Some Social Factors Contributing to the Prolonged Hospitalization of Chronic Disease Patients in a General Hospital

by

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ABSTRACT

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ABSTRACT

In the consideration of chronic illnesses, social, emotional and economic factors are as important as the purely medical ones in determining the needs of the patients. Since hospital personnel believe that prolonged care of chronic patients in a general hospital involves a waste of hospital facilities, it would be of value to discover some of the social factors which are contributing to the prolonged hospitalization of a group of chronic disease patients.

Chronic diseases were defined as those which are insidious in onset, progressive, usually long term, and from which there is never complete restoration to normal. Within this meaning of chronic illness, as arrived at through consultation, the three resident interns of the Royal Alexandra Hospital, Edmonton, selected all the chronic disease patients in the medical, surgical and children's services, on July 15, 1946. Data about these eighty patients were collected from their hospital files, through correspondence with the attending physicians, and through a case work interview, adapted to the individual situation. Long term hospitalization was arbitrarily defined as thirty days stay. According to definition forty-two of the eighty patients were long term chronic

disease patients. These patients were grouped according to the type of care they required; active medical, nursing or custodial; and the data were then analysed to find what social factors were contributing to their prolonged hospitalization.

The greatest single contributing factor to extension of hospitalization was the fact that twenty (fifty percent) of these patients had nowhere else to go. A combination of factors such as, no family, family unwilling, unemployment, old age, lack of early medical care and insufficient community facilities for their care, were found to be contributing to this problem. Although statistical analysis or tabulation was not found possible, grouping according to the needs of the patients was indicated in order to account for prolonged hospitalization, where an adequate medical social plan could not be arranged outside the hospital. Of the fourteen patients requiring active medical care, five were in need of a special , prolonged type of care not available elsewhere; in three cases treatment was not known, and in six instances medical care was not available until too late in the progression of the disease; due largely to the inability of these patients to pay for it. Of the thirteen patients requiring nursing care only; six lacked family facilities for care, and nursing or boarding home placements were not available; the remaining seven had homes but nursing care was not available to them because of the expense and the scarcity. Fifteen patients remained in hospital a prolonged time, though not requiring medical or skilled nursing care. Nine of these patients remained longer than

three months, and two of them longer than seven years. These patients required a custodial type of care, not only for medical reasons, but because poverty made home care impossible.

In six of the forty-two long term cases, hospitalization was extended because of inappropriate treatment, which was usually due to the failure of the physician to treat the patient as a whole. It was obvious throughout that there is a great need in the community for facilities for the care and treatment of the chronic sick, who do not actually require treatment in a general hospital. Perhaps more important at the present time, was the indication of the need for medical social workers to insure the use of the existing facilities in the community to the best advantage of these patients.

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Chapter I

INTRODUCTION

1. BACKGROUND OF THE CHRONIC DISEASE PROBLEM

Of late years the students of vital statistics have been calling our attention to the increased longevity which is having a profound effect on our way of living. Since the beginning of the century certain characteristics of the Canadian population have changed. From 1921 to 1941 the proportion of the population over forty-five years of age has increased from nineteen[1] to twenty-five percent.[2] It has been estimated that by 1970 more than half the population will be over forty-five years of age.[3] This ageing of the population has far reaching significance not only

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(1) 6th Census of Canada, 1921, Vol. II, Population, Ottawa, Kings Printer, 1925.
(2) 8th Census of Canada, 1941, Vol. II, Population by local subdivisions, Ottawa, Kings Printer, 1944.
(3) Kresky, B., & Luykx H.M.C., "Patients are older and stay longer, Hospitals, Vol.18, no. 2, February, 1944, p. 22.

medically but also interlacing with all spheres of our social structure. The ever increasing number of people in the older age groups have created new problems; one primarily medical having to do with chronic illness, the other a social problem having to do with employment and security.

The problem of the chronically ill and the increase in the older age groups has its origin in the advances in medical science and public health during the past fifty years. Death rates from communicable diseases have decreased sharply, as a result of them, while death rates from degenerative diseases have increased steadily.(4) Reduction of infant mortality, prevention of acute infectious diseases such as typhoid, diptheria, small pox and scarlet fever, the institution of better sanitation and the improvement in such actual foodstuffs as the milk supply, have all been factors in lowering mortality among infants and children. Improved diagnosis and early recognition of disease resulting in rapid and early cures have all been factors in extending

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(4) ibid. p. 21.

the life span. As a result of the factors mentioned the numbers of persons suffering from chronic illnesses continues to increase.

Fundamentally the chronic patient differs from the acute patient in that the former suffers from a disease that is of long duration, and the latter suffers from a disease, possibly the same, that is of comparatively short duration. One person may react acutely to a disease that makes another a chronic invalid. There is no absolute classification of diseases as acute or chronic. The degree of disablement is variable and disability may be minimal, partial or complete. Although damage to the human body by chronic illness is permanent and irreversable it should not be considered incurable, since in all cases medical relief can be given and in some cases rehabilitation of the patient to the point of economic self sufficiency is possible.

Fundamental to all medical treatment is the basic realization that the physician is dealing with the whole individual. This is particularly important in the management of patients with chronic diseases. The chief

aim in treatment is to arrest the progress of the disease and to enable the patient to maintain or resume his accustomed role in his family and in society. Every measure to ease the suffering of the patient should also be tried. The confusion between senescence and chronic illness leads to neglect and maltreatment. Persons between the ages of fifty and seventy should be regarded as sick not senile.

In the past it was assumed that the chronically ill needed custodial care and that constructive medical care was not necessary. Recently, however, it is being emphasized that medical care is required in various degrees according to the stage of the illness, and classification of chronic patients by type of care rather than by disease is suggested.(5)

Chronic diseasesare for the most part, obscure in origin. Most important are diseases of the heart, arteries, kidneys and liver, organic affections of the nervous system, mental disorders, cancer, tuberculosis and non-tubercular diseases of the lungs such as

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(5) Boas, E.P., Proceedings of National Conference of Social Work, 1939.

asthma, various forms of rheumatism, diabetes mellitus, and other disturbances of the glands of internal secretion or of metabolism. Seventy years ago these chronic diseases caused only one fifteen of all deaths; today they are responsible for as many as one half.(6) Boas(7) has the following to say about the nature of the problem of chronic diseases.

> "The infectious diseases are recognized as a constant menace. Relaxation of methods of control quickly lead to their recurrence in epidemic proportions--- Chronic diseases do not present themselves in such cyclic stages; but they are a dry-rot constantly weakening and destroying the social organism. There is no realization that they are ever present and inescapable; that they occur at all ages; that if we are spared them in our youth they will almost inevitably overtake us in our older years."

Physical incapacity arising from these diseases is at first insignificant but gradually assumes greater proportions. In the earlier stages of the disease the subject is ambulant and able to work but gradually he becomes more disabled and eventually becomes an invalid. Chronic diseases

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(6) Boas, E.P., The Unseen Plague, Chronic Disease, J. J. Augustin Publisher, New York, 1940. p. 4.
(7) ibid. p.4.

differ from acute diseases not only in their essential medical characteristics but in their social and economic consequences as well. In most acute diseases the medical considerations are paramount, compared with them the social and economic difficulties are unimportant. In chronic disease the medical social and economic elements are inextricably interwoven and of equal significance.(8) Because of the extended duration of the average case of chronic disease, the special requirements for diagnosis and treatment, and the inadequacy of present facilities, the chronic disease problem is a major one.

Accurate figures on the prevalence of chronic diseases are not as yet available. Mortality figures tell only a small part of the story, as most deaths follow years of disability, yet the changing trend of mortality is very evident. Diseases of the heart and arteries accounted for 31,788 deaths in Canada in 1945. (270 per hundred thousand). Cancer was the second greatest cause of death,

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(8) Boas, E.P., The Care of the Aged Sick, Social Service Review, Vol. 4, June, 1930, p192

nephritis third and pulmonary tuberculosis fourth.(9)

Exact information regarding the actual prevalence of chronic illnesses could only be gained by a most intensive medical survey of large population groups. In the past fifteen to twenty years numerous surveys have been carried out in larger centres in the United States, and Canada in order to determine the incidence, nature, and needs of the chronically ill. These surveys reveal startling data in re gard to the incidence of this problem and to the facilities which are needed to understand better the nature of the problems and to provide a necessary means for their investigation and control. Perhaps the most extensive investigation has been the National Health Survey conducted in 1935-36 by the United States Public Health Service, which was a nation wide family canvass of sickness in relation to its social and economic setting. It was found that on any given winter day in the United States forty-two percent of those unable to pursue their usual activity because of illness

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(9) Canada Year Book, 1945.

or injury, are suffering from a chronic disease.[10] The incidence of illness was one hundred percent higher among the poor than among the moderately well to do and chronic disability illness was eighty-seven percent higher among relief clients than among families with annual incomes in excess of three thousand dollars.[11] The Committee on Chronic Illnesses of the Welfare Council of New York City made a survey of the chronic sick in that city in 1928. They found that one percent of the population were disabled by chronic illness and that three-fifths of all individuals with chronic disease needed medical care, one third of these in hospitals. One quarter of those living at home should have been in institutions. Nearly half of all the chronically ill persons were under forty years of age, one third were children under sixteen years of age chiefly with cardiac and orthopedic disorders. One fifth of the whole number were aged persons

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(10) Social Work Year Book, 1939, Medical Care, P. 241.

(11) Medical Care, Social Work Year Book, 1939. p. 238.

of seventy years and over.[12] This estimate of prevalence was supported by studies carried out in other centres. The Massachusetts Department of Health in a house to house survey in some communities found that twelve percent of the population were suffering from some form of chronic disease. It was also found that prevalence increases with age.[13] The Boston Council of Social Agencies estimated that the chronically ill, excluding those with tuberculosis and mental disease, who were receiving care from Welfare agencies numbered one in every one hundred and eighty-five persons in the city.[14] A Philadelphia survey estimated that in any American industrial city, one in every two hundred individuals was disabled by chronic illness. It was also reported that acute general hospitals were burdened with chronic patients for whom their facilities were unsuited and too costly for the type of care needed by most chronic invalids. It was felt that most of

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(12) Chronic Disease, Social Work Year Book, 1933, p. 78.
(13) Boas, The Unseen Plague, p. 7.
(14) The Care of the Chronically Ill in Montreal, Metropolitan Life Insurance, Ottawa, 1940, p. 3.

these patients could be cared for in institutions that cost to operate about one half the cost of care in acute general hospitals.(15) In 1940 the Eastern Canada district of the American Association of Medical Social Workers sponsored a study of the care of the chronically ill in Montreal. This study also supported the previous studies done in American centres. It was found that one percent of the population were permanently disabled by chronic illness and one-third of these people were dependent wholly or in part for their support and medical treatment.(16) This study pointed out that the problem is not limited to old age and that there is a high incidence of chronic illness in childhood.(17) The following is one of the conclusions arrived at by the study committee.

