Bulletin of the

University of Minnesota Hospitals
and
Minnesota Medical Foundation

Current Problems in Patient's Care

Volume XIX | Friday, April 30, 1948 | Number 24

BULLETIN OF THE
UNIVERSITY OF MINNESOTA HOSPITALS
and
MINNESOTA MEDICAL FOUNDATION

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INDEX

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I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

Visitors Welcome

May 3 - May 8, 1948

No. 201

Monday, May 3

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.
9:15 -	Fracture Rounds; A. A. Zierold and Staff; Ward A, Minneapolis General Hospital.
10:00 - 12:00	Neurology Ward Rounds; A. B. Baker and Staff; Station 50, U. H.
11:00 - 11:50	Physical Medicine Conference; Hyperventilation During Artificial Respiration; Joe Brown; E-101, U. H.
11:00 - 11:50	Roentgenology-Medicine Conference; Staff; Veterans' Hospital.
11:00 - 12:00	Cancer Clinic; K. Stenstrom and D. State; Eustis Amphitheater, U. H.
12:15 - 1:20	Obstetrics and Gynecology Journal Club; M-435, U. H.
12:50 - 1:20	Pathology Seminar; Peripheral Circulation in Lupus Erythematosus; Stanley Huff; 104 I. A.
12:00 - 1:00	Physiology Seminar; Review of Research at Hormel Institute; H. O. Halvorson; 129 M. H.
12:30 - 1:50	Surgery Grand Rounds; A. A. Zierold, Clarence Dennis and Staff; Minneapolis General Hospital.
1:30 - 2:30	Pediatric-Neurological Rounds; R. Jensen, A. B. Baker and Staff; U.H.
2:00 - 3:00	Surgery Problem Case Conference; C. Dennis and Staff; Small Class Room, General Hospital.
4:00 - 5:00	Pediatric Seminar; The Etiology of Congenital Malformations; Mary P. Christensen; 6th Floor Seminar Room, U. H.
4:00 - 5:00	School of Public Health Seminar; Subject to be announced; Joseph E. Aronson, Henry Phipps Institute, University of Pennsylvania; 113 MeS.
5:00 - 6:00	Urology-Roentgenology Conference; D. Creevy and H. M. Stauffer and Staffs; M-515, U. H.

Tuesday, May 4

8:30 - 10:20 Surgery Reading Conference; Lyle Hay; Small Conference Room, Bldg. I, Veterans' Hospital.

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

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and Robert Hebbel; 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 - 4:20 Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U. H.

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

4:00 - 5:30 Surgery-Physiology Conference; O. H. Wangensteen and M. B. Visscher; Eustis Amphitheater, U. H.

4:00 - 5:00 Pediatric Rounds on Wards; I. McQuarrie and Staff; U. H.

5:00 - 5:50 Roentgenology Diagnosis Conference; D. L. Fink and Staff of Veterans' Hospital; M-515, U. H.

Wednesday, May 5

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

8:30 - 12:00 Neurology Rehabilitation and Case Conference; A. B. Baker and Joe R. Brown; Veterans' Hospital.

11:00 - 11:50 Pathology-Medicine-Surgery Conference; Retroperitoneal Tumor; O. H. Wangensteen, C. J. Watson and Staff; Todd Amphitheater, U. H.

4:00 - 5:00 Infectious Disease Rounds; Todd Amphitheater, General Hospital, Veterans' Hospital.

Thursday, May 6

8:15 - 9:00 Roentgenology-Surgical-Pathology Conference; Walter Walker and H. M. Stauffer; M-515, U. H.

8:30 - 10:20 Surgery Grand Rounds; Lyle Hay 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-Radiology Conference; Daniel Fink and Lyle Hay; Veterans' Hospital.

11:00 - 12:00 Cacner Clinic; K. Stenstrom and D. State; Eustis Amphitheater, U. H.

