Bulletin of the

University of Minnesota Hospitals
and
Minnesota Medical Foundation

Social Service Reports

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BULLETIN OF THE
UNIVERSITY OF MINNESOTA HOSPITALS
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I. SOCIAL SERVICE REPORTS

A. THE UNIVERSITY HOSPITALS USE OF NURSING HOMES

Annie Laurie Baker

The medical staff of the University Hospitals makes extensive use of privately owned nursing home facilities. All the services of the hospital transfer patients to nursing homes; however, the nature of the illness and the type of treatment given requires the use of these facilities by some services more than others. The policy of the hospital is to transfer patients to nursing homes when they no longer require continuous medical supervision, but are in need of nursing care.

The University Hospitals began using nursing homes about twenty-five years ago for the care of patients in the terminal stages of cancer. At that time the University Cancer Clinic was one of the very few medical resources in the state able to provide care for cancer patients, and many came here for treatment. This was before people knew much about cancer, and frequently patients came for medical care when the disease had progressed to the stage where little could be done for them. Many of these patients had no place to go where they could be cared for so they were sent to nursing homes.

The number of private nursing homes was small. The better ones were owned and operated by doctors for the care of their own patients suffering from mental illness. The homes available for patients from the University Hospitals were crowded and gave only a poor standard of care. There were homes where patients were exploited and others where the operators were sincerely interested in providing a good standard of care; but since these homes were so much better than the others, they were kept crowded so that they could not give patients the care they required. The rate paid for such care was $1.75 per day. In order to provide more adequately for cancer patients, the late Dr. William O'Brien interested the Catholic Order of "Our Lady of Good Counsel" in establishing a home in St. Paul where patients in the terminal stages of cancer could be cared for.

In 1937, the Old Age Assistance Act was passed which provided financial assistance for people over 65. However, one of the provisions of the law was that people receiving assistance could not continue to get the Old Age Assistance check if they lived in a home operated at public expense. In order to keep their grant, when they became ill, they had to go where ever they could find anyone who would take care of them on the small amount they could pay. There were people who had a chronic invalid in their home, usually a relative, and as they were already tied down caring for one sick person, not too much more was involved in having another sick person in the home. So they took in these older people and started nursing homes. With the great need for such places, these people were encouraged to take in others, and soon were crowded beyond their capacity and ability to adequately take care of patients. There were those who took advantage of the situation and exploited the patients by giving low standards of care, insufficient and poor food, and by crowding in many more beds than space permitted. Most of the patients were off in these homes and no one knew much about them. However, the patients sent out from this hospital to these poor standard homes came back to clinic. The doctors saw what kind of care they were given, and the social workers visited the patients, and were aware of the conditions. From the experience of the staff of the University, Mr. Ray Amberg, Director of the Hospitals worked with various organizations interested in medical care, and a law was passed requiring every home with more than two patients to be licensed by the State Board of Health. The law was passed in 1941 and Minnesota was the first state to have a comprehensive licensing law. Since that time there has been marked improvement in the standards of nursing home care.

One of the big contributions the Uni-

versity Hospitals has made in the way of community organization for better medical care is in this very area. The staff of the University Hospitals has continued to assist the nursing homes to raise the standard and improve the quality of care given to patients. The nursing service under the direction of Miss Florence Brennan, gave a course on certain aspects of nursing to the operators and nurses. The course was well attended and successful. Dr. Frederick Kottke and Miss Hazel Erickson and others from the Department of Physical Medicine have talked about rehabilitation of patients at meetings of operators in an effort to teach them how essential it was to get patients out of bed. As a result the good homes now pride themselves on the number of patients they are able to get up. Other members of the medical staff have spoken at meetings and participated in the Continuation Center courses for nursing home operators. The Social Service Department with the assistance of Mrs. Irene Foster, Director of Volunteers and the Minneapolis Council of Church Women has established a corp of about 130 volunteers who visit patients in nursing homes. The volunteers provide a contact from the outside and help break the monotony. The University Hospitals has a real interest in nursing homes, for without an attached facility for the care of convalescent or chronically ill patients, privately owned nursing homes will continue to serve as auxiliary facilities to the hospitals and staff.

There are 210 licensed nursing homes in the state and 49 in Hennepin County. There are approximately 1300 patients regularly in nursing homes in Hennepin County. The 49 homes in Hennepin County are privately owned businesses. Over the county the average investment of a small 16 bed home is $20,000 and that of the larger homes we use, in excess of $200,000.

In order to open a nursing home the operator must obtain a license from the State Board of Health and pass the inspection by the State Fire Marshall. Since these are private businesses, they are subject to various taxes and must be heavily insured. The rate of nursing care in Minneapolis is currently from $135 to $200 per month.

There is a national organization, the American Association of Nursing Home Operators and there are also active state and local chapters. The progressive operators, throughout the country, are all interested in raising the standards of nursing home care. The American Association will hold its annual meeting in Minneapolis this fall and no doubt some of the members of the medical staff will participate in the program.

The Social Service Department made 817 nursing home placements this past year. The number placed from the medical and surgical services is about equal. As best we can figure from the statistics which we have gathered at different times, the 817 placements made represents a total of around 12,000 days of hospital care which would accommodate an equal number of patients. In the last year's annual report of the University Hospitals, the average length of hospitalization was 14 days per patient. Through the system of transferring patients to nursing homes, the University Hospitals was able to care for an additional 800 patients. The facilities of the hospital were thereby extended to the equivalent addition of an extra station, the size of Station 22, without the expense or the problems of maintenance.

With this much background, let us consider the benefits of the plan to the medical staff, the county welfare boards, and the patients. We will then consider certain aspects from the Social Service staff's viewpoint and give you some of the conclusions and principles we have evolved after twenty-five years experience.

The medical staff, by placing patients in nursing homes, is able to give better medical service than would be possible if the patient returned home. The living conditions in a nursing home are very similar to those of the hospital; they are designed and established to take care of sick people. The living

situation is fairly well controlled. Since the homes used by the University Hospitals all have skilled nurses, technical procedures can be carried out. Patients can be brought back to clinic where the doctor may observe the progress at regular intervals. The nursing homes have made a substantial contribution to the medical staff in their research, by continuing specific procedures, and in making it possible for patients to remain near the hospital, where their progress can be observed. From the viewpoint of teaching, the turnover of patients made possible by this plan of transferring patients has merit. A teaching program is enhanced by a new group of patients. The total of an additional 800 patients has real significance in teaching value.