> "The problem of chronic illness at the present time handicaps the work which is done in the general hospitals and in convalescent homes, which were not primarily intended for such conditions. The large numbers of chronic patients occupying the beds in these hospitals for undue lengths of time, prevents

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(15) What Philadelphia citizens spend on medical and hospital care, The Modern Hospital, vol.37, no.2, p.58, August,1931.
(16) The Care of the Chronically Ill in Montreal, 1940, p. 29.
(17) ibid. p. 29.

fully efficient service being offered to those with acute illness. The large number of chronically ill patients in the so called homes for the aged, interferes also with the work of these institutions and results in numerous individuals who apply for admission being turned away". (18)

2. THE HOSPITAL'S PROBLEM

At the present time many types of institutions, homes for the aged, homes for incurables, almshouses, infirmaries and general hospitals offer refuge but sometimes little else to chronic patients. There is at present an utter inadequacy and indecency of existing facilities for the care of long term patients, as evidenced by the studies done on the problem. "Almshouses, poor farms, and homes for incurables have no place in modern society". (19) Whether or not the chronically ill should be hospitalized in institutions dedicated to that purpose or whether they should be housed in wings built as additions to present hospitals for acute diseases, is a subject still under debate. Some believe that they should be cared for in separate wings of so called 'acute' hospitals, (20) and

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(18) ibid. p. 29.
(19) Bluestone, E.M., "The Chronic has a Claim to Care and Cure in the Acute General Hospital", The Modern Hospital, Vol.63, no.3, Sept.1944, p.69.
(20) ibid. p.69.

others believe that special hospitals should be built for them.(21) In planning the extension of facilities in either direction, it should be borne in mind that prevention of these various diseases may reduce in the future the number of cases that will require institutional care.

Dr. E.M. Bluestone, director of the Montefiore hospital in New York, advocates a radical break with tradition in order to plan a complete community program for the long term patient. If there are not enough beds for the care of the long term patients, then he feels that they should be established in or around the general hospital.(22) He advises a general hospital for acute illnesses and emergent surgery; a hospital for treatment of chronic diseases and orthopedic cases; and a custodial home for the permanent and seriously disabled. These should be one medical centre under the one central supervision.(23)

> "Since the chronic patient requires every facility of the general hospital without exception plus certain added facilities, physio therapy, occupational therapy and

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(21) Boas, The Unseen Plague, p. 96.
(22) Bluestone, op. cit., p. 68.
(23) McClurkin, E., "Chronic Disease from the patient's point of view," The Modern Hospital, vol.65, no.5, November, 1945, p.78.

rehabilitation therapy; it would be costly to duplicate these at a distance."(24)

Dr. E. P. Boas, points out that in New York City fully twenty-one percent of the patients in general hospitals are suffering from chronic illnesses.(25) He feels that many of these patients may belong in the wards of a general hospital, but that when study reveals that they will need permanent prolonged hospital or custodial care they should be transferred to a special institution. He estimates that hospitals for chronic diseases should contain at least one hundred beds for smaller units would mean greater expense per person. For prolonged care and treatment chronic disease patients do not in his opinion belong in a general hospital. Facilities for treatment are not adapted to their needs and it is unnecessarily expensive type of care. In a single year four chronic patients may occupy one bed that otherwise might accommodate twenty-five patients with acute illnesses.(26)

There are few adequately equipped hospitals for chronic disease. The first representative of

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(24) Corwin, E.H.L., The American Hospital, The Commonwealth Fund, New York, 1946. P.9.
(25) Boas, The Unseen Plague, p.35.
(26) ibid. P.35.

the hospital with every modern appliance for treatment of the chronic sick in a homelike atmosphere, was Montefiore Hospital for Chronic Diseases, in New York, founded in 1884 as a Home for Chronic Invalids and gradually evolving as a hospital. The new sixteen hundred bed Welfare Hospital for Chronic Disease in New York city is the newest institution of its kind and marks the first comprehensive attempt on the part of a city to provide hospital facilities for the chronic sick.(27) However it must be understood, as pointed out by Morrison(28) that the provision of chronic hospital facilities are not cheap, and the chronic hospital requires facilities not found in a general hospital.

Throughout the whole of Canada, to serve over eleven million people there are only twenty hospitals for chronically ill persons, with a total bed capacity of 3,415; and these are totally unable to cope with the situation.(29) The findings of the National Health Survey(30) indicate that if

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(27) McClurkin, E., Chronic disease from the patient's point of view.
(28) Morrison, Pearl, "What do we mean by chronic patients?" The Canadian Hospital, p.36-38.
(29) National Health Survey Report, conducted by the Canadian Medical procurement and assignment board, Kings Printer, Ottawa,1945,p.147.
(30) ibid., p.147.

chronically ill patients could be transferred from our acute institutions a considerable percentage of the available space in such hospitals could be made available for acutely ill persons.

Fear of contagion and fear of bodily harm have roused the community to spend huge sums of money for the care of patients suffering from pulmonary tuberculosis and mental diseases, and also for the study and investigation into the origins of these diseases. The treatment of these diseases has developed through almshouse care, then special custodial home care, then treatment diagnosis and research centres. At present chronic illnesses are in the almshouse care stage; the community is still well satisfied to give custodial care to the chronic sick. However there are a number of recent developments which owe their existence to the war and to the threat of insecurity generally. Provisions for social security are including more public funds for the care of the patients who cannot finance themselves. The extension of voluntary group insurance schemes will confer benefits for those who can afford them. Apart from these economic developments there is increasing interest on the part of physicians, social workers and the public generally, in chronic

diseases and the realization of the present inadequacies for care.

As we have seen in the foregoing review of studies done on the nature and prevalence of chronic disease, there is a close link between poverty and chronic illness. "Poverty and chronic diseases lie within a vicious circle which must be broken somewhere".(31) It is futile to patch up the individual stricken with chronic illness without going through to the ways in which our social and economic system aggravates the disease, or ways in which disease brings social destruction in its wake. There are two chief groups of maladjustments caused by chronic illnesses. First are the emotional and mental maladjustments which affect both the patient and his family. If the illness is prolonged the patient may become fearful of what is to become of him and if a good deal of pain accompanies the illness there is usually an accompanying irritability developing. The presence of an invalid in a family may often determine the recreation, work, and the development of the lives of the other members of the family. Prolonged illness places a great strain on the varied human

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(31) Bluestone, E.M., The Emergence of the Chronic Patient, Journal of the American Medical Association, vol.23, no.6, p.374,Oct. 9,1943.

relationships comprised in a family. Parents often become a burden to their children who will welcome any means of getting rid of them. Daughters and sons are sometimes compelled to postpone marriage in order to help the family financially, or in keeping the home. Second are the economic maladjustments resulting from chronic illnesses. When the wage earner is stricken a host of problems arise which usually result in the dependency of the family. When it is the mother of a family who is ill there is an added expense, and usually a drain, of hiring a housekeeper to care for the family. When the illness is prolonged the cost of medical treatment is usually more than the average family can bear. Unfavourable economic circumstances make difficult the arrest of the disease and the rehabilitation of the patient. Lack of time, money, and energy to use special drugs and diet regime is also responsible for the development of much chronic sickness. Because of all these factors we see family after family disorganized, with shattered morale and resultant destitution. These ill effects are often a drain on the hospital's resources as well.

3. MEDICAL SOCIAL WORK AS IT RELATES TO THE CHRONICALLY ILL

Of recent years the profound influence of health, or the lack of it, on all aspects of community living has been more clearly manifested so that greater emphasis is now being laid on the medical component of social work. In any public welfare program today, chronic disease plays so large a part in the determination of dependency, that all case workers need to possess a fundamental grasp of what constitutes adequate medical care; in terms of housing, diet, mental hygiene and other public health matters.

Realizing that an understanding of the patient's social and emotional situation is important, many hospitals have established Social Service Departments, to contribute to a complete diagnosis and treatment of the individual patient. Throughout the past forty years, medical social workers have been carrying on studies in an effort to define more clearly the contribution they could make in the medical setting, and to improve the quality of their work. In a statement of standards, published by the American Association of Medical Social Workers, the role of the Social Service Department has been summed up by the following words:

> "Medical Social Service has been developed in the hospital as a service to the patient, the physician, the hospital and the administrator and the community, in order to help meet the problem of the patient whose medical need may be aggravated by social factors and who therefore may require social treatment which is based on his medical condition and care."(32)

By aiding the physician in the treatment of the ill the medical social worker enhances the usefulness of the medical care and thus helps the hospital to achieve its purpose in medical treatment.

There is a growing awareness among medical social workers of the needs of the chronically ill, and a search for ways to relate their services to these needs. The patient with a chronic disease is long term and his illness is more frequently controllable than curable. This would be hopeless picture if the focus were upon the disease rather than upon the patient with the illness. The connotation of the word chronic, has for a long time been an unpleasant one signifying to many people, incurable and therefore, hopeless. But with the growth in understanding of the

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(32) Statement of standards to be met by Medical Social Service Departments in Hospitals and Clinics, American Association of Medical Social Workers, January, 1943, p.3.

potentialities within those with chronic diseases, social workers are no longer content to assume that because cure is unlikely, the future is hopeless. In the light of increasing psychosomatic understanding, it is a mistake to type patients as "diabetics" or "cancer cases". What is significant to the medical social worker in chronic and acute cases alike, is the individualized knowledge of the patient with the illness, and the use of this knowledge toward helping him achieve maximum adjustment to his incapacity, in relation to his environment.

Essentially the kinds of problems presented by the chronically ill are as varied as the patients themselves and are in no way unique in the manner in which the social worker relates her services. Each patient suffering from long term illness has a right to be known as an individual with hopes and fears for himself. The limitations of the illness cannot be overlooked but they are seen as a part of the patient, affecting the whole of him but not obliterating him as a person. The one distinctive factor in social service for the chronically is time, and it is this time element which makes all the difference not only to the medical agency but

also to the patient who has been ill for months and sometimes years. This time element is especially important in the treatment of the aged, with chronic diseases; who make up the largest proportion of this study group. Theoretically society provides the needy aged with means of subsistence but beyond the statutory visits of the welfare worker, there is no further obligation for anyone to take an interest in the client. The situation is further complicated by the lack of good institutional accommodation for old people, who, though chronically ill, refuse to end their days in the poor house. They are often right in their stand, since adequate care is not available for them in the poor house. With their cash benefits they could be cared for in a boarding home, or their own home; provided that a greater amount of social service and medical care were available. The volunteer worker has an important part to play here; if directed by an experienced organizer, in the provision of diversion and comforts. This service may make a great contribution to the patient's happiness and is in no way a substitute for the essential case work of the professional social worker.

The staffs in social service departments in hospitals are often inadequate to carry on the prolonged supervision of chronically ill patients, following their discharge from hospital. In the case of the Royal Alexandra Hospital, where there was only one social worker, this was seen as a limiting factor in the service available to the chronically ill. Follow up with case work service, for the chronic patient was impossible after discharge, due to the pressure of work, and theoretically, the social service department could give service only to patients while they were in hospital. As prolonged care of the chronic patient in a general hospital involves a waste of medical facilities, the medical social worker was often confronted with the problem of arranging for his care elsewhere. This usually proved a difficult task, for various reasons. The patient was reluctant to leave the shelter of the hospital; community resources such as visiting nurse and medical service, housekeeper service, custodial, boarding, and nursing homes, were lacking; or the family was unable to care for the patient, due to poor housing facilities, inability, or unwillingness.

Provision of adequate care for the chronic

sick is a complex problem because we are dealing not with one disease but many. Therefore, before planning for the chronically ill in the community it would be valuable for the hospital administration to know something of the extent of the problem to be dealth with; the number and types of patients in hospital using facilities which they do not actually need, and some of the reasons for their extended stay. Knowing the extent and nature of the problem adequate plans could be made, for planning must concern itself not only with the strictly medical phases but also take into consideration the wide spread social and economic implications of chronic disease. Therefore it is proposed in this study to discover some of the social factors which contribute to the prolonged hospitalization of chronic disease patients in a general hospital.

