Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

SOCIAL SERVICE

Volume XVII | Friday, January 11, 1946 | Number 10

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume XVII | Friday, January 11, 1946 | Number 10

INDEX

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William A. O'Brien, M.D.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
Jan. 12 - Jan. 18, 1946
Medical Visitors Welcome

No. 97

Saturday, Jan. 12

9:00 - 9:50 Pediatrics Grand Rounds; I. McQuarrie and Staff; W-205 U. H.

9:15 - 10:20 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler, and Staff; Todd Amphitheater, U. H.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; M-515 U. H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221 U. H.

11:30 - 12:20 Anatomy Seminar; The Dorsal Root Ganglion Cells of the Selachian Fishes; Dr. Berry Campbell; I.A. 226.

Sunday, Jan. 13

11:00 - 1:50 Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U. H.

Monday, Jan. 14

9:00 - 9:50 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff; Todd Amphitheater, U. H.

9:00 - 10:50 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Interns Quarters, U. H.

12:15 - 1:15 Pediatrics Seminar; Irvine McQuarrie and Staff; 6th Floor Eustis.

12:15 - 1;15 Obstetrics and Gynecology Journal Club; M-435, U. H.

12:30 - 1:20 Pathology Seminar; Experimental Production of Adrenal Tumors in Mice by Castration; Dr. Fern Smith; 104 I. A.

12:30 - 1:20 Physiology Seminar; The Physiological Basis for Treatment of Hypertension; Dr. Fredric Kottke; 214 M. H.

Tuesday, Jan. 15

9:00 - 9:50 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Eustis Amphitheater, U. H.

12:30 - 1:20 Pathology Conference; Autopsies; Pathology Staff; 104 I. A.

3:15 - 4:15 Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U.H.

4:00 - 4:50 Surgical-Physiology Conference; Peripheral Circulatory Tests in Surgical Patients; Drs. Dennis and Taylor; Eustis Amphitheater.

4:30 - 5:20 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

5:00 - 5:50 Roentgen Diagnosis Conference; Dr. Oscar Litschultz and Dr. Harry Mixer.

Tuesday, Jan. 15 (Cont.)

8:00 - Minnesota Pathological Society; Medical Science Amphitheater.

Wednesday, Jan. 16

8:00 - 8:50 Surgery Journal Club; O. H. Wangensteen and Staff; M-515 U. H.

9:00 - 10:30 Pediatrics Staff Rounds; W-205 U. H.

9:00 - 10:50 Neuropsychiatry Seminar; Staff; Station 60 Lounge, U. H.

11:00 - 11:50 Pathology-Medicine-Surgery Conference; Cirrhosis of the Liver; E. T. Bell, C. J. Watson, O. H. Wangensteen and Staff; Todd Amphitheater, U.H.

12:30 - 1:20 Physiology Chemistry Journal Club; Staff; 116 M. H.

4:00 - 6:00 Medicine and Pediatrics Infectious Disease Rounds; W-205 U. H.

Thursday, Jan. 17

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; Todd Amphitheater.

12:30 - 1:20 Physiological Chemistry; Biochemistry of Nucleic Acid; Cyrus P. Barnum; 116 M. H.

4:30 - 5:20 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

5:00 - 5:50 Roentgenology Seminar; Regurgitation of Bile as Demonstrated by Cholangiography; Dr. Harry Mixer; M-515 U. H.

Friday, Jan. 18

9:00 - 9:50 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U.H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221 U. H.

10:30 - 12:20 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Otolaryngology Department; U. H.

11:50 - 1:15 University of Minnesota Hospitals General Staff Meeting: Infectious Mononucleosis; Dorothy Sundberg; New Powell Hall Addition Amphitheater.

1:00 - 2:00 Dermatologic Allergy - Dr. Stepan Epstein; W-312 U. H.

2:00 - 3:20 Dermatology and Syphilology; Presentation of Selected Cases of the Week; H. E. Michelson and Staff; W-312 U. H.

1:30 - 2:20 Roentgenology-Neurosurgery Conference; H. O. Peterson, W. T. Peyton, and Staff; Todd Amphitheater, U. H.

II. SOCIAL SERVICE

Miss Betty Lightman
Dr. B. J. Lannin
Mrs. Frieda Van Hale
Miss Rose Green
Dr. Burtrum Schiele

Case I - _____

The Role of the Social Worker in the Treatment of a Surgical Patient

Dr. B. J. Lannin:

Mr. , a white male age 18, was admitted to the University Hospitals on December 28, 1942. On admission the patient gave a history of having been in a motorcycle accident on October 13, 1942 at which time he sustained severe burns of the face, the left hand, and the entire surface of both lower extremities. He had been confined at his local hospital since the time of injury, and it had been observed that during the past few weeks he had been steadily going down hill.

