Bulletin of the

University of Minnesota Hospitals
and
Minnesota Medical Foundation

Social Service Reports

Volume XX | Friday, April 29, 1949 | Number 25

BULLETIN OF THE
UNIVERSITY OF MINNESOTA HOSPITALS
and
MINNESOTA MEDICAL FOUNDATION

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INDEX

Published weekly during the school year, October to June, inclusive.

Address Communications to: Staff Bulletin, 332M University of Minnesota Hospitals, Minneapolis 14, Minnesota.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

May 1 - 7, 1949

No. 246

Sunday, May 1, 1949

9:00 - 10:30 Surgery Grand Rounds; Station 22, U. H.

10:30 - 11:00 Clinical Evaluation of Vagotomy for Peptic Ulcer; Clark Marshall; Rm. M-109, U. H.

Monday, May 2

8:00 - Fracture Rounds; A. A. Zierold and Staff; Ward A, Minneapolis General Hospital.

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; M-109, U. H.

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

11:00 - 11:50 Physical Medicine Seminar; Oximetry in 1948 Poliomyelitis Epidemic; G. K. Stillwell; E-101, U. H.

11:00 - 11:50 Roentgenology-Medicine Conference; Veterans Hospital.

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

12:00 - 1:00 Physiology Seminar; Production of Gamma Globulin by the Mammary Gland; William E. Peterson; 214 M. H.

12:15 - 1:20 Obstetrics and Gynecology Journal Club; Staff Dining Room, U. H.

12:30 - 1:20 Pathology Seminar; A Report of Boston Meeting; James McCartney; 104 I. A.

12:30 - 1:30 Surgery Problem Case Conference; A. A. Zierold, C. Dennis and Staff; Small Class Room, Minneapolis General Hospital.

1:30 - 2:30 Surgery Grand Rounds; A. A. Zierold, C. Dennis and Staff; Minneapolis General Hospital.

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

4:00 - Public Health Seminar; 113 Medical Sciences.

5:00 - 5:50 Clinical Medical Pathologic Conference; Todd Amphitheater, U. H.

5:00 - 6:00 Urology-Roentgenology Conference; D. Creevy and H. M. Stauffer and Staffs; M-109, U. H.

Tuesday, May 3

8:00 - 9:00 Fracture Conference; Auditorium, Ancker Hospital.

8:30 - 10:20 Surgery Seminar; Surgery of Bleeding Ulcer; D. C. MacKinnon; Small Conference Room, Bldg. I, Veterans Hospital.

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

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and Robert Hebbel; Veterans Hospital.

12:30 - Pediatric-Surgery Rounds; Sta. I, Minneapolis General Hospital; Drs. Bosma, Wyatt, Chisholm, McNelson and Dennis.

12:30 - 1:20 Pathology Conference; Autopsies; Pathology Staff; 102 I. A.

1:00 - 2:30 X-ray Surgery Conference; Auditorium, Ancker Hospital.

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

4:00 - 5:30 Physiology-Surgery Conference; Posture and Vital Capacity; G. Lenz & G. Campbell; Eustis Amphitheater, U. H.

5:00 - 5:50 Urology-Pathological Conference; C. D. Creevy and Staff; Todd Amphitheater, U. H.

5:00 - 6:00 X-ray Conference; Drs. Rigler, Stauffer and Staff; Todd Amphitheater, U. H.

Wednesday, May 4

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

8:30 - 9:30 Clinico-Pathological Conference; Auditorium, Ancker Hospital.

8:30 - 10:00 Orthopedic-Roentgenologic Conference; Edward T. Evans, Room 1AW, Veterans Hospital.

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

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

12:00 - 12:50 Radio-Isotope Seminar; Dosage Determination with Radio-Active Isotopes -- Practical Consideration in Therapy and Protection; James Marvin; Rm. 212, Hospital Court, Temp. Bldg.

3:30 - 4:30 Journal Club; Surgery Office, Ancker Hospital.

Thursday, May 5

8:15 - 9:00 Roentgenology-Surgical-Pathology Conference; Craig Freeman and H. M. Stauffer; M-109, 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; M-109, 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 Cancer Clinic; K. Stenstrom and A. Kremen; Todd Amphitheater, U. H.

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

12:00 - 1:00 Physiological Chemistry Seminar; Effect of pH on Respiration of Brain Tissue; Arnold Osterberg; 214 M. H.

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

2:00 - 3:00 Errors Conference; A. A. Zierold, C. Dennis and Staff; Large Class Room, Minneapolis General Hospital.

4:00 - 5:00 Bacteriology and Immunology Seminar; Chemotherapy of Brucellosis in the Chick Embryo; R. L. Magaffin; 214 M. H.

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

5:00 - 6:00 Urology Seminar; Incontinence in Children; Robert Evert; E-101, U. H.

5:00 - 6:00 X-ray Seminar; Congenital Dislocation of the Hip; Vernon Hart; Todd Amphitheater, U. H.

Friday, May 6

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, O. S. Wyatt, A. V. Stoesser and Staffs; Minneapolis General Hospital.

11:30 - 12:50 University of Minnesota Hospitals General Staff Meeting; Penathol-Curare Mixture with Endotracheal Nitrous Oxide and Oxygen in Infants; Christine Furman and Frederick H. Van Bergen; Powell Hall Amphitheater.

12:00 - 1:00 Surgery Clinical Pathological Conference; Clarence Dennis and Staff; Large Classroom, Minneapolis General Hospital.

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 - 3:00 Pathology-Surgery Conference; Auditorium, Ancker Hospital.

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

4:00 - 5:00 Electrocardiographic Conference; George N. Aagaard; 106 Temp. Bldg., Hospital Court, U. H.

Saturday, May 7

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; Station 20, U. H.

8:30 - 9:30 Surgery Conference; Auditorium, Ancker Hospital.

