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

Medical Care and Medical Social Service

Volume XVIII | Friday, April 25, 1947 | Number 24

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

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William A. O'Brien, M.D.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

April 28 - May 3, 1947

No. 155

Monday, April 28

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; L. J. McKelvey and Staff; Interns' Quarters, U. H.
10:00 - 12:00	Neurology Ward Rounds; A. B. Baker and Staff; Station 50, U. H.
11:00 - 11:50	Roentgenology-Medicine Conference; Staff; Veterans' Hospital.
11:00 - 11:50	Physical Medicine Conference; Physical Therapy in Relation to Some Neurological conditions; Aaron A. Feinstein; E-101, U. H.
12:15 - 1:15	Obstetrics and Gynecology Journal Club; M-435, I. H.
12:30 - 1:20	Pathology Seminar; Myositis; B. J. Clawson; 104 I. A.
12:15 - 1:20	Pediatrics Seminar; Clinical Pathological Conference; 6th Floor Seminar Room; U. H.
12:30 - 1:20	Physiology Seminar; Chest X-ray Findings in Poliomyelitis; Eugene Aherne; 214 M. H.
4:00 - 5:20	School of Public Health Seminar; Subject to be Announced; Speaker - Miss Mary Switzer, Assistant Federal Security Administration; 113 MeS.
4:00 - 4:50	Special Lecture; Multiple Myeloma; I. Snapper; Auditorium, Natural History Museum.

Tuesday, April 29

9:00 - 9:50	Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Eustis Amphitheater, U. H.
7:30 -	Surgery Seminar; John R. Paine; Small Conference Room, Bldg. I, Veterans' Hospital.
10:30 - 11:50	Surgical Pathological Conference; John R. Paine and Nathanial Lufkin. Veterans' Hospital.
12:30 - 1:20	Pathology Conference; Autopsies; Pathology Staff; 102 I. A.
2:00 - 2:50	Dermatology and Syphilology Conference; H. E. Michelson and Staff; Bldg. III, Veterans' Hospital.
3:15 - 4:15	Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U. H.

3:30 - 4:20 Clinical Pathological Conference; Staff; Veterans' Hospital.

3:45 - 4:50 Pediatrics Staff Rounds; I. McQuarrie and Staff; W-205, U. H.

4:00 - 4:50 Surgery-Physiology Conference; Cerebrospinal fluid; Nathan Lifson and Lyle A. French; Eustis Amphitheater, U. H.

5:00 - 5:50 Roentgenology Diagnosis Conference; Staff; Ancker Hospital.

8:00 - Annual Journal-Lancet Lecture; Radioactivetracers; Prof. Georg Hevesy; Museum of Natural History.

Wednesday, April 30

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

8:30 - 9:50 Psychiatry and Neurology Seminar; Electroencephalogram; Russell A. Anthony; New Powell Hall Amphitheater.

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

12:00 - 12:50 Physiological Chemistry Journal Club; Staff; 113 MeS.

4:00 - 5:50 Medicine and Pediatrics Infectious Disease Rounds; Staff; W-205, U. H.

Thursday, May 1

8:30 - 9:20 Surgery Grand Rounds; John R. Paine and Staff; Veterans' Hospital.

9:00 - 9:50 Medicine Case Presentation; 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 - 11:50 Surgery X-ray Conference; Daniel Fink and John R. Paine, Veterans Hospital.

12:00 - 12:50 Physiological Chemistry Seminar; Lipid Metabolism; Walter O. Lundberg; 214 M. H.

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

4:00 - 4:50 Bacteriology Seminar; Animal relationships and virus susceptibility; R. G. Green; 214 M. H.

5:00 - 5:50 Roentgenology Seminar; Case presentation; Harold O. and Stanley C. Peterson; M-515, U. H.

7:30 - Physical Medicine Seminar; William G. Kubicek; 111 MeS.

Friday, May 2

9:00 - 9:50	Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U. H.
9:00 - 9:50	Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, U. H.
10:00 - 11:50	Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.
10:30 - 11:20	Medicine Grand Rounds; Staff; Veterans' Hospital.
10:30 - 11:50	Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department; U. H.
11:30 - 12:50	University of Minnesota Hospitals General Staff Meeting; Curare in anesthesia with special reference to combined pentothal curare nitrous oxide anesthesia; Ward R. Johnson; New Powell Hall Amphitheater.
1:00 - 1:50	Dermatology and Syphilology; Presentation of Selected Cases of Week; H. E. Michelson and Staff; W-312, U. H.
1:00 - 2:50	Neurosurgery-Roentgenology Conference; W. T. Peyton, Harold O. Peterson, and Staff; Todd Amphitheater, U. H.

Saturday, May 3

7:45 - 8:50	Orthopedics Conference; Wallace H. Cole and Staff; Station 21, U. H.
9:00 - 9:50	Neurology Grand Rounds; A. B. Baker and Staff; Station 50, U. H.
9:00 - 9:50	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; M-515, U. H.
10:00 - 12:50	Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U. H.
11:00 - 12:20	Anatomy Seminar; Androgens in anaplasia; W. L. Williams; 226 I. A.

