two responsibilities are present concurrently in the course of the worker's service to the patient. Each derives from the caseworker's particular competence in understanding the interrelationship between psychological, social, and medical factors and in assessing the influence of these interrelationships on the patient's illness, his response to technical medical procedures, and his ultimate rehabilitation.¹

In differentiating between the two roles, Miss Hemmy continues that

...as a consultant, the caseworker's function lies in obtaining and evaluating with the physician pertinent social and personal data which have a bearing on the differential diagnosis of the illness by the physician—in evaluating such data with the physician and other members of the health team as one factor in de-

determining the timing, selection, and application of the treatment choice. It should be noted in this regard that ruling out personal and environmental problems as contributing or complicating factors in illness and treatment may constitute as essential a contribution to the patient's total care as the identification and handling of such problems.

As a therapist, the caseworker's function is essentially that of the caseworker in any setting: to help the person in trouble assess his situation, the problems and assets within himself and his environment, in order that he may capitalize on his strengths and resources in moving toward maximum responsibility in his own behalf. Essential to the successful performance of this function is the caseworker's professional knowledge and experience: an ability to search for facts, analyze and make use of them in service to the patient; ability to create with the patient a relationship in which the latter is helped to view as he is able the reality confronting him—both forces contributing to his difficulties and forces in himself, his family, his community, and the hospital which he may use to meet his situation or change it.¹

For the purpose of this study, case illustrations were used to show how the medical social worker on the Pediatric Service at Receiving Hospital functioned in these two roles. The methods and processes employed were not sharply differentiated, as in any given case, the social worker's role shifted and overlapped.

The treatment of the ill child, if infused with an understanding of the normal needs of growth and development, can not only speed the child’s restoration to good emotional and physical health, but can enlighten the parents on how health needs may be met. The family is the child's main source of psychological support and the behavior and feelings of those caring for him affect his emotional and physical security.

The nature of the support the child requires from his family depends on or varies with his stage of psychosexual development. During infancy, the

¹ Ibid., p. 112.
child's ego is weak and he is completely dependent, physically and emotionally, upon his mother. The mother is his whole life and he has not yet learned to trust and depend on others. When the child's emotional security is threatened, due to the lack of love and attention, he attempts to find some direct means of expressing his dissatisfaction. When he is faced with a situation created by emotional conflicts and family tensions, he

...sets up various defense mechanisms to handle the anxiety created by family tensions. An escape into illness may be the child's only way of handling pressures that are too heavy for him to bear. The child's threatened security with either the father or the mother often sets up tension which find discharge through the organ pathways of disease. Disease then becomes a means of expressing frustration and dissatisfaction. As long as the frustrations continue, the child may find in recurrent or chronic illness a solution for his conflicts.2

When in illness—that is, the reaction of the child to the frustrating situation—has started, the procedure of approach is first to ascertain the cause (namely the frustrating situation) and the need that is being frustrated. The physician who is called to treat a child with a gastro-intestinal disturbance should inquire as fully into the emotional experience of the child as he does into the chemical composition of the food the baby has been receiving.3

It has been said that chronic diarrhea can be a symptom of both organic and neurotic disturbances which may be present simultaneously.4

Case I

The following case illustrated a situation in which a five week old male

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1 Upham, op. cit., p. 62.
2 Ibid., p. 69.
was hospitalized for vomiting and diarrhea. The social worker conferred with the physician in order to gain an understanding of the child's medical problem. The doctor felt that the patient's home situation was unsatisfactory and that the mother was unreliable. He requested an evaluation of the home situation relative to discharge planning. The social worker made a home visit and interviewed the patient's mother.

Chief Complaint: Up to two weeks of age, the patient was breast fed, each feeding supplemented by an ounce of formula because "he was always hungry." At approximately two and one-half weeks of age, the patient developed diarrhea. He was brought to the emergency room and placed on a "salt water formula." He was on this formula for four days and the diarrhea cleared. The mother then nursed him again for three or four days, but because he was always hungry and never satisfied, she stopped giving him the breast, and put him on the bottle (16 ounces water, 8 ounces milk, 2 tablespoons Karo) "everytime he cried." On the formula he developed diarrhea again and began to vomit. He was taken to the emergency room again; was again placed on the "water formula" and given an appointment for the clinic. (There was no vomiting or diarrhea as long as he was on the "water formula.") On Thursday, 10-18-56, he was seen in clinic and the mother was advised to put him on skimmed milk for one day and then on the formula. Friday, after a feeding of skimmed milk, he vomited and had diarrhea. The mother called the emergency room and was advised to put the baby on a ½ and ½ formula for one day; skimmed milk the next day and then the regular formula. The patient got along all right on Saturday on the ½ and ½ and skimmed milk formula, but on Sunday, following a feeding of the regular formula, he began to vomit and have diarrhea again.