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

8:00 - 9:00 Surgery Literature Conference; Clarence Dennis and Staff; Minneapolis General Hospital, Small Classroom.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; E-101, U. H.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amph., U. H.

9:00 - 11:30 Surgery-Roentgenology Conference; Todd Amphitheater, U. H.

9:00 - 12:00 Neurology Conference; Powell Hall Amphitheater.

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

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

11:00 - 12:00 Anatomy Seminar; Bone Marrow in Infectious Mononucleosis, Ruth Hovde; Comparisons of Granulomatous Lesions in Infectious Mononucleosis and Brucellosis, Sarcoidosis and Tuberculosis, R. Dorothy Sundberg; 226 I. A.

II. SOCIAL SERVICE REPORTS

SOCIAL SERVICE DEPARTMENT

Annie Laurie Baker

The social service department shares the same responsibility for teaching, research, and services to patients as do the other departments of the hospital. Our program has always been primarily focused on service to patients, but for the past several years, the staff has engaged in an extensive teaching program. We have long been responsible for teaching graduate students of the school of social work, and in the past few years have participated in the teaching of nurses, nutritionists, occupational therapists, and other allied groups in the hospital.

Because we have never felt we had the time to devote to it, we, as a department, have never done research, although we realize that the opportunities here are exceedingly great. However, we have always had graduate students doing projects for advanced degrees.

At these medical staff meetings, the various departments have frequently reviewed the research which their departments have done, so we thought we would give you the high lights of three studies made by members of our staff who are working for their masters degree from the School of Social Work.

The department has a group of graduate students who are always interested in study projects and since we maintain a close relationship with the county agencies, it is possible for us to secure information about patients. We should be most happy to consider working on studies which you may be doing where you feel that information about the patient's family, home life and social adjustment would be valuable in your research. The three studies we are reviewing for you are on topics which are of special concern to us, and, we belive, will be of interest to you.

1. FACTORS IN PATIENT'S ADJUSTMENT TO REST HOME CARE

Helen Kretchmer

The privately owned rest homes in Minneapolis and St. Paul become a permanent home for many patients who need continued nursing care and cannot obtain such care in their own community. They also make it possible for our hospital to treat a good many patients on an outpatient basis. Whatever our problems are in making use of their facilities or theirs in taking our patients, the fact remains that they are a necessary adjunct to the hospital.

Each rest home has its individual personality, largely reflected from the attitudes of its proprietor. Some prefer women, most prefer men, and a few limit the diagnostic groups they will accept. One preferred to specialize in post-surgical patients as this group presented the greatest nursing challenge. Another preferred diabetics and a third, aged persons where senility was a greater problem than nursing care. To date none had developed a particular liking for the unlucky patient equipped with an indwelling catheter. We also have our preferences in choice of rest homes to fit the need of individual patients, not only for standards of care but for physical facilities and staff personalities. Patients are sent to rest homes not only for active nursing care and special diets, but for physical inability to climb stairs, go to meals, dress and feed themselves; assistance in preparation for examinations for reasons of blindness, senility, feeblemindedness.

According to a study done by the director of our department, 51 people were placed in rest homes from University Hospitals during the month of March - 41 men and 10 women. 32 of these people were placed from the outpatient clinics, W212, and Admissions, 19 were placed from the house. 17 went to Parkview Hospital, a 160 bed facility north of Camden, and 12 to Central Hospital, another large rest home. The others went to seven small rest homes, with the ex-

ception of one placement at Our Lady of Good Counsel, a free home for cancer care. Estimating an average stay of ten days at a minimum charge per day of $5.00, University Hospitals business averages a gross of $2500 per month to the local rest homes. Most of our patients come from distant counties and the rest homes of ten have delays and difficulty in collecting the money due them. Since most rest home care is usually paid by the county from which the patient comes, delay and difficulty in collection is often met, partly because of distance and lack of direct contact between the rest home proprietors and the county welfare boards. Our department is responsible for placement and supervision of patients in rest homes. We try to determine who will pay for the patient's care before placement is made. The new patient is often thoroughly convinced that he is to have a hospital bed on arrival. He is not too amenable to the suggestion that he is to go to a rest home half way across town and have to arrange payment for it besides. We found that half the placements required contacting the county or township to guarantee rest home care. Some rest homes refuse patients from certain counties because of past experience in attempting to collect bills. We try to make a clear cut arrangement before placing the patient to prevent these financial problems that might prevent later patients from finding a place to stay.

During the past year, our department became concerned about the out of town patients left in Minneapolis and St. Paul rest homes after the period of active medical care was past. We knew that some patients could not return to their home communities because there were no nursing homes in the county and they had no family who could care for them. We questioned whether the patients remained under constant or sporadic supervision of our hospital, whether they were transferred to a doctor in the community or stayed in the rest home without current medical recommendations. Did their family and friends still visit or were contacts with their communities broken by distance? Did they have the opportunity and flexibility to establish new contacts here? Because we do not necessarily follow long time patients in the rest homes, and as the social workers in this department do not visit patients in rest homes, it seemed desirable to make a survey of the individual adjustment of a number of patients in rest homes.

Twenty-seven patients in seven rest homes were interviewed in relation to different aspects of their adjustment. Each of these patients had been in their respective placements over ten days. The length of placement was found to vary from 14 days to 5½ years. Ten patients had lived in the same rest home three years or more. Twenty three of the group were receiving chronic care. Three of the 27 were receiving convalescent or temporary care while going through University Hospitals clinics. Only three of the chronic care patients had a chance of returning to their previous living situation. I went to see the patients in their respective rest homes so that we could know more about how they lived, and know the proprietors and nurses better.