The County Welfare Boards are requested to pay for nursing home care, so it might be well for us to consider what this plan means to them. The County Welfare Boards are concerned about the patients they send to the University Hospitals for medical care and desire them to get the full benefit of the medical care. They also have a sense of responsibility to contribute to the teaching and the research of the medical staff as they are interested in the general welfare of the people. Sometimes, too, they are relieved that the Social Service Department has taken over and made plans to take care of patients for whom they have no local resources.

The financial saving to the county no longer exists. Placing patients in nursing homes cost the same or more than care in the hospital. For example, it costs the county $6.25 per day or $43.75 per week for hospital care. The county pays one-half of the $12.50 daily rate for hospital care. The nursing home rate is $5.75 per day or $40.15 per week. However, transportation to clinic is an additional $3.00 per trip, so whether or not the rate is less depends upon the number of times a patient comes to clinic per week.

The money to pay for University Hospital care comes out of the County Revenue Fund, which is administered by the Board of County Commissioners. The money to pay for nursing home care comes out of the Welfare Fund administered by the County Welfare Board. The amount of money in the poor relief budget of the welfare fund is always short and there are many demands made on it. While from the overall viewpoint, it might look like "robbing Peter to pay Paul" as far as the financing of patient care is concerned, the county prefers to have the expense come from the Revenue fund as there is more money and less demand on it. In short, the counties would just as soon have patients kept in the hospital.

We have considered the use of nursing home facilities from the viewpoint of the hospital, the medical staff, and the county welfare boards. Now let us look at the patient and consider what it means to him to be transferred to a nursing home.

What does the experience of being sent to an unheard of place, away on the other side of the city, at the end of a bewildering first day in clinic, do to a patient who is tired, sick, and anxious? What is the effect upon him as a patient? Does it lessen his confidence in what the hospitals and staff have to offer? What can we all do to help the patient accept the plan? The patient comes to the clinic with the arrangements made by his family doctor, who has given him University Hospitals authorization forms, sent him to the welfare board to have them signed, and has assured the patient everything is in order. Knowingly, or not, the doctor often gives patients the idea he will be admitted to the hospital as soon as he arrives. At the end of the first day, he is not admitted and although the county welfare board has given him forms, told him all expenses will be paid by the county, it is often necessary for the social worker to question the patient about his financial situation. The social worker unfortunately increases his anxiety, by telling him she will have to secure authorization for his nursing home care, since his county papers do not cover that expense.

The position of a patient in the hos-

pitals is similar. In his own way of thinking he is still in the critical stage of his illness. He has just become familiar with the ward routine and personnel, and then he is told that he is able to be transferred to a nursing home. What happens to the doctor--patient relationship so essential to good medical care under these conditions? This relationship is of greatest value to the patient at the time of crises and for him this is a crisis.

We have pondered these problems many times and have found from years of experience that it is essential that doctors, nurses, and social workers be aware of the patient's feelings in the matter, accept his reactions and to give him a good idea of what he is to expect. The doctor in charge of the treatment is very important, for in him rests the patient's hope for recovery or improvement. In order to maintain the confidence which the patient has in his doctor and the medical staff it is essential that the doctor discuss this aspect of medical care with him just as he does any other procedure. The patient must consider his transfer to a nursing home as a part of the total treatment plan for him. He needs to understand he is not being shoved off out of the way, but that the doctor had this plan in mind all of the time and that this is a routine way of doing things. When these steps are taken the patient leaves with a good feeling of security and has faith in the hospital. This makes it easier for him to make the adjustment to the new situation.

The problems with hospital patients are more acute and here we need to differentiate between patients who need nursing home care temporarily and those who will require this type of care as long as they live.

For the patient who needs temporary care only, it is very essential that he understand his medical condition and the progress he is likely to make so that he does not become overwhelmed by the number of chronically ill people around him and convinced that nothing more can be done for him and become discouraged and depressed. The patient who is being transferred to wait out his life in a nursing home needs much consideration. Usually he knows before he came there was little chance for recovery. However, the University Hospitals staff has a great reputation throughout the state and this is, as it were, the last court of appeal. The patient has a ray of hope for recovery or improvement up to the point of discharge. The transfer of a permanently ill patient should be made with the greatest possible consideration, to prepare him as well as possible, to aid him in understanding his medical condition, and in accepting the fact that nothing further in medical treatment can be offered him at this time. Many of these chronically ill patients are old, a bit confused and for the most part are inarticulate but they have feelings which get in their way of their adjustment. These patients need more than any others to be reassured by the medical staff that they are interested in them and are ready to be of service whenever they need care.

The Social Service Department at University Hospitals has always been responsible for the transfer of patients to nursing homes. In performing this service the department assists the medical staff to practice better medical care, makes a contribution to the teaching program and helps patients get the full benefit of medical care. One of the functions of a social service department in a hospital is to facilitate medical care, and in the area we perform a part of that service.

From the medical social worker's point of view, the transfer of patients involves many factors. The necessity of the patient understanding his physical condition, the reasons why he is being sent out of the hospital, and the importance of his seeing this as a part of the medical plan, have been discussed. In all these aspects social workers help the patients and the staff. It is essential for the social worker to interview the patient about the plan of transfer, to determine where best to send him, to obtain his cooperation and that of the relatives, and to learn where to solicit

financial assistance to pay for the care. In her discussion around these factors she is able to supplement and to interpret the information the doctor has given, to assess his attitude about the placement, and what it means to him. She is able through her knowledge of his medical condition and her acquaintance with nursing home facilities to help him understand the importance of following the doctor's recommendations and to let him know more about the nursing home. Sometimes the nursing home placement is the first step in the patient's rehabilitation, and in her casework with him he must see it as such a step.

