McGill University

M E D I C A L S O C I A L S T A T I S T I C S:

AN INDEX TO THE CONCEPT OF FUNCTION IN MEDICAL SOCIAL WORK

A Thesis Submitted to

The Faculty of Graduate Studies and Research

in Partial Fulfilment of the Requirements

for

The Master's Degree in Social Work

by

EDITH LEWIS CLEMENT

Montreal - April, 1949.

PREFACE

This study in the area of medical social statistics was begun in 1945 when the writer was engaged as a student worker on a fellowship at the Massachusetts General Hospital, Boston, in the Social Service Department. It seemed appropriate at that time to undertake some evaluation of the new scheme in medical social statistics which had been inaugurated at that hospital in January of that year. In the course of enquiring into the background of this new plan, the writer found it both necessary and intensely interesting to examine the reports of the department's work from its beginning in 1905. Special attention was given to the forms of medical social statistical reporting which were developed throughout the years and it soon became evident that running through each of these was the thread of an evolving purpose. That is, that as the function of medical social workers became more clearly defined, the method of statistical reporting changed in accordance with it. With this theory in mind, the writer determined to test it on a broader scale. On returning to Canada in 1946, further consideration of this problem convinced the writer that there was sufficient evidence in the material already assembled to warrant further exploration and development of the emerging theme.

The writer is indebted to several people for encouragement and assistance without which it would have been impossible

to complete this study. In the first place, to Miss Ida M. Cannon, former Chief of Social Service at the Massachusetts General Hospital, the writer is indebted for her suggestions and never-failing enthusiasm about the possibilities of a study. Because of Miss Cannon's objective point of view, the writer was encouraged from the outset to be critical of the new statistical method which Miss Cannon had been instrumental in developing. But had it not been for the interest and guidance of Miss Eva Younge, Faculty Thesis Adviser at the McGill School of Social Work and for the help of Mrs. Carol Elledge, Professor of Medical Social Work at the same institution, the writer might have failed in her objective. To these people and to all who may unwittingly have aided in the accomplishment of this purpose, the writer extends her grateful thanks.

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Chapter I

Introduction

The title of this study is best understood in the light of its twofold purpose and against a background of a philosophy of social statistics. In the first place, by examining statistical methods used by medical social workers during the period 1905 - 1945 with special reference to the methods used at the Massachusetts General Hospital, Boston, (hereafter referred to as M. G. H.), Social Service Department, we propose to show the relationship which has existed between changing concepts of function in Medical social work and changes which have taken place in methods of obtaining medical social statistics. In the second place, by examining in detail the most recent development in medical social statistics at one leading hospital on the continent, we shall show that at least one medical social service department is accumulating material which can be of vital importance in both the medical and the social work fields.

It is a generally accepted fact that social agencies need to have some index to the volume of their work and that from their experiences in dealing with social problems they ought to be making available some material for social research. There are several reasons for this. An index to volume of work which a given agency is carrying is useful to

the agency's administration. It may, for instance, be considered in relation to the size of the agency staff. It may also provide some insight into the quality of work being done. In a children's adoption agency, for example, where it is understood that each adoption requires much careful study and planning, a desirable caseload per worker per month might be set at twenty cases, but when this number rises to an average of forty cases per worker per month, the agency ought to consider making a study of the problem of the size of caseloads. In so doing, consideration would have to be given to the various factors creating such a situation, i.e., policy of intake, standards of employment, size of staff, the community's needs, etc. Volume of work when measured statistically is also useful in inter-agency planning, in community councils which are organizing to meet community needs and as a basis for establishing standards for agencies doing similar types of work. Providing material for social research has long been the practice of many social agencies. Wherever an individual or a group of individuals may indicate an interest in studying a particular social problem or set of problems, social agencies are asked and should be asked to provide material from their own experience which will form at least a part of the basis of such a study. For example, a study of the problems created by overcrowding and bad housing in a given community would scarcely be valid without reference to information which might be obtained from community social agencies.

In addition to this type of research, there is also the type of study which is directed towards an understanding of the problems which social workers are being asked to deal with, i.e. an examination of the nature of the requests made to social agencies so that the workers may have some basis on which to improve their own techniques and resources. Because social work is a profession, that is, a "vocation, calling, especially one that involves some branch of learning",[1] the training of social workers must be towards a specific end. This "end" or goal is that of helping people to handle their problems. Hence, it is important to know what these problems are and how social workers may be trained to help with them.

If, then, the purposes of all social statistics are: (1) to measure volume of work; (2) to provide material for social research, are not these purposes of social and medical social statistics identical? In addition to these general reasons medical social workers have special reasons for feeling obligated to provide material for social research and they have a stimulus from the medical profession to do so. The medical profession is concerned with three well-defined diagnostic groups - acute illness, permanent physical handicap, and chronic illness. Although in the past much of the research in connection with these has been carried on in the laboratory, there is an ever-growing concern on the part of medical men for the social aspects of these groups. The problem of increasing demands for medical care is in these days of housing shortages

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1 The Concise Oxford Dictionary.

inseparable from the resultant overcrowding. It therefore behooves medical social workers to provide information which will throw fresh light onto the problems which confront both the medical and the social work professions and, if possible, to show what relationships exist between them.

As one studies the changes which have taken place in statistical methods of medical social work one is impressed by the fact that, as medical social work has matured, it has been able to outgrow a number of its early mistakes and has been able to focus its efforts on tasks which clearly became its appropriate function. From infant flailings in all directions in an effort to discover its own identity, this new branch of the profession of social work has grown, albeit by halting steps, to a degree of maturity which can be objective, which can look critically at the results of its work and which can speak with authority from its own point of view concerning the particular problems of living with which it is concerned.

In order to accomplish the first of our two major objectives, i.e. a study of the relationship between concepts of function in medical social work and changes which have taken place in medical social statistical methods, we shall make use of documentary material from the Social Service Department of the Massachusetts General Hospital as found in the annual reports of the department from 1905 to 1945. We shall refer in detail to the statistical methods which were devised from 1933 to 1939 by the professional organization of

medical social workers, the American Association of Hospital Social Workers. It is our intention also to indicate the influence each may have had on the other. We shall show how, as the function of medical social work became more clearly defined, medical social workers were able to focus on this area and were able to devise statistical methods which fulfilled the basic purposes of social statistics, namely measurement of volume and material for social research.

Our second major purpose is to show how one medical social service department has formulated methods of defining statistical concepts, and therewith made uniform medical social statistical reporting possible. For this purpose a detailed study will be made of the method of recording medical social statistics in current use at the M. G. H. with special reference to the results obtained after the first year of its use in 1945.

Two reasons entered into our choice of this material on which to base an evaluation of this new method. In the first place, during this year (1945) the department had the advantage of still having as its chief, Miss Ida M. Cannon whose long years of experience had much to do with her responsibility for devising this method. From Miss Cannon it has been possible to obtain a statement of the fundamental principles involved in developing this method and also some helpful comments on its future usefulness. Added to this is the fact that the writer was on the staff of the Social Service Department of the M. G. H. during that year and took

part in the process of putting the new method into practice. The other reason for choosing this material is simply that, because this is a continuing project, it seemed worthwhile to use the first year's experience as the basis for a study. We shall, however, make use of other material more recently available which may aid in forming an opinion about the permanent value of this method. This will consist of information about official changes which the department may have found necessary as well as informal comments from members of the staff who are actually using the method. We shall endeavour to evaluate this method from the point of view of its usefulness to both the medical social work group as well as to the medical profession.

For purposes of evaluation and comparison, and since the Social Service Department of the M. G. H. was not the only department which experimented in statistical methods for medical social work, we propose also to draw on material published by the Russell Sage Foundation, New York, in "Statistics of Medical Social Casework in New York City, 1944." While this is not a country-wide survey it does represent the thinking of fifty-three hospitals in the United Hospital Fund in co-operation with the Russell Sage Foundation's Director of Statistics, Dr. Ralph G. Hurlin. The Russell Sage plan is used here for comparative purposes, since no other project similar to that of the M. G. H. Social Service Department could be found.