Early Sunday morning, the mother's step-father was watching the baby while the mother went to the store. When she returned, her step-father advised that the patient looked like he had a convolution, but the step-father rocked him and he went to sleep. The mother concluded the baby had been "mad and was having a tantrum." Later that evening, after being fed the formula by a neighbor, because the mother had gone out, he vomited and had diarrhea. The mother was called home and thereupon brought him to the hospital. On the way to the hospital, the mother tried to feed him again, and again he vomited.

In attempting to account for the patient's vomiting and diarrhea, the mother explained that just previous to the first attack, the house had been infested with flies and commented that the Public Health Nurse had told her that flies often caused diarrhea. She also explained that she had often caught an older son putting food into the baby's mouth and once she found a lump.
of bread in the baby's regurgitated material. She had also observed the older son, who had a severe cold and cough, taking the baby's bottle, sucking it, and placing it back in the baby's mouth. She also felt that the patient was starved, not because of mishandling on her part, but rather because of the water formula which had been recommended by the doctor in the emergency room. She felt that following the water formula, the baby had been unable to keep down the ever changing milk formulas.

Social Situation: The family consisted of Mrs. B. (age 26) and her four children, J. 3½, Je. 2½, L. 1, and the patient, 5 weeks. They lived in a two bedroom project, which at the time of the home visit, by appointment, was rather dirty, very disorderly, and disorganized. Housekeeping standards, to say the least, appeared quite low. The family was supported by the Welfare Department. Mr. B. deserted in March, 1956 when Mrs. B. was three months pregnant with the patient. This was Mr. B's second desertion, having deserted the first time in 1953 when Mrs. B. was pregnant with Je, and he remained away for fourteen months.

Mr. B. was described as an alcoholic, who was abusive toward Mrs. B. and the children. Mrs. B. stated that "it got to the point where I was ashamed to take the children out on the street because they were so bruised and black and blue." She said that Mr. B. worked erratically and literally starved the family. Following Mr. B.'s desertion, Mrs. B. was very upset. She cried continuously, was unable to eat, was extremely overwrought, and stated that "I thought I was going crazy." In April, she moved into the Project and slowly had been pulling herself together, though she was still unable to eat. She felt better as she had decided to divorce her husband and build another life for herself and her children.

Medical Problems: The two boys were present during the interview. They were ill-clothed, barefooted and somewhat dirty. Je. (2½) had a severe cold, cough, running nose and ear. One side of his face was covered with scratches; his toes were blistered (Public Health Nurse said he had impetigo.) Mrs. B. advised that she had taken Je. to a private doctor for his ear and the doctor put "crystals" in his ear. The condition was corrected for a while, but recurred. She had not done anything about his cold, cough or ear since. In regard to the scratches, she said he was in a fight with another boy. Both boys were active during the interview, though Je. appeared retarded. Mrs. B.'s behavior toward the boys was inconsistent. At times, she yelled and hollered at them and threatened to hit them with a tree switch. At other times, she spoke more softly and cuddled them.

The one year old girl was sleeping and was not seen. Mrs. B. advised that this was her sickest child. When only a few
months old, she had an operation for "twisted bowels." Soon after this she had the measles. Since February or March, she had had a chronic running ear. She was allegedly seen at our Ear, Nose, and Throat clinic and by a private doctor. Like Je., "crystals" were put in her ear, but the condition recurred. She also had a perforated ear drum. Mrs. B., advised that the doctor told her that the children's tonsils and adenoids should be removed, and when this was done, the ear condition would probably be corrected.

Two weeks before the patient was born, L., the one year old girl, had scarlet fever. She was allegedly isolated in her room for ten days and was taken to a private doctor. He gave her a penicillin shot, following which she broke out in red blotches. She was then given sulphur. The doctor questioned that she had scarlet fever, but rather felt it was the German measles.

Evaluation: As indicated, the situation in the home was very questionable. Generally, the home was unclean and untidy, and infection was rampant (i.e., colds, running ears, etc.) Although a superficially pleasant, friendly, cooperative woman, the worker felt that Mrs. B. was a rather inadequate, hostile, aggressive, rejecting individual unable to assume responsibility for caring for four children. Emotionally, she appeared unable to give to the children, even though she verbalized love for them. The worker felt that it was not unlikely that the patient's symptoms could be due to a physical condition as yet undiagnosed, but she also felt that there was little doubt that Mrs. B.'s inadequate handling of the patient was also a major contributing factor.

In view of the medical social situation, the social worker suggested to the doctor that the patient remain in the hospital until he was completely asymptomatic and firmly established on a formula. At the time of the discharge, she felt that the mother should be thoroughly and clearly instructed as to formula, diet, vitamins, etc. She also informed the doctor that the Public Health nurse would be requested to call at the home and supervise more closely, and that the Welfare Worker would be alerted to the situation and requested to follow the case for potential neglect. It was also suggested that Mrs. B. be instructed to bring the other children to clinic, particularly Je. and L.