The age of the patients interviewed varied from 26 to 86, a span of 60 years. The eight patients from 30 to 60 were grossly handicapped and three were completely bedfast. Three of this group had multiple sclerosis and two were arthritics. The younger patients seemed to accept things as they were. They knew that their diagnosis, disability and home situation make it necessary for them to remain in the nursing home indefinitely. Their adjustment was tempered by the knowledge that they would want another way of living if it were physically possible. The youngest patient, age 26, did the bookkeeping for the rest home where he lived, took correspondence courses in accounting and played the guitar in his spare time. His main hope was that he would have a roommate near his own age and interests. The oldest patient, aged 86, read his Bible and listened to the radio during his waking hours. His principal concern was whether he would get the customary allowance of five dollars for incidental expenditures

from the Old Age Assistance Division. Some of the older patients with no close family ties and no promise of a more interesting life on the outside accepted the rest home as the best living situation for them. One patient I interviewed talked of nothing but his fear that the county welfare board would send him back to the rest home where he had fallen and broken the hip that cost him two years of invalidism. His home had been broken by divorce and his children were uninterested in him. He hoped to remain in the rest home. On the other hand, one 75 year old talked of nothing but getting back to his little shack by April 25th because he expected a consignment of baby chicks on that date and he wanted to have the brooder house warm when they arrived. A 76 year old patient with terminal cancer and a double colostomy exercised daily in the hope that he might gain enough strength to move back to his housekeeping room on lower Washington Avenue.

Twenty two of the patients were under the supervision of University Hospitals clinics. One was seen in the clinic once a day and some came at intervals as long as three to six months. Three of the patients were under care of the rest home's house doctor and two said they were under no doctor's care but knew that the nurse would call the house doctor if they needed medical attention. Most were satisfied with their medical attention. The few complaints were that they did not receive enough information from their doctor about their current medical situation. The nurses and house doctors also said that they seldom received enough information from the hospital about diagnosis and recommendations for care to be able to give adequate help in case of an emergency. The house doctors also wanted a fully detailed written referral from our doctors when they assumed the total care of a patient discharged from medical supervision here.

The majority of the patients were satisfied with the nursing service received. There were some reports of personality clashes and too rapid turnover of personnel for care. The complaints were principally in regard to care given by employees who were not graduate nurses.

Six of the patients were totally bedfast, 9 were able to use wheelchairs and 12 were considered ambulatory. Three of the wheelchair patients were double amputees. The majority of the patients who used wheelchairs were in a rest home with an elevator and ambulance entrance so they were able to go outside in good weather. The lavatory facilities were arranged so they could care for themselves quite independently. One of the greatest problems in facilities for the long time patient living in a large ward was lack of storage space for personal belongings, reading lights and privacy. The rooms for one to five patients usually were equipped with a dresser and closet besides a bedside stand, had better reading lights and provision for radios. Only one rest home had a telephone where the patient could call out, and only one had a regular plan of weekly shopping for the patients. The food seemed to elicit a variety of responses. In one home, one patient said the food was not good and another said it was wonderful. One bedfast patient said her day was ruined by starting off with a cold lump of cooked cereal and another bedfast patient in the same place said he often wondered how the kitchen could manage to serve so many patients and keep the food hot when it arrived on the tray. The standards by which the patients judged the food and the standards we would like to see met in preparation of special diets were not always compatable. One diabetic patient whose wife could not keep him out of the bread box at home was accepting his diet uncomplainingly in the nursing home. Two of the younger patients would like to see more fruits and green vegetables in the diet and one suggested that a dietetic consultant be made available to the rest homes who did not regularly employ a dietitian.

The frequency with which families visited the patients seemed to be related more to a feeling of family responsibility than to how far away they lived, how long the patient had been in the rest home or

how the patient got along with his family. Few of the patients had immediate families. Twelve lived alone before entering the nursing home, three lived with a brother or sister, three with children, three with parents, and six were married. Nine of the patients were widowed, 11 were single and one was divorced. Only fourteen of the patients had family visitors more than once a month and six had none.

The patients who had infrequent visitors seized the opportunity to be entertained and to entertain in return. One old gentleman rather outdid the others in hospitality. After cooperating politely in the interview, he showed me a picture of himself as a stiff, bespectacled cadet in Kaiser Wilhelm's army. He wrote the opening lines of the Odyssey in Greek, divided Gaul in three parts in French. Then he wanted to know if I would like to see his hernia.

Four of the patients had contact with ministers of their own church and eight preferred to see none. Three of the patients had no contact with the other patients in the rest home, although most visited with one another. One man said he did not mind seeing none of his family, "the fellers in my ward are good enough for me." Volunteers in most of the rest homes were limited to religious groups, frequently Bible school students. Some of the patients welcomed this entertainment, but some thought the students were practicing on them and made them feel bad.

The nursing home personnel formed the contact with the outside for those who had no family or friends or saw them seldom. The nurses and proprietors did their shopping, sometimes gave them spending money and, in more than one instance, provided clothing. One patient was supplied with clothing, given a $30.00 a month reduction in cost of care so she would not be moved from what she considered her home, and was given an allowance that she was helped to understand as pay for the few services she was able to give.

Only one patient had made new friends locally while in the rest home, She was a member of a fraternal organization.

The care of the majority of the patients was being paid by county welfare boards. Representatives of these agencies saw the patients seldom, except for those whose placements were supervised by Hennepin County. The Hennepin County social workers visited their patients about once a month. It seemed advisable that all out of town patients be referred to Hennepin County Welfare Board workers for help in meeting their problems. The average patient on Old Age Assistance received from three to five dollars a month for spending money. Some of the patients received money from their families and several had no income at all.

At the time the twenty seven patients were studied, there were none whose family and medical situations indicated they could receive adequate care outside a rest home. A number could have been cared for in their local communities had there been facilities to meet the need. Most of these patients will continue to live on in rest homes. We feel that a cooperative relationship with the rest home personnel is essential in arranging the best possible living situation for patients requiring long time, chronic care.