II. MEDICAL CARE AND MEDICAL SOCIAL SERVICE

Charlotte S. Henry

Introduction

When I was a very young social worker in a family welfare agency, I learned some things about social work from an old city physician. He was the crossest, most profane, most tender hearted, most delightfully exasperating person I have ever worked with. I suspect that his knowledge of medicine had enormous gaps. He probably never read a medical journal or went to a medical meeting. I am sure he never read a book on psychology. Yet intuitively he understood the art of healing not sickness alone but sick people. In his thoroughly unorthodox way, he anticipated some of today's developments in psychosomatic medicine. I remember how he barked at me over the telephone "Listen, Sister, I want you to get some groceries over to that White family today. What do you blankety blank social workers expect folks to eat while you're doing your blankety blank investigating? And listen, I want you to stop sympathizing with old man White. Sure he's half paralyzed, but he's not dead yet. I've been spending my good time arguing with him about the Bible till he's so burned up he's sitting in a chair today writing a letter to the mayor to get me fired. You go in there with your blankety blank sympathy and the old boy will fall right back in bed. Then I won't be responsible."

Old Dr. McDonald made no contribution to the advancement of medicine. He was an old fashioned family doctor, accustomed to using make shifts and his own ingenuity rather than the latest medical equipment and technique. If all physicians were like him, there would be no reason for this meeting today. He did his own medical social work, crudely but usually with effect. The division of medicine into specialized fields has helped to make possible the miraculous achievements of medical science. Like all scientific progress, however, the gains have been in terms of diagnosis and treatment in a medical institution which functions through specialized clinics, but in so complicated a setting, the human patient sometimes gets lost in his syndromes.

The medical social worker, a specialist from another profession has come comparatively recently into the dramatic atmosphere of the hospital at the invitation of physicians themselves to supplement the physician's skill in making the patient well, her focus is on the patient as a social being whose scheme of life is thrown off balance for the time, by illness. For the most adequate person, illness creates problems, - in his own feelings, in his family, in relation to his job and in his social life. Sometimes they are practical situational problems, related to finances, care of children etc. Sometimes, they are emotional, and perhaps more frightening because less easily understood. The wife of a patient who had a fenestration operation came to a social worker in a mild panic. She had an intelligent understanding of the implications of the operation and she had no idea why she was so anxious except that her husband had never been ill before. She was normally an adequate wife and mother and had been a successful nurse's aide during the war. Her feelings seemed to her too ridiculous to discuss with her own family. She did discuss them two or three times with the social worker. Her relief was so great that later during her husband's convalescence, she brought him to the social worker to talk about his own anxieties, in relation to the outcome of the operation. The physicians had discussed this with him many times, but he was ashamed to tell the physician of the silly fears he had suddenly developed about his own worth which he thought had no direct bearing on the operation. The social worker was "less official" and he wanted chiefly a chance to talk. The difficult period of adjustment following the operation was still difficult, but it was less unbearable and perhaps shorter because the social worker accepted his self styled "griping" as a normal part of convalescence.

What of the patient with a chronic illness, the one who must accept a permanent handicap? Some people have so great a talent for living that they can surmount such hazards through their own inner resources, but they are the lucky few. For many, the handicap becomes at once a life in itself and a defense against living. The war has made us all more aware that for the handicapped person, the thrill of having perhaps outwitted death may be gradually eclipsed by the terrors of being different from one's fellows. Rehabilitation for the individual needs to include preparation for those terrors before they are an insurmountable problem. The patient who has weapons to meet them, practical and psychological, the patient whose family is prepared for them and ready to give him confident support, has already made a start in his revised design for living. The successful rehabilitation of any patient is not achieved by medicine alone, nor by social work alone, nor by any of the other specialties that serve the patient. It is only through cooperative fusion of all team work functions that the person who is the patient can best find help in the slow rebuilding of a satisfying life.

