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Social Service Reports

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INDEX

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I. SOCIAL SERVICE REPORTS

SOCIAL SERVICE DEPARTMENT

Annie Laurie Baker

The Social Service Department for its presentation to the Medical Staff will offer three studies made in the department this past year.

Every year we attempt to study some section of our own job so that we may more accurately evaluate the services we give, and review the type of requests made of us in an effort to learn where our program needs strengthening. We made a review of the work done on two Medical Wards of the Hospital.

The graduate Medical Social Work students as a part of the requirement for the Master of Social Work degree conducted a research project with the people going through the Cancer Detection Center. Six students participated in the study and this is the first time we have ever had the entire class take part in one project. We have found this an excellent method of conducting research for graduate Social Work Students and hope to be able to organize projects on this plan for each class.

The third is a study of the interruptions of medical care. We were interested in learning more about failures to return to Clinic as we found we were unable to be as helpful to County Welfare Boards as we should be because patients in whom they were interested failed to complete their examinations.

The Social Service Department always has a group of graduate Students who are required to do study projects and our own workers are interested in the possibilities of research in relations to some of the projects you are carrying on. We have a very close working relationship with local County Welfare Boards so it is possible for us to secure social information about patients. We should be most happy to assist you in studies you might be making where information about the patients home life, family and social adjustment would be of value in your research.

1. A STUDY OF ADMISSIONS ON STATIONS 30 AND 31

Marion Ekholm

Periodically we need to look at what we are doing to determine its value. Among the natural sciences we have rather well established empirical means of testing our hypotheses and arriving at conclusions. In the social sciences our means of measurement are less satisfactory, our determination of value must, to a degree at least, be subjective. Yet it is only by continued review that we are likely to see the whole process more clearly.

For the purposes of this paper we have chosen to examine only a portion of a particular worker's task in the hospital. It was hoped that through a clearer understanding of the group of people we were serving, what we were being asked to do, and what we were doing, we would be in a better position to evaluate our services and to see guideposts which might enable us to give better service in the future. In order to do this, intake and referrals over a two month period (November and December, 1949) on two hospital medical stations were studied. As far as is known the group would be representative of the larger body of patients.

During the period under study, a total of 210 patients were admitted or transferred to the two stations. The great majority of these were on the medical services although there was a small proportion of various kinds of surgery, neurology and dermatology patients. Sixty-nine, or approximately one third of this total, were referred to a social service worker before the completion of their current hospitalization. In some instances patients were transferred to other stations, and the referrals were made from these. At least eleven additional patients of the group studied have been referred to social service since their discharge.

The total group represents people from many occupations, economic and social classes. Fifty one of Minnesota's eighty-six counties were represented (seventeen counties by only one patient apiece). In addition there were patients from North and South Dakota, Illinois, Michigan, Wisconsin and Montana. Perhaps we should include here, too, the patient who was at first believed to be a Minnesota resident but actually belonged to California. Private and per diem patients were frequently those from the greatest distances although there were some county patients whose homes would be about four hundred miles distant. It is fairly obvious what this means in terms of separation from family and friends as well as in terms of repeated clinic visits or constant medical care. There is, of course, a correlation between the economic status of the more distant, generally poorer counties and the amount of readily available local medical care.

The occupations of the patients studied were extremely varied and perhaps the man who classified himself as a "jack of all trades" could best be chosen as representative. Forty-six out of sixty-six women for whom occupations were available classified themselves as "housewives". About one third of the men identified themselves as either farmers, retired farmers, or as farm laborers. Probably to this number could be added a few whose occupation was listed simply as labor. In general, information on occupations could be of little statistical value because of lack of information in many instances regarding the current situation. Some women classified as housewives had been unable to do even light housework for many years and the same fallacy was even more evident in statistics on men, many of whom had been unemployed because of illness, age, or both, over a period of many years.

The question arises as to whether there is any easily measurable difference between the patient group referred to social service and those not referred. Taken as individuals social service referrals cannot be restricted to any particular social or economic group because problems are not, and never have been, "respecters of persons". However, as a group, we do see a significantly greater number of older people among those referred. Whereas the median age among those not referred was fifty-three years, among the referred group the median age was sixty-one. This result might be expected as throughout our society we see increasing problems around age and chronic illness. Faced with increasing dependency while having a will for independence, we see conflicts which center in the hospital regarding the acceptance of medical care. Loss of the security of being needed and loved are combined for many people with lowered physical and material resources.

Another difference that can be noted between the two groups is the lack of private patients referred to social service and the comparatively small number of per diem patients referred. This, no doubt, reflects the ability of money to solve some of the environmental problems which frequently result in referrals. It may also be a carry over of the association in the past of the social worker almost entirely with financial need rather than including the concept of trained counselling. There is also a significant difference in the average length of stay and the number and length of previous University Hospital admissions in cases referred to social service. Of 115 cases not referred on which figures were secured the average hospital stay was 14.83 days and of 56 cases referred for which figures could be secured, the average stay was 27.71 days. The cases referred averaged 1.1 previous admissions and 20 previous days University Hospitalization in the past five years while those not referred averaged .72 previous admissions and an average of nine previous days hospitalization. Two patients had two admissions each during the two month period studied.

Again we see a multiplication of problems with chronic illness and an increasing need to call on outside resources to meet emergencies. The need for continued medical surveillance, frequently in the out-patient department, no doubt is a factor here in the referrals.

Referrals to Social Service

In considering those patients referred to social service, we will try to answer three basic questions: That was the original source of the referral? Why was the referral made? and What was done with it?