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2. STUDY OF REFERRALS TO SOCIAL SERVICE

Rose Baldwin

We conducted a study of fifty referrals to the social service by the doctors on the Neurosurgery, Urology, and Tumor clinical services, and Station 31, Medicine and Dermatology hospital station. Our study included the social problems presented by the doctor and their relationship to the medical problems. We considered further the extent to which the

doctor was informed of the continued activity of social service and whether there was some report to him of the progress or outcome of the referral.

We were interested in this study for two different reasons: to evaluate the adequacy of our service to the medical staff and the patient, and to measure our work against the standards of the American Association of Medical Social Workers. In judging the adequacy of our service we considered the way in which our work measured against the requirements of the original request and the problems we found in further discussion with the patient. We are aware that in thinking about this we have only our own viewpoint, for the most part, and would need to know as much about the attitudes of the doctor and the patient who were also involved in each situation for a final determination.

In consideration of the second point of measurement of service against the standards of the American Association of Medical Social Workers, we considered the definition which appears in the interns manual, page 74, for medical social case work. "Medical Social Case Work involves the study of the patient's social situation, interests, and needs in relation to his illness, and the medical social treatment of the patient in collaboration with him and his physician, when these social needs and interests affect the physical and mental health of the patient. The aspect of study mentioned in the first half of this definition is an integral part of the case work process with patients and continues as part of the interviewing and treatment planning. In treatment we mean providing the medical staff with information about the patient which will assist him in his treatment and effecting the personal and environmental changes which are essential for the full benefit of medical care.

We are making a subjective measure of this material, and like to ask you, therefore, to kindly interpret as such. Our purpose was to make a survey of what we were doing in comparison with what was asked of us with the goal in mind of improving our service to our medical staff and patients. We had the second objective of measuring our work at University Hospitals against the standards of the field of Medical Social Work as a whole.

We have a reason which is basic to our service for being interested in referrals from you. Patients who come to University Hospitals do so because they are seeking relief from illness and want the help of doctors. They do not come because they want help for social problems which may be caused or contributed to by their illness. If they have social problems they are seeking help elsewhere or think they can or must handle them themselves.

We believe we should consider the decision patients make in the evaluation of their problems and give every consideration to the fact that these people are seeking medical help for the relief of illness. A patient should have the same choice in seeing a medical social worker that he has in consulting a social worker in a family agency about a family problem. Since the patient is seeking medical care the help we give him should be integrated with his medical program.

In addition to referrals for case work service, we accept as part of our hospital function many tasks of an administrative nature which would give little reason for discussion or direct referral. Also some referrals come from social or medical agencies outside of the hospital and non-medical staff within the hospital which involve serious social problems, but in assisting patients with these, we should do so with the knowledge of the doctor responsible for medical care. We are interested in referrals therefore because we are dependent upon them for the work we do. There is truth in the statement that "we cannot do more than we are asked to do", and should respect the right of the patient to include medical social work in his program or to have his doctor inquire if he wishes to utilize such help.

This picture is presented as it appears to us with the realization that it is the social service point of view. For further interpretation, we should have the opinions of the doctors who are responsible for the medical care of these patients in the light of our objective in making this study to improve our service to the patients and the medical staff.

These fifty referrals were collected on a non-selective basis during a six-week period. Sixteen days were included in all with intervening days of the same number in order to include variations which might arise in different periods of the month. About two-thirds were new referrals, and one-third had previously been known to the social service department. All fifty of the referrals were interesting and valuable for purposes of this study. In all cases the doctors indicated both the social problems present, and medical condition to be taken into consideration. We found on further discussion with the doctors that they were well acquainted with the patients as individuals and had made an accurate estimation of the social difficulties of these people. The doctors also had an idea in mind of what social service might do to assist these patients.

There were some characteristics the group had in common, both in the medical and social problems. Sixty per cent of the patients in the group had far advanced cancer. Forty per cent were considered terminal. A number of patients died during the course of this study or were expected to do so within a few months. One case is included in the discussion following which indicates the serious social problems attendant on terminal cancer. Problems of a serious nature were found in many family groups in which a parent had far advanced cancer, and individuals got into similarly serious difficulty because of prolonged unemployment, anxiety about the illness, and loss of community ties. These far advanced cancer cases occurred on the medical and urological services as well as in tumor clinic. An additional twenty-five per cent had serious medical diagnosis such as brain tumor, or tuberculosis, or malignant hypertension, with attendant social problems of a critical nature. Ten per cent who had severe emotional disturbance and less critical physical illness complete ninety-five per cent of the total. These also were in social difficulty of a serious nature.

In working with this patient group we contended with complicating factors in that seventy-five per cent of the patients lived out of Minneapolis, half of them were over fifty years of age, and eighty per cent were over thirty-five years of age. We have given an indication in the three case situations which we discussed as to what social service can do to relieve such very difficult social situations.

In the first instance the problem was family breakdown because the illness of the patient which had greatly affected his personality. Our work in this situation was with the family because the illness of the patient progressed to a point that he had to be committed to state guardianship and we could be of no direct assistance to him. In the second situation we helped to reinforce the efforts which a woman with terminal cancer was making to plan for her family. In the third situation the family had completely broken down temporarily because of the illness of both parents and we were required to seek outside assistance for the children. We are presenting these three situations because they indicate the related seriousness of the medical and social problems of our patients and the awareness which our doctors have of these needs. These fifty referrals would indicate that there are almost always severe repercussions in the environment of the patient from such prolonged and serious illness. The problems with this particular patient group seem to be of such a serious nature that the case work approach can only be in terms of giving a patient a chance to express his resentment of overwhelming odds, helping him to accept his difficult medical and social picture,

and to utilize what few opportunities are offered for improvement of his situation.