On 10-25-56, the social worker talked with the Public Health Nurse and advised her of conditions in the home. The nurse felt that Mrs. B.'s care of the children was "very bad." On her visits to the home, she had repeatedly seen the house extremely dirty, and the children half-dressed and dirty, frequently covered with bruises and scratches. Je., particularly seemed abused. Several months ago, the Health Division received a complaint from neighbors that the children were being mistreated.
by Mrs. B. When questioned, Mrs. B. admitted beating the children with a strap because she couldn't control them any other way. Since that time she had not used a strap on the children, but continued her poor care of them.

The nurse advised that Mrs. B. was rarely home. She allegedly had a boyfriend and was "always on the go" entrusting her children to the care of a neighbor. According to the nurse, Mrs. B. was particularly rejecting of Je., who appeared retarded to the nurse also. On the above date, the mother had advised the nurse that Je. did not talk, did not mind her and seemed "sub-normal."

The nurse agreed to supervise the situation more closely, particularly after the patient was discharged from the hospital. If the situation did not improve, she planned to urge the welfare worker to consider filing neglect. She had already spoken with the welfare worker about her observations of Mrs. B.'s care of the children. The social worker's findings were also reported to the welfare worker.

This case clearly represented a situation where there was reason to doubt the mother's ability to provide for the patient's physical as well as emotional needs. It pointed out the role of the social worker in bringing into focus social and emotional factors which possibly had a bearing on the patient's medical problem and subsequent planning for the patient. In this capacity, she served as a consultant in evaluating with the physician the degree to which these factors contributed to the patient's illness. She acquainted the doctor with the attitude and feelings of the mother toward the patient and his illness, and brought to his attention medical problems of other family members.

In addition to reporting on the primary basis for the referral, the social worker also included other material directed toward a better understanding of the patient and his situation. She shared with the doctor the development and progress of her planning on behalf of the patient and timed her services in relation to the total medical care of the patient.

As a therapist, the social worker provided the mother an opportunity to
express her feelings regarding her own marital difficulties which brought into focus other strains and inadequacies in the situation originating apart from the patient, yet threatening to him. She was understanding and accepting of the mother's feelings and indicated her interest in the patient and her desire to help in meeting his medical needs.

She also served as a therapist in interpreting the needs of the patient to the Public Health Nurse and the Welfare worker, and clarifying with them the negatives in the home which possibly disturbed the patient's physical and emotional adjustment. Her services were directed toward affording the mother fuller understanding of the medical needs of the patient through the services of the Public Health Nurse. To protect the patient, if the home situation continued to be a health hazard and lacking in the requirements for the patient's normal physical and emotional development, the worker referred the case to the welfare worker for closer observation.

Case II

This case presented a situation in which a 6 year old female patient, suffering from congenital heart disease, was refused hospitalization at Receiving Hospital, and because of the services of the medical social worker, hospitalization at another hospital was made possible.

The mother and aunt of the patient were in clinic with a note from a private physician, addressed to the Board of Health, recommending placement of the patient in a special class for Rheumatic Heart Disease. In conversation with the mother, the worker learned that the patient was seen in clinic in September when the cardiac condition was discovered. At that time, the doctor referred the patient for admission. At the admission office, the mother was given Michigan Crippled Children's Commission forms and advised to apply for hospitalization expenses before admission. This the mother did, but the Commission denied the application. The mother then took the patient to a private physician. The social worker gave the mother an application for placement in a special cardiac school and instructed
her to have the private physician complete the form and mail it to the Board of Education.

Later, in discussing the situation with the chief resident, the social worker became concerned about the reason for denial of the mother's application for hospital expenses, especially as the doctor felt that the patient should be hospitalized. She telephoned the Crippled Children's Commission and learned that the application had been denied under a special act (Congenital Heart Disease Act) and Receiving Hospital was not approved for care under this particular act. The worker also learned that there were two other hospitals in the city approved for care under the Act.

The worker telephoned the patient's mother and advised her not to take the application for admission to a special school to the private physician, and that she would discuss the case further with the doctor and advise her further.

The worker further discussed the case with the chief resident and informed him of her findings, and together it was decided to refer the patient to one of the approved hospitals and arrangements were made for the patient to be examined there in the Pediatric clinic.

The following day, the mother was interviewed in the office and the patient's condition was thoroughly explained to her as well as the reason for the Crippled Children's Commission denial of her application. She was given a letter of referral from the chief resident including a Pediatric appointment at the designated hospital. A few days later, the social worker telephoned the mother and learned that the patient had been admitted.

As a consultant, the social worker conferred with the physician and discussed the medical needs of the patient. She shared with him her findings regarding the refusal of admission and together they defined means of best meeting the patient's medical needs.

She served as a therapist in interpreting the patient's medical condition to the mother, and in giving her information about the reason for denial. This aided in helping the mother to evaluate the reason for denial in a clear perspective, and to understand why this had been necessary. She recognized and acknowledged the steps the mother had taken in solving the patient's medical problem, and indicated her willingness to work with her in seeing
that the patient received adequate medical attention. Her services were
timed in accordance with the medical needs of the patient. Yet she moved at
the pace set by the mother.