SCOPE AND METHOD

Chapter II

Scope

The present study was started at the Royal Alexandra Hospital, Edmonton, Alberta, in July, 1946.(See appendix 2) At that time the hospital administration had become concerned about the numbers of chronic disease patients who were staying in the hospital for prolonged periods of time. Pressure was being put on the staff physicians to discharge these patients as quickly as possible in order to make room for the admission of patients requiring more active types of medical care. The total hospital personnel were concerned about the problem of providing adequate care for chronically ill patients and this concern was becoming apparent in the community, especially in the Council of Social Agencies, where awareness of the need for planning was being felt. It was believed that a study of chronic patients then in hospital, in order to determine some of the reasons for prolonged stay in hospital, would be helpful to a planning group, and on this basis the study was attempted.

Definition of chronic illness, for purposes of this study, was arrived at through consultation with the Acting Medical Superintendent and the three resident interns of the hospital. Mental illnesses and pulmonary tuberculosis were excluded from the definition by reason of the fact that these ailments are treated elsewhere in separate hospitals.

It was further decided to exclude such disabilities as fractures, blindness and deafness, and to be concerned in this study with those diseases, usually considered chronic,(33) which are insidious in onset, progressive, usually long term, and from which there is never complete restoration to normal. Within this meaning of chronic illness, as arrived at through consultation the interns listed the names of chronic patients in the medical, surgical, and children's services in the hospital. The lists were compiled on July 15, 1946, and since the concern of the study was to be prolonged hospitalization, no effort was made to follow up over a period of time. Rather, the subjects of this study are chronic disease patients who were in the hospital on that one day.

It was found that out of an available three hundred and twenty-two beds, eighty,(twenty-four percent) were being occupied by chronic disease patients. Eighty-four percent of this total were in the medical wards, while eight and a half percent were in the children's service and seven percent in surgical wards.

Method

In order to have a uniform selection of cases, a conference was held with the three resident interns in order to explain the purpose of the study, and to reach an agreement

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(33) Boas, The Unseen Plague, p.19.

among them, on a definition of chronic diseases. They then submitted a list of the chronic patients in their service, together with the diagnosis and hospital number. A schedule was then drawn up on which to record the data about each patient. (see Appendix 1) As much information as possible was gathered from the medical chart and the general office files and recorded on the schedule. Previous medical history was obtained from the intern's history on the medical chart, and from previous hospital files, where available.

A case work interview, adapted to the individual situation was held with each patient able to be interviewed, to supplement hospital files. Thirteen of the patients referred were unable to be interviewed for various reasons; six patients died shortly after referral, four paients were in the terminal stage of their illness, and three were discharged before they could be interviewed and could not be contacted upon discharge. Four of these patients, unable to be interviewed, came within the group of long term patients but it was felt that sufficient information was available about these four, without the interview, for them to be included in the study. The attending physicians were consulted in each case in order to obtain the prognosis and the degree of incapacity suffered by each patient.

Since there is no absolute classification of a disease as acute or chronic it was found cumbersome to attempt to classify the patients by type of ailment. Classification by type of care received, or required, was found to be a simple

and a more valid means of dealing with the patients in this study. Chronic disease patients fall roughly into three main groups according to the type of care they require. The first group, Class A, are those patients who are in the "acute" or exacerbation phase of their illness in which they require active medical and nursing, diagnostic and or treatment care.

The second group, Class B, is composed of those patients who have passed the acute phase of their illness but still require skilled nursing care for a prolonged period of convalescense. Usually the nursing care required is for relief of pain, and maintaining comfort of the patient, where nothing will restore the function of the damaged tissue. This involves careful dieting and the administration of medication. Many patients in Class A and B need the highly specialized care such as offered by the general hospital but they need it for a period of months.

The third group, Class C, is composed of patients who are no longer a medical problem. The disease process is arrested leaving the patient with a permanent physical disability. He may require some assistance in dressing, bathing and eating, but no expert nursing or medical care is necessary. This type of patients require custodial care only. Patients in B and C do not necessarily require care in a general hospital. Some patients in Class B, and all in Class C, could be cared for in a good nursing home, boarding home, or in their own home if available.

On grouping the eighty chronic patients according to the class of care required, it was found that forty-nine percent required medical and nursing care or were in Class A; twenty-six percent required only skilled nursing, or Class B care; and twenty-five percent required custodial care only. (see Appendix 3, table No. i)

The distribution of patients according to length of stay in hospital was calculated in order to determine the number of patients who had been in the hospital for a prolonged period of time. Thirty days care was chosen as the arbitrary point of division between short and long-term care.(34) It was found that forty-two of the chronic patients had been in the hospital longer than thirty days. (See Appendix 3, table no.ii) Thus this study was concerned primarily, with fifty-two percent of the chronic disease patients in the Royal Alexandra hospital, July 15, 1946.

Through the presentation of case material, and some discussion of individual patients; a chapter being devoted to each of the groups according to type of care required; some social factors which might have contributed to prolonged hospitalization, are discussed. The cases presented are illustrations of the outstanding social factors or problems presented by these patients and no attempt was made to

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(34) Hundenburg, Roy, A., A study of bed distribution according to length of stay, The 1946 Directory, Hospitals, vol. 20, no. 10, pp. 52-54, October, 1946.

analyse or tabluate the findings statistically, since the data did not lend themselves to this treatment. Although the chief emphasis in the study was on the long term patients, those considered short term by arbritrary definition were not excluded from consideration since it was obvious that the two groups were not essentially different. It is suggested that long term hospitalization of chronic disease patients in this hospital is largely dependent upon several contributing social factors which will be discussed in the following chapters.

Chapter III

LONG TERM PATIENTS REQUIRING ACTIVE MEDICAL OR DIAGNOSTIC TREATMENT

Of the forty-two long term chronic disease patients, one third required an active type of medical treatment, such as is available in a general hospital. In every case this need for medical care was the main reason for extended stay in the hospital. For ten out of the fifteen cases, adequate medical care could not be given elsewhere. For the other five, adequate care could be given in a nursing home or in the patients own home, if skilled nursing care and continuous medical supervision were available. In each of these five cases it was more convenient, for patient and physician, to have the patient in the hospital for care, because of the inability of the patient to pay a physician for home visits, and in some cases because of the distance of the patient's home from the city. All of these patients, without exception, were financially unable to supply themselves with the necessary nursing care and there was no visiting nurse service in the community; though four of the patients were people who did have a home or a family who could care for them.

Only one patient in this class was receiving care in the public surgical ward; the remainder being in public medical wards. The most common disease in the group was diabetes which was the diagnosis in four cases. Heart and kidney disorders occurred with equal frequency, each account-for three cases. Three patients were disabled by asthma,

osteo-myelitis and cancer respectively, and the condition of the remaining patient had been provisionally diagnosed as cancer, but this had not been confirmed.

The number of days care in hospital ranged from thirty days to ninety-three days care, thirty days being the mode, and only two patients being in hospital more than ninety days. The patients ranged in age between sixteen and eighty-six years, one half the group being under fifty, and only two patients over sixty. This means that the majority of the patients in this group were in the productive years of their lives, and treatment of their illnesses was imperative in order to prevent progression to total disability.

Only two patients in this group were comfortably able to pay for their medical care. Six patients belonged in the marginal income group. Although they were able to support themselves they were not prepared for the additional expense of prolonged illness. The remaining one half of the group were entirely dependent for their support, three on family, two on the city relief assistance, and one on an Old Age Pension; these patients were unable to pay either for their support or their medical care. Thus, all but two of the long term chronic disease patients requiring active medical treatment in hospital were not able to pay for the special medical care they required in order to prevent the progression of their diseases.

Although need for medical care was the main reason for prolonged hospitalization in each case, an examination of the

social background of these patients brings to light some factors which may be contributing to prolonged hospitalization. In one half of the cases financial inability to plan for care elsewhere was seen as a factor in contributing to the extension of the hospital stay.

When illness strikes there is an immediate disruption of living routine; new emotional adjustments must be made and additional economic problems must be met. In cases of acute illness, the duration is usually not sufficient to make either the psychological or the financial strain critical. After a few weeks, daily life becomes normal and the extra expense is absorbed gradually into the budget. But, when the disease is protracted, the case is quite otherwise. A chronic invalid in a home is always a tax on the other members of the household either emotionally, physically or both. Among poorer families these difficulties are accentuated. Many families, not alone of the poor, but also of the so called middle class, are inevitably pushed to destitution by the continuous financial drain of chronic illness. The following case illustrates not only how poverty may be a cause of delay of discharge, but also how it may have contributed to the development of the condition.

Case of Mrs. A.A.

Mrs. A.A., a widow, age eighty-six, had been in hospital ninety-three days with a diagnosis of diabetic gangrene. Treatment consisted of amputation of the great left toe, and following the operation, dressing of the wound and regulation and supervision of diet. The patient was dependent

for her support upon an old age pension. She had no family living, and prior to admission had been living alone in a rooming house. She had been suffering with diabetes mellitus for a number of years and had been hospitalized twice previously for regulation of diet and medication. She was seventy-five percent disabled by her illness and because of her age and lack of family resources, some form of custodial care would have to be provided for her upon her discharge.

It is a fair assumption that the patient's deficient income and poor living conditions may have been contributing factors in the development of the gangrene. It is known that in cases of diabetes mellitus great care must be taken in the regulation of the diet and in caring for the extremities in order to prevent the development of gangrene. Also, present knowledge about the control of diabetes makes rehospitalization for the condition unnecessary, if the patient is able to obey the rules of diet and insulin dosage. Although this is rather a severe case, it is perhaps not unusual to find this type of patient in a general hospital. One would expect that a person eighty-three years of age would suffer with some breakdown in body function. However, it is fair to assume that this patient's most pressing problem was that of securing adequate living accommodation, which problem was complicated by her poor physical condition and her inadequate income.

Although the greatest proportion of the patients in this class were in the older age group, one third of the group were under thirty years of age. The outstanding problem for this

younger group was the securing of sufficient and appropriate medical treatment in order to arrest or cure the disease. This was found to be a problem for various reasons; either treatment for the condition was not known or easily available, or the patient was unable to pay for treatment or sufficient convalesence to insure against recurrence. The following example, which is illustrative of this problem, is the case of a boy in need of special medical care and rehabilitation, yet lacking the financial resources to pay for it.

The case of AB

Billy, a sixteen year old boy with a diagnosis of osteo-myelitis, had been in hospital for seventy-two days receiving surgical treatment. His illness had totally disabled him for a period of at least six months. For one year prior to his admission he had been entirely self supporting through heavy manual labor. His family lived in a distant town and he said that it was impossible for him to return there for convalescent care, as there were four younger children in the home and the parents were financially unable to bear the added burden of his care. His treatment consisted of drainage of the wound and change of dressings. The attending physician reported that the boy could be discharged to his home and come into the hospital for this treatment. Since the boy had no home to be discharged to this plan could not be carried out and he had to remain in the hospital for a longer period than was strictly necessary.

This case illustrates the necessity for the provision of special care for young people suffering with incapacitating

illnesses. The patient's rehabilitation, physical, psychological, and economic, depended upon his finding a job within the limits of his handicap. Work that would be too taxing would accelerate the disease and soon lead to total disability. It was necessary that the boy support himself yet he lacked the training to do any job that was suited to his physical limitation. His family was unable to help and the community lacked adequate facility for his training toward rehabilitation.

Carelessness, or failure on the part of the patient or his family to understand the true nature of his disease and the importance of following a prescribed program, together with adverse social and economic factors and lack of medical supervision, often tended to nullify the benefits of hospitalization. In all but five cases in this group these factors were in evident operation, in varying extents. Some patients were repeatedly readmitted to hospital because of cardiac decompensation that could have been prevented, diabetic coma that should not have occurred, and a host of other conditions, that satisfactory medical supervision would have averted. Although inadequate medical supervision is sometimes the result of failure on the part of the physician to understand the whole problem, often the trouble is in the personality of the patient and in his inability to accept appropriate treatment or medical supervision. Understanding of the medical, social and emotional factors contributing to the patient's condition is imperative in treatment; and under-

standing of these interwoven factors gives some indication of their contribution to the repeated and prolonged hospitalization in the following case.