The past history was essentially negative except patient had been told he had developed "leakage of the heart" following an attack of rheumatic fever when a child.

Physical examination revealed a chronically ill, cachectic, bedridden white male who had obviously lost a great deal of weight, and who was in considerable pain. The temperature was 98.6, pulse 100, and blood pressure 95/70.

Examination of the head showed the entire left side of the face covered with granulation tissue with surrounding scarring. Both eyelids on the left were scarred and contracted so that patient was unable to close the left eye. The entire pinna of the left ear was destroyed. Examination of the heart revealed a blowing systolic murmur heard best over the aortic area.

The extremities - The dorsum of the left hand, was covered with granulation tissue which appeared to be infected. There was marked limitation of motion of the fingers. Both lower extremities were a mass of infected granulations, extending from the ankles to the groin and covered with a whitish-yellow purulent exudate. There was a marked plantar flexion deformity of both feet and a large decubitus over the sacrum. The estimated burned area was approximately 40 to 45% of the entire body surface.

The patient was treated with multiple blood and plasma transfusions and placed on a high protein diet. The burned areas were covered with a bland ointment and compression dressings. The patient's condition gradually improved and on January 21, 1943 the burned areas on the face and on the left hand were covered with split-thickness grafts. The grafts took nicely and on February 4, 1943, large grafts were taken from the abdomen and sutured on the burned areas on the right thigh. Additional grafts to the right leg were sutured in position on February 25, 1943.

On July 27, 1943, a full thickness graft was taken from behind the right ear and the left upper eyelid was reconstructed.

During the next few months the patient's nutrition failed and considerable difficulty with the healing of the donor sites was encountered. Because of this, it was necessary to resort to pinch grafts and several of the donor sites had to be grafted in this fashion. It was thot inadvisable to denude any more areas with the dermatone because of this and so multiple pinch grafting procedures were done on the lower extremities.

However, in December 1943, and in January 1944, the patient's general condition had improved and again large areas on the lower extremities were covered using the dermatone. Additional pinch grafting procedures were done during the next few months and by September 1944 the burns of the lower extremities were finally healed.

The patient was then treated by the

Orthopedic staff and an attempt was made to correct the deformities of the feet by corrective manipulations under anesthesia and casts. Following this the patient received many physiotherapy treatments and he was finally discharged from the hospital on December 23, 1944 after a hospital stay of nearly two years.

He was readmitted on December 29, 1944 for correction of the ectropion of the left lower lid. This was done on January 11, 1945 and the patient was again discharged on January 24, 1945.

For the next few months the patient was followed in the Out Patient Department where he continued with his physiotherapy treatment. He was able to be up and about with the aid of two canes and employing specially constructed Orthopedic shoes and elastic stockings.

During this time the medical social worker contributed to his adjustment within the hospital and participated in obtaining some specific things recommended by surgery.

In April 1945 it was observed that two areas of ulceration had broken down on the thick scarred area about the lower legs which had not previously been grafted. Because of this he was again admitted on April 22, 1945. On April 26, 1945 these areas were excised and grafted and he was discharged on May 10, 1945.

During the next few months the patient did very well and was able to be up and about at his home and carry on ordinary activities including driving a car. He was followed at intervals in the Out Patient Department and again in December 1945 it was observed that small ulcerations had developed over the lower legs. He was accordingly admitted for the fourth time and these areas were grafted and have healed nicely. At the present time the patient is under the care of the Orthopedic Department for further correction of the deformities of the feet.

This patient has obviously had a very prolonged convalescence during which time he has undergone at least 20 separate operative procedures. However it would appear that with proper guidance and training he can become a useful self-supporting citizen and can live a fairly normal life. The continued services of the social worker are implied in this prognosis.

Mrs. Frieda Van Hale:

18 years of age, was referred to the medical social worker by a nurse on February 5, 1943 because he had been badly burned and was emotionally upset. He was undoubtedly concerned about the effects of his burns and would need help in adjusting to being burned and to the resulting treatment.

During some of the first interviews, Carl was in a great deal of pain and cried so much that the medical social worker did not remain long to talk. Carl dreaded the thought of the pain when even the dressings were to be changed. He said many times he was lonesome for his family and when they did not come he became depressed.

In appearance was badly scarred. The left side of his face was severely burned, and his left eye could not close. Much of his left ear was missing and deformed. His hand, arms, and legs were also burned. He was a friendly boy, but serious. He related information in a reserved and quiet manner. He had a good vocabulary and was probably of average intelligence. He seemed to recognize the parent's difficulties of poor health, a large family, and lack of finances, as he talked about these things.

Toward the end of February, the patient was moved to a double room because his moaning and crying disturbed the other ward patients. The doctors felt that he did not experience as much pain as he expressed, although he was uncomfortable.

