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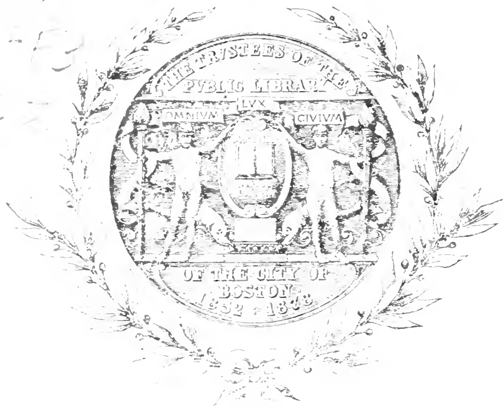

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A STUDY OF 500 ADMISSIONS TO THE FOURTH MEDICAL SERVICE, BOSTON CITY HOSPITAL

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FOREWORD

BY FRANCIS W. PEABODY, M.D.

DURING the last twenty years the Social Service Department has become generally recognized as an essential part of the modern hospital, and no open-minded clinician of broad hospital experience can fail to appreciate the contribution which the social worker makes to the welfare of the individual patient, as well as to the more effective functioning of the institution as a whole. On these points there is no longer need for discussion. It may not be amiss, however, to call attention to another, though limited field, in which coöperation between the social worker and the physician can be made significant and to comment briefly on the Department of Social Work in relation to the teaching of medicine.

The Fourth Medical Service of the Boston City Hospital is assigned to the Harvard Medical School for teaching purposes. Throughout the greater part of the year from six to ten students in their final term of study spend the whole time for periods of one or two months attached to the service, and their relation to the patients is made so intimate and so responsible that they virtually form a part of the hospital staff. This period of continuous contact with the patients on a large service of a busy Municipal Hospital, equipped with all modern methods for the diagnosis and treatment of disease, is unquestionably one of the most important in the whole medical curriculum for it gives to the students an insight into

medical science and offers them an opportunity to follow the course of disease from day to day and from week to week. The duty of the teacher in charge of such a service is to train efficient physicians, and one of the problems which confronts him is to make the circumstances under which the students work as closely analogous to those of medical practice as is possible within the limits of the hospital walls. Among the criticisms which are often directed against the training of medical students in a modern teaching hospital is one which is in effect that the student comes to regard the patient as a "case" for scientific investigation rather than as a sick human being. Unfortunately, it cannot be denied that there is frequently some justice in this criticism. The intricate and interesting problems of the diagnosis of organic disease are so absorbing and so time consuming that it is extremely difficult for the overworked student or intern to go into the broader aspects of the case, and the very fact that the patient is removed from his normal environment necessarily subordinates or masks many situations, the significance of which would be only too apparent if he were seen in his own home. It may suffice to mention three points of the greatest medical importance which are thus liable to be overlooked in the care of patients in hospitals. The first of these is the *personality* of the patient, which, together with the circumstances of his personal life and his reactions to his immediate social environment, may have a fundamental bearing on his clinical condition. The second has to do with his *convalescence* and the opportunities which he will have for the completion of his recovery after discharge from the hospital. The third bears on his relation to those about him—his family and the community at large—

and is essentially the *public health* problem of the spread of disease. All of these points, so evident to the physician in practice and so frequently lost sight of in the hospital, must be conscientiously faced by the teacher and must be continually brought by him to the attention of the student.

The value of a didactic discussion about what may be broadly termed the social aspects of a case in relation to its medical aspects is, however, comparatively limited and a much deeper impression is made on the student by the facts which he elicits for himself and by the concrete problems that may be presented to him by some one who looks at the situation from the point of view of the patient. The interest of the student is, therefore, first aroused by requirng that a brief "social history" be taken as a part of the routine medical record of every patient. It would be a dull student indeed who could question a patient for even five minutes regarding his financial status, the character of his dwelling, the social group with which he is associated, his work, his recreation, and the other circumstances that go to make up the background of his personal life, without becoming profoundly impressed with the various ways in which all of these factors may bear on the cause, course, and cure of the disease. If the matter is left at this point, however, it remains entirely abstract. The student has grasped the significance of the social aspects of the case, but the patient is, after all, sheltered within the hospital walls, and, as far as the student goes, the social problems are entirely of theoretical interest. They are not concrete problems for the student to solve, but remote difficulties for the patient to face. It is at this point that the social worker steps in and converts the theoretical problem

into an intensely practical one. She stands at once as the representative of the patient and of his family. In order that she may carry out her own function effectively she needs certain medical information to supplement the results of her own investigations and the questions which she asks are exactly the questions that would be asked of the physician if he had visited the patient at home. How long will he be sick? When will he be able to return to work? Can he go back to his former job? Will he need special care during convalescence? Is there any danger of his infecting his wife or children? What change in the circumstances of his life will help to prevent a recurrence of his present condition? This is the type of question that arises constantly in private practice but which rarely comes to the student in the hospital. When thus confronted he cannot regard his patient merely as an "interesting case" but he is forced to look upon him as a person with social relationships and responsibilities—as the member of a community.

As a result of the helpful coöperation of Miss Farmer, it has been possible to have a social worker attached to the Fourth Medical Service and, in addition to putting on her the ordinary burden of medical social work, the attempt is being made to develop the relation just described in which the social worker represents before the Staff and the students the interests of the patient, his family, and the community. Once a week she makes a ward visit with the Staff and the students and, while on the visit, she contributes to the group the information that she can add to the case and asks the questions on which she needs assistance. The student in charge of the case answers the questions and the group discusses them. Every one thus has brought before him the situation as

a whole and what has first appeared to be a problem of disease in an institution becomes converted into the problem of a sick human being.