The family has to be considered. Sometimes they have considerable resistance to the transfer and have more difficulty accepting it than the patient. At times they are opposed to the procedure and delay or refuse to participate in working out the financial arrangements. At other times, they insist on taking the patient home, in spite of the fact, that the medical staff and the nurses have told them about the physical care the patient requires. The family may need help in taking over the responsibilities of the patient. Just now all patients from rural areas are anxious about their spring work and concerned lest it be neglected. The family may need help in getting assistance for themselves as well as the patient.

Obtaining the money to pay for this type of care is often a problem. As explained before county papers do not cover nursing home care, so funds for this expense have to be secured from some other source. There are occasions, when plans for nursing home care just cannot be worked out, placement in another hospital may be indicated or the patient may need to go home with the assistance of a public helath nurse, or others to supplement what his relatives are able to do. It is not as necessary to interpret the recommendation for nursing home care for patients to the county welfare boards as it used to be. The careful case by case discussion, the medical reports that have been sent, and the personal conferences with county social workers, over the years, have been profitable. However, there are still a few county welfare boards most reluctant to authorize nursing home care and in the counties operating on the township system of poor relief, it is sometimes impossible to secure the financial aid necessary to pay for nursing home care.

When the patient leaves the hospital, to continue treatment on an out-patient basis while staying in a nursing home, the social worker bridges the gap and is the continuity between the hospital and the clinics. She is likely to be the only person he sees in both situations. The social worker also assists the patient, his family, and the county welfare boards in making any plans indicated for the patients continued care and treatment when he leaves the nursing home.

There are many emotional and social factors involved in the transfer of patients to nursing homes and it is important that we all work together so that the best medical care can be given to the patients who come for treatment.

The Social Service worker attempts to place the patient where he can receive the best medical care for his condition. The University Hospitals and clinics however, have certain other requirements which somewhat limits the choice of the nursing home to be used. There are some good homes in the city which will not do business with the hospitals. The social worker obtains authorizations from counties to pay for the patients care and in some instances the nursing homes have not been able to collect their bills and they usually have to wait for their money. The Hennepin County Welfare Board has excellent business procedures and the nursing home operators prefer to take patients placed by them. It should be stated here that the placement of patients in nursing homes is not always one of the functions of the social service department. In many cities the agency paying for the care arranges the transfer. The number of nursing home beds in Minneapolis is just about sufficient. The need for beds is not competitive, except during the winter months, but there is no surplus to allow for much

choice. In attempting to place difficult patients, sometimes as many as ten homes are contacted.

The majority of patients sent from the University Hospitals and Out-patient department are to come back to clinic for further care. Therefore, it is important that transportation be available to take them back and forth. Taxi service is not sufficient, as the insurance carried by them does not extend to patients who require assistance in getting in and out of the cab. Only the two large homes, Parkview and Oak Ridge, have transportation. Since there are many wheel chair patients and others who have difficulty in walking, elevator service is often important. Most of the patients who leave here require nursing procedures which can only be administered by a trained nurse. Due to the shortage of nurses many of the smaller homes do not have trained nurses on their staff. The medical staff has done considerable work in special diets and patients are sent to nursing homes for dietary control. These need the supervision of a dietitian. Parkview is the only nursing home which has a dietitian on its staff. Patients are sent to nursing homes as part of their medical treatment and as these homes operate as auxiliaries to the hospitals we must make certain that the medical requirements are always provided. The social worker considers all these factors and attempts to make the most satisfactory placements possible.

Patients placed in nursing homes have certain adjustments to make and it might be well to review some of the factors they meet which seem to concern them most. Any person going into a nursing home the first time is impressed by the very ill bedridden patients. To a patient who has been ill a long time and is just out of the hospital the sight of these bedridden patients is a shock. He sees himself in the same situation and becomes frightened and depressed. The patient going out to a nursing home feels very much alone as he is in a strange place not known to his family and friends. He misses the hustle and bustle of the hospitals and notices the quiet. Most nursing homes have wards of four to twenty patients. In the beginning this is a trial to patients, and they feel surrounded by beds. Nursing homes have no means of providing any privacy. Since these patients are ill and many of them are waiting for death, the death of other patients is very disturbing to them.

In private practice doctors often wish to consider the possibilities of placing chronically ill patients in nursing homes. After twenty-five years in the business, the Social Service Department has developed some criteria out of the experience which we will pass on to you.

We believe that chronically ill people should be placed in nursing homes when their families resent having them at home. Our feeling is that chronic illness itself is cross enough to bear, without having the added suffering which comes from the hostility of relatives. This is especially important in the in-law relationships where the patient's presence adds to family conflict.

We believe too that when the chronically ill patient presence in the homes hampers the normal life of children he should be in a nursing home. Those of us working in hospitals, where all our attention is focused on the patient are apt to consider his good only, forgetting the family unit. When the old grandfather takes the only bedroom or must have his bed set up in the living room we feel it would be better for the family to have him placed elsewhere. Small children should not always be hushed up because of a chronic invalid in the home, and adolescents should not have to seek their recreation outside their home because there is no place in the house to go to but the kitchen. We feel in these instances the best interest of the family supersedes that of the patient.

Here at the University Hospitals we meet patients who have no relatives and very few friends. In these instances we attempt to place those patients back in their local community. Since these patients have nothing but the community,

we feel it is more important to them to be back where they can hear talk about familiar things, and see people they know; than that the facilities of the home be as good as those of the Twin Cities' homes.

For your guidance, too, we will give you what we believe to be the advantages to the chronically ill patient in a nursing home placement.

The first and most important advantage is adequate care and nursing supervision. Relatives might have the best intentions in the world of following out the doctor's recommendations but are helpless when it comes to managing the patient. Patients placed in nursing homes regain a certain part of their independence and freedom. They are totally dependent on others, but there is not the sense of obligation which is always present when relatives are concerned. The patient is being cared for and the people who take care of him are paid for their work. This is a business arrangement free from emotional entanglements. They are free from the family and again independent of them. This in a way restores their feeling of status, the loss of which is reported by retired people to be the greatest disappointment old age brings. They obtain freedom in another way too. In a nursing home they do not need to pretend; if they are in pain they can give way to their feelings. On the other hand, they are not called on to exhibit neurotic behavior to get attention. Patients placed in a nursing home are relieved of the competition involved in family life. They do not need to participate in family decisions or take sides. They are removed from that responsibility. The greatest advantage is that they are with their contemporaries, they can share the past generation with the patients around them. The people they are with think and feel pretty much as they do.