Case History

Mildred C. Iverson

For purposes of this discussion let us consider briefly a hypothetical case of a patient coming to a medical institution such as University Hospitals for care. Mr. Dean, age 59, married and father of several minor children, comes alone to the Out Patient Department. A local physician from the patient's home community some 200 miles from Minneapolis, had referred him with a diagnosis of arteriosclerotic gangrene of the left foot. Mr. Dean has excruciating pain and is tired and worn from the strain of travel and sleepless nights. He finds upon arrival that he is not to be admitted to the hospital as he expected but must find a place to stay and "go through" the clinic. His case, although serious could not be considered an emergency and therefore he was not admitted. He is bewildered by the complexity of clinic routine. Tests which are ordered are frightening to him. He is subjected to many experiences which to him seem to have no bearing to the pain in his foot. He has no understanding of the diagnostic studies for which he is being referred. He is lonely being here amongst strangers and many times is about ready to give up and go home. During the time all these mystical procedures are taking place, no one tells him much that is understandable to him. Suddenly one day he is told he must have an amputation of the left leg. At hearing this, he becomes emotionally upset, because he had so hoped that there would be some pills or medicine he could take to effect a cure. He is faced with making a big decision and he must make it alone. He cannot think clearly, he seems blocked emotionally and he is frightened. He does not see how he can face losing part of himself and still continue living. Mr. Dean knows his life and activities will be altered and changed. Finally he is admitted to the hospital where he is forced to make even more radical changes in his manner of living. He now has even more time to think. He worries about who will support his family and about the limitations which are going to be imposed on him due to the loss of a limb and what are those artifical limbs like? He has never known one who has worn one. Mr. Dean is prepared for surgery, and with much trepidation and apprehension is taken to the operating room where the amputation is performed. The problems which Mr. Dean must work through are just beginning --- that is <u>living</u> with his handicap. Mr. Dean could have easily become so discouraged that he could have broken down anywhere during his clinic and hospital experience and gone home without the necessary care.

It is true, I am sure, that many of you know cases similar to the one Mr. Dean presents. How much easier it would have been for him if he had been referred to someone who could have given him supportive help in going through with the medical recommendations, someone to whom he could turn for help with his practical problem, someone who had the time to listen to his troubles and try to relieve him of some of his anxieties and fears,

someone who could accept his feelings and assist him through the rough spots. Mr. Dean also needed someone who had knowledge of community resources to arrange for financial aid for his family and assist him later to procure funds for an artificial limb. Then following discharge from the hospital, how helpful it would have been if there had been someone who would have taken an interest in him and followed his condition and see that medical recommendations could be carried out. Then too, maybe Mr. Dean needed someone who could point up some of these difficult spots to the physicians, someone who could have helped the physicians see the patient as a whole.

Medical social workers were added to the team of professional personnel in hospitals and clinics to be that "someone" to patients with problems like Mr. Dean's and to help him make the most constructive use of medical care. Such a worker has a definite function to perform, just as dietitians, physical therapists or technicians have definite roles to carry out. The medical social worker spends two years in graduate training to prepare herself to utilize social case work concepts in dealing with problems which a patient may have attendant to his medical care. Unfortunately, the role of the medical social worker is not as clearly defined or understood as some of the other auxiliary services in the hospital and therefore the skills which she has to offer the patient may not be used to the fullest extent. There is a danger that she will become so involved with pure mechanical duties of arranging for rest home care and the like, that the true purpose of her function, and the skills which she has to offer the patient maybe lost sight of. If her work is to be effective, the role she plays must be understood and there must exist a sound cooperative relationship between the physician on one hand, who is rendering the medical care, and the medical social worker who is helping the patient accept and obtain such care. Her opportunity to serve is determined to a great extent by the physician with whom and through whom she must work. The physician, as the leader in the medical plan, is in a strategic position to discover situations which can be appropriately referred to the medical social worker on his service, and all of her planning for the patient must be based on the doctors findings and recommendations.

It is impossible in this brief time to discuss all of the ramifications of the work of the medical social worker, but in order to help you to gain a further understanding of what her function is so that she can be used most effectively, some of the typical aspects of her work will be mentioned.

Generally social workers are identified with only welfare agencies, where persons come who have financial need or problems in their living. The problems pertaining to health needs which a patient may bring to a medical agency represent as much of a problem in living as problems relating to financial need which a person brings to a welfare agency. The central problem for a person coming to a health agency is illness. The needs surrounding illness are many and may be divided into two types, namely those which are concrete and tangible and those that are intangible and deal with feelings and emotions. It is in this latter area that the function of the medical social worker is least understood, probably because the results are less tangible and visible.

The medical social worker deals only with feelings and emotions that are concrete and conscious and does not attempt to work with those of a deepseated nature which would be treated by a psychiatrist. The conscious feelings which a patient has towards his illness and obtaining medical care are today considered very important factors in whether or not a patient can make use of medical care. Take for instance a patient who maybe antagonistic or uncooperative in carrying out the physician's recommendations. A medical social worker's job in such a situation would be to attempt to determine what factors were contributing toward this behavior and whether or not she could help the patient to be more accepting of medical recommendations. Probably an actual situation may help

make my point clearer. An obstetrical patient whose pregnancy was complicated refused to remain in the hospital, in spite of the physician's recommendations. She was hostile to the medical staff and other hospital personnel, and uncooperative in following instructions. The medical social worker in talking with her was able to learn that there were real problems in her family situation which needed to be solved before she could be emotionally ready to accept the recommended care. Good health was important to her but she needed to be concerned about other things first. She had two small children at home with no one to care for them during the night while the father worked. Their finances were limited and even though help could be found, they did not have the funds to pay anyone to stay with the children. The worker through her knowledge of cummunity resources was able to effect a plan with a children's agency to board the children out during the mother's illness in a licensed home. When the mother was made aware that a satisfactory plan could be made for the children, she was able to relax and carry through with the medical plan of remaining in the hospital and following treatment prescribed for her. Medical care may be facilitated before it is too late, if problems such as this type are made known to the medical social worker in time so she can determine if she can be of any help.