Of the sixty-nine referrals of patients entering the two medical stations during this period, 38, or slightly over half, were from resident or staff doctors, ten were from internes, ten were from nurses, 6 were from other hospital social workers, three were from outside social agencies, one was from a relative and last, but not least, was a referral from a tenant of a landlady who had once roomed with the patient's daughter-in-law! In several cases referrals were made from two or more different sources (sometimes for different reasons), but in each instance only the original referral has been considered. It should be noted also that referrals from hospital personnel are not limited to the two stations but in the case of transfer might be from the new station.

We have seen that as a group patients referred to social service are somewhat older and have spent more time in the hospital. Considering these facts we are not surprised to find 38 of 69 referrals were originally made for help with discharge plans. Of these, 18 were placed in rest homes, two were committed, two were placed in sanatoriums, twelve went with relatives, one was placed in another hospital, two in boarding homes and one died before plans were completed. Three or four additional rest home placements were made in instances where this request was not the original reason for the referral. Out of the group of 38 in at least three instances the patient has died since placement (in two instances after admission) and in at least six additional cases, prognosis was considered as very poor. Terminal placements are usually more difficult both from the standpoint of locating a nursing home willing to accept the patient and of helping the very sick patient accept the transfer. In two of the terminal cancer cases accepted for care by relatives, the resources of Our Lady of Good Counsel, a terminal cancer home, was discussed. Whether or not the patient or the family are ready for this kind of a placement, it is felt that the knowledge of alternative care may make it easier for them should the pressure of care become too great.

In the minds of many patients, any placement at a nursing home suggests terminal care. For those with chronic illness it means surrendering the struggle to manage by themselves, of being independent, capable or not. It means adjusting to new surroundings when reserves may be at a low ebb and of giving up cherished possessions. Sometimes it means relinquishing unrealistic hopes of being taken in by children, friends or other relatives. The cost too may be a cause for worry. With old age assistance recipients there is sometimes a concern about liens on property or fear of refusal on the part of the county to assist.

In this connection it is to be remembered that University Hospital care, in which the state shares the cost, may be cheaper for the county than rest homes that start at $5.00 a day. There have been instances in which counties have either refused to authorize the care or have later either not honored the bill or have sought reimbursement from the patient or legally responsible relatives.

These problems do not, of course, arise in every instance. Although in a hospital of this kind where beds are at a premium, sometimes it is not practical to give much advance notice, it is gratifying to note that in a number of instances where rest home placements have been particularly difficult, referrals have been made several days in advance. Some opportunity to anticipate the time when the patient is to leave the hospital helps him make a more satisfactory adjustment to the rest home and feel less rejected by the hospital.

The primary purpose of rest home care in many instances is to continue treatment carried on in the hospital and to

preserve gains made. In the same general area of assistance in supplementing the medical care are referrals for authorizations for blood when all other attempts to secure donors have failed, requests because of concern over finances, cost of special nursing, glasses and orthopedic appliances. These account for an additional eighteen referrals. Requests for medical reports account for four more referrals. Social histories, or evaluation of the home situation, were the reason for referral in only three instances and psychological support five others (three of these from other social workers). One referral was concerned with counseling a family desiring to move to Arizona to help the wife's bronchiectasis.

While the above takes care of the reasons for referral, it only partly answers the question of what was done with the referrals received. Some explanation of what has been done with the referrals received is implicit in the services requested. Florence Hollis, in an article on "Techniques of Casework" (Journal of Social Casework, June, 1949) has classified the kind of service a caseworker can offer as 1) environmental manipulation 2) psychological support 3) clarification and 4) insight. In the hospital environment it has been found that the great majority of cases come within the first three categories and that it is only in the exceptional case that insight is given. However, no matter what the level of treatment, the method of help, known as casework, is the process by which 1) the patient and the social worker together explore the patient's immediate social situation. 2) point out existing problems and their causes and 3) develop and carry out a plan which may help the patient to adjust to and meet the problems himself, or which may bring about changes in his environment.

It is neither very often possible nor is it good social work to deal with only the environment without considering the patient's psychological needs and desires as well as the necessity of the occasion. Rarely do we have comatose patients, as occurred in one referral, for whom plans were made in another hospital without first consulting him. In general, the patients who we see are insecure and fearful. They need help from outside resources as well as belief in their own ability to make decisions and to be respected as individuals. In 38 of the 69 cases it was necessary to contact other social agencies as resources for help. This would include authorizations from counties for financial assistance with such things as rest home care or special nursing service. In 34 cases there were contacts, frequently several, with various relatives. In one instance the daughter of the patient was found to be a seriously emotionally disturbed person and after several interviews it was believed that she was able to recognize her own need for help and contact resources for this. While rarely does one find as disturbed a relative as was true in this case, problems of illness in the family create many stresses, and frequently one will find relatives returning to the social service department after visits to patients to express some of the fears and anxieties aroused.

It should be noted too that while it has been shown that most of the referrals have been centered around physical needs, contacts with the doctors have shown them to be extremely aware of the social problems patients face. Sometimes the original reason for the referral seems to have been used only as a means of enlisting the activity of the social worker in the expectation what she will find some of the other problems present. There seems to be real hesitancy in asking for service if the formulation of what is desired is not in the realm of the concrete. Some of this is no doubt the result of worker's questions concerning referrals. These are asked because an understanding of the situation faced by the patient and what the doctor sees as the social worker's role can enable the worker to be more understanding and more intelligent. In these referrals enough information has been given by the doctor or the referring source to enable the worker to approach the patient with some idea of the needs that might be present.