The case of Mrs. AC

Mrs. AC a woman of forty-five had been in the hospital sixty-eight days. She had a record of fifteen previous hospitalizations in eight years. The patient was first known to the hospital in 1931 when she was admitted for treatment of dysmenorrhea. At that time she gave a long history of previous illness including, measles, mumps, scarlet fever, and influenze; and operations including appendectomy, removal of an ovary, and a perineorrhaphy. In 1934 the patient was readmitted and treated for neuritis and constipation, both conditions being considered functional disorders. Nine years later she returned to the hospital suffering with valvular heart disease. During the next four years she was admitted to hospital twelve times for the treatment and the control of this condition.

Little information was available from the patient about herself and her social background. She stated that she was of Italian descent, born and brought up in Alberta, in the protestant faith. She had seven years public school education, and did domestic work prior to her marriage at nineteen years of age. She then had two children in quick succession.

When the patient had been in hospital two months, her husband gave notice that he would no longer be responsible for medical bills, claiming that he could not be held respon-

sible since he was not married to the patient. This decision was the result of a quarrel in the ward, on the occasion of a visit, in which the patient stated that she did not wish to see him again.

In discussing the situation with the husband, and in later contact with the patient's family, the social worker discovered that much of the information given by the patient, about herself, was not true. It was found that the patient was of ukrainian descent, and brought up in the Greek Catholic faith. Seven years before her admission to hospital she left her husband and went to live with the present common-law husband. Her heart condition developed around this period and she remained an invalid. The common-law husband paid all medical bills, until the argument, and then decided to have nothing further to do with the patient. As a result of this decision the patient was left in a dependent condition and lacking the ability to earn due to her serious physical condition. In view of the circumstances the social worker attempted to help the patient make a suitable plan for care in the event of discharge. However, the patient refused to admit that there was a problem, and repeatedly affirmed that there was no need to talk about discharge since she would surely die in hospital.

As Weiss and English (35) have stated, the mere discovery

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(35) Weiss, Edward and English, O.S. Psychosomatic Medicine, p. 79.

of unpleasant circumstances in the life situation of an individual is no indication of emotional complication and still less of psychogenic origin of the difficulty. The significant factors are the patient's ability to adjust to such situations, his pattern of reacting to them, the degree of anxiety in his make-up, the nature and seriousness of his conflicts; as well as physical defects and his patterns of physical behaviour. This patient exhibited little insight into her problems, and a failure to accept realistically her life situation. She evidently had a good deal of conflict about her national origin and religious upbringing and she gave the worker false information in a manner that suggested that she believed it true. Since her physical condition was made worse by emotional excitement as evidenced by her relapse after the quarrel with her husband, the social worker avoided arousing the patient's anxiety by questioning the discrepancies in her story. Although information about the patient was sketchy, there was sufficient evidence to indicate that her condition had been influenced by her emotional reaction to her life situation, and because of her habitual pattern of reaction, which had resulted in a complicated social situation, her discharge from hospital had been delayed.

In this class of patients whose hospitalization had been prolonged primarily because of need for medical treatment there were several social factors which were contributing to the extension of the hospitalization. Two thirds of the patients in this group, while having serious medical problems

to be dealt with, at the same time had social problems which may have contributed to the development and extension of the illness. Stated simply the most prevalent problems was poverty. In some cases this was the end result of the illness, but in others it clearly contributed to the development of the condition. Lack of medical care and its appropriate application, which is tied up with economic status, was found to be a contributory factor in several cases. In a small minority of instances, it was fair to assume that the patient's personality problem was responsible for prolongation of the illness and consequently the hospitalization.

Chapter IV

LONG TERM PATIENTS REQUIRING SKILLED NURSING CARE

Slightly less than one third (thirteen) of the long term chronic disease patients in hospital were in need of skilled nursing care only. In every case the disease process had been arrested or brought under control, but the organism had been permanently damaged, and nothing could restore the function of the damaged tissue. The patient was either totally disabled, as in the case of the patient with rheumatoid arthritis who could not care for his own needs; or was in the terminal stages of the disease, such as the patient with far advanced cancer which would not yield to surgery and was not amenable to radiation treatment. However, expert and sympathetic nursing care was necessary in these cases to relieve the patient's misery or to avoid serious complications such as the development of bed sores. Such care was often necessary for a period of months and included not only routine nursing care, but sometimes careful dieting and the administration of hypodermic medication. Such nursing care may be available in a general hospital but it is also available in a fully staffed nursing home, or in the patient's own home by a trained visiting nurse; but perhaps most appropriately of all, in an institution for chronic patients.

Only two patients in this group were able to pay for their care in hospital or could afford home care. Four of the patients were in the marginal income group and payment for their prolonged medical care would make them destitute.

The remaining seven patients were dependent for their support, either upon their families as in the case of three young people, city relief assistance as in two cases; or Old Age Pension as in two cases. These dependent patients were totally unable to pay for any type of medical care.

One half the patients in this group were over seventy years of age and one quarter were under forty. Seven patients were without families or the family was unable to assume the care of the patient at home, because of lack of housing facility, skill, or poverty. Six patients had families who were financially able to care for them at home but who found it more convenient to have the patients in the hospital, because of lack of nursing skill or ability or due to unwillingness to assume the responsibility of such care.

One patient in the group was receiving private ward care, two were in public surgical wards and the remainder of the group were receiving care in the public medical wards. Four patients suffered with conditions of the heart, the most common ailment; cancer was the next most common, accounting for three patients. Two patients were diagnosed as suffering with senility and the four remaining patients had the respective diagnoses of cardiac lues, glomeruo-nephritis, rheumatoid arthritis and diabetic gangrene. The number of days care ranged from thirty to three hundred and eleven days, eight patients staying longer than sixty days and five longer than ninety days. Two patients in the group died within thirty days of the date of the study.

The following case is illustrative of the most typical kind of patient in the group and points up the most common factors which are contributing to prolonged hospitalization of these patients, namely poverty and lack of community resources or facilities for care elsewhere.

The Case of B.A.

Mr. B.A. a widower, seventy-six years of age had been in the hospital ninety-eight days. Upon admission he was suffering from an old tubercular lesion of the spine and treatment by surgery had been successfully performed. When the patient was nearing readiness for discharge, new symptoms developed and it was discovered that he was suffering from coronary occlusion. His treatment consisted of bed-rest and sedatives, his condition was poor and there was little hope for recovery. B.A. had a long history of illness and accidents and also a history of frequent changes of residence and occupations since the death of his wife, twenty-seven years previous. He was dependent for his support upon an Old Age Pension. He had two sons living in another province but had no home of his own, anywhere. Prior to his admission to hospital he lived with a friend, who could not take him back upon discharge, because of the nature of the care he required. In his condition, B.A. could have been discharged from the hospital, had he a place to go where he would receive adequate nursing care. However, since such care was not available to him outside the hospital, it was necessary for him to remain, probably until his death.

Here is an elderly man, without family or friends able or willing to care for him; frightened and demoralized by his illnesses and hard luck, feeling that fate is against him; lonely; and wanted by no one. This is a case of human suffering, a result of neglect of proper medical supervision when it was really necessary. The patient's present problem is a straight question of poverty, and his case illustrates clearly the need for medical provision for the proportion of our population who are unable to pay for medical care and are thus without supervision until the disease process threatens life. It also points up the need in the community for medical services, such as nursing homes, and visiting nursing service, which would be available to the medically indigent. This case is not an uncommon one, rather it is the typical type of case seen by the medical social worker, in hospital clearance work.

The following history is also a common type of case seen in a general hospital and it is illustrative of the misuse of general hospital facilities.

The Case of B.B.

Mrs. B.B., a widow, age eighty-five, was admitted to hospital following a fall from bed, suffering with cerebral thrombosis, arterio-sclerosis, and senility. The patient's daughter had been caring for her at home during the previous six months of her illness. She was totally bedridden by her illness and she required nursing care and a good deal of attention. The daughter found it impossible to continue with her mother's care, and since this type of care was not avail-

able elsewhere in the community, the patient was admitted to the general hospital. After seventy-eight days of routine nursing care in hospital, the patient died.

Although this patient was not in need of special medical attention or supervision she did require skilled bedside nursing care to keep her comfortable and to ease her suffering. This type of care requires the service of a trained nurse and it is difficult if not impossible for the patient's family to give such service. When the family must do so out of necessity it often results in physical or emotional hardship for some members of the household. In this case the patient was given home care until her fall from bed, a common occurrence in cases where skilled nursing care is not available. Since there was no other place to go, she was admitted to the general hospital, where she remained until her death, occupying a bed which was sorely needed for the more acutely ill who required the special services available in a general hospital.

In the following instance the medical social worker was able to help make plans for the patient's discharge from hospital only after routine hospital check indicated that the patient was not in need of general hospital care. This case illustrates the impoverishing effect of chronic illnesses and is an example of hospitalization being prolonged because the patient had nowhere else to go.

The Case of B.C.

Mr. B.C. a seventy year old single man of Ukranian origin, had been in the hospital two hundred and two days suffering

from apoplexy. The patient, totally incapacitated by his illness, could not help himself at all. He was able to sit up for a few hours at a time, his speech was slurred, his memory clouded, and he was hard of hearing. Although he was not in need of medical attention he required nursing care to keep him comfortable.

The patient came to Canada from the Ukraine at the age of forty-five and worked as an occasional laborer and handy-man until his stroke. Although he had been a city resident for twenty years, he had never taken out naturalization papers and was thus ineligible for an Old Age Pension. Prior to his hospitalization he had been living with friends, who stated that they would be unable to take him back in view of the amount of nursing care and attention that he would require. The patients small bank account was garnished by the hospital for partial payment of the bill and the city relief office was notified (by the collections office) of its responsibility for the care of the patient. The patient was then referred to the social worker who with the cooperation of the city relief officials and the patient was able to arrange transfer to a private nursing home where he could receive the practical nursing care that he required.

This patient was not in need of treatment in a general hospital. A more appropriate plan could have been worked out through the social service department of the hospital in teamwork with the physician, but this was not done because the physician did not understand or accept the role of a

Social service department in a hospital.

It was not until his financial resources were exhausted by the payment of medical bills that thought was given to the provision of some more appropriate type of care. Once the patient was no longer able to pay his hospital bill his case was brought to the attention of the social worker who was able to make a plan for his discharge. However, he was not eligible for admission to a city nursing home until he was destitute, and under the care of the city relief office.

In the foregoing cases the patients stay in hospital was prolonged to varying extents because there was no other place where the patients could get the care he or she required. This was for various reasons; such as, no family, or family unwilling, or poverty, either personal or of the community in providing medical care for the chronically ill. Usually it was a combination of several factors which complicated the situation. In all these cases, however, the attending physician and hospital staff, were aware that the patient no longer required care in the hospital but discharge was delayed because of insufficient facilities in the community for the care of the indigent, chronically ill.

In some cases it was found that the patient's hospital stay was extended for some of the foregoing reasons but was complicated by inadequate medical attention. This was due to either the lack of the physician's understanding of the patient, or was the result of the inability of the patient to carry out the instructions of the physician or to adjust to

the limitations of his illness.

In the following case the physician failed to help the patient, because he failed to treat the individual, rather concentrated upon the disease itself.

The Case of B.D.