This is just one example of many where a patient becomes so blocked with his own big problem that he cannot accept medical care without help. He needs someone with professional skill to help him come to terms with his problem and break it down into parts which he can face realistically and do something about. Other examples of where medical social workers might be needed might well be drawn from other services, such as the cardiac patient who must be helped to accept restrictions in living, the diabetic patient who must adjust to new routine in living, the blind and deaf patient who has many fears and anxieties, the patients with serious burns who have difficulty adjusting to long time care, the patients with venereal diseases who have many guilt feelings and insecurities, the patients with a terminal illness who need help in planning and accepting terminal care, the unmarried mother who needs help with her many social problems from someone in the hospital trained to work confidentially with those situations. These and many more require much interpretation reassurance and help in adjusting to their conditions. In pediatrics, children need much help in going through difficult periods in their illness. Parents need help in accepting illness situations in children and planning for their care.

Then there are patients who need help in making decisions regarding acceptance of medical recommendations or interpretation regarding procedure. The social worker frequently finds there is some factor in the patient's life which influences decisions they make regarding acceptance or refusal of surgery or other medical care. Take for example a patient in Tumor Clinic to whom the social worker talked because he would not consent to a recommended operation. She was able to learn from him that a biopsy had been done previously in clinic and the relatives were simply horrified that an "operation" was preformed in clinic without admission to the hospital or without an anesthetic. They told the patient he must not have further operations if that was the way they did them here. The patient was able to talk this through with the worker and she was able to clarify these procedures with him, pointing out the difference between the two, and assuring him about care in the hospital. After the patient had had a chance to talk out his feelings about operations and when it was recognized what was blocking him, he agreed to have the recommended surgery and was listed for admission. The social worker in this instance used her position effectively to interpret to the patient the various procedure in the medical setting.

Now let us look at some of tha tangible needs which a patient may have and how the medical social workers also can help in this area. One of these needs may consist of arranging for convalescent care, sanatorium care or terminal care upon the physicians recommendation. In

the event that the patient has no relatives or friends who can provide the services he will need following discharge, the medical social worker can assist in making arrangements for him. Much hospital time, beds, and work of personnel could be saved if discharges could be anticipated early and the medical social worker notified in advance. The arranging for rest home care entails numerous details, The most difficult problem is the shortage of available nursing homes at present, and secondly, working out plans as to who will pay for such care as this is not included in payment of the hospital bill as authorized by the county. It is no exaggeration to say that 24 telephone calls have been made by a worker in arranging for one discharge.

The medical social worker also functions in helping patients obtain appliances or in receiving other services not furnished by the hospital. They also assist in arranging for services of a visiting nurse for follow up care after the patient has been discharged from the hospital.

Many patients may also need assistance in locating possible resources for retraining, obtaining financial aid, learning of recreation facilities, procuring talking books, Braille magazines, etc. All of these may contribute towards the patient's rehabilitation and making their life more worthwhile.

For purposes of clarity we have divided the obstacles a patient may encounter in following medical recommendations, into two types, those that pertain to concrete and tangible needs and those that deal with a patient's feelings, attitudes and ideas. But since patients are human beings, we know that life cannot be divided that distinctly. Rest home care might be a specific problem, but the feelings of the patient regarding such a recommendation will be a part of this placement plan. He may have emotional resistances but we know that feelings can be helped if he can see a practical way of bringing about solutions. The social worker's skill lies in being able to integrate these two types of services which she renders.

We have no startling statistics compiled to show results of our work and anyone might justifiably ask - how valuable are medical social workers in a hospital such as this and what do they accomplish?

The real value of her work lies in how well her function is understood and how her services are utilized. If she is under constant pressure performing the routine mechanical tasks then it is impossible for her to render professional social case work services which she is equipped to give.

Probably it might be well for all of you working directly with patients to ask yourselves, how can I most effectively use the services which the medical social worker has to offer. The contribution she makes in the medical team depends not alone on her skills, but also your acceptance of her worth.

Social Responsibility

Schuyler P. Brown

I have been asked to discuss the role of the medical social worker in contributing to the effectiveness of the medical and surgical treatment of the patient and of the role of the intern and resident in contacting the medical social worker in those cases where her assistance is particularly needed in contributing to such effective treatment. Considering the number of medical social workers authorized by the University Hospitals, it is obvious that it would be impossible for a medical social worker to contact every hospital patient, doing even a brief case study to determine if he is in need of the assistance of that department. Not only would this be impossible, but in many cases it would be unnecessary. Furthermore, it is frequently true that the need for the assistance of the social worker does not arise until a later stage in the treatment of the patient.