The first patient referred to previously mentioned an operation for the removal of a brain tumor two years prior to his referral. The patient had returned to his employment as an engineer following his operation. The family group was a stable middle class unit, and attractive intelligent couple in their forties with two adolescent children. The patient had gotten along well and worked steadily for two years and he and his wife had almost succeeded in forgetting the warning of the doctor that the tumor would recur,--that it would probably be inoperable, and that the wife should expect changes in the personality of her husband. They had begun to get into difficulties a few weeks before they were first referred and had spoken a number of times to the doctor who asked the social worker to see them. The patient was doing a highly technical kind of work involving the care of heating and electrical units for a number of office buildings in Minneapolis and was afraid that the forgetfulness, and dizziness, and blurring of vision that he was noticing would cause him to make a mistake in his work which would destroy lives or property. To a non-medical person during an interview at this time he seemed alert and intelligent and in excellent condition beyond the fact that he seemed watchful of himself and what he was saying lest he should unconsciously make an error. He had stopped his work and was waiting for the recommendation from the doctor so that he could return to it. The doctor did not feel that he could give this recommendation.

The doctor referred this patient to social service because the family was unable to support itself, and pay for medical care. He thought further that the social service worker might be able to assist the wife by talking over with her the anxieties she had.

There were rapid changes in the personality of this patient and two weeks later when the worker talked with him briefly on Station 60, he could not carry on a conversation. He was committed to a state hospital.

The wife of this patient was an adequate person who will probably succeed within a short time in readjusting her family life. She seemed torn between wanting to take care of her husband herself and feeling that she and the children might be injured by him, and she knew that he might have a bad influence on the children and that he would be gossiped about by the neighbors because of his strange behavior. It seemed of great importance to her that her neighbors recognize that he was not really insane but had a brain tumor. However, she did not feel she could discuss this with her friends or relatives. The worker let her discuss this question, and supported what she seemed to feel was a hostile act against her husband in having him committed to a state hospital. She carried through with the commitment procedure but was unable to accept the fact that her husband did not receive individual attention at a state hospital, and was treated like an insane rather than a sick person. She took him out of the state hospital within three weeks and had him moved to a private hospital, and later took care of him at home with the aid of a practical nurse. The social worker did not attempt to influence any of these decisions, but permitted this woman a chance to discuss them. She has entirely resumed responsibility for her problem herself. The last time she was in she spoke about making arrangements to get a job.

In our evaluation of this case against standards of service to the doctor and the patient, and the standards of the American Association of Social Workers, we considered that the doctor had recognized clearly the social problems present at the time he made the first referral. He had talked over the medical diagnosis with the patient and his wife, and in telling them that he did not feel the patient could return to work, he learned what the family anticipated their difficulties would be. He had already dis-

cussed with the patient and his wife previously the personality changes which were causing the patient and his wife so much anxiety. The social difficulties arose directly from the medical problems in this situation as the family was an adequate one, and would have continued to be without such a problem.

The social worker worked closely with the neurosurgery staff and the psychiatric service with the patient until his commitment to a state hospital. She continued contacts with the wife for some time after the patient was last seen by the medical staff in order to help her make plans for the future. The resident on Neurosurgery and the intern on Station 60 made several inquiries about the progress of this couple and a report was given on the completion of the service to the doctor who made the original referral. We think that social service did an adequate job in assisting this woman with her difficult problems and that our work would measure favorably against standards of the American Association of Medical Social Workers.

The second patient was referred to us because she had failed several appointments for tumor follow-up study. She had not responded to the routine follow-up letters. The worker found she lived in Minneapolis, and when she failed to respond to one letter, asked a worker from a local social agency to visit her. The agency worker called to report a serious family situation and made an appointment for the patient to talk with the worker. This patient came in about a week later and spent several hours weeping copiously and telling the worker why she considered herself at the end of her rope. Her medical diagnosis had been clarified for her about a year previously and the fact that she was a trained nurse gave her excellent understanding of the meaning of the metastasis from her cancer of the breast. She had received as much x-ray therapy as the medical staff thought would be helpful to her. She had felt from what the doctors told her that she would only live a few months. She had nothing but bitterness, it seemed, against fate for allowing her this extra year in which she had to watch the break-up of her happy home life.

Her husband had been missing for three days, and had taken all the money in the house, presumably to spend on liquor. Her six children were old enough to be humiliated by his behavior and needed his help as a parent since she could only live a short time. She said she was still fond of him, and realized he was upset, but was considering having him arrested for his behavior. She had asked the parish priest and the family doctor to talk with him, and apparently he had been severely reprimanded but it had done no good. She said she had thought during the past three years that they had won the long battle against his alcoholism, but he had started again the past few months and seemed worse than he had ever been. She said she wished she had not lived to see him like this again. She said she could have faced her cancer if her husband had behaved himself, or she could have handled her family problems if she had not had cancer, but the two problems were an impossible burden for any mortal and she couldn't stand them any longer.

The worker accepted the hostile attitude she had toward her husband and began discussing with her the practical steps to take in having him located and arrested. The worker emphasized the hostile judgments she was making of him and tried to help her figure out some way of keeping him permanently in prison. She began to defend him, and to describe how wonderful he had been about her illness for almost a year; that he had been cheerful and patient, and waited on her constantly, but that he seemed to wear out under the strain. She said he was a wonderful husband and father when he wasn't drinking. He was a devout Catholic, and several months previously had taken her to the Shrine of St. Anne De Beauprea in Canada, hoping for a miracle. He had seemed unable to accept her illness.

The worker talked the situation over with the doctor on the tumor service who

felt he might be able to relieve the tension by talking with the patient and her husband. The husband was located through a friend of his at Alcoholics Anonymous and he came very quickly to the hospital. His attitude toward the worker was belligerent as he seemed to anticipate further reprimand. If the doctor on the tumor service saw the "chip on the shoulder" of this man, he ignored it. He succeeded remarkably well in developing a positive attitude on the part of both the patient and her husband. He gave one of the best demonstrations of interviewing skill that the worker has seen in getting this husband and wife disposed to leaving the hospital together and making a fresh start toward trying to cope with their very serious problems.