This growing interest in the well-being of the patients after they leave the wards and our increasing desire to do a constructive work that will not only consist in sending our patients out of the hospital in a convalescent condition, but will enable them to adapt themselves better to the life of the community, will be greatly stimulated by the following survey. It gives us a reliable cross-section of the group of people whom we are working with and a deeper insight into their backgrounds and their problems.

THE DEPARTMENT OF SOCIAL WORK AT THE BOSTON CITY HOSPITAL

BY GERTRUDE L. FARMER AND ANNE L. ESTABROOK

In addition to the South Department, for the the care of contagious diseases, and the Pediatric Service, for the care of medical children, there are on the medical side of the Boston City Hospital four House Services for the care of ward patients. To these any adult in Boston, who is acutely ill and cannot be cared for at home, may be admitted. If able he is expected to pay sixteen dollars a week; very few do so. If unable to pay and Boston settled, he is admitted free. If not Boston settled, the community in which he has a settlement, or, failing that, the state is responsible for his bill.

In such a hospital, established in a large seaport city, with admissions to both medical and surgical wards reaching, in the heaviest season, to over eighty or ninety a day, interrelations between medical and social conditions are often

obscured. The doctor may be ignorant of the most important and typical social situations; the social worker may place her emphasis on things of minor importance. Yet as soon as the doctor, becoming House Officer, takes charge of the sick, he should have a fair working knowledge of social conditions,—housing, wages, race, education, resources, occupation,—within their limits of variation, in the group he is caring for as a whole. This is the general knowledge of his community that he must gain later in private practice. In the hospital, as there, it gives him certain working social hypotheses to go on with every new patient. On the other hand, the social worker's business in the hospital is to meet social situations as revealed by sickness, remove the social obstacles to the hospital's medical work for individual patients, adapt as far as feasible the patient's environment to his condition on discharge, bring to the doctor's knowledge social conditions and resources outside the hospital, and stimulate the development in the community of resources that are lacking. She cannot even attempt this efficiently unless she has a grasp of her group of patients, not as a collection of a certain number coming to her attention more or less by chance, but as a whole.

In a hospital as large as the Boston City and with a limited staff of social workers it has, so far, been impossible for social workers to make even the most casual contact, as do doctors and nurses, with a hundred percent of the patients admitted. A study of a sufficient number of admissions on one medical service, with a grouping of the most obvious medical and social facts, ought however to give a fair cross section of the adult medical patients at any given time. For this reason, five hundred consecutive admissions on the Fourth Medical Service at the Boston City Hospital were analyzed. It was hoped that

the result would give both doctors and social workers a better understanding of existing medical-social conditions as a whole, and so suggest the situations that the worker should choose to concentrate upon, as well as the means by which, with the help of the doctor, she can take to discover them.

GENERAL OUTLINE

Period Covered and Number of Individuals

At the time this survey was made monthly admissions to the Fourth Medical numbered about one hundred and twenty-five. The period covered therefore was approximately four months—from the first of October 1923, to the twenty-ninth of January 1924. As somewhat more than eighteen of the five hundred admissions were of patients who were admitted, discharged and admitted again to the Service during the time, the five hundred admissions are equivalent to about four hundred and eighty-two persons. This indefiniteness is due to the fact that it is impossible to say how many of the alcoholic patients were admitted more than once. Almost exactly two thirds of those admitted were men, the greater proportion of male to female admissions being largely due to diagnoses of alcoholism, but in part accounted for by the fact that male beds are in excess on this service.

Length of Stay in Hospital (Table 1)

Over half of the four hundred and eighty-two persons remained less than one week on the Service, which usually means in the hospital, although there were a few transfers to the Nerve or Surgical services or to the Department for Contagious Diseases. These figures are influenced by admissions of patients with diagnoses of alcoholism, such patients generally staying

TABLE 1

346 Patients Grouped by Length of Initial Stay, Sex, and Readmissions (Including Those with Diagnosis of Alcoholism with Complications)

Length of initial stay	Patients still in hospital January 31: Patients who had two admissions		Patients who had one admission		Total	Patients discharged before January 31: Patients who had two admissions		Patients who had one admission		Total
	Men	Women	Men	Women		Men	Women	Men	Women	
Less than 7 days	0	0	6	5	11	0	2	66	47	115
7 - 14 days	0	1	5	7	13	6	1	45	33	85
15 - 30 days	3	0	8	6	17	0	1	38	22	61
Over 30 days	1	0	5	6	12	1	1	17	13	32
Total	4	1	24	24	53	7	5	166	115	293

only over night, or a few days at most. But of those without diagnoses of alcoholism including alcoholism with other medical complications, a large proportion received less than a week's care. Two hundred and ninety-three of the three hundred and forty-six patients admitted for other diagnoses than that of alcoholism, or for alcoholism with a serious medical complication, were no longer on the wards by the end of January. Of these, nearly forty percent had remained on their first admission less than seven days, although two were readmitted later; and sixty-eight percent had remained from a day to two weeks. On the other hand, ten percent, on their first admission alone, had remained a month and over, "over," both in their case and that of the patients no longer in the hospital, meaning sometimes two or three months, or even more. Nine percent died on the service during the four months.