At the University Hospitals, it is the intern and the resident who are most

directly in contact with the patient and the details of his treatment, the staff members being concerned with the more involved medical and surgical problems which his condition presents. If the intern and resident are thorough and painstaking in their examination of the patient, they will learn not only the purely medical history but also the social and economic status of the patient, his home situation and his family responsibilities. As a result thereof, he acquires an understanding of the patient's problems, the worries he may consequently have, and estimates what effect they may have in impeding the normal progress of his treatment.

It is well recognized today that the effective treatment of any illness involves the treatment of the whole man, whether he be suffering from a broken bone or from cancer. If anxieties exist, treatment will be less effective. It is the medical social worker who makes those arrangements calculated to solve, or at least partially solve, the family and economic problems of the patient, the existence of which in their unsolved state contribute to the anxieties which detract from the full effectiveness of medical and surgical treatment, no matter how skillful it, of itself, may be.

The treatment of the whole man, so to speak, with the exception of required specialist care, is even today quite effectively accomplished by the country doctor or general practitioner who through long association with the patient and his family, knows the patient's problems and his limitations in solving them, the nature and extent of the aid which the patient can expect from his relatives, his church, and his local social agencies, and he frequently made the necessary contacts which contribute to the solving of these problems.

Here at the University Hospitals, on the other hand, the time of the staff, the residents and the interns is taken up almost entirely by purely medical and surgical treatment. Furthermore, the patients, with few exceptions, are not members of the local community but residents of relatively distant areas. But even if our contacts with the patient's community were relatively close, we still lack the specialized training and experience of the medical social worker which enables her, with the greatest economy of time and expense, to solve the problems of the patient.

Basically, all of the required information can be obtained by a few simple questions: How is the health of your wife and children? How are they being cared for while you are here? Who is looking after your farm and your stock? I need not give further examples. The patient will supply the information on which additional questions can be based, and in five minutes you will have a complete picture of the home and economic situation, and with this picture you will know whether or not the assistance of a medical social worker is needed in caring for this patient. It is the duty of the intern and the resident to make this brief initial investigation as a part of their history taking. They are the contact men and, of necessity, must be the contact men in this respect.

In the case of all per diem patients, the intern and the resident should know whether the patient's treatment is getting beyond his ability to pay for it. This knowledge may be of great value to both the hospital and the patient. For example, there was recently on one of the surgical services, a patient who, to any one with any power of observation, could be seen to be developing an acute anxiety several weeks following his admission to the hospital. What is to be done about it? Each of us has his own technique. Fundamentally, it is a matter of sitting down with the patient in a friendly way, avoiding the formidable, though perhaps necessary, character of our usual rounds, and trying to get at the reason for the patient's reaction. In this case, the patient, due to the limitations of a chronic illness, had earned but $600 a year during the two years prior to his admission. He was too proud to apply for county care, so he borrowed $150 from his friends to defray his expenses at the hospital. Not only was his stay much longer than he estimated it

would be, but his most recent hospital bill, not including operating room charges or special nurses, was running over $40 a day, the reason being that he was receiving streptomycin. How was he to pay his bill? Being a conscientious man, his anxiety was extreme. Obviously he should be transferred to county care, and quickly. At first, he would not consent to application for county papers, and it was only the skillful and sympathetic interview with one of the medical social workers to whom I referred the case, that the problem was solved to the complete satisfaction of the patient.and the hospital.

Another duty of the intern and resident is to see that all possible steps are taken to prevent the good accomplished by hospitalization from being lost by defective post-hospital care. In some cases, this may be very difficult, if not almost impossible, but in all cases the best possible arrangements should be made.

Where is the patient going when he leaves the hospital? Will be have the care he requires? How is he going to get there? For example, not long ago a surgery patient discharged five days after the repair of an inguinal hernia, was planning on hitch-hiking to his home some 150 miles away. A few words with the patient explaining the limitations of his condition, and with the medical social worker relative to his plans, and the problem is solved.

In closing, I refer to a matter of greatest importance - the obligation of the intern and resident to see to it that the discharge slip is filled out as early as possible, preferably 48 hours before contemplated discharge, so that the medical social worker has a fair chance to make the necessary post-hospital arrangements for the patient. These arrangements cannot be made in a matter of five or ten minutes, or perhaps even in five or ten hours. For example, you may want the patient to remain in a local boarding home for a week or ten days. As is not uncommon, the patient has 17 cents in his pocket and no county authorization for boarding home care. It is obviously impossible for the social worker to get this patient out of the hospital unless she has been given adequate notice of his contemplated discharge.

