MCGILL UNIVERSITY

CONVALESCENCE PROBLEMS OF MARRIED WOMEN PATIENTS

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by

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PREFACE

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CHAPTER I.

INTRODUCTION

Convalescence, derived from the verb to convalescence, which means to grow strong, is the subject of this study. Although the principle of convalescence has been practiced for hundreds of years, its definition has taken time to evolve. Dr. Woodruff[1] has formulated the following:

> "According to the Oxford dictionary the word convalescence, in its present medical meaning, did not come into use until the 19th century. Before that a person was 'sick' or he was 'well.' Now, convalescence is recognized as a state of gradual recovery from illness. In other words, the term convalescence is applied to the transitory condition when a person is neither wholly sick nor wholly well; and it is just that understanding of the convalescent state which makes the care that a patient receives during this period such a factor in determining whether he goes forth into life well and sound and able to meet its stresses and strains, or undermined, with lowered resistance and more likely to succumb to some disease of either physical or psychic origin."

Elizabeth Gardner in her book on "The Road to Recovery from Illness" has also quoted the definition formulated by Doctors C.C.Lund and James A. Halstad which includes the following salient points[2]:

> "Convalescence is a period of recovery after a period of disease. Disease includes fatigue in all its aspects, psychoneurosis and other mental states. Convalescence also includes periods of partial recovery between operative procedures and, at times, periods spent in recovery from fatigue or other disability in preparation for surgery... . The likelihood of important improvement in health is a necessary condition to distinguish convalescent from chronic care."

There are no rigid limitations as to how long the care during this period lasts or should last. It must be considered in terms of the individual needs of the patient and his recuperative potentialities rather than in terms of a general medical standard. Since the convalescent stage

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1. Eliz. G. Gardner & F.T.Thomas. The Road to Recovery from Illness. New York, 1945, p.12.
2. Ibid. p.12.

is preceded by some kind of physical breakdown, all patients spend some time convalescing after an illness.

The change in the understanding of the needs of sick people has increased tremendously during this century. This has had its effect on the growth of the concepts of convalescence and on the treatment of patients in this stage of recovery. This change has evolved from two main factors.

The first has been the widening horizons of medical understanding and responsibility. The need for convalescence has been recognized since the beginning of civilization. External factors, such as rest, change of air, moderation of exercise, proper diet, tranquil sleep, personal hygiene and regular habits were the important recommendations of the early medical authorities. Experience from the two world wars and the integration of psychiatry into the treatment and understanding of people has helped general medical practice put the basic principle of medicine, so aptly expressed by Osler: "to treat the patient and not the disease," very much to the fore. In its broadest sense modern medical care now embodies diagnosis, treatment, convalescence and rehabilitation. Convalescent care is, therefore, only a part of the total treatment of the patient. According to Dr. Rusk, a leader of the medical profession in the treatment of the armed forces during World War II, total treatment has indeed expanded in its concepts:

> "To obtain maximum results, reconditioning has to begin at the earliest possible moment following acute disease or injury. It has to be purposeful, progressive, and graduate..."[1]
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> "... to meet the needs of the whole man regardless of what those needs were - medical, physical, psychiatric, social, vocational, educational, or personal."[2]

The historical background of the evolution of convalescent care will be more fully discussed in Chapter II.

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1. Howard Rusk. "Rehabilitation & Convalescence". Medical Addenda, New York 1947. p. 104.
2. Ibid. p.112.

A second factor that has changed the planning of convalescence is sociological. Since the industrial revolution has caused an increase in the growth of cities, living habits have changed. Housing has changed during the last century, even during the last ten years. With increased importance of material possessions and the rise of cultural standards in education, etc., the pattern of family life has changed. Families are smaller. Present day society offers many kinds of careers to women. Consequently more married women are working outside the home. The result of these trends is that there are now fewer resources in the family to contribute to the convalescent needs of the sick.

Although the need for convalescence has always been recognized, doctors, nurses, social workers and public health authorities have given the subject little study, compared to other subjects that have been chosen for research. This neglect seems to be associated with several factors. At the beginning of this century, when the focus and fascination of medicine was around the diseases and their clinical studies, interest in the patient lapsed after the disease entity was conquered. The emphasis given to the psychology of the patient was a kind of blanket recognition which overshadowed the individualization which is now recognized as necessary in the careful treatment of any patient. The variables and diffuseness of the thinking of what the convalescent state involved, led to confusion which, instead of being tackled directly, was sidetracked. Clarification of the goals of convalescence has been a slow process. The importance of continuity of treatment was not universally integrated with practice until the effects of lack of continuity of care were felt by patients and healers alike. Until these factors were obvious, however, there was an indifferent attitude to the convalescent.

The small amount of responsibility assumed by community groups for providing convalescent facilities must also be considered as an element in the lack of interest in the problems of convalescence. In many communities other problems have loomed larger and more urgent. Lastly, co-ordination between health and welfare services has been slow in developing and this has been a deterrent to full understanding of convalescent care, which is both a medical and social problem.

Even at this stage of self-awareness, the amount of literature in the medical, psychiatric and social work field devoted to convalescence, convalescent care, convalescent state and convalescent needs both in terms of the patients and the community, is scarce. Index Medicus, the modern index which lists current medical literature shows few articles written on any aspect of convalescence. Some modern books devoted to the treatment of patients have not used the word. In his thesis on the background to current thinking regarding convalescent care, Mr. Peddy indicated that the first compiling of the opinions of the earlier authorities was in 1732 when Heylerus presented his graduation thesis at Leipsic under the title "De Status Convalescentia." In the first half of the 19th century when interest in convalescent institutions became fairly widespread there was an increase in literature written on what the standards and purposes of these homes should be. Fourcade and Maret in France, Robertson in England, and Cook in the United States were four writers who discussed convalescence from such viewpoints as the following: where the convalescent should go, general considerations for the convalescent patient, the influence of over-protective friends, and the possibilities of decreasing the incidence of chronic illness by increasing the focus on patients in the convalescent stage. The second half of the

Nineteenth Century was unproductive insofar as any new development or thinking on convalescence was concerned.

The next major development came during the early part of this century when the Burke Foundation was established in New York in 1915. The principle of fitting the institution to meet the needs of the patient rather than choosing patients who suited the hospitals was established. Dr. Frederick Brush gave leadership and shared his thinking in literature which received world recognition. Convalescence received considerable attention during World War I. Advances in convalescent practice and an increase in the amount of literature continued in the United States between the two world wars. Two major conferences on convalescent care were held, in 1925 and again in 1939. The proceedings of these meetings have been published. The most productive period in the advancement of thinking about the importance of convalescence seems to have been during the decade ending in 1950. The main reason for this is that it is the time when members of armed forces during and after World War II were receiving treatment. This was a fruitful period in understanding many aspects of illness, one of these being the convalescent state.

Literature devoted to convalescence to date includes accounts of a few medical experiments, broad aspects of concepts of convalescence, general standards required for the convalescent hospital and community problems. Children's needs and programs necessary for their individual care have received more attention from the social case worker than have the problems of adults. In his foreword to the book "The Dynamics of Illness", Dr. Van Horn[1] states:

> "All medical care and practice are aimed primarily at returning the patient to an optimum state of health so that he can function as an effective member of his family and community. In this sense the primary functions of medicine is a social one and as such must

1. Frances Upham. "A Dynamic Approach to Illness." New York, 1949. p.4.

concern itself with the social component of illness."

With the broadening scope of medical care the need of the services of the social case worker becomes more acute. If the social work profession is to share in this stage of treatment, then it must also assume some responsibility for research in the social component of convalescence.

What are these components which we label "social"? Studies around the actual problems that the individual patients reveal before and during convalescence have been few. No studies have been done in Montreal about the community problems of convalescence. Several such factors stand behind the choice of this topic.

Interest in this subject was first aroused from the writer's experience as a social case worker in a large general hospital. One of the first requests made to the writer was "to have Mrs. Chalmers return to the convalescent hospital next week." Three subsequent interviews with Mrs. Chalmers, who supposedly was crossing the last hurdle of her illness, revealed that she was afraid to walk, afraid to return to well-meaning but judgmental aunts, afraid to face demanding adolescent children, and afraid of exacerbations of her pain if she returned to her previous kind of work.

When another patient asked to see a social worker because she was worried about her bill, and when her additional problems of a cold house, an alcoholic husband and a feeling of guilt over her illness and her separation from her young children were revealed, the question of how such mothers managed on the road to recovery was raised. Shame over social status and other factors may prevent the patient from telling her physician about the adverse factors of her environment. Further hospitalization away from the family, for whom the mother feels a keen sense of responsibility, may make her reject the medical recommendation of institutional convalescence. What

else is there to offer her? With no home care plan within the hospital setting and no housekeeping service available to the Montreal citizens without first establishing their ethnic group, language and religion, discharge planning can be quite inadequate. Patients return home and then what? They may continue to feel poorly. Follow-up in the hospital is assumed as part of its responsibility but it is still not too adequate. It is not unlikely that many patients are left invalided in their own mind for years to come. What the problems are for the patients who live between illness and health and how they are treated are the beginning questions for this study.

Since the writer wished to make a study of the actual problems of patients, it was decided to choose the married woman group for this study. Her illness has meaning not only for her but for the family, the basic unit of our society. Married women with family ties includes, for the purposes of this study, not only those women who are established in a home with their husbands, but also those who are widowed, deserted or separated. Family ties include children in any age group, husband or parents. In other words, this term includes members of the immediate family group for whom the married woman has responsibility or on whom she is, in some way, dependent. Families, whether they be nearby or far away, can help or hinder recovery.

The objectives of this study are: (1) to gain a clearer and more concrete understanding of the problems involved for married women during their convalescent period. (2) to point out areas of further need where the hospital and community can improve services to help in the total treatment of the patient.

Since this study is being done from a medical-social point of view the scope includes such questions as the following: What problems do the

married women face when planning convalescent care? What is the influence of housing conditions and economic factors in planning care? What are her attitudes and feelings towards her illness, her treatment, and her convalescence? What is the role of the family in making convalescent plans? When is the family a strength? When is it a weakness? What types of care are being offered to the married women? Is there a need for expansion of convalescent services? What casework services are necessary during this period? What other services are also necessary?

As a preliminary to this study a survey was made of twenty women who were known to the Main Social Service Department of the Royal Victoria Hospital. To evaluate the feasibility of this topic, broad problems such as medical diagnosis, medical-social classifications and types of care were tabulated. It was found that the topic would allow for analysis and comparison Since the study was started in the Fall of 1948, the year chosen for the survey was 1947. This would allow for a fair follow-up to be made to see how many patients needed continued treatment, both from a medical and a social point of view. Taking a year would also give a fair cross-section of the kind of problems this group of patients encountered.

The patients used for this study were found by scanning the files of the Main Social Service Department of the Royal Victoria Hospital and reading those that seemed to fall within the limitations of the study. It is very likely that a few patients have been missed if their cases had been re-opened for service. This meant that their records were not in the central files. The files of a total of one hundred and ten married women were read. Seven were discarded because it was not clear whether they had any immediate family attachments. This left one hundred and three patients for whom information could be transferred to a schedule[1]. Several patients

1. Appendix A. page 157.

were found to have died when their records were followed up. Since the doctors had referred them for convalescent care, and recovery was apparently expected, they were left in the group.

For these one hundred and three patients the accummulated information showed considerable variation in the degree of completeness. This is due to the variety in the quality of the three kinds of social service records kept in the Main Social Service Department. These three forms are the folder case, the social summary and the rough intake sheet that contains handwritten notes and identifying information. The most complete records are those kept in folders which are written in fully recorded form. They include a good deal of what has been said between the patient and the case-worker, and they give a fairly complete picture of the problem and a clear cut casework plan. The social summary is shorter and more condensed than the folder record, and gives a more objective description of the environment, the feelings of the patients and the plans. The last kind of record is unorganized in form and is written in longhand. Information is scanty in these records, but factual details are included which make it possible to include them for this survey. Only fourteen patients had fully completed folder records; forty-seven had typed social summaries, and forty-two had their records kept in the rough intake form and in letters or special memoranda. The low proportion of the standard kind of social record accounts, in part, for the reason why this study has to be limited to broad general problems [2]

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2. The medical social classification for all patients has been broken down into primary and secondary problems. For each patient, one problem has been diagnosed as primary. The additional problems which would be numerous have been called secondary. This breakdown is an effort to show the over-all problems that confront the patient and those treating the patient, at the same time giving some feeling of perspective to a community health problem. The basis for the medical social classification found in Appendix C. is a modification of the system used in Massachusetts General Hospital which has been discussed by Mrs. Edith Clement in "Medical Social statistics", unpublished M.S.W. thesis McGill University, 1949, pp 117-120.

After the patients were selected from the social service files, the medical charts, both indoor and outdoor, were read to verify diagnosis, and length of hospitalization; other data necessary for the present study were also taken from the medical charts. Since only the files of the Main Social Service Department were used, the medical problems are primarily those of a medical and surgical nature. However, gynaecological, obstetrical, neurological and psychiatric patients who are treated in other parts of the hospital, which have their own social service facilities, may be found in this study, if medical or surgical problems were present. Following the collection of the data, tables were compiled, corresponding to the topics on the schedule found in Appendix A.B.and C. From these tabulations the statistics for this thesis were procured.

Since this is a study focussed on the problems of the patients, evaluation of the administrative policies and the methods of co-operation and referrals between the Montreal hospitals will not be discussed. A brief description of the community resources at the time of this study will give the reader some orientation to the reality situation facing both the hospital and the patient.

There is one large convalescent hospital in Montreal which serves all the general hospitals, the private physicians and the social agencies. Although it is run by English-speaking personnel it accepts patients of any ethnic group, religion or language. Its two limitations are age and illnesses of a terminal or infectious nature. The lowest age limit is set at sixteen years but exceptions are quite easily obtained for special reasons. There is no set upper limit in the age category, providing the patient is not senile, has good prospects for recovery and has a home to go to after the convalescent period is over. Occasions do arise, however, when a patient is refused admission because the adjustment had been poor during

previous convalescent periods.

During the summer months another convalescent hospital is open at a summer resort over two hundred miles from Montreal. This hospital takes men, women and children. Women who are pregnant are not accepted nor are patients with any infectious disease. Since the hospital is situated on a steep hill, and has no downstairs bedrooms, patients must be fairly agile to be able to get around. Patients with crippling and limiting illness such as heart trouble and arthritis are usually refused admission.

There are several other convalescent hospitals in Montreal which are owned and operated by French religious orders. Although they are willing to take English-speaking patients and Protestants, the language barrier is a real problem and these hospitals are not used very frequently by the English-speaking hospitals.

There is no home care program in the Royal Victoria Hospital but some of the social agencies have a housekeeping program which enables them to meet the needs of some mothers who are ill. These homemakers are usually trained to be mother substitutes to look after the home in the absence of the real mother. When the mother returns home and the immediate family emergency is over, the homemaker is released to meet the needs of another family. Special exceptions can be made but housekeepers who can work in the same home under the guidance of the mother require different qualities. The supply of this kind of help seems limited.

The National Employment Service has a domestic and housekeeping division where applications for housekeeping help can be made, but there is no guarantee as to when an application can be filled. Two or three private domestic bureaux also exist. With these agencies there is always a problem of not having someone available when needed. Furthermore, housekeepers from these agencies usually have no orientation to the problems

of illness and convalescence.

Visiting nurses of the Victorian Order of Nurses, La Societé des Infirmières Visiteuses and the Metropolitan Insurance nurses make daily calls upon request of any individual provided they have the recommendation of the attending physician. They cannot assume household tasks although this might be an important item in lightening the work of the mother when she returns home.

Numerous nursing homes are found in and around Montreal who can take convalescing patients. They are licensed and inspected periodically by the nurses of the Health Department of either the Province or the City. These homes are run privately for profit; consequently their aim is not so much to enhance the environment of the patient as to make money. Admission policies are not standardized, and there is little medical continuity of care.

The convalescent problem in Montreal is not so much in the narrowness and rigidity of policies of the existing resources, as is found in surveys of such large cities as New York. Rather, there is a great need for further expansion of services to meet the variety of the problems of the patients.

Before discussing the problems of the married women this study will devote two chapters to general considerations which hopefully will give the reader some orientation to this project. The second chapter will be devoted to the changing concepts of convalescence and the historical background and medical cycles through which convalescence has moved. Closely allied to this is the method of meeting needs, and the possible types of care will then be discussed. Since convalescence is a part of illness some general principles of the dynamics of illness and some general physical aspects of a convalescent patient will be discussed.

The third chapter will describe the patients as a group, breaking down such identifying information as the age, religion, etc. The kinds of medical problems that were found in the group used for this study will be compared to the group found at another convalescent hospital in Yonkers, New York.

The fourth chapter will discuss more fully the actual planning process and the problems involved in this stage of treatment from the point of view of the patient, the doctor, the nurse and the social worker and the convalescent institution. How referrals to the social service department can best be made, is as important as the plan itself. The precipitating factors that necessitated a convalescent plan is a logical sequence for the discussion of the decision of care. With the introduction of the precipitating factors leading into a plan for convalescence the actual problems of patients are brought to view. In breaking down the numerous problems that confront the married women there are three main components, namely the medical, the emotional and the environmental. One chapter will be devoted to each of these three main aspects.

The last chapter will go into some general considerations for an integrated plan of convalescent care. The use of case work and the community resources will be discussed on a reality and on an idealistic basis. The problem of re-admissions to hospital will be reviewed. Discussion of where the care and resources of both the hospital and the community can be expanded will be presented at the end of the analysis. The conclusions and recommendations that the writer has to offer will follow in Chapter IX.

CHAPTER II.

THE EVOLUTION OF THINKING REGARDING CONVALESCENT CARE[1]

This chapter will discuss the historical sequence of the medical aspects of convalescence that have been emphasized from the time of early recordings to the present. The various types of modern convalescent care, with some discussion of the advantages of each, will follow. The last section will discuss some physical and psychological aspects of the individual in a convalescent stage of illness. A description of the writer's concepts of the dynamics of illness will conclude the chapter.

Hippocrates seems to be the first physician to have mentioned convalescence; his emphasis was on moderation of exercise. Celsus in 25A.D. stressed rest after meals. A century later, Galen advised travelling and exercise. "Peace of mind" was stressed by Seneca. Other pioneer names include Calcedonius, Solon, Cato, Wadelius. Although they have recognized convalescence as an entity and laid the base for the need of a rounded approach to convalescence, their philosophy was neither enlarged in theory nor put into practice for many centuries.

The year 1640 was the next important date in the history of convalescence. At this time, two hospitals of Paris, Hotel Dieu and La Charité instituted the idea of separate, convalescent wards which were attached to the hospital. Allowance was made for one-third of the total bed capacity to be set apart for convalescent patients. The four factors

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1. The material in the first part of this chapter was adopted from the Master of Science Thesis, "The Background to Current Thinking and Problems in Convalescent Care" written by Mr. Lester Peddy, New York School of Social Work, Columbia University, New York, 1947.

that were stressed during this stage of treatment were spacious grounds, resident sfaff, advisory specialist, and a quart of wine a day for the patients. During this same century Hoffmannus emphasized the necessity for tranquil sleep, and Sydenham stressed personal hygiene and regular habits.

The next sign of growth occurred in the first half of the Nineteenth Century. Again the lead was taken by the French. Fourcade raised the question of separating the ill from the convalescent and concluded that appropriate food was necessary; since general hospitals were tinged with disagreeable odors, segregation was recommended. It was thought segregation also contributed to the psychic restoration of the individual because the causes of fears and depressions could be avoided to a greater extent.

The second writer of this period was Maret. He was the first person to give consideration to the individual characteristics of the convalescent patient. "Capriciousness" of appetite, nervousness, instability, poor circulation and muscular exhaustion, poor memory and lack of imagination were recognized as traits that were normal to the convalescent. Treatment included the factors as already aligned by the previous writers. Occupation was the one new concept that he introduced. He felt that recovery was dependent upon "the regaining of morale and intellectual control over the body[1]."

Up to the Nineteenth Century, the main emphasis of convalescence was put on the physical aspects of the convalescent institutions. In England this coincided with the industrial revolution. People crowded into cities and lived under many adverse living conditions. The natural outcome, therefore,

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1. Lester Peddy, op. cit. p. 5.

was the establishment of convalescent retreats outside the city. During the first half of the Nineteenth Century, Florence Nightingale and Robertson were forceful exponents of change of scene, early ambulation and aversion to visits from the outside world. On this basis the number of convalescent institutions in Great Britain grew from nine, prior to 1850, to forty-nine by 1870.

The last impetus in the development of convalescence has been felt in the United States during this present century. In tracing the beginning of the growth of convalescent institutions in the United States, Lester Peddy's research shows that the New York Hospital recognized a need for some type of special care for convalescent patients as early as 1801 and set aside part of its accommodations for this purpose. It was not until 1872 that separate institutions were opened. For the next fifty years the number of institutions increased in number. It would seem that the increase in the importance of convalescence is only an increase in the number of institutions. This pattern repeated that which was started in Europe in the last century.

Six main contributing factors in the progress of convalescent care during this century stand out. The first was the founding of the Speedwell Society in 1902. The purpose of this society was to give children convalescent care in foster homes rather than in institutions. Although convalescence of adults in foster homes has been planned and had received attention no formalized plan was set up. The necessity of meeting the individual needs of the patfent has, however, led to convalescent planning to be carried out in the home of the patient in some of the discharge programs in other cities. The Speedwell Society was established at a time when the concept of convalescence was very strongly allied to the idea of institutions. It served children's needs and acted as a forerunner for later ideas in the development of broader programs.

The second impetus to the growth and devlopment of convalescence was the founding of the Burke Foundation in 1915 in New York. Dr. Frederick Brush was the leader who helped this hospital achieve world-wide fame. For the first time an institution was made to fit the needs of the patient rather than have the institution formulate its limitations as to the type of patients acceptable to them.

One of the objectives of convalescence that Dr. Brush emphasized was that of "normalizing" the patient[1]. He strove to make the convalescent period constructive and preventive. With this theory he introduced recreation and gradual occupation.

During World War I, between 1914 and 1918, Doctors Bridgman, Thayer and Bryant were the third group of physicians whose ideas contributed toward the theory and practice of convalescent care. They spoke of preparing the patient,both physically and mentally, for this period of recovery. One of Bryant's main methods of treatment for this goal was the proper use of occupational therapy.

Dr. Bryant continued his interest in convalescence following World War I. He felt the most effective plan of convalescence was in an institution, small in size, situated in the country. In such a hospital his general plan of organization included four main departments: Medical, Physiotherapy, Occupational Therapy and Social Service. This was the first time that the use of Social Service had been deemed necessary. Dr, Bryant said [2],

> "It may be questioned if social service should be grouped as a component part of such a convalescent unit but --- social service distinctly should act - for the worthy purpose of aiding in eliminating the clinical neglect which has been the prevailing attitude toward the convalescent patient."

The introduction of the use of social service in a total convalescent plan followed ten to fifteen years after the introduction of hospital social

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1. Lester Peddy, op.cit. p.7.
2. Lester Peddy, op.cit. p.8.

service in the Massachusetts General Hospital in 1905. Since literature about the problems of convalescent care in general was scarce, as was literature regarding medical social work, it is to be expected that a period of time would lapse before social work would be mentioned in the literature on convalescence.

The fourth milestone in the development of convalescent care was the first conference devoted to it in 1925. The New York Academy of Medicine compiled a "Statement of Standards for Convalescent Care." This was stimulated by the doctors' concern over lack of co-ordination, and about the poor quality of care that patients were receiving. During 1924 and 1925, sub-committees of the Committee on Public Health of the New York Academy of Medicine were formed to study the needs of the patients and determine some principles for the care patients required. Their general conclusions in summary were as follows[1]:

> "The principles laid down in these reports as defining a convalescent as one who has passed the acute stage of illness but was not yet able to resume his usual life and activity. The value of proper convalescent care was seen to be in the opportunity it offered for the recuperative processes to continue unhampered and thus hasten the return of the patient to his customary mode of life and work."

With the work and thinking of these committees came the beginning of greater individualization of the patient. In 1930, Doctors Corwin and Kidner published "Standards for Convalescent Homes", which is largely devoted to administration and organization.

The uneven growth of concern for the convalescent patient and his convalescent needs during the '30's was climaxed in 1939 at which time a second Conference on Convalescent Care was held under the auspices of the

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1. Peddy, Op.Cit. p.9.

Public Health Relations of the New York Academy of Medicine. This marks the fifth landmark in development of convalescent care.

In his foreword at this conference, Dr. Goodridge set the tone and scope of what modern convalescent care should involve[1],

> "In considering adequate convalescent care we must think in terms of the individual, of his nutritional, psychosomatic and economic states. Convalescent care should be considered as a continual service in which the physician, the hospital, social service and the convalescent home all have a share."

Some of the opportunities neglected in convalescent care were enumerated by Dr. Woodruff[2],

> "The first of these is the opportunity for the discovery and adjustment of environmental factors and family situations which may have contributed to the occurrence of the patients' illness and which may be factors militating against the preservation of health, once recovery is attained and the patient is back in his usual milieu. This is particularly useful in patients showing psychosomatic disorders and emphasis is laid on the necessity of getting the co-operation of the relatives in helping the patient back to health."

The sixth and last impetus to convalescence to date are the experiences and concepts that evolved out of World War II. In the third civilian conference on convalescence of the New York Academy of Medicine, held in 1944, the proceedings were published under the title of "Convalescence and Rehabilitation."

The value of physical conditioning and occupational therapy were again emphasized, and educational reconditioning was added. To help the patient become a better individual and to restore him to his optimum level of functioning, became the aim of medicine. During the war, medical men began restoration while the patient was still in bed. The process was gradual but the final

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1. Goodridge, Proceedings - Conference on Convalescent Care, New York Academy of Medicine, 1940, p.11.

2. Woodruff, Proceedings, Conference on Convalescent Care, New York Academy of Medicine, 1940, p.230.

aim, rehabilitation, was always kept in mind. The influence of the emotional problems of the patients were given special consideration. Dr. Kubie verbalized the psychiatric principle that,[1]

> ..."everyone carries forward from infancy and early childhood a residue of undigested experience, of misconceptions, misunderstandings, apprehensions about himself, about his body and about the world. Out of these undigested residues grow unconscious fears, unconscious guilt feelings, unconscious resentments and unconscious longings. Inevitably these underground streams are tapped by any profoundly moving experience...."

The importance of illness and the meaning to the patients not only of the illness but also of convalescence are influenced by these underground streams in terms of their past experiences.

Through this evolution of the understanding of the needs of the convalescent patient has grown a high aim of medicine in which the medical social worker is a member of the treatment team. These aims include "physical rehabilitation, psycho-social adjustment and vocational reorientation."[2]

The second part of this chapter will discuss the different ways that convalescence can be planned. The reason it is included in this chapter is that the evolution of the philosophy of convalescence has pointed the way to methods of planning convalescence other than merely sending a patient to another hospital.

Continuity of medical supervision is an important factor in treating patients. Only if this can be maintained, can the individual needs of the patient best be served. How these needs can best be met cannot follow a standard recipe.

There are two main alternatives for convalescence: the patient's own

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1. L.S.Kubie, "Motivation and Rehabilitation". Proceedings, Conference on Convalescence & Rehabilitation, 1944. New York Academy of Medicine, p.177. Borrowed by Mr. Peddy op. cit. p.14.
2. L. Peddy, op.cit. p.14.

home or a special institution. In the middle of the last century, when institutions were growing in Great Britain, the advantage of going to the country were: the air, good food, rest, change of scenery, and distance from over-solicitous relatives. In this present day, the material advantages of modern convalescent institutions can be easily listed over what could be expected in the average home. Furthermore, in developing a broad treatment program it seems easier to develop these advantages in one central spot which would be possible if one limited a program to only one kind of plan.

Elizabeth Gardner[1] has listed the following reasons why patients may do better in a convalescent hospital than in a home: The patient has protection from physical strain, balanced by constructive activities suited to the individual's returning strength. The patients also have protection from emotional strains and tensions, including too early resumption of responsibilities. Presumably skilled persons are available to give treatments and supervise the patient's regimen as ordered by the physician. A range of activity that the average urban household cannot possibly provide can be organized in an institution. The members of the treatment team have a better opportunity for study of the patient away from his own home, and under comparatively relaxed conditions. Furthermore, institutional care relieves families of responsibilities that they are unable to assume.