Our conclusions, based on the findings herein presented

will, we hope, point the way to further use and adaptation of the medical social statistical method now in use at the M. G. H. However, before any widespread progress can be made in the field of medical social statistics the stimulus is needed which comes from group thinking about the problem. Perhaps the American Association of Medical Social Workers will be able to finance further leadership in this direction soon again.

With this much orientation to the problem at hand we are now ready to proceed with our study.

CHAPTER II

PIONEER EFFORTS IN ONE DEPARTMENT TO DEVELOP STATISTICAL METHODS AND THEIR RELATION TO CURRENT CONCEPTS OF FUNCTION

Fortunately for our study of medical social statistics we have had access to annual reports of the Social Service Department of the Massachusetts General Hospital which throw a good deal of light on the trends of its early development. The early reports were lengthy, and into them went a great deal of the thinking of those primarily responsible for the department's growth. But they also contain statistical material which, taken by itself, is a reflection of the emphasis of its work and therefore of its concept of its own function.

"First Annual Report of Social Work Permitted at the Massachusetts General Hospital, October 1905-October 1906."[1] is the unimposing title of the report of a new field of social work which was destined to become not only a part of a great medical institution but also a natural link between two professions serving the well-being of the community. The very title of this report reflects the fact that what is now known as Medical Social Work was, at its inception, only a grafting, if you will, of one very new profession onto another very old and respected one. "...Social Work Permitted at..." implies

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1 This was a separate report from that of the hospital as a whole. The report of the Social Service Department was not incorporated in the annual report of the Massachusetts General Hospital until 1926. 113th Annual Report, Massachusetts General Hospital, Boston. 1926.

that it was not an integral part of the Massachusetts General Hospital. It is therefore significant for our study to note that this first annual report does two things. In the first place it emphasizes the fact that in the beginning, the activities of a social worker in a hospital were tolerated, but they were not generally accepted by the hospital personnel, and also that these activities varied from the teaching of public health and hygiene to the giving of "moral support and advice". In the second place, it emphasizes the recording of "volume of work" by showing the number of patients served, the number of visits made and received, the number of letters written and received and the number of telephone messages sent and received. Thus, from the first we have an effort to show statistically what social work "permitted" in a hospital meant in terms of activities performed and in terms of the number of people being served.

When a record was kept concerning work with an individual patient, certain information was required on the front of his social record which, it was hoped, would prove of scientific value. This material was in four sections: (1) medical diagnosis, (2) sociological data, i.e. the chief need for which he was sent to social service, (3) what was done for the patient, that is disposition of the case, (4) outcome (after 1 month, 3 months, 12 months, etc.). It was hoped that "classified catalogues of the sociological diagnosis and of the dispositions

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1 First Annual Report of Social Work Permitted at the Massachusetts General Hospital, October 1905-October 1906. p. 29

made" would be prepared from these data but, as far as can be ascertained, no such attempt was ever made. Perhaps this ought not to be surprising, for in this and in many ensuing years, social workers in hospitals were very conscious of the fact that they were "on trial" and therefore they felt that they must justify their existence by showing how "busy" they were. This tendency to emphasize their "busy-ness" is evident throughout the first six years' reports. Beginning in the Third Annual Report[1] however, there is a new attempt to show the statistical distribution of patients according to certain disease groups. But this plan was dropped in 1913 when emphasis was placed on distribution of patients according to the hospital's clinics. In the Seventh Annual Report in 1912,[2] we find an attempt to analyze the "Social Treatment" required by certain diseases according to the following headings:

1. Support for Patient and Family.
2. Prevention of Contagion and Discovery of Cases in House.
3. Advice and Guidance in Plan and Place of Treatment including Institutions.
4. Help in Finding or Changing Work.
5. Persuasion, encouragement, consolation and training.
6. Nutrition and Hygiene of Person and Home.
7. Home Nursing.[3]

It is evident from this list that the hospital social worker was still being used for purposes which we would now consider to be the proper function of the public health nurse, and modern case workers might raise their eyebrows at the thought of being

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1 Third Annual Report, Social Service Department, Massachusetts General Hospital Oct. 1, 1907-Oct. 1, 1908.

2 Seventh Annual Report.....Jan. 1, 1912-Jan. 1, 1913. p. 18.

3 Ibid. p. 18.

reported as giving "advice, persuasion, consolation and training"! But a purpose was served at this time by demonstrating that someone ought to take responsibility in these areas. One outgrowth of this demonstration was the subsequent strengthening of the programme of the community's Public Health Department and its assumption of responsibility for health education, particularly as it applied to the care of tuberculous persons. The important thing is, that by this very analysis of their 'busy-ness' the workers were enabled to see more clearly what they were doing and they were thus able to begin their task of self-evaluation. They were showing statistically what they believed to be, or perhaps what the hospital believed to be their function. In so doing they were developing a factual basis for self-examination.

We have seen that in the early days at the M. G. H., "volume of work" seems to have been estimated on the basis of the number of persons referred to the department for help, the number of visits to and from patients, etc. They made no distinction between those patients offered a case work service and those patients served in some other way. Only as medical social workers have been able to concentrate on case work and, as case work itself has been developed as a special service, has the concept of using the 'case' as a unit of measurement of volume of work, been accepted. When hospital social workers began to make this distinction between 'cases' and 'non-cases', one sees that here is a clear indication that they were making a conscious effort to define their function.

As early as 1911 there is a reference to this distinction:

> .....in addition (to total volume) we have co-operated with other societies in the care of fifteen girls, but as we have done only a portion of the work, we have not considered them as regular cases.[1]

Judging by this comment 'regular cases' were those for whom the hospital social worker assumed full responsibility. There must have been some feeling that it was unfair to count statistically a case in which another social agency was co-operating. This is in contrast to present day practice of including cases which are carried co-operatively, in the total case count. Again, in the report for the January 1, 1914-January 1, 1915, we find the statement:

> Whatever can be done for many by a few, whatever can be done without knowing the patient personally is not social work. When well-chosen helpfulness rests on the basis of a personal and friendly relation, social work is going on.[2]

Here we have evidence that hospital social workers were beginning to recognize two factors in what we now term the case work process. These factors are, individualization of the patient and treatment based on an understanding which comes from this individualization. In the report for 1915-1916 there is a distinction between "Intensive Social Work" and "Short Service" cases, the real distinction here resting on the amount of time spent on each case. The M. G. H. material does not explain how this was accomplished in actual practice, but Miss Cannon, who was for many years chief of the department, has emphasized that

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1 Sixth Annual Report....Jan. 1,1911-Jan. 1,1912. p. 32

2 Ninth Annual Report....p. 6.

it was the amount of time and not necessarily the skill required in handling the case, which was considered to be important. Nor is it clear just when or how the first distinction between 'cases' and 'non-cases' came to be made.

Thus by 1916 the M. G. H. social workers had taken two steps towards defining their function. They had come to recognize that not all patients referred to them were offered or were in need of social case work. Furthermore, they recognized that not all cases required the same amount of a case worker's time. By this time also, an annual record was being kept of the carry-over of work from one year to the next. Statistics of 1916 showed the number of patients for whom the department took responsibility for social work continued from the previous year, the number of new cases, the number of reopened cases, and the total cases open during the year. From then until 1918, it was possible to make yearly comparisons of volume of work on the basis of cases. From time to time new recording methods were developed concerning sources of referral, that is, from doctors, agencies, special clinics or services within the hospital. These very definitely influenced both the size of social work staff and new developments in the department. It has not been possible to obtain data with which to substantiate this general statement, but this is a point which has been stressed by Miss Cannon. Therefore these statistics served an important purpose at this time.