11:30 - 12:30 Clinical Pathology Conference; Steven Barron, C. Dennis, George Fahr, A. V. Stoesser and Staffs; Large Class Room, General Hospital.

12:00 - 12:50 Physiological Chemistry Seminar; A Function for Biotin; M. R. Buchdahl; 214 M. H.

1:00 - 1:50 Fracture Conference; A. A. Zierold and Staff; Minneapolis General Hospital.

4:00 - 4:50 Bacteriology Seminar; Factors Influencing the Growth of Fungi and Micro-organisms in Stored Corn; R. A. Bottomley; 111 MeS.

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

5:00 - 5:50 Roentgenology Seminar; Results of X-ray Therapy in Treatment of Malignant Exophthalmus; J. B. Coleman; M-515, U. H.

Friday, May 7

8:30 - 10:00 Neurology Grand Rounds; A. B. Baker and Staff; Station 50, U. H.

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 - 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.

11:00 - 12:00 Surgery-Pediatric Conference; C. Dennis, A. V. Stoesser and Staffs; Minneapolis General Hospital.

11:30 - 12:50 University of Minnesota Hospitals General Staff Meeting; Isuprel, A New Bronchodilating Agent; Ellis Cohen; New Powell Hall Amphitheater.

12:00 - 1:00 Surgery Literature Conference; Clarence Dennis and Staff; Minneapolis General Hospital, Small Class Room.

1:00 - 1:50 Dermatology and Syphilology; Presentation of Selected Cases of the 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 1

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; Station 21, U. H.

8:00 - 9:00 Pediatric Psychiatric Rounds; Reynold Jensen; 6th Floor West Wing, U. H.

8:00 - 9:30 Psychiatry and Neurology Grand Rounds; Staff; Veterans' Hospital.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, 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; Correlation of structure and function in the nervous system, Berry Campbell; Retrograde degeneration following lateral tractotomy in the rat spinal cord; Chia-Chi Li; 226 I. A.

II. SOCIAL SERVICE -- CURRENT PROBLEMS IN PATIENT'S CARE

Helen Kretchmer

Present day medical care of the patient is extremely complicated and involves large numbers of people - not only the doctors but administrators, nurses, technicians, therapists, clerical personnel, social workers and innumerable individuals and groups outside of the hospital. This complex of specialized care has both positive and negative factors - it provides more comprehensive care for the patient and also makes it more difficult to know him as a person.

Problems in patient's care that come to the attention of the Social Service Department by referral are evidenced to a greater or lesser degree in other departments of the hospital, in the community of which the hospital is a part and in the community from which the patient comes. We become aware of his problem because of breakdown in the patient's effectiveness in meeting his needs and inability to use the resources available to him. The size and complexity of the hospital setting, the large geographical area from which the patients are drawn, cultural differences in a rural and urban population of many nationalities and religious background, the varying types and degrees of assistance available in the local community all present intricately related factors with direct bearing on the present and future care of the individual patient.

We all recognize that the problems of a specific patient grow not only out of his present medical care, but out of his total life situation, his abilities and disabilities, needs and desires, his accomplishments or lack of them. They come with him and he will carry most of them away with him. They may be modified or increased by his feelings about his present medical care, his diagnosis and its complications for his future, the recommendations made by the doctors at the time of discharge, and his ability to carry them out effectively. Some of these problems are likely to be evidenced at the time of admission. Consequently, an early evaluation of social complications and mobilization of resources may effect a more comprehensive plan for aftercare.

We may deduce from the fact that a patient has signed out against advice that he may have had fears about the medical care plan, of death, or worry about difficulties at home. We may discover afterwards that he showed restlessness, anxiety, hostility, and possible resistance during his hospitalization. These may be the warning signs that indicate an earlier investigation of the problems that may be blocking his acceptance of medical help.