Medical reasons alone often accounted for the unusually long or short stay in the hospital. Social causes, however, contributed: patients with chronic illness, requiring care that their homes cannot give and without resources to pay for long time service in a private hospital will be found in the group whose discharges are delayed. Once admitted to a municipal hospital intended for the treatment of acute illness such patients are often difficult to discharge for various reasons. Both the patients themselves, their relatives and friends will be loath to accept transfer to an almshouse hospital when such is the only resource available. Where a patient is discharged after a very short stay, the reason may be anxiety about those left at home, the antipathy of a timid or ignorant person to the treatment received from the hospital, the inability of a foreign-born patient to adapt himself to its food. Where a patient only needs a few days care,

admission may mean home conditions too poor to give adequate care even in illness which ordinarily should not require hospitalization.

Readmissions

There were fifteen readmissions of patients with medical diagnoses. In the case of seven of these return to the wards was an entirely natural procedure, in that for medical reasons the patient belonged in a hospital; whether or not abnormal social conditions existed, they in no sense influenced his readmission. In the case of the other eight, it is fair to say that social conditions mainly contributed, as, for example, in causing the readmission of the three old people with varying degrees of senility, one leading a forlorn life in cheap lodgings, the two others, so affected mentally that they were later committed to state hospitals.

TABLE 2

DIAGNOSES

Diagnosis	Male	Female
Pneumonia	4	2
Typhoid	1	0
Erysipelas	3	2
Influenza	6	1
Nasopharyngitis	5	3
Tuberculosis	6	4
Lung abscess	1	0
Bronchitis and asthma	3	4
Syphilis (tertiary)	5	1
Salpingitis	0	2
Infectious dysentery	1	0
Scarlet fever	0	2
Diphtheria	0	1
Constipation	5	1
Gastro-enteritis and indigestion	4	1
Tonsillitis	1	4
Rheumatic fever	3	1
Diabetes	5	10
Gout	1	0
Obesity	1	1
Poisoning (gas, lead, food, etc.)	11	5
Smoke inhalation	1	0
Drug addiction	1	3
Tapeworm, Trichiniasis	7	7
Carcinoma	6	4
Peptic ulcer	2	0
Neuroses of stomach	2	1
Hysteria and neurasthenia	1	4
Psychopathic personality	1	2

Gastro-colic fistula	0	1
Jaundice	2	1
Cholecystitis	1	0
Cirrhosis of liver	2	0
Hypertension	2	7
Nephritis	3	7
Pyelitis	0	1
Renal stone	0	1
Cardio-renal	1	0
Kinked ureter	1	0
Hydronephrosis	0	1
Cardiac	19	6
Chorea	0	1
Arterio-sclerosis or cerebral hemorrhage	18	15
Anemia	5	2
Arthritis—		
Gonorrheal	5	2
Other types	1	2
Periostitis	0	1
Osteomyelitis	1	0
Diseases of thyroid	1	3
Epilepsy	3	2
Sciatica	1	0
Parkinson's disease	1	0
Angio-neurotic oedema	0	1
Dementia praecox	0	1
Hypertrophied prostate	1	
Gangrene of foot	1	0
Appendicitis	2	0
"Foreign body"	0	1
Varicose ulcer	0	1
Torticollis	0	1
Non-toxic oedema	0	1
Haematuria	2	0
Subcutaneous emphysema	1	0
"No disease"	1	1
"Undetermined"	6	2
Meningitis	1	0
	186	138
Alcoholism	120	16
Alcoholism with complications	15	7
	321	161

Medical Diagnoses (Table 2)

On these five hundred admissions, over sixty different medical diagnoses were made. The largest group was that of the alcoholics, then the pneumonias, then the patients with arterio-sclerosis or cerebral hemorrhage, then the cardiacs. The diabetics come next, unless we take diseases somewhat arbitrarily grouped together. Arthritis, anaemia, nerve conditions, both functional and organic, venereal disease, nephritis—all these, even without being taken in connection with social data, have social implications. From the list it is evident that there must have been many with chronic disease incapable of any re-

lief that would justify their presence in an acute hospital. Personal acquaintance with the wards of the service for these four months and knowledge of conditions in the hospital for a much longer time bear out the impression that such cases form a burden which makes it impossible for the hospital to do justice to the bedside care of patients with acute disease. A municipal hospital, which cannot easily refuse a patient, is apt to have many such. The fault is largely in the community, which both fails to provide adequate resources for chronic illness and insists that they are the responsibility of the acute municipal hospital.

On 202 of the 500 admissions no effort was made to get fuller information than the above facts, all matters of routine hospital record. This group included the twenty-seven who were too ill to be interviewed, and who died before relatives were seen; ten who were too precipitately discharged to be interviewed, some against advice; nineteen private patients, ten of whom were doctors or nurses; eight patients who were almost immediately transferred to other services; two hospital employees admitted for temporary indispositions; three patients whom it was felt unwise to interview; two who refused to be talked with; and, finally, one hundred and thirty-one of the alcoholic group. There remained a group of two hundred and eighty patients—two hundred and ninety-eight admissions—that was studied socially to some extent, both as being the group from which the hospital social worker would expect to choose the patients most suitable for her care, and that most available for study.

Alcoholism

To have included the one hundred and thirty-one alcoholic patients in our more intensive so-

cial study would have entailed modifying it into one of alcoholism as well, since social data could not have been gathered on so large a group without going more deeply into the medical and social roots of alcoholism itself. Also such data, on so large a percentage of patients, would have somewhat obscured the picture of the more normal, non-alcoholic group. Several points in regard to this aspect of the five hundred admissions must, however, be touched upon. The following table shows the percentage of alcoholic and non-alcoholic admissions:

TOTAL ADMISSIONS

	Male	Female
First admissions for alcoholism	120	16
First admissions for alcoholism plus complications	15	7
Other first admissions	186	138
Readmissions (known) for alcoholism	1	1
Readmissions (known) for alcoholism plus other complications	1	0
Other readmissions	10	5
	333	167
Total 500		

Taking those patients with a definite diagnosis of alcoholism alone, they made over twenty-seven percent. Including conditions recently or closely connected with drinking, as alcoholic pneumonia or alcoholic neuritis, it is conservative to say they constituted thirty-two percent of the total admissions.