Before accepting these advantages one must consider what the institution means for this patient. Does the patient feel he has personal attention or has depersonalization crept in so that maximum efficiency can be maintained? Does the idea of another strange place and new faces make the patient feel uncertain and fearful? What does separation from the family mean? Does not the familiarity and security of a family group have strengths that could contribute towards a patient's recovery? If family tension is high is the

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1. E. Gardner & F.T.Thomas, op. cit. New York, 1945, p. 14.

institution just one way of escape?

Since this study is concerned with the married woman, it is necessary to recognize her role in the home. Very often her responsibilities are many, especially if there are children. The separation may cause more worry than the bright, modern, convalescent institution can allay by rest and quiet. Where the mother is the dominant person in the family, her presence at home may assure the least amount of disruption to the family equilibrium. If the mother feels that she is the stable influence who minimizes family feuds, separation from the family makes her anxious, which in turn may hinder her recovery. For those patients who feel guilty over separation from home and family, return to home can bring some peace of mind.

Dr. Bluestone[1] has enumerated some of the advantages of home care over institutional care. The nearness of the patient to his family and friends is important. The individual families can give more personal attention than is given in an impersonal setting. Home cooking is a good tonic. The easy return to his normal habits of life can be gradual in the patient's own home. The opportunity to sleep in his own bed is sometimes conducive to sleep. Freedom from institutional environment generally relaxes a person. The lessened expense to the community and to the family can lighten one's worry.

It must be recognized that all homes cannot provide these advantages. However, with the individualization of treatment and the increased recognition given to the emotional component of disease, new methods for supplementing the strength of an individual family situation as well as resources to meet a variety of problems will have to be evolved.

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1. Bluestone, "Institutional Convalescence". Proceedings - Conference on Convalescent Care, New York, 1940. p. 178.

In Montefiore Hospital in New York, a home care program to help meet a community problem of chronic illness, was started in 1947. It has proven the advantages that the home can give in the care of the sick. Organized home care for convalescents is still in the early stages of development.

Other plans which are possible and which have been used to a limited degree both in Montreal and other cities include: day convalescence institutions, foster homes, summer convalescent hospitals, nursing homes, relatives and friends.

A general understanding of the physiological and psychological aspects of patients in the convalescent stage is helpful as background information in such a study as this. Weakness is a common factor for all people who are ill. A rise in body temperature also accompanies injuries, infectious diseases and operations. Amongst the physiological changes, fever causes is the rise in the body metabolism - which is the term used to cover the sum total of all the processes taking place in the body. The basal metabolism rate is what the body produces at rest, lying down, with no digestion taking place. Exercise and digestion cause a rise in the metabolism. When the temperature returns to normal the drop in metabolism is sudden. Fluctuation of the body metabolism is expected during illness. The fluctuation and/or stabilization of the body metabolism is significant during the convalescent period.

Body chemistry, blood pressure, cardiac action, endocrine function, gastric acidity, histamine productivity and intestinal motility, are some of the physiological processes affected by illness and which continue to be affected during the convalescent period.

The physiological processes that can occur during recovery have been greatly stimulated in recent years through the application of physical

medicine. Such physical agents as heat, diathermy, effective types of exercises have contributed not only towards the regaining of an optimum state of health and activity but also towards the maintaining of the maximum residual abilities of the patient. These agents help to alleviate pain, to increase the peripheral circulation, to expedite the healing of diseased or injured tissues and to improve the functional capacity of muscles and joints[1].

Undernutrition is another common factor at the beginning stage of convalescence. Nutritional studies[2] indicate that malnutrition sets in as soon as an injury or a disease occurs. Two reasons for this are the toxic destruction of protein and the diminished intake of food. Essentials in nutrition are water intake to balance the output caused by perspiration and micturition, salt, protein and fat. When haemorrhaging has occurred careful diet is important to offset the nutritional deficiencies of the body.

The physiological processes are only part of the individual's total response. In thinking of illness, one thinks of a person. To think of a person in toto - three main components come to the fore: the emotional, the physical and the environmental. Each is important and relates to the other as do the sides of an equilateral triangle. These factors are with the individual from the time of birth to death.

Emotional responses occur within an environment that is ever changing. The tone of the environment can determine the intensity of an emotional reaction. Even before the emotions are stimulated there is a physical

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1. Lederle Laboratory Bulletin. The Present Status of Physical Medicine & Rehabilitation, Montreal, p.2.

2. J.P.Peters & Robert Elman & Committee on Convalescence and Rehabilitation of National Research Council "Nutritional Aspects of Convalescent Care." J.A.M.A. 124:17, April 22, 1944. pp.1206-1209.

mechanism whose complications can be innumerable. The individual's strengths and weaknesses are built up or crumble according to the balance reached in the interaction of these three factors that form the tripod of life. Although they develop concurrently they do not develop at the same tempo.

The influence of one's emotional experiences is important in evaluating the maturity attained by each individual and can be reflected in the way a patient adjusts to illness. Although growth always entails some painful experiences for the person involved, this growth can be helped or stunted by one's early personal relationships during the formative period of one's life. These early experiences happen within a cultural milieu and the immediate family unit. Early parental management can therefore have a significant influence on how patients react to treatment and to convalescence.

One important factor in this regard is the kind of dependency pattern that is moulded in these early formative years. Frequently individuals have difficulty in resolving their desires to be dependent and are in considerable conflict because society gives stronger approval to the achievements of independence than to dependency. However, with illness comes a natural regression; consequently, dependency is a natural stage through which ill people must pass.

One of the happy memories of one's childhood is usually the fact that it is a time when one has no responsibilities and when one can depend on one's parents for care, affection and protection. Since illness gives patients an opportunity to recapture some of the advantages of childhood, is it not feasible to suppose that human beings have an unconscious wish to remain ill and recapture some of the satisfactions of their early life

experiences? Dr. Weiss[1] feels that adults who become ill have an unconscious wish to return to childhood.

The emotional and environmental strains and satisfactions have a very important influence on the physical progress attained by medical care. Those who have been well adjusted and happy before illness and who are not threatened at the thought of getting better are apt to abandon the dependency pattern caused by illness sooner than are those persons whose level of adjustment and maturity is low prior to the onset of the illness.

The convalescent period is a time when the trauma of illness can be deepened or gently healed. Flanders Dunbar has stated that she believes seventy-five per cent of convalescent problems are in the mind of the patient. The prevention of both psychic and somatic scars involves a dynamic approach and a dynamic attitude to the patient and to his convalescence. Individualization is necessary to understand the impact of illness on any one particular patient. The following statement expresses the importance of this concept for both the patient and his immediate associates:-[2]

> "The effects of illness on an individual, his family and his close associates can have as many different meanings as there are possible combinations of such factors as personality development, social conditions, environmental pressures, ways of becoming ill or handicapped, methods of treatment and possible end results.
>
> "The significance of the patient's reactions as revealed by submissive, depressed, over-active and anxious or overtly hostile behaviour need to be understood in terms of the meaning of his body to him."

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1. Weiss & English. Psychosomatic Medicine. Philadelphia & London 1949. p. 182.
2. Caroline Elledge. "The Meaning of Illness." Unpublished paper. Read at Canadian Conference of Social Work in Vancouver, June 12, 1950.

Since total treatment continues until the patient's rehabilitation has been reached, the patient's reactions remain significant during the convalescent period.

The number of patients who have been closely followed during convalescence and rehabilitation is small both for patients in this study and for previous investigations. The problems revealed in this study were discovered for the most part immediately prior to the patient's discharge from hospital. The classification of problems made at this late date therefore might differ from a diagnosis made after a social evaluation that was initiated at an earlier period of the patient's illness.

In tracing the historical development of convalescence, it can be seen that the focus of treatment in this stage of illness has changed. Instead of some outside force superimposing rules and regulations on an individual, in a convalescent and somewhat helpless state, the reverse process of first evaluating and understanding the inner dynamics of the patient is needed in order to offer help to meet the particular needs of the individual. The psychology of convalescence can no longer be summarized by such short, trite phrases as "capriciousness of appetite." An evaluation of the physical, emotional and environmental influences within a patient's total situation is needed. The need for this wider approach has been fortified with the development of the current concepts on the dynamics of illness which embodies the importance of emotional development and environmental stresses and strains.

With this broader scope in the treatment of patients, more professional personnel become involved not only to diagnose but also to contribute toward the total treatment of all the patient's problems. Since convalescence is a continuation of an illness it must involve some of the same problems that

the patient had in the early stages of the illness. If the treatment team is to be more effective it must be able to accept responsibility for continuity of care.

Before discussing what problems are involved between illness and a realization of convalescence, the next chapter will be devoted to becoming acquainted with the characteristics of the population of the patients used in this study. Age, marital status, ethnic group and other demographic aspects of the patients will be studied here. The medical problems of both primary and secondary importance will be tabulated. In special instances, comparisons will be drawn between the population of the Royal Victoria Hospital patient group and the group of patients used in Miss Gardner's book on "The Road to Recovery from Illness."

CHAPTER III

THE PATIENTS AS A GROUP

This chapter will be devoted to factual details of the patient group. Tables have been compiled to show the marital status, age, ethnic origin, religion, family constellation, occupation, medical problems, according to primary and secondary illness. The record system of the Royal Victoria Hospital does not lend itself to comparison of the figures of this study with the total hospital population nor with the figures for the total number of married women who were hospital patients. In some instances comparison has been possible with the figures in Elizabeth Gardner's book entitled "The Road to Recovery from Illness."

The first limitation set in choosing the patients for this study was their marital status. The following table shows the breakdown of the married women according to marital status and broad age groups.

Table I shows that only sixty-three patients were living with their husbands. This represents sixty-one per cent of the total distribution. The greater proportion of the patients in this group were the women in the younger age group, whereas the number of widows, which represents 23.3 per cent of the total group, appear in the older age brackets. Since the statistics of mortality show that women have a longer age span than men, it is to be expected that this group of patients would include a fairly high number of widows.

In the age group between thirty and thirty-nine, where there were no widows, the patients who were not with their husbands had the highest number of deviations regarding marital status. The age group between forty and forty-nine years of age follows in second place regarding deviations from the cultural norms of marriage, widowhood or spinsterhood. A total of six patients were

TABLE I

MARITAL STATUS OF 103 MARRIED WOMEN WITH FAMILY TIES WHO RECEIVED CONVALESCENT CARE DURING 1947 AND WHO WERE KNOWN TO MAIN SOCIAL SERVICE DEPARTMENT ROYAL VICTORIA HOSPITAL ACCORDING TO AGE[a]

		AGE GROUPS IN DECADES					
	Total	20-29	30-39	40-49	50-59	60-69	70 and over
TOTAL	103	10	20	28	22	13	10
1) Married (Living with Husband)	63	10	13	19	14	5	2
2) Widow	24			4	5	7	8
3) Divorced or Legally Separated	6		2	3	1		
4) Other	4		2[b]	1[c]		1[d]	
5) Separated - no legal basis	4		1	1	2[e]		
6) Remarried	1		1				
7) Common-law Union	1		1				

a) In future the titles for the tables will be shortened as it is understood the 103 married women had family ties and were known to Main Social Service Department at Royal Victoria Hospital and required some kind of convalescent planning.

b) The two patients in this category were separated and widowed from a common-law union.

c) This patient was in the process of procuring a separation from her husband.

d) This patient's history indicates a divorce after first marriage and then remarriage, now living with a third man and assuming his name.

e) No legal basis seemed to be established for these patients' marriage.

divorced or legally separated while four were separated without legal basis. One patient was in the process of getting a legal separation. One patient was remarried and one was living in a common-law union. Other complications of the marital status include two patients who had lived in common-law union but one was left "widowed" and another was separating from this union. One patient appeared to be living as a common-law wife at the time of her illness. Previous to that she had had one divorce and one separation.

Problems in planning convalescence can be expected when the marital status is not clearly established. Legal complications arise. Shame and guilt are crystallized for the patient when certain reality factors must be faced in making plans.

The next table shows the age distribution of the married women who form the group for this study:

TABLE II

AGE DISTRIBUTION OF MARRIED WOMEN
WITH CONVALESCENT PROBLEMS

AGE IN YEARS	Number of Persons in Group	Percentage Distribution
TOTALS	103	100.0
20-29	10	9.7
30-39	20	19.4
40-49	28	27.3
50-59	22	21.4
60-69	13	12.5
70 and over	10	9.7

This table has no women under twenty years of age. The main factor accounting for the lack of married women in the early adult years, is that the obstetrical patients are not included in this group.

The age distribution of a selected group of patients in another study made in New York is as follows:[1]

TABLE III

AGE DISTRIBUTION OF FEMALE PATIENTS IN NEUSTADTER STUDY

Age Group	Number of Patients in Age Group	Percentage
TOTAL	51	100.0
20-39	19	37.3
40-59	25	49.0
60 and over	7	13.7

Comparison of the two age distributions is not entirely valid because there was no distinction made of the marital status in the outside study. Furthermore, in the New York study, the figures represent only those patients who required special treatment and services during convalescence. In this study, the group included those patients for whom the recommendations would be simple and would require little special care apart from routine rest and diet. Also in this study the gynaecological patients were not included.

However, the fact that the forty to fifty-nine age group of the Royal Victoria Hospital patients represents 48.7 per cent of the total while this same group represents forty-nine per cent for the outside study does indicate a trend that women most in need of convalescence are in the middle-age group.

The largest number of patients are found in the forty to forty-nine age group which includes 27.3 per cent of the total number of patients in this study. The second largest group requiring convalescence is the fifty

1. Gardner, op.cit. p.21. Extract of part of Table.

to fifty-nine group. The third largest group is the thirty to thirty-nine age group. To understand these percentages the total hospital population of married women who were known in the main part of the hospital during 1947 would have to be compared to see if these percentages were parallel to the total hospital population. As already mentioned, the record system at the Royal Victoria Hospital does not lend itself to this breakdown. The conclusions from this table emphasizes the fact that convalescence is more necessary in the middle-age group for any group of married women.

Why convalescence is more necessary in the middle-age group can be traced to the fact that physical and emotional breakdowns are more apt to occur later in life. This group would be even higher if the gynaecological patients had been included. Although children of the women in the middle-age group might be old enough to assume some responsibility in the home and thus eliminate the need for some of the referrals for institutional care, it is likely the children are busy at work which is in keeping with the present pattern of our culture. The fact that Table I indicates a trend that the majority of women in the middle-age group are also still living with members of their immediate family shows that having a family does not solve the problem of convalescence.

The following table points out how many of the immediate family were living with the patients of this study.

TABLE IV

NUMBER OF PEOPLE IN FAMILY CONSTELLATION[a] LIVING WITH PATIENT, ACCORDING TO AGE.

Number of Persons in Family	Total	AGE GROUP IN DECADES					
		20-29	30-39	40-49	50-59	60-69	70 & over
TOTAL	103	10	20	28	22	13	10
1 Person	27	5	6	4	5	5	2
3 Other People	22		4	9	7	2	
2 Other "	16		6	4	2	2	2
4 Other "	13	2	4	1	3	2	1
0 Other "	10	1		4	1	1	3
Not clear	5				2	1	2
5 Other People	4	1		2	1		
6 Other "	4	1		3			
Over 7 Other People	2			1	1		

a) Members of the Family Constellation include parents, husbands, in-laws and grandchildren.

This table reveals that the highest percentage of married women who received convalescent consideration were from families with one, three or two other members, respectively. Grouped together this comprises sixty-five patients of the total group of one hundred and three patients.. Apparently it is the women from the smaller families who require convalescence or who at least are given consideration for this care. A patient from a home where there is only one other member of the family would require special consideration because the other member in the family is no doubt working. Isolation would present a problem.

The number of married women in this survey who came from families with five, six or more members, numbers ten of the total group of one-hundred and three patients. Women who are ill and have large families require convalescence the same as other women; in fact, their burdens at home are heavier. Since figures cannot be procured for the hospital population to compare percentages it cannot be deduced accurately if the women from larger families are being neglected. The discrepancy of this low figure can very possibly be traced to the fact that present concepts of convalescence as practiced in the Royal Victoria Hospital have been to think of convalescent care in terms of sending the patient to one of the two main convalescent hospitals. For various reasons neither the patient nor the doctor may raise a separate issue of convalescence when "there is somebody at home who can look after you" consequently no referral is made to social service.

It is very possible that a physician would recommend a rest away from home and the patient could not accept such an idea. Since the community has little else to offer the matter may be dropped. Consequently the social worker does not become acquainted with all such patients unless a patient is referred for help in modifying her attitude.

The fact that women from larger families are not more numerous can also be explained on the basis that the average size of families is smaller than it used to be. Also, the more members in the family, the more likely it is that some member will be able to come to the rescue and possibly save the cost of the convalescent care.

The preponderence of the problems that are discussed in Chapters V, VI and VII would indicate that lack of family, over-protection of family, and other duties of the family all present problems. The size of the family

does not appear to have as much influence as the other problems.

The ethnic origin and religion of the patients is not of special significance except to show how cultural problems arise. People of all races and creeds are eligible for the Montreal hospitals. Although the Royal Victoria Hospital is English-speaking, it serves a cross section of the city population as is seen by the following tables.

TABLE V

ETHNIC ORIGIN OF THE 103 MARRIED WOMEN RECEIVING CONVALESCENT CARE.

Ethnic Origin	Number of Patients	Percentage
TOTAL	103	100.0
British	44	42.7
Hebrew	31	30.9
French	13	12.6
Italian	5	4.8
Germanic	4	3.9
Syrian	3	2.3
Slavic	2	1.9
British West Indies	1	.9

TABLE VI

RELIGION OF 103 MARRIED WOMEN RECEIVING CONVALESCENT CARE

Religion	Number of Patients	Percentage
TOTAL	103	100.0
Protestant	39	37.7
Hebrew	31	30.9
Roman Catholic	30	29.1
Greek Orthodox	3	2.3
No Religion	-	-
No Information	-	-

Although the study is concerned with married women, the majority of whom would be housewives, it will be helpful to see how numerous and variable their occupations were.

TABLE VII

OCCUPATION OF 103 MARRIED WOMEN WHO REQUIRED CONVALESCENT CARE, CLASSIFIED BY AGE.

OCCUPATION	TOTAL	AGE GROUPS IN DECADES					
		20-29	30-39	40-49	50-59	60-69	70 & over
TOTAL	103	10	20	28	22	13	10
Housewife - full time	65	6	13	18	15	8	4
Outside work - full time outside of home	24	2[a]	4[b]	9[c]	4[d]	3[e]	2[f]
No occupation - living in rooms	8	2	1			2	3
Housewife - part-time work part time	4		2[g]	1	1		
Not known or indefinite	2				2[h]		

a) Telephone Operator 1; Stenographer 1
b) Bookkeeper 1; Practical Nurse 1; Factory 1; Waitress 1
c) Charwoman 1; Operator of Store 1; Maid 1; Newsvendor 2; Baby Nurse 2; Stenographer 1; Seamstress 1
d) Cleaner 1; Maid 1; Practical Nurse 1; Factory 1
e) Nurse 1; Cleaner 1; Housekeeper 1
f) Housekeeper 1; Companion 1.
g) Patients work with Husbands.
h) Dressmakers (?)

Sixty-five of this patient group were full time housewives while twenty-four were occupied full time outside of the home. Eight had no occupation, four did part-time work and two were indefinite as to how they spent their time.

The patients in this study cover a cross-section of the social status of the hospital population, since the Main Social Service Department makes its services available to the private and the semi-private patients for whom institutional convalescence is required.

Patients work because of an economic necessity, because of the demands of the husband or because of a personal need to be occupied. These factors can have an effect on the patient's use of convalescence. A husband could easily be punished by the wife prolonging convalescence. Economic necessity could increase anxiety and stimulate a patient to return to work as soon as possible. Idleness can become frustrating for the over-active person.

Convalescent planning and problems arise, alike, for the married woman who works either inside or outside the home.

The final breakdown that is to be included in this chapter is the diagnostic classification. It is not possible to show which married woman with which illnesses were most in need of convalescent care nor to compare the diagnosis for this group and the hospital population. Several disease groups are not represented in the potential total that needed convalescent care, because patients in the neurological, the psychiatric, the obstetrical and the gynaecological services are not served through the Main Social Service Department. Some women might have had one of the aforementioned type of medical problem as a secondary illness.

Since this study was done at a general hospital, patients with tuberculosis are not mentioned. Although patients suffering from tuberculosis may be inadvertently found in the wards, the referral to Social Service and the problems presented would be for sanatorium care. Treatment and convalescence would be included in sanatorium care.

For the purposes of this study, the diagnostic classification has been divided into two main groups: (1) those patients who had only one medical problem and (2) those whose medical problems were more than one. The first breakdown of the medical problems follows in Table VIII.

TABLE VIII

MEDICAL PROBLEMS OF 103 MARRIED WOMEN WITH CONVALESCENT PROBLEMS

Diagnostic Classification	Number of Patients in Group	Percentage
TOTAL	103	100.00
With more than one illness		
1. Multiple Diagnosis	22	21.40
2. Multiple Diagnosis with Psychiatric Complications	13	12.70
With Only One Illness		
3. Gastro Intestinal Disorders	17	16.70
Liver and Gall Bladder	11	
Ulcers	3	
Other	3	
4. Fractures	12	11.80
5. Metabolism and Endocrine Dysfunctions	8	
Thyroid	7	
Diabetes	1	
6. Cancer	7	6.80
7. Orthopaedic	5	4.90
8. Cardiac Diseases	5	4.90
9. Not Established	4	3.30
10. Diseases of Genital Urinary System	2	1.94
11. Chronic Tonsillitis	1	0.97
12. Ear Trouble	1	0.97
13. Arthritis	1	0.97
14. Infections (? Tuberculosis)	1	0.97
15. Lacerations	1	0.97
16. Psychoneurosis	1	0.97
17. Respiratory Disease	1	0.97
18. Circulatory Dysfunction	1	0.97

Those who had more than one illness either of a purely medical or medical and psychiatric nature were grouped together. This group included thirty-five patients which represents 34.1 per cent of the total. Of the sixty-eight patients who had had only one illness, the gastro-intestinal disorders were most prevalent. Eleven patients had liver and gall bladder diseases, three had duodenal ulcer and three patients had other conditions of the gastro-intestinal tract such as appendicitis and bowel obstructions. Patients with fractured arms and legs were second in incidence while those suffering from metabolic and endocrine dysfunctions included eight of the married women. In this group, seven suffered from thyroid disease while one patient had diabetes. Five patients had orthopaedic problems and five suffered from cardiac dysfunctions. Two patients had genito-urinary problems as the one and only disease. One patient had each of the following: tonsillitis, mastoiditis, arthritis, infection, lacerations, psychoneurosis, respiratory disease and circulatory disturbance. There were four patients whose diagnosis was not clearly established.

In her book, "The Road to Recovery from Illness" Miss Gardner has shown the wide variety of medical problems of a group of patients that were referred to Neustadter Hospital, a convalescent hospital in Yonkers, New York. It cares for men and women patients from the medical, surgical and gynaecological services of Mount Sinai Hospital in New York City. From her Table 31[1], the diagnostic classification of the female population has been used for Table IX which shows the comparison of the Royal Victoria Hospital patients to Neustadter Hospital patients.

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1. Gardner, op. cit. p.138.

TABLE IX

COMPARISON OF MEDICAL PROBLEMS OF 94 FEMALE PATIENTS ADMITTED TO NEUSTADTER CONVALESCENT HOSPITAL AND 103 MARRIED WOMEN REQUIRING CONVALESCENT CARE WHO WERE REFERRED TO MAIN SOCIAL SERVICE ROYAL VICTORIA HOSPITAL

Medical Classification[a]	Number at Neustadter	Percentage Neustadter	Percentage[b] Royal Victoria Hospital
TOTAL	94	100.0	100.00
Infectious Diseases	3	3.2	0.97
Neoplasms	16	17.0	6.80[c]
Metabolism, Endocrine and Vitamin Deficiencies	14	14.9	7.80[d]
Cardiac Disease	2	2.1	4.90
Vascular	4	4.3	0.97
Diseases of the Respiratory System	4	4.3	0.97
Diseases of the Digestive System	23	24.4	16.70
Diseases of the Genito-Urinary System	20	21.3	1.94
Non-traumatic Diseases of the bones and organs of movement	1	1.1	4.90[e]
all Other	7	7.4	44.05[f]

a) Based on Neustadter Hospital
b) See Table VIII
c) Royal Victoria Hospital figures have not shown a clear statement of prognosis nor are the gynaecological patients included.
d) Royal Victoria Hospital figures do not include any vitamin deficiency diseases as a primary problem.
e) Royal Victoria Hospital classification termed this group under the title of orthopaedic conditions.
f) This figure looms large for the Royal Victoria Hospital study because thirty-five patients have not yet been tabulated according to the complexity of their medical problems and this group represents 34.1 per cent of the total patient group.

More patients suffering from infectious diseases, neoplasms, metabolism, endocrine and vitamin deficiencies, vascular diseases, diseases of the respiratory, digestive and genito-urinary systems were given convalescent care at Neustadter Hospital than those patients in the same diagnostic group at the Royal Victoria Hospital. Only the patients in the cardiac and orthopaedic groups show a higher incidence of convalescent planning at Royal Victoria Hospital. In the case of patients suffering from fractures the percentage of the Royal Victoria Hospital patients is 11.8 per cent of the total group while the fracture patients at Neustadter Hospital are apparently small and are grouped under "other."

The reasons for the wide variation of the percentages in Table IX are not easily explained and would require further study of the administrative policies, community resources and practice of the professional groups treating the patients in both of these hospitals. A few reasons can be enumerated. Patients with infectious diseases are very difficult to place in Montreal and are not kept in a general hospital if at all possible. The low number of referrals of patients with vitamin and nutritional problems in the Royal Victoria Hospital group seems appalling. This consideration might warrant further study before any conclusion could be reached. A subsequent table breaking down the incidence of medical problems includes one patient with chronic under-nourishment as the main diagnosis and one patient suffering from malnutrition as a secondary problem from cholecystitis. Throughout the comparison the fact that the Royal Victoria Hospital group includes an over-all group of women requiring convalescence while the Neustadter group includes only those who had institutional care would influence the variation of percentages.

The incidence of the medical problems in the group of patients who suffered from more than one illness is shown in Table X that follows:

TABLE X

RELATIONSHIP BETWEEN THE MAIN DIAGNOSIS AND THE SECONDARY MEDICAL PROBLEMS OF THE THIRTY-FIVE MARRIED WOMEN WHO HAD MORE THAN ONE ILLNESS.

MAIN DIAGNOSIS	SECONDARY MEDICAL PROBLEM																												
	Total number of patients involved	Syphilis	Chronic Mastitis	Drug Addict	Pheno Sensitivity	Varicose Veins	Chronic Retinitis	Diverticulitis Sigmoid	Cholelithiasis	Duodenal Diverticulitis	Bronchitis	Epilepsy	Fistula	Malnutrition	Pregnancy	Obesity	Haemorrhoids	Cancer	Pyelitis	Sciatica	Arthritis	Diabetes	Arteriosclerosis	Endocrine	Neoplasm non-malignant	Blood	Cardiac	Psychoneurosis
TOTALS	35	9	5	4	3	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
1. Colecystitis	5	1	1	1		1	1							1	1														1
2. Circulatory Dysfunction	4	1						1			1						1					1		1	1				
3. Fracture	3		1	2				1																					
4. Psychoneurosis	3				1																								
5. Orthopaedic Problem	3	2	1		1								1																
6. Hernia	3		1	1						1	1																		
7. Diabetes	2		1			1							1																
8. Lacerations	1						1		1																				
9. Diverticulitis	1	1																											
10. Chronic Hepatitis	1											1																	
11. Duodenal Ulcer	1	1																											
12. Allergy, dermatitis	1									1	1																		
13. Bronchiectasis	1				1																								
14. Chronic Undernourishment	1	1																											
15. Varicose Veins	1															1													
16. Lymphoedema	1															1													
17. Cardiac Problem	1	1							1																				
18. Cancer	1													1															
19. Polyp.	1	1																											

Neither the social nor the medical records were complete or specific enough to indicate whether the main or secondary illness necessitated convalescent care. Sometimes the complicating illnesses have a direct effect on the problem of convalescence. In some instances the convalescent problems arose because of the emotional connotation of the illness. This is exemplified in the case of such patients as those who had exogenous obesity as a secondary problem. One felt too "different" to go to a place where people would stare at her and so she convalesceed with friends who were used to her. Inadequacies of plumbing and sanitary facilities in this friend's home contributed towards a secondary infection that interfered with further surgery. Thus the physical, the emotional and the environmental components all can have a bearing on convalescent care.