Rehabilitation

A. B. Baker

Of all medical conditions, the subacute and chronic neurological disorders present a most glaring need for both emotional and physical rehabilitation, not because they are in any way different from the numerous other medical illnesses, but because the nervous system involvement so frequently manifests itself in a visible defect in the motor function which prevents any overestimation of the degree of physical recovery. The frequent pessimistic philosophy of the physician in regard to many therapies is a direct result of his specialized interest in the function of a single diseased organ, which, not uncommonly, does not respond to complete repair even with the present highly developed advances in medical knowledge. As a result, many individuals are brought back to a state of partial physical adjustment and then discharged, the physician feeling that he has gone as far as present day medicine will allow. In may instances today the physician loses track of the fact that in any type of illness one must treat not only the disease but also the individual. It must be remembered that the amelioration of a physical condition loes not assure that the entire situation has been therapeutically resolved.

Many patients will continue to improve and remain well if there is a service beyond simple medication or complicated laboratory studies, extending the care and study outside the office or hospital and offering information and encouragement to the patient, thus enabling him to meet and understand the limitations caused by his illness and to adjust to them emotionally, socially and economically. Such a service, although time consuming and therefore often neglected by the physician, is an essential to the complete recovery and

continued health of the patient as the specific medication which often at best results in but partial improvement.

In the chronic neurological disorders such as poliomyelitis, spastic paraplegias due to injuries, strokes, parkinsonism, multiple sclerosis, etc., it is now apparent that one must treat the entire individual rather than the illness alone. When one does, there is every reason to assume a more optimistic attitude toward these individuals and a more dynamic effort toward both their emotional and physical rehabilitation. Using the available facilities such as medicinal therapy, physical therapy, occupational therapy, vocational rehabilitation, etc., all organized and directed toward the mental, social, and economic restoration of the patient, one can often accomplish a partial or even a complete therapeutic success where the office or hospital maneuvers alone fail completely.

Naturally, such a treatment program requires the cooperation of many individuals, particularly the patients, friends, family, and employer. It is a time consuming procedure whose rewards must be measured predominantly by the results achieved rather than monetary returns. Obviously the individual physician could not afford to give such intensive care and time to any large number of cases, but he can, by his understanding of the problem, draw upon the skills of others to aid in carrying through such a program, - a program, however, which must progress under the guidance and understanding of the physician. I should like to limit my present comments to the most important role played in such a program by the social worker whose skills are readily available in many hospitals and in most communities.

In attempting to establish such a program on the Neurological Service at the Veteran's Hospital as well as in the large number of chronic poliomyelitis patients resulting from last year's outbreak, it was soon apparent that the entire project could be greatly facilitated through the aid and cooperation of the social worker. By preliminary contact with the patient and a discussion of the home, family, relatives, and work interests, the social worker could often develop a friendly and encouraging interest on the part of the patient and thus could subtly lay the groundwork for a healthy philosophy of readjustment and a willingness to accept a state of independent although modified usefulness. Thus at the onset of the illness, the social worker can often help provide the patient with a favorable mental attitude and a sustaining incentive.

During their continued interviews and contacts with the patient as well as with the family, the social worker is able to discover much valuable information concerning the environmental resources which might be of great help to the doctor in formulating his final goals and plans for the patient. The social worker also can help the patient as well as the family appreciate the definite goals and steps indicated in a program of rehabilitation. This continued interest alone often aids materially in maintaining the courage of such individuals at times when progress is slow and discouragement is great. However, in order to advise the patient and the family adequately and to help both plan correctly, the social worker must have a complete understanding of the nature of the patient's illness, the limitations of recovery, and the ultimate physical and economic adjustment that will be possible. Such guidance can only come from the doctors who, although entrusting a good deal of the time consuming work, must stand ready to lend a helping hand in preventing gross errors in effort and planning. Mistakes in planning with resulting discouragement and frustration are not handled well by these patients and should be carefully avoided whenever possible. Therefore, all individual skills that are drafted to help with the patient treatment must remain under the constant coordination of the physician who understands the patients basic illness and who, therefore, can advise adequately as to trend and degree of effort.

As the patient's adjustment progresses, the social worker plays a very important

role in helping guide and orient the family in their participation in the patient's problems and recovery. An understanding family can be most helpful to the patient and the physician. Lack of cooperation on the part of the family often is the result of not understanding their role rather than their unwillingness to help. Again the press for time often prevents the physician from having adequate contact with the family, a role that the social worker can fill admirably.

Finally, as the recovery both physically and emotionally progresses, the social worker plays a dominant role in arranging for proper occupational situations outside the hospital or within the home. Such occupational situations must fit the patient's limitations and hence must be guided by the doctor. These final plans are of utmost importance because they often enable the patient, in spite of certain physical limitations, to assume a position of at least partial economic independence. Many of the necessary skills can be developed in the hospital or the home, but it is a great step to transfer from the protected environment of a hospital to a harsh competitive atmosphere of society. The social worker again can play an important role in helping the patient bridge this gap and make the adequate outside adjustment which ultimately leads to a complete recovery.