Concepts of auxiliary help needed by the hospital patient change with the changing concepts of medicine. The increased valence given to consideration of the patient's total personality and life situation, through the present psychosomatic approach of medicine, brings new resources into play. Army hospitals demonstrated the value of unified programs of medical care, physical reconditioning, occupational therapy, recreation, and social service. The function of each department is a changing one, and through cooperative planning, new programs and resources can be mobilized to meet the patient's need.

One of the most common and ever present problems is that of a patient whose social and emotional needs conflict with his physical ones. A 57-year old, single, woman patient, who has been known both to the psychiatric and cardiac service, has been followed some time by different social workers. She was depressed and had rheumatic heart disease manifested by mitral stenosis and chronic auricular fibrillation. She had numerous operations within a five-year period and two state hospital admissions within the last three years. Because of her cardiac condition it was advised that she have a long period of complete rest. Working, for her, was about the only way she could successfully keep in contact with reality and maintain enough self-esteem to give her the will to live. She had vacillated from the extreme of wanting complete physical care through fear of what would happen to her heart

if she did not accept it, to being overzealous about wanting to return to hard work before she was physically ready. Actually, a compromise was reached by the doctors in which the patient could do some limited work, rather than none at all, since her anxiety would be unbearable if she were able to do nothing. The patient was referred through Social Service to Vocational Rehabilitation for employment placement; the patient was unable entirely to accept this plan, because of her need to refuse help once she had asked for it. In this instance, various doctors and social workers followed the patient closely with frequent conferences and observation of her reaction to her condition. By giving her time to make up her mind and a chance to see that it had to be her choice and not the social worker's or the doctor's, the patient was able to partially adjust to her limitations. Had she been pressed to follow one course or another, she probably would have rejected assistance until her condition became such that she could not go on.

The problem of obtaining blood occasionally looms large in the care of the patient. For a long time we were not involved in the staff problem of obtaining donors, but became so when individual patients showed emotional disturbance and inadequacy in meeting this responsibility. Our facilities are not sufficient to bank a large supply; blood is increasingly used for therapy and finer divisions are made in the kinds of blood that may be used for any one patient. The problem grows and our hospital is not alone in facing it. Responsibility here for obtaining blood rests primarily with the interne on the service where the patient is. The social worker accepts responsibility in assisting, only where social and emotional problems of the patient exist. In any one instance, the interne, the patient, his family, his friends, the Blood Bank personnel, Bookkeeping, the Admissions Office, social worker, and local Welfare Board or private agency may be drawn in on a blood situation. The distance travelled by donors, the availability of donors, the expense, time of recognization of existence of the problem, are sometimes interwoven into a situation unsolved when the patient leaves the hospital. Many patients do not have families who can help them. Often the patient receives care here, because he does not have financial resources other than general relief, or one of the categorical aids, such as Old Age Assistance. Should such a patient require Rh negative blood at $35 a pint, it would be evidenced at the outset that he would need considerable help in carrying through. Obtaining blood has been a problem for Social Service, one of recognized unwieldiness, because of the necessity of cross reporting to the hospital personnel involved in the procedure. The following case illustrates the range of difficulty that might arise in one situation:

A 42-year old woman was admitted January 27, 1948, for an exploratory laporatomy because of a bleeding tumor. She had no relatives, was a former resident at, and employee of, Glen Lake Sanatorium. The request was made of her for ten donors first and later raised to 20 or 25. She returned to Glen Lake and their Social Service Department enlisted the aid of the Minneapolis Council of Church Women in obtaining the necessary blood. This arrangement was satisfactory to the Bookkeeping Department, with whom the verbal arrangement was previously confirmed. The Minneapolis Council of Church Women sent us a guarantee that, at first 10, and, later 20 to 25 donors would be coming in to give blood for this patient. A copy of the written guarantee was filed at the Bookkeeping Department. The doctor who had asked us for some kind of guarantee was informed that we had it; the Blood Bank was notified; the patient was told that Glen Lake Social Service and the Minneapolis Council of Church Women were cooperating in getting donors for her. This reassurance was particularly important to her as her whole hospitalization had been rather unhappy. She missed Glen Lake Sanatorium and her friendly contact with fellow employees there. She was quite uncomfortable physically and ashamed of requiring county help. She had not been disturbed by previous county care at Glen Lake for tuberculosis as she felt her status there as an employee made that instance a little

different. She was a sensitive person and was aware of her obligations to the hospital.