There are disadvantages in placing a patient in a nursing home which also need to be considered. The most common complaint is against the regimentation. A nursing home is a busy place and in order to get the work done, routines and regulations have to be established. All he may keep is what can be stored in a bedside table. His environment is stripped of all the things he enjoys having around him. For older people this is an important factor.

The utter lack of privacy, of never being able to turn away from the sight of other sick people, is especially hard on the patient who has lived alone most of his life. Life becomes monotonous, each day, is a repetition of the same routine. It is exceedingly difficult to provide a patient with any intellectual stimulation or incentive once they have settled into the routine. Keeping a chronically ill patient mentally alert is as essential to his enjoyment of life and his well being as it is to get him out of bed to prevent stiffness and contractures.

As a patient in a nursing home is relieved of the responsibilities of family life so he is also deprived of the satisfactions and pleasures which are a part of family living. Loneliness is another complaint, and "out of sight, out of mind" seems to operate here. Families make a few visits, to satisfy themselves that the patient is being well cared for and then forget to come back to see him. All these disadvantages are also found when patients are in a hospital for a long time.

However, patients in nursing homes are by and large a happy group, and well satisfied after they make the initial adjustment. There are some wonderful, kind people operating nursing homes or working in them. We are apt to be too conscious of the very small minority who are in the business for the money and make their profits by exploiting sick and helpless people. There are many dedicated folks in nursing homes who become family and friend and life itself to patients they serve. As Mrs. Adele Pearson, President of the Minnesota Association of Nursing Home Operators, often says "They take care of the people no one else wants."

Providing adequately and satisfactorily for the chronically ill is one of the big problems medical facilities and communities must now solve. We have invited Dr. Helen Knudsen of the Minnesota State Board of Health to discuss the legal requirements for Nursing homes and to tell us about facilities outside Hennepin County.

B. NURSING HOMES AND RELATED FACILITIES IN MINNESOTA

Helen L. Knudsen

In Minnesota today there are approximately 270,000 persons 65 years of age and over. The majority of these individuals live in their own homes, with relatives, in rooming houses or hotels. Several thousand are in the state hospitals for the mentally ill and mentally deficient. Many occupy beds in general hospitals which are intended for the acutely ill while others are receiving care in the chronic disease units of general hospitals where Minnesota has only 409 beds at the present time.

There are approximately 9,000 beds in nursing homes, homes for the aged and boarding care homes in the state. Although utilized to some extent by individuals of all ages, these homes provide care primarily for people in the older age groups. Many of the individuals in these homes are in need of personal care or attention beyond board and room and a large number are chronically ill or disabled. In spite of the fact that there are approximately two-thirds as many beds in these homes as there are in general hospitals, relatively little attention has been paid in the past to the provision of good standards in existing homes or in planning for new homes. The public and the more progressive nursing home operators themselves are insisting on improved standards of care and practically all states now license such homes. Undoubtedly considerable stimulus will result from the interest being shown on the part of the Commission on Chronic Illness which is presently studying all nursing home patients in the State of Maryland. Data to be secured include social characteristics, diagnoses, ambulation status and the amount and type of nursing care and personal service received. It is expected that other states will be encouraged to study the nursing care patients in their institutions on a comparable basis.

In 1951, the Minnesota legislature amended the Hospital Licensing Law and empowered the State Board of Health to classify homes on the basis of type of care provided and to adopt and enforce reasonable regulations which are found to be necessary in the public interest. For purposes of classification, homes are defined as follows in Minnesota:

Nursing Homes

Homes licensed to provide care for aged or infirm persons requiring or receiving nursing care. These persons may be bedfast or ambulatory. For purposes of classification, Homes for the Aged are considered nursing homes since most of them have infirmaries. As a rule, individuals entering a home for the aged, usually for permanent care, will not require nursing care at the time of admission but may later.

Boarding Care Homes

Homes licensed to provide care for aged or infirm persons requiring or receiving personal care or custodial care such as assistance with bathing, dressing, walking, getting in and out of bed, the serving of meals and general supervision.

For the most part, nursing homes and boarding care homes are operated by private individuals who are dependent upon the operation of the home for a livelihood. Usually these are small homes of a family dwelling type which do not adapt themselves readily to the care of patients because of the lack of an elevator and a dumbwaiter, narrow corridors and doorways, and limited toilet facilities. Most homes are located within the limits of the city or village. The development of nursing homes in rural locations is discouraged since it is extremely desirable that these homes are readily accessible to medical service and fire protection. It is also advantageous to locate homes within walking distance of churches, lodges, stores and other places where aged persons are accustomed to meet. Those who live in institutions should not be segregated but their lives should be a continuation of normal living with its contacts and activities.

It is desirable that people remain in their own homes as long as possible. The development of homemaking and housekeeping services as well as the use of the services of the visiting nurse will aid considerably in making this possible. The use of the foster home where one or two individuals can live with a family should be studied from the standpoint of making it possible for patients to live and adjust outside of an institution.

Requirements have been established covering the physical plant, sanitation, food service, room areas, equipment for care, reports and records, and personnel. In nursing homes a registered nurse or a licensed practical nurse must be responsible for the nursing service. The admission record should contain the diagnosis and definite instructions for care and treatment of the patient and be signed by the patient's physician. A physician must also be designated as responsible for the supervision of the care and treatment of the patient during his stay in the nursing home.

Minimum areas for patients' rooms are specified but many homes remain overcrowded. This is understandable because of the demands made on these homes and the need to obtain a maximum income in order to meet increasingly high costs of operation and realize a return on the investment. Day room facilities are considered essential for recreational purposes, visiting and occupational therapy.