Table XI has been made by combining the figures from Tables VIII and X. This gives an accummulative total of the incidence of the disease enities that have presented convalescent problems for married women at the Royal Victoria Hospital during 1947.

The gastro-intestinal disorders was the largest medical problem for the group of patients in this study, with thirty married women in this group. There were fifteen patients who suffered from fractures; fourteen women had metabolic and endocrine disturbances, and thirteen suffered from various kinds of psychoneuroses. There were eleven women with cardiac dysfunction and ten who had cancer. Orthopaedic conditions were found in eight of the married women and vascular disturbances in seven. Four married women had definitely diagnosed genito-urinary problems. Since the one infectious disease[1] was suspected to be tuberculosis of the kidney, this means the

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1. To maintain consistency throughout the tabulation this case has been classified under infection in all the tables.

TABLE XI

TOTAL INCIDENCE OF MEDICAL PROBLEMS FOR 103 MARRIED WOMEN WITH CONVALESCENCE PROBLEMS

	Total	One Illness Only	Multiple Medical Problem	
			Prime Medical Problems	Secondary Illnesses
TOTAL	157	68	35	54
Gastro Intestinal Disorders	30	17	8	5
Liver and Gall Bladder	17	11	5	1
Ulcers	4	3	1	
Other	9	3	2	4
Fractures	15	12	3	
Metabolism and Endocrine Disturbances	14	8	2	4
Diabetes	5	1	2	2
Thyroid Problems	9	7		2
Cancer (malignant)	10	7	1	2
Cardiac Dysfunctions	11	5	1	5
Orthopaedic Problems	8	5	3	
Circulatory Disturbances	7	1	4	2
Genito-Urinary Diseases	4	2		2
Arthritis	5	1		4
Psychoneurosis	13	1	3	9
Respiratory Diseases	3	1	1	1
Lacerations	2	1	1	
Chronic Tonsillitis	1	1		
Ear Problem	1	1		
Infections	1	1		
Other	32	4[a]	8[b]	20[c]

a) These were patients whose diagnosis was not established.

b) Hernia 3, dermatitis 1, undernourishment 1, varicose veins 1, elephantiasis 1, polyp 1.

c) Blood 4, neoplasm not malignant 3, chronic mastitis 2, exogenous obesity 2, pregnancy 1, malnutrition 1, fistula 1, epilepsy 1, eye dysfunction 1, phenobarbital sensitivity 1, drug addiction 1, varicose veins 1, syphilis 1.

total genito-urinary problems were five. Five patients suffered from arthritis, three from respiratory diseases and two from lacerations. One patient suffered from tonsillitis and one from chronic mastoiditis.

Combining the totals that occur in the last category, such additional medical problems as malnourishment (2), blood deficiencies (4), hernia (3), non-malignant neoplasms (3), chronic mastitis (2), exogenous obesity (2) and varicose veins (2) occur for more than one patient. Dermatitis, elephantiasis, polyp, pregnancy, fistula, epilepsy, eye dysfunction, phenobarbital sensitivity, drug addiction and syphilis are medical problems that occurred only once amongst the patient group for this study.

This chapter has shown that convalescent problems arise for married women any time after twenty years of age. The largest number of patients appear in the middle-age group. Having a husband and family does not obliterate convalescent problems for married women, nor does work inside or outside the home prevent the occurrence of complications. The most prevalent medical problems for this patient group are gastro-intestinal disturbances, fractures, psychoneurosis, cardiac dysfunctions and cancer. Medical, emotional and environmental problems all contribute towards convalescent needs. These three components will be discussed separately in Chapters V, VI and VII.

To give the reader additional orientation to convalescent problems as well as to some general casework problems, the following chapter will discuss some important aspects of precipitating factors that precede the formalized convalescent period.

CHAPTER IV

IMPORTANT CONSIDERATIONS PRECEDING CONVALESCENCE

Before the medical, emotional and environmental problems of the one hundred and three married women are discussed in the three subsequent chapters, this chapter will consider some of the broader aspects that are important for members of the treatment team to be aware of prior to the formalized convalescent period. Frequently the beginning process of planning convalescence is as important as the actual period itself. It can lay the basis for the outcome of total treatment.

This chapter will first discuss the referral process and the preparation of the patient for the necessity of convalescence. Following this, the choice of a convalescent plan will be discussed from the point of view of the place selected and why. In regard to the problems necessitating institutional care it will be possible to compare the figures for a Montreal group with those of a similar study done at Neustadter Hospital in Yonkers, New York. The chapter will conclude with a discussion of the potential values of various plans and the after-effects when there are gaps in the lack of services such as housekeeping aides.

In the planning of convalescent care three main elements are involved for the doctor, patient, social worker and the community agencies: (1) the referral process, (2) the kind of convalescence selected and (4) the reasons for the plan. These will be discussed in this order in this chapter. Case material will be used to illustrate the various points and to reveal the real life problems of the patients.

Regarding the referral process, four important considerations are: the content of the recommendation, the timing, the person or source of the referral and the degree of participation of the patient in this stage of treatme

Since the practice of social casework is the prime function of a social worker in a hospital setting, the content of a referral for help in planning convalescence on behalf of a patient is of particular significance for the case worker. What is told the patient will often influence how the patient will benefit from casework. To have the doctor ask the nurse to call the social worker for "a bed at the convalescent hospital" is unsound in many respects, and indicates a need for further clarification as to how the patient can best be served by the caseworker. If the doctor has certain emotional and environmental reasons for recommending convalescent care, the significance of these gets lost in a secondhand referral. Also, if the doctor and nurse begin to talk of the "convalescent hospital" in the presence of the patient before the social intake interview the idea can easily become ingrained in the mind of the patient before the social worker has seen the patient to discuss the problem in general. Just telling the patient the social worker is going to arrange a bed misinterprets her function and perhaps prevents the patient from getting help in other areas. Such referrals camouflage the real underlying purpose which the social worker considers to be the essence of the first interview. Furthermore such referrals have an effect on the alternative plans that perhaps could be worked out regarding the convalescent plan.

Variation in the physician's understanding of the referral process and of the use of the caseworker is reflected in the difference between the two illustrations that follow:

> Mrs. Munch[1] , a Hebrew patient of 53 years of age, was referred to Social Service by the nurse with the request that transfer to the convalescent hospital be arranged for two to four weeks. Mrs. Munch suffered from cerebro-vascular thrombosis with aphasia for which the doctor prescribed rest and exercise. After

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1. Case No. 60.

> reading the chart and interviewing the patient the caseworker found that Mr. Munch was under treatment for alcoholism, that there was a very dominating sister who interfered with any self expression on the part of the patient and that the patient had no children. Mrs. Munch gave the impression that she had a great need to share her paramount problem: how she should behave and help towards the rehabilitation of her husband. When the caseworker was discussing plans for the patient the doctor designated he wanted only a convalescent bed and said he would refer the patient again if he felt the patient required help during the convalescent period. Nothing further developed.

The physician is the leader in the treatment team. The quality of casework his patients receive is therefore largely dependent on what he wants for his patients, how he can interpret the role of the caseworker, in simple terms, to the patients and how well he understands how he can give leadership to the treatment team. This is exemplified in the following case which shows the positive factors that developed out of a referral with meaningful content:

> Mrs. Longines[1], a 33-year old housewife of British origin, was referred by the doctor during her first week in the hospital for help in alleviating her concern over the bill, and for help in laying "the foundation for adjustment on discharge" i.e. convalescence and rehabilitation. Mrs. L. was hospitalized thirty-one days with diffuse toxic goitre for which she was treated by medication, rest and surgery. She had twenty-nine days of convalescence at the Montreal Convalescent Hospital and one week at home without the children, who were being cared for by friends and relatives. Mrs. L's background indicates that she had a marked attachment for her mother who died when the patient was seventeen. She completed Grade VII in school, took a business course and worked six years as a waitress before her marriage at twenty-six years of age. Mrs. L. has three children, twins, aged three and a son aged six. Mr. L., who can hardly read or write, earns $30 a week as a second chef. His father also lives in the home. For two years, patient suffered marital incompatibility, largely because of Mr. L's gambling habits. She worried considerably while in the hospital. Because of these disappointments she felt alone during illness and profited from supportive role of caseworker as well as planning for convalescence.

In such a referral as this, made during the first week of Mrs. Longine's hospitalization, the worker has been able to make a social evaluation and give

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1. Case No. 43.

help in the total treatment of the patient. In addition to the supportive role, the worker enlarged her focus from one area to another, the bill, the fears of the operations, the personal problems and finally convalescence. Follow-up did not seem to reveal any overlay of dissatisfaction around the illness. What the long separation from the family meant to the children is one area that could be questioned. This is a problem that will be discussed further in Chapter VI under the emotional component of convalescent care. Although these two illustrations are at the opposite extremes of the practice of referrals at Royal Victoria Hospital, the contrast of the content shows the difference in the kind of help these two patients received as well as the use made of the convalescent period.

A poorly timed referral seems rather useless. The effect of making a recommendation for institutional care when discharge from hospital is imminent, is often unfair to the married woman who has other people in the family to consider and plan for. Before she comes to a hospital a mother has probably worked out an arrangement for herself and family as best she can. If the plans involve other relatives, or friends, sudden changes cause inconvenience and embarrassment to all.

The following case of a married woman is an example of the futility of the referral because of the late date it came to the attention of the social worker:

> Mrs. Barrouche[1] was a 27-year old housewife of French origin who had an ill husband, two young children ages 3½ and one and a half and a mother living with her. Since Mr. B's illness was the result of an accident at work, the family were in receipt of Workmen's Compensation, which in Quebec is below minimum standards for daily needs and is often sent out at irregular intervals. The patient appeared to be a neat, methodical person who had become excitable and anxious with family responsibilities. Although public assistance had been accepted, she seemed sensitive about being a public patient on the ward.

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1. Case No. 7.

> Mrs. Barrouche had been hospitalized to undergo surgery for a diffuse toxic goitre. She remained in the hospital thirteen days and was then ready for discharge. The referral for convalescent care was made by the nurse on the day of discharge after it was noted that the patient seemed over-active and concerned about how she would get adequate care. The worker offered to try to get a bed for the patient at the convalescent hospital, but Mrs. B. said she had already planned to go with relatives outside the city.

Nothing constructive was accomplished during the interview. The worker tried to give this women the feeling that somebody was ready to try to help her. Such a situation can be detrimental to the feeling of satisfaction the patient has about the outcome of her total treatment. If the patient tends to be neurotic she can use the lack of convalescence as one way to maintain a semi-invalid state.

The advantages and disadvantages of the various sources of referrals is the third factor involving referrals which will be given attention. Fifty-six of the referrals in this study came from the nurses who acted on behalf of the doctors who would necesarily have had to make the original recommendation. The doctors made thirty-one of the referrals, themselves. Patients with multiple medical problems, including those of a psychiatric nature, and the cardiac group were those who had the highest incidence of direct referrals from the physician, while the patients on the surgical service had the lowest incidence. This can be explained on the basis that the surgeons are occupied with operations and are not as readily available as other doctors. The worker does not participate on surgical ward rounds nor is her office very accessible to the surgical wards.

Apart from the doctors and nurses, referrals also came in eight instances from various agencies in the community. Six patients used for this study came to the attention of the social service department by non-professional people in the hospital and community. One patient and one member of the family requested convalescence. This direct application gives the worker the

advantage of understanding and evaluating a problem first hand.

Where suggestions for convalescence come from sources other than the physician the caseworker's early and prompt discussion with the physician is of utmost importance. The physician may not approve of the plan. The antagonism these patients can arouse against the treating person will be seen later where the meaning of convalescent care is discussed in Chapter VI [1] in connection with the emotional component of convalescence. The recommendation of convalescence by a person other than the physician usually has less meaning to the patient. This is especially true for patients who consider any illness a sign of weakness. A professional opinion is easier for them to accept than a request on a personal basis.

However, if someone besides the physician does make the referrals, then the medical social worker should assume certain responsibilities in a liaison capacity. Suggestions initiated by outside sources can be misinterpreted by the patient. On the other hand workers in agencies initiate plans involving both time and money that cannot be substantiated by a medical recommendation. Such situations leave the patient confused. A patient may feel rejected if she has a tendency to be sensitive. Recognition of these feelings of the patient in terms of a medical recommendation is as necessary for negative experiences as it is for positive planning, and this philosophy would not exclude something that arose about a convalescent plan.

Even when the agency prepares the patient for the medical social worker and the social worker confers with the physician who concludes convalescent care is advisable, there is still the important factor of the participation of the patient in the plan. How meaningful such plans are to the patient who does not really expect to make the most of convalescence is exemplified here:

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1. Infra P. 94. Mrs. Hatch, Case NO. 92.

Mrs. McLagan[1] aged 71, a widow living with a married daughter was referred by the Maternity Social Service to see if convalescence could be arranged. The reason given for this request was to relieve Mrs. M. from family strains which were making her miserable. The patient suffered currently with bronchitis but her history also revealed hypertensive cardiovascular disease and old cancer of the cervix. The patient had one daughter in Montreal and three sons outside the city. She lived with the daughter and complained of incompatibility that often resulted in days of silence. During her period in the convalescent home it was planned to evaluate the situation at home to see what could be done. The daughter said that the patient was extremely independent and would not allow anyone to do anything for her. After two weeks of convalescence the social worker felt that the patient responded only moderately well. The patient confided to the doctor in clinic that she felt no better. Although she said she felt happier, Mrs. M. showed no increased capacity for handling her problems. She did regain enough strength to visit other children and thus lessen family tension in the daughter's home. She admitted later that she would have to become resigned to her life situation.

Since a social worker had suggested institutional care the patient did not feel free enough to indicate any criticism to someone in the same profession. Or, she may have felt that if anyone were kind enough to offer her something she should not refuse. Actually, the value of convalescence was partially lost because the patient and family were using it as an escape rather than as a constructive form of treatment.

The second topic of this chapter is the places selected for these patients' convalescence. As already pointed out in Chapter 1, present concepts of convalescent care have evolved out of the thinking that this care is synonymous with an institution. The following table shows where the 103 patients in this study spent their convalescent periods.

Table XII shows that 62.3 percent of the women went to an institution. When this convalescent period was over, it was very possible that some patients still considered themselves "convalescent." Indications of either

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1. Case No. 63.

TABLE XII

CONVALESCENT PLAN FOR 103 MARRIED WOMEN

Place Selected for Convalescence	Number of Times	Percentage
TOTAL	103	100.0
Institution	64[a]	62.3
Home	23	22.5
Home and Institution	4	3.9
Relatives	3	2.9
Institution and Relatives	3	2.9
Remained in Royal Victoria Hospital	2	1.9
Friend	1	0.9
Hotel	1	0.9
Nursing Home	1	0.9
Institution and Nursing Home	1	0.9

a) The Montreal Convalescent Hospital was the resource used in sixty cases, Murray Bay Convalescent Home was used to help three patients and St. Joseph's Hospital was used for one woman.

a medical or medical-social evaluation follow-up for this group were rare. The plan of this study has not focussed on the follow-up aspects although some discussion will be contained in Chapters VIII and IX. The four patients, or 3.9 percent of the total, who divided their convalescence between home and hospital, had to do so because of special problems. These included mental changes on the part of the patient, financial and emotional dependency problems, development of friction at home, and the development of psychotic tendencies on the part of the husband.

Twenty-three patients went home for convalescence, which represents 22.5 percent of the total number of patients in this study. Relatives' homes were used exclusively by three patients and in addition to an institution for three more of the patients. Only two patients or 1.9 percent had to remain in the Royal Victoria Hospital during their convalescence. Since it is not the policy for the Royal Victoria Hospital to keep convalescent patients, these

women had problems peculiar to the community, i.e. drug addiction, no legal residence, no public assistance, or else had to remain because of lack of physiotherapy facilities in the convalescent hospital. One patient went with friends and one had to go to an hotel room because of a bed shortage. A nursing home was used for two patients. In one instance, this plan followed a trial period at the convalescent hospital.

Table XIII has been compiled to show the reasons why sixty-four women went to an institutional setting for their convalescence. Other tables were made to analyze the kind of convalescent plan in relation to the diagnostic classification and to living conditions. No valid conclusions could be drawn from them however because the majority of the referrals made for the patients in this study were made very explicitly for insitutional care. The following table gives a forerunner of the kinds of problems that were encountered for this patient group.

These precipitating factors that necessitated institutional care for sixty-four of the married women fall within three main groups. The factors enumerated in numbers 1, 7 and 14 relate to a medical problem; factors enumerated in numbers 8, 9, 10, 12, 13, 15, 16 and 17 relate to an emotional problem and factors found in 2, 3, 4, 5, 6 and 11 relate to environmental problems. These three components reflect the original concept discussed in Chapter II about the three main aspects that comprise a unity for each individual's existence.

In her book on "The Road to Recovery from Illness" Elizabeth Gardner showed statistics of 112 patients who were discharged from Neustadter Hospital in Yonkers, N.Y. during two months in 1942. Of these 112,[1] at least 97 gave evidence of social situations at home which were unfavourable to normal convalescence. Typical home conditions leading to the choice of institutional care were as follows:[2]

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1. Gardner & Thomas. op.cit.p.14

TABLE XIII

PRECIPITATING FACTORS NECESSITATING INSTITUTIONAL CARE
FOR 64 MARRIED WOMEN

Serial Number	Reason for Institutional Care	Number of Patients	Percentage
TOTAL		64	100.0
1	Insufficient Information	12	18.7
2	Problems of family responsibilities (a)	9	14.2
	No one home during day	5	
	In rooms	2	
	Family will not add to their responsibilities	1	
	Home too near business	1	
3	No home	9	14.2
	Live where they work	6	
	Gave up room	2	
	Out of town	1	
4	Adverse living conditions	6	9.2
	Overcrowding	3	
	Low income, drab life	2	
	Dampness in flat	1	
5	Rest from strained family relationships	4	6.3
6	Rest from family responsibilities (a)	4	6.3
7	Other illness in family	3	4.8
8	Patient hopes rest will help her	3	4.8
9	Husband's insistence	2	3.1
10	Patient's insistence	2	3.1
11	Await alternative planning	2	3.1
12	Patient will not follow diet regime at home	2	3.1
13	Rest for "nerves"	2	3.1
14	Gradual return to activity	1	1.5
15	Medical situation is aggravated at home	1	1.5
16	To spite husband	1	1.5
17	For physical and emotional rest	1	1.5

(a) Differentiated from 2 because 2 is from the point of view of family and 6 is from point of view of the patient.

TABLE XIV

SOCIAL CONDITIONS UNFAVORABLE TO NORMAL CONVALESCENCE FOR 143 PATIENTS DISCHARGED FROM NEUSTADTER HOSPITAL IN 1942

Serial Number	Reason for Institutional Care	Incidence of Problems	Percentage
TOTAL		112	100.0
1	No one at home daytime	21	18.7
2	Unsuitable physical aspects of the home	20	17.8
	Crowded	8	
	Stairs	12	
3	No one in patient's home capable of caring for patient	15	13.4
4	Dissensions and strains	11	9.8
5	Persons in home cpable of caring for patient too busy with other responsibilities	8	7.1
6	Business and other responsibilities in too close proximity to home	8	7.1
7	Others at home apt to be adversely affected by patient's presence	8	7.1
8	Lived in lodgings	8	7.1
9	Domestic servant	4	3.6
10	Lived alone in apartment	4	3.6
11	Patient neglected self at home	3	2.9
12	Lives in institution	2	1.8

The figures for Gardner's study cannot be compared closely to Table XIII because her figures included men and the reasons listed were not all comparable to those for this study. In 90.3 percent of the cases where institutional care was chosen for the patients in her study, the reason was of an environmental nature. For 9.8 percent of the group, there was an emotional problem based on dissension and strain in family relationships. For this study the figures showed that 53.3 percent of the reasons for institutional care were environmental, 25 percent were medical reasons while 21.7 percent were associated with emotional factors. Gardner's group included larger percentages of patients with other problems around family responsibilities, adverse living conditions and lack of home.

For 18.7 percent of the patient group at the Royal Victoria Hospital the information was incomplete. Patients with stresses and responsibilities at home and problems with strong emotional connotations appeared more frequently at Royal Victoria Hospital than at Neustadter Hospital. There were 3.5 percent of the Neustadter patients possibly would neglect themselves at home and 3.1 percent of the Royal Victoria Hospital patients who would not follow prescribed regime at home. This group is the only one where the figures are the same for the two studies.

The next part of this chapter will discuss the value of institutional convalescense in relation to the individual problems of the patient. Many of the precipitating factors indicated problems that were far reaching and in many instances could not be treated. Institution care however, can be used as a palliative measure, and as such can contribute to the patient's care. It can be a source of comfort when no one is home during the day or when a patient has no home, lives in a room or lives where she works. An institution can give a sense of independence to mothers who fear rejection by their family and feel unwanted by their children when incapacitated. Frequently such problems as new living arrangements and re-employment loom up at the end of the institutional period which can provoke anxiety during the convalescent period. This would be a reality problem regardless of the convalescent plan.

Women who suffer from adverse home conditions such as overcrowding, drabness, dampness, do not always think in terms of the quality of their home and reject home in favour of an institution. None of the six patients in the Royal Victoria Hospital group asked on their own behalf to go to an institution All expressed a strong maternal tie to their home. With four of the patients there was a similar inability of the mothers to admit that the physical environ ment of the home was poor. Two patients expressed disillusionment over their

marriage and home, indirectly, through open criticism of the husband and through frequent requests for an extension of care. The importance of institutions on which they had become very dependent was very marked for these two latter patients.

The following case illustration shows the strength of the tie the mother can feel even though her basic feeling towards home may be one of rejection. It also shows the importance of the patient's participation and the complications that can be encountered in organizing community resources to the best advantage for the patient:

> Mrs. St. Theophile's[1] problems started as a child when she suffered many deprivations. An abscess in her right hip went undiagnosed and untreated as a baby, leaving her permanently deformed. Her parents were not compatible. She was frightened when one of her mother's lovers tried to seduce her. Later she became pregnant by another man, 20 years her senior, whom she married for the sake of a home. He did not meet her needs for the affection she craved. Further pregnancies only increased her hostility to her lot in life.
>
> Mr. and Mrs. S. live in two rooms in a ramshackle house outside of Montreal. This is shared by three children aged three, two and one years, and Mrs. S's mother who is mentally ill and who continues to be promiscuous. Mr. S., shell-shocked from World War I is said to suffer from asthma, bronchitis, ulcers and arthritis. His earning capacity is severely hindered. It has been necessary for the family agency to give relief. The assistance received was inadequate to meet the minimum needs of the family.
>
> When Mrs. S. was referred by the doctor he felt she suffered from chronic undernourishment and psychoneurosis and that she should have rest to build up her extremely poor nutritional state. Numerous details had to be worked out for the care of the children. When she arrived at the Convalescent Hospital she telephoned home constantly. After one month's care she returned home.
>
> Her behaviour on subsequent hospital admissions reflected very clearly how her hostility towards her own deprivations made her reject the children. On one occasion after punishing her second child, she developed a coughing attack of sufficient seriousness to warrant admission. She would not remain in the hospital until the completion of her investigation, however, because she felt she should return home. On another occasion when ante-partum complications for the fourth baby arose, she came into hospital but became very critical of the care and left against advice.

> The S. family have been active with one or more agencies for several years. When the question of convalescent care arose again in 1948 and 1949, efforts were made to have both the mother and children go to the country together. Unfortunately, circumstances were such that these plans could not materialize.

This patient's situation illustrates one of the many combinations of problems which can occur. Mrs. S's strongest feeling was around her guilt over her rejection of the children and her resentment about life. She was not happy with her husband. Physically she remained thin and frail. The low income was not enough to allow her to build up her own nutrition, let alone supply the children with the necessities of life. Convalescent care in an institution would have little or no value because of her long standing problems. There will probably always be an emotional blocking to any help offered that could build her up.

Institutional convalescence can serve to give immediate relief to women who require rest from strained family relationships. Frequently a change gives the patient an opportunity to become more objective about her problems. Efforts to work through these problems with the husband or children were not successful with the families in this study. The reasons for this are not too clear. The content of the referrals and the lack of skill of the social worker seem to be two reasons for this failure. The fact that the referrals were initiated by someone outside the patient's immediate sphere, such as the doctor, psychiatrist or friend, may also have some importance. If the idea were proposed before the patient was ready to accept help, it takes a great deal of casework skill to handle the problem and have the patient not refuse help because of the threat it may involve for her ego. The lack of the participation of the husband and/or children was reflected in their defensive, indifferent or evasive behaviour. The one patient who was helped in this group of four patients was given an

opportunity "to take stock" of her environmental problems, by having the interviews focussed on how she could cope better with the situation as it was, without involving other members of the family.

Four women had institutional convalescence in order to give them a rest from family responsibilities. None of these social case records were very full but there seemed to be a tendency for the mothers to want or request care in order to be reassured of some protection which they doubted their husbands would give them if they had gone home. An interview with the husband was held in only one instance[1]. He quite openly enumerated the many things that were undone at home, even before his wife had left the hospital.

In discussing the area where the emotional component seemed to be the strongest precipitating factor necessitating institutional care it must again be stressed that there were additional elements which made for other problems in the total situation. If the records were more complete it would be possible to group these women more precisely in other categories. When the statement was made that "I need a rest for my nerves", and subsequent social data was scanty, this classification seemed to be the most valid. Because particulars were not as clear as they might have been, the reasons for rest have been labelled, hence the use of two categories eight and thirteen in Table XIII[2] .

The first group included those women who presented a subjective reason for convalescent care. They thought very definitely that they required it. All had a different diagnosis. One patient had cancer but was not aware of the true nature of her illness. After a major operation, her recovery was slow and she became discouraged, the more so, because she did not understand

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1. Infra p.78. Case of Mrs. Zalrahy
2. Supra p.56.

the situation. A second patient, on the other hand, thought going to a convalescent hospital would help her because she just wanted care. The third patient in this group, suffering from hypertensive cardiovascular disease with poor compensation, said she had been working hard at home and thought a rest would help her. Her husband, with whom her relationships had been poor, was in an institution for the chronically ill. An unmarried daughter, a married daughter and a son-in-law whom patient considered worthless, were all at home. After two weeks in the convalescent hospital the patient said she was not feeling appreciably better. She recognised the effect of her anxiety on her condition, said she felt that there was no solution to her problems and the case was closed.

The two husbands who were insistent on convalescent care for their wives were described as anxious men. In the case of Mrs. Randolph[1] who will be discussed in Chapter V, in connection with nursing care problems, the husband was very worried after his wife had undergone the thirty-sixth operation.

When the wife insisted on convalescent care, there appeared to be an element of family rejection which she felt, but coult not express. To maintain her place in the family a mother might become very dependent so her family would rally round to meet her needs. This took the form of quiet demands or aggression. Hospitalization gave some patients an opportunity to remain dependent and an excuse for continuation of their demands.

In the two situations where patients had eating problems when at home, there was evidence of very minor help in one instance and a good casework service in collaboration with total medical treatment in the other. The following illustrates the value of planning convalescence carefully:

> Mrs. Balfour's[2] diagnosis was not clearly established but there was a possibility she would require an operation for a tumor.

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1. Case No. 75. Infra p. 82.
2. Case No. 5.

> She was an extremely wiry woman who had worked as a waitress full time. Her stepdaughter was out of the home. Patient and her husband had previously had a car but had given it up for economic reasons. Worker and the doctor recommended convalescent care but the patient was not too receptive. Casework service was of immediate help to her in accepting treatment. Offering this care was a great source of relief to the husband who was getting a little impatient with Mrs. B. trying to treat herself. She seemed to be evading the reality of her illness. Mrs. B. said she knew she could not eat if she were home alone in a quiet atmosphere because she would be too nervous.

The patient was given an opportunity to verbalize many of her feelings and gained sufficient understanding and insight to enable her to accept convalescent treatment and the advisability of certain changes in her life. In this situation the active participation of the patient made it possible for her to benefit from institutional care.

When the wife said she needed a rest for her nerves her whole life situation seemed to be the problem. The two patients in this group were both reticent about using social service. One patient who was in the older age group was however helped to make constructive use of the convalescent period. The opportunity for helping her do this could be traced to the content of referral made by the doctor and the positive attitude of the caseworker. When the patient was made aware of the broader aspects of the use of the recuperative period, her degree of recovery was increased as well as her general satisfaction about her everyday life.

The patient who felt her medical stiuation was aggravated at home suffered from a duodenal ulcer and duodenal diverticulitis. This is a disease entity where the emotional environmental strains can be very important.