The patient was discharged from the hospital on a weekend when the social worker was not on duty. Discharge had previously been planned for the following Monday or Tuesday. Apparently a copy of the blood guarantee had been mislaid as the patient was asked about bringing in donors at the time she was cleared for leaving the hospital. She returned to clinic the following Tuesday, at which time it is believed that someone in the clinic told her, "the least she could do was to pay for the blood she owed". She was obviously hurt. Apparently there had been no check with Bookkeeping or the Blood Bank or Social Service, three places a copy of the guarantee was filed. Patient then paid $40 out of her small savings of $100 to Bookkeeping that day. Upon a letter of inquiry and several phone calls from the Glen Lake Sanatorium and Minneapolis Council of Church Women later that week, asking what had happened, the patient was refunded $40, the cost of the actual blood used - six pints. This case is cited as an example of the degree of confusion that might be attained under the present complex system of arranging for blood. The various departments have been aware of the difficulty involved, and a concerted attempt is being made to simplify the procedure to better serve the patient's need - and allay any anxieties which arise.

On another occasion two social workers became involved in obtaining blood for one man and received three separate requests from three different doctors in the process. In reply to the first letter, an authorization was received by another office in the hospital and was on file there. Since the social worker did not receive the authorization, a follow-up letter was sent from our office. After checking with the Blood Bank and finding the deficit still listed, the doctor referred the matter to a second social worker who wrote a third letter. The County Welfare Board sent in a guarantee in reply to each request, writing to ask whether the patient was requiring 21 pints of blood when in reality 7 were needed. The picture was finally fitted together. Fortunately, the confusion in this instance did not directly affect the patient, since it had already been determined that the county would be the only source of assistance in obtaining blood for him because relatives were unable to come or pay for the transfusion.

There are times when the expense of drugs may exceed all other expenditures for hospital care and cause the patient great concern; for example, the case of a patient with subacute bacterial endocarditis for whom was prescribed ten million units of penicillin daily over a period of six weeks. The patient was a sixty-year old woman, the wife of a farmer who was himself a heart patient. She was admitted on a per diem basis, and her husband thought, if her hospitalization was not too prolonged, he would be able to meet the hospital expenses and had made no plans with the County Welfare Board regarding such care. When penicillin costing $48 a day for a period of six weeks, was prescribed, the whole family was thrown into a panic. They considered taking the patient out of the hospital, because they knew such a bill would mean the loss of their home. It was first considered not suitable to refer this situation to the county as such expensive treatment for one patient would quickly deplete the funds available for medical care of others. However, the family later took the matter to the county who immediately authorized care on the basis that the man could not meet such a staggering financial responsibility. This was particularly important as the emotional strain on the patient was great. This family was most fortunate in coming from a county which would authorize such care. Had the patient come from a county in which the township was the governmental unit handling financial assistance, there might not have been sufficient funds to cover this expense. The question might easily arise, can the patient be given the care she needs where sufficient public funds are not available?