Following his parents visits, he always felt better and was more relaxed.

He stated they had had a bad year on the farm and he supposed they would have to take things as they came. He said that he too would have to accept whatever happened to him. He was able to talk more freely of his illness and was very interested in his skin grafts.

As time passed, had told the social worker the following social information. He was born on February 23, 1924 in a farming community about 115 miles from Minneapolis. He graduated from grade school at 15 and did not go to high school because of lack of transportation. He worked on his father's farm for several years, then did truck driving. Previous to his accident, he polished stones in the local stone sheds. The father, a German Catholic, had always farmed. Their farm home burned to the ground three years ago, after which the father had a nervous breakdown. He still worried about finances and illnesses but was able to manage his farm. The mother who was a French-German Catholic, had had three operations and was under treatment at this time for hyperthyroidism. had nine brothers and sisters ranging from 6 to 23 years of age. The family raised corn and oats and sold milk and cream on their 180 acre farm. The two story, seven room farmhouse more recently occupied, was not modern.

As accepted the medical social worker, he talked about his motorcycle accident, saying he had been driving slowly with a lad on the seat behind him. He felt that nothing would have happened if they had been going faster. received his burns when the motorcycle exploded. Everyone expected the other lad to live, as he was not burned, but was pinned under the motorcycle. No one told of his friend's death until long afterwards. He felt very badly about this. The medical social worker attempted to help him accept the situation of the loss of his friend and with less guilt.

When began to feel better, time passed more slowly. He enjoyed reading and drawing, but could not do either because of his burned arm. He was sorry he had not gone to high school because the doctors told him he could only do light work for a time. The social worker suggested that he could take some vocational training which pleased him.

The medical social worker visited him one day before he was to have more skin grafting. He said he experienced more pain than anyone realized, and he disliked thinking of going through another painful episode. The social worker said she could appreciate how he felt and perhaps some of his family would be here. He hoped so.

During March, the medical social worker wrote the County Welfare Board requesting social data on and his family. Later they answered by stating the family was unknown to them, although the county was paying for the patient's hospital care.

One day, Mr. & Mrs. and his sister, , two years older than , came to the social service office. The parents were poorly dressed and appeared careworn and worried. The mother was outgoing and talkative. The father had the typical ruddy outdoor appearance of a farmer. He was unusually quiet but interested in the discussion of 's progress. was young, pretty, and nicely dressed. She was friendly and dominated the interview. The parents apparently felt more comfortable when she talked. They had been discouraged, feeling that 's prognosis was poor, but lately he was beginning to look and feel better. They had worried since he wrote fewer letters and they felt he was depressed by his long hospitalization. They realized that time passed slowly, so they brought a radio for him. They were all very fond of and were willing to be helpful in any way, as he had been "a good boy and a hard worker". They placed no blame on him for the motorcycle accident and were sympathetic.

They were interested in discussing the patient's future and understood that would have to remain in the hospital for some time as he was to have more skin grafts, and that upon discharge

patient would need a rather long period of convalescence. The medical social worker questioned Mrs. 's ability to care for , as she had a large family and was said to be in poor health. She admitted poor health and said she was nervous. The family was a close and affectionate one and this constructive relationship would be a positive resource upon which to draw.

The medical social worker conferred again with the doctor in April and learned that in the past two months there had been slow but steady improvement in the patient's appetite, his strength and his morale.

In July, a skin graft was done to patient's left eyelid.

Arrangements were made in the fall for patient to obtain glasses. This was done, and the sister paid for them.

In early December, the social worker arranged a conference with the plastic surgeon to consider the matter of recommending patient as a handicapped person who would benefit from a vocational rehabilitation. The patient wanted this course, it was educationally sound, and the patient had the capacity to profit by the training. Socially, the patient was a good applicant, but a surgeon's estimate of his physical limitations and abilities would be necessary. The surgeon felt that the patient would be hospitalized at least six more months as he needed more skin grafting, so it was decided to defer the application until nearer the time of discharge.

During a visit to patient in February, was considering where to go upon leaving the hospital. His sister was recently married but her husband was overseas. She had moved to Minneapolis to work and to be near . She visited daily to keep him from becoming lonesome. He might go to live with her. He appreciated all she did, as his family came only every two months because of gasoline rationing. His sister paid all his incidental expenses which he felt was all right as he had helped her when she was in Business School.

He was now interested in obtaining help regarding high school work. The social worker told him there were no facilities in the hospital for school work, but the librarian could select good material for him. He was interested in such magazines as "Popular Mechanics" and "National Geographic". He wanted to work days and go to night school. The social worker suggested he ask the doctor when he would be ready for that much activity.

The medical social worker met patient in the hall several times riding in a wheel chair. He had improved, was getting more exercise, and was very enthusiastic about this.