Conclusion

Lydia B. Christ

We hope that through this meeting that we may bring about more extensive team work with the physicians and nurses for better all around care of the patients, particularly in looking to his future. We shall have to depend on you to make it possible for us to use our skills to the fullest extent.

There is at present a great shortage of medical social workers and a recruitment program is being carried out by our National Association of Medical Social Workers. The available pamphlets were printed for this use and are here for distribution. If any of you have a friend, wife or sweetheart who is interested in becoming a medical social worker, please take a pamphlet.

I want to thank all who have participated in the program: Miss Henry, Miss Iverson, Dr. Baker, Dr. Brown.

III. GOSSIP

Enroute to New York with a stopover in Chicago to attend the Medical Education meeting of the New York Academy of Medicine - - I had breakfast with Zoologist Dwight E. Minnich on the way to his alma mater (Miami) to help install their new president. Later with Chemists, Lloyd H. Reyerson and Dick Arnold to visit a cutlery store, chock full of knives, knive sharpeners, kitchen and other home gagets. I bought a special knife sharpener which consists of an emory wheel and a guard mounted on top for holding the knife. Next we went to the Pendelton story in the Palmer House where Chemist Reyerson amazed us by his intimate knowledge of the colors, fabrics, and styles which one should use in completing a summer ensemble. My purchase was a red necktie, which puts to shame all ordinary red neckties. Psychologists usually make much of behaviorisms like this.....The Pennsylvania left late, but we expected to be on time as we were yanked on our way by a new diesel. This was her maiden trip and crowds came out along the way to observe the new engine (wonder what the John L. Lewis thought). Relays of engineers and inspectors tried their luck at running it with disasterous results to the passengers behind. After leaving Harrisburg we slept the balance of the night as it is electrified from here in.....Early morning at the Park Plaza and nothing is quite so dingy and droopy as a hotel lobby early in the morning. As usual we are told to come back later for our room. Each new customer is given the same treatment, so it isn't too difficult to take. Shortly afterward the ladies and gentlemen start coming down with their dogs to give them their constitutional. Next to wearing a derby, it requires as much to walk a dog with poise.....Breakfast with genial, dynamic Victor Johnson who is spreading his talents between the American Medical Association and the Mayo Foundation, preparatory to taking over at Rochester. It was good to hear of his plans for the development of a Mayo Medical Center and closer cooperation between the Foundation and the University. After breakfast by cab to the Academy in time for a walk through Central Park, which is lovely at this time of year. Our meeting opened promptly "after" the scheduled time in a room lined with immense oil paintings of New York's medical leaders. The panel took its place in the front of the room and for the balance of the morning we spoke to a goodly crowd squirming on uncomfortable chairs, while in the background the panorama of whishers gazed gravely at us. Why is it that most medical meetings are such long affairs and so little thought is given to comfortable seating? The only other way in which this meeting ran true to form was in the commotion caused by searching for light switches when slides were shown. Subject for discussion was The Continuing Education of the General Practitioner. Those of us who were in charge of programs told of how we did it, (Minnesota; Winnipeg; Mount Sinai Hospilal, New York; Kellogg Foundation; Joseph H. Pratt, Diagnostic Hospital, Boston; New York Academy of Medicine; Columbia University.) Michigan scheduled to appear did not show. Everyone indicated that a mighty effort was being made, but there was some question as to the response in terms of attendance by those who should come. There are ways of continuing one's education other than courses. But many of the men who do not attend courses do not concern themselves with using other educational methods. Everyone stressed the desirability of bringing the medical centers and the profession closer together. The effort costs much in time and money but it is worth while. The most interesting presentation was made by Dolald M. Clark, a general practitioner from Peterborough, New Hampshire. He had made a breakdown of his practice into its various activities. He has a nurse and a technician a well equipped office, and uses the facilities of a 40-bed hospital. He does a limited amount of emergency surgery and a fair amount of obstetrics. Most of his practice is medicine, pediatrics, and preventive services. During this twenty years of general practice he has spent upwards of $25,000 in "keeping up". He was discouraged about it and felt that in training general practitioners for the future we should think of two types, one mainly medical, and the other mainly surgical. They should work together, and