Case III

One of the duties of the social worker on the Pediatric Service at
Receiving Hospital is to take a census of all children admitted with a diagno-
sis of rheumatic fever and nephritis as they are two of the many diagnoses
having broad social implications. The first few months following an attack
of either disease may be crucial ones, and the threat of recurrence may be
particularly great. Carol Cooley points out that convalescence is highly im-
portant at a time when these children are gradually returning to as normal
a life as possible.¹

It is recognized that it is preferable that the child convalesce in his
own home. Accordingly, the medical social worker evaluates the home situ-
ation and the possibilities of care of the patient in his own home before
considering other resources for convalescent care.

...Any disease whose treatment is characterized by a regime,
and by the necessity for the acceptance of limitations and
preventive care, affects the social living of patient and
family. Whenever possible the patient, the family, and
others closely associated with him should have a general under-
standing of the regime so that they can plan intelligently
and participate responsibly in the patient's care.²

When the parents are emotionally secure and are able to approach the
child without undue anxiety, where the physical surroundings are adequate,

² Vera M. Keylin, "Some Aspects of the Use of Institutional Convalescent
Care for Children," Readings in the Theory and Practice of Medical Social Work
and home routines are subject to adjustment, the social worker can supplement the family's own resources with the needed services from other community resources.¹

The following case exemplified the social worker's role in planning for convalescent care for a ten year old male patient, whose diagnosis was acute glomerulonephritis with hypertension and congestive heart failure.

The social worker made a home call and interviewed the patient's mother. The mother was cooperative during the interview and expressed interest in and concern for the patient. She appeared, however, to be of limited intelligence, and displayed a limited understanding of the patient's illness. In spite of a lengthy discussion regarding the patient's illness, it was questionable that her understanding was very much increased. She was able, however, to comprehend what was involved, and the importance of convalescent care for the patient, and felt that she would be able to provide him with the adequate care. She could anticipate no difficulty in keeping the patient in bed for complete bed rest, and understood the need to keep him protected from infection.

Social Situation: The family consisted of Mr. and Mrs. C., ages 43 and 37 respectively, and five children; the patient, aged 10, F. aged 8, D. aged 6, B. aged 3, and F. Jr. aged 1½. The patient and F. were illegitimate children of Mrs. C., their father being someone other than Mr. C. Eight years ago, Mr. and Mrs. C. married, the three youngest children having been born of this union. Mr. C. was employed at a Metal Industry earning approximately $70 per week.

The family occupied a five room flat in an old deteriorated three family dwelling. The house appeared to be fairly clean and orderly at the time of the call, indicating fair housekeeping standards. Two of the rooms were converted into bedrooms. Mrs. C. and the two girls slept in one bed in one room; Mr. C. and the two boys slept in one bed in the other bedroom. The baby had a crib to himself. There was an empty bedroom in the house, and Mrs. C. advised that the patient could have this room to himself when he came home from the hospital, if she could scrape up enough money to buy a bed, mattress, and dresser. The room had remained empty due to lack of money with which to purchase bedroom furniture. Providing the patient with his own room and bed was Mrs. C.'s biggest obstacle in planning for his convalescent care. This obstacle was resolved,

¹ Upham, op. cit., p. 88
however, as the worker suggested that a contact with the Salvation Army might result in their providing her with a bed, mattress, and dresser. If this could be accomplished, Mrs. C. could see no difficulty in providing the patient with adequate care.

In regard to the physical condition of the family members, Mrs. C. advised that everyone was in generally good health. However, B. had a sore throat. She was seen in the emergency room, and the doctors diagnosed her condition as a throat infection. F. Jr. had an ear infection and a bad cough. Keeping these children, as well as others who were ill, away from the patient was stressed with Mrs. C.

Evaluation: Although Mrs. C. appeared to be a passive individual, limited in intelligence, and limited in her understanding of the patient's illness, she seemed concerned about the patient. With specific instructions and supervision, it was felt that the mother could care for the patient fairly adequately. It was felt, therefore, that the patient could be discharged to his home for convalescent care. A visiting nurse was also requested to supervise the patient.

Upon returning to the office, the Salvation Army was contacted. The medical-social situation was explained to them and they agreed to provide a bed and mattress in order that the patient could have his own bedroom. (A letter of confirmation was also sent to the Salvation.)

After the patient was discharged, a follow-up contact was made with the Public Health Nurse. She had made a home call and reported that the patient seemed to be doing very well; he was in bed, had his own bedroom and the mother understood his convalescent needs and care.

In the role of a consultant, the social worker gathered data relative to the patient's social situation and evaluated with the doctor the positive and negative aspects of convalescent care in relation to the total family situation. She shared with the physician her feelings regarding the mother's limited understanding of the patient's illness, yet felt that she was capable of providing the patient with adequate care with specific instructions and supervision. She also discussed with the physician the medical recommendations for convalescent care.

She served as a therapist by interpreting the nature of the disease process
to the mother, the limitations and demands created by illness. She explained fully the physician's instructions regarding hygienic and precautionary measures to protect the patient from infection.