Later the medical social worker conferred with Dr. Lannin about referring Carl for vocational rehabilitation. He agreed and filled out the medical report. Patient had a 25% to 50% loss of use of his lower extremities, but he could be improved with physiotherapy. His general condition was good. He would have to avoid walking, climbing, standing, kneeling, and reaching. The medical social worker sent in the application with the medical report to the Division of Vocational Rehabilitation.

In October, patient was transferred to Orthopedics for correction of his deformed feet. Later Dr. Lannin reported that the Orthopedists were pleased with the good results of his straightened left foot.

The Orthopedist asked the medical social worker to help obtain some leather shoes that would come up around the ankles, and with leather soles. As the sister offered to pay for them, they were obtained from an Orthopedic Shoe Company.

One day stopped the social worker in the hall to tell her he had just been to physio-therapy. They helped him walk and they felt he had

done well. But was disappointed as he did not feel sure of his steps. The social worker told him it would take time to gain confidence and feel capable of walking alone.

In the middle of December 1944, the Orthopedist said patient could go home for Christmas week if he continued his manipulation exercises, which he agreed to do. He now got about with canes. On the 23rd of December a friend drove home for the Christmas holidays.

After the patient returned, the social worker visited him to learn how he felt about going home and meeting people again. He had missed the hospital but everything at home was changed. The family had a new milk-house, but the car and other things were run down. All the boys he knew were away in military service. But he loved being home with his family. All his younger sisters and brothers played musical instruments and his mother the piano. This was entertainment and fun. He had even driven his father's dilapidated car, much to his delight. He had been apprehensive because of his crippled hands and feet. He had the same ambivalent attitude towards returning to the hospital. He liked the hospital and staff but dreaded further surgery and proposed dental work.

During a subsequent visit, told the social worker that the man from the vocational rehabilitation agency had visited him and thought he could go to Dunwoody Institute to take mechanical courses. However, he must finish all his medical treatment first.

The following day a dermatone graft was done to the left eye.

Several days later, as the social worker came into the ward, she heard the interne tell patient he must walk more and use the wheel chair less.

The medical social worker was told patient could be discharged on January 24, 1945. He had decided not to go to his sister's because she lived on the third floor and there were 22 steps approaching her apartment. Another plastic surgery patient was taking patient home with him. They would both return to physio-therapy on Monday, Wednesday, and Friday. They wanted to know if the county would pay 's Board and Room. The social worker said she would find out and let them know later. The social worker then explained the patient's need for help to the Town Board who paid patient's friend $80.00 for two months board and room, after which the patient was able to work and pay his own board.

Late in February, was checked in Surgery Clinic and found to have an ulcer on his left foot, so he was to return in three weeks. He was working half days, four days a week at 55 cents an hour, running an automatic machine. He was disappointed at the low rate of pay and felt it was "girl's pay". He had talked this over with his boss who told him he only worked part time and was a handicapped person. His big trouble was his inability to stand and balance well. The social worker pointed out that his working ability had changed and he would have to realize that it would be a long time before he could do a full day's work. Patient wanted to get a good easy job paying big wages. The social worker discussed the value of getting more training through the help of vocational rehabilitation and his getting into a good field. He understood, but was dissatisfied at his slow progress. The social worker tried to help him to be more accepting of this.

Later, during 's hospitalization for skin grafting, Dr. Lannin suggested that patient obtain elastic stockings to keep down the swelling when he walked. The social worker discussed this with Carl's sister and she bought him a pair.

On May 9, 1945, patient was discharged to his sister's home and she was going to accompany him to their parent's home by bus later.

During the remainder of the summer . reported to Plastic Surgery Clinic for regular examinations.

When he returned in October, he told

the social worker he had learned to "take life easy" such as sleeping until 10 a.m. and doing only light work. He helped his father fix up and paint the farm buildings. He drove a milk truck occasionally but did not do the heavy lifting. The patient was now accepting his limitations.

was admitted on December 12th for further skin grafting, and this was done on the 20th. He told the medical social worker that he had made up his mind not to be concerned about being in the hospital during the holidays as he wanted to improve and return home again.

This case is still active after a long period of time. When .'s medical care is finished, we plan to have the Vocational Rehabilitation Division help in a retraining program so he will become a self supporting person.

It is hoped this case reveals how the medical social worker helped the patient with the many problems resulting from his illness. This was done by participating actively with the doctors, the patient himself, the family, and other social agencies.