Approval by the State Fire Marshal of the fire protection of an institution is a prerequisite for licensure. Minnesota has been exceedingly fortunate in having experienced no major fire catastrophe in recent years. Data on fires in hospitals and related institutions show that we have an incidence rate of about one each day in this country. The result is loss of life, untold pain and suffering and an annual property loss of millions of dollars. Immediately following any disaster prominent enough to merit nationwide publicity, local communities become apprehensive for the safety of their own institutions. Only at such times do they become acutely aware of their problems and responsibilities relating to fire safety. The Fire Marshal will permit no bedfast patients on the second floor of non fire-resistive buildings unless the building is provided with a sprinkler system. Under certain conditions, homes must be equipped with automatic fire alarms.

Much can be done to encourage these individuals to lead more useful and more satisfying lives with the use of various types of physical and occupational therapy procedures. The acute shortage of trained personnel to staff institutions providing care for the chronically ill, the disabled and the aged is well recognized. Until sufficient qualified personnel is available to supply the need, the only answer is that of extending the services of presently available well-trained personnel to assist in the development of and to extend and supervise the services in the smaller institutions. It is recognized that homes providing programs in rehabilitation are more expensive to operate than those furnishing only domiciliary care. However, the expenditure for these services will be repaid many times by a reduction in the over-all tax burden if those who are in the working age can return to a job or if the older individual recovers to the point of self care.

Ideally, a nursing home should be located adjacent to or in close proximity with a general hospital so the complete services of the hospital are readily available to these patients when needed. Communities are being encouraged to convert their old hospitals to homes of this type when new hospitals are built. In most cases these homes are being equipped with automatic sprinkler systems. Some of the small county tuberculosis sanatoria in Minnesota which are no longer needed are being converted into nursing homes. These additional facilities will reduce the crowding and permit improved standards of care.

The Hill-Burton Program which is now in its sixth year of operation specifies a need for two beds per thousand population for chronic disease hospitals. The question has been raised as to whether

or not this figure of two beds per thousand should also include facilities in nursing homes. At the present time nursing homes are not eligible for participation in the Program since institutions providing primarily domiciliary care cannot receive aid in construction. The present concept of a chronic disease hospital is a hospital which provides the maximum in rehabilitation and physical therapy and which is built as a part of a general hospital having available all of the services and facilities for acute care and diagnosis. It must be remembered that chronic disease occurs at all ages with a large proportion of the chronically ill in the productive years of life.

St. Louis County has taken the leadership in the state by providing two facilities, one in Virginia, a 122-bed chronic disease hospital which was built entirely with county funds, and a second facility, 150 beds in size, which was built under the Hill-Burton Program in conjunction with St. Luke's general hospital in Duluth. A third unit of 150 beds is proposed in conjunction with St. Mary's Hospital in Duluth. The facilities and services for rehabilitation in the Virginia Infirmary are somewhat limited and the institution is actually serving as an excellent nursing home. The facilities and services at the St. Luke's Infirmary are much more extensive, but because of lack of staff and the present admission policy which gives priority to old age assistance recipients, the institution is not serving presently for the purpose for which it was designed.

The chronic disease hospital plan which has been developed in Minnesota in conjunction with the Hill-Burton Program designates the University Hospitals as the base hospital for the state. A total of $2,000,000 in Hill-Burton funds has been allocated to assist in the construction of the Mayo Memorial Medical Center with $750,000 of this specifically earmarked for the two floors devoted to physical medicine and rehabilitation. This hospital will provide special training for physicians and therapists in physical medicine and rehabilitation and the Center for Continuation Study will offer refresher training and practical experience for all hospital personnel engaged in and interested in providing such services. As a result of this, all allied basic training courses at the University should provide considerable training and experience in these fields. The plan also provides for chronic disease units of at least 25 beds in size with departments of physical and occupational therapy as units or wings of regional hospitals which by definition are at least 100 beds in size. Community hospitals of 50 or more beds are also encouraged to provide departments of physical therapy and other services which will aid in restoring the patient to as full a measure of physical health as possible. Smaller community hospitals, nursing homes and homes for the aged are urged to secure the services of qualified therapists on a part-time basis or arrange to use rehabilitation services at a nearby hospital. Obviously, this is a long-term program which will require many years to develop.

The community must recognize that it has the responsibility for providing the modern physical facilities necessary for the care of these patients in the same way that it has the responsibility for providing general hospitals. Community groups should also recognize the social, religious, educational and recreational needs of these patients. Only through such individual and community understanding and support can the problems of the chronically ill and the aged and their associated disabilities be resolved.

Minnesota Department of Health
Section of Hospital Services

Table 1
Nursing Homes, Homes for the Aged and Boarding Care Homes in Minnesota
April 10, 1953

	Number of Homes	Number of Beds
Facilities Available		
Total	297	8,903
Fire-Resistive Character		
Completely Fire-Resistive	34	2,072
Combination - Fire-Resistive	11	829
- Non Fire-Resistive		941
Completely Non Fire-Resistive	252	5,061
Sprinklered Buildings	8	730
Per cent of Beds in Fire-Resistive and/or Sprinklered Buildings		41%
Type of Ownership		
Private	210	3,342
Non-Profit Association	76	4,650
Governmental	11	911
Size		
100 Beds or More	12	2,408
55 - 99 Beds	31	2,171
25 - 49 Beds	53	1,741
10 - 24 Beds	134	2,132
Under 10 Beds	67	451

Minnesota Department of Health
Section of Hospital Services

Table 2
Hospitals and Related Institutions Provided in Minnesota 1947 Through 1952

Facilities and Total Beds			Construction Costs Provided By: Local	State	Federal	Total Cost
I. Hill-Burton Program						
40 projects	2,011 beds		$22,257,738	$ 7,698,762*	$12,334,670	$42,291,170
II. Outside Hill-Burton Program						
32 general hospitals (Estim. @ $10,000/bed) 1 chronic hospital	1,548 beds		$15,127,422	--	--	$15,127,422
III. State Hospitals						
15 units	2,274 beds		--	$10,562,250	--	$10,562,250
IV. Nursing Homes and Homes for the Aged						
15 new buildings or additions (Estim. @ $4,000/bed)	804 beds		$ 5,167,500	--	--	$ 5,167,500
18 conversions, remodeled and/or sprinklered buildings (Estim. @ $1,500/bed)	1,301 beds					
Totals	121 institutions	7,938 beds	$42,552,660	$18,261,012	$12,334,670	$73,148,342

* Includes State appropriations of $7,018,640 for Mayo Memorial and $680,122 for Anoka Receiving Unit.