Also as a therapist, she provided the mother an opportunity to discuss the obstacles to adequate convalescent care, and to express her feelings around the patient's illness and the adjustments to be made. Through expression of her understanding of the problems involved in the care of the patient and assuring the mother of her interest in and concern for the patient, the social worker was able to promote the mother's confidence in her ability to carry out medical recommendations. Here, she addressed herself, as far as possible, to the positive strengths in the mother's personality and the assets in the social situation in arriving at the twofold goal of reducing the pressures in the environment and fortifying the family to bear the pressures.¹

Therapeutically, she recognized that convalescent care could be hampered by anxiety over such problems as the lack of finances and available facilities for adequate care. Consequently, she planned with the family toward the alleviation of the home problems through the use of community resources.

Ofttimes, because of financial difficulties, the family is unable to follow through on recommended follow-up medical treatment of the patient. The medical social worker has the responsibility of assisting the patient and his family with problems that hinder the patient from making the best use of available medical care.

...Timely help with reality planning frequently enables patient and family to handle their anxiety about the medical situation. Clarifying the problems involved provides

¹ Hamilton, op. cit., p. 268
them with a sound supporting basis for activities, freeing them from floundering about in a morass of questions and doubts. It helps them mobilize their energies for constructive handling of the problem. Appropriate environmental arrangements can prevent the pyramiding of future difficulties which may otherwise get beyond control.\footnote{Upham, \textit{op. cit.}, p. 49.}

Case IV

The following case illuminated the social worker's role in a situation where the doctor was concerned about the follow-up care of the patient and requested the social worker's assistance. The patient, a five year old male, had missed several clinic appointments and the doctor requested that the social worker contact the mother regarding failure to follow medical recommendations.

Following the conference with the doctor at clinic, the social worker wrote the mother a letter explaining that the doctor was very interested in examining the patient again in order to determine how he was getting along, and advised her that a clinic appointment had been made for the following week. The letter was returned as the family had moved. The social worker contacted the Welfare Department, obtained the family's new address and sent another letter.

In the interview with the mother at the clinic visit, the social worker learned that there was an acute financial problem. The family consisted of the mother and six children aged 2 to 11 years, the first four of whom were illegitimate; the last two her husband's. The mother was separated from her husband and the Department of Public Welfare had refused assistance because of the lack of information on the alleged fathers. An Aid to Dependent Children application was pending, and the family was living from meager handouts from relatives.

The social worker gave the mother four bus tickets to go home and return for the next clinic appointment. The mother was also advised to reapply for welfare assistance.

The next day, the mother came to the office and informed the social worker that she had just come from the Welfare...
Department and that assistance was again refused. The mother was pregnant and expected to deliver in about three weeks. She explained that she had been thinking of giving the children up because she did not know how long she could 'tough it out.' She shared with the worker experiences of her own parental rejection and the difficult time she had had since that time. She had applied to the Salvation Army for assistance and felt that she had exhausted all available resources and she, herself, was equally exhausted.

The social worker telephoned the ADC office and learned that they were denying the application as the mother could not give evidence regarding the alleged fathers of the children. An 'uncle' seemed to have been a boy friend or alleged father.

A few weeks later, the social worker made a home call to deliver Christmas toys, and was informed by the mother that the 'uncle' had returned to work and was now supporting her and the children.

In a therapeutic role, the social worker helped the mother to resolve the transportation problem by providing her with bus tickets. She listened to the mother's story of her early childhood experiences, which provided the mother an opportunity to give ventilation to her feelings around her own parental rejection. The worker availed herself of community resources in an effort to assist with the financial problem, and further interpreted to the mother the reason for her ineligibility for assistance from these resources.

Case V

The increasing interchange of knowledge among physicians, psychiatrists, and social workers is an encouraging development. Through the contributions of the doctor and psychiatrist, significant theory is being suggested regarding the role of psychic factors not only in relation to neurotic illness but also in relation to the etiology, recurrence, and chronicity of physical illness itself.¹

The cases thus far presented have pointed out the role of the social worker in teamwork with the doctor. On the Psychiatric Consultation Service at Receiving Hospital, the social worker makes her contribution to the team by submitting a psycho-social history of the patient. Grace White writes that

...it is tacit that the social worker shares with others caring for the patient as much of these psychosocial findings and as much of her understanding of the situation as would be helpful to others. It is also tacit to good collaborative effort that plans for treatment be shared by all who are working with the patient. It may be that the patient cannot use social service help; the decision may be to do nothing more than refer the patient to such community resources as would be helpful in his rehabilitation.¹

The role of the medical social worker as both a consultant and therapist was readily seen in the comprehensive evaluation of the patient's illness in the following case.

The patient, 7 year old male, was referred by the psychiatrist for a social history and an evaluation of the patient's emotional adjustment. The mother was interviewed in the office, at which time the worker also scheduled psychological testing for the patient.