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Case II - _____

The Role of the Social Worker in the Treatment of a Severely Incapacitated Psychoneurotic

Dr. Burtrum Schiele:

, age 19, was admitted to the Outpatient Department in July, 1944 with the complaints of abdominal pain, severe constipation, dyspnea, orthopnea, tachycardia, fatigue, and a 24 pound weight loss. She had been ill slightly over one year, had seen several physicians and taken much medicine without benefit. Her physician prescribed bed rest. This was carried out for six months but she continued to go downhill. He then referred her to the University Hospitals with the diagnosis of neurasthenia, gastric ulcer and a heart ailment.

In the past she had been healthy except for pneumonia at age 10 which was followed by a period of shortness of breath. She had a stomach disorder at 16 which was diagnosed gastric ulcer without the use of x-rays. Although she recovered from this in a short time, she remained out of school and continually complained of loss of pep. It is probable that the present illness began at that time.

The physical examination revealed poor nutrition and a systolic murmur of the heart as the only positive findings. The prominent psychiatric features in this case were promptly recognized, and the patient was referred immediately to the Psychiatric Clinic. At the same time the value for further physical evaluation was recognized and carried out. The Cardiac Clinic concluded that the murmur was of no clinical significance and that the patient had a normal heart. BMR was +19 and the G-I series was negative.

The psychiatrist found the patient to be a severely neurotic individual who did not accept the possibility that much of her difficulty was on an emotional basis. Early anorexia nervosa was considered as a possible diagnosis. Because of the severity of her symptoms it was evident that hospitalization on the Psychiatric Service would be necessary if an adequate treatment program was to be carried out. At this point the psychiatric social worker was called into the case with the hope that she could facilitate the hospital admission as well as begin the psychiatric investigation.

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Miss Lightman:

In the social worker's first contact, the patient and her mother, Mrs. , signed the voluntary admission blank after the nature of the psychiatric service had been explained. Shortly afterward, however, the mother returned to see the social worker, expressing concern over the admissions procedure, and wondering whether she could take out if she so desired. She was reassured that she could and was admitted to the Psychiatric

unit on August 28. She was a wistful, pale, shy girl who was somewhat retiring in her relations with the other patients. She ate well although one of her presenting complaints had been an inability to eat.

In her second interview with the worker, she talked easily of her physical condition with apparent enjoyment. She asked numerous questions about the use of laxatives and whether she could have them. The worker suggested that this could be discussed with her doctor. We were more interested in her social situation; we wanted to know about her schooling, the kind of work she had done, and her family.

told the worker that she had done housework mostly but that it didn't pay very well and for this reason she had taken a job in the "Produce" because this meant earning more money, but this job was too heavy. She hadn't been too interested in going beyond the first year in high school and besides her health had interfered. Now she wanted better employment but felt handicapped by her lack of education. She volunteered little information regarding her family situation but when questioned she spoke of living with her mother and stepfather. Four older sisters lived elsewhere and she knew that a divorce had taken place between her father and mother when she was two. Nor was Louise in a hurry to discuss work plans. Instead she sought assurance that she was too sick to work at the present time. We agreed that she was.

A history had been received from the County Welfare Board which filled in the gaps concerning the family situation. It stated that the mother was a potent source of the patient's difficulties and that got along fine when she was not at home. Mr. , who had custody of the four older girls, was thought to have made a sincere effort to keep his family together. On the other hand, Mrs. was described as a poor manager who had unfavorable references in the community. Mr. had been an misanthropic bachelor who drank a great deal, and one night under the influence of liquor, Mrs. had appeared with him at the local justice of the peace and a marriage had taken place.

In July of 1941 had been running away from home to stay with sisters in the next county. Her mother reported her as a delinquent but investigation revealed that Mr. had whipped her and that her mother had beaten her kitten shortly before she had left home.

The County Welfare Board took custody of on a protective basis but when they asked Mrs. for her clothes this was refused. The County Welfare Board purchased new clothes and sought medical care for her in September 1942 when some of the present symptoms started.

Additional medical information revealed that a local physician thought she would be better off if she could stay away from her mother who had always been over anxious about 's health.

It can be seen that although we had a clear indication of the difficulties through a fairly objective report, the patient had not verbalized anything relating to her own feeling about a troubled home situation and how it affected her. In the meantime, Mrs. was reluctant to leave Minneapolis and she took a room across from the hospital and found herself a job washing dishes in a neighborhood restaurant. She wanted to visit Louise every day. Although she didn't wish to talk to the social worker, she began to question the treatment Louise was receiving, for example, wondering why the patient had been given an enema rather than a laxative, which she knew to be the best thing. She painted a rosy picture of the home situation, making it appear as though were the town belle rather than an invalid. She blocked completely at the mention of after care and insisted that when Louise was well she would, of course, come home. She was a controlling person who found it hard to have to request help and was obviously strongly threatened in having to turn 's care over to anyone else.