As to readmission: no definite data can be given, because an alcoholic patient does not always return to the same service, there is an inevitable inaccuracy in getting the names and addresses of such patients, and the social worker could not see all personally. Certain of them, however, were surely "repeaters," and some, entering usually for this diagnosis alone, may be called habitués.

As to age: taking this data from the admission slips at its face value, the male admissions for alcoholism and alcoholism with complications were, in age, as follows:

Ages	Male admissions
Undetermined	27 patients
21 - 30 years	15 (12 were 25 years and over)
30 - 45 years	50 (36 were 35 years and over)
45 - 60 years	35
Over 60 years	10
	137 male admissions

At least seventy-seven percent, then, of the male admissions for alcoholism were of men twenty-five or over, while over sixty-three percent were thirty and over, the majority of these being at least thirty-five years old.

Social Study of Two Hundred and Eighty Patients

The more intensive study of the two hundred and eighty patients was made in an effort to learn something of their roots and affiliations in the community, where they came from, the work they did, whether or not they lived in a family group or as isolated individuals, their education, income, resources. The Fourth Medical Service itself takes a social history from the patient. Some data was therefore gathered from these histories, but in addition, in all but a very few cases, information was obtained from talking with the patient at the bedside, and confirming and supplementing this, where necessary and possible, by interviews with friends seen at the hospital, home visits, and reports of other agencies.

There are limitations to the possibilities of such a study: as the patient has come to the hospital for medical treatment, if he dislikes or refuses any medical questions or examination, he

is not accepting the conditions under which he was admitted. But this is not true as regards social investigation, for he has not implied readiness, by coming to the hospital, to have his social condition either altered or studied. He may be willing to talk very frankly about it, and he often wishes to do so, and his mind is greatly relieved by it, but he is likely to feel that the social worker has a right to demand this only when he asks social help, or when a very definite social need, perhaps even preventing his discharge is revealed. A survey of this sort, therefore, can never be conducted like a compulsory physical examination. Most of the patients were ready to talk very frankly about their financial situation for example. To some this would have been extremely disagreeable. It was felt that no data gathered for the survey could have outweighed the harm done by disturbing the tranquility of the sick person and perhaps rousing the antagonism that can spread so quickly from bed to bed in a ward. It seemed wiser never to press, sometimes never to begin, such questioning.

As it was, there were only four of the two hundred and eighty who, at the outset, requested that no questions should be asked. Contact with all four was entirely pleasant, and the relatives later provided some data. To a good many patients, the reasons for making a survey were frankly given.

Connection of Patients with Other Agencies

Thirty-eight percent of the two hundred and eighty had had previous contact with some outside social agency, a little less than a third of this thirty-eight percent being cases where the agencies were medical or nursing, so that the problem might not have indicated any financial or other

social disability.* Fifty-four percent were unknown to agencies of any sort, while identifying data for eight percent was insufficient to determine whether or not the patients were previously known socially to any organization. In some cases, many agencies had worked either with temporary or permanent social problems of the patients. Some of them were known already to the Department of Social Work of the City Hospital. With a few, outside agencies were working at the time the Survey was made.

Economic Data

Perhaps the only statistics as to income and property that would have any value would be those gathered from the records of good casework, based on intimate personal knowledge, where knowing the patient's financial resources has been an essential part of work for him. No definite conclusions, therefore, can be drawn from a superficial survey of this sort. Yet it would be unsatisfactory not to gather together some suggestions as to the financial situation of the patients cared for on the Service.

Savings and Property

Sixty percent of the two hundred and eighty stated that they had no savings. Of the twenty-six percent who acknowledged savings, some were living comfortably. With some the "savings" took the form of ownership of the home, but with many it meant exactly what they said—"a few dollars"—put aside perhaps for burial, not enough to provide care for an indefinite convalescence, certainly not enough to provide chronic care for life. Of the fourteen percent from whom no statement was obtained, some were poor people by every evidence.

*Statistics gathered on 7,338 patients dealt with for a five-year period showed 44.3 percent previously known to outside social agencies. While studies made of single year periods showed that from 41 to 45 percent were so known.

Income (Table 3)

Any individual living on less than $15 a week, any family of two, three and four members with less than $25, any group of four persons who has not over $35 a week, is certainly dependent on an income not only utterly inadequate to the strain of illness, but to its prevention. From one hundred and ninety-four patients, some liv-

TABLE 3

194 Approximate Incomes

Size of groups in which pt. shared income	Less than $15	$15 to $25	$25 to $35	Over $35	Total
1 person	34	28	10	2	74
2 persons group	2	15	8	3	28
3 " "		6	7	3	16
4 " "	1	4	7	7	19
5 " "	1	4	5	8	18
6 " "		2	1	5	8
7 " "		5	4	9	18
8 " "		1	1	3	5
9 " "		1		2	3
10 " "			1	2	3
11 " "				1	1
12 " "			1		1
	38	66	45	45	194

ing alone, some parts of a family group, data was obtained according to which forty-eight percent—or thirty percent of the two hundred and eighty in the whole group—had inadequate incomes, which in most cases were wholly or in great part cut off by the sickness itself.

From the above facts, it is evident that if only a very small number of patients in the hospital pay ward rates, only a very small number are, probably, able to do so. The main burden of their sickness must be borne by the community.