Informant: Mother, Mrs. B., aged 34. Mrs. B. was very concerned about the patient's behavior and was particularly concerned about the relationship of the present symptoms in terms of their being signals of teenage delinquency and/or adult criminality. She also expressed concern over her own emotional state, indicating that she was frequently depressed and nervous.

Presenting Problem: For the past three years, the patient had become 'nervous,' sucked his lip, was very withdrawn, seemed frightened of adults, mother included, and 'liked to hurt' smaller children. He was slow and 'pokey' in all of his movements, complained of stiff joints, fell frequently and slept excessively.

Further illustrating his intense feelings of fear, Mrs. B. insisted that she was always home, his explanation was always, 'I was afraid you weren't home.'

Onset: Three years ago, at age 4, the mother discovered that the patient was masturbating whenever he thought he was alone. He lay in bed, sucked his lip and masturbated. The mother scolded him and told him that his penis would become sore, swell up and would have to be cut off. (He continued to masturbate, though less frequently.) At around the same time
(age 4) Mrs. B. became aware of other symptoms, i.e., the 'nervous' withdrawn behavior, etc. Last summer, he began to torment little children stating that they were 'soft.'

Medical History: The patient had measles at age 1, and chickenpox and whooping cough at age 3. He had had nose bleeds all of his life which were particularly severe in the winter. He recently began complaining of headaches. The school nurse suspected impaired vision, but the patient refused to allow the doctor to examine him. For the past three years, the patient had complained of 'stiff joints.' Because of 'stiff fingers,' he was unable to dress himself and had a poor grasp; because his 'legs were stiff,' he fell frequently. The mother was also concerned about his slow, lethargic manner and his need to sleep so much.

School adjustment: When the patient first began school, he would cry bitterly every day, would turn back at the door of the school in an attempt to return home. In school, he was quiet and withdrawn, and refused to mingle with the children. This went on for a whole semester, after which time he went to school without crying but still didn't like it, still refused to mingle with the children, and frequently fell asleep in school. He was currently in the 2A and the teachers had no complaints about his adjustment. He usually received all 'A's' in citizenship and did equally as well academically. The teachers advised that he was a 'very nice boy' in school.

Developmental History: The patient was the middle child of seven siblings. He was born May 20, 1949, weighing 9 lbs. He was described as a 'fine, healthy' baby, ate well, rarely cried and was rarely fretful. He was breast fed until six months, and on the bottle until eighteen months. He was difficult to wean from the bottle and this process was concluded very abruptly. He had disliked milk since. Toilet training began at nine months and again, he was difficult to train. He continued to soil and wet during the day until he was four and now often 'forgot' to clean himself after going to the bathroom. He sat at six months, stood at nine months, walked at eleven months, spoke a few words at two and one half years and formed sentences at three years of age.

Social Situation: The family consisted of Mrs. B. and seven children aged 2 to 12 years. An older child died in 1954 at age 12 of a brain tumor. The two eldest children were born prior to Mrs. B.'s marriage in 1943. Her mother cared for the children while Mrs. B. worked. After her mother's death, Mrs. B. married but continued to work, with friends and neighbors caring for the children. She described a disturbed relationship with her husband, who appeared to be emotionally upset following his discharge from service. (At one point in the interview, she remarked that the patient frequently reminded her of her husband before Mr. B. became so acutely upset, i.e.,
both were 'so quiet and withdrawn.' When Mrs. B. was two months pregnant with the patient, Mr. B. deserted. The children were placed with friends and Mrs. B. came to Detroit. She secured employment as a housekeeper for three single men and worked throughout her pregnancy. Although physically well, she was emotionally upset. She worried about finances, the children in the south, etc., and verbalized the fact that she did not want the patient. When the patient was nine months old, she sent for the older children and established a home for all of her children. She continued to work, again having neighbors look after the children. Mrs. B.'s three youngest children were illegitimate.

As stated, Mrs. B. worked throughout her pregnancy with the patient and returned to work shortly after his birth. She worked until she became pregnant again, at which time she began to receive Aid to Dependent Children. When she again became pregnant, ADC was discontinued and Mrs. B. returned to work. While she worked, the older children were kept from school to look after the younger children and the patient was sent to live with an elderly woman. This woman was described as a strict, rigid individual. She kept the patient for seven months and when he returned home, Mrs. B. soon noticed the onset of the previously described symptoms. Prior to the patient's return to the home, the Board of Education insisted that the older children return to school and that Mrs. B. give up her employment. The oldest child, (who died of a brain tumor) was ill at the time, eviction was threatened, and the pressures became so great that Mrs. B. 'cracked up.' One night she began to scream and pull her hair, was irrational and incoherent. A private physician treated her and in a few days, she recovered and returned to work.

Almost immediately Mrs. B. became pregnant with her last child. She was very upset over this pregnancy, and did not want the child and attempted to abort. Again the Board of Education began to put pressure upon her to return the children to school; the oldest child was dying and again eviction was threatened. In Court, on the eviction case, Mrs. B. became so overwrought she leaped at the landlord and stabbed him. She was jailed in 2-54 and then placed on six months probation. The oldest child died during 4-54; the family was evicted a week later and her last child was born in 7-54. She almost 'cracked up' again, but her probation worker arranged for her to quit her job; the children returned to school and ADC was effective again.