In another case, a patient with tuberculosis, not particularly interested in his diagnosis and refusing to comply with

regulations except in a haphazard manner, was advised to have sanatorium care. All arrangements were finally completed and the patient grudgingly accepted a place at the sanatorium. The county would assume the cost of care. About the time the patient had been able to accept this recommendation, the doctors decided to postpone sanatorium care in favor of streptomycin treatment here, for a three or four-months period and at a cost of four hundred dollars. The patient had no funds; the county was on a township basis which meant this board rather than the County Welfare Board would need to accept the financial responsibility for this care. The officials were contacted by the social worker in regard to authorizing the cost of the drug. Before the township officials were able to give their decision, it was necessary for them to hold a special town meeting, and the streptomycin was finally authorized. Later, care at the sanatorium was also authorized, but the township did not see the necessity of paying ambulance transportation from University Hospitals to the state sanatorium. This transportation costs $87.00. Social Service will need to contact any other possible resources to raise the money in the next two months, so the patient may be transferred to the sanatorium following completion of care. There are few natural resources in rural areas other than the County Welfare Board and Town Boards; consequently, an item such as the $87.00 ambulance fee may cause delay of removal of the patient from the hospital.

The problem of obtaining authorization for special care such as prostheses and expensive appliances arises frequently, since routine county papers do not cover these items. Sometimes it is a simple matter of a telephone call or a letter to the Welfare Board of the county, if the patient has no resources of his own. Of the 87 counties, however, 21 are on a township system, which means that it is necessary to find the official in charge of the local public assistance program in order to secure the authorization. The degree of understanding of the elected employee or paid official in the local unit varies from place to place. The timing of their response varies and the pressure of need for the patient may be such that immediate action is desirable. These officials do not always understand the urgency of our requests, nor give immediate response.

Another problem frequently referred which is of real concern to the social worker is that of the patient who is worried about paying his bill. A fifty-eight-year old, single man of Rumanian descent with Guillain Barre's disease had spent all told $3000 on medicine and provisions for his family in Roumania during the war. He was proud of the fact that he had always paid his bills. He was to be hospitalized at home for three months and was to be on semi-bed rest at home for six months. He would not be able to work at all during that time, according to the doctor who originally referred the problem.

The patient had come in as a private patient three days before. At that time he had $19.60 left in the bank. He had cashed some war bonds to pay for an ambulance and other expenses coming here. As of March 4, he had a bill of $216.05. His Blue Cross Hospital Insurance would pay only an estimated $70 to $80 on the bill, since we are not a member hospital in the Blue Cross plan. St. Louis County Welfare Board was contacted for county papers to cover hospital expenses here, but they refused since the patient was supposed to be receiving social security benefits, and had not worked out arrangements with them before coming to University Hospitals. The final plan worked out on the day of discharge was that he would pay a little on the bill each month when he began to work. The problem in this instance seems to be that of interpretation of the patient's responsibilities in relation to paying for care before admission. Many patients come in who, because of unexpectedly lengthy care, find midway in their hospitalization that they cannot pay the bill. It is often too late from the County Welfare Board's point of view to accept retroactive responsibility for expenses already incurred although usually, after rather involved investigation, they do assume the balance of the patient's care here on proof of financial need. Early referral of financial problems anticipated at the outset

provides an opportunity for interpretation of his need for help to the patient's family and community agencies. A patient helpless in bed is often markedly upset and progress delayed as a result of such financial worries.

Many of the difficulties of the patients at the hospital could be lessened by explanation of what they might expect when they come here. They often arrive with the idea that they will be admitted directly, that it will take no time at all to go through the clinic, and consequently there is no need to make any preparations for staying here in the city for any length of time. We had one patient come in almost totally incapacitated with arthritis. She expected to be admitted when she was brought here, since the local doctor had told her so. Our doctors did not recommend admission to the hospital, as the condition was chronic and the patient could go through the Out-Patient Clinic with the aid of a wheelchair. Nursing home care was recommended. There were no places for women available in the Twin City area for several months to come. The patient was much disturbed. Arrangements were finally made to have her stay with a sister in Minneapolis while coming in for gold therapy and physiotherapy. The cost of the ambulance would have been $20 a day, but a driver from the rest home was persuaded to carry the patient in and out of the sister's home. Since the patient's sister was unable to care for the patient without financial assistance, the county paid her for the help she had to give, as well as for the transportation and medical care. This case serves to highlight other difficulties - lack of nursing home space and problems in arranging transportation for patients who are in frequent attendance to clinic.