Referrals from doctors for social hist-

ories have again revealed an awareness of the importance of a knowledge of social and emotional factors in the plan of medical care. Examples from this group of cases would include one instance where in the case of a heart patient the doctor had real question concerning the amount of activity the patient was doing and desired an avaluation of the patient and her home. Another example of the use of the caseworker in this way was a request for a social history to be used by the doctor in determining the possible functional component in an illness. Some of these patients known on the stations and returning to the Out-Patient Department are still being followed by a social service worker. It is not possible in this relatively brief paper to be more detailed concerning what has been done. The ultimate test, of course, lies in the future as services are seen as helpful or not helpful.

Conclusion:

A social service department in any hospital is dependent for a large part of its functioning on services which the administration and medical staff can see as valuable and necessary aids to a total treatment program. It is this which, in the long run, determines the referrals made. The preponderance of referrals which are for environmental manipulation may be the result of four major factors: 1) their relationship to treatment is most obvious 2) there are no other situations in which the social worker is needed 3) if there are other needs, they are not seen and 4) the social worker's own limitations, not only of skill, but of time and in interpretation. Perhaps the necessities of a limited social service staff and a hospital giving maximum services requires on the part of the medical staff some degree of choice in referrals, and discharge is that function which meets the most obvious and pressing need.

We would not want to underestimate either the importance, the value, or the skill that help with discharging may entail. We know it enables the hospital to give treatment to more individuals by reducing the number of in-hospital days needed per patient. After working with slow progress, if any, in complicated emotional problems there can also be a satisfaction to the worker in "seeing the job done", and perhaps at times we cannot help but be grateful that more referrals of other types have not come our way at a particularly busy time. Pressure from out-patient clinics in which the social worker also has a responsibility has a disconcerting way of going up at the same time as pressure from the stations, particularly when referrals are delayed and emergent ones. This combination of factors may at times make us seem even busier than we are and block referrals which on a long time basis might be more valuable for the patient. We cannot, of course, be sure that this is true, nor can we say that we are able to give the time that would be required for all the potential social and emotional problems on the station. We would like to invite more discussion if there are situations which are suspected of having social or emotional problems. Patients have a right to decide themselves whether or not they wish the worker's help with personal problems, anxieties and tensions. However, it is only by knowing what is available that they can make a choice. The chance of "helping a patient help himself" is dependent on his desire and interest in the process. Should he not need or want outside help at the present time, through his understanding he may be able to ask for it when he is ready. For most people, accustomed to being independent, it takes real strength to ask for help. It is part of the task of the caseworker to see that the help given is of the kind that utilizes the patient's own resources, both inner and material, and enables him to achieve constructively a better adjustment to himself, others, and/or his environment. Medicine, too, is aimed at achieving maximum well being for the individual. Its major emphases is in doing this through the knowledge and skills involved in the art of healing. It is when a contribution can be made by social service in helping the patient's recovery or adjustment that referrals are made.

We feel we are fortunate in having the privilege of working with medical men who have shown an unusual awareness of the significance of social and emotional factors in the lives of their patients. Their recognition of our unity of purpose has meant a fuller implementation of the concept of treating the patient as a whole.

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2. A STUDY OF SELECTED SOCIAL AND EMOTIONAL FACTORS OCCURRING AMONG INDIVIDUALS EXAMINED IN A CANCER DETECTION CENTER

Helen Graham
Eldred Gorder
Audrey Neime
Raymond Newman
Thelma Levine
Alice Quist

Introduction

This is a preliminary report on a study which is being made at the Cancer Detection Center, University of Minnesota Hospitals, by a group of six student medical social workers in the Graduate School of Social Work of this same university.

At this Cancer Detection Center, as in others which are approved by the American College of Surgeons, only symptom-free, well people are to be examined.[1] There is speculation, however, as to the constellations of factors--social, economic, emotional, physical--which result in such an individual's decision to avail himself of an examination at a Cancer Detection Center. Here he may learn, sooner than would be discovered otherwise, of abnormal physiological conditions which might be cancerous, pre-cancerous, or the manifestations of other diseases requiring extensive medical care and treatment.

At University Hospitals and elsewhere persons have thronged to the Cancer Detection Center for complete, thorough physical examinations. Despite the interest in knowing these persons better, there has been little opportunity to study them in relation to the social and environmental milieu from which they emerge for examination at the Center. One reason for this is the shortage of professional personnel. Medical social workers, for example, are to be available for the purposes of the Center,[2] and yet it has not always been possible to provide the services of such personnel in a quantity sufficient to encompass more than the emergency base of social service. This has prohibited the participation in collaborative research with other members of the professional staff or independent research within the social service department.

Purpose of the Study

This study was undertaken with the approval of the Director of the Cancer Detection Center under the joint sponsorship of University Hospitals Social Service Department and the Graduate School of Social Work. The purpose was to learn something more about the examinees as persons, for example: What distinguishes them as individuals? What has brought them to the Center for examination? With what expectations and/or fears do they come? What is their reaction to the services provided? From an examination of such selected data an attempt will be made to discover whether any social and emotional differences exist among persons examined at the Cancer Detection Center and grouped according to presence or absence of physical findings. The assumption was that there may be different patterns of social and emotional variables which distinguish groups of persons with different organic disorders or no discernible abnormalities.

Methods of Study

The method of obtaining the necessary information was through the utilization of a schedule in which certain social information was recorded for each person studied. The data on the schedule included such items as nationality background, education, occupation, income, marital status, number of children, recreation, and the like (see attached schedule for further details). Additional

items of social information as well as medical data available in the clinical record were obtained from that source.

Certain of the emotional and personality variables were measured by employing the group form Minnesota Multiphasic Personality Inventory. This inventory yields data that are suggestive of the degree to which persons are alike in their responses to persons clinically diagnosed as abnormal or suffering from those emotional ills suggested by the names of the several scales contained in the inventory.