Birthplace and Citizenship

Of the entire two hundred and eighty, over forty-nine percent—nearly half—were American born. The fathers of over half these were either negroes or foreign-born.* Twenty percent were Irish, ten percent born in Canada, six percent in Russia or Poland (all but one of Hebrew extraction), four percent in Italy. The remainder gave fourteen different countries as their birthplaces.

The over-whelming majority—fully fifty-eight percent of the foreign-born—had been in the Uinted States for over twenty years. Only a small group, about ten percent of the total, had been here less than five years. The presence of even this small group, in a four months' period on one service, is significant of the hospital's responsibilities to the recently arrived immigrant. Fifty-seven percent of the foreign born had already become citizens, and eight percent had already at least taken out "first papers."

Settlement

Over sixty-two percent had in all probability Boston settlements. Without going into the intricate matter of settlements, it is enough to say that this, in the case of an adult, means five years' residence since reaching the age of twenty-one, without receiving public aid, and without the receipt of public aid by a dependent. Settlement may also be obtained from a husband or a parent. This sixty-two percent at least were, then, entitled to care in the hospital at the expense of the city, if unable themselves to pay. Probably some settlements among those undetermined when the survey was completed would be found to be Boston. Of the remaining thirty-eight percent the majority were mainly either

*In our study of 7,338 patients dealt with by the department during a five-year period 62 percent were American born.

Boston residents, or else those persons who, being taken ill while temporarily in Boston, ought, in decency, to be brought to its municipal hospital if without other resource. There were a few patients admitted from out of town.

Ages

Age is so important a factor in the decisions and procedure of a social worker, that the age groups into which the patients fell, is perhaps the best approach to those facts as to work, education and home conditions which complete this outline. The age groups of these two hundred and eighty were as follows:

Under 16	14	5%
16 - 21	12	4 plus %
21 - 30	48	17 "
30 - 45	76	27
45 - 60	64	23
60 and over	63	22 plus
Undetermined	3	1 "
	280	

It is interesting, from the point of view of social work in hospitals, to notice that five percent of those admitted were children under sixteen, the age which is ordinarily considered a suitable working age; not a large group, and one easily handled, and probably giving opportunities for really constructive case work. At the other end of the scale, we have twenty-three percent who were over sixty, at the age where, perhaps, many were becoming less desirable industrially. About half of these lived in lodgings or otherwise alone. Comparing these facts with the large group of chronic patients and patients with the disabilities of old age which the list of diagnoses indicates, remembering that few patients had savings, this age group is socially significant. These are the patients whose discharge

is often most difficult to arrange for, so that to the doctors they unfortunately sometimes seem the only ones, for whom a social worker is needed. Yet the table of ages immediately suggests to the social worker the adolescent cardiac, the mother who has left a young family, the wage-earner whose family income is entirely cut off by his illness, the pneumonia patient without savings who lives alone in cheap lodgings.

Home Conditions

The most suggestive division as to home conditions, is the grouping together on the one hand of those who lived in some sort of a family unit, or with a friend so close that a measure of household permanence and mutual responsibility was assured, and on the other hand of those who either lived alone in lodgings or in a tenement, or boarded with some one not bound naturally or permanently to them. Of the entire two hundred and eighty, one hundred and thirteen were married, one hundred and five single, forty-six widowed, fifteen divorced or separated, while the civil status of one was undetermined. One hundred and eighty-one lived as members of a household group, even though this might mean only two in a furnished room, but at least this semblance of a family unit meant living with some one who was regarded as owing the patient something more than the kindness of the kindest landlady, and assured a certain amount of mutual responsibility. Ninety-five lived, in the sense described above, alone.

About forty-nine percent of the two hundred and eighty patients who were over twenty-one, and about fifty-six percent of all the single, widowed and separated, belonged in this group of ninety-five. Several lived in families where they were employed. A few boarded with friends, or shared a room with someone, so that

they were not utterly isolated, and one boarded in an excellent, semi-endowed home for elderly women. Sometimes the landlady was very kind; (there is practically no experience with sickness which a South End landlady may not expect to have). Several had little tenements, therefore probably some of the roots and ties that a neighborhood gives. The majority, however, of the ninety-five had not even these substitutes for family life. The people with whom they were living could not be called upon to accept responsibility for them. Yet nearly all had relatives near enough—though perhaps far away or overseas—for the tie of blood to be normally strong could it have been reunited.

In the course of this study not quite half of the ninety-five homes were visited. Probably a little over a third of these could be called good or fair. The rest, about a third of the entire ninety-five, were poor. Of these sixty-five—over two thirds were lodging houses. In many cases this meant the one-night lodging house for men, so significant of a lack of stability in the patient's life, and which must make any deviation from normal health more painful and hopeless, physically and mentally, that we can possibly know. One of the problems which a municipal hospital's contact with the "homeless man" holds for the social worker is this aspect of his sickness. Among this fairly large group of unattached men opportunities for preventive medical-social work would surely exist, and it is therefore one of the groups which the hospital social worker should study in selecting the points where she will concentrate.