Because of these lacks in the local community, the discharge of patients may need to be delayed unduly, thereby causing bed shortages - an acute situation that often cannot be avoided during the present lack of adequate rest home facilities for chronic and convalescent care.

In another case, a young man of 19 years with an infection in a jaw, injured in a farm accident, was sent from Ottertail County for medical care. This county is on a township basis. He had county papers to cover medical care and $1.25 with him. The county commissioner had told him he would be admitted to the hospital on arrival. The patient discovered this was not so. He spent seventy-five cents for a room for one night and was referred to Social Service on the following day. There was no possibility of the patient borrowing money for board and room, as he had no relatives or friends here. The county commissioner, when telephoned by the Social Worker, refused responsibility, as the township where the patient resided must take care of financial help to the patient. Six other telephone calls were made, trying to get someone to accept responsibility for board and room expenses for this patient. None of the township officials contacted would do so; finally the patient was placed in a boarding house, as he had to have some place to stay, and the loan was made from a small social service revolving fund to cover the necessary expenses. He was admitted after two days; later he repaid the loan as soon as he could secure funds.

This case would illustrate our need to inform local Welfare Boards and other township and county officials, local doctors, and public health nurses of the admission procedures here at the hospital so that the patient can be better prepared when he comes.

Relatives are often the primary resources in any plan of assistance to the patient. On the Neuropsychiatric Service, there has been increasing focus on getting acquainted with relatives because of need for their participation in the tightened admission and discharge procedures. An opportunity to see relatives when the patient comes in or when they visit the patient on the wards, is a real chance to interpret the care he is getting, to evaluate the help they can give in treatment and preparations for after care. Sometimes both relatives and the patient are inarticulate. Many times they are unable to relate themselves to the medical need unless it is explained to them in some detail. They may be un-

aware of the resources in the hospital unless they are pointed out directly to them. Because of the size of the hospital setting, it is possible for many persons to know factors in the patient's situation and yet fail to coordinate their knowledge. The son of a patient once came to the Social Service Office after the death of his father to say that he was never contacted by a nurse, doctor, social worker, or anyone else concerning his father's care. His father was a patient here on three occasions and was placed in a rest home three times without any of his relatives being consulted. The son did not see the doctor who treated his father. He was, as it happened, referred to Social Service by the superintendent of the last rest home in which his father had been placed. Through interview, it was learned that this man was willing and able to contribute to the plan for, and partly finance his father's care. He was probably not persistent, nor took initiative in a normal degree in attempting to actively help his father, since he knew that some agency must be paying the father's way; but he could have been found fairly easily and his cooperation enlisted, had we done a more intensive investigation at the time his father was placed in a rest home. Possibly, too, there is a need for fuller interpretation of services to relatives of patients in the hospital.

On occasion, relatives will react to their concern about the patient with aggressive tendencies and hostility toward those who contribute to his care, to the extent that the staff finds it hard to be patient with them. One six-year old patient, observed for rheumatic fever and later discovered to have a malignant condition with a poor prognosis, was referred for investigation of the home situation. The doctors felt that there were sufficient emotional problems already existent in the family relationship to question whether they would be able to give the patient satisfactory care. The mother was deeply disturbed and the father did not feel the necessity for specialized help with her emotional problem. He had no insight into his own problems, and blamed the doctors for being unable to cure the daughter. When he accepted the hopeless prognosis, he felt she had been kept in the hospital too long if she could not be helped. He thought he and his wife had been most cooperative where in reality they had requested special privileges and consideration throughout. There are times when an acceptance and an understanding of the causation of hostile and aggressive feelings can open the way for interpretation of the real situation.

The function of the Social Service Department changes with new concepts of social and emotional needs of the patient. Flexibility of service and cooperative planning are requisites in each individual case. An imaginative use of resources can only follow understanding of the patient's immediate problem from the standpoint of his total life situation.