Study Procedures

The population for this study included persons who came to the Center during the period from October 18, 1949, through January 26, 1950, except for the week of Christmas. Although the information was obtained from all individuals, those who came for periodic evaluations as well as those who were examined for the first time, only the data on the new examinees were utilized. Each person was asked to complete the schedule for social data and to take the personality inventory. The schedule and the inventory were administered either by the clinic personnel or by the student social workers. There were unavoidable breaks in the continuity of time available for completing the inventory. However, in general, these interruptions did not produce invalid records since the inventory contains scales which make possible the judging of the validity of the entire record.[3]

In order to determine whether the group selected for study was representative of persons examined, a random sample was taken of new registrants during the period from October, 1948, to October, 1949. Social data, such as age, sex, religion, residence, marital status, ethnic origin, occupation, and mobility, were obtained for every fifth new case during the year selected. A total of 159 cases was included in the random sample, and these are being analyzed to determine how the group selected for study departed in the social factors listed above from the sample of the yearly load of the Center.

In general individuals are classified according to the major groupings used in the Cancer Detection Center.[4] This classification is: I Cancer; II Pre-cancerous; III Benign Tumors; IV Suspicious Tumors needing further diagnosis; V Non-cancerous needing medical attention. Some modification of this system of classification was necessary for this study in order to make the data statistically operable. This was done in consultation with the Director of the Cancer Detection Center. The major groupings used in this study are as follows: I Cancerous; II Pre-cancerous and other conditions; III Suspicious and other conditions; IV Benign and other conditions; V Other conditions requiring medical care; and VI No conditions.

General Description of Study Population

The personality inventory and the social data schedule were given to all examinees during the period, or a total of 482. Of this number, 250 were new cases; 144 were females and 106 were males. The inventory yielded valid scores for 112 females and 95 males. Records were rejected as invalid on the basis of an L score of 70 or above and an F score of 80 or above.[5] The L or lie score is made up of 15 items to detect the person who is lying in the sense of trying to place himself in a highly conventional and socially acceptable light. The F score is not a personality scale but serves as a check on the validity of the whole record. If the F score is high, the other scales are likely to be invalid either because the subject was careless or unable to comprehend the items, or because someone made extensive errors in scoring the items on the record sheet. A low F score is a reliable indication that the subject's responses were rational and relatively pertinent. Another validating scale is the K scale which indicates something of the individual's attitude toward the items in five of the clinical scales.[6] Scores on the several clinical scales were computed for each person in each of the major groupings previously

described. The clinical scales in the inventory are: Hypochondriasis; Depression; Hysteria; Psychopathic Deviate; Paranoia; Psychasthenia; Schizophrenia; Hypomania; and Interest; plus the validating scores, F, L, and K;and the more recently derived Scales of Status, Academic Achievement, Prejudice, and Extroversion-Introversion.[7] Forty-three of the 250 cases failed to complete the inventory for various reasons; resistance to taking the test was the most apparent one.

Analysis is being made of the data which describes the persons within each of the major groups. These analyses involve the comparison of various frequency distributions of factors and measures of central tendency computed for certain factors of information when they are applicable. The process of testing the significance of the difference in social and emotional factors describing the groups is being done by employing such statistical devices as the critical ratio of differences, T test of differences and Chi Square test in order to determine whether the difference observed are due to chance or whether it may be assumed that the groups studied do differ in the manner suggested by the data collected. An effort is being made to determine whether the several major groups differ significantly in social and emotional characteristics.

A few interesting facts have been obtained to date from the social data schedule. In response to one of the questions, "Where did you first obtain information regarding the Cancer Detection Center?", the following answers were obtained from the examinees: 159 read about it in the newspaper; 24 heard about it over the radio; and 10 were told about it by their own physician.

Most people gave several reasons for coming to the Center for physical examination. One hundred and fifty-nine persons came because they read about the program in the newspaper; 106 said they needed to know that they did not have cancer; 69 came because there was cancer in their families; 69 listed other reasons, among which were: "I am at an age where a checkup is a good idea", "I don't want to be too late", "it seemed only fair to my family to find out if I had cancer", "my husband wanted me to come", "my wife insisted that I come", "I feel that the Center is better equipped to give a more thorough examination than a private physician." On the basis of these data it would appear that the medical education of the public in regard to cancer is becoming more effective.

The last item on the schedule asked the patient's opinion of the Center. Almost 100% of those responding were complimentary. They were enthusiastic about the thorough examinations given, the privilege of being able to go through the Center, and the considerateness received from all of the personnel.

To date nothing of significance has been found to differentiate the major groupings. Although it is still too early to formulate any final conclusions, the trend of the analyses already made would seem to suggest that the several factors, both social and emotional, selected for study may not be most meaningful in differentiating the groups studied. It is also possible that the populations which fall into the classificatory groups utilized in the study may not differ in any respect.

This report is intended only to indicate the nature and scope of the study which is under way. The data collected are in the process of being analyzed, and until this work is completed it would be premature to present anything more than a description of the study.

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3. INTERRUPTIONS OF MEDICAL CARE

Annie Laurie Baker

In the past year, it has seemed to us in the Social Service Department that there were a large number of clinic patients who failed to complete their medical care. We were concerned because we received so many requests from the County Welfare Board asking for medical information about patients who had not completed their examinations.

We were interested in the reasons why patients failed to return and in obtaining some idea of the actual percentage of failed appointments. In the Social Service Department we are apt to be working with the patients who are obviously less able to look after themselves so situations as they appear to us may be out of focus and not apply to the general group of patients attending the Out-Patient Department, so we decided to review a group of medical charts to learn what we could about failures to complete medical care.