Miss B.D. a girl of nineteen had been in the hospital forty-two days on her sixth admission to hospital. The previous admissions had been for, trench mouth, pneumonia, diptheria, rheumatic fever and appendectomy. The diagnosis given by the intern for this patient had been 'personality instability'; the attending physician had provisionally diagnosed it as rheumatic fever, but had not confirmed it. For the previous seven years the girl had exhibited such diffuse symptons as, weakness, nausea, joint pains, shortness of breath, loss of appetite, and fever. The patient's mother had suffered with inflammatory rheumatism for a number of years.

A consultant physician reported that the rheumatic fever was now quiescent and that the girl's trouble was "largely functional" and would require treatment by psychotherapy. Her treatment in hospital consisted of medication to the joints and sedatives, to which the patient failed to respond, after a month and a half.

The continuation of treatment of the physical symptoms alone, indicates the physicians lack of understanding of the girl's problem; her failure to respond suggests the inadequacy of the treatment. Prolonged hospitalization in this case was due to inadequate and inappropriate treatment

on the part of the physician. The girl, now a confirmed invalid, with a doubtful prognosis, will continue to receive hospital care as long as her family continue to pay the bill. Although this was not a common type of problem in this group, inappropriate medical treatment was felt to be contributing factor in prolonged hospitalization in four of the fourteen cases.

The outstanding social problem in this group of patients, was poverty. The essential difference between this group, and the one discussed in the previous chapter, was the type of medical care required, and there was no outstanding difference in the types of problems which were affecting the length of hospitalization. In only four cases was the need for nursing supervision urgent enough to warrant continued hospitalization. In the remaining ten cases continued care was necessary because the patient had no place to be discharged to. Five were without family or home and five had both relatives and home but could not be accepted there for various reasons, mainly because sufficient nursing care would not be available.

Chapter V

LONG TERM PATIENTS REQUIRING CUSTODIAL CARE

The remaining one third of the forty-two long term chronic disease patients belonged to class C, patients requiring custodial care only. These patients no longer presented a medical problem. In them the disease process was arrested, leaving a permanent physical disability. Many needed some assistance in dressing, bathing, and eating, but no expert nursing or medical care was necessary. Such patients may live at home if the home is adequate. In only two cases in this group did the patient have a family both willing and able to care for them at home, and in both cases the patients were discharged to home care at the time of the study. Another two patients had families who were able financially, but were unwilling to assume the burden of the care of the patient in the home. Instead they paid for the patient's care in the hospital.

Of the fifteen patients in this group, only three were able to comfortably pay for their hospital care; two others, although not yet destitute were unable to pay for their care without becoming destitute. The remaining two thirds of the group were totally dependent for their support; five upon city relief, and five on Old Age Pensions. One half the patients in this group were over seventy years and all were over forty years of age. The number of days care in hospital ranged from thirty-five days to 2,925 days, with seven patients in the group being in the hospital longer than

two and a half years.

All the patients in the group were receiving care in the public medical wards. The most common ailment was diseases of the heart which accounted for five patients. Neuro-syphillis was the diagnosis in two cases, and the conditions of the four patients were given as, asthma, brain tumor, neurogenic diarrohea, and malnutrition, respectively. In two cases the diagnosis was given as senility, which meant that the patient was suffering the natural degenerative changes of old age and that there was no specific diseased organ. One patient was described as a boarder; no medical diagnosis had been made and the patient was not in need of care in a general hospital, she merely 'boarded' there.

In this group of patients, the most outstanding single factor contributing to the prolonged hospitalization, was lack of facilities in the community for the care of the aged sick. In seventy-five percent of the cases, the elderly patient had been admitted to hospital for medical treatment, and once the disease process was arrested and the patient ready for discharge it became apparent that discharge would be impossible since the patient had no place else to go. The most common reasons were, poverty and inability of the patient to pay for care elsewhere, and lack of public provision of custodial homes for the aged. The following illustrations are typical in this group of patients of what happens once the elderly indigent patient gains admission to the general hospital.

The Case of C.A.

Mr. C.A., a single man, aged eighty-three had emigrated from Sweden at the age of twenty and worked in this country as a transient laborer. He claimed he had no family or friends in this country. For unknown reasons the patient had failed to obtain Canadian citizenship and was thus not eligible for an Old Age Pension. He had, however, established residence in the city and was in receipt of city relief allowance, living alone in a rooming house. He was admitted to hospital during an acute psychotic episode which had been precipitated by malnutrition and a vitamin deficiency. He was up and around the hospital and did not require skilled nursing care. His treatment consisted of nourishment and sedatives.

When interviewed the patient stated that he had never been sick before, or had never had medical attention. He had no idea of how long he had been in the hospital and said he had nowhere to go upon discharge. He stated that he hoped he would die in the hospital and then he would be put underground and out of the way.

The Case of C.B.

Mrs. C.B., an eighty-five year old widow had been in hospital three years at the time of the study. Upon her admission to hospital the patient's only daughter, living in California, was contacted and it was discovered that she was willing to have the patient with her. However, since the daughter did not have complete naturalization papers, the patient was refused entry into the United States.

The patient remained in hospital and each month her Old Age Pension cheque was turned over to the hospital. She was allowed a few dollars each month for comforts. Her treatment in hospital consisted of routing care and regulation of her diet. She also required a hypodermic injection each night in order to prevent an asthmatic attack. However, it was found that a hypodermic of sterile water was as effective as any of the drugs used, to control the attacks.

After two years of hospitalization the daughter got her final citizenship papers and it was possible for the patient to go to her. By this time the patient was terrified to leave the hospital and her condition made such a long trip impossible for her. She stated that she could not leave the hospital and that she had not long to live now anyway. At the time this study was made the patient had received care for a year following this event.

The point emphasised in these illustrations is that adequate provision has not been made in the community for the care of the aged sick. As seen from the above illustrations there is no one scheme which will meet the needs of the aged. In the case of Mr. C.A. medical supervision was not necessary once the acute phase of his condition had been dealt with. His is a problem of poverty and neglect and illustrates the inadequacy of the care provided by the city relief department. It also points up the gap in our national provisions for the aged, which does not provide for non-citizen residents who are in need. Mr. C.A.

was in need of adequate physical maintenance, the lack of which had precipitated his admission to hospital. Since he was without family and financial resources he required some type of custodial care at public expense. Such care could have been had in a boarding home. Instead, the patient was given a financial allowance and he attempted to live alone in a single room, and care for his own needs, without medical attention. Although many old people do not wish or require institutional care; boarding care being better suited to their needs; they require the same medical service which should be available to the aged in their own homes. This service should include, out patient clinics, visiting nurses and physicians, and medical social service.

Although a good number of the aged chronically ill may be cared for in boarding homes, there are still many who need institutional care. Homes for the aged have long provided domiciles and security for the rest of their lives, to homeless men and women. However, they have often refused to take chronically ill old persons who are in need of nursing care. Since a most urgent problem of the aged is chronic illness, homes for the aged should provide, not only room and board but also simple nursing supervision and medical care directed to making the patient comfortable and arresting the progress of his disease. There should be some human contacts as well as a provision for sustaining the patient's emotional and intellectual life.

In the case of Mrs. C.B., her life was circumscribed

by her enforced immobility. The time consumed by the simple proceedures of bathing and feeding her and making her bed was so great that care could hardly be given by a visiting nurse service at home or in a boarding home. Neither of these patients were in need of general hospital care. Although they were enfeebled by degenerative diseases, progress was so slow that vigorous medical treatment was not indicated. They required custodial care only, and due to the lack of such care in the community, either at public or private expense, these patients could not be discharged from the hospital.

The problem of custodial care, was not limited to the old age group. The practice of limiting admissions to homes for the aged to certain age groups assumes that human beings age physiologically. Actually the persons age is not always an indication of the need for financial assistance or custodial care. An individual well past eighty may still be able to care for himself, while his neighbor in his sixtys who suffers with heart disease may be in need of financial assistance or custodial care, or both. The following case illustrates the similarity in the need of the chronic patients not yet seventy, and those who are eligible for Old Age assistance.

The Case of C.D.

Mr. C.D., a single man, aged forty-three, had been in the hospital 2,831 days. As a result of an operation to remove a tumor from the brain the patient was bed-ridden and

totally paralyzed on one side. Although he was not in need of care in a general hospital, he did require routine nursing care. Previous to his illness the patient had worked as a clerk, and his savings were soon used up on medical bills. He had one brother, living in the city, who could not assume the burden of his care. Since care was not available elsewhere in the city, the city relief department paid the hospital $20.00 a month to keep the patient. Although this amount was not enough to pay for general hospital care at the regular rates, the relief department reasoned that if the amount was not sufficient, the city would be taking the loss anyway, since it was a city hospital.

Very few laymen and not enough physicians have accepted the importance of the early recognition of chronic diseases through periodic medical examinations of the individual by his own physician. The community as a whole still believes in seeking medical advice only when the symptoms of the disease appear and then in withdrawing from the doctor's supervision until the same or new symptoms again become evident. In the interval the disease may be insidiously progressing. One of the great wastes in the field of medical care is the periodic hospitalization of persons suffering from a chronic disease, who during their symptom free intervals, have failed to receive medical supervision which might have prevented the further progress of their disease. Not only is medical care often inadequate

after the onset of the disease, but often the condition is diagnosed too late for the treatment to be effective. The following case illustrates a lack of medical care which if it had been available might have discovered the condition in time and prevented the progression of the disease.

The Case of C.E.

Mr. C.E., a fifty-nine year old widower, was invalided in a mine accident in 1922. From that date until August, 1938, he was dependent upon his brother and City Relief for his support. He had no medical attention during this period. He was admitted to hospital in 1938 suffering from what appeared to be a stroke. Further examination showed that the patient was suffering from neuro syphillis. Although the patient's lower extremities were paralyzed and he was confined to a wheel chair, he was under no medical treatment.

The patient had been in hospital 2,925 days and would long since have been discharged had he a place to go. His prognosis was poor and his conditon would become progressively worse until admission to a mental institution is necessary.

Syphillis, as cancer and tuberculosis, may be cured or arrested, if discovered early enough and adequate treatment given. Treatments for these disease are known, the problem lies in getting the treatment to those who need it, and early enough to be effective. In the case of Mr. C.E., medical care was not available to him since he could not pay for it, and routine medical examinations were not supplied by the city relief department. Since he did not

exhibit symptoms he had no need to consult a physician. Had medical care been available to him early enough, he might have been saved the deterioration that syphillis brings, and the public might have been saved the expense of providing custodial care for him. To date the patient has spent eight years in a general hospital, because there was no other facility for his care elsewhere. Surely this is a misuse of a general hospital.

The majority of human ailments do not permit of such logical therapy as salvarsan or penicilin in the case of syphillis. In some cases the cause of the disease may be known but not the means to eradicate it. Or it may, cause unknown, induce permanent alterations in structure and function in many organs of the body. Therefore, in a great majority of illnesses treatment is not strictly curative but is directed to restore the functional capacity or to remove the causative agent. Fundamental to all medical treatment is the realization that the physician is dealing with a whole individual.

Often, as has been pointed out in the preceeding chapters, the lack of proper treatment is not wholly the result of inability to pay, or inequal distribution of medical service, but is the result of ignorance on the part of the physician of how to treat certain ailments. It is well understood by many physicians and patients, too, that emotions may be a force that will produce sickness in various parts of the gastrointestinal tract, but often beyond paying

lip service to this concept, very little of a practical nature is done about it.

The Case of C.F.