In 1920 the American Hospital Association published a report of a committee which was making a survey of Hospital

Social Service.[1] This report gives us probably the first attempt to formulate a clear definition of the function of hospital social service:

> Function - the basis of hospital social service is its relation to the medical care of the patient. The restoration and maintenance of health depend in many instances not only on accurate diagnosis and direct medical treatment of pathological conditions of the body, but also upon dealing with the patient's personality and upon the alteration or adjustment of his home conditions, occupations, habits and community relations. The wise physician understands the connection of social and medical elements and seeks knowledge of both before determining his final program for treatment. Within the medical field itself, the advance of science requires the physician to call upon specialists in many branches, upon the laboratory and the X-Ray, in order that he may be able to secure all necessary data and judgments about his patient. The social worker is called upon to secure facts, and to aid in interpreting them, in order to provide a basis for a plan of treatment which takes into account both the medical and the social elements. The social worker also aids in the carrying out of treatment. The merging of the social work with the medical work is essential to effective use of the social worker. Social treatment must have as its aim the promotion or accomplishment of the doctor's plan of treatment... a plan that has taken into consideration the personal and environmental elements as well as the medical. The primary work of hospital social service, therefore, is work with individual cases. In this respect the work corresponds to that of the medical service of the same institution.[2]

Perhaps it is significant that in 1919, only one year previous to this pronouncement, the Social Service Department of the M. G. H. was, for the first time, recognized as a unit

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1 Report of the Committee of the American Hospital Association Making a Survey of Hospital Social Service, Bulletin Number 23, 1920.

2 Ibid.

of the hospital. It had now become an integral part of the institution which it served.

It may also be significant that just at this time the terms "Brief Records" and "Case Records" were used at the M. G. H. and that in explaining these terms the following reference is made to medical social case work as such:

> All recorded work consists of either "Brief" or "Extended" record. Discrimination in recording is guided, not only by the quality of service rendered, but rather (sic) by the capacity of the patient for self-adjustment and the extent to which the worker is carrying responsibility, the amount of investigagion necessary before action can be taken, the length of time that supervision must be given and the extent of social treatment.... A more elastic record form is necessary for patients requiring medical social case work, for whom the Social Service Department assumes responsibility; that is, in which social investigation, plan and treatment must be correlated with medical examination, diagnosis and treatment. Such cases now present situations in which the patient, because of ignorance, character, disruption of normal life owing to chronic illness or from the overwhelming effects of sickness, now needs advice, counsel and education or skilled social service to promote effective medical treatment.[1]

In other words, distinctions between types of recording now no longer rested on the amount of time spent on each case, as they had in 1915-1916, but on whether or not the patient was receiving medical social case work. And the statistical count of "extended case records" was therefore an index, not only to the volume of medical social case work being done but also to the quality, as distinct from "brief records" concerning patients receiving another type of service. One cannot

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1 Annual Report for 1919, 1920, 1921. Social Service Department, Massachusetts General Hospital, Boston. pp. 20, 21.

help but be impressed with the similarity between this new emphasis in the statistical count of the M. G. H. Social Service Department and the definition of function as made by the American Hospital Association Survey. At least one department had reached the stage where the medical social case was the unit of count in measuring volume of work. Moreover, medical social case work was recognized as a distinct service "in which social investigation, plan and treatment must be correlated with medical examination, diagnosis and treatment."[1] This is further exemplified by the 1922 report of the department's work which shows the total number of patients referred to the department, the number receiving Social Treatment and the number receiving Social Service only. Once again, the distinction was made between those patients referred, those given social case work and those served in some other way. In the annual report of the department for the years 1922-1926 the following statement reflects the effect which its acceptance as a real part of the hospital was having upon the department's concept of its own function:

> We realize that the period of demonstration has passed along with the rather stimulating necessity for justifying the use of the social worker in a hospital. Now that we are accepted as a member of the hospital family our responsibility is that of thinking more inclusively about social service to the patients in the wards and outpatient clinic.[1]

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1 Ibid. pp. 20, 21.

2 Annual Report of the Social Service Department, Massachusetts General Hospital, Boston, 1922-1926. p. 3.

The department was now able to think of its function in the broader sense than just being 'busy', it was beginning to feel free to concentrate on "social service to the patients". From this time until 1929 there continued to be a distinction made in the year's statistics on the total number of patients referred to the department, as between the number given "social study" and those given "social treatment".

In 1923 a further effort was made to define "Hospital Social Work" by the American Hospital Association. In the report of the Committee on Training for Hospital Social Work we find the following definition:

> Hospital social work may be defined from the point of view of the hospital as that part of its organization which deals especially with the personal and environmental factors in the health of its patients. Its function includes service to patients, education, research and certain administrative duties which are helpful to the hospital in the maintenance of its community relationships. A general aspect of its function is its contribution to the defining of social policies of the hospital..... To summarize, hospital social work is the application to the uses of a medical institution of a method of adjustment of environmental relationships, which is being developed in the field of social work. Its purpose is to contribute to improvement of individual and public health through study of and influence upon social behaviour. Through study of the patient's experience, social work should aid in medical diagnosis; through teaching and through changes made in home and work, it should aid in medical treatment; it should help the administration of the hospital through a special knowledge of neighborhood characteristics, needs and resources. The specialization of the social functions of the hospital should make possible research into the social elements of physical and mental health.[1]

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1 Excerpts from Report of the Committee on Training for Hospital Social Work, appointed by the American Hospital Association. Bulletin No. 55, 1923.

Thus we have the medical social worker performing five distinct tasks related to personal and environmental factors:

(1) adjustment of environmental relationships by study of and influence on social behaviour; (2) aid in medical diagnosis; (3) aid in treatment; (4) aid to the administration through specialized knowledge of the community; (5) research.

The statistical methods used at the M. G. H. during the ensuing three years do not show any noticeable influence that the above pronouncement may have had. Yet the new emphasis on "social service to the patients"may have been strengthened if not precipitated by the definition. During the years 1922-1926 the statistics again show "volume of work", breaking down the figures on the basis of "carried over", "new" and "reinstated" cases.

By the year 1926, further thinking about social service to the patients had led to the acceptance by the Social Service Department of the M. G. H. of a definition of three types of social problems which might properly be dealt with by a medical social worker:

> (1) That in which the medical situation creates social problems which have not existed previously, e.g. chronic disease;
>
> (2) That in which the medical situation - the fact of the patient being ill and having to come to the hospital - calls attention to a social need coincident with but not in any way dependent upon it, e.g. unemployment from industrial causes.
>
> (3) That in which social conditions have caused a medical situation to arise which may in turn create a social need of a different variety. Thus poor housing, long malnutrition due to poverty or ignorance, un-

> sanitary working conditions may cause industrial disability and financial need.[1]

It was now possible for medical social workers to focus on their unique contribution to the care of sick persons receiving treatment from the medical institution. They recognized that not all the social problems of these patients were within their scope of treatment, and they now defined the types of social problems which they believed to be appropriately their concern.

While it is not intended that this study shall be concerned primarily with the development of the definition of function in medical social work, it is necessary to give it more than casual attention if we are to have a basis for examining to what extent medical social statistics provide an index to the stage which the profession had reached in evaluating its function. No review of the development of this concept would be complete without making reference to the statement adopted in May, 1928, by the American Association of Hospital Social Workers. "A Statement of Minimum Standards to be met by Social Service Departments" bears witness to the threefold nature of medical social service, i.e. it is based on the medical need of the patient whose social conditions may require treatment if his medical condition is to be relieved; it is an aid to the physician in deepening his understanding of the patient; it may aid the patient in carrying out the physician's plan of treatment.

> The primary purpose of a hospital social service department is to further the medical care of the

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1 113th Annual Report, Massachusetts General Hospital, Boston, 1926. pp. 5-6.

> patient by a method of social case study and treatment. The major activity of the department, therefore, should be social case work.[1]

Thus by 1928 medical social workers had recognized that their chief function "should be social case work". There is no doubt that the earlier (1926) statement of the M. G. H. Social Service Department[2] had considerable bearing on the formulation of this concept. It was as if the profession had to undergo a purifying process in which, one by one, the non-essentials were eliminated and finally, at the heart of it all, the basic element of social case work had begun to emerge.