spell one another off for education and vacations. It was obvious that while everyone had spoken in glowing terms of the general practitioner and of his educational needs, only Doctor Clark actually knew what it was all about. Here at Minnesota we have arranged for a similar study by a general practitioner, first of his own practice, and then of other representative practitioners. As a companion piece to the study, we plan to invite groups of practitioners to come to the Center for Continuation Study for two or three days every four weeks or three or four days every six weeks. Sections will be 25 to 30 physicians each. The program will be beamed to meet the needs of the individuals concerned. A grant by the Commonwealth Fund before the war for this purpose was not used because of the emergency. Under the present plan, the Kellogg grant will be employed for the purpose.....An outstanding general practitioner is coming to be with us for the first yeat to act as an advisor...In the afternoon the subject was Group Practice. Dr. Carl Eggers who had presided in the morning, turned the job over to David P. Barr in the afternoon for a Group Practice Discussion. The Health Insurance Plan of greater New York; Long Island; Minnesota; Montefiore Hospital; Mary Imogene Bassett Hospital, Cooperstown, New York; Mary Hitchcock Memorial Hospital, Darthmouth, Dallas Medical and Surgical Clinic; and Kellogg Foundation were represented..... Minnesota, California and Montana are most group practice minded, while New York, New Jersey and Pennsylvania are least. Only 2 per cent of the physicians in the United States practiced in groups in 1946 and there are only 407 groups in our country. The group idea has invaded the East with a bang. Medical school staffs are going "full time groups" and all their practice is to be confined to the institution. Residents, interns and clerks will be part of the scheme and incomes will be limited to a certain figure with the excess ploughed under for salaries of juniors, research, and for making living adjustments for younger staff members in need. Funds also will be available for travel and attendance at meetings by residents and juniors. Doctor Sevringhaus (the other one) told us about the private pay clinic at Vanderbilt in which one medical senior has 2 private patients in the morning. Each group of two seniors (four patients) has one staff coordinator. In addition to working up their cases in the clinic, they make home visits to complete their social historys. During a service, each student saw many private patients under good supervision. One could sense the projection of Pre-pay plans into the idea as one means of providing University medical school support. With the growth of prepayment plans and the development of welfare programs, the numbers medically indigent individuals grows less (witness the sweep of obstetric patients from the teaching wards into the voluntary hospitals in recent years). Teaching programs in the Veterans Hospitals are another step to link teaching, investigation and welfare. The enthusiasm the East is displaying in group clinics is amazing in view of their reluctance to take up the idea in the past. Apparently they do not realize how difficult groups are to establish and to run. One speaker raised this point and wondered if students were given special instruction along these points.(No) Our graduates would like to work together in small groups in smaller places but not much is being done to help them realize their ambitions. In the afternoon session, although we tried to stay on group practice, we wandered on to general practitioners and specialists on every occasion. The New York Academy Building is a gem. Most unusual are its rare book collection and special exhibit hall. The secretary confided to me that exhibits do not get much attention from the average visitor. Our hosts were delightful and did everything possible to make our stay as comfortable as possible. I brought home extra copies of the program which I now have left lying around the office to impress visitors. I am still a country boy at heart and the idea of being invited to New York to express my views pleased me no end. I suppose I shouldn't get too excited about it as on one occasion when I went East with an exhibit at Atlantic City a visitor looked at the sign, Uni-

versity of Minnesota, and said you are from out in Wisconsin aren't you?....... On Friday evening to see "Barefoot Boy With Cheek", the Minnesota Musical which has the critics extending themselves to pan it, then to try to explain why they have done so. The cast is young and full of pep. The dancing is unusually good. I liked the music, including several tunes which will become popular but the gags are probably "too much" for some of the people who attend in N.Y.C. College students would find them hilarious, but I am sure that many who were there when I was couldn't see anything very funny about professor who teaches Sociology I or the dumb giant who is a football player or the cracks made at student communists. Minnesota's colors have changed from maroon and gold to red and white but the new rouser is something to hear, I liked it.....Slept late on Saturday morning for a change and then for a walk after breakfast. The organist in St. Patrick's Cathederal appears to be a midget when viewed from down below and he was letting forth his spring spirit on the mighty organ. Madam president of the Ladies' Altar Society was changing the linens. She was attired in an expensive plain black silk dress, wore nose glasses and carried a cane. I imagined that if anyone even "thought" of taking over her job she would erupt. The Cathederal is still my favorite spot in New York and I think it must be for thousands of others, for the aisles are jammed with people going through.....The flowers of Rockefeller Center were beautiful and a spring day in New York is something to enjoy. I ran on to Miss Odegard, who is now doing public health nursing in New York. I tried to tell her the news, but she knew more about Minnesota than I did. Miss Carliss is the gossiper informer. A pleasant trip home on the Broadway with so much service and bowing and scrapping that one wonders if the railroads are beginning to wake up...It is good to travel far from home and to temporarily deviate from your usual routine. Someone has referred to it as "blessed anommity" which all souls require in this hectic world just to sit down and think things over. One of our foremost public men spends a full hour each day in which he does nothing except let his thoughts play along without trying to give them direction.

Announcement

.....The many friends and associates of Miss Frances M. Money have expressed an interest in establishing a memorial fund in appreciation of her many years of service as Director of the Social Service Department of the University of Minnesota Hospitals. The Minnesota District of the American Association of Medical Social Workers has accepted the responsibility of raising this fund and planning for its use. Because of Miss Money's long association with the student training program and her deep interest in the progress of young Medical Social Workers, it seems appropriate to establish a loan fund for students of Medical Social Work. If you wish to participate in the memorial plan, contributions may be sent to Miss Frances Flynn, Treasurer, 1092 Ashland Avenue, St. Paul, Minnesota.