We had three main reasons for our interest in this subject:

(1). People who come to the clinics are ill and come here at considerable effort and expense to themselves for help with their medical problems. Yet after doing so, for reasons unbeknown to us, sometimes fail to complete the care their condition requires or receive the help they come to get. We were impressed with the waste of doctors time spent on patients who do not accept the treatment offered them and of the unwise use of county funds in bringing them here when they fail to follow the medical plan which would help them regain their health.

(2). We were interested to learn whether or not a more comprehensive plan of follow-up of patients than is now in operation was indicated. There are a few clinics in the Out-Patient Department that have a plan for continuous follow-up of patients, Tumor, Gyn., etc. The Social Service Department has participated in follow-up of patients from other clinics and we wished to learn whether or not more should be done in this area.

(3). We were interested to know, too, how county patients make use of the available medical resources provided for them. We hear about methods and plans of furnishing medical care for people and we thought it would be interesting to know how far the people here in our own state took advantage of what was at present offered to them.

During the last year, of 1949, there were 3,986 new patients admitted to the Out-Patient Department. We reviewed 2,000 medical charts selecting an approximately equal number from each of the 12 months during the year. We took the first series of charts for each month, about 165, so as to avoid seasonal fluctuations as there is a difference in clinic attendance during the various periods of the year. The medical records were divided in a way which may be of interest to you.

Charts reviewed	2,000
County patients	946
Private patients	258
Health Service	220
Direct Hospital Admission	242
Emergencies - W212	53
Staff and Employees	49
Out of State	22
Miscellaneous	210
Newborn - X-ray only - Cancer Detection etc.	

The Per Diem patients were included in the county patients because as far as clinic care is concerned there is no difference made. In comparing these figures with the last annual report of the Hospital the percentages are similar so apparently sample made was representative. In reading through 2,000 charts it was possible to verify many impressions about the patients who come to the clinics. In going through the Out-Patient Department on a heavy clinic day, we have often been impressed by the number of old people, particularly old men who come for care. On some days it would seem that the clinics treated practically no one but very old men. In making the survey of charts the age of patients was tabulated. It was found that there was about an equal number of men and women; 47% males to 53% females. The women were younger than the men, the medium age for women was 43 and for men 54. The largest number of women were between 25 and 45 and the largest number of men were between 55 and 75. There were eleven men and three women in the very aged group from 80 - 85. Eighteen per cent of the patients whose charts were reviewed were receiving care in Pediatric Clinic and were under 16 years of age. About 60% of the adults whose charts were reviewed were married. This means that 40% were alone and in evaluating the age group particularly of the men in relation to plans for living arrangements after medical care this fact presents many complications.

In considering the locality from which patients come - about 40% live within a radium of 100 miles of Minneapolis. The group of counties surrounding the hospital are Township system counties with the exception of Ramsey, from which there is a very small number of patients. In these counties it is most difficult to secure the things patients need to complete their medical care such as Nursing Home care, appliances, special nursing service, etc., because of the very limited financial resources of so small an area. The lack of resources to pay for board and room, transportation, etc. might well account for clinic failures among patients from these areas.

Over 60% of the patients came from the Northern half of the state. Perhaps the majority of these came from what are usually considered the poorer counties, although it has been our experience that we have more difficulty in obtaining requirements for patients from the wealthier northern counties which are on the township system. The patients who come from the southern part of the states are from areas where more resources for financial help and medical care are available. A large number of the patients residing in the Southern half of the state are from Counties located in the extreme west corner of the state, near the South Dakota border.

It was not possible to get much idea of the financial status of patients coming to the University Out-Patient Department. Since the county cases were the particular interest of the study it can be safely assumed that these patients were from the lower income groups since the County Commissioner of the district in which the patient resides had authorized the patient's care to be paid from county funds. However, the occupation was sometimes recorded. There were 340 adult charts in which an occupation was listed. The women were sometimes listed as housewife, but in many instances the husband's work was given. Therefore, both the patient's and the husband's occupation were included. Of the total of 340 charts where occupation was given 23% listed their occupation as farmer, 11% skilled labor and 6% unskilled. Of this total group 23 were getting Public Assistance, 7% in business, 6% retired, 7% unemployed and 3% were brought to clinic by social agencies.

The number of clinics patients were attending was checked and it was found that adult patients average treatment in three separate clinics.

A careful review was made of the last entry to determine what plans had been made for the patient's future medical care and to learn the number who had failed to follow through the clinic routines to the point of establishment or completion of medical care. It was found that out of the 946 patients whose charts were reviewed, 11% were advised that no further medical care was indicated. The doctor wrote into the medical chart either "no return" or "discharged." 23% were referred back to the local doctor for care. This fact was indicated by letters filed in the chart or by a notation made by doctor to that effect. 11% failed to return to clinic to complete their medical examinations and to continue their treatment. A patient was considered to have failed after a lapse of one month from the time of the appointment. Those who were discharged as in need of no further medical care and those who were referred back to the local doctor constitute 54% of the 946 patients therefore 46% of the total receive their medical treatment in the clinics. It would seem that out of 946 cases a percentage failure of only 11% would be considered very small. In considering the age of patient, the seriousness of the conditions for which they come for treatment and the distance which so many of them need to come, the percentage of failures is small and no doubt occurs for very valid reasons.

In order to learn what the reasons might be, we sent out a questionnaire to those patients who had failed - a total of 146 patients. On the questionnaire we asked 7 simple questions which were as follows: "I did not come back to the University Hospital because:

1. I did not think it was necessary because I was feeling better.
2. I decided to have a local doctor continue my care.
3. I was too sick to make the trip to the hospital.
4. I did not think I was being helped.
5. Family or other problems prevented me from going back.
6. I did not have the money (They were asked to check whether they had gone to the Welfare Board or County Commissioners for help.)
7. I did not know I had another appointment.