* * *

NEWER TRENDS

Lydia B. Christ

Because of the rapid changes and growth in the hospital, various problems naturally arise and these are encountered by our Department, as you have just heard. In reviewing the year's work, newer trends are also observed.

Our approach to the patient is somewhat different. One school of thought advocates the functional approach. By this we mean that the work with the patient should begin and continue with the immediate problems. Any areas of past history which have a bearing on the present problem should also be explored, but only if the situation requires it.

Because of the fact that much emphasis in our case work is placed on the emotional elements of disease and what the illness or permanent handicap does to the individual, careful evaluation in this area is necessary to help the patient to the fullest extent.

This also places a different emphasis on our recording. Process recording as it is known tries to bring out the patient's attitudes and behavior in a given situation. The worker in turn attempts to evaluate these reactions and

notes progress of acceptance of his illness with its limitations from the emotional point of view. We speak of the fact as to whether the patient can "move ahead" in his situation and if so, what the social worker is able to do to help such movement.

The worker must always attempt to put herself in the patient's situation and by proceeding in her case work, attempt to "help the patient to help himself".

For better use of our recorded material we have from time to time considered the practicability of unit record system. Because of the fact that, here, patients may still handle their own records, it has not seemed feasible. The plan we are now using is to record in the medical record, summary statements of social service information at pertinent designated times. These summaries are to be informational but in no sense incriminating to the patient. It is hoped that those of you who need more information will contact the worker in the Department for a fuller evaluation of the patient as she knows him.

Since you are referring more patients at the outset, we should be more able to help them intelligently at the time they are released. This we believe is a very wholesome development of Social Service activities.

The plan which the Neuropsychiatric Department has developed we should like to see fully worked out for the medical workers. This is that the social worker might know when relatives of patients are with them, either at the time of admission or when they visit the patient on the ward. This would give us an added opportunity for interview with them and be able to evaluate the patient's situation far more than could be done otherwise. In a sense, such a contact with relatives would compensate for the home visits which we formerly made, when patients came from the Twin City area, but which are now largely impossible because of the long distances from which patients come to the University Hospital.

The increasing awareness of a closer working relationship of various departments within the hospital in the total care of the patient has been a very gratifying one to us. We greatly appreciate the interchange of information of those working with the patient for a fuller understanding of him as an individual.

Case conferences where ideas can be exchanged and controversial points discussed are exceedingly helpful and stimulating to us, and we believe a profitable teaching device in the hospital.

Our primary function in the hospital is, we believe, to serve the patient and give him the best possible assistance in relation to the hospital and community facilities available to him in order that his medical treatment may be most effective.

We trust that through the frank discussion of some of our difficulties we can bring about even better understanding of each other's problems, thereby producing a better end result. We welcome suggestions and invite you to feel free to come to us at any time to discuss mutual interests.

We have been short-handed during the past two years and the turn-over of the staff has caused increased difficulties. At the present time our staff is more complete than at any time during those two years.

I feel that we have a fine staff, which is exceedingly interested in their work and alert to existing problems.

Mr. Amberg suggested that I present my staff to you. I do this with a great deal of pride and satisfaction. I cannot introduce them individually but for your convenience I have listed the workers and their assignments in the staff bulletin. Each Station has a copy of this for your use.

I want to take this opportunity to thank those who invited us on this program, particularly the late Dr. William A. O'Brien and Dr. George Aagaard, and in giving us an opportunity to present our problems to you for your help and consideration.

MEMO TO STATIONS

Following is the list of Medical and Psychiatric Social Workers and the services to which each one has been assigned as of January 15, 1948. This includes House and Out-Patient, unless the patient is already known by another worker, in which case the first worker will carry the case.