Of the one hundred and eighty-one persons counted as forming an integral part of a family group, one hundred and twenty-six homes were either visited, or reports received from a reliable agency which knew them. Of the entire one

hundred and eighty-one we may say that while thirty percent were undetermined, twenty-seven percent were good, twenty-nine percent fair and thirteen percent decidedly poor. "Good" while not meaning luxury, means considerably more than the bare essentials of comfortable living. Among the "fair" homes were many that fell pretty far below any really adequate standard of sunlight, space, toilet facilities, desirable neighborhood. Anyone unaccustomed to tenements and the lower grades of apartments would unhesitatingly have called them poor, though under ordinary circumstances the social worker would have been reasonably well satisfied with them. *Sickenss, however, may change a fair home to a decidedly inadequate one.*

While definite statistical conclusions cannot be gathered from such small figures as were dealt with in this study, one fact stands out clearly, the vital importance to the patient of an understanding, on the part of the doctor who has cared for him, of the home condition to which he is discharged. If a picture of the homes of many of the patients were in the mind of the House physician, such a picture as has often impressed the very ambulance men who brought them in, he would far more often call upon the social worker in those cases where the nature of the disease makes environment especially important.

Work

A little less than half of these two hundred and eighty had been wage-earners within the past six months, although we included in the group a few fathers of families who had been idle a month or two longer but who might be expected to return to industry. Some, of course, would never be able to do the same work again. The greater number of these wage-earners were

men and women who, though forming part of a family group to whom their wages were of importance, did not have dependents in the sense that those with wives and minor children did. A significant group, about fourteen percent of the entire two hundred and eighty, were mothers still caring for their households when interrupted by the sickness which sent them to the hospital. The rest of the two hundred and eighty were composed largely of those with chronic illness and incapacitated, married women without children, women who were not wage-earners, and others of like type. The majority therefore of the group more intensively studied were persons whose illness meant withdrawal either from wage-earning occupations, or from equally important work in the management of their homes.

The occupations followed covered so wide a field, that it is more worth while to enumerate some of the principal ones, than to try to give the numbers in each group. Of course, there were many patients who did the heavy, unskilled work of the community, laborers, charwomen, teamsters, freighthandlers, laundry workers, seamen. Several did the more skilled outside work, forestry or gardening. There were several nursing attendants, salesmen and women, skilled clerical workers, a draftsman. There were factory workers of various degrees of skill, a sheet-metal worker, foundrymen, a wire-worker, a fur worker. There were chauffeurs, tailors, wood-workers, a cigar-maker, policeman, private detective, men who were in the printing industry, domestic servants, cooks, hotel workers. The difficulty of adjusting a physical handicap to many of these occupations is self-evident. On the whole the occupations gave a fairly comprehensive picture of the working people of the city, not, perhaps, the most highly skilled. Few appeared to have union affiliations.

Education

To complete this outline of four months admissions we may note certain facts as to education. About twenty-two percent had graduated from Grammar School, five percent from High School as well, some going even beyond that, while a few, though not graduating, had been to High School for a year or two. About five percent were still in school. Twenty-four percent, though not graduating, had had some grammar schooling, nine percent had had either very little schooling or none, while twenty-four percent had received their education before coming to the United States, the majority of these receiving probably not at all the equivalent of an American Grammar School education. It cannot be far wrong to say that fifty-seven percent had most probably received less than the schooling of the grammar grades, many receiving only the barest elements, some nothing at all. From about fourteen percent no definite data was obtained.

Such facts as these give, however, only the slightest suggestion of the variety of experience which the educational backgrounds of these people implied. Everythng was represented, from a British university to a dame school of many years ago in Ireland, a nuns' school in Syria, Hebrew schools in the Jewish pale of Russian cities, district schools in New England and Canada, a German gymnasium, in which an old cook employed by a dairy lunch room, whose relatives had hoped to make him a pastor, had studied Latin till reluctance to receive further education contributed to his emigration—all of these educational backgrounds were mentioned as the patients told of their early school experiences, and suggest some of the modes of thought that hospital doctors and social workers must expect to find, and to which they must adapt themselves.

Remarks

What are some of the questions suggested by this little survey of 500 admissions, the answers to which, if they could be found, might be of service in our work at the City Hospital as a whole? The percentage of patients admitted who need social work in *any* form? The best method a small staff of social workers can employ in selecting these from among the many hundreds admitted? An estimate of the proportion of really chronic patients carried by the Fourth Medical Service who do not belong in a hospital avowedly intended for the care of patients with acute diseases, and who hinder and hamper such care? How many alcoholic patients are admitted and readmitted for short term stays? Do the incomes and living conditions of the patients indicate that they are suitable for treatment in a free, municipal hospital? These were some of the questions on which we hoped our survey might throw some light.

As to the numbers who need social coöperation to round out and supplement their medical care: It was obvious that all the 482 patients did not need the service that a social worker can offer. A majority of the 280 more intensively studied had never been known to any social agency. These very patients may, indeed, have had grave social problems growing out of their present illness, perhaps produced by the illness itself. A hospital worker, by virtue of her approach from the hospital, might have been able to give social service in the form of advice and guidance to outside resources which even intelligent and well-to-do relatives would have been anxous to receive, just as they might want legal or medical advice. Nevertheless, in a municipal hospital there will always, and very properly, be a certain group who, in medical and nursing care,

receive all that they need from the hospital. With this reservation it is however fair to say that there are conditions which should indicate to the doctor and the social worker the possibility of the need of social after care: Patients with small means and no savings; the foreign born or those with foreign born parents; the recently arrived immigrant; living conditions of such a nature as to be unfit both for the care of the convalescent patient and for those suffering from chronic illness; alcoholic patients repeatedly discharged and readmitted; the constant presence of helplessly bed-ridden persons forming a serious hindrance to work in an acute hospital.

With these groups in mind is it possible then to say, for practical purposes, in figures, what proportion of these four hundred and eighty-two persons—these five hundred admissions—did need some form of contact, even if the services were slight, with the social worker? The answer will only be a guess because the investigation of real social case work,—something more than the rapid study of a survey—would be necessary to determine how many of the others should have been socially cared for.