Replies were received from 106 of the 146 letters sent out. This is an unusually high percentage which amounts to about a 70% return. The patients were advised that their answers would be kept confidential and that the schedule would not be put on the medical chart. Most of them wrote explanations or comments. In fact, of the total, only eight were returned with no comments.

Of the total of 106, about 33%, did not return to keep their clinic appointments because they were feeling well and did not think it necessary. As one patient said, just to know there was a place like the University Clinics where she could come for care made her feel better. Others stated that they were feeling well but if there was any return of the trouble for which they originally sought treatment they would be back.

Seventeen returned to the care of their local doctor. Six reported that this was necessary because they were unable to take time off from their jobs to come to clinics. Six others reported that they returned to the care of their local doctor because they did not have funds to return here. Two stated that the reports sent to the local doctor had made it possible for him to continue their treatment in the local community.

Eight said they they were too ill to make the trip back to clinics. Reports were received that five had died. There were only three patients out of 196 who gave as their reason for not returning that they did not think they were being helped. One of the three wrote a note to the effect that he had multiple sclerosis, all the known treatments had been given him with no results so he felt there was

no use in keeping his appointments.

It was expected that question 5, "Family or other problems prevented me from going back" would provide a variety of answers and may give specific clues as to why patients fail appointments and some indication as to what kinds of assistance might be required to help them return to clinic. Of the total of 106 patients 20 marked this as their reason for failure to return. Only one patient failed to make any comment. The largest number of patients (8) stated they were unable to return because the clinic appointments interferred with their work. As one patient said, it took her three weeks to go through all the clinic procedures and this was too much time off of his work. Another commented that he was to return for X-rays but he could get off only on Saturday afternoons. Another job took him out of the state. Three were unable to keep their appointments because of illness of other members of the family. Three could not leave their young children. Three complained of bad roads, and transportation difficulties. One adolescent boy said returning to clinic would interfere with his football practice. One patient stated she had failed to return because she was told she would have another doctor, and that was too upsetting to her.

In considering the difficulties which these 20 patients gave which prevented them from continuing medical care here the reasons are valid and fairly personal. The majority listed problems which would be difficult to do much about. Of the 20 the three who could not return because they had no one to look after their young children might have been assisted had their medical condition been serious enough to warrant placement of the children. The three who complained of transportation difficulties were all old people.

"I did not have the money to go back," was the reason checked for failure to return to clinics in 13 instances. Patients were asked to check whether or not they had requested financial assistance from their County Welfare Board. Of the 13, 2 stated they were unemployed and had not requested assistance. Two had requested assistance and had secured County papers. Two checked this as their reason and commented that they had applied for assistance but were refused. In one instance there was difficulty in establishing legal settlement for poor relief purposes and the other patient stated that the Welfare Board had advised him he should be able to pay his own expenses. Three marked the question, and said they had not requested assistance. Four gave this as their reason for failure to return but made no comment as to whether or not they had requested financial help.

From among a group of 946 patients whose care was certified by County papers it might be expected that the number who were unable to continue their medical care because of insufficient funds would be much larger than 13. The percentage of patients from among the total who gave this as their reason is so small as to be negligible. Even of the 106 who failed the percentage who did not return for financial reasons is less then 8%. Apparently lack of financial assistance is an insignificant factor as far as failure to return to clinic is concerned. Of the 13 who gave this as their reason the two unemployed, two others and probably the four who made no comment---a total of eight, had not even requested financial assistance from the County Welfare Board. This would indicate good planning on the part of County Welfare Boards when making arrangements for medical care. Thirteen patients said they did not return because they did not know they had another appointment. These patients either failed to pick up their appointment slips or the notes on the chart did not record the final plans made with the patient.

Among the group of failed appointments there were 8 children who had failed to return to pediatrics clinic. Of the total this is 7% which would indicate that parents are more regular in bringing children back to clinic than are adults in attendance. Of these 5 returned to the care of the local doctor, two had re-

covered.

The number of patients who failed appointments and to whom letters of inquiry were sent 106 out of 946 County patients is probably too small a group from which to draw any specific conclusions. It is possible, however, to get certain impressions which could be applied to the whole clinic group. The percentage of failure 11% would seem to us to be very small. This is particularly significant when it is recalled that the people who come to clinic are in the higher age groups and come to the University Clinics because of serious medical conditions.

The third of those who failed who stated they did not come back because they were feeling better should give us concern. No doubt many of these patients have recovered but for others this probably means a delay in treatment for conditions which will persist. The review of charts and the letters received indicates good relationships with the local doctors. Patients come here for consultation service and are referred back to their local doctors for care. Of the 946, 23% were sent back to the local doctor by the Medical Staff here. Of the group 106 who failed to return 16% went back to their family doctor when they found they were unable to return. In fact six patients who didn't have money to return here went back to the local doctor for care. This shows good cooperation between the local physicians and the clinic, and bears evidence of successful achievement on the part of the Medical Staff in keeping the continued interest of the local physicians in patients who come here for treatment. There appears to be a nice sharing of responsibility and a mutual concern for the medical care of these patients.

In reading through 2,000 charts and in reviewing the letters received there is another definite impression which might be difficult to isolate or study. In providing medical care for patients in large clinics it is exceedingly difficult because of pressures of time, teaching responsibilities, and other duties to be able to give patients a feeling of a positive doctor patient relationship. Yet, in reading the letters written by patients filed in the medical charts and reviewing the comments made on the schedules, we sent out, very positive feelings were revealed. The fact that the large percentage of schedules were returned indicates a friendly feeling towards the clinics. These patients had not attended many clinics but doctors were mentioned by name and the majority added a note of appreciation and thanks for what they got here, which by the clinic standard was usually the preliminary to service and treatment.