We recognize the fact that the six weeks' period which has elapsed since this interview during which the social worker and the doctor have had a number of contacts with this family and found them getting along satisfactorily, may be a temporary interval. We have informed a family agency about the problem because we feel they may require housekeeping service, and we are not sure that the father will have the stability required to care for his children after the death of his wife.

We have included this problem because it represents the kind of difficulties that arise from serious illness of a parent in the family. In this instance the mother had managed to maintain stability in the home in spite of the weaknesses of her husband but the additional complicating factor of illness destroyed what balance the family had.

This case came up during routine follow-up of failures to tumor clinic. The referral from the doctor was indirect, therefore. The doctor in tumor clinic would not have had to attempt to assist this woman with her social problems but what medical care could be given to her she had received.

The tumor clinic has continued to work with this family situation, and has given some sedatives to the patient for relief of pain. We fulfilled the objective of our indirect referral in that the patient returned to tumor clinic. This case fulfills adequately also the requirements of the American Association of Social Workers as to case work treatment.

The doctor in the urology clinic asked the worker to talk with the third patient we are considering. He said she was very ill and should be admitted to the hospital at once. He did not think he could get a bed for her until the following day, however. He said she had sat up all night in the Great Northern Depot for two nights because she could not pay for her board and room. He gathered that she was very worried also about some family problems.

The worker found a dazed woman of about forty in the clinic, barely able to integrate her ideas and present them in a coherent fashion. She seemed exhausted to the point that talking was too much effort to make. She said she was unable to pay for medical care but her husband would not let her apply for help from the county for herself and her six children. The county had taken her husband away from them the night before she came down to clinic but she was so sick she had not been able to wait long enough to ask the county to arrange for her medical care. Worker asked where the county had taken her husband and was told that he went to Fergus Falls hospital. She had to leave her six children in the charge of the fifteen year old girl, and did not think there was any food in the house, and maybe they were out of fuel.

Worker placed this patient in a rest home for the night and telephoned the county. She learned that the county had already taken charge of providing the children with a housekeeper and food and fuel. They were well aware of the problems of this patient, and anxious to assist her. They readily agreed to the payment of medical expenses.

The following day the worker talked this over with the patient and she was

greatly relieved to find her children were being taken care of and that she would not need to worry about the expenses of her medical care. The worker told the patient that she was sorry she had not asked for some assistance sooner and that we felt badly about her sitting up all night in the depot. The patient said she hated to complain. Everyone at the clinic, she felt, was very sick, and if the doctor had not asked her if she had a place to stay overnight until she could get into the hospital, she would not have said anything. She did not like to bother anyone about her troubles.

The doctor who referred this patient had discovered in asking her whether she had a place to stay for the night what her immediate difficulties were, and of the acute problem unsolved at home. The doctor asked for a report the following day about the problems of the patient. This patient had social problems closely related to her illness, and further difficulties at home which were greatly aggravated by her illness. The doctor was aware of both her social problems and her medical difficulties at the time he called the social worker. He maintained a continued interest in her welfare.

We have indicated in these three situations the way in which we evaluated our cases for service to the medical staff on the basis of referral, and for assistance to the patients with their problems. We thought these situations would indicate better than discussion the extent to which we are dependent on the medical staff for referral, and on their recognition of social problems as they contact the medical staff about such needs, and not come directly to us. These three cases discussed indicated the seriousness of the social as well as the medical problems; this was also found to be true in the review of the other fifty referrals considered in the study.

In clinics as large as those from which the referrals were made, the doctors see many people in a short period of time. We were greatly impressed by the interest the doctors took in the social problems and with the fact that they took sufficient time to determine those who had serious social as well as serious medical problems. Since patients come here for medical care and as the focus of a clinic must be put on that care, the social problems are sometimes obscured. However, since continued medical care is frequently dependent upon the solution of the social problems we need a close working relationship with the doctors, so that we all might give the best possible service to the patients who come to the clinics for medical care.

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3. THE FAMILY AS A FACTOR IN THE EPILEPTIC'S SOCIAL ADJUSTMENT

Jean Cummins

Dr. Tracy Putnam in his book Convulsive Seizures makes this statement:

> "Of great, sometimes determining importance, in the course of a case of Convulsive Disorder, is the attitude of the family toward the patient. This is most striking when the seizures begin in childhood. The parents may take either of two attitudes, or both; they may be oversolicitous and over protective, or they may be resentful of the illness, attempt to hide it, and punish the patient in subtle ways for it. At the one extreme, the child who is afflicted may receive an undue share of love and attention, be relieved of every duty in the home and at school, and may in the long run be transformed into a spoiled invalid incapable of taking his place in life even if the seizures are controlled, unless at the expense of a determined struggle. At the other extreme, the existence of seizures may be felt to be a disgrace to the family and the patient may find himself regarded as unworthy of any educational and so-

cial advantages."[1]

As the social worker in the Clinic for Convulsive Disorders, we function as a part of the rehabilitation team consisting of: the doctors, nurses and clinical psychologists. The social worker, of all people in this group is the person who best can follow through on the rehabilitation of these patients, particularly those who live outside of the Twin Cities area, because of her knowledge of and contact with community resources. When there are emotional problems it is often the visiting nurse or the county welfare worker who can give us a broader understanding of the problem. Because of proximity to the home the nurse or county social worker can interpret to the entire family the importance not only of following the medical regime but also leading, insofar as possible, a satisfying life. The medical social worker can and should be expected to do a great deal of "public relations" work with the welfare and nursing agencies, schools, churches, social groups, institutions and employment agencies.