Mrs. B. was getting along fine until five or six months ago, when she once more began to feel nervous, depressed, and tearful at the least provocation. She attributed this to worry over her financial situation. Aid to Dependent Children gave $240 per month, out of which $65 was for rent. Because she was under-budgeted, the lights and gas were on the verge of being shut-off. The ADC worker advised that Mrs. B.'s case was very questionable. Although she kept the house clean and appeared in-
terested and concerned about the children, there were always various men hanging around the house. Aid to Dependent Children had received several anonymous complaints that there were always men in the house drinking and that Mrs. S. might have been prostituting. The case, therefore, was currently under special investigation.

Sibling Relationships: The patient was usually withdrawn in his relationship with his siblings. However, he was quite aggressive with the two youngest children. He picked on them constantly, took their toys, and had them screaming and crying for hours. On the other hand, T., aged 5, generally picked on the patient. With T., the patient would fight back. He was the only one the patient would fight back. With others, the patient did not attempt to defend himself and took 'punishment easily.'

When B. aged 4, was born, the patient was very interested in her. He would stand and stare at her for long periods of time, and would try to peek at her when her diaper was removed. He did the same thing with the youngest child, aged 2, and often commented that he looked funny to him. He laughed when the baby cried and went into gales of laughter when he observed him masturbating.

According to Mrs. B. all of her children, except T., aged 5, were very quiet and obedient and all were good in school. T. was the only child who was 'fiery' and aggressive.

Interests: Aside from movies or television, the patient had no outside interests or favorite past-times. He had been begging his mother to get a telephone. He insisted that he had 'some friends' he wanted to talk to and insisted that he had 'something to say' to a friend. He would come home from school with telephone numbers of friends and begged and cried for a telephone. Mrs. B. did not understand this as she did not know of any friends the patient had, and felt this was all his imagination.

Also, for months the patient had been asking to live with a Mr. S. Mrs. B. went with Mr. S. for two years, after she came to Detroit and for years, the patient insisted that Mr. S. was his father. When the patient was four or five, he continuously asked if Mr. S. was his father and could not accept Mr. S.'s explanation that he was not. (It should be noted that when Mrs. B. first applied for ADC, she told the worker that Mr. S. was the patient's father. With the medical social worker, Mrs. B. insisted that her husband was the patient's father and that they separated when she was two months pregnant.) Six or eight months ago, the patient began to insist upon being allowed to live with Mr. S. He would state, 'S gives me more things than you do; he gives me more to eat than you do. I want to live with him. I love him.' He cried for days about this and still expressed the same desire though less frequently and with less intensity. Mrs.
B. was now going with another man, a 36 year old minister, whom the patient seemed to like.

Sleeping arrangements: The patient slept with his mother until T. was born. After T's birth, Mrs. B. tried to place the patient in his own bed but he cried. T. was put in a baby bed and the patient continued to sleep with Mrs. B. and continued to do so until B. was born when he was required to sleep with C. and H., the two older boys. He cried and resisted the change, but Mrs. B. would not relent. This year, the patient began to sleep with T. but frequently sneak into bed with C., claiming that he was afraid of the dark. Now, even when invited, he would not get into bed with Mrs. B.

The patient was also interviewed in preparation for psychological testing. The decision of the team was to refer the patient to Children's Center for psychiatric treatment. A letter was sent to the mother regarding the referral.

As a consultant, the social worker obtained and evaluated with the team members social and personal data which were important in understanding the total functioning of the patient. Through the interpretation of social and emotional problems in the home situation, the personality of the patient, and interpersonal relationships, the social worker contributed to an understanding of the psychological dynamics involved in the presenting problem. Referral for psychiatric treatment, was therefore based on the joint decision of all team members.

The social worker served as a therapist in encouraging the mother to talk freely and express her feelings about the patient's illness. She was understanding and accepting of the mother's own personal and emotional problems, and gave assistance to the mother in thinking through the reality factors in the situation.
CHAPTER V

SUMMARY AND CONCLUSIONS

There has been increasing recognition that the child's social environment has a tremendous effect upon his physical and emotional development, and that effective treatment of the sick child cannot be departmentalized, but it must be integrated in the total medical care of the child. Through the teamwork approach, the various professional disciplines concerned with the treatment of the ill child, cooperatively apply their skills, knowledge, and techniques toward the restoration of the child to his fullest functioning capacity, physically, emotionally, and socially.

The purpose of this case study was to define the role of the medical social worker as a member of the Pediatric team in the treatment of children with social problems relating to their illness. An effort was made to show some of the specific services rendered by her in carrying out her function within the framework of the total medical care of the child. The study included twenty cases referred to Social Service from the Pediatric Department at the City of Detroit Receiving Hospital, from October 1, 1956 to January 1, 1957.