Miss Frances Boone	White Surgery, Genito-Urinary Neurosurgery
Miss Lydia B. Christ	Polio - Rosemount Research Center Dental (if not known to any other worker)
Miss Helen Cole	Pediatrics (including Pediatric Dentistry) Includes children ENT Dept.; also Orthopedic, Poliomyelitis (All Pediatrics except Eye and Cardiac)
Mrs. Mary Cordingly	Children's Psychiatric Worker
Miss Jean Cummins	Neurology and Medicine (half time on each service)
Miss Madeleine DePreter	Medical Specialties, including Diabetic, Chest, ENT, and Orthopedics
Mrs. Mary Jo Grathwol	Adult Psychiatry
Miss Kay Hornung	Red, Blue, Purple, Plastic, Yellow and Vascular Surgery
Miss Helen Kretchmer	Obstetrics, Gynecology and Dermatology
Miss Viola Lundin	Out-Patient Department Admissions West 212; Medicine Clinic Green, White, Yellow Medicine (except Cardiac, Chest and Diabetic)
Miss Dorothy Smith	Adult Psychiatry
Miss Gertrude Tennant	All Cardiac Patients (adults and children)
Miss Helen Griffin	Summer Substitute and Rosemount Research Center (Half time at present. Full time as of July 1.)

The office secretaries are Mrs. Helen Brewer and Mrs. Martha Vetter.

III. MEDICAL SCHOOL NEWS

World Medical Council Visits Medical School

The Medical School and the University will be host to representatives of the Council of the World Medical Association on May 5. Members of the Council who are expected to visit the campus are Professor Eugene Marquis, Director of the School of Medicine of Rennes, France; Dr. O. Leuch, Switzerland; Dr. T. C. Routley, Canada; Dr. Dag Knutson, Sweden; Dr. Jose A. Bustamente, Cuba; Dr. Paul Cibrie, France; Dr. Alexander Hartwich, Austria; Dr. John Yui, China; Dr. P. Z. King, China; Dr. J. A. Pridham, England; Dr. N. C. Sen, India. They will tour the campus of the University of Minnesota and have luncheon with members of the faculty at the University Hospitals and spend the afternoon conferring with members of our staff who are working in similar fields.

The World Medical Association was organized in Paris in September 1947 for the purpose of promoting closer ties among national medical organizations, assisting all people in the world to obtain the highest possible level of health, furnishing information to the doctors of the world, cooperating with the World Health Organization, the United Nations educational, scientific and cultural organization, and promoting world peace.

The Council has been holding a four-day meeting in New York beginning Monday, April 26. Members of the Council who will visit our campus will come to us after a visit at the Mayo Clinic in Rochester. They will leave for Chicago on May 5 to continue their tour of American medical centers.

Epidemiology in Rural Practice

Dr. William N. Pickles, Medical Officer of Health, Aysgarth, Yorkshire, England recently visited the Medical School. Dr. Pickles has conducted a rural general practice for 35 years in northern England. During most of this time he and his wife have kept careful records of the incidence of various infectious diseases occurring in the various English villages in the area which he serves. Information that was obtained is contained in a book which Dr. Pickles has written. Dr. Gaylord Anderson invited Dr. Pickles to lead the School of Public Health Seminar on April 26. Much of this material was presented at that time. Dr. Pickles demonstrates what can be done in a rural practice by any physician who is interested in pursuing scientific studies.

Atlantic City Meetings

The meetings of the Association of American Physicians and the American Society for Clinical Investigation will be held in Atlantic City, New Jersey, May 3 through May 5. Members of the Medical School who will attend include Dr. Cecil J. Watson, Dr. Wesley W. Spink, Dr. Paul S. Hagen, Dr. Richard V. Ebert, Dr. Carleton Chapman, Dr. Craig Borden and Dr. George N. Aagaard. Dr. Ebert will present a paper on the results of studies on Right Heart Catheterization. Dr. Spink will go from Atlantic City to Washington, D. C. where he will attend the meeting of the National Research Council's committee on Public Health Aspects of Brucellosis.

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