There are many limitations in a study of this kind, and one of the greatest lies in the subject matter. It was necessary to limit the interview to an hour's time and in that hour we tried to obtain what amounts to a very thorough social history. It is possible that at least some of the patients deeply resented a stranger's intrusion into such a personal matter as family relationships. This sort of attitude could have distorted many of the answers given. Then, too, we have only the patient's evaluation and not the evaluation of the members of his family, both past and present. The limitations of time and geographical distribution of our patient groups made the contacting of families impossible. This study is presented only as a pilot study, in the hope that others will follow it. As Dr. Baker suggested, it would be of value to the Seizure clinic, for instance, to compare the attitudes and adjustments of patients attending the clinic for the first time, and those who have attended over a period of time and have been known to social service. The writer hoped to find evidence that would indicate whether there had been problems of family adjustment for this particular group--about twenty three of the patients attending the Seizure clinic. We wondered whether we were meeting these problems, when and if they exist, not only problems concerning family and patient but problems in other spheres as well. In what areas did their families help them the least, perhaps necessitating the assistance and reassurance of a visiting nurse, teacher or county social worker?

The Group Studied and the Method Used:

The writer attempted to interview between 25 and 30 patients attending the Seizure clinic between March 3rd and April 14th. It was thought best to interview those who were capable of understanding the questions and could participate meaningfully in the interview. We used a schedule as a guide in talking with the patient, but the questions were asked, not from a paper, but as in a case work interview. It was hoped that, as a result, the patients would feel more secure and would talk more freely about their problems. Twenty three patients were interviewed, in all, and as yet the series is not complete. The age range in the patient group was from 16-69. Twelve of the twenty three patients lived in Minneapolis, three were from the northern part of the state, and east, south, and west were represented. None of the patients had had a college education and only six had completed four years of high school, while two had gone through the third year.

Nationalities represented in the majority were: four persons of Swedish extraction, three of English extraction and three of German extraction. Other nationalities were: Norwegian and German, Irish and German, Irish and Dutch, Indian and

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1. Putnam, Tracy J. M. D., Convulsive Seizures, J. Lippincott Co., 1943, p. 26.

French, Finnish, English, Irish and a Russian.

Only one patient had no brothers and sisters. Twelve of the patients were married, one in the group having separated from her husband and the other having obtained a divorce. Six of this group had children. In 12 cases out of the 23 the patients started having seizures as children or young adolescents; the other 11 began to have attacks in later life. Six had symptoms beginning in their twenties, four in their thirties and one at the age of 45.

Illness

Almost the entire patient group felt that their families had helped them to develop the healthiest possible attitude toward their illness. There were only three who did not feel this way: The first was a 35 year old woman whose convulsions had begun at the age of 16, and whose family had sent her to Cambridge at the age of 18. This patient's five sisters were her only family at the time her seizures started,--the father having deserted and the mother having died in a sanatorium. The second patient, a 39 year old former engineering superintendent whose convulsions were the result of a head injury suffered during civilian defense work in the last war said that his brothers had become extremely aloof since the onset of the convulsive disorder. The third patient, twenty years old, was interviewed following one of many stormy quarrels with her mother. In addition to the seizures, this patient is handicapped by a hydrocephalus and extreme myopia. She is an immature personality because her mother, frustrated and worried primarily about the seizures, has made the girl a basically dependent person needing to play up one symptom after another in order to gain attention.

Eleven of the patients and their families either had no particular fears or conflict around the diagnosis of epilepsy, or both patient and family, having learned the diagnosis, had also learned to live with it. Of the remaining twelve patients, four felt that, though their parents and siblings had used common sense and insight in facing the illness with them, the illness had really spoiled many things for them; jobs were impossible to obtain and hold, the scope of job possibilities was so small and marriage was entirely out of the question. One of the two high school students interviewed felt disappointed and frustrated about not being able to exercise violently, having had two Grand Mal seizures during try-outs for the track team. The other student had found that society at large had grave misconceptions about seizures and finding satisfactions in the world outside of his home had been a difficult achievement for him. The reactions of the three patients who emphatically said that their families had not been a positive influence have been mentioned. One young patient said that she asked her family physician to commit her to Moose Lake State Hospital when first told the diagnosis, and though this was four years ago, her brothers and sisters still tease her by telling her that she is "crazy." An interesting attitude expressed, which shows one of the disappointments some of these people experience, was that of the Russian patient: "Epilepsy is bad, he said, I cannot drink the beer."

School

Thirteen of the patients interviewed had no problems with seizures during the school years, since illness did not begin until later life. Four of the other ten patients enjoyed school and made what seemed to them a satisfactory adjustment to it. Two of this group of patients had to quit high school after two years for financial reasons, not because of conflict over their illness. The parents of all these people would have wanted the children to go further if they had not felt it necessary to have the additional income. A sophomore in high school wants to become a chemist and said that his parents are now planning his college education.

Of the others, those who did not get along in school, it was found that one

had to quit because of the severity of her seizures, and another, a young farmer who has had convulsions since the age of 13, found his studies too difficult for him. The latter said that his seizures made him a laughing stock among his school mates. Another boy, 17 years old, quit after his first year in high school to go to work, but said that "all of the kids were afraid of me--after seeing three men try to hold me down during an attack." Two other young men, an Indian boy of 23 and a white boy, 24, discovered that their teachers were unsympathetic toward them. The latter had to leave school in his sophomore year because his principal had requested it, and the patient had learned from a teacher, a close friend, that the teachers in this Minneapolis public school had brought pressure to bear on the principal. Another patient, visually handicapped, had to discontinue her education in the 9th grade because of mental retardation and unhappiness with institutional living at the Faribault Sightsaving School.

Employment

Twelve of the patients interviewed were not employed, but of this group three were housewives and one was a high school student. The Russian patient mentioned before has not worked for 1½ years, in spite of his wife's and brother's repeated efforts to motivate him. Another patient, the 23 year old Indian, lives at home and does farm chores, whenever possible. A 49 year old man who has had electrical training, has not been able to find work in his small home town, but feels that his elderly parents are reluctant to have him live anywhere but in their home. There has been a great deal of conflict for him since he, his wife, and child, want to move to Minneapolis and, having nothing to do, he worries about himself to an extreme. He feels that his parents' attitude has hindered him a great deal.