Taken altogether, our recollection of the personalities of the patients as revealed by the bedside interview, the friends, the life on the wards, the doctors' refers, perhaps it is fairly accurate to say that though twenty percent probably covered the most obvious and the emergencies, it would be worth while for the social worker to be able to make a fairly thorough study and to have offered a measure at least of actual social work for about forty or fifty percent. In considering the social needs one has to take in consideration the percentage previously known to outside social agencies. One must also bear in mind the fact that the ideal of social work in a hospital is not only to meet the emergencies but

to help to make the hospital a vital force in the patient's community life.

In considering the best methods which the hospital doctor and social worker can employ in order to select the patients most in need of social after care from among the hundreds admitted and in the hurry and rush of a crowded hospital, it is necessary also to bear in mind that twenty-five new patients a month, in addition to those already carried, constitute a full quota for anyone attempting social work in connection with ward patients. All the more is it essential then that a wise selection be made. What are some of the methods which can be employed?

Sometimes the patient himself asks to speak with the worker. Sometimes his friends tell the doctor or nurse of a difficulty and are sent to her. Sometimes the attention of the social worker is caught by the type of visitors—young children, foreigners unable to speak English and so on. Sometimes she makes a practice of talking with as many patients as she can. Probably the best basis for selection of those on whom to concentrate would be these brief personal interviews. But they alone, without a plan of choosing from their revelations, would be insufficient, and if from pressure of work even these brief interviews are impossible, what sort of circumstances should indicate to the doctor the need of her services, and in what groups should she train herself to look?

The doctor will always be quick to refer the bed-ridden chronic patients to the social worker because without her help discharge will sometimes be indefinitely delayed and beds will not be available for acute cases. But more truly constructive work could be done if the doctor were to call her attention to those patients who have not yet developed a chronic condition so that the social worker might be able to plan ahead, per-

haps arrange an environment that would check the disease or adapt itself to its progression. Possibly thus preventing or delaying a later readmission with no resource but the almshouse hospital.

Patients with potential cardiac disease, cardiacs requiring limited activity, convalescents from rheumatic fever, are examples of those that should be referred by the doctor to a social worker, because in the light of our survey as well as our other hospital experience, it is clear that both the home conditions and work of such patients are often poorly adapted to these diseases. The alcoholic "repeater," the young alcoholic, the incipient case of tuberculosis, the patient recovering from pleurisy, the venereally diseased should be referred. After the statements above as to income and savings, it is clear that where illness necessitates prolonged convalescence, a special diet, a change of occupation on discharge, the assumption should be that the patients will need some social help or guidance, and it is often as much the function of the social worker to study the social problem involved and decide that patients do not need her services, as it is the function of the doctor to make an examination and decide for or against operation.

Besides these medical reasons for refer, the doctor, in taking his history, will often discover some anxiety in the patient's mind regarding his own future or that of his family. He will know if the sick person is a father or mother of dependent children, or belongs to that isolated group living outside any family circle that has been referred to. In the former case, social or nursing care in the home during the parent's illness may be vitally important, while the latter group are those who are in danger perhaps of being discharged without proper plans for

whatever time must pass before they are again self-supporting.

These are a few of the medical and social conditions which should indicate to the doctor the patients who need some contact with the social worker. Whether, as has been said, she will find that they need such actual service as she can give is another matter. No one thing alone determines that, for the patient with no savings and an inadequate income may have an interested employer, and the man alone in lodgings may have a kind landlady or a brother on the next street. The investigation implied in careful social case work may be needed however to discover these resources, to make them function or to develop others, and doctors do not always realize that time is needed for all this. A social worker cannot expect the unlimited lesiure in which to make her diagnosis that is allowed the doctors for making their's. Yet she must go out into the community to study her patient, and she is very dependent on resources in the community—friends, relatives, private societies, other hospitals and Homes—for proper provision for him. Even if these coöperating organizations and persons outside the hospital were able always to work at white heat in arranging for a hospital case on discharge, the hospital worker has no power to make them do so. Also many crying needs for adequate after care are still lacking. The best coöperation between doctor and social worker depends largely on his referring the patients for whom he wishes her help a scufficiently long time before they are ready for discharge, also on his preparing them for the worker's interview so that she seems a legitimate part of hospital care, without on the other hand making any promises or raising false hopes as to what the worker will or can ultimately do.

But even with a sympathetic and socially-minded medical staff, if the social worker is to choose wisely, she must always have some comprehension of the group of patients as a whole. She can never act most efficiently for patients, hospital and community, if she simply takes what comes to her—no matter how many come, what services she performs for them, or how hard she works. She must be constantly looking beyond those she knows, to the silent and unknown groups in other beds. There is no better way of doing this than by allowing herself to be constantly seen on the wards, so that the patients and their friends naturally turn to her themselves, and by training herself always to have certain groups in mind.

We hoped that the survey might indicate the proportion of the really chronic cases carried by the Fourth Medical Service that do not logically belong in a hospital avowedly intended for the care of cases of acute disease. For, as in alcoholism, it is on the general municipal hospital that such a strain falls. We hoped we could show definitely how many of the chronically sick and chronically poor patients, the typical so-called "other public institutions" cases there might be who obviously had no adequate homes to which they could be discharged, whose pre-admission places of residence had been unheated rooms in cheap lodging houses, who did not belong in an acute hospital, but who would need bed care on discharge and for whom the community apparently offered no resource but the much dreaded almshouse hospital. One of the difficulties we met with was the finding out from the doctors the degree of real chronicity existing. In other cases the doctors held that certain of the chronic patients were suffering from acute exacerbations and rightfully belonged, for a time at least, in an acute hospital.