By the year 1930, the results of the work of the Committee on Functions of the American Association of Hospital Social Workers were published in "Functions of Hospital Social Service". Here we find these three aspects of the medical social worker's function emphasized in the following summary of the findings of the study:

> The social worker's major contributions to medical care gauged by frequency of performance are: (1) the securing of information to enable an adequate understanding of the general health of the patient; (2) interpretation of the patient's health problem to himself, his family, and community welfare agencies; (3) the mobilizing of measures for the relief of the patient and his associates.[3]

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1 Quoted in A Handbook on Statistical Reporting in the Field of Medical Social Service (United States Government Printing Office, Washington. 1933). p. 33.

2 Annual Report. 1926. op. cit. p. 3.

3 Functions of Hospital Social Service. American Association of Hospital Social Workers, Committee on Functions. 1930. p. 48.

The report goes on to show that there are three groups of social factors which may properly be considered the concern of hospitals and particularly of hospital social service departments:

> (1) Social conditions which bear directly on the health of the patients, either inducing susceptibility to ill health or helping or hindering the securing and completing of medical care.
>
> (2) Social distress caused to others by the illness of patients such as loss of income, neglect of children and so forth.
>
> (3) Social problems not having direct cause-and-effect relation to the health condition, but collateral to it. Such problems would exist independently of the sickness. These factors exist in many possible combinations.[1]

The study establishes a "test of appropriateness of function" which a social worker in a hospital might apply in evaluating her work:

> (1) Do the activities meet an actual need?
>
> (2) Are they carried out by persons able and equipped to perform the service?
>
> (3) Are the best interests of the hospital and the community served by having these activities directed by the hospital or would some other arrangement with outside agencies for meeting the need of social services in the hospital be more expedient?[2]

We scarcely need to point out the similarity between the above description of social factors which this report considers appropriately the concern of medical social workers, and that

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1 Ibid. p. 59.

2 Harriet M. Bartlett. Medical Social Work: A Study of Current Aims and Methods in Medical Social Work. American Association of Medical Social Workers. Chicago. 1934. p. 18.

made by the Social Service Department of the M. G. H. in 1926.[1] One reason for this undoubtedly is, that the M. G. H. Social Service Department was one of the participants in the study on which the 1930 report was based, and we believe that this similarity was therefore no mere coincidence. In addition to this, the earlier statement must have had considerable influence on the latter since, after all, the M. G. H. department was recognized as one of the leaders in the field of medical social work and what was said and done there was generally considered to represent the best thinking of the profession.

Turning again to developments at the M. G. H., we find that in the years 1930 and 1931 the annual reports of the department contained for the first time, a statistical analysis of its case load in terms of age groupings of the patients and the particular hospital unit to which the workers were attached. The reasons for this new classification were twofold. In the first place, President Hoover had called the White House Conference on Child Health and Protection, and the M. G. H. department, along with other medical social service departments, participated in a study in preparation for this conference. Each departmental head was asked for statistics on the type of hospital, number of admissions (total, and number of these who were children under fourteen years of age), number for whom case work was done, etc. It should also be noted that Miss Cannoh, chief of the M. G. H. department, had been appointed Chairman of a sub-committee of the section of the conference

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1 Supra. p.15

on medical social service. Thus, while we cannot claim that the M. G. H. Social Service Department by its statistical method actually determined that the conference should be concerned about a particular aspect of medical social work, we can say that it had a part in supplying material and some working principles for consideration by the conference. Similarly since Miss Cannon had such a strategic position in the conference itself, her department had a discernible influence on its deliberations.

The second reason for the change in statistical emphasis is to be found in the fact that new Old Age Assistance legislation was coming into effect on July 1, 1931, in Massachusetts. It was to have an important bearing on the welfare of hospital patients in the age groups over sixty years. In addition to this, information about the age groups of patients known to the Social Service Department was of interest in the light of growing concern about facilities for the care of patients with chronic disease.

In preparing for the White House Conference, the M. G. H. Social Service Department, was using statistical methods of research, one of the functions considered appropriate to the work of a medical social worker by the American Hospital Association in its 1923 report.[1] By 1933 therefore, we may say that while the Social Service Department at the M. G. H. continued to keep a statistical count of volume of work in terms of the number of patients it served, it had also developed more

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1 Supra. p. 23

flexible concepts for specific purposes. We may conclude that this department was reflecting its function in its statistical methods; that is, it was using its statistics for research purposes which had a direct bearing on community problems.

It is appropriate that we should at this stage try to discover what influence the 1930 study of functions had on the medical social work group as a whole, and particularly in the area of medical social statistics. Since this marks the beginning of a new phase in the history of medical social work, we shall proceed with this in the next chapter.

Chapter III

GROUP EFFORTS TO FORMULATE A SYSTEM OF MEDICAL SOCIAL STATISTICS AND CONTINUOUS EFFORTS BY INDIVIDUAL DEPARTMENTS TO IMPROVE ON THESE

It is significant for our study that the American Association of Hospital Social Workers should have published its first monograph on the subject of function in June of 1930 and that not until three years later was there any organized statement concerning medical social statistics. This does not mean that the Association was uninterested in the problem of statistical reporting but rather that establishment of any acceptable system was dependent upon a number of related factors. As early as 1922 the records committee of the Association was interested in the problem and in 1927 the North Atlantic District co-operated with the Russell Sage Foundation in a statistical reporting project and their experience contributed to the achievement of 1933. The first work on general reporting of medical social statistics was begun in 1928 when the American Association of Hospital Social Workers co-operated with a committee of the Association of Community Chests and Councils and the Local Community Research Committee of the University of Chicago in a social statistics project. In 1930 the project was taken over by the Children's Bureau in the United States Department of Labor, but it continued to have the support of the former joint committee. Both the Social Service Department of the

M. G. H., Boston, and that of the Johns Hopkins Hospital, Baltimore, were among the departments participating in experimental schedules of statistical reporting during the years 1931 and 1932. As a result of these experiments the joint committee of the American Association of Hospital Social Workers and the committee on registration of social statistics in the U. S. Children's Bureau adopted a plan of statistical reporting. A "Handbook on Statistical Reporting in the Field of Medical Social Service" was published in June, 1933. In the foreword to this we find the following explanation of the aim of the joint committee:

> .....(it was) to formulate a method of statistical recording in the field of medical social work that will enable those who use it to express numerically the volume of medical social work done. (And they add),.....any method of statistical recording must be adapted to the processes it is intended to measure, and must change as they change.[1]

It was recognized that since medical social work was still in the process of defining its function, methods of statistical recording should aim to keep pace with developments in this area. The importance of relating statistical methods to accepted standards of work was also stressed, particularly since statistical reports are generally used in the field of social work as a basis of inter-agency and inter-city comparisons and as a fund-raising tool by community and welfare federations. It is particularly valuable for this study to have the committee's statement of objectives of

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1 A Handbook on Statistical Reporting in the Field of Medical Social Service, United States Government Printing Offices Washington, 1933. p. vii.

statistical recording as a background not only for some observations on the results of their thinking but also as a comparison for later developments in the field. These objectives are as follows:

(1) To keep account of the volume of service rendered to patients by medical social service throughout the country.
(2) To show change in volume of service from time to time, i.e. month to month and year to year.
(3) To obtain facts of value in making comparisons, such as comparisons of the work of different social service departments and of medical social work with other social work activities.
(4) To yield facts of value in making decisions within the social service department and by the hospital administration.
(5) To furnish a means of interpreting the work to those who support it.[1]

The committee was fully aware that its decisions as to the best means of meeting these objectives might change as the functions of medical social work became more clearly defined and as the possibilities of qualitative statistical measurement of medical social case work were clarified. Indeed it frankly asked for such changes.