The social worker talked of her experiences with Mrs. to the doctor, who agreed that the mother was stirring up emotionally by her attitude. It was desirable that the mother's visiting

privileges be denied but such arbitrary action might have resulted in the mother removing Louise from the hospital. Instead visiting was limited to Sundays and within two weeks Mrs. had left for home.

showed marked improvement within a week after her arrival. She had some complaints, but ate well, and had normal eliminations. In interviews with the worker continued somewhat superficially and was fearful to think of her future. The psychiatrist informed the worker that was an intensely lonely girl in need of affection, who despaired of her abilities to find a good job or a devoted husband. These were important goals to her. She also showed a strong sense of obligation to her mother but this was mixed with much antagonism. While the psychotherapy was progressing, the social worker continued to have contacts with the patient and had occasional conferences with the psychiatrist, in order to parallel our efforts.

Arranging for after care in the form of a suitable job was a part of the therapy, specifically the social worker's contribution. However, remarkably little progress was being made along these lines. had improved symptomatically, continued to gain weight and looked better, but she still felt unready to work. was given library books about various jobs and the social worker talked with the nurses about having assume more responsibility for clerical tasks on the Station and she was allowed to use the typewriter. However, was conflicted about work, rejected housework in favor of an office job and then complained that a girl with her degree of education could not hope to work in an office. She seemed unready to consider leaving her own county and spoke of going back to work there where the opportunities were limited. She seemed to be circular in her thinking and it all illustrated her unreadiness to assume work. The psychiatrist contributed to the social worker's performance at this step by showing that was an extremely inarticulate girl whose insight at the present time was limited. Her potentialities for developing it were questionable, so that he guided the worker into playing a supportive role. This meant helping to act out her achievements in so far as the hospital situation could permit.

The social worker realized that unless could be helped to discuss the family situation further no plan could really work through to completion. s ties to her mother, her feeling of obligation to her, combined with a desire to break away from home were clearly behind her inability to decide about work. The social worker took more responsibility in explaining to how necessary it was for us to understand her situation and we indicated that we knew some of it from the County Welfare Board but that we still didn't have her side. For the first time seemed to feel free enough to tell her story. She said her mother had always objected to her going to dances and that she could never bring her friends home. She had also been ashamed to bring her friends home. When she had run away her mother had refused to have anything more to do with her and when she passed her in the street wouldn't even talk to her. This had made feel very guilty about having broken away and when her mother offered to have her return home two years later, gladly decided to do this. In other words there had been two years when mother and daughter had not spoken to each other. In addition Mr. had commented that he thought a girl ought to make her own living after she was 18. This meant that had felt unwelcome there during the past year. She had a great sense of pride in her own father mixed with regret that she didn't know him better.

Within two weeks of this discussion was openly talking of work with the nurses and other patients, between her interviews with the social worker. An opportunity presented itself with a faculty member agreed to have do housework and set her own pace. They were extremely accepting of her slowness on the job and gave her encouragement freely. Although her work was satisfactory, was dissatisfied, continuing to

juggle housework against office work as possibilities for her future.

In spite of her reluctance to return home, she insisted that her mother would object to her working away from home. The psychiatrist's direction to the social worker was to keep) as far away from her mother as possible, but since this seemed to be too big a step to take at the present time, we thought of a job in a town near home as a compromise solution. Accordingly the County Welfare Board was contacted and this plan was discussed with them. The County Welfare Board executive visited the hospital and spoke with the worker. He agreed that should not return home and that if she or the mother insisted on doing so, the Board might assert guardianship and make other plans. This was the eventual outcome of the situation.

), while in the hospital, continued to seek employment, vacillating between her desire to do housework and office work. However, when Mrs. came at Christmas time and offered to take home she wanted to do this.

Until this time) had verbally accepted from the psychiatrist that her illness was on a psychogenic basis. She had voluntarily given up many medications. The fact that she wanted to return home seemed to belie that she had made any real gain and it was only after she had left that we were able to evaluate the help which she had been offered here. On February 10th we learned from the County Welfare Board that had been placed at the home of the minister where she did housework. When seen in the Outpatient Clinic in the following month looked well, had retained her weight gain of twelve pounds but was not satisfied with her job and had some minor epigastric complaints.

It was seven months before she returned to clinic again and this time she came on her own initiative. The story which told made the entire hospital experience cling together in a new fashion. She related having given up the job for another housework job where they are "just plain ordinary people like me". Working for a University staff member or minister had filled her with awe and was too hard an adjustment for her although at the time she was aiming at an even higher employment level along clerical lines. It remained for to try the various steps which had been discussed with her before she had the satisfaction of feeling her own achievement. Talking of office work no longer precipitated a flood of ambivalent protest. She simply remarked that housework was the right thing for her. She felt like one of the family. Mrs. who accompanied her on this visit was in the background and) told her own story with no interference from mother. Besides having gained weight, she had a new enthusiasm which displaced the lassitude which had characterized her previously. She had also entered more into community affairs, resumed corresponding with some of her boy friends in service, and according to the last we heard, was partial to the navy.