Then as to the actual resources which some of those apparent "other public institutions" patients could call upon: Hospital doctors are apt to classify as "almshouse cases" (O. P. I.) any chronic patients whom they wish to discharge, who appear to need nursing care and to be without obvious resources. Only careful social case work could, in many instances, have brought to light possible relatives and friends, lost or alienated, former employers, fraternal orders, racial groups, to say nothing of available private, charitable agencies that might have been called upon to provide care outside a public institution. This in spite of the fact that Boston is deplorably lacking in resources for the adequate care of needy, chronic patients.

As to judging the adequacy of the homes: It is not quite fair to make a general statement based on the needs of some chronic patients. It takes more than a "good" home to provide nursing and bed care for a paralyzed patient. The fact that a chronic patient cannot return to his home does not necessarily mean that such a home should be graded as "poor," or even as low as "fair."

In trying to arrive at any estimate then of the numbers of needy chronic patients admitted during our survey: basing our percentages on medical diagnoses, income, relatives, degree of disability, and personal idiosyncrasy it might be fair to say that perhaps 8 or 10 percent of the 482 were chronically sick patients for whom so little could be done that they should not have been admitted to an acute hospital. That about 7 percent of the 500 admissions had diagnoses of senility, arterio-sclerosis, cerebral hemorrhage. perhaps bears this out, as does also the fact that 22 percent of the 280 studied more intensively were sixty and over.

In regard to the 32 percent of alcoholic pa-

tients admitted and readmitted on an especially equipped medical service intended for the treatment of patients suffering from acute diseases: Alcoholism in itself is, of course, a most serious medical-social problem, implying possible social causes as well as consequences, and the exclusion of the greater part of the alcoholic group from our study was not due to a disregard of this fact. There are, however, so many admitted, their stay is so brief, most cases being discharged as soon as they have recovered from their acute toxic condition, community resources for social work amongst them are so few, although for this type of person social work must be so constant and continue so long to even hope to accomplish anything, that a social worker in an acute general hospital cannot attempt such work except in the exceptional case.

The fact that over 60 percent of the male admissions for alcoholism were thirty years of age and over is of interest and might at least seem to indicate that the present alcoholic problem may be with the older rather than the younger men, contrary to certain prevailing opinions as to the increase of drunkenness among the younger group.

As to the burden on the hospital: Staying, as such patients do, for very short periods, the percentage of admission does not, fortunately, indicate the amount of time spent on them by the hospital personnel, although board and lodging while they "sober up" is sometimes all the "treatment" they can be given. Yet even if each individual stayed only one day, the total male and female admissions would mean about 19 weeks' care for alcoholism on this one service alone in a four months' period. Of course many of them, the majority, stayed longer than a day. No comment is needed upon the strain placed upon an acute general hospital, on its re-

sources for feeding, recording, laundry work, to say nothing of medical and nursing care and energy withdrawn from patients to whom doctors and nurses would gladly give more, and who would, it is fair to say, profit more by such service. It is of course on a municipal hospital that almost the entire burden of medical care for acute alcoholism, at present, falls.

What proportion of the patients admitted had a right to care in a public, tax-supported institution? That 60 percent of the 280 patients studied more intensively had no savings; that there was every evidence that 30% had inadequate incomes which were wholly, or in great part, cut off by sickness; that the living conditions of 49 percent appeared totally inadequate, judged by any accepted standard of American living to meet the stress and strain of sickness; that 62 percent appeared to have Boston settlements; that over 49 percent were American born, and a great majority of the foreign-born had been here over twenty years would seem to indicate that the majority of the patients admitted had a right to care in a city hospital.

As to any contribution which a hospital social worker can bring to a medical service as indicated by such a study as this: Enough has been indicated perhaps to show the need there is for a medical staff in a large free hospital to recognize the social side of their patients' illness and aftercare, and the part that a hospital social worker can take in helping to disclose and provide that care.

In conclusion one must remember that the bare facts of a report cannot even suggest the variety of human type and experience shown in the daily interviewing of such a group as has been described. Those who know and have felt the appeal and fascination of a large municipal hospital in an industrial seaport city, do not need

to be told that on its wards, as is said of some of the famous streets on the old trade-highways of Europe and the East, everyone on earth will sometime or other appear. In one bed is the old Newfoundland fisherman who "in the name of God pulled up courage" to go to the hospital when he developed pneumonia, provided that, if incurable, he would be brought home to his friend's tenement to die. In another, in the same ward, is the Chinese boy sent in by the immigration authorities, only a few weeks from Canton. Nor can the bare facts of income, race, work, education suggest the many complications of marital discord, or maladjustment to environment, or past family history, or personal experience, or intellectual inferiority to the average in his group, or moral delinquency—all the factors in personality—which differentiate every single one of these many patients. The only way for doctors, nurses and social workers to approach this constantly shifting group, is with a firm grasp of its main outstanding features, an understanding of the social conditions they may usually expect to find, a quick recognition of smaller groups and exceptional cases.

If the social worker is known on the wards, if constantly, with a fresh and open mind, she is looking for the presence and needs of certain groups; if the doctor is alive to the social significance and demands, the social handicaps, of medical diagnoses and conditions, if he is prepared to find always a group from what we call the "unprivileged classes," or at least those who have no margin to allow for illness, among his patients, then doctor and social worker together will have a fair comprehension between them of the medical-social aspects of their wards as a whole, and be in a position to recognize the endlessly varying combinations that unite with individual temperament and experience to make up the individual patient's problem of aftercare for mind, body, and estate.

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