Mrs. C.F., widowed twice by fifty-seven, was admitted to hospital for treatment of diarrohea of which she had complained for seven years. The patient had been employed as a janitress until two years before her admission when she had been forced to stop work because of her poor health. The patient gave a history of many gastro-intestinal complaints including, ulcer; also a uterine suspension and the removal of one ovary. At the time of the study she had been in the hospital eighty-four days, receiving routine nursing care and sedatives. A consultant physician was called in, and after x-rays of the stomach, heart, and gall bladder, a barium enema, electro-cardiogram and spinal puncture, he reported that the patient was "suffering from many psychosomatic complaints". He diagnosed her condition as "angina secondary to hypertension, and an abdominal condition".

The patient continued to receive routine nursing care and sedatives, and the attitude of the hospital attendants was that she was a nuisance, since there was nothing organically wrong with her and she was "merely" neurotic. Finally, the physician indicated his decision to discharge the patient and she appealed to the charge nurse for assistance in arranging discharge. She was referred to the Social Service Department by the nurse. It was discovered that the patient had been receiving relief assistance prior to her admission to hospital. Her only son had a large

family and a small income and would be unable to help her. Since the patient's condition made it impossible for her to work, the worker helped make arrangements with the relief department for transfer to a nursing home where the patient would get room and board.

It is a fair assumption that this patient's hospitalization has been prolonged because of unrealistic treatment and also because of inadequate treatment in the past. The traditional line of physical and laboratory investigation, diet and medication, have been tried, but no real effort has been made to understand the life situation of the patient. Even though the patient understands that she has 'neurogenic diarrohea', she still believes that medication will answer the problem. The physician also seeks to accomplish a cure along organic lines, since he would not know what to do or say if the patient should ask for treatment by psychotherapy.

Chapter VI

SHORT TERM AND POTENTIALLY LONG TERM PATIENTS

Thus far, only the forty-two patients who had been in the hospital a prolonged time, on the date of this study, have been considered. The decision as to what constituted prolonged hospitalization was made arbitrarily thus ignoring the possibility of any of the remaining thirty-eight chronic patients becoming eligible for long term classification at any future date. That forty-two of the eighty chronic patients in hospital happened to be long term was dependent upon the date chosen for the survey. Had the check been made on another date the sample might have been markedly different.

In order to determine roughly which patients in the short-term group might be considered potentially long term patients, a check was made thirty days after the date of the study, in order to determine the disposition of the patients. Of the thirty-eight patients in this group, twenty-three were discharged from the hospital before receiving thirty days care, thus leaving them in the group of short term patients. Six patients were discharged after being in the hospital thirty days, thus making them eligible for the long term group. These patients were admitted to hospital for treatment of their various disease conditions and were discharged once the physician was satisfied that treatment had been accomplished. All these patients had families and homes of their own to be discharged to. However, the fact that these patients were

discharged from hospital does not insure that they were cured, nor does it exclude the possibility of readmission to hospital. Depending upon, the success of the treatment received, the patient's ability to adjust to his limitations and the amount and quality of medical supervision available to him outside the hospital, plus any number of complicating medical and social factors, the patient may or may not be readmitted to the hospital and his condition may either progress to the extent of total disability, or it may be satisfactorily controlled. In view of the fact that there is no health insurance scheme or medical care plan, operating adequately in this province, the risk is great that any of these patients may become impoverished in paying for their medical care.

Nine of the thirty-eight "short term group" remained in the hospital at least thirty days after the date of this study, definitely qualifying as long term patients. Thus of a total of thirty-eight patients who were considered short term on the date of the study, fifteen eventually remained in the hospital a prolonged period. It is suggested that this group of patients is not significantly different from those already discussed. In some cases the patient's stay in hospital was extended because he required special medical attention for a prolonged period due to the nature of his disease. The following case is illustrative.

The Case of D.A.

Mr. D. A., a single native born man of twenty-four, was admitted to hospital suffering with rheumatic heart disease, the aftermath of an attack of rheumatic fever five years

previous. Treatment consisted of sedatives and complete bed rest and would be required for a long period. This patient was receiving private ward care and had been in hospital eighteen days at the time of the study. His family lived on a farm in a neighboring district and were fairly well to do. The patient had his left arm amputated at the shoulder at the age of eight, as a result of an accident. He was unable to do heavy farm work, but was able to do carpentry work, at which he earned his living. Because of his weakened heart condition the openings for employment would be few for him.

This is the type of patient who requires care in a special hospital adapted, to his needs. Rheumatic fever is an infectious disease of unknown cause that injures the heart by crippling the valves. Although the onset of rheumatic infection may be acute, its course is drawn out over a period of many months and there is a tendency for the infection to recur year after year. The main medical problem is to prevent infection and reinfection, the second one is to spare the damaged heart harmful overstrain. This patient had evidently not had sufficient medical attention to prevent the recurrence of his disease. Unless he is able to continue with his treatment long enough, and remain under close supervision he will eventually become a permanent burden upon his family or the community.

In the following case, need for medical care is evident, but it also illustrate the need for intensive research into cause and treatment of certain diseases, plus some public

provision for the treatment of those in financial need.

The Case of D.B.

Mrs. D.B., a widow of fifty, was admitted to hospital with a history of swollen joints over a period of four years. Between 1936 and 1944 the patient had been hospitalized five times, three for operations, (thyroidectomy, appendectomy, and hysterectomy) and twice for treatment of rheumatoid arthritis. Although the patient had suffered with rheumatic pains and varicose veins since 1938 she received her first treatment in 1942 when she was hospitalized for two months. She was readmitted to hospital in 1945 when she received three months gold treatment. At the time of the study she had been in the hospital eight days, and she was still there thirty days later.

At the age of five the patient came to Canada with her parents, from Austria, and settled on a homestead in Alberta. She had no opportunity for education and little or no medical care. At an early age she married a man ten years her senior. For twenty years, until the death of her husband, the patient lived the hard life of the wife of a prairie farmer, where medical care was so scarce it was considered a luxury. For the ten years following her husband's death she supported herself and three children, by dishwashing and domestic service jobs. At the time of the present admission the children had established their own homes and the patient was living alone on her farm. The expense of repeated hospitalization and medical treatment had drained the patient's financial resources and she was no longer able to pay for her care.

In addition to the patients who required medical care to

prevent the progress of their disease, and who did not always have the financial resources to pay for it; there were cases, like the following, where lack of facilities in the community for the custodial care of the indigent and aged chronic sick were the causes for delayed discharge.

The Case of D.C.

Mrs. D.C., a widow, ninety two years of age was admitted to hospital in a confused state. Her condition was diagnosed as senile psychosis. At the time of the study she had been in the hospital only five days. Because of her condition and her poor memory it was impossible to interview the patient and scant information was available from the medical file. There was no record of family or where patient had been living prior to admission. Patient was listed as responsible for account. She was receiving routine nursing care which would be available in a nursing home. Her stay in hospital will depend upon how long she lives.

The Case of D.E.

Mrs. D.E., a widow, seventy-nine years of age lived with a friend and contributed her Old Age Pension cheque for her support. She was in bed suffering with rheumatism when she fell out of bed and bruised her head. This fall resulted in her loss of memory and she became irrational. After two days care the friend found it impossible to give the patient the necessary nursing care, and the patient was admitted to the hospital. The patient's daughter, living in another part of the country, accepted the responsibility

for the payment of the hospital bill. This patient's stay would probably depend upon how long she lives.

These two patients were not in need of general hospital care. Although enfeebled by degenerative disease; progress was so slow that vigorous medical treatment in an institution was not indicated. They required a custodial type of care such as should be available in a home for the aged. However, institutions caring for the aged, to provide adequate care, must be endowed with better facilities than most of the present day homes for the aged, yet these need not be complex and expensive.

From these brief case presentations it is evident that the factors contributing to the extended hospitalization of the fifteen potentially long term patients, were not essentially different from those presented by the forty-two long term patients. The same types of problems, namely inadequate provision of medical care, insufficient income, poor adjustment to limitations of the illness, lack of community facilities for care and inappropriate treatment were seen as factors which were contributing, or will contribute, to the extension of the hospital stay.

Chapter VII

FACTORS CONTRIBUTING TO PROLONGED HOSPITALIZATION

From an analysis of the forty-two long term chronic patients in this sample, it is evident that the greatest single contribution to the extension of hospitalization is the fact that many of these patients had nowhere else to go. For the most part, when these patients were admitted to hospital they were in need of active medical treatment. Due to the nature of the diseases they required a prolonged course of care; and once the acute phase of the illness was dealt with, they required either a prolonged course of nursing care or an adjustment of their life situation to the limitations set by their illnesses. In the case of these chronic disease patients this often meant a loss of earning power and thus the patients greatest problem was a financial one. In twenty of the forty-two long term cases the patient remained in the hospital primarily because he had nowhere else to go. It was found impossible to analyse statistically and define clearly the reasons for this since combinations of factors such as, no family, unemployment, old age, lack of early medical care, and insufficient community facilities for care, were contributing to the problem. However, three main groupings of these factors were indicate, to account for patients remaining in the hospital when no adequate medical social plan could be made outside the hospital. An understanding of the social problems was best gained by grouping them according to the needs of the patients, namely, need for medical care, need for nursing

care, and need for custodial or boarding care.

Fourteen of the long term patients required active medical care which was available to them in the general hospital. In five of these cases the patient was in need of special, prolonged care in order to arrest the development of the disease. Since there was no special hospital for this type of care they remained in the general hospital although not requiring the expensive and specialized service it was equipped to give. In three instances treatment was not known that would arrest the disease, therefore the condition progressed to the point of death. In six cases it was evident that medical care had not been available to the patient until too late in the progression of the disease and therefore was not effective in arresting the condition. This was found to be the result of the inability of the patient to pay for medical care and the inadequacy of medical resources in certain areas, particularly in rural sections.

There were thirteen long term patients, in the study, who were in need of nursing care and six of them remained in hospital a prolonged time, solely because they had no place to be discharged to. They required placement in a nursing or boarding home where they could receive the nursing care they required. Although the remaining seven patients had homes to which they could be discharged, nursing care was not available to them there; because of scarcity of this service in the community, and inability of these patients to pay for private nursing care. With a good system of home, medical and nursing care properly organized; and the addition of some form of disability pension or allowance; many of

these patients could remain in their own homes.

Two thirds of the patients who required custodial care, remained in hospital because they had no place else to be discharged to. These patients were well enough to be on exercise but had no homes, were unable to support themselves, and could not be forced to leave the hospital. They usually required institutional care, not for purely medical reasons, but because poverty, usually brought on, or accentuated by long drawn out antecedent illness, had made home care impossible. Improvement could not be expected in these patients yet they required care on humanitarian grounds. Two patients in this group had remained in hospital over seven years because they were without homes or financial resources. This was a misuse of a hospital and was not only economically unsound but undesirable in other respects.

Although lack of other accommodation was found to be the main contributing factor to prolonged hospitalization, it was found in a small minority of cases that hospitalization was extended due to inappropriate medical service. This was evident both in the past history of the treatment and in the present hospitalization. In six of the forty-two long term cases it was evident that inappropriate treatment had contributed to extended hospitalization. This was due, for the most part, to failure, or inability on the part of the physician to treat the patient as a whole.

Obviously, throughout it is evident that there is a need for more community resources for the care of the chronically ill, who are not actually in need of General Hospital care. Such services as visiting nurses and housekeepers, and medical services; and such facilities as special

treatment centres, nursing homes and homes for the aged, are urgently needed in the community. Perhaps more important is the need for more medical social workers in the community in order to assure the use of the existing community facilities to the fullest extent.

Appendices

1. Sample of schedule used for collection of data.

2. The Royal Alexandra Hospital and the community served by it.

3. Tables

   (i) The distribution of 80 chronic disease patients in the Royal Alexandra Hospital, July 15, 1946, by class of care required and hospital service.