Institutional care can give temporary rest and relief and as such may be considered useless. But, if it is something that the patient wants, even temporarily, then it is better to give her some happiness than to make her

feel rejected and punished, which would have equal emotional repercussions.

What goes into convalescent care at home was one of the questions raised at the onset of this study. It was amongst this group that the need for further community service, especially housekeeping aides, became obvious. The following table shows why this group of patients went directly home or remained in the home for the recommended period.

TABLE XV

REASONS WHY 23 MARRIED WOMEN WENT HOME FOR CONVALESCENCE

Number	Reasons for going home	Number of Patients	Percentage
TOTAL		23	100.0
1	Lack of institutional beds when needed	5	21.8
2	Patient refused institutional care	4	17.4
3	Patient preferred security of home	3	13.0
4	Patient felt responsibility to children	3	13.0
5	Other family illnesses increased patient's responsibility	2	8.8
6	Lack of sufficient financial help	2	8.8
7	Sensitivity about social stigma	1	4.3
8	Further hospitalization meant weakness	1	4.3
9	Never thought of anything else	1	4.3
10	Not clearly shown	1	4.3

In the group of 103 patients, five women or 21.8 percent had to return to their home because there were no institutional beds when they needed them. This is 4.8 percent of the total patient group. Two of these patients were quite anxious about this refusal. Both here Hebrew and felt they were being rejected for social reasons which was not true. Three were hospitalized during the spring when there is more apt to be overcrowding in the convalescent hospital. Three of the patients were able to make plans to have a housekeeper come into the home, which relieved their anxiety about care. A fourth patient, whose case was scantily recorded, received the services of a Victorian Order

of Nurses. The fifth patient was unfortunately the victim of poor team work between doctor, nurse and social worker. She was referred very late and the nurse understood there would be no bed. There was no follow-up by the social worker on any of these cases as they apparently all went to private physicians upon discharge.

The refus of convalescence for the patient who requested an institutional bed was very traumatic. Refusing to consider the individual's needs has quite a different meaning for the patient than to state simply that there is a lack of institutional facilities. Four patients were refused care in this group of 103 women. The rejection suffered by these patients was acute and for some it had long term results. It was not significant who refused, whether it was the doctor, the institution or the social worker. The patients felt they were not being understood - their needs were not being met. Refusal coupled with other problems increased one patient's indifference towards herself. One patient became aggressive and engendered feeling in her community against the hospital. The use of Victorian Order Nurse for reassurance and follow-up at home was not sufficient to meet her needs. To prove she was too weak to go home she fainted the first day after discharge. This increased the neighbourhood anxiety and hostility which was naturally a source of satisfaction to the patient. Her basic problem extended beyond this brief period of her life. Efforts of both hospital and community were made to help this patient accept casework and/or psychiatric help. Her other problems will not be discussed at this point.

The relative merits of home convalescent care began to come into full view when the mother stated that her attachment to her family was of major importance both to her and to them. This attachment was different than that found for the patients in group four who felt a responsibility to the children. In group three, the mothers felt the family would look after them. In their

dependent situation they wanted the personalized care of the family rather than care in the institution. They did not feel upset about being a burden on others. They had given to their families, were secure individuals and felt worthy of receiving.

For all of the three patients in group four, the question of receiving care in an institution arose. The decision reached in one case was not evaluated very carefully. The basis for a decision for home care was illustrated quite strongly in Mrs. Benoit's attitudes:

> Choosing convalescence for Mrs. Benoit,[1] aged 40 years, was discussed at length by the husband, the patient, the doctor and the social worker. Mrs. B. suffered from pleurisy with effusion and she required at least six months convalescence. There was no bed at any preventorium. Even if there had been one she was not happy about separation from her husband. Her concern about the children aged twelve and ten was not acute because they adjusted well with relatives. The strong tie was the patient's dependency on her husband. He worked as a night porter in a local hospital. He suffered from arthritis and a chronic cough. He was very anxious to do what he could and was happy to be able to have his wife at home. She had always been fearful of staying alone. She said she felt the sleep she missed sitting up at night while her husband worked caused her breakdown. What bothered her most was the indefinite length of time that would be involved away from her husband.

Having some type of homemaker service would have been a great help to both Mr. and Mrs. B. The physical and emotional burden that Mr. B. would have to carry for at least six months would be a very great responsibility. A housekeeping aide would have prevented any damage that the long separation might have caused the two children. A companion would offset Mrs. B.'s fears of being alone.

The three women in the group who felt responsibility towards their family to the extent that they could not accept further care for themselves, all had dependent children. Some of them were placed with relatives, others were at home receiving care from the husband and/or neighbours. None of these

1. Case No. 6.

women were being treated by a psychiatrist but they indicated basic an ieties. One woman had a difficult husband who had been in jail. In addition to her feeling of responsibility towards children she seemed ashamed of going elsewhere because of the disgrace her hsuband's sentence meant to her. All these women had been recommended to have convalescent care by the doctor yet none of them received additional care in the hospital before going directly home. In all three cases, the relief and extra rest that the presence of a housekeeper would have given, would have allowed the mother to be in her own environment and to supervise the children yet get the additional rest that was recommended.

The use of a housekeeping service during convalescent care would also be beneficial for married women who felt they should go home because other members of the family were ill. The services of a housekeeper could be secured in only one instance for the two patients in this group. The second patient whose husband had been suffering from bronchial asthma and was in the midst of trying to make a better work adjustment, felt that had she gone to an institution at this time the separation "would have been on her conscience."

Inadequate living conditions should not negate the feasibility of the use of housekeeping aides. When living quarters are small, awkward and inconvenient, keeping house requires more patience than in more spacious quarters. Even part-time domestic services would enable the patients to have the rest the doctors order.

Two of the 103 women were denied convalescence because of lack of funds. This group did not include those who had other problems around finances for daily needs. Both of these cases have been chosen for illustrative purposes.

Mrs. Poulin[1] was 56 years of age and suffered from hypertensive cardiovascular disease. The doctor recommended convalescent care for three weeks. Since her husband earned $30 a week and one son worked, she was not considered eligible for Q.P.C.A.[2] nor could the family afford to pay for convalescence or care in a boarding house. General hospital funds did not cover such expenses. Mrs.P. has continued to follow up at clinic. She complained of shortness of breath and by 1949 had reached the stage where she could not work. Increased rest had been recommended.

Mrs. Colderisi[3] not only could not afford extra care but she too felt a responsibility to return and supervise her children. She was a 29 year old Italian woman who had four children between 11 months and 10 years of age. Her husband was a labourer on the C.N.R. with a $33 a week income. Q.P.C.A. was refused for the eleven days of hospitalization so additional convalescence in an institution was out of the question. Mrs. C. was discharged directly home. Within six months she returned to clinc still complaining of pain. Objectively she was told that the medical results of her operations were excellent. In 1948 she was diagnosed as suffering from an anxiety state because of her frustrating life with her husband. He gambled, stayed out late, left all the work for Mrs. C. and made many sexual demands. Mrs. C. feared further pregnancies.

The late timing of the referral, the lack of casework service and insufficient medical follow-up were marked in this situation. However, the need for housekeeping aid still stands out. The case of Mrs. Poulin raises a realistic question. How can a woman with household responsibilities rest more and more when her husband's needs continue as before and sons require almost as much attention as the husband? It became an impractical situation. People hesitate to impose on their relatives and neighbours over a long period of time and when a chronic illness is involved the need for an outside service is that much more important.

For the last three patients who convalesced at home, only one patient expressed subjective feelings on the subject of a "change to rest her nerves."

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1. Case No. 22
2. Note about Q.C.P.A. Infra P. 122.
3. Case No. 14

The fact that one of these patients felt the other patients "were beneath her" could have perhaps been offset if she had had a choice of plans and the intake interview had been more careful.

The last case showed incomplete data. The patient was provided with housekeeping services by the family agency before she had completed her clinical investigation. Co-ordination of those helping the patient was poor and slow. The diabetes which was the medical problem did not seem to get attention even though the patient had said she could not afford her diet, a very vital factor in her future health.

Of the ten patients in this group of twenty-three patients who required housekeeping service, follow-up indicated the following results:

TABLE XVI

MEDICAL RESULTS OF 10 PATIENTS WHO INDICATED A NEED FOR HOUSEKEEPING SERVICE

Number	Diagnosis	Follow-up in Social Service	Medical After-effects
1	Non-toxic Nodular goitre	Not followed	Anxiety state
2	Anxiety state	Not followed	Anxiety state
3	Chronic Cholecystitis	Not well followed	Situation anxiety
4	Cholecystitis	Carried one week	Fainted at home
5	Hypertensive cardio-vascular disease	Not followed	Shortness of breath
6	Pleurisy with Effusion	Not followed actively	None
7	Hypertensive cardio-vascular disease	Not followed	Not known
8	Fibrosarcoma abdominal wall	Not followed	No ill effects
9	Fractured arm, diabetes, myocarditis	Not followed	None known
10	Chronic tonsilitis	Not followed	None known

The follow-up medical information for this table was only briefly discussed in the medical records of the patients. The subjective feelings of the patients about the outcome of their convalescence was not available because case work was not carried on a continued basis for any ofthese women. Three cases were later diagnosed as having anxiety states. Three patients were not seen again at the hospital. One patient's heart condition got progressively worse and one patient fainted at home. Two patients appeared to have no ill effects from going home for convalescence in spite of family responsibilities. Work and worry were no doubt increased for the husband.

In reviewing the twenty-three patients who convalesced at home it was found that only five patients were able to have housekeeping services. Three found their own independently, one was found through National Employment Services by the efforts of the hospital social worker, and one was provided by a family agency.

Four of the 103 women patients divided their convalescence between home and institution. Two of these women chose to go home first but later changed their mind. Part of the basis for this choice was traced to family relationships. One patient whose husband had also been sick decided she would be better in an institution after she got home. How she felt about convalescence before discharge was not know, since she was not referred to social service until after she left the hospital. Another patient, referred prior to her discharge, wished to go home during the Christmas season, but it was necessary for her to have institutional care because her husband was becoming increasingly psychotic and was becoming abusive. Her husband caused her much embarrassment at the time of his visits to the Montreal Convalescent Hospital. Although he wanted treatment he had to be helped complete plans and co-operation with other agencies was necessary. His committment was arranged during the time patient was at the hospital. Upon discharge she had to be helped to face the reality of his mental illness.

The other two women in this group went directly to the convalescent hospital. Both patients had a long term illness where convalescence was going to be necessary from nine to twelve months. One woman was mentally retarded and underwent mental changes that made her compatability with the other patients poor. When she became aggressively hostile it was necessary for her to go home.

For the other patient the inactivity of being in a cast and dependency on others for care bothered her. She had always worked hard. At the Montreal Convalescent Hospital she was lonely for her children and grandchildren. At home she fretted over the care she was to her daughter. When financial problems became acute in the home, she preferred to return to the Convalescent Hospital to lessen the financial strain on the family.

In the group of 103 married women, six used their relatives (other than husband, children or parents) for all or part of their convalescence. Three went directly to their relatives. One patient had no alternative. The choice in two instances was based on the emotional tie that the patient felt towards the family. Both of these women were young married women who were immature and extremely dependent. The older members of the family gave them a comfortable, secure feeling.

The theory expressed by Dr. Liss [1] in his article on "Convalescence" that the rapidity of convalescence was dependent upon the level of maturity of the individual was clearly seen in the case of one of these patients who had never grown away from her family.

> Mrs. Pierre[2], a young French-Canadian woman of 26 years of age was hospitalized first, early in 1947 for eleven days because of regional ileitis. She cried herself to sleep every night in the hospital. She said she was "the lonely type" and that she still considered herself

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1. Liss, Edward. "Convalescence", Mental Hygiene XXI, 4, pp.619-32.
2. Case No. 67.

> as a "baby". During the convalescent stage in the hospital she was not prepared for a transfer to another institution. She felt that the idea had been sprung on her suddenly. Mrs. P. said that she had wanted to stay with a sister in whose home other relatives also lived. This plan was approved by the physician. Because of the strained finances it was a relief for the husband.
>
> Medical complications have continued for Mrs. Pierre which have necessitated further hospitalizations and regular clinic care. One physician who got to know her quite well apparently aroused her feelings about having a family. Patient became quite apprehensive and quickly refused the suggestion that she go to sterility clinic. Notes on her chart during subsequent admissions indicated that patient was still crying to go home.

This patient has continued to have immature self-centred attitudes. She could not conceive of herself reaching out to give something to someone else. Although nothing was known about the relatives, the attachment the patient felt towards them indicated the strong meaning they had for her.

The three patients who spent part of their time at Montreal Convalescent Hospital and part with relatives were all facing an indefinite future. None of them had a home they could call their own. One woman was in the midst of a legal action over her home and support from her husband. She could not afford to stay too long in an institution nor could she bear the thoughts of being dependent on her children, even though the parent-child relationships were good. A second woman was separated from her husband and had to support herself. Her bill was submitted for Q.P.C.A. consideration but the investigation was not completed before her transfer to Montreal Convalescent Hospital. With the legal complications that necessitated the investigator seeing her husband, her embarrassment became so acute that she refused to remain. The third woman was getting rested prior to her return to England.

Only two patients remained at the Royal Victoria Hospital for their convalescent care. One had to remain because she was an extremely difficult

patient, addicted to drugs, and her husband assumed an irresponsible attitude towards financial matters. There was no other place in the community where she could go. The second had to stay in the private pavilion because of special physiotherapy treatments which she could not get at Montreal Convalescent Home.

Those who used nursing homes were the elderly women convalescing from fractures and falls who required care but who, for reasons of age, were senile or incontinent. On these two scores they are ineligible for Montreal Convalescent Hospital.

Another patient went to her hotel room because there was no convalescent bed available when she wanted one.

The last patient lived with a friend and her family. Housing conditions were very poor, dirty and inadequate. However, this was where the patient felt comfortable. Being extremely obese, she was sensitive about going to a new institution and facing new people.

In concluding this discussion of the important factors to be considered prior to the convalescent period, it can be seen that the referral process is the first step that points the way to giving the patient the maximum benefit that can be achieved during this period. An early referral with meaningful content, by a professional person, preferably the doctor, made directly to the social worker should be the goal of hospital practice. The use made of convalescence depends on the individual patient but this is influenced by the interpretation the doctor and social worker give to the patient as to what can be accomplished during convalescence in terms of the "stock taking" advocated by Dr. Woodruff.

Although 64 or 62.3 percent of the married women went to an institution for their convalescence, the decision as to where a patient can best convalesce, made after a medical and social evaluation, is largely dependent on the indi-

vidual situation of the patient. Other possibilities used by women in this situation were patient's home, relatives, friends, nursing homes, hotel and the Royal Victoria Hospital.

If the patients' homes are to be used, special needs arise such as housekeeping aides which would require a broader program of the treatment hospital. Protective care alone will not solve all problems whether they are of a medical, emotional or environmental nature. Collateral care and medical follow-up are necessary. How this can be done will not be solved by this study. If the reader is made aware of the married women's problems, a solution for some will perhaps follow at a later date. Since the beginning problem of all convalescence is considered to be medical, the next chapter will discuss some of the more particular problems in this regard as they arise in relation to the convalescent patient.

CHAPTER V

CONVALESCENCE PROBLEMS WITH A MEDICAL COMPONENT

Apart from the medical problem that accounts for the patient's physical or mental breakdown which becomes the basis for the necessity of convalescence, there are other medical problems which can be tabulated with the problems of convalescence. For the purposes of this study they have still been called medical. Because they are the smallest group, they will be discussed first in this chapter before the emotional and environmental problems. For a few patients, medical complications arose that could not be tabulated under the medical social classification. They remained within the area of the general medical problem that necessitated convalescence and as such will not be included in this study.

The following table shows the incidence of problems with medical components in the medical social classification:-

TABLE XVII

MEDICAL PROBLEMS ENCOUNTERED DURING CONVALESCENCE FOR 103 MARRIED WOMEN

Medical Social Classification		Incidence of PrimaryProblem	Incidence of Secondary Problem
TOTAL	43	7	36
Other Illness in Family	26	3	23
Physical Incapacity	7	2	5
Nursing Care	6	1	5
Nutritional Problems	4	1	3

6

Tables XVII, XVIII, and XX are broken down according to the primary and secondary problems from which married women suffered during the time they required convalescent care. The problems have been broken down by the writer during the reading of records. Personal interviews might have changed the incidence of these problems.

Problems created by other illnesses in the family was the most prevalent problem in this group. The incidence of illness was as follows: ill husband, sixteen cases; ill children, six cases; ill husbands and children, three cases; and one case other relatives.

Having other people ill in the family appeared to be of prime importance for three women. In two instances it necessitated institutional care while in the third the patient felt she could not remain separated from her husband because his health was not too good and he would need her. For the first two patients the illnesses of the husband were severely crippling or disturbing for the patient. One husband was an alcoholic and the other was crippled with Paget's disease. Both of these husbands could create enough constant pressure on their wives that they would welcome an opportunity to escape from them and have a change. In the case of the third wife, the husband suffered from bronchial asthma. The patient assumed a rather maternal role towards her husband. In addition to the influence that his illness had on her decision to return home there was the fact that he was telling his wife how homesick he was without her. Going to another institution would have "pricked her conscience".[1] In this small group other illnesses in the family created a primary problem because it was the motivating force behind the patient's decision as to the kind of care she chose. Amongst the patients who had this problem as secondary factors, other more complicating medical social problems were their first source of concern.

Having other members of the family ill during the convalescent period can affect a married woman in different ways. Pursuing the theory as mentioned in Chapter II that illness creates a dependent state that in turn is "used" or abandoned according to the maturity of the individual, it might be expected that the illnesses of other members of the family would be

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1. Supra p. 67

minimized by the patients in this study because the patients themselves were in some stage of regression. Some patients look upon sickness of others as a nuisance. Some, however, project the blame for their illness and the need for added expense for convalescent care on the illness of others. Some remain indifferent. In such instances, the prime concern of the patient is in her own self. This characteristic of extreme self-centredness was revealed in only five of the patients' records.

Some wives, whose anxiety is quite marked about their own bodies, also focus anxiety around the husband and children. This can be one way of rationalizing resentment about others which patients cannot express themselves, in an overt way. This was evident in the history of Mrs. St. Theophile[1].

Anxiety can also indicate the ego weakness of the patient. This is generated by her need to gain approval from others which might be done by giving the other person's illness more importance than her own. By minimizing herself to an extreme degree, the mother puts herself in the role of the martyr; a mechanism that, hopefully, can be used to gain further sympathy and attention. If this mechanism is not successful, the disappointment can cause further resentment and/or perhpaps other psychosomatic manifestations will appear.

Fourteen of the twenty-three women in this group had ill husbands. Illnesses of the husbands included two psychiatric problems, two general poor health problems, two multiple problems, two ulcer complications, one cripple, one tuberculosis victim, one alcoholic, one cardiac patient, one accident case, one cancer patient and one husband eventually died after a chronic illness, the exact diagnosis of which was not known.

Having more than one illness in a family can re-create sibling rivalry

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1. Supra P. 59

situations. Social background information was not consistently complete enough for this group of married women to evaluate this trait during the course of this study. It appeared in five case histories. The following case illustrates what happened in one of the patients' situation:

> Mrs. Zalrahy[1] was referred to Social Service for convalescent care because she had to undergo surgery for an intestinal obstruction (adhesive band from a previous operation).
>
> On the surface the social situation appeared to be quite normal except that the patient was British and Protestant while her spouse was Italian and Catholic. Mr. and Mrs. Z. had their own flat. Their three children, aged 16, 15, 13, were still in school. Mrs. Z. appeared to be a conscientious mother. Although Mr. Z. operated his own plastering business and employed two other men, he considered their financial situation precarious. He was not eligible for any financial assistance; consequently, he had to assume responsibility for his wife's hospitalization.
>
> In the case worker's first interview with Mr. Z. he began to complain about the cost of his wife's illness. He then began to enumerate his own medical problem. His complaints were many and were always followed by excuses for himself. His manner was overbearing and his attitude to his wife was quite dictatorial. Mr. Z. was not in favor of sending his wife to a convalescent hospital because he thought one hospital should be enough.
>
> The question of convalescence remained undecided for fifteen days. Mr. Z. remained unconvinced during the waiting period, but he finally agreed to let his wife have a few days. She went to the convalescent hospital for six days.

What impressed the case worker in this situation was the way Mr. Z. always tried to channel the worker's attention and sympathy around himself. The fact that he did get some attention during his wife's illness probably enabled him to "give" at least six days rest to his wife.

The last and perhaps most expected reaction of other illnesses in the family on the married woman was that of escape. The high proportion (twenty-one out of twenty-six) married women who went to institutions bore this out

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1. Case No. 97

on a numerical basis. The more ill the husband was, the easier it was for the patient to rationalize her need to get away. Some patients, such as Mrs. Longines[1], were encouraged to accept institutional care for various reasons. Some wives looked upon it as a necessity because of other precipitating factors that were of more importance at the time.

The desire to get away from other illnesses was expressed in words by two patients while one other patient whose reaction to illness is illustrated acted out her need to escape and to maintain her state of dependency in a protected invironment during her long illness:

> Mrs. Salvatori[2], was a 38 year old wife of British catholic extraction married to an Italian man 43 years of age. There were three children aged 10, 6, and 3. The family lived in a cold, dampt flat which patient believed was part of the cause of her illness and its many complications. Mr. S. was employed with a large steel manufacturing firm, earning a good average salary until his health failed in 1947 at about the same time as Mrs. S. developed chronic otitis media with mastoiditis.
>
> Mrs. S. was first referred to Social Service in August 1947. The V.O.N.[3] had requested convalescent care because of family pressures. Prior to this Mrs. S. had had two hospitalizations. Upon the nursing and medical recommendations, she convalesced for thirty-four days at the Montreal Convalescent Hospital and was readmitted to the Royal Victoria Hospital for the third time. Between January and March 1948 she was in the Royal Victoria Hospital for the fourth time and underwent a radical mastoidectomy, following which she had another long convalescent period. In December 1947 the industrial nurse at Mr. S's place of employment had called the hospital requesting convalescence for him. This could not be planned without a medical evaluation which, when completed, warranted psychiatric help rather than convalescence. Acceptance of this was very difficult for Mr. S.
>
> Family tensions had always been present between Mrs. S's family and Mr. S. With the breakdown of health of both Mr. and Mrs. S. her idealogy of what she though had been features of her husband and his strength was somewhat

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1. Supra P.49
2. Case No. 16
3. Victoria Order of Nurses - a community agency that supplies nursing services in the home.

> shattered. She had been the real strength of the home. Illness was a severe drain on both her health and emotional stability. This in turn affected Mr. S. Mrs. S. became disappointed. The length of her illness was a contributing factor toward Mr. S's slowness in becoming rehabilitated. He also showed evidence of jealousy of the attention his wife got. Through the sustained and understanding support of the caseworker and the physician, he eventually was able to accept psychiatric help.
>
> After Mrs. S. was cured and Mr. S. was re-established at work, the family became re-united.

The disillusionment felt by Mrs. S. about Mr. S's weakness is something that has not actually been measured. It caused many additional problems and humiliations for both Mr. and Mrs. S. which they will never forget. If Mr. S. had not been ill there would have still been problems. If Mr. S's recovery had been faster, financial strains would not have been so great nor would the ciriticism of Mrs. S's family perhaps have been so sharp. The effect of his illness will last for many years.

The stress and strain of the care that the husband's illness involved necessitated only one of the married women going to a convalescent hospital following his death. She had become quite exhausted from the steady care she had given him.

The worry and concern that the married women expressed on behalf of their husbands appeared only twice for sixteen men. Whereas the illnesses of the children were definite areas of worry that were verbalized in five of the six situations.

Having both the husband and children sick seemed to aggravate whatever use the patient was going to make of other people's illness. If the mother had a strong feeling of responsibility for the family, then their illness sharpened this. If family relationships were poor and several people were ill, the patient's concern over others was not increased. If the patient felt that her family rejected her illness she in turn tended to minimize

theirs. Having several people ill made some patients more concerned about how they could convalesce with so many other responsibilities. The use that patients made of other illness in the family, was an individual problem that depended more on their personality than on home ties.

In the group of seven patients whose physical handicap became a problem during the convalescent period, six women had suffered from fractures and one woman had an orthopaedic problem. Six of these mothers were dependent on themselves for their maintenance, while the seventh was an active housekeeper for her sons. Having to remain in bed made her feel that she was not maintaining her rightful role in the family. Similarly for the self-supporting mothers, their incapacity became a threat to them. The loss of their earning power because of a handicap increased their feelings of insecurity about their future. This was usually on a reality basis and a sustained relationship was helpful towards preparing the future for change of work or change in living conditions.

All seven of the women who fretted over their physical incapacity had children on whom they could, to some extent, become dependent. Except for one patient none of these mothers wished to take advantage of this possibility. Knowing that one's family can and will help can be a strength. However if a mother feels she is going to be incapacitated, the fear of rejection, with a new physical handicap, is increased. A woman whose family relationships are good and who realizes this advantage might be even more sensitive to becoming dependent and jeopardizing this good relationship.

All of these mothers were in the older age troup, three being between forty and forth-nine years of age and four being over fifty years of age. Growing old can be difficult to face. There is considerable feeling in our culture that growing old diminishes one's usefulness. Statistics indicate that the ratio of old people is increasing in our population. Helping old

people in large groups to adjust to this elongated span of life has not yet been too successful. Added to this threat, physical handicap thus becomes an additional problem to old age and requires further adjustments as well as rehabilitation.

Whatever anxiety the physical handicap generates for the married women, what it means for each individual is largely dependent on the personality. Those who feel unworthy feel more so - those who realize they are rejected feel more so and may make a strong transference to a social worker who is a better daughter as a substitute than any blood relative.

Nursing care is a necessary part of any convalescent hospital. Whatever the simple technique might be, if the family have never seen it done before, it can assume importance out of proportion to reality. In such instances the family require extra reassurance. Nursing problems for the patients in this study were secondary for five of the six patients and families and were a primary problem once.

The nursing problems that were most difficult were those of a permanent nature that were coupled with difficult psychiatric components of the patient's personality. Senility or incontinence can be physically exhausting for those caring for the patient but a chronic anxiety state is more emotionally wearing on the family. This can be felt in this illustration:

> Mrs. Randolph[1], a 36 year old woman was described by the psychiatrist as an immature, dependent individual who evaded responsibility. Her symptoms seemed related to the fact that at an early age many demands were made upon her by her family which were beyond her capacity to handle. Being the oldest in the family, she had to look after the younger children. In spite of her fears of responsibility she married - but to a man fifteen years her senior who had a grown family. She never cared much for him and early in her marriage she rejected him.

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1. Case No. 75

> Mrs. R. had her thirty-sixth operation in June 1947. She suffered from bowel obstruction and intestinal adhesions. It was felt that she was addicted to surgery and that her psychoneurosis was not amenable to treatment. Her dependency on the hospital was extreme. How her husband could care for her at home was a constant source of worry for him. It was felt that she would continue to have a need for operations. She had been at the Montreal Convalescent Hospital so often that they refused to take her again. Victorian Order of Nurses gave some care but for such a patient, as this, continuous care was necessary. Although a policeman, Mr. R's earnings were small and were insufficient to meet the constant drain the care of his wife would involve.

It might be questioned if such a patient as this is not a chronically ill person. Medical interpretation at the time however indicated that although exacerbations were probable, it was also possible she would improve.

The incidence of only four nutritional problems for a group of one hundred and three patients seemed low in view of the fact that malnutrition accompanies illness. Furthermore it is a well known fact that nutrition in Montreal is poor. Even in this small group there was no incidence of the problems encountered in the patient's inability to eat or "capriciousness of appetite", which would be expected in such a large group as this. A patient's eating pattern is an important reflection of the meaning of care to them. Eating habits reflect personality. It is felt that these problems did exist but were not recorded.

In this group of four were included two diabetic patients and two patients suffering from malnutrition. One diabetic was not accepting of her dietary regime and the other was suffering from lack of money to carry out her diet instruction. Financial problems were paramount for the two patients with chronic malnutrition. As already seen in the case of Mrs. St. T.[1] treatment was not very far reaching in modifying the financial strain, the nutritional deficiency or the emotional problems.

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1. Infra P. 59

This chapter has shown that the convalescent problems with a medical component was small in comparison to the emotional and environmental stresses and strains which will be discussed in the next two chapters. The most prevalent problem that seemed to have the strongest influence necessitating institutional convalescence was illness amongst other members of the family. These problems affect the patient according to their personality. Such traits as extreme egotism, rationalizing a reason for escape, martyr-like behaviour, indifference, materialism, were accentuated by the patients in this study. The illness of children was more anxiety-provoking than the illness of a spouse.