II. MEDICAL SCHOOL NEWS

Coming Events

May 4	Seminar on History of Medicine; "The History of Colon Surgery"; Dr. William C. Bernstein, Minneapolis; Todd Amphitheater; 7:45 p.m.
May 7	E. Starr Judd Lectureship; "The Endocrinology of Mammary Cancer"; Dr. Charles B. Huggins, Chicago; Owre Amphitheater; 8:15 p.m.
May 7-9	Continuation Course in Surgery for General Physicians
May 10-17	1953 National Hospital Week
May 11-13	Continuation Course in Arthritis and Allergy for General Physicians
May 12	Duluth Clinic Lecture; "Some Aspects of Antibiotic Therapy"; Sir Alexander Fleming, London; Owre Amphitheater; 8:00 p.m.
May 13	Symposium on Antibiotics; Sir Alexander Fleming; London; Owre Amphitheater; 2:00 p.m.
May 21-23	Continuation Course in Radiology for General Physicians
June 8-12	Continuation Course in Electrocardiography for General Physicians

* * *

Continuation Course

The University of Minnesota will present a continuation course in Arthritis and Allergy for General Physicians next May 11 - 13 at the Center for Continuation Study. Practical management of problems in both of these fields will be emphasized. The visiting faculty will include Dr. Walter S. Burrage, Chief of the Allergy Clinic and Associate Physician, Massachusetts General Hospital, Boston. The course will be presented under the direction of Dr. C. J. Watson, Professor and Head, Department of Medicine, and the remainder of the faculty will include members of the clinical and full-time staffs of the University of Minnesota Medical School and the Mayo Foundation.

* * *

Sir Alexander Fleming to Visit Campus

The Medical School will be privileged to have as its guest an internationally famous scientist during the middle of May. Sir Alexander Fleming, St. Mary's Hospital, London, England, discoverer of penicillin and recipient of the Nobel Prize, will deliver the annual Duluth Clinic Lecture on Tuesday, May 12, in Owre Amphitheater at 8:00 p.m. His subject will be, "Some Aspects of Antibiotic Therapy." He will also participate in a Symposium on Antibiotics on Wednesday, May 13, at 2:00 p.m. in Owre Amphitheater. Other participants in this symposium will include: Doctors Wesley W. Spink, Wallace Herrell, Wendell H. Hall, and Professor Lester E. Hanson.

* * *

Faculty News

Dr. H. E. Michelson, Professor and Director, Division of Dermatology, presented two lectures entitled, "Sarcoidosis" and "Lupus Erythematosus" at the New York University Bellevue Postgraduate School during March.

The meeting of the American Association for Cancer Research held in Chicago on April 10-12 was attended by Dr. John J. Bittner, Professor, Division of Cancer Biology.

Dr. Gaylord W. Anderson, Professor and Director, School of Public Health, attended the annual meeting of the Epidemiological Society at Bethesda, Maryland, April 11

and 12, and the meeting of the Association of Schools of Public Health at Chapel Hill, North Carolina, April 13 and 14. Dr. Anderson was re-elected President of the latter organization, making this the third year that he has served in that capacity.

Dr. Joseph J. Buckley, Clinical Instructor, Division of Anesthesiology, addressed the Red River Valley Society at Thief River Falls, Minnesota, on April 22.

The following members of the Department of Bacteriology and Immunology recently attended the meetings of the Federation of American Societies for Experimental Biology in Chicago: Doctors J. T. Syverton, D. W. Watson, H. C. Lichstein, K. R. Johansson, R. K. Lindorfer, W. F. Scherer, F. J. Roth, H. H. Shear, and D. T. Imagawa. Dr. Syverton also attended the meetings of the American Epidemiology Society in Washington, D.C.

On April 11 and 12, Doctors Roy G. Holly, Donald W. Freeman, and Rodney F. Sturley, all of the Department of Obstetrics and Gynecology, spoke at the meeting of the South Dakota Chapter of the American Academy of General Practice at Huron, South Dakota.

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Publications of the Medical School Faculty

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III. UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
WEEKLY CALENDAR OF EVENTS

Physicians Welcome

May 4 - 9, 1953

Monday, May 4

Medical School and University Hospitals

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; W-612, U. H.

10:00 - 12:00 Neurology Rounds; A. B. Baker and Staff; Station 50, U. H.

11:30 - Tumor Conference; Doctors Kremen, Moore, and Stenstrom; Todd Amphitheater, U. H.

11:30 - 12:30 Physical Medicine Seminar; Rehabilitation Techniques with Braces and Crutches; Sarah Gault; Heart Hospital Auditorium.

12:15 - Obstetrics and Gynecology Journal Club; Staff Dining Room, U. H.

12:30 - 1:30 Physiology and Physiological Chemistry Seminar; 214 Millard Hall.

1:30 - 2:30 Pediatric-Neurological Rounds; R. Jensen, A. B. Baker and Staff; U. H.

4:30 - ECG Reading Conference; James C. Dahl, et al; Staff Room, Heart Hospital.

4:30 - Public Health Seminar; 15 Owre Hall.

4:30 - 6:00 Physiology 114A and Cancer Biology 140 -- Research Conference on Cancer, Nutrition, and Endocrinology; Drs. Visscher, Bittner, and King; Role of Adrenalectomy in the Control of Metastatic Breast Cancer; Claude R. Hitchcock; 129 Millard Hall.

5:00 - 6:00 Urology-Roentgenology Conference; C. D. Creevy, O. J. Baggenstoss, and Staff; Eustis Amphitheater.

* 7:45 p.m. Seminar on History of Medicine; The History of Colon Surgery; Dr. William C. Bernstein, Clinical Assistant Professor, Department of Surgery, University of Minnesota Medical School; Todd Amphitheater, U. H.