Because this first effort to guide departments of medical social service in their statistical reporting was so closely related to the work of several committees of the American Association of Hospital Social Workers we need not be surprised that in defining the field of medical social service they leaned heavily on the work of the committee on functions and referred many matters to it for further

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1 Ibid. p. vii.

consideration. As a result of this co-operation the field of medical social service is defined by the joint committee as follows:

> .....departments doing medical social examination and treatment in distinctly medical institutions or centers, and meeting the minimum standards adopted by the American Association of Hospital Social Workers.[1]

The minimum standards here referred to are, of course, those adopted by the Association in May, 1928.[2]

Since the terms 'medical social examination and treatment' are basic to an understanding of the 1933 plan, it is important for us to know what they meant to the committee. The definitions as formulated by the committee are as follows:

> A medical social examination is a study of the personality and environment of the patient in order to discover the social and psychological factors influencing the physical or mental health of the patient, social problems coexistent with the health condition, and to reveal both causes of the problems and the elements on which treatment may be built, when indicated. It is differentiated from the interview or inquiry that is primarily for the purpose of ascertaining the economic and medical eligibility of patients for clinic or hospital admission.
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> Medical social treatment is the attempt to carry into effect a plan whose purpose is the adjustment of the social problems of the patients as revealed by the medical and social examinations. Responsibility may be carried solely by the medical social workers or in co-operation with others.[3]

In order to meet its objectives, the committee established a Monthly Report Form to be used by departments of social service in the "metropolitan areas co-operating in the

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1 Ibid. p. 2.

2 Supra p. 25.

3 A Handbook etc. op. cit. p. 2.

Children's Bureau's social registration project."[1] The form itself consisted of six sections:

A. Patients given full social examination.
B. Patients under social treatment.
C. Patients receiving other recorded social services.
D. Admitting service.
E. Relief.
F. Staff.

Section A. was a count of all those patients whose social examinations were initiated during the month and of those whose social examinations were terminated and who were not accepted for social treatment. Section B. was a detailed account of the number of patients 'under treatment'.[2] It is sufficient for our purpose to note that in this section there was an opportunity to keep an accurate count of the number of patients for whom the department had assumed responsibility for case work activities - continued from the previous month, intake during the month (new, old, recurrent). Of this total, the number for whom some activity was undertaken during the month, and the number for whom some future activity was planned but for whom no contact was made during the current month were noted. A count was also made of those for whom social case work treatment was discontinued during the month and finally, of the number of patients for whom further case work treatment was planned in the coming month. Section C of the Monthly Report Form was a method of counting 'other recorded services' rendered i.e., services requiring case work techniques but not requiring

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1 Ibid. p. vi.

2 Ibid. pp. 7-10 for a complete explanation.

intensive social examination. These services might be worth recording for future contacts with the patient either in his medical record or in the social service department. It was made quite clear that the purpose of recording these 'other services' was not to account for the workers' time! For the purpose of obtaining a comparable count of these 'other services' they were classified under the following headings: interpretative, administrative, discharge, medical follow-up.[1] Patients already counted in A. or B. should not be counted in C. Section D. of the Monthly Report form was for the use of those institutions whose social service departments were responsible for handling all admissions to the hospital. Here a distinction was made in the count between patients interviewed for admission to the hospital and for admission to the out-patient service; a count of the number refused was also made. Patients counted in either of the previous sections might also be counted here. Section E. of the Monthly Report form was an account of the amount of relief given to patients, "when such relief is given from funds controlled by the medical social service department".[2] Section F. was a count of the staff of the department and included paid staff, workers-in-training and volunteers. This section was subdivided so as to show numbers of administrative workers, supervisors and case workers, clerical and all other. Of the workers-in-training and volunteers, an estimate of the total number of hours of

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1 Ibid. pp. 13, 14.

2 Ibid. p. 15.

service during the month was called for.

To obtain the information required on each Monthly Report form the committee recommended the use of daily tally sheets by each worker, a social treatment card for each patient under social treatment, and a statistical card for each patient. From the tally sheet the count required in Section A. of the Monthly Report could be obtained as well as the count for sections B., C., D., and E. It was hoped that by using the social treatment card "certain information concerning patients under social treatment would be tabulated from time to time" which would be valuable to the administration of the department. The committee also hoped that various social factors in cases requiring social treatment might be shown to be correlated. The statistical card for each patient under social examination or treatment as well as for those receiving other recorded services made it possible to have an accurate count of the number of individual patients receiving each type of service. A new card for each patient under social examination or treatment was to be made at the beginning of each calendar year. A card was also made for other subsequent patients served the first time during the year.

In sections A. and B. as we have seen, the basis of count for this plan was the patient who received case work service. It was assumed that social case records were kept which would demonstrate that medical social examination and treatment were being given according to the definitions. In section C. it was considered that social case work skills were employed but to a lesser degree, and that recording was not necessarily of

the same kind as that for patients in sections A. and B. There is a very marked relationship between this plan and the 1930 statement of the Committee on Functions. This is particularly evident in the latter's definitions of medical social examination and treatment which are reflective of the Committee's conclusions that there are three types of social factors with which it is appropriate for the medical social worker to be concerned:

> (1) Factors influencing the physical or mental health of the patient.
> (2) Social distress caused to others by the illness.
> (3) Problems coexistent with the health condition.... and plans for adjustment of these problems based on an understanding of the causes of the problems and of the elements on which treatment may be built.[1]

The Functions Committee recognized that while problems coexistent with the health problem might generally be considered the responsibility of the outside community, yet there would be occasions when the "best interests of the hospital and of the community might be served by having these activities directed by the hospital."[2] And, we might add, to say nothing of the best interests of the patient!

In its preliminary report of May, 1928, in Hospital Social Service the Functions Committee had emphasized the facts that medical social diagnosis is more than a medical plus a social diagnosis; that it should show the interaction between the medical and the social situation; and that only a diagnosis

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1 Functions of Hospital Social Service: A Report of the Committee on Functions, Chicago, American Association of Hospital Social Workers, 1930. p. 59.

2 Supra p. 27.

based on the joint thinking of the physician and of the medical social worker could be used as a basis for any medical social plan of treatment or 'prognosis'. Again, the Committee noted that in the past the medical social worker had been too concerned with enquiring into the social situation of the patient and reporting it to the physician; the result of this had been to leave the physician out of the planning. It was therefore pointed out that the worker and the physician should collaborate in making the medical social diagnosis and in establishing a goal for the patient, and that the social worker's function was to help the patient achieve this goal. In spite of these statements of principle, the 1933 plan for medical social statistical reporting placed insufficient emphasis on this fundamental process which we call the 'teamwork relationship' between physician and medical social worker. This relationship ought to permeate all medical social examination and treatment.

The 1933 plan for medical social statistics provided a record of volume of work on the basis of a distinction between medical social examination and medical social treatment. As we shall see this distinction was challenged later by those who tried to apply it. The plan also distinguished between those patients given "full, recorded social examination," those "under social treatment," and those "receiving other recorded social services". This division said, in effect, that those patients counted in sections A. and B. belong to one human subspecies and those patients counted in

section C. are another human subspecies when actually the individuals in all three groups are patients requiring the services of a case worker.

This plan fulfils the first purpose of social statistics, namely measurement of volume. It is not clear that it provided a means of securing statistics which could be socially useful. Although the committee had originally hoped that various social factors in cases requiring social treatment might be shown to be correlated, it did not explain how this method could be used to produce these results.

The conclusions about the 1933 plan for medical social statistical reporting therefore are that it did reflect the current concept of function but that it did not completely satisfy the philosophy of social statistics.

As might have been expected, the weaknesses of this plan became evident when it was put into practice. For some examples of these let us turn to the experiences of one department and then find out how the joint committee handled the problems which arose.

On page 34 of the Annual Report of the M. G. H. for 1934, we find that the Department of Social Service acted in accordance with the request of the American Association of Hospital Social Workers, and the Children's Bureau of the Department of Labor in using the approved method of medical social statistics during that year. In spite of this, however, the statistics are presented in the annual report, for the sake of comparison, on the same basis as in the previous year. That is, within the department itself the new method

was used, but in the annual report for the hospital the statistics appear in the same form as in the report for 1933. There is a comment in the report for 1934 concerning the new method which reads:

> We are working towards a more discriminating statistical accounting which will make it possible for us to compare data with other social service departments.[1]

One result of adopting the new method of statistical accounting was that, according to the new definitions, the total number of recorded patients was reduced in comparison with the total for the previous year.