Out of a total of 946 County patients only 3 felt that they were not being helped. The only conclusions which can be drawn is that patients coming here do get the feeling that the staff is very interested in their medical care. If this is true for the patients who fail to take full advantage of what the Out-Patient Department had to give them it would be much more true when applied to the patients who continue treatment.

County patients who come to the Clinics for medical care continue treatment or accept the plans made by the Medical Staff for care elsewhere. Very few fail to return and of this group a good percentage go back to their local doctor for care. The reasons given by patients for failure to return are valid. Judging from the replies received from the 106 who failed to return to clinics the relationship between patients and the Clinic is good.

II. MEDICAL SCHOOL NEWS

Coming Events

May 1 - Special Lecture - "Clinical Aspects of Hypopituitarism," Dr. H. L. Sheehan, University of Liverpool - Medical Science Amphitheater - 4:00 p.m.

May 9 - Duluth Clinic Lecture - "Metabolic Effects in Man of ACTH and Cortisone," Dr. J. W. Conn, University of Michigan Medical School, Museum of Natural History Auditorium - 8:00 p.m.

May 11-13 Continuation Course in Eye, Ear, Nose, and Throat for General Physicians

May 22-27 Continuation Course in Proctology for General Physicians

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E. T. Bell Fund Drive for 1950 Is Open

On May 1, the 1950 program of the University's Greater University Fund gets under way and with it the 1950 campaign of the Minnesota Medical Foundation for the E. T. Bell Pathology Museum Fund. Last year over $30,000 was raised toward the $100,000 three-year museum goal. A total of $35,000 must be raised in 1950 and a similar amount in 1951 if the needs of this important project are to be met.

During the first year of the campaign, members of the profession were urged to contribute $100 as a minimum gift. Many of those who could not give this amount in a single gift indicated a desire to give this amount in two or three installations. Some have given much larger sums. One friend of the University Medical School and of the Minnesota Medical Foundation gave $5,000. Others have given $10.00 and $25.00. But all of these gifts added together are splendid evidence of interest in this very necessary and desirable project.

Medical students, practicing physicians, research scientists, and clinicians will all benefit from this pathological museum once it is properly equipped. The committee again urges members of the profession and their friends to support this project in 1950. Gifts may be sent in advance of the campaign or at anytime during the year and may be mailed to either the Minnesota Medical Foundation, 132 Medical Sciences Building, University of Minnesota, or to the Greater University Fund, 205 Coffman Memorial Union, University of Minnesota, Minneapolis 14, Minnesota.

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Undergraduate News Page Begun

The following page is devoted to news of undergraduate medical students activities. It is hoped that this may become a regular feature of the Bulletin appearing once a month or oftener as material and interest grow. An undergraduate editorial committee headed by Jesse E. Douglass is in charge of this section of the Bulletin. Comments and suggestions may be given directly to the Undergraduate Editorial Committee or to the office of the Editor.

Undergraduate Activities Section

The lead-off article is concerned with the type of work being done by various members of the Junior Class (1951). This class likes to feel that it is unusual in the sense that so many of its members are engaged in research work "above and beyond the call" of examinations, quizzes, lectures, and the multitudinous duties of the Junior clerkships.

During the fall quarter, Alex Rattelle conceived of the possibility of the mechanical dilatation of a stenosed pulmonary artery (as in the Tetrology of Fallot) by means of a sleeve-balloon on a rubber catheter. After discussing the idea with members of the Pediatrics Department who gave him enthusiastic moral support, he carried it to Dr. Richard Varco of the Surgery Department. Dr. Varco was also impressed with the idea and helped Alex obtain laboratory space, dogs, and money to set up an experimental trial. With the help of Van Lawrence and Bob Stanchfield, the idea was crystallized into action.

In the meantime, Alex had devised a catheter with which to perform the dilatation. It is a modification of the type of catheter being used by Dr. Forrest Adams of "heart catheterization" fame. In essence, it is constructed in such a way as to have a sleeve balloon near the distal end. When in use, the operator can determine when he is in the pulmonary artery by taking pressures. When he is certain he is in the stenosed area (as noted by a lowered pressure), he merely pumps up the balloon, thus putting pressure on the stenosed area. It is hoped that repeated trials will dilate the stenosed artery enough so that there will be an increased blood flow through the artery. This would be immediately evident by the operator, noting an increase in the pulmonic pressure.

The next problem was to create a stenotic pulmonary artery in a dog. The first trail was unsuccessful, the animal expiring from causes other than could be attributed to the surgery. The next trial resulted in an encouraging stenosis which has apparently persisted for several weeks. The stenosis is evidenced clinically by a persistent systolic murmur and palpable thrill to be noted over the entire chest wall of the animal.

The operation consisted of making a trans-thoracic approach, freeing the pulmonary artery of pericardium and making a double cat-gut tie about the artery, drawing it tight enough to cause a palpable thrill to be noted in the artery distal to the tie. This procedure narrows the artery down to about one-half its normal diameter. The animal is allowed to recover from this procedure and at a later date another entrance and another tie are made. In a period of two to three weeks, the gut will have been absorbed and fibrosis of the artery proceeded to the point of a permanent stenosis. As mentioned above, a persistent stenosis has apparently been produced in one animal and the second gut constriction is about to be made.