Physical incapacity, nursing care and nutritional problems were not very prevalent for the married women. It is felt that the nutritional problems were not properly tabulated so that the low incidence was no doubt out of proportion to the reality situation.

CHAPTER VI

CONVALESCENCE PROBLEMS WITH AN EMOTIONAL COMPONENT

This chapter will discuss some of the emotional problems that confronted this group of married women during their convalescence. It will be noted that the emotional factors necessitating convalescence accounted for 21.7 percent of the total participating factors discussed in Chapter IV. The actual emotional problems that were evaluated by the medical social caseworker comprised 43.4 percent of the total medical social problems which represents a higher incidence than that found in the participating factors necessitating a convalescent plan.

Since the social evaluations made for the one hundred and three married women in this group varied in quality the figures of Table XVIII which follows would differ from those done in a study where the caseworker interviewed the patients with the special purposes of a study in mind or in a department where fully recorded records were kept. Accompanying many of the emotional problems are numerous environmental problems which will be discussed in the next chapter. In the individual life situation of the patient the emotional and environmental problems are not so easily divided and it is recognized that they would be closely inter-related.

Recognition and management of personality disturbances plays as an important a part in treatment as medical and surgical techniques[1]. Measures for combatting resentment, dissatisfaction, anxiety and fears will help to minimize symptoms during convalescence. Personality disturbances can be related to many factors in the patient's life situation - at home, at work, at play. The extent and severity of an emotional response to illness will depend to a large extent on the early experiences of the individual. Additional factors are prenatal influences and parental relationships. The physical,

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1. K. Brodman, B. Mittelman & H.G.Wolff, Psychologic Aspects of Convalescence: XX J.A.M.A. 129:3. Sept. 15, 1945. p.179.

intellectual and psychological status of the patient at the onset of the illness can help or hinder recovery. The nature of the illness and the meaning of this illness to the patient can counteract modern medical techniques unless the patient is clearly understood as a person. The interpersonal relationships of the doctor, nurse and patient are also significant. The doctor and nurse may represent the authority and/or permissiveness that a patient seeks. The accumulation of the life experiences influences a patient's reaction to illness and convalescence.

From the information available for these one hundred and three married women the following table shows the incidence of the primary and secondary problems that were found in the emotional area:

TABLE XVIII

EMOTIONAL PROBLEMS ENCOUNTERED BY 103 MARRIED WOMEN DURING CONVALESCENCE

Medical-Social Classification		Incidence of Primary Problem	Incidence of Secondary Problem
TOTAL	172	51	121
1 Patient's attitude to illness	42	18	24
2 Patient's attitude to convalescence	37	20	17
3 Family Relationships	29	5	24
4 Personality Characteristics[a]	24	5	19
5 Family attitude to convalescence	14	1	13
6 Separation from family	11	2	9
7 Family attitude to illness	9	0	9
8 Behaviour problems of children	6	0	6

a. Not diagnosed as a psychiatric problem.

The patient's attitudes to illness were not indicated in the case histories for all the patients. When it was shown, it was of primary importance for eighteen patients and of secondary importance for twenty-four patients. Grouped together the attitudes around illness were the most

prevalent problem for the group. Table XIX has been compiled to show what the patients' attitudes to illness included.

TABLE XIX

BREAKDOWN OF PATIENTS' ATTITUDES TO ILLNESS
FOR 42 MARRIED WOMEN

Attitude to Illness		Incidence
TOTAL		42
1 Anxiety		20
	(a) Fear regarding pregnancy, sterility	4
	(b) Fear about future	4
	(c) Fear about prognosis	3
	(d) Fear of physical impairment	3
	(e) Anxiety about family situation	2
	(f) Not clear	2
	(g) Natural worrier	1
	(h) Fear of the threat of surgery	1
2 Resistant Attitudes		6
	(a) To psychiatric implications	3
	(b) Diabetic regime	2
	(c) Injections	1
3 Depressed Attitudes		5
4 Dependent Attitudes		3
5 Overwhelmed about Treatment and Care		1
6 Denial of Illness		1
7 Felt Physically Repulsed at outcome of Surgery		1
8 Felt her Operation was bad		1
9 Apprehensive about moving body		1
10 Injury Threatened her working capacity		1
11 Impatient		1
12 Fatalistic		1

Anxiety was the most common attitude found in regard to the married woman's attitude to her illness. The anxiety producing situations have a direct relationship to the medical situation in those cases where their fears were around pregnancy and sterility, their future in general, their prognosis, fears of physical impairment and where there was a possibility of surgery.

Amongst the four women whose anxiety wascentered around pregnancy, two feared their ability to have children. One patient feared the threat of

sterility following X-ray treatment. The fourth patient had undergone a gall bladder operation in the midst of her pregnancy, and quite naturally she became protective of herself and apprehensive about the forthcoming delivery.

The four patients who expressed their fear about their future had one common factor - namely their demanding attitude towards the doctor, the social worker, the family and/or the convalescent institution. These demands would appear to be an expression of their anxiety. Three of the patients quieted down after a decision about the living conditions was settled. For the one patient whose demands continued, the rejecting attitude of the family was not changed, either by the caseworker or by sending the patient to a convalescent hospital. Fearing this rejection, but determined to receive attention as a substitute for affection, the patient will no doubt continue to be demanding. Because of her personality the family will probably continue to be rejecting.

The three women who were anxious about their prognosis had reasons to be. One patient had had cancer, but she had not shared the full implications of what her operation would or would not do. The second patient had already been hospitalized once and had been given up as a somewhat hopeless case. Both the wife and husband felt rejected and discouraged about the future. When interest and hope was renewed by the doctors, they both remained skeptical of the eventual outcome of surgery until the end of convalescence. The third patient had been having a great deal of pain in her back. Because of a heart condition, surgical repair for a hernia was held in abeyance until it was decided which was paramount, her backache or her hernia. Accumulation of problems, in addition to the alternative possibilities for treatment which would extend treatment over a long period of time made the patient quite apprehensive both during her illness and her convalescence.

Those patients who feared physical impairment presented a combination of problems. All three suffered from orthopaedic complications. One patient's anxiety was brought on by a sudden decision for her discharge. She had been hospitalized for four days after fracturing her scapula and ribs. She could not easily grasp the idea of mobility without fearing something worse would happen. For the second patient who had been a lady horseback rider in a circus, her body had been of very great importance and no doubt it had been greatly admired and was an attention-getting device. Going stiff meant losing her mothod of holding people's admiration, including the attraction she held for her common-law husband. For the third patient, Mrs. Chalmers[1] , remaining stiff was what she verbalized as a fear. Since she had many problems to encounter after a prolonged hospitalization, mustering enough strength and determination to complete the uphill road to recovery created a certain degree of ambivalance - to remain stiff and remain dependent or to fight for strength and regain independence. The emotional connotations for these last two patients were more far reaching than briefly discussed here and warranted psychiatric attention. The second patient also suffered from drug addiction and little could be done to help her, while Mrs. Chalmers was able to have her anxiety about having a nervous breakdown allayed by the psychiatrist.

Two patients showed anxiety about their family situation. One patient who suffered from hypertensive cardiovascular disease, thought a convalescent hospital might help. Getting away gave her an opportunity to become more objective about family tensions and with insight gained from her physician and caseworker she decided herself that she would have to cope with things as best she could and not become too complaining. The second patient who had rheumatoid arthritis, was living in a house with an alcoholic landlady. Her husband was also alcoholic and he often threatened to take away the one child

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1. Supra p. 6.

of the marriage from the mother. With convalescence, sustaining casework relationship and careful use of community agencies, the patient was helped to make as constructive use of convalescence as possible. Some elements, however, could not be changed.

The patient who said she was a "natural worrier" would continue to be one. For the patient who feared surgery, a medical regime and careful follow-up saved her from this. Being able to express the fears was important for both current and future understanding, in case surgery should again be considered. Two patients showed anxiety in a general way.

Six patients indicated a resistent attitude to the implications of their illness or to treatment. That the other ninety-seven women had complete acceptance of illness and convalescence is not to be concluded. For these six patients it was an obvious problem that received careful attention by the social worker in four instances and from the physician in five instances. Three patients resisted the psychiatric implications of their illness very strongly. None continued a sustained course of psychotherapy. All were carried by a caseworker. How this resistance was felt and how the caseworker could help was seen in the case of Mrs. McDonough[1] who will be discussed more fully in the next chapter in connection with diversional activities. Two of the diabetic patients verbalized an inability or distaste about following a diabetic regime while one patient's resistance was in connection with injections

Discouragement is recognized as a natural feeling to accompany an illness. Five women became despondent in a way that had individual significance. Although they did not sink into a despression, their attitude to their illness was one of despair. Part of this despair could be attributed to the long term nature of the medical problem. Two patients had fractures, one patient

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1. Case No. 85. Infra 130.

suffered from chronic otitis media and the treatment and convalescence was long. One patient, suffering from cancer had expected to be cured after surgery. Since she did not understand her diagnosis, and recovery was very slow, her discouragement was all the more difficult to treat.

The fifth patient who took a rejective attitude towards her illness had a multiplicity of problems - varicose veins, pleuritis, obesity and epilepsy. Surgery had not been entirely successful; dieting had no appreciable effect on her weight. When one doctor said he doubted she would ever get thin, the patient gave up the battle. Having many complaints can make patients become sensitive about how they will be accepted at clinic. A negative attitude of others may crystallize their ego weakness, their insecurity as a person and contribute to their discouragement by making them feel unworthy of care. They withdraw from help and in future they may postpone seeking care on the basis of what their previous experience has been.

The three patients who were found with dependent attitudes quite openly expressed "that they needed someone to look after them." Their long dependency period during the convalescent period was highly indicative of their need to escape. Using illness as an escape is something that patients, themselves, cannot readily understand, as this is usually an unconscious mechanism.

The following illustration shows an interesting sequence of how one patient who apparently had many latent dependency needs achieved a higher level of satisfaction when her needs were met. She transferred her dependency from the hospital to her husband and then became happier after her convalescence:

> Mrs. Killarney[1], a 42-year old French-Canadian woman, suffered from a cerebral thrombosis for which rest and physiotherapy wereprescribed. She remained on the medical ward from July 14th to July 30th and was then

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1. Case No. 46.

transferred to an English-speaking convalescent hospital where she remained from July 30th to September 12th. Following this she underwent a gynaecological operation and then returned home.

Mrs. K. was the mother of five children, who ranged in age from 1 month to 9 years. Although her husband (an Irishman) earned an average salary as an accountant, his concern about his children and family bills prompted him into operating a tourist home. To increase business the family occupied the drab, damp basement. Mrs. K. with her strong drive to get things done, shared in this extra undertaking even though she found her role as mother and caretaker distasteful. During her illness she expressed her resentment about her domestic role. On one occasion she expressed considerable hostility about all this by embarrassing her husband openly on the ward about the hospital bill.

Because there was no housekeeping resource in the agency responsible for this patient, the children were sent to foster homes and Mrs. K. went to an institution. Once her health had failed she was quite satisfied to remain ill. She took no initiative in facing her many reality problems.

During the supportive relationship that was maintained with both Mr. and Mrs. K., Mrs. K's dependency shifted from the hospital to the worker and later to her husband. As she verbalized her dislike for domesticity and after she embarrassed her husband, she showed more affection towards him and sought his support and attention. Unfortunately Mrs. K. was not closely followed during her convalescence, nor after her return home but she showed a positive outcome of meeting dependency needs which contributed towards recovery.

For the other eight patients who had a variety of feelings about their illness, casework helped the patient who considered her body was physically repulsive, the patient who feared her work capacity was jeopardized, and the impatient and fatalistic patients. The two most serious problems were numbers six and seven[1] who denied the need for active treatment as well as convalescence. In the final analysis, it was found one patient remained financially dependent on an agency longer than was necessary. This was a case referred by an out-

side person and liaison between the doctor and the social worker was poor, which, it is felt, reflects the poor use made of the convalescent period.

The patient who said surgery made her feel physically repulsed had a deep-seated emotional problem involving her obesity. This prevented her accepting institutional convalescence which might have prevented a secondary infection that broke out because she went to a very unsanitary home that belonged to a friend, rather than a clean institution where she would have to face new people, who would no doubt show curiosity about her extreme obesity.

Since this study is patient focussed around convalescence, it is to be expected that this phase of treatment has had some meaning for all the patients in the group. Just as illness has meaning so does convalescence. Many of the behaviour patterns that are apparent during the early stages of illness (such as submissiveness, escapism, dependency and anxieties) carry over during the convalescent period.

In the total group of one hundred and three patients, twenty-six records gave some feeling that convalescence was a meaningful experience for the patient but the records were either considered too incomplete or the attitude seemed too scantily evaluated to be tabulated. Twenty-four records did not indicate what convalescence meant to the patient. Sixteen records showed that the patients were willing and co-operative about the convalescence plan. This left thirty-seven patients for whom the attitude towards convalescence was significant. It was a primary problem for twenty patients and a secondary problem for seventeen patients.

Of the thirty-seven patient attitudes, extreme anxiety was most prevalent, having been found for twenty patients. Anxieties were expressed largely around the fear of further medical complications arising in their body. The second prevalent attitude was that of non-acceptance of care on the part of the patient. This was found for six patients.

in 1921, the year after her marriage, the death of one child in early childhood, marital incompatibility that ended with separation in 1932 and financial insecurity, indicated that she has had a consistently barren social situation with no compensation for her many traumatic experiences.

Mrs. H. has had frequent admissions and regular clinic care at Royal Edward Laurentian Hospital and at Royal Victoria Hospital for quiescent tuberculosis, hypertension, psychoneurosis, as well as acute medical problems. At this time she had been admitted for removal of bilateral exostosis and for repair of hallux valgus.

Mrs. H. earned a small wage as a cleaning woman in one of the local large industrial offices. She lived alone in a rooming house while her one living son lived with an uncle because he was able to offer him more opportunities, while he attended McGill on a veterans' plan, than his mother could. The pain of this reality was indeed great for Mrs. H. and contributed to her rejection of considering her own drab living accommodation " a home." Nor could she call the place where her son was living "home". Wanting to feel the security of something, therefore, she said "the hospital was her home."

Mrs. H. had been referred to the social worker by the nurse on December 8th, 1947 because the patient said she needed to go to the convalescent hospital. Although the doctor was willing to keep her in hospital a few extra days, he was not going to recommend a transfer to a convalescent hospital. This was very upsetting to the patient. Interestingly enough she developed a secondary infection on the ward and was discharged to her dark, dingy room to continue treatment of simple boracic compressions. The doctor had said she could certainly do everything herself so no referral was made to the visiting nursing service.

Nine days following her discharge home the patient's foot infection had become severe enough to necessitate her readmission to hospital. Here she remained for nineteen days.

This illustration showed how the patient's concept of convalescence which to her was a real necessity, must be recognized and her emotional thirst at least recognized, otherwise a battle of patient versus doctor ensues. The doctor's authority can be counteracted by the patient devloping additional complaints. In the long run, ten days convalescnce would have satisfied Mrs. H. and nineteen days re-hospitalization might have been saved.

Apart from the emotional connotation that convalescent care has in terms of the medical situation there are other problems such as family relationships, personality characteristics, family attitudes, separation from family, behaviour problems of children, that also have an emotional basis.

Twenty-nine patients had problems because of family relationships. These were of primary importance for five married women and developed as secondary problems for twenty-four women. Extreme demands for convalescence in an institution or extreme ambivalence about the best plan, and definite refusals of care, can be traced to the kind of relationships found within the family group. Understanding these ties clarifies the meaning of convalescence to the patient. A break down of the areas of friction within the family group shows that fifteen patients had problems that involved only the husbands, nine involved only the children, four cases involved both husband and their children and one patient had trouble because of her husband and sister.

The main areas that created a problem directly between the wife and her husband were marital incompatibility, found in ten cases, extreme dependency, found in three cases, and one case of a non-commital husband and one case of a jealous husband.

The problems of marital incompatibility found in this study were revealed concurrently with other problems consequently they may or may not have received treatment or efforts at treatments. But because of their existence convalescence became of utmost significance to the patient. Lack of the sympathy, that patients require, and ordinarily receive from their spouse, can contribute to a patient's fears about being deprived of convalescence. It will increase her need for a more protected kind of care.

This deprivation can also contribute to an elongation of the dependency period during illness and convalescence. People often crave what they cannot have; in their ensuing struggle to have a substitute, satisfaction and fulfillment of a need takes a longer time to be realized.

Marital incompatibility also contributed towards increasing the patient's desire to escape. Bickering, physical abuse, extreme sadism and cruel denial are distasteful for anyone. The pain caused by these experiences may be so great that a patient will make strong efforts to avoid discussing them. Rather than become embroiled in old trouble, one patient refused to exert her legal rights to procure financial help which might have enabled her to have the long term convalescence that had been recommended for her.

For patients who do not internalize their problem and blame themselves for failure, a marital problem can become an excellent medium for projection. "Everything is wrong because of my husband" -"because everything is his fault, I'll punish him by staying ill". Thus convalescence lingers on. There was one extreme case of such a situation amongst this group of ten women who had problems of marital incompatibility.

Trying to treat a marital problem by advising a rest for a woman has little effect without collateral attempts to crystallize the source of dissension. Sometimes a situation cannot be changed - such as the chronic illness of the husband, in which case trying to modify the wife's attitude towards the husband results in more peace of mind on her part.

Using an illness as a method of getting sympathy with hopes for subsequent improvement of the marital relations is another rationalization a married woman might use to obtain convalescence. There was no evidence of this amongst the patients in this study. This can be attributed to the fact

Four patients expressed impatience over the limitations that convalescence incurred in their life. This attitude became a problem for such women as athletes, active housewives and those dependent on themselves for their own livelihood.

Four patients developed a distorted idea as to what convalescence could and would do for them. They all went to institutions. This served as a base for false security for two women and contributed towards escaping realities for two mothers. In this last group indefinite living conditions were at the basis of why the patient had an exaggerated idea of what convalescence would do.

Three patients were in conflict about how and where and why they should convalesce. An extreme case of ambivalence can be seen in the case illustration on Mrs. St. Theophile[1]. Her resentment towards her husband and her guilt over rejection of the children and her ambivalence about the strong feeling she had for them on occasion, interrupted the peace of mind that a better adjusted person might enjoy during a convalescent period.

Not only does the concept of convalescence have meaning for the patient, but the kind of care in a particular setting takes on special significance for certain women whose personal security is dependent on the protection they can feel from a hospital. When institutional convalescence is denied then it is usually the hospital that feels the repercussions. Institutional convalescence was denied by two physicians in three cases. The following sequence shows the end result of denial of a bed in a convalescent hospital for one patient:

> Mrs. Hatch[2] was a 49-year old Hebrew woman who married in 1920 soon after emigrating from Russia to Canada. Although all the details of her life situation were not known the sequence of psychosomatic complaints beginning

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1. Supra P. 59.
2. Case No. 92.

that the marital problems that were revealed, seemed to be deep and long standing. A different referring system and a fuller recording system in the hospital might have pointed up further problems in this area.

The need for convalescence can create a problem of family relationships by the extreme dependency that the desire for care engenders on the part of the patient. The weight of this was felt by three husbands. Although the three husbands found in this study appeared to be quite acquiescent they felt the burden very keenly and sought outside help and support in meeting this burden. For one patient who suffered from marital incompatibility, but who became dependent, there is evidence that the husband shirked his responsibility and evaded the whole situation.

Amongst the nine women whose adjustment to convalescence was hindered by abnormal relationships with their children were three mothers who were alone with one daughter. None of them would separate from their daughters during the convalescent stage. Because of this, one mother did not get the convalescence she required. Lack of co-ordination and proper reports at timely intervals between the social agencies, and the lack of community resources also contributed to the problem. How one mother-daughter relationship was handled will be illustrated when the case of Mrs. McDonough is discussed in Chapter VII in connection with diversional activities.[1]

Two mother-child relationship problems were augmented by illness because of cultural factors. This interfered with convalescence in such ways as displacing the mother from the dominant position in the family which she had enjoyed during good health. Separation necessitated by illness increased the anxiety of the mother. For some European mothers who have not allowed their adolescent children the freedom given to children in Canada being away from home makes them more uneasy.

Two mothers felt that convalescence forced them to ask more of their

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1. Infra. p. 130.

children than they wished to accept. Our society takes for granted that just as parents take responsibility for children and grandchildren, so there is a reciprocal duty on the part of children and grandchildren to care for parents. It is assumed that children should love and respect their parents. Unless the parents have given security (both emotional and financial) this assumption does not follow. Moreover with living quarters more crowded than they used to be, children are not always in a position to assume this responsibility. If early relationships have been strained, close living quarters add to parent-child resentment. Parents feel unwanted. Their desire for independence may be an expression of their wish to remain young, thus dependency on children even during convalescence, threatens their "status quo." Parent-child relationships became a problem for two mothers because of personality conflict.

For the four mothers whose problems of family relationships involved both the husband and children, the whole social situation was involved as seen in the case of Mrs. St. Theophile[1]. All of these women went to an institution for care. This gave them some relief but total treatment had to involve a sustained and creative use of casework and use of community agencies. Thse problems were more complicated than those of marital incompatibility.

In the one situation when family relationships involved the husband and sister the request made to the social worker was to arrange for a convalescent bed only. Although the social evaluation was not very comprehensive, offering something to the patient created a marked indication of jealousy on the part of the sister. She became very dominating; since the doctor requested the worker to discuss only convalescence, the meaning of the sister's behaviour could not be clarified. Some sisters might criticize the doctor to such an

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1. Supra P. 59.

extent that the patient would not feel right in accepting care. On the other hand, to offset such domination a patient might extend care longer than necessary.

Personality characteristics is a term that is used in a rather general way in this study. It indicates the bizarre characteristic of the patients, extreme reactions and personal traits that have not otherwise been diagnosed. This medical-social classification was not minutely broken down for this study primarily because it would necessitate too many deviations and secondly the records were too incomplete to allow for a very effective analysis. Some records indicated a personality problem without much clarification.

The characteristic that recurred the most frequently amongst this group was that of childishness and dependency, exhibited by crying and extreme helplessness. This was found amongst nine women. An example of the significance of such traits in the total illness pattern and the effect of convalescent planning can be seen in the case of Mrs. Pierre which was described in Chapter IV.[1]

Petty characteristics that decreased the patient's acceptability to the family, the other patients and the convalescent hospital included chronic fretting, talking to one's self, pestering other people about little things, excitability, quick tempers, talkativeness. Also in this group of women were those who were abnormal in their constant efforts to maintain a facade; those women who constantly sought approval or advice and those who were over-active or phlegmatic.

In an effort to understand the meaning of convalescence to the family which appeared as a primary problem for one woman and as a secondary problem for thirteen women learning what the attitudes were was hampered by the fact that fifty-five of the one hundred and three records did not reveal the family feeling. It was presumed that this figure was as large as it was be-

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1. Supra P. 71.

cause the family were either not consulted or else their collateral participation in the convalescent plan was weak. This figure would also include married women whose family would not be accessible. Also included were those husbands whose rejections of their wife was so deep that she was deserted during illness or was at least left to fend for herself in making a convalescent plan.

In analyzing the information that was available it was significant to have the attitudes revealed to the extent that they were. Twelve husbands and children indicated their willingness for care on behalf of the wife and mother. Eight families appeared to be relieved at having the problem of convalescence settled in an institution. Six families became over-anxious about the patient and five families showed apprehension at the thought of taking responsibility for the patient's care, alone. Three husbands became very dependent on the hospital. In this group were wives suffering from cardiac and cancer diseases both anxiety - provoking illnesses.

Rejection of the patient on the part of the family was found for eight married women. This rejection can be felt in the way the family indicates they are glad to get rid of the patient and in the way they complain about extra expense. By becoming critical of the hospital the family can also indirectly show that the bother is more than they wish to invest on behalf of the mother or wife. Since the hospitals are the community agencies responsible for illness, they project the responsibility for convalescence back to the hospitals.

Separation from family has been included under the emotional components of convalescence in view of the fact that this problem arose because of the emotional connotation it had for the married woman. It was possible to count the problem from a statistical point of view because of the keen sense of loss

and loneliness the patients expressed when away or without the support of relatives. In situations where the patient was relieved to be away from the family and was seeking an escape from family responsibilities, the problem has not been included here.

Eleven patients indicated that they felt lost and threatened when separated from family during the time of illness and convalescence. The threat of separation was sometimes as hard for the patient to bear as pain. When hospitalization has been necessary for an acute illness the patient must accept institutionalization. The recommandation of convalescence however can be refused, if convalescence has been interpreted as a bed in an institution, (as was done for three patients). When the basis for this strong rejection of institutional care was related to the strong dependency needs of the patient, the resistance to such treatment became marked. Even if the patient may go to a convalescent hospital for a special reason such as relieving the financial burden in the home, parting from the family is not pleasant if ties are close and home life is meaningful.

Apart from institutionalization, separation can be caused by geographical remoteness, lack of housing, desertion of husband, children going to live with relatives, children growing up and getting married and children committed to reform school. Such situations as these could perhaps be termed as a problem regardless of illness. Being ill however increases a person's need for warmth, and support. Being handicapped leaves them more helpless thus they have a feeling of need for their family to be right near them. Even when a wife may be near her husband geographically their inter-dependence may be so strong that separation caused by lack of housing becomes significant. The uncertainty of when a house can be found is very anxiety-provoking during the period of convalescence. Mixed with the joy of coming together are the doubts and fears about reuniting if the illness has been long.

p 94 - "limitation convalescence imposed, not wanted."

What does "indefinite living conditions" mean - show how it contributes. This is not clear.

[illegible] on p 95, is well summarized & pointed up.

p. 96 - first sentence - what does it mean?

96 - 'What is a non-committal husband?

p 97 - marital incompatibility increased patient need to escape - escape what = example suggests more practical problem involved in getting care - does he mean this?

For patients who do not blame self - why introduce this idea - why not say - marital incompatibility frequently reason for separation.

p 100 - Is it justifiable to use term personality characteristics to indicate negative traits only?

101 - 'Only collateral participation' - isn't collateral redundant.

- Also included are those husbands - and it also included where the cases were rejection by the husband etc

Last sentence para 2 should read. It is more comfortable to proceed with the hospital, who are asking further consideration for the wife, feelings of rejection [illegible]

p 103 - spouse of patient is singular - then goes on to speak of they.

Separation can perhaps contribute to the patient's conception of what caused her illness. Constant worry about relatives far away can be debilitating. The fact that the relatives living nearer do not substitute for the main member of the family who can give the patient security and understanding can be significant if the patient is clearly understood as a person. If not, the gnawing will continue, in spite of rest and diet.

When separation from family is a necessity superimposed by circumstances outside of the patient's control, the patient's whole attitude to her illness is affected. This deprivation increases their demands and their dependency on the hospital. In extreme situations a patient can have a recurrence of symptoms. If they feel shame and guilt about some unwholesome aspect of the separation then they will tend to withdraw and perhaps in considering themselves unworthy, will deny themselves care and consideration.

For the eleven patients in this study for whom separation from the family was significant, five had had no real home and convalescence had to be considered in terms other than home care. Of the six women who had homes, all returned there for all or part of convalescent care. Only one had the services of a housekeeper. Three needed this service while two had other problems which would have interfered with such a plan.

Illness of the mother of the home quite naturally had its repercussions on the attitudes other members of the family group had towards illness. It appeared as a secondary problem for nine families. This small number does not allow for a very thorough analysis, nor does it show very much over-all understanding. In those cases where family relationships created a problem, it was found that the husbands involved in marital conflict were rarely seen in conjunction with convalescent planning. Frequently husbands who wish an excuse to escape, evade any of their responsibility around the illness of other members of their family. In such instances apparently no notation was

made of what the illness meant to the family.

When illness has been a chronic or recurrent problem the added responsibility of a patient's care adds to the family's frustration and feeling of hopelessness. For the two husbands where this was noted there unfortunately was very little indication that the caseworker at Royal Victoria Hospital offered much relief to their frustration. Both husbands had been known at other hospital social service departments. Whether this was due to pressure of work or lack of understanding was not clearly indicated.

Anxiety and worry were no doubt more prevalent amongst the family than revealed in these records. When other members of the family were involved in treatment and were considered to be part of the medical etiology such as psychiatric problems, the illness of the mother or wife created guilt in addition to anxiety. In such cases the family began to strongly deny that there was a psychiatric problem, or else they became extremtly over-protective.