In 1935, the Children's Bureau and the Committee on Statistics of the American Association of Medical Social Workers[2] decided to change the form of reporting. They believed that this would lead to more clear-cut definitions of the degree of intensiveness of treatment. It was assumed that recording was being done according to the recommendations of the Records Committee. It was also assumed that activities thus recorded were characteristic of those defined as appropriate by the Committee on Functions (1930) and the Committee on Standards of the A.A.M.S.W. (1936).[3] A bulletin issued by the Children's Bureau in 1937 outlines the new form hereafter referred to as Form H-4. After some experimentation by several departments the method was adopted by the joint committee. One of the departments participating in the experiments was that of

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1 Massachusetts General Hospital, Boston, Annual Report, 1934. p. 44.

2 The term 'Medical' had been substituted for 'Hospital' in 1934.

3 Infra p. 42.

the M. G. H. In the hospital's Annual Report for the year 1936 is a statistical analysis of its social service case load based on experimentation with Form H-4. The following exerpt from the report is a comment on the change:

> We no longer keep a permanent record of patients for whom arrangements are made for care by a visiting nurse, for transportation or of consultations that do not involve us in a case work plan for which we are responsible or for letters to school nurses or teachers.[1] (sic)

The H-4 Monthly Report form was comprised of three main sections:

A. Social Case Work.
B. Admitting Service During the Month.
C. Staff During the Month.

The most important change in the plan was the classification of four levels of case work. There was still a distinction between Medical Social Study and Treatment but the count for both was included in Section A. Medical Social Case work was defined as follows:

> Medical social casework may range from a simple and abbreviated process to a full and comprehensive one. Such considerations as the need in each individual case, the decision by the doctor and worker to treat all or part of the problems presented, the limitations set by the administration and the availability of community resources, determine the degree of service to be given.[2]

The members of the committee were convinced that it was important to distinguish between degrees of intensity of the case work offered. It was therefore agreed to recognize four levels of

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1 Massachusetts General Hospital, Boston, Annual Report, 1936. p. 43.

2 A Statement of Standards to be met by Medical Social Service Departments in Hospitals and Clinics. Report of the Committee on Standards adopted in May 1936. The American Association of Medical Social Workers, Chicago. p. 4.

social case work service. The first three were considered as medical social treatment and the fourth was considered social study only. Since this method of statistical reporting was designed to account only for those case work services which were recorded, it did not make provision for unrecorded services. It was a count of case work services and not of the workers' activities. This is a far cry from the days when medical social workers felt obliged to account for their time and a need to justify their existence.

For the purpose of clarity, we ought to take note of the fact that the above-mentioned terms medical social study and treatment were re-defined by the committee. In an effort to make them clearer and simpler the Form H-4 states them in these terms:

> Medical social treatment is the process of attaining the medical-social objectives formulated in collaboration with the physician and the patient. Treatment will be based upon social study of the personality and environment of the patient in relation to his illness. A full social study (social examination) should reveal the social and psychological factors influencing the physical and mental health of the patient. Social problems coexistent with the health conditions may also be discovered.[1]

Now let us examine each section of Form H-4 in detail.

Section A. Social Case Work: the four levels of case work are defined as follows:

> Group I.
> Patients who are receiving full social study and treatment, those with complex medical social problems. A longer time for each is usually required because of

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1 Form H-4 Social Statistics, U. S. Department of Labor, Children's Bureau, Washington, 1937. p. 2.

the nature of the problems but occasionally such intensive study and treatment may be accomplished in a short time.

Group II.

Patients receiving less comprehensive social study and treatment than those in Group I. This may be due to the fact that the medical social problem is simpler or that only part of the problem is being treated. The process may require a long or a short period of time. The degree of intensiveness of the treatment should determine the classification not the length of time the case is under care.

Group III.

Patients who received during the month only a limited social case work service. The service must be recorded and must have involved some medical social study.

Group IV.

Patients accepted for social study but for whom no treatment is planned. Social study may be "full social study" as defined above or it may be just an inquiry as to whether 'further medical social casework is needed'. Only terminated cases are to be counted in Group IV.[1]

As in the earlier plan (1933) an account was kept of the cases under treatment who were being served co-operatively, of the total number of persons currently being served or for whom some future service was being planned, of discharges and the total number of cases to be carried over to the next month.

Section B. Admitting Service: again reports were requested from those departments which had members assigned to the admitting service of the hospital. The count was again based on the distinction between applicants for admission to the clinic service and applicants for admission to the in-

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1 Ibid. pp. 2, 3.

patient service. Information was requested as to how many of each group were refused admission.

Section C. Staff: the count of staff during the month included both full and part-time workers, staff-in-training (students receiving school credit) and volunteers.

The reporting of relief expenditures by social service departments under the 1933 plan of reporting had been unsatisfactory. It was decided to discontinue the attempt to make these comparisons in the Form H-4 plan.

The only reference made to "other services" is this comment "if many services other than casework services are given by the department they should be summarized in a footnote."[1]

In order to obtain the necessary information for each section of the H-4 Monthly Report, daily tally sheets and statistical cards were recommended for use by the workers.

The most significant thing about this new type of medical social statistical reporting is its emphasis on the quality of treatment as indicated by the four levels of treatment, rather than on length of time under care or in terms of services rendered to patients. This bears a direct relationship to the thinking of the leaders of the profession in regard to its function. That is, by confining its count of "cases" to those patients receiving services which are defined as appropriate to the activities of a medical social worker, it was hoped that workers would be made increasingly

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1 Ibid. p. 1.

aware of the need to be selective when they used the term "medical social case work" and hence more conscious of their function as caseworkers in the medical setting. It also seems significant that whereas the 1933 plan in its definition of medical social treatment emphasized that the plan for this was based on the medical and social examination, the 1937 scheme went even farther and stated, that the doctor and the patient have a part in making the medical social plan as well as the medical social worker. Something new had been added to the definition of medical social casework. Perhaps this emphasis on co-operative planning had been assumed to be basic in the previous statistical plan. Yet one cannot help feeling that the explicit statement reveals a growing recognition of the importance of the concept of 'teamwork' between physician and social worker in collaboration with the patient.

It is the writer's belief that the committee responsible for this method was consciously trying to make it reflect current concepts of function in medical social work. One may here refer to the study made by Miss Bartlett[1] in which she emphasized the importance of each of these factors, teamwork of physician and social worker, and selectivity or awareness of the appropriateness of an activity in the light of the setting, the patient's needs and the hospital's responsibility.

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1 Harriett M. Bartlett. Medical Social Work: A Study of Current Aims and Methods in Medical Social Work. Chicago, Amer. Assoc. of Med. Soc. Work., 1934.

When the Form H-4 had been tried on an experimental basis for the first quarter of the year 1936 at the M. G. H., Mrs. Helen Field made a study of its use by six workers in the department.[1] She pointed out that the method of classifying casework as recommended in Form H-4 tended to obscure the patient and to emphasize medical social casework:

> Is it of significance that the phrase "classification of patients" tends to obscure the actual process of classification upon which judgment is brought to bear but practise in classifying leads one to feel that the medical social case in its totality, rather than the patient is the subject of classification.[2]

Mrs. Field's conclusion was that the medical social case work process is a valid basic unit for statistical reporting by medical social departments and that as a measurement of social case work this method stands. However, she did point out that monthly classification according to these levels may be too hasty to give a true picture of the level in which a particular case is to be classified. She suggested waiting until after a case had been open for two months.

Mrs. Field's study was followed by discussion within the department which emphasized the difficulties of premature classification and the complexity of the system with its wide variety in interpretation of the classes. A great need was felt for a clearer definition of the purposes of keeping statistics and for a method more closely related to these

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1 Helen Field. A Study of the 1936 Statistical Classification of Social Case Work Activities as applied to the case work loads of six workers of the Massachusetts General Hospital during the First Quarter of 1936. Unpublished research project, Massachusetts General Hospital, Boston.