   (ii) The distribution of 80 chronic disease patients in the Royal Alexandra Hospital, July 15, 1946, according to length of hospitalization and class of care.

   (iii) Numerical distribution, by class, of forty-two long term chronic patients according to method of financing care in the Royal Alexandra Hospital, July 15, 1946.

   (iv) Licensed institutions in the city of Edmonton for the care of the Aged, Infirm and Chronically ill, July, 1946.

4. Bibliography

   (i) Selected references

   (ii) General references

Appendix 1

Sample schedule

Ward Public Service Med. Race White Sex Male

Name John Albert Address Edmonton

Birthdate 1907 Birthplace Vilkaviskis, Lithuania.

Religion Lutheran National Origin Lithuania

Citizen No

Immigration May, 1927 alone, at the age of twenty.

Education 2½ years elementary school. One year barber school.

Occupation history Railway section man, labourer. Unable to work at all since 1943 when he finished barber school.

Income bracket Dependent Source Municipal charge

Marital status single

Spouse birthdate occupation illness cause of death

none

Children

none

Patient's illness history

Date	Diagnosis	Duration	Where hospitalized
1925	Typhoid fever	7 weeks	Lithuania
1925	Jaundice		Lithuania
1937	Acute infective arthritis	18 days	R.A.H.
1943(Jan)	Auricular fibrillation	4 days	R.A.H.
1943(Apr)	Acute appendicitis and rheumatic heart X-ray showed previous rheumatic heart disease	15 days	R.A.H.
1943(Oct)	Respiratory infection Cerebral embolism	19 days	R.A.H.

Present Illness

Duration Since 1943 Admission to hospital February 6, 1946

Provisional diagnosis Congestive heart failure

Diagnosis Congestive heart failure

Complaints Weakness, anorexia 2 years, pain in chest, palpitations, orthopnoea, edema, some heart enlargement.

Responsibility for account Self

Ability to pay able to pay part, will then have no resources

Active care being received Bed rest, routine nursing care

Degree of incapacity Total, unable to do any type of work.

Prognosis Poor, hopeless.

Could care be given elsewhere Yes, requires custodial type of care but should have medical care available.

Reason for prolonged stay in hospital

The patient has no family or friends who could care for him and has little money left out of his savings. Requires sedatives and bed rest and is unable to do the simplest types of work without tiring. As there was no further treatment available the physician recommended that arrangements be made for the patient's care in a nursing home. Arrangements for discharge made by social worker and the patient was discharged on July 22, to a private nursing home, financed by the civic relief department, (where there was no medical care available.)

Family history

Parents

Income bracket	Marginal		
Normal family life	No		
Broken family	Yes	how	by father's death
when	1915		

	Father	Mother
Occupation	farmer	housewife
Illness	unknown	good health
Death	1915	unknown

Siblings

Birthdates	Sex	Marital Status	Occupation	Illness	Dates
1900	male	m.	blacksmith (B.C.)	good health	
1905	female	m.	housewife (Alberta)	"	
1903	female				
1901	male		whereabouts and present condition unknown, remained in Lithuania.		

Appendix 2

The Royal Alexandra Hospital, Edmonton, Alberta.

The Royal Alexandra Hospital, Edmonton, is a general hospital of 572 beds including an isolation unit of 102 beds. It is approved by the American College of Surgeons, maintains membership in the American Hospital Association and the Alberta Hospital Association, and is approved for internship by the Canadian Medical Association. It is a teaching hospital affiliated with the University of Alberta, Faculty of Medicine, Edmonton. The School of Nursing which was established in 1905, is accredited by the Senate of the University of Alberta and its graduates are eligible to take examination for registration in the province.

The hospital is owned by the city of Edmonton and governed by the Edmonton Hospital Board of 15 members, which is appointed by the city council. The present building was opened in 1911 and the plant was enlarged in 1920 and again in 1929. The hospital provides services in general medicine and surgery, 258 beds; pediatrics, 64 beds; obstetrics, 80 beds; contagious diseases 65 and pulmonary tuberculosis 37 beds, in the Isolation Unit. It also provides services in cancer, dermatology, diabetics, gynecology, neurology, opthamology, orthopedics, syphillis and urology. Special departments include, x-ray, clynical and pathological laboratory, physical therapy and social service. There is no out-patient department in the hospital, and patients cannot be admitted to the hospital for staff care. The medical staff is not divided into services, rather each patient whether public or private comes into the hospital under the care of his own physician. For each medical service there is a resident graduate intern who is responsible, to the patient's physician, for the medical care and treatment of the patient in hospital and is also in charge of the supervision of the undergraduate interns.

Social Service Department.

Early in 1944 the Social Service Department was established by the hospital board, on the

recommendation of the Edmonton Council of Social Agencies. One social worker with experience and considerable skill in the child, family welfare, and psychiatric fields was appointed. Rather limited office facilities were set up in a central location in the hospital and the organization and development of the department was left very much to the worker. A number of routine tasks previously preformed by the superintendent and other members of the staff automatically became the responsibility of the department. One of the first problems was the 'hospital clearance' of a number of aged and chronically ill, and a few whose only illness was "hospitalitis" and lack of any place to go. This necessitated a search into community resources for the care of such patients, and the findings of inadequacies in these resources started the Council of Social Agencies on a survey of the care of the aged and sick.

As the medical and nursing staffs became aware of the benefits to the patients of trained service dealing with social emotional and psychological problems, there was a steady increase in the number of such cases referred to the department. Success in interpreting this line of the work so effectively was due to the skill, training and personality of the worker. In addition to the hospital clearance and case work services, the worker has been responsible for the clerical work of the department, supervision one day a week of a student nurse, lectures to senior and intermediate nurses, assistance with clinics and seminars for interns and medical students on psychosomatic cases, lectures to university students in the School of Nursing and Arts' faculty, committee membership on problems affecting the hospital and its needs, addresses to groups in the community and consultation with staff members on personal emotional and psychological problems.

Staff

Executive 2, Medical staff 134, Nurses 274, Dietitians 3, Interns 12, Orderlies and ward aids 46, Technicians 20, Clerical workers 39, Social worker 1.

Financial

Daily rates - Private $5.00 - $7.00
Semi-private $4.50
Ward - $3.00, Operating room fee - $3.00 - $10.00
Delivery room fee - $5.00.

Operating cost percentages - Administration 12.6%, professional care 40.9%, kitchen and dining room care 20.8%, house and property 22.4%, maintenance 3%.

Operating cost per patient day $4.35 (1)

Revenue per patient day $4.27

Government grants (2)

Municipal - municipalities are liable for the public ward charge per day of the hospital only in the case of indigency, and liable for not more than $2,000.00 in any one year from date of admission.

Provincial - The maximum per diem allowance per patient as provided by the Alberta Hospitals Act is 50¢ --- 45¢ per day is the rate presently being paid.

(1) for the eight months previous to July, 1946, for month of July the cost was $5.15 per patient day.

(2) Directory of Hospitals in Canada 1942 p. 146.

The Community Served by the Royal Alexandra Hospital

Edmonton is the capital city of Alberta, one of the newest provinces in Canada and in spite of its population of nearly one hundred thousand it still has many aspects of the frontier town. The city covers an area of 42.5 square miles. Of a total population of 93,819 (3) 62,775 are of British extraction

(3) 1941 Census.

29,955 other European and 6,070 Ukranian (many of whom have a language difficulty. 30,925 inhabitants are first generation immigrants although 69% of the population are protestant there is a large Roman Catholic minority of 29% and a great number of smaller sects and denominations. Although rapid development in size has continued, social service progress has been slowed by the curtailed financing imposed by drought and depression. The Council of Social Agencies is six years old, and the Family Welfare bureau has been giving service for three years. Provincial welfare and child care services are understaffed and inadequate. The "Civic Relief and Children's Aid department" of the city government dispenses relief to the city's needy inhabitants.

General Medical Facilities

There are four general hospitals in Edmonton with a total bed capacity of 1504. Additional hospital facilities are; two private hospitals specializing in the care of maternity cases and unmarried mothers, 112 beds; a dominion government tuberculosis hospital for Indians, 250 beds; the Provincial Mental Institute, 425 beds providing custodial care for the overflow of 'chronic patients' from the provincial mental hospital; and two private hospitals for incurables, 140 beds.

Medical practitioners in the city include 131 physicians (one to each 716 persons). The medically needy may receive care from the outpatient department of the university hospital which is maintained as a separate clinic in a central location in the city. There are a number of nursing homes and institutions in the city which will provide convalescent or custodial care for certain types of patients (see table one). These must be licensed by the civic relief department, under city by-law 1082, in order that the city may be reinbursed by the provincial government 50% of the amount paid for care of indigent patients placed in them. When a patient is an Old Age Pensioner, the reimbursement to the city is 50% over and above the pension. However the city still only pays $30.00 a month for nursing home care of indigents, and the provincial grant which was intended to improve the care of the

chronically ill has just cut in half the cost of such care to the city. The following are the standards of licensing as explained by a civic relief official. The building inspector judges the safety of the building and overcrowding, the fire department inspects for fire hazards, the health department judges the general health standards, sanitation and quality of food, and the relief department judges on grounds of general welfare. This inspection is done at the time of the annual application for license and there is no provision for checking to see if the standards are maintained. There have been serious complaints of abuse and neglect against these homes made by patients admitted to the Royal Alexandra Hospital. The civic relief department has failed to check up on these complaints.

Institutions caring for chronic patients

At the time of the study the Royal Alexandra Hospital had under construction a building to provide sixty beds for chronically ill patients, which was to be known as the "chronic wing". Apart from this there were in the community only two institutions which would accept chronically ill patients for care. St. Joseph's hospital which is run by a Roman Catholic sisterhood provides care for convalescents, incurables, aged, and a FEW CRIPPLED CHILDREN, without restriction as to age, denomination, or nationality. This hospital is self supporting and does not receive a provincial grant, however, it does get $125.00 annually from the city. There is some trained nursing care but the service is mostly custodial.

Youville Convent at St. Albert is an Indian School but as the government does not send enough children, at present, to keep the large building in use, the ground floor is used for the care of old people, mostly Old Age pensioners. The sisters prefer to accept persons who are not bedridden and who can care for themselves. However, arrangements can be made by the city to admit a chronically ill person requiring custodial care. There is no restriction as to race or religion and patients may leave when they please. There are no old

folks homes or infirmaries maintained by the provincial government. Several service clubs in Edmonton maintain as their philanthropic effort small cottage type institutions for old folk, and arrangements can sometimes be made for the chronically ill patient, who is married and in the appropriate age group.

Appendix 3

TABLES

Table i

The distribution of 80 chronic disease patients in the Royal Alexandra Hospital, July 15, 1946, by-class of care required and hospital service.

Service	Class A	Class B	Class C	Total	%
Medical	33	14	20	67	83
Surgical	2	4	-	6	7.5
Children	4	3	-	7	8.5
Total	39	21	20	80	
Percentage of total	49%	26%	25%		100%

Table ii

The distribution of 80 chronic disease patients in the Royal Alexandra Hospital, July 15, 1946, according to length of hospitalization and class of care.

Length of Stay	Class A	Class B	Class C	Total
Under 30 days	25	7	6	38
30 - 59	8	5	2	15
60 - 89	4	3	4	11
90 - 119	1	3	-	4
Over 120	1	2	9	12
Total	39	20	21	80

Table iii

Numerical distribution, by class, of forty-two long term chronic patients according to method of financing care in the Royal Alexandra Hospital, July 15, 1946.