Needless to say, we are all breathing down Alex's neck, hoping that all will go well. The clinical application of such a procedure has a great many possibilities, and we are all looking forward to the day when such a more physiological procedure can be substituted for the present highly technical surgical reduction of pulmonary stenosis.

III. UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

April 30 - May 6, 1950

No. 287

Sunday, April 30

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

10:30 - 11:00 Surgical Conference; Eye Injuries and Emergency Ocular Surgery; Richard Horns; Rm. M-109, U. H.

Monday, May 1

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 - Pediatric Rounds; Erling Platou; Sta. I, Minneapolis General Hospital.

11:00 - 11:50 Physical Medicine Seminar; 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; Protein Binding of Ion; Charles Carr; 214 M. H.

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

12:30 - 1:20 Pathology Seminar; Botulism; A. S. Rathkey; 104 I. A.

12:30 - 1:30 Surgery Problem Case Conference; A. A. Zierold, C. Dennis and Staff; Small Classroom, 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; Subject to be announced; 113 Medical Sciences.

4:00 - Medical-Surgical Conference; Bldg. I, Main Conference Room, Veterans Hospital.

4:00 - Pediatric Seminar; 6th Floor West, Child Psychiatry, U. H.

*4:00 - Special Lecture: Clinical Aspects of Hypopituitarism; H. L. Sheehan, University of Liverpool; Medical Science Amphitheater.

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

5:00 - 6:00 Urology-Roentgenology Conference; C. D. Creevy, O. J. Baggenstoss and Staffs; M-109, U. H.

Tuesday, May 2

7:30 - 9:00 Fracture Rounds; General Hospital.

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

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

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

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and E. T. Bell; Veterans Hospital.

11:00 - Contagion Rounds; Forrest Adams. Sta. L, General Hospital.

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

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

1:30 - 2:30 Pediatric-Psychiatry Conference; R. A. Jensen and Staff; 6th Floor, West Wing, U. H.

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 Physiology Surgery Conference; The Nature of Certain Benign Lesions of the Breast which Seem to Arise on the Basis of Hormonal Imbalance and the Relation to Cancer; Cushman Haagensen, Columbia University; Eustis Amphitheater, U. H.

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

5:00 - 6:00 Porphyrin Seminar; C. J. Watson, Samuel Schwartz, et al; Powell Hall Amphitheater.

5:00 - 6:00 X-ray Conference; Presentation of Cases by Ancker Hospital Staff; Doctors Aurelius, Peterson, and Marshall; Todd Amphitheater, U. H.

Wednesday, May 3

8:00 - 8:50 Surgery Journal Club; O. H. Wangensteen and Staff; M-109, U. H.

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

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

8:30 - 10:00 Orthopedic-Roentgenologic Conference; Edward T. Evans and Bernard O'Loughlin; Room 1AW, Veterans Hospital.

Wednesday, May 3 (Cont.)

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

11:00 - . Pediatric Rounds; Erling Platou; Sta. I, General Hospital.

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

12:00 - 1:00 Radio-Isotope Seminar; 113 Medical Sciences.

12:00 - 1:00 Surgery Problem Conference; General Hospital.

12:15 - Staff Meeting; Main Classroom, General Hospital.

3:00 - Pediatric Rounds; C. J. Huenekens; Sta. I, General Hospital.

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

4:00 - 5:00 Infectious Disease Rounds; Main Conference Room, Bldg. I, Veterans Hospital.

5:00 - 5:50 Urology-Pathological Conference; C. D. Creevy and Staff; E-101, U. H.

Thursday, May 4

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 - Pathology Conference Clinic; Main Classroom; General Hospital.

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

12:00 - 1:00 Physiological Chemistry Seminar; The Determination of Heparin; Mary Jeanne Ochs; 214 M. H.

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

4:15 - 5:00 Bacteriology Seminar; Mode of Action of Penicillin; Karl R. Johansson; 214 M. H.

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

5:00 - 6:00 X-ray Seminar; Polyostotic Fibrous Dysplasia; Richard Bridenbaugh; Todd Amphitheater, U. H.

Thursday, May 4 (Cont.)

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

Friday, May 5

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; Veterans Hospital.

10:30 - 11:50 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department, U. H.

11:00 - Pediatric Rounds; Erling Platou; Sta. I, General Hospital.

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

11:45 - 12:50 University of Minnesota Hospitals General Staff Meeting; Narco-analysis for Criminal Interrogation; James H. Matthews; Powell Hall Amphitheater.

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

1:00 - 1:50 Dermatology and Syphilology Conference; Presentation of Selected Cases of the Week; H. E. Michelson and Staff; W-312, U. H.

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

1:00 - 3:00 Pathology-Surgery Conference; Auditorium, Ancker Hospital.

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

4:00 - 5:00 Clinical Pathological Conference; A. B. Baker; Todd Amphitheater, U. H.

4:15 - 5:15 Electrocardiographic Conference; 106 Temp. Bldg., Hospital Court, U. H.

5:00 - 6:00 Otolaryngology Seminar; Book Review - 1st half of "Clinical Audiology"; Dr. D. R. Kusske; Todd Memorial Room, U. H.

Saturday, May 6

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; M-109, U. H.

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

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; E-221, U. H.

Saturday, May 6 (Cont.)

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

9:15 - 10:00 Surgery-Roentgenology Conference; F. Ruzicka, O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

10:00 - 11:30 Surgery Conference; O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

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 - Contagion Rounds; Forrest Adams; Sta. L, General Hospital.

11:00 - 12:00 Anatomy Seminar; Review of Papers Presented at Meeting of American Association for Cancer Research, Arthur Kirschbaum; Effects of Prolonged Glucose Administration to Alloxan Treated Rats, Lewie O. Ingersoll; 226 I. A.

* 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.