For the purpose of the study, the role of the medical social worker was classified as a consultant and as a therapist. As a member of the Pediatric team, she played a vital role in the total medical care of each patient studied by providing a link between the patient and his family and the hospital. She acquainted the members of the team with her findings regarding the social and emotional factors which were important for diagnosis and treatment. She interpreted to the team members the feelings and attitudes of the patient and his family in relation to the patient's illness. She evaluated
with them all of those factors which had or could have had an adverse effect upon the patient's illness and which prevented or could have prevented him from making the best use of available medical care.

Although the family is recognized as the child's main source of psychological security and bears the bulk of the responsibility for the child's care, it is also the main source of emotional tension. Because of social and emotional factors within the family groups studied, it was often difficult for the family to adjust to the demands and limitations imposed on them as a result of the patient's illness. The medical social worker interpreted to the family the nature of the disease process, its limitations and demands, and assisted the family in making the necessary adjustments. Through the appropriate use of community resources, she aided in relieving tension, preserving and strengthening family relationships, and in insuring the adherence to medical recommendations.

In the performance of her role, as both a consultant and therapist, the medical social worker employed the basic skills and techniques characteristic of her profession. This was accomplished within the framework of the total medical care of the patient, which in itself, required some distinguishing features of her work. Her specific skills included an understanding of the physical and emotional components of illness, an understanding of the reactions of the patient and/or his family to his illness, knowledge of social and environmental circumstances which might contribute to illness or affect the adjustment and the care of the patient, and skill in the utilization of community resources.
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APPENDIX
Schedule

1. Name of patient ____________________________ Sex ______

2. Parents:  Mother _____________________ Father __________________

3. Other persons having responsibility for care of the patient __________________

4. Reason for referral to Social Service:
   A. Planning for convalescent care upon discharge____________
   B. Evaluation of patient's emotional adjustment____________
   C. Referring patient for specialized therapy or needs____________
   D. Interpretation of prescribed treatment and clinic follow-up care____
   E. Assistance in the patient's home adjustment____________
   F. Securing social history for presentation at Pediatric-Psychiatric Conference____________
   G. Obtaining pertinent information regarding the patient from outside resources in order to assist the physician in making an adequate evaluation____________

5. Source of Referral:
   A. Hospital:  Doctor______ Nurse______ Other hospital personnel______
   B. Community:  Other hospital or clinic______ Nursing Service______
                     Social Agency______ School______ Others______
   C. Parents or relatives____________________________
   D. Social Service Review____________________________
   E. Others____________________________

6. How was referral made:  Ward round______ Conference______
                           Telephone______ Letter______

7. Was the patient aware of the referral to Social Service? Yes ___ No ___

8. Was the patient's understanding of his illness determined? Yes ___ No ___

9. Was the patient's reaction to the limitations and demands imposed on him by his illness determined? Yes ___ No ___
10. Was the patient included in plans for his care and encouraged to assume responsibility for treatment? Yes_______ No_______

11. Was the patient helped to accept the need for convalescent care? Yes_______ No_______

12. Number of home visits made_______ Reason for home visit_______

13. Was the patient's attitude toward his family evaluated? Yes_____ No_______

14. What members of the family were interviewed?____________________________

15. Was the patient's illness, limitations and demands interpreted to members of the family? Yes_______ No_______

16. Was assistance required in helping the family adjust to the patient's illness? Yes_______ No_______

17. Were the requirements for adequate convalescent care interpreted to the family? Yes_______ No_______

18. Were the positive and negative aspects of convalescent care evaluated in relation to the total family situation? Yes_______ No_______

19. Was a referral made to other community resources? Yes_______ No_______

20. To whom was the referral made?_______________________________________

21. Reason for the referral________________________________________________

22. How was referral made? Letter_______ Telephone_______ Conference_______

23. Were the patient and his family prepared for referral? Yes_______ No_______

24. Was a follow-up report requested from the referral agency? Yes_______ No_______

25. Was the patient's reaction to his illness and prescribed therapy interpreted to members of the team? Yes_______ No_______

26. Was the family's attitude and feelings toward the patient and his illness interpreted to team members? Yes_______ No_______

27. In addition to reporting on the team's primary interest, i.e., the basis for referral, did the social worker also include other material directed toward a better understanding of the patient? Yes_______ No_______

28. Were the social worker services timed in relation to the total medical care of the patient? Yes_______ No_______
29. Was the social worker able to gear her interpretation to the members of the team in accordance with the team member's level of understanding of the patient? Yes______ No_______

30. Did the social worker share with members of the team the progress and development of her planning with the patient and his family? Yes____ No____

31. How was information exchanged between the social worker and members of the team? Information recorded on medical chart______ Daily oral interpretation______ Formal lecture______ Post clinic conference ______ Ward round and conference______ Social history recording________

32. Was the social worker able to maintain a positive working relationship with members of the team? Yes______ No_______

33. Was the social worker's recommendations accepted by the members of the team? Yes______ No_______