All Cases	Class A	Class B	Class C	Total
Privately financed				
Private ward	-	1	1	2
Public ward	6	6	5	17
Publicly financed				
Municipality	1	1	2	4
O.A.P.	1	-	4	5
Part pay	1	1	-	2
No pay	5	4	3	12
Total	14	13	15	42

Table iv

Licensed[#] institutions in the city of Edmonton for the care of the Aged, Infirm and Chronically ill, July, 1946.

Name	No. of Patients	Monthly Rates $	Type of Care	Management	Hospital Provincial per diem Grant	Type of Patient
Eventide home	50	none	Custodial	Sal. Army	no	aged
Men's Hostel	-	-	"	" "	"	homeless men
Women's Hostel	20	none	"	" "	"	homeless women
St. Josephs [x]	95	45 - 60	Medical	R.C. Sisters of Providence	no	incurables
General Hospital	357	none day rates	Medical	R.C. Sisters of Charity	yes	general
Youville	50	30 - 40	Custodial	R.C. Sisters Gray Nuns	no	aged - no bedridden

City bylaw 1082

[x] Refuses to take city charges as the City Relief Department will not pay adequate fees. City will pay only $30.00 per month.

Table iv (cont'd)

Name	No. of Patients	Monthly Rates $	Type of Care	Management	Hospital Provincial per diem Grant	Type of Patient
Craven	3	30-35	Nursing	Private	no	convalescent
Hildebrandt	5	25-30	"	"	no	unmarried mothers
Payne	17	30-40	"	"	no	convalescent & chronic
Wickhurst	4	30	"	"	no	convalescent
Forgan	5	40-60	"	"	no	convalescent

Appendix 4

BIBLIOGRAPHY

SELECTED REFERENCES

1. Bluestone, E. M., "The emergence of the Chronic patient", Journal of the American Medical Association, October 9, 1943, vol. 123, no. 6, p. 374, A short magazine article which points up the special problems in the medical care of the chronic patient.

2. Bluestone, E. M., "The Chronic has a claim to care and cure in the acute general hospital" The Modern Hospital, Vol. 63, no. 3, September, 1944, PP. 67-69. The case for the care of the chronic patient in a wing of the general hospital.

3. Boas, Ernst P., "Chronic Disease", Social Work Year Book, New York, Russell Sage Foundation, 1933, PP. 78-81, A description of Organized activities in Social Work and related fields.

4. Boas, Ernst P., "Convalescence and Chronic Illness", in Convalescent Care, Proceedings of the Conference held under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine, New York, The Academy, 1940.

5. Boas, Ernst P., The Unseen Plague, Chronic Disease, J. J. Augustin, Publisher, New York, 1940. An Analysis and description of problems peculiar to chronic diseases. A case is made for the establishment of special hospitals for the chronically ill.

6. Boas, Ernst P., "The Contribution of Medical Social Work to Medical care." Social Service Review, December, 1939. Vol. 13, PP. 626-633, University of Chicago Press, Chicago, Ill.

7. The Care of the Chronically Ill in Montreal, Printed by the Metropolitan Life Insurance Company, Ottawa, April, 1940. A study of the facilities available for the care for the chronically ill in Montreal, Quebec.

8. Cox, Donald M., "Desirable features in a Chronic Disease Hospital," The Canadian Hospital, Vol. 23, no. 4, p. 30-32, April, 1946.

9. Ellis, William J., "How New Jersey is Caring for it's Chronic Sick", The Modern Hospital, August, 1931, Vol. 37, no. 2, PP. 53-58.

10. Fairfield, Letitia, "Care of the Chronic Sick", The Lancet, Vol. 245, no. 6267, PP. 455-457, October 9, 1943.

11. Hundenburg, Roy., "A study of bed distribution according to length of stay", Hospitals, Vol. 20, no. 10, Pages 52-54, October, 1946.

12. Jensen, F., & Weiskotten, H. G., & Thomas, M. A., Medical Care of the Discharged Hospital Patient, The Commonwealth Fund, New York, 1944.

13. Kretschmer, Herman L., "The Problem of the Chronically Ill Patient", The Journal of the American Medical Association. Vol. 127, no. 16, PP. 1025-1027, April 21, 1945. A comprehensive report of the special problems of the chronically ill, together with an analysis of the various methods of meeting these problems.

14. McClurkin, Eleanor, "Chronic Disease from the patient's point of view", The Modern Hospital, Vol. 65, no. 5, pp. 78-79, November, 1945.

15. Morrison, Pearl, "What do we mean by Chronic patients?", The Canadian Hospital, Vol. 23, no. 10, pp. 36-38. A statement by the matron of a chronic disease hospital, who stresses the importance of distinguishing between patients who re-

quire medical treatment in hospital, and persons who require only custodial care.

16. Potter, Ellen, C., "Social Service in the treatment of the Chronic", The Modern Hospital, vol. 27, no. 4, p. 140. October, 1926. Article suggests that a much larger number of chronic cases can be rehabilitated by careful diagnosis and active treatment.

17. Richardson, Elizabeth, "An adventure in Medical Social Work," The Social Worker, Canadian Association of Social Workers, Ottawa, vol. 14, no. 4, pp. 2-4., June, 1945.

18. Paice, H.A., Letter to the writer, The results of a one day survey of Chronic Patients in the Royal Victoria Hospital, Montreal, September, 28, 1945.

19. Sartwell, Ransom, "How can we best care for the chronic?" The Modern Hospital, vol. 27, no. 3, pp. 67-70, September, 1926.

20. Schless, Bessie, "Achieving Maximum adjustment in Chronic Illness," Journal of Social Case Work, vol. 27, no. 8, pp. 320-325, December, 1946. A discussion of the ways in which social case work can be related to the needs of the chronically ill.

21. Thornton, Janet & Knauth, Marjorie Strauss, The Social Component in Medical Care. A study of 100 cases from the Presbyterian Hospital in the City of New York, New York, Columbia University Press, 1937. An intensive study of the social background of illness.

22. Walker, Eugene and Dixon Jennie, F.I., "Chronic Disease Ward, ten years after; Report on a decade of Experience in operating a chronic disease ward in a general hospital, Springfield Massachussets," The Modern Hospital, vol.64, no. 6, p. 55-62, June, 1945.

23. Walker, T. W., "Better provision needed for the chronically ill," The Canadian Hospital, vol. 23, no. 1, p. 34., January, 1946. A canadian physician's statement on the extent and seriousness of the problem of chronic diseases.

24. Ward, Percy, "How much hospitalization is really necessary for the Chronically Ill," The Canadian Hospital, Vol. 23, no. 1, p. 35. A hospital administrator raises the question of the need for first determining the numbers of patients who really require hospital care, before planning for the care and treatment.

25. Warren, Marjorie W., "The Care of the Chronic Sick, A case for treating the chronic-sick, in blocks in a general hospital," British Medical Journal, no. 4329, pp. 822-23, December 25, 1943.

GENERAL REFERENCES

1. Bartlett, H. M., Some Aspects of Social Case-work in a Medical setting, A study in the field of Medical Social Work., Committee on Functions, American Association of Medical Social Workers, Chicago, Illinois, 1940.

2. Bishop, Dorothy, "Moving Ahead in Medical Social Work," The Social Worker, Canadian Association of Social Workers, Ottawa, Vol. 14, no. 4, p. 27, April, 1946.

3. Boas, Ernst, P., "The Care of the Aged Sick," Social Service Review, Vol. 4, pp. 191-198, June, 1930.

4. Brown, Malcolm, and Carling, Freda, C., "A Social Study of Hospital treatment," British Medical Journal, no. 4396, pp. 478-480, April, 1945.

5. Cannon, Ida, M., Social Work in Hospitals, a contribution to progressive medicine, New York, Russell Sage Foundation, 1923.

6. Cassidy, Harry M., Public Health and Welfare Reorganization in Canada, Ryerson Press, Toronto, 1945, p. 399.

7. Convalescent Care, Proceedings of the Conference held under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine, Nov. 9, 10, 1939, New York Academy of Medicine, New York, 1940.

8. Corwin, E. H. L., The American Hospital, The Commonwealth Fund, New York, 1946.

9. A Directory of Hospitals In Canada, 1942, Compiled by the Institutionals Branch Dominion Bureau of Statistics, King's Printer, Ottawa, 1944, p. 146.

10. Dunbar, Flanders, H., Emotions and Bodily Changes, A survey of literature on Psychosomatic Inter-relationships, 1910-1945, Columbia University Press, New York, 1946.

11. Dunbar, Flanders H., Psychosomatic Diagnosis, P. B. Hoeber, Inc. Medical Book Dept. of Harper and Brothers, New York and London, 1945.

12. Eaves, Lucile, "Almshouse Care for Chronic Patients", The Survey, Vol. 61, no. 12, pp. 807-808, March 15, 1929.

13. Eaves, Lucile, "When Chronic Illness hits the Wage Earner", The Survey, Vol. 62, no. 8, pp.448-450, July 15, 1929.

14. Eaves, Lucile, "Children who are Chronically sick", The Survey, Vol. 62, no. 4, pp. 241-43, May 15, 1929.

15. Eighth Census of Canada, 1941, Vol. 2, Population by local Subdivisions, Ottawa, King's Printer, 1944.

16. Fifield, J. C., (ed) American and Canadian Hospitals, A Reference book giving historical, statistical, and other information on the hospitals and other allied Institutions of the United States and possessions and the Dominion of Canada, Midwest Publishers Co., Minneapolis, U.S.A., 1933.

17. Hospital Personnel and Facilities, A study made by the Canadian Hospital Council as part of the National Health Survey of the Canadian Medical Procurement and assignment Board, Bulletin no. 46, 1943.

18. Hundenburg, Roy, "Survey indicates patient's pay one dollar a day below costs," Hospitals, vol. 20, no. 9, pp. 49-51, September, 1946.

19. Hyman, Harry, "Convalescent Care, A neglected factor?" Hospitals, vol. 20, no. 1, pp. 62-63, January, 1946.

20. Kresky, M. S., & Luykx, H.M.C., "Patients are Older and stay longer, An analysis of the change in admissions to Bellevue Hospital, New York City, for 1923-27 and 1935-39," Hospitals, vol. 18, no. 2, pp. 21-25, February, 1944.

21. Lee, Roger, I., "What is adequate medical care?" Journal of the American Medical Association, vol. 129, no. 5, pp. 989-991, December 8, 1945.

22. Liss, Edward, "Convalescence," Mental Hygiene, vol. 21, pp. 619-622, October, 1937.

23. "Medical Care, the results of a study of committee on Chronic Illness, Welfare Council of New York City," Social Work Year Book, Russell Sage Foundation, New York, 1937, pp. 264-271.

24. "Medical Care," Social Work Year Book, Russell Sage Foundation, New York, 1939, p. 238.

25. Pfirman, Howard, S., "For the Patient's Welfare," Hospitals, vol. 20, no. 1, p. 63, January, 1946.

26. Province of Alberta, Annual report of Department of Public Health (including Vital Statistics Branch) 1944, Edmonton, 1946.

27. Statutes of the Province of Alberta, Chapter 14, 1945, An act respecting homes for aged and infirm persons.

28. Seltzer, Edith, G., "Difficulties experienced by hospitals in the placement of certain types of patients in convalescent homes," in Convalescent Care, New York Academy of Medicine, New York, 1940.

29. Seymour, William, B., "Medicine is not all, these patients are still people," Hospitals. Vol. 18, no. 12, pp. 64-65, December, 1944.

30. Philadelphia Health Survey, 1929, The Modern Hospital, Vol. 37, no. 2, p. 58., August, 1931.

31. Weiss, Edward, and English, O. Spurgeon, Psychosomatic Medicine: the Clinical Application of psychopathology to General Medical problems, Philadelphia, W. B. Saunders Company, 1943.