The doctor who saw her at Neuropsychiatry clinic on this occasion assured that she was quite a well person, who need no longer feel in need of Medical or Psychiatric help.

Discussion of the Case
Workers' Responsibilities

Miss Rose Green

In both of the cases presented, the socka worker carried a responsibility for a connection between the patient and his immediate family. Interestingly enough, these two cases illustrate widely different problems in the relationship between patient and family, widely differing problems that demand sensitivity and depth of understanding of family relationships, good judgment in evaluating the possible influences of those relationships upon the patient and upon the use of the hospital and medical resources, and skill in handling those problems for the purpose of sustaining and encouraging constructive use of the hospital resources by the patient.

In the psychiatric ase, we see an active, aggressive, perhaps dominating mother who wants to tell the doctors how they should prescribe for her daughter, who criticizes the care her daughter is receiving (all this in the face of rather startling improvement within the first week of hospitalization), who is quite insistent on seeing the "head doctor", and who, after signing the voluntary admission papers, returns in three days to find out if she can take her daughter home at any time, if she wants to do so.

The pattern of attempting to dominate and control the hospital, which pervades even these few contacts, gives the case worker some picture of what the patient lived with for the nineteen years within which her struggles and problems developed. This could be an important contribution to understanding the realities of the life experience of the patient and her various attempts at adjustment to it, and important also in directing therapeutic efforts.

The case worker not only has a responsibility for understanding this mother-daughter relationship, but she also carries a responsibility to handle the hazards that this particular relationship may put in the way of the patient's best use of the hospital. With this mother there was areal possibility of a precipitate removal of the patient from the hospital, and a stirring up of complaints and criticism in the patient through frequent visiting.

In the situation presented we can see the case worker aware of these hazards, and skillful enough in her handling of them so they do not block the patient's use of the hospital and psychotherapy.

In the case in surgery, we see an entirely different problem in the patient-family relationship. The patient, among the older children of a group of ten, within a closely knit and affectionate family, is seriously burned in an accident which takes him into a hospital within fifteen miles of his home for a two and one-half month period before he is admitted to University Hospitals. The indications are that there was frequent visiting sustaining the warm and close ties between the patient and his family. The family has musical interests and enjoys playing and singing together. The patient helped his sister financially when she was getting business training. This sister helps the patient with incidentals during hospitalization. There is give and take between members of the family, an interdependency and need of each other.

Within five weeks after his transfer to University Hospitals the patient is referred to the social worker because he is emotionally upset. He cries and moans a great deal, to the disturbance of other patients, and expresses feelings of pain beyond what the doctors think is natural to his condition.

The beginning visits of the case worker are cut short because the patient is so filled with his sense of pain. She does learn, however, that the patient is very lonesome, that he counts on weekly visits from his family, that he feels better and is cheerful when they do visit, and feels worse and depressed when they do not. When the parents do get to a conference with the social worker, they say that they had been discouraged. Not only hospital staff, but the patient's family is aware of the emotional disturbance in the boy.

Doctors and nurses expressed experienced judgment in their comment that the patient's physical condition did not warrant the degree of disturbance the patient was making. I wonder if there might not be something in the emotional area of family relationships that might throw some light upon this young man's extra feelings of pain.

Most people need their families more when they are sick than when they are well and busy in the round of routine activities. The degree of this patient's incapacity -- his inability to read, or draw, to entertain or amuse himself, put him in a state like the very dependent state of young childhood when parents are near and usually are very comforting and supporting. The patient's need to have his family close was just as

great as when he was in the hospital near home, but great distance, time, effort, costs, and gasoline rationing broke harshly, though realistically, into the continuing of the patient's feeling of well-being that is very important to his attitude about his illness and his efforts toward making the most use of the hospital resources.

We see in this situation a very different kind of problem in patient-family relationships than that presented in the psychiatric case. For the patient's peace of mind, emotional balance, and most constructive use of the hospital resources for health and self-dependence, the case worker carries the responsibility to develop and encourage an active sustaining of the patient-family relationships. The case worker offers to write the family, to talk with them, and encourages them every step of the way. She works on this same problem from the patient's angle, helping him to see and accept some of the obstacles. All this has important results in the patient's attitude toward himself and his degree of incapacity, important results in a slow but continuing movement toward self-dependence.

These two cases illustrate widely different problems in the area of the family's connection with the hospital. In one, social work activity is directed toward encouraging contact; in the other, activity is directed toward discouraging contact, not arbitrarily but rather thoughtfully and planfully from the focus of greatest good of the patient and his deepest use of the resources offered.