Ancker Hospital

8:30 - 10:00 Tuberculosis and Chest Conference; Auditorium.

2:00 - 3:00 Surgery Journal Club; Classroom.

Minneapolis General Hospital

9:30 - Pediatric Rounds; Eldon Berglund; Newborn Nursery, Station C.

10:30 - 12:00 Tuberculosis and Contagion Rounds; Thomas Lowry; Station M.

11:00 - Pediatric Rounds; Erling Platou; Station K.

12:30 - Surgery Grand Rounds; Dr. Zierold; Sta. A.

Monday, May 4 (Cont.)

Minneapolis General Hospital (Cont.)

1:00 - X-ray Conference; Classroom, 4th Floor.

2:00 - Pediatric Rounds; Robert A. Ulstrom; Stations I and J.

Veterans Administration Hospital

1:30 - Cardiac Rounds; Drs. Ebert and Berman, and Richards.

4:00 - ECG Conference; Drs. Ebert, Berman, and Simonson.

Tuesday, May 5

Medical School and University Hospitals

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

9:00 - 12:00 Cardiovascular Rounds; Station 30, U. H.

12:30 - 1:20 Pathology Conference; Autopsies; J. R. Dawson and Staff; 102 I. A.

12:30 - 1:30 Physiology 114D -- Current Literature Seminar; 129 Millard Hall.

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

4:30 - 5:30 Clinical-Medical-Pathological Conference; Todd Amphitheater, U. H.

4:30 - ECG Reading Conference; James C. Dahl, et al; Staff Room, Heart Hospital.

5:00 - 6:00 X-ray Conference; Presentation of Cases from Ancker Hospital; Drs. Aurelius, Peterson, and Azad; Eustis Amphitheater, U. H.

Ancker Hospital

9:00 - 10:00 Medical X-ray Conference; Auditorium.

Minneapolis General Hospital

10:00 - Pediatric Rounds; Spencer F. Brown; Stations I and J.

10:30 - 12:00 Medicine Rounds; Thomas Lowry and Staff; Station F.

12:30 - Grand Rounds; Fractures; Willard White, et al; Sta. A.

12:30 - Neuroroentgenology Conference; O. Lipschultz, J. C. Michael and Staff.

12:30 - EKG Conference; Boyd Thomes and Staff; 302 Harrington Hall.

1:00 - Tumor Clinic; Drs. Eder, Cal, and Lipschultz.

1:00 - Neurology Grand Rounds; J. C. Michael and Staff.

Veterans Administration Hospital

7:30 - Anesthesiology Conference; Conference Room, Bldg. I.

8:45 - Surgery Journal Club; Conference Room, Bldg. I.

9:30 - Infectious Disease Rounds; Drs. Hall and Zinneman.

9:30 - Surgery-Pathology Conference; Conference Room, Bldg. I.

Tuesday, May 5 (Cont.)

Veterans Administration Hospital (Cont.)

10:30 - Surgery-Tumor Conference; L. J. Hay, J. Jorgens; Conference Room, Bldg. I.

1:00 - Review of Pathology, Pulmonary Tuberculosis; Conference Room, Bldg. I.

1:30 - Combined Medical-Surgical Chest Conference; Conference Room, Bldg. I.

2:00 - 2:50 Dermatology and Syphilology Conference; H. E. Michelson and Staff; Bldg. III.

Wednesday, May 6

Medical School and University Hospitals

8:00 - 9:00 Roentgenology-Surgical-Pathological Conference; Paul Lober and L. G. Rigler; Todd Amphitheater, U. H.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Pediatrics Case; O. H. Wangensteen, C. J. Watson and Staffs; Todd Amphitheater, U. H.

12:30 - 1:20 Radio-Isotope Seminar; Treatment of Hyperthyroidism with Radioactive Iodine--Review of Cases; L. Schulz; 12 Owre Hall.

1:30 - 3:00 Physiology 114B -- Circulatory and Renal System Problems Seminar; Dr. M. B. Visscher, et al; 214 Millard Hall.

4:00 - 5:30 Physiology 114C -- Permeability and Metabolism Seminar; Nathan Lifson; 214 Millard Hall.

4:30 - ECG Reading Conference; James C. Dahl, et al; Staff Room, Heart Hospital.

5:00 - 5:50 Urology-Pathological Conference; C. D. Creevy and Staff; Eustis Amphitheater.

8:00 - 10:00 Dermatological-Pathology Conference; Review of Histopathology Section; R. Goltz; Todd Amphitheater, U. H.

Ancker Hospital

8:30 - 9:30 Clinico-Pathological Conference; Auditorium.

12:30 - 1:30 Medical Journal Club; Library.

Minneapolis General Hospital

9:30 - Pediatric Rounds; Max Seham; Stations I and J.

10:30 - 12:00 Medicine Rounds; Thomas Lowry and Staff; Station D.

11:00 - Pediatric Seminar; Arnold Anderson; Classroom, Station I.

11:00 - Pediatric Rounds; Erling S. Platou; Station K.

12:00 - Surgery Seminar; Dr. Zierold; Classroom.

12:15 - Pediatric Staff Meeting; Classroom, Station I.

1:30 - Visiting Pediatric Staff Case Presentation; Station I, Classroom.

Wednesday, May 6 (Cont.)

Veterans Administration Hospital

8:30 - 10:00 Orthopedic X-ray Conference; E. T. Evans and Staff; Conference Room; Bldg. I.

8:30 - 12:00 Neurology Rehabilitation and Case Conference; A. B. Baker.

9:00 - Gastro-Intestinal Rounds; Drs. Wilson, Nesbitt, Zieve, Hay and Goodnow.

12:30 - X-ray Conference; J. Jorgens; Conference Room, Bldg. I.

2:30 - 4:00 Psychosomatic Rounds; C. K. Aldrich; Conference Room, Bldg. I.

4:00 - Combined Medical Surgical Conference; Drs. Flink and Hay; Conference Room, Bldg. I.

7:00 p.m. Lectures in Basic Science of Orthopedics, Conference Room, Bldg. I.