The family attitude towards illness was most interesting in three situations where the husband was also ill. Husbands, when ill, become dependent like any other ill person. In an effort to have their own needs met, they may therefore become more demanding of the services of the caseworker than the patient. Because of the rivalry situation two illnesses created, they expressed their resentment by criticizing the hospital and the expense involved for care. Not to be overshadowed by their wife, they began to minimize her complaints and condition and focussed on their own.

For husbands who are already tense and anxious, the illness of the wife may aggravate their own complaints. Men who suffer from duodenal ulcers may become more tense. It was interesting to note that the two men who suffered from ulcers leaned very heavily on the caseworker during the time that discharge plans were being made for their wife. This sharing can help to diminish the full impact that numerous illnesses create in a family.

In the case of Mrs. Salvatori[1] Mr. S's physical and emotional breakdown seemed aggravated by Mrs. S's long-term illness. Feeling between the families, having never been good, became more negative. As Mrs. Salvatori began to feel that she had lost her capacity to cope with the family and maintain her strong supporting role, Mr. S. felt more alone, more guilty about the troubles he was causing his family and more inadequate. This did not contribute to his recovery. One source of courage was the fact that the caseworker verbalized for Mr. S. the fact that he was still loved by his wife. Such reassurance was necessary in order to give the husband the feeling of hope so his road to recovery was not threatened by the fear of rejection. Wives may be quite disappointed in discovering certain weaknesses in their spouse and may harbour this feeling for many years, as has already been raised in connection with this case. This increases the necessity for some kind of outside reassurance to the husband from someone with whom the relationship is deep and meaningful.

The last problem that was involved under the emotional component of convalescence was in connection with the behaviour problems of children. Six mothers had some kind of such difficulties to cope with during the convelescent period. The presence of behaviour problems amongst the children either increased the mother's anxiety during the convalescent period or increased her desire to remain ill so she had an excuse to escape. When the anxiety was strong, the drive to return home and keep battling with the problem for which they felt responsible and guilty was very strong.

Amongst these six mothers the behaviour problems of the children could be divided into the problems of eneuresis found amongst children in the younger age group and the problems of adolescence in the older age group.

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1. Supra P. 79;

This latter involved conflicts between parent and child in terms of discipline, authority and feelings of rejection because the mother was ill and out of the home.

The behaviour problems affected the mothers in three different ways. In two cases the mother felt very protective and responsible and could not accept convalescent care in an institution. One mother went at the insistence of her son but another mother, sensing the inadequate discipline of her husband and the repercussions this would have in the neighborhood absolutely refused to go to an institution. This patient later complained that she had not felt well since her operation. A housekeeping aide would have given her the chance to return to her family and would have relieved her of responsibilities for which she was not strong enough following her illness.

The second kind of reaction was seen in two cases where the extra burden that the children's problems would mean on discharge home, added to the escape factor that the mothers indicated in seeking institutional convalescence. In neither of these cases was the problem gone into by the caseworker. What children meant to them was not revealed.

For the last two married women in this group, the children's problems had an effect on the patient in that the mother fretted considerably. It neither added to nor detracted from the actual convalescence itself because one boy was out of the home having been committed by court to the Boy's Farm and Training School. In the other situation the mother had to continue institutional convalescence because her husband was becoming increasingly psychotic and her return at home had been proven impossible because of his physical abuse.

There was no indication to show why none of the eneuretic problems were touched upon by the social worker. In only two cases where the problems were adolescent rebellion did the caseworker take any initiative in trying to

alleviate the strain from the mother and try to encourage further understanding on her part. Sharing the problem while one mother was confined to bed was a great help and furthered the benefit the mother derived from her convalescence. A real opportunity was missed in another instance when a very dependent mother separated from her husband verbalized the burden her son would be for her.

This chapter has discussed the emotional problems of the patient group. Their prevalence increased between the time of referral at which point the precipitating reason for convalescence was divulged by the patient, and the end of the social evaluations. The comparative figures in this study were 25 percent for the emotional reason necessitating convalescence and 43.4 percent of the total social problems, with an emotional component. This comparison cannot be considered conclusive for the patients used in this study because of the fact that the records were not consistent in quality nor were the social intake interviews of the same quality and depth. Therefore the evaluation must be considered to be partial only. That there was such a wide discrepancy may possibly reflect a weakness in the way this aspect of care has been approached.

The main problem within the emotional area was found to be in relation to the attitudes of the patient and family to the illness and convalescence. The most prevalent attitude found about illness and convalescence was that involving anxiety in some particular or general way. Non-acceptance based on a particular aspect of the patient's personality appeared as the second most prevalent problem in the emotional area both as regards the illness situation and the convalescent plan. Although despair was third in incidence for the attitude to illness it did not have this significance as regards an attitude towards convalescence. The reason for this might be that their discouragement was directly based either on the long term nature

of the illness or the personality of the patient. Convalescence, therefore, was absorbed in a more general way as a part of what was involved in the total situation and did not become a separate entity around which the patient focussed feeling.

The other problems of illness and convalescence did not occur sufficiently often to draw any conclusions. The other problems with an emotional component included family relationships, personality characteristics, separation from family and the behaviour problems of children. Whatever form or forms an emotional problem assumed, it always seemed related to the basic personality of the patient.

The personality of the patient was also reflected in the meaning that environmental conditions assumed for the patients. In the next chapter an effort will be made to classify and then discuss the various environmental problems for this patient group.

CHAPTER VII

CONVALESCENCE PROBLEMS ARISING FROM ENVIRONMENTAL CIRCUMSTANCES

In his concluding remarks at the 1939 Conference on Convalescent Care sponsored by the New York Academy of Medicine, Dr. Woodruff recognized certain medical and social inadequacies both in philosophy and actual practice in the treatment of the convalescent patient. He felt that the pessimistic attitude to the environmental problems confronting a large majority of the patients left patients and members of the treatment team alike with feelings of defeatism.[1] He believed that there were opportunities for doing away with neglect and by assuming a positive attitude such as recognition that "the first of these is the opportunity for the discovery and adjustment of environmental factors and family situations which may have contributed to the occurrence of patient's illness and which may be factors militating against the preservation of health once recovery is attained and the patient is back in his usual milieu. This is particularly useful in patients showing psychosomatic disorders and emphasis is laid on the necessity of getting the co-operation of the relatives in helping the patient back to health".[2]

This chapter will discuss the environmental problems that were revealed in the records of the 103 married women used for this study. To enable a quick survey of what these problems included, Table XX has been compiled.

Comparing Table XX with Tables XVII[3] and XVIII[4] that showed the incidence of convalescent problems in the medical and emotional spheres, it can be seen that numerically the emotional and environmental problems for the convalescent married woman were almost equal whereas in precipitating factors necessitating

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1. Woodruff. "Present Day Concepts of Convalescent Care". Proceedings - Conference on Convalescent Care, New York Academy of Medicine, 1940, p.226
2. Ibid, page 230, Supra p. 19.
3. Supra, p. 75.
4. Supra, p. 86.

TABLE XX

BREAKDOWN OF ENVIRONMENTAL PROBLEMS
OF 103 MARRIED WOMEN WITH CONVALESCENT NEEDS

Medical Social Classification	Total	Incidence of Primary Problem	Incidence of Secondary Problem
TOTAL	171	36	135
1. Problems of family responsibility	38	14	24
2. Living Conditions	29	9	20
3. Financial Problems at home	25	0	25
4. Costs of medical care	25	9	16
5. Occupational readjustments	17	1	16
6. Legal complications	15	0	15
7. Diversional activities	6	0	6
8. Isolation from family	6	3	3
9. Cultural factors	4	0	4
10. Lack of community resources	3	0	3
11. Other[a]	3	0	3

a) Problems around senility, low intelligence and cost of special brace.

convalescent care, the environmental strains accounted for 53.3 per cent of the problems. The reason for this would be that more problems within the emotional area were raised after closer study.

In discussing these various problems most of the case illustrations will show when the case worker was playing an active role in the treatment of the patient. This study, however, was not focussed on an evaluation of how and if the case worker met all the needs of the patient, nor on the quality of case work. The case examples were chosen partly for the illustrative value they had.

The most prevalent environmental problem for the married women, was that of family responsibilities. In this group were (1) those women who were alone during the day time while the rest of the family worked;(2) those with too much work to cope with in proportion to their stage of recovery; (3) those who had other members in the family who required special care that would be particularly exhausting for the wife or mother, and (4) those who were considered to be too much of a care by the family.

Responsibility can develop into a problem when its impact is felt not only by the patient but by the husband, children and other relatives. The weight of the responsibility can be carried willingly or unwillingly. When it is ignored by one member of the family, the burden falls that much more heavily on another member. If this is carried to extreme, resentment can mount on the part of the willing member which in turn makes the patient more uncomfortable. The onus of responsibility was felt by the patient in eighteen cases, by the children in twelve cases, by husbands in four instances, and four times by other members of the family.

The impact of responsibility was felt by the married women in two main ways, either it increased the subjective concern she had for herself and her own body or it intensified her objective concern for those around her and raised anxiety on her part as to how they would react to her illness.

In the first group were nine women who had responsibilities for children. Seven women were under forty years of age. Six of these women were very anxious for institutional care which would give them added protection away from the family. Two patients in this group could not get the institutional care they requested because the idea, which was self-initiated, was refused by the doctor. The effect of the refusal on the patient can be very traumatic, especially if the patient does not have a sympathetic husband who will make an effort to lighten household duties. The feeling of being solitary and alone

cannot be easily offset. In certain situations the services of a housekeeping aide could fill in the gap felt by the patient. If a case worker has already established a good relationship, she can share the impact of the refusal which to the patient has been interpreted as a rejection.

Even when the married woman seems very egotistic in the way she shows her anxiety and how she feels towards the burden of responsibility, recognition on the part of the doctor, nurse and social worker of the reality factors in her individual situation is important. An understanding attitude can diminish some of the frustration of pressure. In two instances where institutional care was provided for mothers with heavy responsibilities, the progress gained during convalescence was noticeable but would not have been long-lasting if the supporting props that the case work relationship gave, had been removed. Institutional care alone, for women suffering from anxiety states, without collateral psychiatric and/or case work services bring about little demonstrable change, especially in relation to the social situation.

In the second group where the responsibility for family was felt in a more objective way were eight married women, four of whom were over forty years of age and four who were under forty years of age. The strongest direction of this pull of responsibility was towards the children but five also included their husbands within the area of anxiety. This group of women did not exhibit the same desire for the protective walls of a convalescent institution. Only two of the patients used institutional care. It was in this group that the need for housekeeping aides was most acute because the family responsibility was a very real problem. Treatment should involve a solution to meet the immediate reality because the combination of the reality and the defense mechanisms of the patients personality would be slow to change. Only one woman had a housekeeping aide to help her during her convalescent period.

It was in this group, also, where the mother seemed to manifest in an indirect way her feelings of guilt over being away from the family. If she had wished to be ill so she could escape some of the daily drudgery or if she were dissatisfied and secretly disappointed in her home and married life, she would have reasons for being glad she was ill. This, in turn, would make her feel guilty. Such wishes would not be consciously recognized for her. Her objective concern over others was therefore one way to rationalize her illness.

The impact of responsibility was felt a third way by one patient in this group pf eighteen married women. This concerned a patient who worried about being a burden of responsibility for her children. This kind of a problem arises when the patient has strong feelings about dependency and independence. Such a fear becomes more marked in cases of long-term and chronic illnesses or when the mother knows that sibling rivalry amongst her children has not been too well resolved and she senses the burden may fall more heavily on the willing members of the family.

In the twelve situations where the onus of responsibility was felt by the children, the age of the patients was found to be in the older age group. The convalescent period was longer and the nature of the medical problems was more chronic. The predominating reaction of the children was how they were going to be able to cope with the care their mother required. Rejection and resistance was seen in the children in three families. In two situations the families appeared willing and co-operative but there was either no home or else financial matters were acute and the patient felt uncomfortable taking food she had not paid for.

Recognition of the feelings of the children is an important factor in the total convalescent phase. In this group of twelve patients, seven patients used institutional or nursing home care which for aged patients with long-term illnesses is one way of relieving the family. The other five went home.

Housekeeping service enabled two patients to go home but there were five patients who could have benefitted from a housekeeper if it had been available.

Of the four husbands who felt the impact of the responsibility very keenly, all showed willingness to do something for the wife but mixed with this was anxiety. In view of the regular responsibilities of the husband it is important for him to share in planning yet feel that he has not the entire weight of the problem. This group was in different age groups and had a variety of medical problems. In the illustration of Mrs. Killarney,[1] already discussed in Chapter VI, the satisfaction that Mrs. K. got from the outward despair her husband showed under the stress and strain, was quite noticeable. After she expressed some hostility over the fact that he had not shown this same concern during periods when she was healthy, she felt some satisfaction. She had harboured considerable resentment about all her domestic duties with the result that she became quite dependent on the hospital during her illness. When some of the family problems were cleared up, she transferred her dependency on to her husband. With some of the basic resentment cleared away, they both began to enjoy a more positive feeling for each other.

For this group of four patients, housekeeping aides were necessary but unavailable for two patients with long-term illness. It would have been very helpful for a third patient.

In the last group consisting of five women where the responsibility fell on others, the effects on the patient were acute for two of the women. Patients were very sensitive to not being wanted and when non-acceptance was acute, the length of convalescence became very important. This can be sensed in the illustration that follows:[2]

Mrs. Chalmers, a forty-one year old mother of two adolescent

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1. Supra P. 91.
2. Case No. 55, Supra P. 6, P. 89.

children, had been deserted by her husband for approximately twelve years. She lived with two maiden aunts who had taken more responsibility for her upbringing than her own parents had. They had disapproved of her marriage and never ceased to express their feelings on this or any other subject. Mrs. C. had continued to live with them after her marriage. When she was forced to work (as a baby nurse) to support her children, her two aunts also assumed a maternal and disciplinary responsibility for the two children.

Mrs. C's past medical history revealed that she had been ill on numerous occasions, most recently as a patient with tuberculosis. She had become quite dependent on institutions for protection. Her last medical problem was being treated by the orthopaedic surgeon because of an undiagnosed pain in her hip.

In this situation there was an insecure, immature mother with responsibilities beyond what she really could handle. During her long illness, her children became older and more aggressive in their demands. Mrs. C. had grown away from them and had left their care to her two aunts. To compensate for the guilt she felt in projecting more responsibilities on to the aunts, she could not feel free to ask anything more of the aunts. Until the patient could work, therefore, she became quite fearful of going home. Because of all her responsibilities, going home engendered fears. The indecision of an undiagnosed hip did not help the two aunts to be warmly sympathetic with Mrs. C. She knew her illness added to their burden; the impact of recovery was very threatening for such a person as Mrs. C. It was not surprising when she expressed the fear of a nervous breakdown.

The impact of responsibility felt by the aunts if patient went home as well as that felt by Mrs. C. when she was recovered was a very definite weight that slowed down her recovery. Sustained casework, with a permissive relationship that offset the aunts' rigid attitudes contributed towards Mrs. C.'s feelings of adequacy. A referral to psychiatry gave her reassurance that she was not going to have a nervous breakdown and that her feelings and complaints were not silly.

The second most prevalent problem of an environmental nature found for this group of one hundred and three married women requiring convalescent care was that of the living conditions. The method for tabulating this problem was not through first hand investigation. Reports from visiting nurses, family agencies and various members of the community were incorporated in the social record. Most problems revealed in this study, however, had been revealed by the patient.

Before enumerating some of the problems, the following table has been compiled to show the kind of home conditions under which the one hundred and three married women lived.

The kind of problems that the twenty-nine married women encountered in relation to living conditions included problems of physical aspects of the home found in thirteen instances, and rooming arrangements found in seven cases, living at work in five cases, no established home, three cases, and lack of accommodations with son, once.

The effects of the living conditions can be divided into three categories. First was the group of four women who attributed the cause of their illness to the cold, dampness and overcrowding of the home. They willingly accepted institutional convalescence.

The second group included four women whose home would be considered inadequate for convalescence by all outside standards because of such reports as only one bed, cold, no sanitation, twelve people in three rooms, etc. This group, however, became very defensive about the negative aspects of their home and could not decide objectively on what kind of convalescence they wished. Only one of these mothers went to an institution. This decision was really made by her son who insisted that she go.

In these two groups the living conditions had emotional significance for the patients either in terms of the illness or the convalescent planning. In

TABLE XXI

DISTRIBUTION OF THE TYPES OF LIVING CONDITIONS
OF 103 MARRIED WOMEN PRIOR TO THE ONSET OF THEIR ILLNESS

	Kind of Living Conditions	Number	Percentage
TOTAL		103	100
1	In own homes with husband and children (Flat, 35; Rooms, 1)	36	35.1
2	In own home with husband only (Rooms, 4; house or flat, 15)	19	18.4
3	In own home with children only (Rooming, 1)	16	15.6
4	Rooming house, hotel or boarding	9	18.8
5	Living with immediate family plus other relatives[a]	8	7.8
6	Living at place of employment	6	5.8
7	Living with relatives	3	2.9
8	No information or not clear	3[b]	2.9
9	In own home with husband and parents	1	0.9
10	With friends	1	0.9
11	No established home	1	0.9

a. Aunt, grandparents, in-laws, three generations.
b. In midst of legal complications, not sure, no information.

the last five women which comprised the third group of the thirteen with problems because of physical aspects of the home, the reality of the housing conditions was accepted. Convalescence was planned in a straightforward way.

Apart from the quality of the home, living conditions became a problem because of the lack of a real home. Rooms, boarding houses, or employers rarely provide adequate facilities for convalescence. The acute problem in this respect apart from getting a room, was the anxiety of the patient in

meeting a situation in an unknown or temporary surrounding. Trying to find a new room at the same time as having a desire to remain in a protected environment can create dissatisfactions. The pressures that mount can aggravate a patient to the point that further symptoms develop. This was illustrated in the case of Mrs. Poirier:-

> Mrs. P.[1] was a 47 year old woman, quite childlike and dependent, who after being left widowed with two children, remarried a man reported to be 83 years of age. Because of sex perversions he was sent to jail and patient procured separation papers and began to work in a different city. Her daughter was a nun and her son was married and living with in-laws. She had been admitted to the hospital with urethral stenosis but it was also found that she had latent syphilis. She had been working as a maid and living in the hospital. Since she could not return to duty immediately, (she was dismissed from the hospital because of an unsatisfactory work record) she had to go to the Montreal Convalescent Hospital. Even before she left Royal Victoria Hospital she began to fret about what was going to happen to her. Urinary complaints continued until her frequency became so severe she had to be readmitted. The doctor could find no physical basis for her frequency.

The social record shows little feeling of support or constructive suggestions to the patient on the part of the two caseworkers involved. Helping a patient face a nebulous future requires considerable sustaining force on the part of the social worker.

In addition to provoking anxiety about a nebulous future, lack of a stationary home also generated a general feeling of blocking on the part of the patient and possibly her children when there appeared to be no alternative for care other than going into a child's home. Fear and dislike of dependency on children already has been discussed.

Apart from the very real problem that a lack of an established home created, the reason for lack of some living accommodation and the emotional connotation behind it must be considered. Such a situation regenerated old personal problems for patients whose marital status was irregular and for

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1. Case No. 66

patients who had been living under false pretences. Having to make a convalescent plan to get around the problem of living conditions aroused guilt and shame, that otherwise could be easily repressed when there was no reality issue to face.

Financial problems in the home did not occur as a prime problem in relation to convalescence for any of the one hundred and three married women in this study but it became a secondary problem for twenty-five women. The following table shows the shift of the source or sources of support for the married women:

TABLE XXII

SOURCE OF SUPPORT FOR 103 MARRIED WOMEN WITH CONVALESCENCE PROBLEMS

Source of Support	Before Illness	During Illness	After Illness
TOTAL	103	103	103
1 Family (a)	63	72	62
2 Combination (b)	18	14	22
3 Self	15	3	10
4 Public and/or Private Assistance only	7	14	9

(a) This included support from husband, children, husband and children.
(b) This term included various combinations of old age pension, D.V.A. allowances or other special allowances in addition to the patient's own wages or financial assistance from family, common-law husbands or former employer.

From this table it can be seen that prior to illness ninety-six of the women were independent by their own or their families' efforts while only seven were wholly dependent financially on public or private assistance. This number doubled to fourteen during illness and lowered again to nine after the illness.

The number of women who again became self-supporting following their illness dropped from fifteen to ten; agencies accepted two patients while families

or special allowances took care of the other three.

Although only seven patients were entirely dependent on either public or private assistance, another eight were receiving financial assistance from private agencies in addition to help from families or income earned amongst the family.

The reasons that the women in this study had financial problems included such problems as patient's inability to work because of illness (seven cases), illness and instability of husband (six cases), separation from husband (four cases), minimal earnings in large families that have to be supplemented (two cases). These reasons coincide with the pattern of the policies of the relief-giving agencies in Montreal. Another six women had financial problems because of inadequate and irregular income of their husbands but for various reasons they were not eligible for more help.

Sixteen of the twenty-five women with financial problems had institutional convalescence, one had housekeeping help, while the remaining eight had care in the home. Four of these eight could have used housekeeping services while the other four were able to manage.

The effect of the need for financial assistance was most keenly felt by those women who had been independent and by those women who were separated from their husbandsor who were in the midst of marital conflict. For those seven women whose illness had cut off their financial security their attitude towards dependency and independency rose to the surface. Four went to an agency, took temporary help and returned to some kind of employment. The three who did not go to an agency had to depend on children or other relatives. This seemed more difficult for them than taking direct help from an outside source was for the four who went to a social agency.

Financial problems plus marital problems were combined for six of the women. With this combination of problems the importance that the married women

in this study attached to getting well was interesting. The records were not complete enough to allow for a close analysis but the following illustration gives an example of the hostility, resentment and escape that one mother lived through and how the refusal of her convalescent request was used to help her face a reality:-

> Mrs. Koolbrook[1] was a Hebrew woman of thirty-eight years of age who was married in 1930 to a man who took little interest in her and who never provided her with a standard type of home. Patient had no children until three years after her marriage. During the war, 1940-1944 she was forced to live in rooms in the same home as her father who was brutal, self-righteous and who showed little understanding of patient. Although patient lived independently with her two children between 1944-1946, it took several years for her to get a home in the image of what was accepted in her culture. Concurrent with the establishment of home was the further development of strained relationships with her husband. His contributions into the home became spasmodic.
>
> Mrs. K. was hospitalized in the spring of 1947 for a sympathectomy because of essential hypertension. She was also diagnosed as having diabetes and psychoneurosis (anxiety state) for which psychotherapy had been recommended. Her psychiatric appraisal indicated that she had both supressed and overt hostility directed at her husband, father, society and authority. She said she wanted to get well to spite her husband. During the time she was in hospital his support dwindled and she signed refusal of treatment stating that she had to continue her legal suit against him. Although an agency was giving support, patient feared this kind of dependency and was anxious to press her legal case to punish her husband. Continuing psychotherapy about which she felt ambivalent was therefore rejected. Several months later she returned to the hospital requesting to go to a convalescent hospital. Her request was refused.

Both her doctor and social worker felt that she was seeking an escape and that convalescence at this time would not be of benefit. The interaction between the physical, the psychological and the environmental factors was very marked. Taking financial assistance reminded her of the painful realities of her unhappy life which made her look upon convalescence as the least painful solution to her problems.

A second way some of the married women expressed their resentment and de-

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1. Case No. 21.

privation was by assuming a martyr-like attitude.

The second kind of financial problem that this group of women suffered from was centered around the costs of medical care. Meeting these costs is an ever present problem. With the wider participation of private insurance schemes, it might be expected that this problem would not be so prevalent. The following table shows the distribution of financial responsibility for the hospitalization costs of the one hundred and three married women in this study.

TABLE XXIII

BREAKDOWN OF COSTS OF MEDICAL CARE

OF 103 MARRIED WOMEN WITH CONVALESCENT NEEDS

Source of Responsibility	Incidence	Percentage
TOTAL	103	100
1 Family	45	43.7
2 Q. P.C.A. (a	31	30.1
3 Insurance	12	11.7
4 Other Combinations	6	5.8
5 Patient	1	0.9
6 Not Hospitalized or Other	8	7.8

(a. Q.P.C.A. is an abbreviation for the Quebec Public Charities Act - the law under which the residents of the Province of Quebec can receive public assistance. To qualify for assistance the applicant must pass the means test. Residency of one year, income of the bread winner, number of dependents and the duration of the illness are the four salient points that have to be cleared and passed on by the Municipality of the applicant. The wording of the law allows for considerable flexibility of interpretation. The guide for the preliminary application allows $18.00 weekly earnings for a single person, $25.00 per week for a married couple and $5.00 for each dependent. These figures, however, are very plausible. In special instances, appeals can also be made to the Special Accounts Department - which handles problems on a provincial rather than a municipal basis.

Forty-five families or 43.7 percent took responsibility for the costs of hospitalization while the government paid for thirty-one women or 30.1 percent.

Only twelve patients or 11.7 percent had insurance benefits. This may appear to be low but in view of the fact that these patients were only indirectly connected with insurance resources such as their husbands' companies where group insurance benefits would be available, the married women would not have this security. Many fathers would be labourers and their own guarantee would be under Women's Compensation which does not allow anything to families. From Table VII,[1] it can be seen that the types of work these women did or could qualify for, were not found in places where it would be easy to obtain group insurance. It is also possible that the records said the family was taking responsibility for the bill when actually the family had taken responsibility indirectly for some insurance plan.

Eight patients or 7.8 percent were not hospitalized and so there was no cost of medical care involved, or else some other person such as employer or common-law husband assumed responsibility. Six patients or 5.8 percent had their bill met by such combinations as Blue Cross and Q.P.C.A., help from veterans' funds and insurance claims from accidents while one patient had to pay for her own care from her own resources.

Costs of medical care were of prime importance for nine of the one hundred and three women, and prevented them from getting the convalescent care they wished. The following table shows the problems that made convalescence either impossible or difficult to get.

Each one of these problems affected the welfare of the patients in some way. Refusal of Q.P.C.A. was based on residency in one case and on adequate income in two cases. All three women remained at home. For Mrs. Calderisi[2] going home without housekeeping aid meant thrusting her into duties she did not feel able to carry out. The reaction to this convalescent plan was seen later when she returned to clinic with further complaints of a psychosomatic

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1. Supra P. 37
2. Supra Chapter IV, P. 68.

TABLE XXIV

PRIME FINANCIAL PROBLEMS OF NINE MARRIED WOMEN

Prime Financial Problem	Incidence
TOTAL	9
1 Not eligible for Q.P.C.A.	3
2 Original Q.P.C.A. evaluation did not recognize patient's needs	2
3 Husband shirked responsibility	2
4 Hospital costs made husband restrict length of care	1
5 Threat of investigation and contacting husband too threatening	1

nature. For another patient the recommendation of rest, without being able to plan anything on a realistic basis, was of no use because there was nothing that could be done for her. The patient who was left dependent on relatives because her residency was not established, suffered much shame and embarrassment over having to be both physically and financially dependent on relatives. For this sensitive person this was a very distasteful experience. With certain disease entities of an orthopaedic nature, the threat of physical impairment and lack of earning capacity made the dependency more threatening and warped relationships that should be kept as positive as possible during the convalescent period.

The effect of slow recognition of the financial needs of the patient either deprived the patient of care or postponed the issue until a crisis was reached. This was seen in one case where the mother had to return home and suffer physical abuse from a psychotic husband. Lack of recognition of the patient's needs was anxiety provoking and even engendered hostility on the part of the patient to the point that her attitude towards recovery became warped. This was seen also when the husband shirked his responsibility. By leaving the patient stranded she has to abide by alternative plans which as a second choice, leave her feeling

more dissatisfied. Such a state of mind increases the chances for further complaints.

The financial problems regarding cost of convalescence combined with a problem concerning the husband cut two women's convalescence short. One woman was unable to do anything because of the legal problem whereas the second patient's feelings promoted her to cut off her own chances to fight for the help she might have received.

When the costs of medical care appear as a secondary problem the nature of the problem as expressed by either the patient or family can be divided as follows:

TABLE XXV

FINANCIAL PROBLEMS THAT WERE A SECONDARY PROBLEM

FOR 16 MARRIED WOMEN

Kind of Problem		Incidence
TOTAL		16
1 Family felt burden keenly		10
	General worry 5	
	Debts 5	
2 Indecision over final responsibility		3
3 Shame over inability to pay		1
4 Husband's indifference		1
5 Shame over Q.P.C.A. investigation		1

When the family assumed responsibility for the costs of medical care, the patients did not seem to be affected directly, as they were with all the other financial problems of both a primary and secondary nature. This group of ten families included those husbands and children who were more protective of the patient and who wished to let the patient feel free of responsibility. Included in the troup, too, were three cases where the patient's regression was so marked that their area of outside interests was narrowed down to their own immediate needs. Consequently they did not manifest concern over a debt

during illness. In one case, that was followed on a long term basis by the caseworker, the patient's concern over the bill did manifest itself after her health was back to normal.