Another area of responsible activity for the case worker is direct help to the patient. This may be through discussion with the patient of his feelings about being in the hospital, his uneasiness or fear in connection with recommended treatment, or problems in relation to leaving the hospital. This activity is also directed to the purpose of helping the patient make more use of the hospital resources.

Specific helps within the hospital - as referrals for glasses and for Orthopedic appliances - I will merely mention as they are time honored in tradition. I would like to take a bit more time to mention the specific helps with resources outside the hospital. The social case worker carries responsibility for knowledge of and ingenuity in discovering other agencies and community resources, and for any activity that is needful to offer that resource for the patient's use. In connection with the patient's total situation, we see in these two cases, social work activity with other agencies -- County Welfare Boards, Town Boards, The Vocational Rehabilitation Division, and incidental services that are practical and helpful such as help in ordering and fitting special shoes, recreation arrangements and library service.

In drawing this together, I can summarize the case worker's responsibilities: to the patient himself, to his family, for use of resources within and without the hospital, all directed toward promoting the patient's most constructive use of the hospital, and toward sustaining and integrating what he has gained from this care and treatment in his personal and social adjustment.

As I look at it, the patient in a hospital, or a client in a social agency, is the focus of the case worker's responsibility and her activity based on understanding the patient as an individual, is directed toward helping him to make the most constructive use possible of the services and resources that her agency provides.

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III. GOSSIP

This is the second year that Medical Social Service has appeared on our General Staff Meeting program. Medical Social Work is a special field of social work, which has developed in relation to the practice of medicine in hospitals and organized programs of medical care. Up until the last few years medical social workers confined their activities to teaching hospitals and clinics, but now they are employed by voluntary hospitals, physicians in group practice, social welfare agencies (crippling, old age, etc.). Although scientific discoveries may continually advance medical treatment, the most expert care is of no avail if the patient's desires or ability to carry out the recommendations are obstacles to its completion. It is a well known fact that patients can be more satisfactorily and permanently restored to health when medical study and treatment take into consideration social and emotional factors. Since the modern practice of medicine is a teamwork process, the medical social worker functions in continuous association with the other personnel, under the leadership of the physician. Changing trends in scientific and clinical medicine and in public health and medical care are enlarging the scope of medical social work. With increasing use of psychiatric concepts in medicine, more attention is now given to the feelings of the individual concerning his illness and medical care. Medical Social Workers are now prepared to make a definite contribution to the physician in his care of the patient and to the administrator in his direction of a hospital or medical care program. In its early years, medical social work consisted almost wholly of direct case work services to the individual patient, but now many workers are acting as consultants on medical care programs. The Division of Vocational Rehabilitation recommends that all such services should have medical social workers on their staffs. Medical social work was established in Massachusetts General Hospital, Boston, in 1905 and shortly thereafter at the Bellevue Hospital, New York City, under the leadership of physicians and laymen who believed that adequate medical care included attention to the social needs of the patient. The late Dr. Richard C. Cabot was the leader in this new movement, and his name is associated with much of the early growth and subsequent progress of medical social work. A study made by the Association of American Medical Colleges in 1942, showed that Social Service Departments had been established in teaching hospitals affiliated with approximately three-fourths of the medical schools in this country and Canada. Since 1918, Medical Social Workers have been associated in an organization known as the American Association of Medical Social Workers. Since the opening of the Center for Continuation Study in 1937, Medical Social Workers have had a special continuation course each year. A number of Universities and Colleges offer the full Medical Social Service curriculum: Bryn Mawr, California, Columbia, Fordham, Minnesota, Montreal, Catholic University, Pennsylvania, Pittsburgh, St. Louis, Simmons, Southern California, Tulane, Washington, Washington University, and Western Reserve. The war brought an increased demand for Medical Social Workers for service in military hospitals and special care programs. The war has influenced the practice of Medical Social Work in clinics and hospitals in many ways, but the supply of experienced personnel is insufficient to meet our needs. During the war the American Red Cross trained staff workers to function in a limited capacity as aides. Medical Social Service in our hospital and out-patient department serves a valuable function. Volunteer workers from the Red Cross and other agencies tell us that one of the most impressive services our organization renders the sick is that of Medical Social Service. Medical students, interns, and fellows have learned to know these services in relation to their patients. This year a Medical Social Service Department staff member, Mrs. Frank Andrus, gave three lectures to the senior medical students on how to use Medical Social Service to best advantage. The way medical men are trained in medical schools and hospitals to use Medical Social Service indicates that it will not be long before all hospitals and group clinics will employ them. The training course is long and the requirements exacting, so it will never be a field which is overcrowded. As Medical Social Workers go over the situation with the physician and the patient, the combination of doctor and social worker is even better than "doctor who knows his patient".