2 Ibid. pp. 1, 2.

purposes. The department continued to use Form H-4 in 1937 but in 1938 its statistics were presented with the following note:

> The method of statistical count of service rendered in the department is always a problem. Each year sees a step toward a more discriminating unit of count. However, the many types of service we are called upon to render do not all lend themselves to statistical measure. The statistical table that follows differs from that of 1937. The unit of count of social case work is on a new basis of analysis. There are more services which have been unrecorded.[1]

In a bulletin issued by the Chief of Social Service to the M. G. H. department in December, 1937, Form H-4 is set aside and instead, the method of statistical reporting which was to be used in the coming year is described as follows:

> We decided to discard the plan of monthly statistical reporting to the Children's Bureau which has been carried on for three years. Our reason for this was that we are convinced that this scheme tended to confusion of thinking, diversity of interpretation and did not clarify conception of function. We shall therefore, have a new plan for 1938 which reflects both our own ideas of a more reasonable counting and the trend of ideas of the National Committee on Statistics.[2]

This new plan called for the use of "Intake Blanks" by each worker on which she entered, in chronological order, the names and identifying information, diagnosis and reason for referral of each patient. From these referrals the worker was to:

> .....accept or reject patients as suitable for service permanently recorded. Only patients for whom service is <u>permanently recorded</u> will be the basis of the statistical count.[3]

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1 <u>Massachusetts General Hospital, Boston, Annual Report, 1938</u>. p. 46.

2 Massachusetts General Hospital, Social Service Department. Bulletin to the Staff, December 29, 1937.

3 Ibid. p. 1.

All permanent recording might be in either of three forms: (a) case work record in a folder; (b) a social summary on the medical record or (c) a briefer record on the regulation card. The following definitions were used as a guide:

> Medical social casework is joint consideration by a medical social case worker and a patient of his situation in which they seek: 1. to determine whether or not he has needs or problems related to his illness, for which he will accept help from the worker, and 2. to modify the situation (which includes people) in the direction of the most constructive adjustment within the limits of the reality situation.[1]

In order to qualify as medical social case work all of the following criteria must appear in some degree:

1. A patient under care for an illness, with problems (potential or realized), related to his illness, which are of significance to him.
2. A relationship of acceptance and understanding between the patient and the worker.
3. A period (varying upward from the length of one interview) during which the worker reaches some conclusions first, about the patient's need of case work, and second, about his willingness and ability to use such service.
4. A growing depth and breadth of understanding during the 'under care' period, reached by consideration of
   a. the patient's own attitudes, desires and capacities
   b. his social relationships (both intimate interactions and broader problems of social status)
   c. the physical environment and material factors (food, shelter, etc.)
5. An opportunity for the patient to gain
   a. increased self-understanding and acceptance and ability to deal with his own problem, or
   b. help in adjusting the situation to his limitations.[2]

A count was to be kept of those patients appearing on the

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1 Ibid. p. 2. In this material where the word 'patient' is used it is to be interpreted to mean responsible member of the patient group (a member of the patient's family or one of his associates with whom plans are being made) when the patient is irresponsible because of illness, incapacity or youth.

2 Ibid. p. 2.

Intake Blanks not counted as cases. While they might be helped to meet medical recommendations, the service rendered was of a simple type not requiring the degree of study implied by item 3. above. No permanent record of this kind of service was to be made, except perhaps a note in the medical record.

The 1938 plan for statistical reporting of medical social service at the M. G. H. was composed of two major sections. Section A. was an analysis in six parts, of all patients accepted:

1. those for whom service was initiated that month - new, old or recurrent.
2. those patients for whom service was continued from the previous month.
3. the total served that month (1 and 2).
4. the number discharged.
5. the number carried over to the next month.
6. an analysis of all discharged or closed records (that month) according to: a. the number who received medical social casework (which met all of the above-described criteria) and b. the number who received medical social casework service (which met 1. and 3. of the criteria but lacked one or more of the remaining items).

Section B. was a count of patients defined above as 'no case count' showing the number served for the first time during the current year and the total receiving service that month.

A comparison of the 1937 Children's Bureau plan with that

of the M. G. H. Social Service Department is in order at this point. One important difference between these plans is that whereas the Children's Bureau plan recognized that the doctor and the patient have a place in formulating the basis for medical social treatment, the M. G. H. plan omitted from its definition of medical social casework any mention of the part that the doctor might play in planning medical social treatment! Anyone who did not know how very basic this concept of co-operative planning always has been to the development of medical social work at the M. G. H., might be led to believe that the medical social workers there were reverting to the days when they functioned in their own little corner 'by permission' and almost 'in spite of' the doctors. The writer is inclined to believe that co-operative planning between physician and social worker had always been so much a part of that department's work that it was taken for granted that it would continue to be so.

There are two striking facts about the M. G. H. plan. One is the great emphasis on the worker-patient relationship, in understanding and trying to cope with problems related to the illness, with particular stress on the right of the patient to determine whether he wished to use the treatment offered. The other important point is that by waiting until cases were closed before deciding what level of casework had been given, it became possible to obtain a much more accurate estimate of the amount of intensive work given by the department than had been obtained by the 1937 Children's Bureau plan. It also seems as if, under the latter plan, once a

service had been classified there would have been a tendency for the worker to try to mould her 'case' to fit the classification, otherwise changes in classification would have been necessary. Meanwhile, both plans reflect the statement of the Committee on Standards of 1936 that medical social casework may range from a simple and abbreviated process to a full and comprehensive one.

By December 1938, the Committee on Statistics of the American Association of Medical Social Workers had concluded that there were some serious omissions engendered by making a distinction between brief and intensive cases. These omissions prevented the accomplishment of one of the original purposes of the association in medical social statistical reporting, i.e. 'to keep account of volume'[1]. The Bulletin of the American Association of Medical Social Workers published in January 1939, contains the report of the committee in which the use of a revised H-4 was proposed.[2] It was believed that this would better accomplish the original objectives already set forth and still considered appropriate:

1. To keep account of volume of service rendered to patients by medical social service throughout the country.
2. To show change in volume of service from time to to time; i.e. month to month and year to year.
3. To obtain facts of value in making comparisons, such as comparisons of the work of different social service departments and of medical social

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1 A Handbook etc. op. cit. p. vii.

2 Bulletin of the American Association of Medical Social Workers, Chicago; Vol. 12. No. 1. "A Report of the Committee on Statistics, December 1938". p. 1.

work with other social work activities.
4. To yield facts of value in making decisions within the social service department, and by the hospital administration.
5. To furnish a means of interpreting the work to those who support it.[1]

It was proposed that the revised H-4 would use 'patients served' as the basis of count of volume of work. The following definition of this new term was suggested:

> A patient has been served when there has been individualization of the interrelationship of the medical and social factors in the situation. Routine unskilled or clerical services should not be counted as medical social service.[2]

This definition made it no longer necessary to distinguish between brief and intensive cases and at the same time broadened the count of volume of work so as to include some patients who had heretofore not been included as part of that total. In the report of the committee it is clear that it did not wish to be interpreted as implying that casework is not the primary function of medical social work but rather, that it is attempting to measure volume of service rendered. It is important for this study that the committee made special note of the fact that it saw its function as "providing the means for reflecting practice, rather than attempting to mould practice, through statistical measurement.[3]

Apropos of the 1937 attempt to define levels of treat-

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1 A Handbook etc. op. cit. p. vii.