When there was a problem over indecision as to who was going to accept final responsibility for the bill the reaction of the patients seemed to be on an individual basis. It can make patients anxious about getting care or about being acceptable to the convalescent institution. It can also be used as a punitive measure against the husbands who are not readily accepting their responsibility. For one wife, separated from a well-off husband, she kept herself in a dependent convalescent state much longer than was necessary.

The problems that costs of medical care raised for patients were frequently an outcome of some more basic family problem such as the situations found for the last three patients in Table XXV. Because of her shame over her inability to pay, one patient cut her own convalescent period short. Another patient brought on numerous temper tantrums and indirect rejection of her children as a reaction to her husband's indifference to her and her bills.

Although only two patients stand out in the last two tables as having a specific problem regarding their feelings about taking help through Q.P.C.A., it cannot be assumed that the other patients had no feelings about public assistance. Because of the incompleteness of the social records, only such feelings that made a definite problem were highlighted. Casework practice and theory has always indicated the importance of the meaning of help to the individual. From the earliest recording this has appeared to be significant, therefore it is assumed that there were feelings present that were not evaluated.

The problems concerning occupational adjustments were divided in two ways for the patients in this study; either worry over their own occupational adjustment or worry over some other member of the family. For ten patients their area of concern involved only themselves. Four kept talking about the unsatisfactory

adjustment of their children during their convalescent period while three showed concern about their husband's poor work record.

Of the seventeen women in this group, fourteen were dependent on themselves for their own livelihood. Of these fourteen, ten women revealed problems about their work. The other four women had the security of knowing their job would still be available. Their medical problems included a high incidence of fracture and orthopaedic problems.

For the ten patients whose concern about occupational adjustment was centred on themselves the women expressed their problem in terms of financial urgency, anxiety about their future, an innate personal problem of hyperactivity and insecurity of their ability to resume responsibility. Underlying these various reasons the caseworker sensed one common denominator, namely - fear of some unknown entity, such as, can they find another job, will they be as physically capable to handle their old job or how will they spend their time? After an illness, during which the patient has regressed to a certain extent, the unknown generates more fear than it would do for a normal person, therefore it is natural to expect this element of fear.

Treatment of such fears should begin with reassurance from the doctor, with supplementary reassurance from the caseworker and others in the treatment team, temporary financial assistance, psychotherapy, verification of patient's status with previous employers and use of community employment agencies. Unfortunately one woman who was a news vendor who had to compete in a large open market for customers could get her worry relieved only by returning back to the news-stand just as soon as possible. In this case this was a month earlier than the doctor had recommended.

The time element involved in the illness is an important factor in making return to work easier or harder for the patient. The longer the illness and hence the longer the dependency, the greater the feelings of inadequacy on the

part of the patient. In the general orientation to the idea of returning to work, the idea should precede any direct pressures. In the case of Mrs. Chalmers discussed earlier in this chapter on page 104 in connection with problems of family responsibility, the pressure of financial necessity and the lack of the sympathy of her relatives served as additional stimulation. Recognition of the achievements of the patient was an important aspect of treatment in the conclusion of the relationship.

The poor occupational adjustments of children and husbands did not have a direct relationships to the patient's illness and convalescence. However, since they were problems expressed by the patients, their significance cannot be minimized. The mothers and wives expressed their concern in terms of annoyance, shame and guilt. It was interesting to note that the four children who presented problems for the mothers were first generation Canadians who also presented general problems in terms of cultural integration.

Except for one case, the problems regarding occupational re-adjustments did not appear as a primary problem, for the convalescent patient. With more time than usual left for thinking, the anxiety provoking aspect does have an influence on the convalescent patient.

The legal problems involved for the married women were another kind of problem that did not have a direct affect on the patient nor create a problem of primary significance. The following kinds of legal problems were revealed amongst fifteen women: (1) eight cases where family affairs were being settled through court; (2) five patients whose costs of hospitalization (apart from Q.P.C.A.) had to go through legal channels; (3) one patient whose discharge became entangled with immigration regulations; (4) one patient whose Q.P.C.A. application would involve her and her husband going back to court.

Although legal proceedings about costs of hospitalization produce anxiety (in some accident cases the final amount of disability has to be evaluated

before anything can be finally settled), the patients who were most deeply upset were those who had recently been involved in legal proceedings about family problems. The following illustration showed what happened to one patient, who was seeking an emotional rest after the stimulation of court proceedings:

> When Mrs. Lenoit[1] presented herself at clinic a diagnosis of an anxiety state was made, on the basis of the physical examination being negative and her marital incompatibility being very marked. Also she was run down and nervous. Patient had three children, aged seven, nine and eleven, who, in addition to patient needed recreational outlets, other than what was provided at home and in the neighbourhood. This decision was made on the basis of the standards of the doctor and social worker. Plans were consequently made for patient to go to Murray Bay. Because patient thought the patients were "beneath" her she remained only a few days.

This patient's real problem was missed by the case worker. It showed how environmental manipulation cannot solve basic emotional conflicts and dissatisfactions. She, no doubt, could not fully admit the trauma that the loss of her husband's love meant for her. Yet, if her general attitudes had been searched more fully for meaningful material, she perhaps could have been given an opportunity to "take stock" of herself, and then convalescence with fewer emotional entanglements would have been concluded.

The seventh most prevalent environmental problem for the 103 married women used in this study was their diversion and recreation. Although only six cases may have been enumerated this does not mean that none of the other ninety-seven had problems in this regard. Only six women brought this problem to the attention of the caseworker who in turn tried to do something about it. Occupational and recreational therapy resources for patients either at the convalescent institutions or for home care are non-existent.

Diversional activities became a problem for the following reasons: Two

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1. Case No. 50.

women had hyperactive personality traits. Two women felt useless with nothing to do. One patient felt completely bored with her long hospitalization while the last patient wanted guidance about planning recreational outlets for her children.

The treatment of these and the unnumerable undiscovered cases of boredom could best be handled by trained occupational therapists who have a definite contribution to make in the treatment of patients on the road to recovery. Women can pick up knitting at odd times but this becomes very boring without some outside stimulation. The following illustration shows how the caseworker's use of Occupational Therapy Centre contributed toward the patient's feelings of adequacy and normalcy:

> Mrs. McDonough[1] was a 62-year old woman who had retained a youthful figure and general appearance. Because of an accummulation of stresses and strains in her past life that were accented by environmental pressures, she developed a reactive depression that necessitated admission to the Allan Memorial Institute. While there, she developed acute diverticulitis and had to be transferred to surgery and undergo an operation that left her with a colostomy.
>
> Mrs. Mc D. was a widow with one daughter, aged 29. Patient and daughter maintained a flat and boarded patient's sister. The mother-daughter tie was too close for the good mental health of the daughter. One very specific psychiatric recommendation included separate beds for mother and daughter after discharge.
>
> As the time for patient's discharge home drew near and the worker was trying to establish a relationship to discover patient's feelings about a plan and help her carry out such plans, the patient's abdominal distress seemed more acute each time the worker returned. Concurrently with the case work done with the patient the psychiatric social worker was trying to evaluate the daughter's feelings about patient's illnes. All efforts to have the patient and daughter accept the psychiatric implications seemed quite futile as long as there was surgical evidence of the colostomy which proved the illness was definitely physical.
>
> When discharge was finally arranged for home care the worker focussed on many reality problems such as Victorian Order of Nurses referral, dietary needs, financial re-adjustments, etc. and offered a very sustaining relationship. When the patient had regained some strength and confidence on a reality basis, she then was ready to discuss her

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1. Case No. 85.

> dependency on her daugher, her uselessness, her guilt over her feelings about the implications of psychiatry. While at home thinking about herself patient tried to fill in time with crocheting, etc. Her work was so neat and finished, worker felt that she would have a real contribution to give to others who might be interested in handiwork.
>
> Worker tried to arrange for her to teach her art to others. Although the patient could hardly believe that she had anything worthy to give, her feeling of prestige went up even though nothing materialized.

For the six patients who suffered because of isolation from the family, the presenting problem was geographical remoteness. Although a simple treatment would seem to be the patient's return home, such reality factors as the necessity for longer treatment, strangeness of settings were additional annoyances for the patient.

The emotional connotation of the fear and frustration in long separation became the more deep-seated problem for two of the patients.

The cultural factors that were diagnosed as problems in relation to the convalescent patient were unrelated to each other in terms of the type of problems and the various cultural groups. The main problems that had cultural significance for this group were: (1) language barrier, (2) parental domination; (3) meaning of social status; (4) problem regarding birth control.

The first three problems definitely influenced the convalescence of these patients. The one patient who would not express herself or find anyone who could speak her language had many other problems regarding family relationships, financial insecurity, low intelligence and emotional deprivation. Every time she had a chance she seemed to flounder around trying to justify her convalescent needs; when she started back to work she kept groping for words to explain her fear over losing her source of income.

When parental domination is very marked it is an integral part of the mother's total personality and her need to supervise in spite of separation

necessitated by illness continues. Her opportunity for close supervision however is interrupted by separation. Convalescence away from home consequently adds to her frustration.

One patient who requested institutional convalescence not only wished care away from her busy household but also care in a place that was held in high esteem in the community. Having come to Canada as an emigrant and having had to work very hard during her life, she felt she had not reached a very high social position. Being ill, she had an opportunity for displaying nice lingerie, such as attractive nightgowns and bed jackets, as an anonymous person. Going to an institution gave her a further opportunity to display her material possessions which helped to give her a false feeling of having attained the social status she had always craved.

The environmental problems that developed because of lack of community resources arose in relation to other family and emotional and medical problems.

In reviewing the environmental problems confronting the one hundred and three married women in this group it has been found that the problems of family responsibility, living conditions and financial problems around daily needs and medical care were the most prevalent. Occupational re-adjustment and legal complications appeared next in frequency. The smallest occurrence of the environmental problems were diversional activities, isolation from family, cultural factors, lack of community resources and other problems, such as senility, low intelligence and costs of special brace.

From the case illustrations and from the numerical count of the problems it can be seen that all problems which accrue before or during a convalescent period are closely inter-related whether it has a medical, emotional or environmental component. Although the treatment of medical problems is the responsibility of the physician, and it is assumed that the environmental problems are treated by the caseworker, and the emotional problems are treated by all

members of the treatment team with the psychiatrist held responsible for guidance and interpretation of special cases, responsibility for leadership must come from one medical authority. Because many environmental problems appear to be on the surface, treatment cannot be easily "manipulated". Time is important to try and test a theory and weigh the emotional components. that will determine the final outcome of treatment.

Having discussed the convalescence problems in terms of the medical, emotional and environmental component, the next problem that can be raised is how to treat the individual patient. Since the caseworker, the Social Service Department, the hospital and the community are involved, some important tenets for a broad treatment program will be raised in the following chapter.

CHAPTER VIII

GENERAL CONSIDERATIONS FOR AN INTEGRATED PLAN FOR CONVALESCENT CARE

The second objective for this study was to find possible solutions to some of the convalescence problems of married women with family ties. Before offering recommendations in the concluding shapter, this chapter will give an objective evaluation of the general outcome of convalescence as it appeared to the caseworker and as it appeared in relation to the number of re-admissions to hospital. The use of the medical social worker will be discussed first in terms of her casework practice within the hospital setting and secondly in terms of her use of the community agencies.

In evaluating the general outcome of the patient's complete recovery after the convalescent stage is supposedly ended, certain clarifications will have to be made for this study. First of all the study did not try to secure a follow-up report from the patient as to how she felt about the outcome of her convalesence. It was not possible to have one person or one standard of measure for evaulating the cases. Consequently the writer has had to put a large group of cases into an unknown category. If the original worker on the case had been available she could have given some indication of the final outcome of total treatment. Or if the department had a policy that some evaluation of the outcome of care had to be incorporated in the closing summary of the social record, then an over-all evaluation would be much more valid. The present evaluation was based on an accumulation of facts and follow-up information. Such information as the continuation of complaints, degree of handicap, outcome of the treatment, modification of environmental and emotional problems, and the general state of happiness and satisfaction of the patient was considered in this evaluation.

From the information available in the charts, the writer's own knowledge

of the case and the evaluations that were incorporated into the social records it was found that the outcome of convalescence was not know for forty-seven of the patients or 45.6 percent of the total population. Twelve patients, or 11.7 percent were classified as having a poor outcome while twenty-three patients or 22.3 percent seemed to have returned to a good state of recovery. Only four patients or 3.9 percent had very good results from their total treatment.

Factors which accounted for the 11.7 percent with poor outcome of total treatment could be found in several areas. The three main areas would be (1) the medical problems of the patient as related to outcome of treatment; (2) casework treatment of the social problems of patients and (3) facilities available through existing community agencies. Each of these will be discussed separately.

One of the measurements of the outcome of medical treatment can be reflected in the incidence of re-admissions to the hospital. Only the re-admissions to the Royal Victoria Hospital could be accounted for in this study as no follow-up interviews were held with the patients, consequently it was not known how many sought additional medical treatment elsewhere.

Of these one hundred and three patients, thirty-two had to be re-admitted to the Royal Victoria Hospital, from the time they were referred in 1947 to to January 1950. Eighteen had one re-admission, six had two re-admissions, one had three re-admissions while seven had over three re-admissions. The incidence of the re-admissions according to the convalsecent plan follows.

The reasons for the hospital re-admission could be broken down as follows: Eleven patients developed a new and different illness. Eleven others had complications of the same illness. Seven had to return because it was part of the medical plan while three mothers had to be re-admitted because the medical plan for convalescence was longer than could be given at one time at

TABLE XXVI

THE PROBLEM OF RE-ADMISSIONS FOLLOWING CONVALESCENCE

FOR THE 103 MARRIED WOMEN

Kind of Convalescence	Total	Occurrence of Re-admissions			
		1	2	3	4 or more
TOTAL	32	18	6	1	7
1 Institutional	19	15	2	1	1
2 Home and Institution	5	1	2	0	2
3 Home	4	2	0	0	2
4 Other	2	0	0	0	2
5 Visiting Nurse	0	0	0	0	0
6 Relatives	1	0	1	0	0
7 Housekeeper in the home	1	0	1	0	0

Montreal Convalescent Hospital for the Q.P.C.A. patients.

In the first group of patients who were re-admitted to Royal Victoria Hospital there were two included who were given convalescence on a planned basis to build up patient's reserve before additional operative procedures were tackled. Three other patients had to wait for time to elapse before gynaecological disorders could be investigated. The other six patients developed illness unexpectedly.

Of the patients who required re-admission to Royal Victoria Hospital because of the fact that their health became worse, there were two main groups. Those whose illness developed gradually over a period of months (five cases) and those whose complaints and symptoms developed immediately during the convalescent period (six cases). In the first group of five were three patients who were suffering from cancer. They had all received institutional convalescence immediately following a serious operation with guarded prognosis or else were being given care to help allay pressures other than medical. The convalescent plan was a palliative measure in the long run.

In the case of the other two married women the reasons for hospital re-admission seemed to have more far-reaching significance. At the time of the one and only referral of both of these patients to social service neither was fully evaluated. In fact one patient carried by the family agency did not have an interview with a medical social worker until over a year later. It was only then that the full significance of the meaning of convalescence to the patient became known to the medical social worker, namely - the mother did not want to go where she could not take her daughter. It was interesting to note that even after the doctor discovered the mother-daughter attachment that prevented patient leaving home the case was not referred to the social worker for interpretation of the problem to the community agency, nor to make efforts to modify the patient's attitude, nor to plan for convalescence other than institutional care. In 1947 the patient had three weeks at Murray Bay but she had two hospital admissions following this. In the meantime no provision was being made for any kind of a convalescent plan. The other patient, who cried to have her convalescence with relatives, also presented an intricate problem of home ties, emotional, medical, and surgical problems. Although the physician in the Medical Outdoor finally diagnosed her problem as psychoneurosis there was no psychiatric evaluation.

In the second group of six patients who became worse during their convalescence, five had gone to Montreal Convalescent Hospital and one had gone home. Close liaison between the convalescent and general hospital is needed and makes for sound treatment. Of these five, three were probably more chronic problems than convalescent problems, one had a personality problem and an environmental strain that made her very anxious and less willing to regain independence while the other patient seemed to have developed every possible complication of her illness before she regained her health. She had convalescent care both at an institution and at home. The plan seemed to have

little effect on the illness.

Of the seven patients who had to be re-admitted according to plan were five who required further surgery and two who were pregnant. The various convalescent plans decided upon in this group seemed satisfactory except for one obese patient with elephantiasis who stayed with friends. Living conditions and sanitary facilities were poor and patient was re-admitted in an unsatisfactory condition. As already mentioned her obesity hindered her social poise and she could not accept institutional care.

In the last group of three patients were those whose convalescence was long term; all these patients had fractures and the bill was being covered by Q.P.C.A. After fifty days, Q.P.C.A. lowers its allowance for patients at Montreal Convalescent Hospital, therefore, they ask for re-admission for evaluation of the patient so that Q.P.C.A. can be reinstated at the higher rate. This is always a source of annoyance, especially for the surgical service. There seems to be no immediate solution to this problem other than mutual understanding and agreement.

The reasons for the re-admissions of the thirty-two patients in this group have not reflected lack of proper medical care. Therefore it would seem that the basis for the large incidence of poor and fair outcome of convalescence lies more within the emotional and environmental areas. This involved the casework practice at Royal Victoria Hospital, the individual's personality, the worker's skill and community resources.

In evaluating the use of casework in the treatment of the convalescent patient it will be necessary to review the statistical practices of the social service department, which has already been discussed in Chapter I.

During the time the patients for this study were being carried in the Main Social Service Department there were three main ways of classifying the patients for statistical purposes. These were (1) continued case; (2) brief case and

(3) no case made. This classification seemed to be based on (1) time element; (2) severity of problem; (3) kind of responsibility the caseworker took for the patient; (4) the intensity of the casework relationship; (5) quality of evaluation and team work between doctor and social worker.

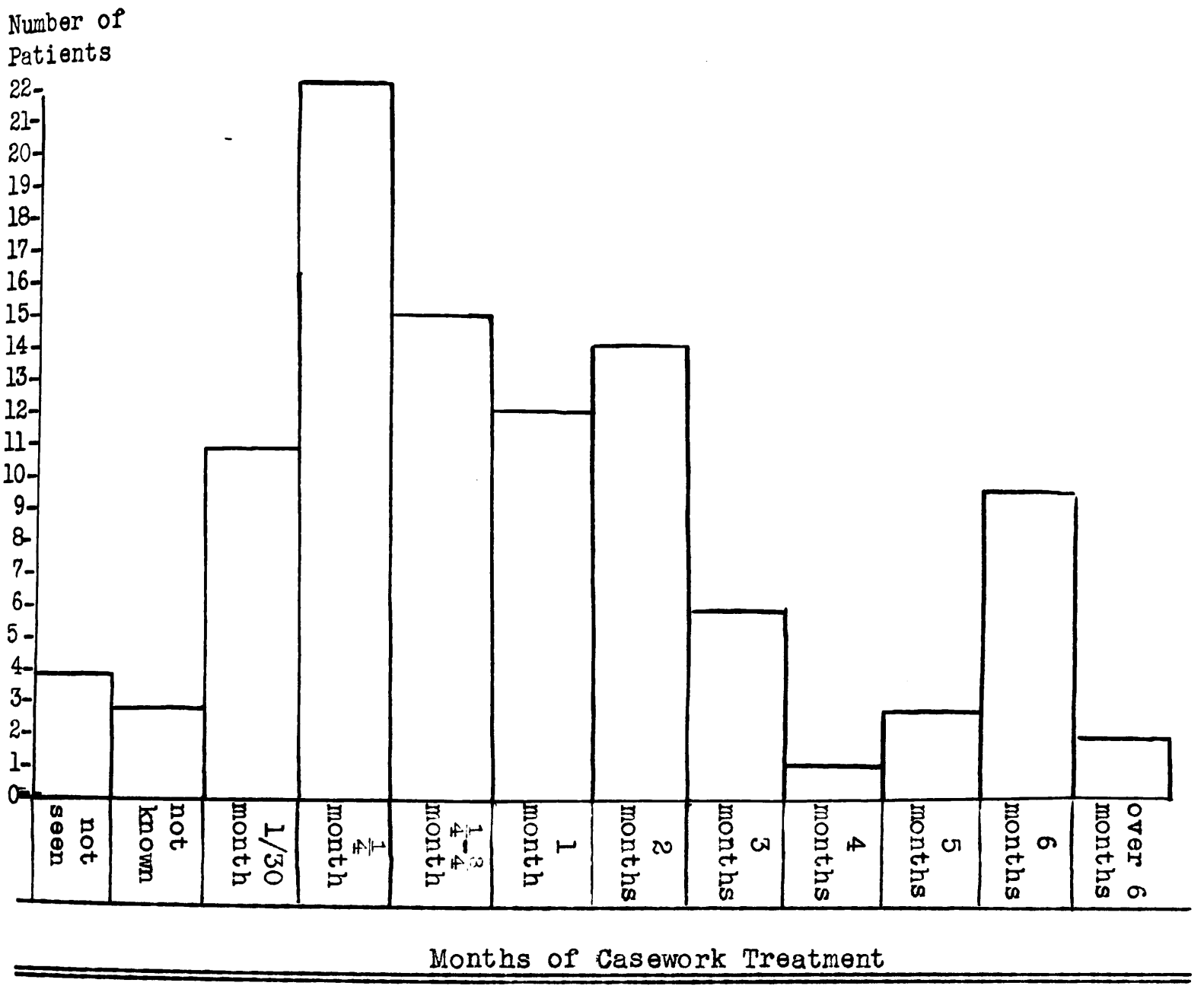
A continued case would include a long-term plan around one or more problems (both medical and social) that would require a sustained relationship. A "no case made" might also involve a long-term plan but it also included short-term contacts. A "no case made" seemed to be a rather loosely used way of tabulating those cases where the patient wanted only a convalescent bed, where the doctor wanted only an arrangement, or where the caseworker was not making a very comprehensive evaluation or else had no time to give the patient the consideration needed to make constructive use of planned treatment.

The brief services were those that involved short-term contact, or contacts where there might be only one plan and the activity of worker would be minimal. There seemed to be no distinction drawn between the exact time factor that showed the difference between a brief and continued case. There was no way of knowing the chronological sequence of problems involved because of the small number of folder records that were kept. The fact that there were thirty-seven brief cases, thirty-six "no case made" and thirty continued cases would point to a discrepancy in the integration of casework in treatment where 35 percent of the cases were not considered cases by the caseworker herself.

In the group of patients used for this study the actual volume of casework involved could not be measured. The length of time that the caseworker was involved was possible to tabulate.

FIGURE I

THE LENGTH OF TIME THE CASEWORKER CARRIED A CASE ACCORDING TO THE NUMBER OF PATIENTS FALLING WITHIN THIS TIME LIMIT.



From this it can be seen that contact with the patients lasted from one day to over a year depending on both the medical situation and the needs of the patient. The highest incidence of contact was in that group where contact lasted one to six days. This obviously reflects the fact that the caseworker has not taken responsibility to see her patients during the convalescent period. Adding the one day contacts to the one to six days contacts there were thirty-three patients which is 32 percent of the total group. Add those not seen and cases not known and the total number shows that 38.7 percent

of the total cases were not followed. It would seem that the caseworker was being used for the preparatory steps of convalescence but had not been a part of the treatment after discharge from the treating hospital. The numerous emotional and environmental problems found in Chapters VI and VII could not be cured by short term treatment. The convalescent hospital does not employ social workers. Therefore it would seem many problems have remained unmodified.

Since this study has not gone into the follow-up of the effects of convalescence, it was not possible to evaluate what additional problems developed for these patients. However, situations as the following arose: Mrs. Atkinson[1] had financial difficulties, but did not want them known so she left the convalescent hospital against advice. The effect of the recreational suggestions for Mr. and Mrs. Balfour[2] promised to be rosy but how the patient resolved her previous pent-up resentment about lack of social activities was not known. Su h problems were revealed during the preparatory period of convalescence. If the worker has uncovered problems, why should she not follow them? It would seem better to finish a few cases satisfactorily rather than have the caseworker's services spread lightly over a larger number of patients.

Forty-one patients or 39.8 percent of the patients in this study were carried between one to eight weeks, while 21.5 percent were carried over two months or for as long as a year and more. Thus it would seem that 61.3 percent of the patients had some collateral casework during their convalescence.

If arranging convalescence is considered to be the function of a social worker, than it would seem that categorizing a patient as a "no case made" has not showed recognition of the value of casework. The fact that nine

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1. Case No. 3.
2. Case No. 5.

patients had no problem indicated, seemed to stem from the fact that only a bed was arranged or else the referral to social service was interpreted in a narrow sense so that an exploratory interview was not very productive. Even amongst the patients who were opened as cases there was a variety in the quality of evaluation and planning. The fact that fifty-six patients were referred by the nurse and thirty by the doctor raises the question of where the hospital focus has been in this aspect of treatment. What has been the doctor's hope during the convalescence of his patients? How active has he been in this step of treatment? How has the medical and social work staff of Royal Victoria Hospital considered the area of convalescence and rehabilitation?

As already pointed out by Dr. Woodruff the two neglected opportunities in convalescent care have been (1) "the opportunity for the discovery and adjustment of environmental factors and family situations which may have contributed to the occurrence of the patient's illness and which may be factors militating against the preservation of health once recovery is attained and the patient is back in his usual milieu [1] (2) "that of helping the patient during this period of rest and relaxation to evaluate himself, to take account of stock, to consider his habits of life and work in relation to their effect on his health, to judge whether both ends of the candle of life have been burning, and to determine whether certain dominating ambitions and tendencies are sufficiently important to strive for when measured against the nervous and bodily toll exacted; an opportunity to help him to develop a new philosophy and habit of life and work compatible with the reserves which age and illness [2]

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1. Ogden Woodruff, "Present Day Concepts of Convalescent Care", Prodeedings Conference on Convalescent Care, New York. 1940. p. 230.

2. Ibid. p. 231.

have left him". If these concepts are to be carried out in their true sense, definite allowance for time, for follow-up and continuity of treatment would have to be recognized.

If the doctor has decided that he has made the social evaluation and knows what is necessary, then it would seem that he could complete the arrangements for the convalescent bed which in itself is a simple procedure. Such cases as Mrs. Hardwick, referred to get a bed after she had gone home, demonstrates the uselessness of a caseworker's time in a convalescent plan where the doctor requested only a bed and the caseworker never saw the patient.

> Mrs. Hardwick[1] was hospitalized twenty days for a gall bladder operation. Upon discharge she went to her own home where she remained eight days before admission to the convalescent hospital. During the time she was home she became anxious, complaining, and became a disturbing element to her family. This may have been more keenly felt in the home because her husband had also been ill for the past six months. Her private physician had maintained a close supporting relationship following discharge. When things became too acute he called social service to arrange for convalescence "to satisfy patient's needs and to give relief to the family."

The caseworker was never asked to see the patient prior to discharge, even during convalescence. There were telephone calls to reassure the family and if the worker had had time for regular visiting at Montreal Convalescent Hospital that patient could have been seen. But since this was not possible and the doctor's focus was not on getting any casework help, he might as well have had his own secretary arrange for a bed. There was no constructive plan that involved the worker. If her services cannot be used for casework contributions it seems unsound for her to be brought into a situation. This was also seen in the case of Mrs.Munch [2].

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1. Case No. 35

2. Supra P. 48

Since the doctor is the leader in the treatment team, he initiates the request for services of a caseworker. It must be recognized that large hospital wards present many problems and obstacles in getting to know the patient as a person who comes from a certain kind of environment. The patient may strive to give a good impression to the hospital personnel. The patient may feel unimportant in such a large setting and keep his problems to himself. In the large turnover of patients the daily duties on the ward often prevent chances for hospital personnel getting to know the patients. For these and various other reasons the doctor should feel that his original referral would include a social evaluation. The caseworker expects such. If the doctor could think in terms of using his caseworker as a person to whom he could go for further help in planning care of a patient and interpret her function in a general way - but still within a social and personal connotation - then the basis is laid for mutual sharing of knowledge and planning. The more socially orientated the doctor is the more he can get for his patient, from his social worker because the basis of referral helps the patient see the function of the caseworker.