Thursday, May 7

Medical School and University Hospitals

8:00 - 9:00 Vascular Rounds; Davitt Felder and Staff Members from the Departments of Medicine, Surgery, Physical Medicine, and Dermatology; Heart Hospital Amphitheater.

9:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

11:00 - 12:00 Cancer Clinic; K. Stenstrom and A. Kremen; Todd Amphitheater, U. H.

12:30 - Physiological Chemistry Seminar; Introduction to Scientific Research -- Analysis of Experimental Data; Christine Jardetzky; 214 Millard Hall.

1:30 - 4:00 Cardiology X-ray Conference; Heart Hospital Theatre.

4:00 - 5:00 Physiology-Surgery Conference; Todd Amphitheater, U. H.

4:30 - ECG Reading Conference; James C. Dahl, et al; Staff Room, Heart Hospital.

5:00 - 6:00 Radiology Seminar; Medical Teaching Mission to India; Leo G. Rigler; Eustis Amphitheater, U. H.

7:30 - 9:30 Pediatric Cardiology Conference and Journal Club; Review of Current Literature 1st hour and Review of Patients 2nd hour; 206 Temporary West Hospital.

* 8:15 p.m. E. Starr Judd Lectureship; The Endocrinology of Mammary Cancer; Dr. Charles B. Huggins, Professor of Surgery, University of Chicago; Owre Amphitheater.

Ancker Hospital

8:00 - 10:00 Medical Grand Rounds; Auditorium.

Minneapolis General Hospital

9:30 - Neurology Rounds; Heinz Bruhl; Station I.

10:00 - Pediatric Rounds; Spencer F. Brown; Station K.

10:00 - Psychiatry Grand Rounds; J. C. Michael and Staff; Sta. H.

Thursday, May 7 (Cont.)

Minneapolis General Hospital (Cont.)

11:30 - 12:30 Clinical Pathological Conference; John I. Coe; Classroom.

1:00 - Fracture - X-ray Conference; Dr. Zierold; Classroom

1:00 - House Staff Conference; Station I.

2:00 - 4:00 Infectious Disease Rounds; Classroom.

4:00 - 5:00 Infectious Disease Conference; Wesley W. Spink; Classroom.

Veterans Administration Hospital

8:00 - Surgery Grand Rounds; Conference Room, Bldg. I.

8:00 - Surgery Ward Rounds; Lyle Hay and Staff; Ward 11.

11:00 - Surgery-Roentgen Conference; J. Jorgens; Conference Room, Bldg. I.

1:00 - Metabolic Disease Conference; Drs. Flink, Heller, and Jacobson, and Bolin.

Friday, May 8

Medical School and University Hospitals

8:00 - 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.

10:30 - 11:50 Medicine Rounds; C. J. Watson and Staff; Todd Amphitheater, U. H.

10:30 - 1:50 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department, U. H.

11:45 - 12:50 NO HOSPITAL STAFF MEETING TODAY.

1:00 - 2:50 Neurosurgery-Roentgenology Conference; W. T. Peyton, Harold O. Peterson and Staff; Todd Amphitheater, U. H.

3:00 - 4:00 Neuropathological Conference; F. Tichy; Todd Amphitheater, U. H.

4:00 - 5:00 Physiology 124 -- Seminar in Neurophysiology; Ernst Gelhorn; 113 Owre Hall.

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

4:30 - ECG Reading Conference; James C. Dahl, et al; Staff Room, Heart Hospital.

5:00 - Urology Seminar and X-ray Conference; Eustis Amphitheater, U. H.

Ancker Hospital

1:00 - 3:00 Pathology-Surgery Conference; Auditorium.

Minneapolis General Hospital

9:30 - Pediatric Rounds; Wallace Lueck; Station J.

10:30 - Pediatric Surgery Conference; Oswald Wyatt; Tague Chisholm; Station I, Classroom.

Friday, May 8 (Cont.)

Minneapolis General Hospital (Cont.)

12:00 - Surgery-Pathology Conference; Dr. Zierold, Dr. Coe; Classroom.

1:00 - 3:00 Clinical Medical Conference; Thomas Lowry; Classroom, Station M.

1:15 - X-ray Conference; Oscar Lipschultz; Classroom, Main Bldg.

2:00 - Pediatric Rounds; Robert Ulstrom; Stations I and J.

Veterans Administration Hospital

10:30 - 11:20 Medicine Grand Rounds; Conference Room, Bldg. I.

1:00 - Pathology Slide Conference; E. T. Bell; Conference Room, Bldg. I.

2:00 - Autopsy Conference; E. T. Bell and Donald Gleason; Conference Room, Bldg. I.

Saturday, May 9

Medical School and University Hospitals

7:45 - 8:50 Orthopedic X-ray Conference; W. H. Cole and Staff; M-109, U. H.

9:00 - 10:00 Infertility Conference; Louis L. Friedman, David I. Seibel, and Obstetrics Staff; Eustis Amphitheater, U. H.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater.

9:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; Heart Hospital Amphitheater.

9:15 - 10:00 Surgery-Roentgenology Conference; L. G. Rigler, J. Friedman, Owen H. Wangensteen and Staff; Todd Amphitheater, U. H.

10:00 - 11:30 Surgery Conference; Todd Amphitheater, U. H.

10:00 - 12:50 Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U. H.

11:30 - Anatomy Seminar; Effects of Growth Hormone upon Fetuses; Carl B. Heggestad; 226 Institute of Anatomy.

Ancker Hospital

8:30 - 9:30 Surgery Conference; Auditorium.

Minneapolis General Hospital

8:00 - Urology Staff Conference; T. H. Sweetser; Main Classroom.

11:00 - 12:00 Medical - X-ray Conference; O. Lipschultz, Thomas Lowry, and Staff; Main Classroom.

Veterans Administration Hospital

8:00 - Proctology Rounds; W. C. Bernstein and Staff; Bldg. III.

8:30 - 11:15 Hematology Rounds; Drs. Goldish and Bolin, and Howard.
11:15 - 12:00 Morphology . . . . . Dr. Aufderheide, Conference Room.

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* Indicates special meeting. All other meetings occur regularly each week at the same time on the same day. Meeting place may vary from week to week for some conferences.