Two of the patients are confident that they will be able to obtain work as soon as they become fairly well controlled. Social Service is planning to refer another patient in this group to Vocational Rehabilitation. A 30 year old man lives at home and works in his father's restaurant. He feels that the reason for his being unable to find work is his spells but the patient is handicapped by severe psychiatric problems. The patient with myopia was recently discharged from her job because she complained constantly of her manifold symptoms, which were not referrable to the convulsive disorder. Of the group employed, one man hoped that he would be able to return to instructing at Dunwoody Institute. Another would prefer to leave his job as a door to door salesman and learn to farm. Another patient feels that his father is trying to discourage him from looking for work other than that of a cook and waiter. A fourth man, a farmer, is torn between his need to stay with his parents and his desire to seek factory work. Only four of the patients in the group spoke about the difficulty they had encountered in finding work, and mentioned their convulsive disorder as the reason.

Social Life

About thirteen of the patients expressed definite dissatisfaction with their social life. Two mentioned that their religious beliefs prevented their participating in playing cards or dancing, for instance. None of the single male patients dated, and only one of the girls dates with boys. Marriage had been considered impossible for some in this group, either because of the possibility of the offspring's inheriting the disease or because of financial reasons. Others found that their friends shied away from them completely and, in the case of one man, it was his family. Some of the patients interviewed felt that they could not participate in sports because of the possibility that it might bring on a seizure. Two of the women, one married and another divorced, stated that their parents had kept them inside, as children, all of the time, because they (the parents) were afraid of possible injury to the children.

Conclusion

We have looked briefly at the family as a factor in some of the phases of social adjustment of the patient with a convulsive disorder. In 11 of 23 cases studied, we found that the family has been a positive factor in that they have adopted, as has the patient, the point of view of minimizing the handicap by taking a hopeful, matter of fact, attitude toward it. It is encouraging to note that in this many cases such has been possible. The fact remains that in 4 of 12 cases, the family's attitude has been a negative factor in the patient's adjustment. It is much less hopeful when we consider that for the remaining eight, in spite of the efforts the family might have made, the efforts have, apparently, been neither negative or positive, and the disease threatens or has threatened to make these people incapable of becoming happy, useful individuals. It would seem encouraging to note, too, that the majority of our groups are employed, but the scope of the jobs held by the group includes only unskilled labor. At least two of the group are capable, ambitious men, one a former engineering superintendent and another, a paper carrier, a former instructor at Dunwoody Institute. Neither has been able to regain his former position because of seizures. About thirteen of our patients felt that they did not have an adequate social life. Not until the problems of the epileptic become as important to the lay groups as cancer and heart disease will we find any sweeping changes made. The responsibility for those in the social work field, helping to rehabilitate these patients, is to feel that rehabilitation does not end in interpretation to the patient and his family. The philosophy must be extended along with modern medical knowledge of anti-convulsive drugs and psycho-therapy through these individuals to other individuals who can continue in the outlying communities our work at University Hospitals.

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III. MEDICAL SCHOOL NEWS

Litzenberg Memorial Fund Drive to End May 1

Anyone who has not contributed to the Litzenberg Memorial Fund is urged to send his check by May 1.

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Mayo Memorial Building

All friends of the Medical School will be happy to learn that the Minnesota State Legislature in its recent session authorized $5\frac{1}{2}$ million dollars for the Mayo Memorial Building to the Medical School. This will make it possible to go ahead with plans and construction of the building. Progress had been delayed due to the fact that rising building costs had outdistanced funds available from various sources.

Dr. Harold S. Diehl, Dean of the Medical School, said "This action of the Legislature is one of greatest possible significance for medical education and research in this state and for the health of our people."

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Doctors Spink and Watson to Attend Meetings

Dr. Wesley W. Spink, President of the American Society of Clinical Investigation, will be in Atlantic City on May 2 to attend the annual meeting of that Society. For his presidential address, Dr. Spink will speak on the subject of "Clinical Research as a Career."

Dr. Cecil J. Watson will also attend the meeting of the Society for Clinical Investigation. In addition, Dr. Watson will attend the meeting of the Association of American Physicians as secretary of that organization.

Biographical Briefs -- Biochemist

Wallace D. Armstrong was born in Hunt County, Texas. He attended high school in the Texas town of Leonard. His undergraduate work was completed at the University of Texas, and he received his Bachelor of Arts degree from that institution in 1926. The next two years were spent in graduate study in organic chemistry at New York University and led to a Master of Science in 1928. The second year at New York University was spent as a Parke - Davis Research Fellow.

Industry beckoned and Wallace became a research chemist for the Texas Company. After little more than one year, however, the desire for the stimulation of academic life could no longer be denied, and Wallace came in September, 1929, to the University of Minnesota as an Assistant in Physiological Chemistry. In 1932 he received his PhD in physiological Chemistry at this University.

While he continued his activities in teaching and research, Dr. Armstrong enrolled in the Medical School as an irregular student. By utilization of summer sessions, he was able to earn his M.D. in 1937. Meanwhile he was ascending the academic ladder and in 1937 also was made Assistant Professor of Physiological Chemistry.

Most of the academic year 1937-38 was spent on a Commonwealth Fund Fellowship studying at the University of Copenhagen and at the Lister Institute in London. During this period, he was privileged to work under such renowned scientists as Professors A. Krogh, G. Hevesy, and Robert Robison.

In 1940 Dr. Armstrong was named Associate Professor of Physiological Chemistry and Director of the Laboratory of Dental Research.

Promotion to full professorship was made in 1943, and in 1946 Dr. Armstrong was made head of the newly-created Department of Physiological Chemistry.

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