The fact that some doctors asked for only a bed, that some patients did not readily transfer to the worker, the fact that some patients had no problems and that five patients were not actually seen by caseworker, would lead to the question of whether convalescence necessarily should involve the caseworker. If her services are not to be used for their true function, there is no value in her becoming partially involved. If she does not have the routines, she could better spend time and energy with those patients whose needs are more acute.

Part of the contribution that a social worker can make lies in her ability to use and consult the resources of a community on behalf of the patient. It is her responsibility to be the expert in this area. Table XXVII

TABLE XXVII

COMMUNITY RESOURCES USED FOR 88 MARRIED WOMEN PATIENTS

REQUIRING CONVALESCENT CARE

Resources	Number of Patients on whose behalf they were used
TOTAL	148
Montreal Convalescent Hospital	68
S.S. R.V.H. (Fund, Taxi, Supplies)	8
Family Welfare Association	8
Victorian Order of Nurses	7
Catholic Welfare Bureau	6
Jewish Family Welfare	5
Murray Bay Convalescent Home	5
Bureau d'Assistance Sociale aux Familles	4
National Employment Service	3
Occupational Therapy Centre	2
S.S. Maternity, Royal Victoria Hospital ✱	2
Department of Veterans' Affairs	2
Canadian Handicraft Guild	2
Immigration Authorities	1
Echo Nursing Home	1
Chaisson Nursing Home	1
Grace Dart Home Hospital	1
Bruchesi Institute	1
Sherbrooke Hospital	1
Mount Sinai Sanatorium	1
St. James United Church	1
Boys' Farm and Training School	1
St. Vincent de Paul Society	1
Society for Protection Women and Children	1
Children's Aid Society of Montreal	1
Camp Lewis	1
Junior League Camp	1
S.S. St. Justine Hospital	1
S.S. Montreal General Hospital	1
Fresh Air Camp	1
Wartime Prices and Trade Board	1
Young Women's Christian Association	1
Trained Attendants' Association	1
R.C.A.F. Benevolent Fund	1
Girls' Counselling Centre	1
City of Windsor Welfare Department	1
St. Joseph's Convalescent Hospital	1
Verdun Press	1
Private Boarding House	1

✱ Since 1947 Main Social Service and Women's Pavilion have become part of one integrated department for the hospital.

indicates what resources were used for this patient group. It does not include the Q.P.C.A. cases as financial investigation is not in the area of the activity of the social workers in the Royal Victoria Hospital.

It was to be expected that the convalescent hospital would be used to the greatest extent for the patients in this study because institutional convalescence has been so much better organized in this community than any other kind of care. The Royal Victoria Hospital Social Service Fund was used to cover transportation costs for those patients who required such long term treatments as X-ray therapy and physiotherapy. One patient got a wheel chair from the department. Funds were also available for special appliances and braces.

Referrals to outside agencies included requests for specific help such as financial assistance, nursing care and supervision, clothing, sharing in co-operative planning as well as consultation. Two examples of consultation were contacts with the Jewish Family Welfare to discuss their adoption policies. Two of the women in this group were apprehensive as to whether they would ever have children of their own. They were still not ready to go down to the adoption agency but they seemed to want clarification of the fact that there were such agencies where they could go when they wished to make a move in this direction.

Outside agencies were used in one hundred and forty-eight instances on behalf of eighty-eight patients. This averages 1.7 resource per patient. Fifteen patients did not get any community help. Community resources can have a very dynamic part in contributing to the patient's care, and the patient's reassurance or as source of inspiration.

Since this study is concerned with the convalescent problems of the married woman the reasons why fifteen married women or 14.5 percent of the patient group did not use any community resource have been broken down.

None of these fifteen women had institutional convalescence nor were there any alternative plans that the caseworker could find within the community.

TABLE XXVIII

REASONS FOR LACK OF SOME ORGANIZED CONVALESCENT PLAN

FOR 15 PATIENTS

Problem	Incidence
TOTAL	15
1 Patient preferred to go home	5
2 Lack of beds when wanted at Montreal Convalescent Hospital	3
3 No funds for care	2
4 Change of medical decision and patient kept at Royal Victoria Hospital for convalescent care	2
5 Poor teamwork	2
6 Case refused by doctor	1

Of the five patients who preferred to go home one lived out of town in a small community. If the doctor had been more persuasive and the case-worker had taken more time with the patient maybe something could have been done. Another patient's family was grown and seemed to be taking initiative in finding their own solution. Another patient lived in rooms, had no family responsibilities and preferred the shelter of her family. Two women in this group received no community help. Both could have used housekeeping aides and financial assistance to cover same.

Of the three patients for whom a convalescent bed was not available, two were referred very close to the day of their discharge. Their ties to home were stronger than their feeling that they needed further institutional care, consequently they did not wait in Royal Victoria Hospital for another bed elsewhere. Both were mothers with children who fretted about the burden they would be to others. Both would have been potential patients for housekeeping

aides with collateral need for financial assistance to cover such a plan. The third patient was from out of town. Because of her colostomy her priority at Montreal Convalescent Hospital was low. She became so impatient in the hospital that she finally decided to return to her hotel room.

Of the two women who had no funds for care, both were declared ineligible for Q.P.C.A. Their family incomes were not large enough to carry out any plan. There was no fund in Royal Victoria Hospital nor in the City of Montreal to whom they could apply for money for convalescence unless the husband could get benefits from the Department of Veterans' Affairs or unless the mother was going to Murray Bay Convalescent Home; in such cases the hospitals can cover transportation and the hospital takes the patient free of charge. Since the number of patients who have not been able to afford convalescence and who have been ineligible for Q.P.C.A. was small, it would seem that a special fund could cover their needs.

For the two patients whose medical recommendation included an extension of hospitalization in Royal Victoria Hospital there was little the caseworker could do as regards the community. Both patients however seemed to have personal problems and anxieties. Since the private physician wanted only a convalescent bed nothing more was pursued.

In the case of the two married women who suffered because of poor team work the referrals were made late and were not made by the doctor. One patient was never seen so her needs were really not known. The nurse said she understood the family was worried about finances. The other patient was referred a few hours before discharge and she had taken for granted that she would have to go home so she did not give a very objective picture of her social situation. The fears she revealed were treated rather quickly and superficially.

The last woman for whom no resources were used did not have access to

the convalescent hospital because the doctor said she had no need for further care. He felt she was altogether too dependent on hospitals. The only alternative the community could have offered her would have been placement in a summer convalescent hospital.

Little reference if any has been made to the use of psychiatry in an integrated convalescent plan. The psychiatrist was used for twelve women and for two husbands. There seemed to be a tendency to use the psychiatrist in cases where the patient's physical recovery was very slow or where there was an extreme emotional problem. Psychiatric evaluations for better understanding of the patient and guidance in total treatment were rare. Only one patient continued with supportive therapy from her home during convalescence. This was of short duration because the psychiatrist decided to limit his therapy and to transfer the supportive role to the caseworker. One patient attended psychiatric clinic following her convalescence.

During 1947 the only physiotherapy resource for the patients was the hospital. Now this service is given by Victorian Order of Nurses. The Montreal Convalescent Hospital hope to have it included amongst their services. This would save much transportation for those having institutional convalescence. For those patients who go out to the Montreal Convalescent Hospital and do their own exercises without any supervision it would be more reassuring.

Occupational Therapy which was actually provided to the patients has not been possible to measure. There are no therapists at any of the convalescent hospitals and although there was a home visitor in the Occupational Therapy Centre, until 1948, no referrals were made for this patient group. Occupational Therapy should be a recognized part of any treatment team.

The use of group activities in any hospital setting is a fairly new development. It is non-existent in the main part of Royal Victoria Hospital or at Montreal Convalescent Hospital and this would seem to be an unexplored area

by which more patients could be helped.

The general conclusions from this chapter indicate that only 3.9 percent of the cases were appreciably improved medically and socially and mentally following the illness and convalescence. The large percentage namely 38.8 of patients whose end results were not known reflects that collateral service and follow-up which has been accepted in theory by both the doctors and social workers at Royal Victoria Hospital has not yet been fully realized in practice and probably has accounted for this low figure for more satisfactory results.

From the re-admission problems it was found that the patient's medical problems after convalescence were not obviously severe. The low rate of satisfactory results of convalescence seemed to stem then from emotional and environmental problems. Although 61.3 percent of the cases had some collateral casework during convalescence, many records indicated a lack of sustained casework cervice. The problem of classifying cases seemed paramount in this respect. What was going to be carried on a casework level of performance and what was done on a manipulative no case made level seemed unresolved.

Regarding the use of community agencies, seventeen agencies were used on behalf of eighty-eight patients. No resources were used for fifteen patients. Such plans as housekeeping aides, day convalescent plans will be needed in Montreal. Since four federations here are separate and have different policies, a uniform community service to meet the convalescent needs of the hospital patients would not be possible. Therefore much planning could best be handled by the treatment centre in collaboration with the medical, physiotherapy, occupational therapy and casework staff already in the hospital.

At present outstanding needs for the patient include (1) housekeeping

aid; (2) financial assistance for special cases; (3) wider use of the concepts of convalescence; (4) further individualization of the patient.

CHAPTER IX

SUMMARY AND CONCLUSIONS

Before drawing the conclusions to this study the two main objectives should again be reviewed. The first aim was to obtain a clearer and more concrete understanding of the problems confronting married women during their convalescent period. The second objective was to point out areas of further need where both the hospital and the community could improve their services in the total treatment of the patient[1]. It is recognized that a broad survey such as this leaves many problems quite widely defined and raises more questions that cannot be easily solved in a short period of time.

The two most nagging problems thatmotivated this study were the lack of good casework service to the patients during their convalescent period and the difficulties that mothers of families had to fact in going home to their responsibilities too soon. Both of these questions loom more to the forefront now because medical treatment has expanded its area of responsibility "to treat the patient, not the disease" from the time a diagnosis is made, until rehabilitation is completed.

In tracing the historical background as to what is involved and what is important for convalescent patients, it can be seen that convalescence has changed in its concepts, especially during this present century. At first it was considered important to have the patient in an atmosphere with many protective, or artificial boundaries. During the 19th century institutional convalescence was considered the methof of fulfilling the needs of the patients during this latter phase of their illness. The extreme outcome of this concept led to the problem of making the patient fit an institution. As a counteraction to this strict policy, and the many unmet needs of the patients, planning

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1. Supra, P. 7.

around the individual needs of the patient has become paramount. However, as soon as the focus shifted to the patient as a person, needs other than medical have loomed up. Since patients are social beings it is only natural that social needs are numerous. Thus, at the end of World War II the concept of total treatment has evolved to include the physical, social, intellectual, emotional and environmental needs of the patient.

The alternative ways for planning convalescence include: institutions, home care with such collateral services as housekeeping aides and visiting nurses, relatives, nursing homes, day care programs that would meet the needs of mothers with children in the pre-school age group. From the records used in this study it would seem that the referrals for convalescence in past years has been geared to the idea that planning convalescence meant getting a convalescent bed rather than exploring the problems with the patient and then arriving at a solution to meet her needs. Also, the referrals showed little indication of the necessity to evaluate and treat personal and environmental problems during the convalescent period, irrespective of the mechanical procedures necessary to organize some kind of a convalescent plan.

In this study it was found that the largest proportions of married women who required convalescent care were in the forty to fifty-nine year old age group. This age range also includes the time of physical and emotional breakdowns which frequently occur in middle life. Although the great majority of the women studied here still had living husbands, the family constellation remained small with one, two or three other people accounting for the size of sixty-five of the households. Although it is the women in the middle age group who are most likely to have healthy husbands and free, unmarried children, these circumstances do not solve the convalescent problem. The fact that the majority of these married women came from home with few other members, points to the problems of isolation. The lower incidence of women from families

with more members in the family constellation points to the fact that the pull of family responsibilities may be so great that many married women's environmental needs may remain undiscovered.

When families consist of more than four members, the pull home seems stronger. Resources focused only to provide institutional convalescence therefore, prevents the women who most need additional rest from getting it. This study does not include the Women's Pavilion where the largest proportion of women is in the younger, child-producing age group. Furthermore, the children in the family constellation would be in the school age group rather than in the working group, and their needs must create still more problems for the mothers, than those highlighted in this study.

Sixty-five of this patient group were full-time housewives while twenty-four were occupied outside of the home. Seventy-two women were living in their own home, which indicates either that more provision could be made for patients' home care or else that the driving force that accounts for so much institutional convalescence is not so prevalent among women from larger families.

Patients with multiple medical problems had the highest incidence of convalescence problems. Following this, gastro-intestinal disorders and fractures and cancer were next in preponderance. Orthopaedic and cardiac diseases were next. Curiously enough there was a marked paucity of nutritional problems. This might reflect a gap in the diagnostic classification rather than evidence that no such problems existed.

The breakdown of the convalescent problems showed that nine patients had no primary or secondary problems. For the remaining ninety-four patients there were 395 problems. These were divided as follows:

From this table it can be seen that the largest group of problems were of an emotional nature, but the number of environmental problems was almost

TABLE XXIX

SUMMARY OF CONVALESCENCE PROBLEMS FOR 103 MARRIED WOMEN

Medical-Social Classification	Total	Per-centage	Convalescence Problems Primary	Secondary
TOTAL	395	100.0	103	292
1 Not shown	9	2.3	9	0
2 Problems with a Medical Component	43	11.0	7	36
3 Problems with an Environmental Component	171	43.3	56	135
4 Problems with an Emotional Component	172	43.4	51	121

equal to those with an emotional component. The problems of a medical nature were numerically much smaller than these two preceding groups.

The average number of problems involved for ninety-four married women who required convalescent care was 4.2. For the total group of one hundred and three women the average number of problems was 3.8. It would seem that this preponderance of problems, apart from the medical problem, indicates a need for better follow-up and practice of the concept of continuity of treatment. The evidence[1] showed that many patients were handled on a short term basis. Since there is no social worker on the staff of the convalescent institutions, continuity of treatment has been limited to those cases where a definite crises has arisen. A policy to rectify this lag would involve more work and time for the caseworker at the treating hospitals.

It has been shown that the caseworker has nothing to contribute to the care of the patient, unless she is used professionally to make a social evaluation and to plan accordingly. Some time might be saved if she limited her intake to those cases for whom the doctor wished a casework interview. Although it would be desirable to have all patients seen by the social worker, services could be improved if her efforts at diagnosis and treatment and follow

1. Figure 1, P. 140.

up were more clearly focused on the patients with severe problems.

Apart from the personal and social problems of the patient, it was found that the present resources in Montreal do not fulfill all the needs of this patient group. The first problem in this respect is the lack of housekeeping aid. Ten women did not get convalescent care because there was no help available.

Secondly there are no financial resources to turn to for help for the border-line families who cannot get public assistance and who cannot afford additional hospitalization or supplementation of any other plan that might be feasible.

Montreal is a city of two languages and three major religious group. Since there is no public welfare program, each cultural group has developed its own welfare resources. The policies of these resources are not consistent, consequently what might be available for a Protestant patient is not always available for a Catholic patient. However since convalescence is a continuation of a medical problem such problems as financing medical care and providing housekeeping aides should remaing the responsibility of the hospital. Therefore it would seem the collateral service of housekeeping aides organized within the hospital setting would be feasible, practical and useful to have for the married women patients.

Additional recommendations that should be made at this time include the following: (1) more realistic classification of the social service cases, (2) more consistency in the quality of the records in the social service department, (3) earlier referrals to social service, (4) a better follow-up program, (5) an extension of other collateral services such as occupational therapy, physiotherapy and recreational activities for the patients during their convalescence.

APPENDIX A.

Schedule

A. IDENTIFYING DATA

Name
Indoor Number
O.P.D. Number
Code Number
Age

(1) Under 20
(2) 20-29
(3) 30-39
(4) 40-49
(5) 50-59
(6) 60-69
(7) 70 and over
(8) No information

Ethnic Origin - when parentage is mixed, that of mother's is taken.

(1) British
(2) Hebrew
(3) French
(4) Italian
(5) Germanic
(6) Syrian
(7) Slavic
(8) Other

Religion.

(1) Protestant
(2) Hebrew
(3) Catholic
(4) Other
(5) No religion
(6) No information

Marital Status.

(1) Married - living with husband
(2) Widow
(3) Divorced or Legally separated
(4) Separated with no legal basis
(5) Remarried
(6) Common-law union
(7) Other

Occupation
(1) Housewife full time
(2) Homeworker - part-time outside
(3) Working outside full time
(4) Other

B. ENVIRONMENTAL DATA

Living Conditions before onset of illness.
(1) In own home with husband and children.
(2) In own home with husband only
(3) In own home with children only
(4) Rooming house, hotel or boarding
(5) In own home with husband and other relatives
(6) Living at place of employment
(7) Living with relatives
(8) Other arrangements
(9) No information

Living Arrangements after convalescence (hospitalization)
(1) Reunion with family
(2) Separation from family
(3) Change of former living arrangements
(4) Other

Family Constellation (living members)
(1) Person
(2) Age
(3) Relationship with patient
(4) Occupation
(5) Health
(6) Remarks

Source of Support for Patient (before, during and after illness)
(1) Family
(2) Combination
(3) Own Wages
(4) Public assistance and/or private assistance

C. FINANCIAL ARRANGEMENTS

Hospitalization
(1) Family
(2) Q.P.C.A.
(3) Insurance
(4) Combination
(5) Patient

Convalescence
(1) Family
(2) Q.P.C.A.
(3) Insurance
(4) Combination
(5) Patient

Problems and Irregularities

D. MEDICAL DATA

(a) Main Diagnosis (b) Treatment (c) Condition on Discharge

Secondary Diagnosis

Length of Hospitalization

Re-admissions

Reason for re-admissions

Clinic follow-up

E. CONVALESCENCE

Recommended Time for Convalescence at time of referral

(1) 1-2 weeks
(2) 3-4 weeks
(3) 1-2 months
(4) Indefinite
(5) Not given

Actual length of convalescence

Type of Convalescent Care Selected

(1) Institutional
(2) Home
(3) Home and institution
(4) Relatives
(5) Institutional and Relatives
(6) Other

Reason for type of care chosen.

Patient's attitude to convalescence while still in Hospital (chief attitude only)

(1) Dependent on hospital
(2) Unworthy of care (martyr)
(3) Over-anxious
(4) Resistant and critical of being discharged
(5) Fearful of change
(6) Impatient to leave Royal Victoria Hospital
(7) Willing and co-operative because (no particular problems
(doctor's insistence
(husband's attitude
(adverse environmental strains
(8) Need a change and rest for nerves
(9) Other
(10) Not known

Family's Attitude to Convalescence while Patient is still in Hospital
(1) Dependent on hospital
(2) Over-anxious about assuming responsibility
(3) Resistant and critical
(4) Fearful of change
(5) Anxious to get rid of patient
(6) Too expensive
(7) Relieved
(8) Willing and co-operative
(9) Not known

Problems Encountered During Convalescence

F. MEDICAL SOCIAL FACTORS

Classification of Medical Social Problems
(1) Primary problem
(2) Secondary problems

Source of Referral To Social Service

Classification of the kind of Case
(1) Brief
(2) Continued
(3) No case made

Resources used in helping patient

Length of time involved in casework

Reason for giving casework help

General Evaluation
(1) Not known
(2) Poor
(3) Fair
(4) Good
(5) Very good

APPENDIX B.

Basis for Classification of Medical Problems

(1) Multiple Diagnoses
(2) Multiple Diagnoses including Psychiatric Complications
(3) Diseases of the Gastro-intestinal System
(4) Fractures
(5) Metabolic and Endocrine Dysfunctions
(6) Cancer
(7) Orthopaedic Problems - disease of the Bone and Muscles
(8) Cardiac Diseases
(9) Diseases of the Genito-Urinary System (cancer excluded)
(10) Chronic Tonsillitis
(11) Diseases of the Special Senses - ear, eyes, nose
(12) Arthritis
(13) Infections
(14) Lacerations
(15) Psychoneuroses
(16) Diseases of the Respiratory System - bronchitis,
(17) Circulatory Disturbances
(18) Not established

APPENDIX C.

Basis for Classification of Medical Social Problems

Problems with a Medical Component

(1) Other illness in family
(2) Physical incapacity
(3) Nursing Care
(4) Nutritional Problems

Problems with an Emotional Component

(5) Patient's attitude to illness
  (a) Anxious
  (b) Depressed
  (c) Resistant
  (d) Dependent
  (e) Other
(6) Patient's attitude to Convalescence
  (a) Dependent
  (b) Unworthy
  (c) Over-anxious
  (d) Resistant (critical)
  (e) Fearful of change
  (f) Impatient of limitations
(7) Family Relations
  (a) Marital conflict
  (b) Rejection of patient by children
  (c) Over dependency
(8) Personality of characteristics
(9) Family's attitude to convalescence
(10) Separation of family
(11) Family's attitude to illness
(12) Behaviour problems of children

Problems with an Environmental Component

(13) Problems of family responsibility
(14) Living conditions - physical aspects of home
(15) Financial problems at home
(16) Costs of Medical care
(17) Occupational re-adjustment
(18) Legal complications
(19) Diversional problems
(20) Remoteness and isolation
(21) Cultural factors
(22) Lack of community resources
(23) Other

BIBLIOGRAPHY

Annual Report, condensation. Department of Home Care, Montefiore Hospital, N.Y. 1948.

Bailey, A.A. & H.G. Weiskotten, "The Problem of the Discharged Hospital Patient". Hospitals, 13: 13-17 August 1939

Beckley, Helen, "Some Social Deductions from Medical Diagnoses" Hospital Social Service XIII 1925, 124.

Boas, Ernst, P., M.D. "Convalescent Care." Redefined. The Modern Hospital. Vol. 55, No. 5, Nov. 1940. pp. 73-74.

Brodman, K., B. Mittelmann and H.G. Wolff, Psychologic Aspects of Convalescence. XX J.A.M.A., 1945, 129: 179-187.

Bulletin - Montreal Convalescent Hospital Twenty-fifth Anniversary 1914-1939. Southam Press, Montreal, Ltd. 1939.

Christian, Henry A., Osler's Principles and Practice of Medicine. 1944, D. Appleton-Century Company, Inc., New York.

Clement, Edith Lewis, Medical Social Statistics. Unpublished M.S.W. Montreal, 1949.

Cockerill, Eleanor & Helen M. Mossett: The Co-operative Venture between Hospital and Patient, Smith College studies in Social Work. Vol. 14. Sept. 1943 - June 1944. pp.184-196

Deardorff, Neva R. Hospital Discharge Study, Analysis of 576, 623 Patients Discharged from hospitals in New York City in 1933. Welfare Council of New York City. 1942, Vol. 1, 1943, Vol. 2.

de la Fontaine, Elise, Some Implications of Psychosomatic Medicine for Casework. The Family, June 1946. pp. 127-134.

Dock, William, M.D. The Evil Sequalae of Complete Bed Rest. J.A.M.A. 125; 16, August 19, 1944. pp. 1083-1085.

Dunbar, H. Flanders, et al. Problems of Convalescence and Chronic Illness. American Journal of Psychiatry, March 1936.

Elledge, Caroline H. The Meaning of Illness. Unpublished paper read at Canadian Conference of Social Work. Vancouver, June 12, 1950

Field, Minna & Schless, Bessie. Extension of Medical Social Services into the Home. Journal of Social Casework. XXIX 3. March 1948. pp.94-99

Fenger, Bodil, Selection of Homemakers for a Family Agency. Journal of Social Casework XXIX, 6. June 1945. pp. 222-227.

Gardiner, Elizabeth G. Socio-economic aspects of Convalescent Care, Hospitals. Vol. 15, No. 1 p. 34, Jan. 1941, or Bulletin of the American College of Surgeons, Vol. 26, No. 1. Jan. 1941.

Gardiner, Elizabeth G. & F.K. Thomas. The Road to Recovery from Illness. Hospital Council of Greater New York, 1945.

Ghormley, Ralph K. The Abuse of Rest in Bed in Orthopaedic Surgery. J.A.M.A. 1925; 16. Aug. 19, 1944. pp. 1085-1087.

Gilbert, N.C. Cardiac Convalescence Symposium or Convalescent Care, Burlington, Vt.

Golub, J.S. The Pattern for complete Service includes preventive medicine and home medical service. The Modern Hospital. April 1946.

Harrison, Tinsley R. Abuse of Rest as a Therapeutic Measure for Patients with Cardiovascular Disease. The Journal of the American Medical Association. Vol. 125, No. 16. Aug. 19,1944. pp.1075-1077.

Jensen, Frode, Weiskotten, H.G., Thomas, Margaret A. Medical Care of the Discharged Hospital Patient. The Commonwealth Fund, New York, 1944.

Landesman, Gertrude. The use of Convalescent Care Facilities: Summary of a group discussion series of Medical Social Workers and Convalescent Home Directors. United Hospital Fund of New York, Spring 1947. Mimeograph.

Lederle Laboratories Bulletin: The Present Status of Physical Medicine and Rehabilitation. Montreal, Quebec. 1951.

Levine, Sarah C. Integrating Home Maker Service with Casework. Journal of Social Casework. Vol. XXVIII, No. 5, May 1947. pp.178-183.

Lewinsky, Corwin, E.H. Convalescent Centres Symposium on Convalescent Care. Reprint of papers at the meeting of the American Conference on Hospital Service 1930. Free Press Printing Co., Burlington, Vt.

Liss, Edward. "Convalescence". Mental Hygiene XXI. Oct. 4, 1937. pp.619-623.

Margolis, H.M. "The Psychosomatic Approach to Medical Diagnosis and Treatment" National Conference of Social Work, Buffalo, May 1946.

Minor, George R. Investigation and teaching on the Field of the Social Component of Medicine. Bulletin of the American Association of Medical Social Workers. Vol. 10, No. 2, April 1937. pp.9-11.

Nicholson, Edna. "The Social Component in Medical Care". A digest of address at annual A.A.M.S.W. banquet, Atlantic City, N.J. Bulletin of the American Association of Medical Social Workers. Vol. 9, No. 4, July 1936. pp. 49-51.

Peddy, Lester. The Background to Current Thinking and Problems in Convalescent Care. Master of Science Thesis for the New York School of Social Work, Columbia University, New York. Aug. 1947.

Peters, J.P., Elman, Robert & Committee on Convalescence and Rehabilitation of National Research Council. Nutritional Aspects of Convalescent Care. J.A.M.A. 124: 17, 1206, April 22, 1944.

Powers, John H. "The Abuse of Rest as a Therapeutic Measure in Surgery". J.A.M.A 125:16, Aug. 19, 1944. pp.1079-1083.

Proceedings, Conference on Convalescent Care, New York, 1939. Convalescent care. Under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine, Nov. 9 & 10, 1939, New York.

Raudin, I.S. "Institutional Convalescent Care for Surgical Patients". New York State Journal of Medicine. Vol. 40, No. 7. April 1, 1940.

Richardson, Henry B. Patients have Families. The Commonwealth Fund, New York, 1945.

Robinson, G. Canby. The Patient as a Person. A study of the social aspects of illness; the Commonwealth Fund, New York, 1939.

Rusk, Howard A. "Rehabilitation and Convalescence, the Third Phase of Medical Care". Medical Addenda Related Essays on Medicine and the Changing Order. The Commonwealth Fund, New York, 1947. pp. 103-126.

Seltzer, Edith G. "Where Shall we send Johnny?" Better Times. XXIX, No. 14. Published by the Welfare Council of New York.City. Dec. 26, 1947.

Senn, Milton, J.G. "Emotional Aspects of Convalescence." The Child. August 1945. Vol. 10. pp.24-28.

Simon, Beatrice K. "Social Casework in a Medical Setting." Social Service Review. Sept. 1946. pp- 362-373.

Tansey, S.P. "Trends in Care of Patient". Bulletin, Americal College of Surgeons. 31:285-286. Sept. 1946.

Thornton, Janet & M.S.Krauth. The Social Component in Medical Care. A study of one hundred cases from the Presbyterian Hospital in the City of New York. New York, 1937.

Upham, Frances. A Dynamic Approach to Illness. New York 1949.

Waters, Lena R. Medical Social Problems of the Surgical Patient. Bulletin of the American College of Surgeons. April 1937. Vol. 22, No. 2, p.77.

Weiss & English. "Psychosomatic Medicine". Philadeelphia & London. 1949.

Woodruff, I. Ogden. "Present Day Concepts of Convalescent Care". Journal of the American Medical Association. Feb. 10, 1940. Vol. 114, No.6. p. 461.