2 Bulletin of the American Association of Medical Social Workers, op. cit. p. 4.

3 Ibid. p. 4.

ment according to degree of intensiveness, the Committee on Statistics of the A.A.M.S.W. concluded that, in reality, we do not have four distinct types or levels of case work which can be accurately identified and reported. And when these categories were used it was often necessary to reclassify cases which had been wrongly classified at the time of opening. It was decided that the logical time, if any, in which to classify a case is upon completion of the case when an evaluation of the finished piece of work would be part of the classification process. But because of the lack of authoritative criteria for evaluation, it was decided to omit classification from the revised form. In order to aid in the establishment of criteria for case measurement, the Committee on Statistics provided a tentative outline (Section A.4) on which to base an analysis of total closed cases. While this was not an accepted part of the monthly report form, it was put forth for those who wished to use it and it is of interest here only as it relates to the concept of function. The monthly report form as proposed by the committee and known as Revised H-4 comprised three sections:

A. Patients Served:
   1. Continued from previous month . . . . . .
   2. Accepted for service during the month . . . . .
      a. individuals not previously reported during calendar year . . . . . .
      b. individuals previously reported during calendar year . . . . . .
   3. Total during month (1 plus 2). . . . . .
   4. Discharged from service during the month . . .
   5. Continued to following month (3 minus 4) . . .

B. Social Admitting Service during month:	In (patients)	Out
6. Applicants interviewed for admission: Total. . . .		
a. accepted		
b. not accepted		

7. Patients under care re-interviewed regarding eligibility or rate: Total . . . . . .
   a. continued under care. . . . . .
   b. not continued under care. . . . . .

C. Staff during month:	Number	
	Full time	Part time
8. Executives and Supervisors		
9. Case workers: Total.		
a. assigned to in-patient and clinic services. . .		
b. assigned to admitting service		
10. Students		
a. assigned to in-patient and clinic services. . .		
b. assigned to admitting service		

The plan for classifying closed cases i.e. section A.4 provided for a subdivision of this section into two groups:

4. Discharged from service during month: Total. . . .
   a. Classification A. . . . . .
   b. All others B (4-4a) . . . . . .

Classification A was to include those patients to whom the medical social worker had attempted to offer medical social treatment whose problems result from the interrelationship of medical and social factors in the area of the patient's illness; and that these factors are of real or potential significance to the patient.[1]

The description of this group points out that the aim of the social worker is to assist the patient or patient group either by helping him to

> gain increased self-understanding and ability to deal with his problems; by giving help in realizing his full capacity; or more directly, by bringing back to the medical staff an awareness and an understanding of the social situation.[2]

The processes by which social case work is accomplished are further defined as including: (1) a study of the patient and his social situation: (2) an evaluation of the significant

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1 Ibid. p. 6.

2 Ibid. p. 6.

social factors....to determine needs and problems "for which he desires and will accept help from the worker"; (3) social treatment when indicated. These elements occur continuously throughout the period that the patient is receiving care and do not take place in any sequence. The whole process implies that

> a relationship of understanding and acceptance existed between patient and worker....that the worker's whole approach was one which made it possible for a person to reveal his problem and to accept help with it. The social case record (whether or not it is a part of the medical record) demonstrates the above characteristics of the cases of this group.[1]

These criteria, incidentally, although unpublished, were the work of the American Association of Medical Social Workers Committee on Functions. Here again we have evidence for stating that medical social workers have tried to reflect the thinking of the professional group in their method of statistical reporting. In order to facilitate accuracy in counting, a daily tally sheet and a statistical card for each patient accepted for service were recommended.

There are some omissions from this report form which the committee believed were in the interests of simplicity but which it recognized might have to be compensated for by individual departments. In the first place, the committee recognized that the revised form H-4 did not account for all patients served by a department but believed that the definition of patients to be counted was broad enough to provide a significant and valid national picture. No separate record

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1 Ibid. pp. 6, 7. (quoted in)

was required of cases carried co-operatively with other social agencies nor of intra-department transfers.

In the Bulletin of the American Association of Medical Social Workers already referred to, considerable discussion is given over to explaining the attitude of the Committee on Statistics to the change from the 1937 emphasis on case work service to patients to a broader type of volume count. The Functions Committee had already decided that

> the essential characteristics of the so-called 'brief and intensive' cases appear to be the same, and that any dividing line between the two probably is arbitrary.[1]

The only help that the Functions Committee could give when the Committee on Statistics raised the question of 'other services' was to say that it had not studied the question! It was the feeling of the Committee on Statistics that the previous plan of reporting had not given a true picture of the total volume of patients served. Therefore, the definition stated above[2] was chosen in the hope that it would include both the medical social casework services which met the requirements of the criteria and the large group of 'other services' which the study of actual practice showed to represent a large proportion of the work of medical social service departments.

If we now compare Revised H-4 with the method adopted by the Social Service Department of the M. G. H. in December 1937, we are immediately impressed with the similarity in two

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1 Ibid. p. 2.

2 Supra, p. 53.

areas. First, the criteria of medical social casework adopted by the M. G. H. department and that of the Committee on Functions, and used in Revised H-4 in its Classification A. are identical. And second, the M. G. H. plan recognized that medical social examination and treatment cannot be two distinctly separate activities of a medical social worker. Thus, in discarding the 1937 Children's Bureau plan, the earlier (1933) belief was substituted, i.e. that patients receiving 'other recorded social services' should appear in a statistical analysis of a department's work. The 1939 Revised Form H-4 also returned to the earlier plan, but it did not ask departments to show a distinction in their statistics between those 'cases' which met the criteria and those otherwise served. It was the belief of the committee that such a distinction was splitting hairs and therefore the unit of count chosen was 'patient served'.

When we attempt to evaluate the 1939 Revised Form-H-4 in the light of current concepts of function, we must recall that Miss Bartlett's study of 1934 was the latest 'Functions Study' available, that the committee which revised H-4 believed that the original objectives of 1933 were still valid and that the concept of the right of the individual patient to decide whether or not he would accept the service offered was just beginning to permeate the whole field of social work. Measured against our original premise that social statistics have a dual purpose, i.e. measurement of volume, and social usefulness, the 1939 plan seems to accomplish the former but there is little evidence that it made any unique contribution

to social research. Thus, while we may conclude that the 1939 plan more accurately measures volume of patients offered service by a medical social service department than any other plan hitherto established, we must look beyond 1939 for a new method of statistical reporting which will fulfil the other purpose. Since the year 1939 was the last year in which the American Association of Medical Social Workers had a committee on statistics, we would therefore expect that information about further developments would have to be sought in individual departments. In the next chapter we shall study the accomplishments in the field of medical social statistical reporting in two centres of medical social work, namely New York City and Boston.

CHAPTER IV

GROUP INTEREST DECLINES AND EXPERIMENTATION BY DEPARTMENTS CONTINUES

In the preceding chapter the work of the American Association of Medical Social Workers Committee on Statistics has been traced from 1933 to 1939. From that time to the time of writing (1948) there has been no Committee on Statistics in the Association. But this does not mean that there have been no further developments in the field of medical social statistical reporting. It does mean that for evidence of further developments we must turn to the work of a particular department and of a group of departments. In this chapter it is our purpose to continue our study of methods used at the M. G. H. during the period 1939 to 1944 and to study a method of medical social statistical reporting developed by some hospitals in New York City in 1943. These methods will be evaluated against current concepts of function and against our original statement concerning the purposes of medical social statistics.

At the M. G. H. the plan devised in that hospital in 1936 was continued in 1939 with the exception that they no longer tried to classify closed records according to the criteria which the department had established in 1938 but only a total count of closed cases was kept. Beginning in January 1940, the Chief of Social Service issued instructions to her staff concerning the use of Revised H-4. In this she comments:

> .....we are again to comply with the request of the Boston Council of Social Agencies by joining the other Social Service Departments in reporting our monthly statistics to the Federal Children's Bureau. The American Association of Medical Social Workers and the Children's Bureau have now agreed on a simplified form much like the one we used in 1939.[1]

Revised H-4 was used by this department for the ensuing year but in 1941, for the sake of having a clearer picture of comparative case loads as between workers and between clinics and services, the term 'Active' and 'Inactive' of total patients served and 'Transfers' to and from workers were added to the Monthly Report Form. In the year 1942 an item 'Medical Relief' appears in the annual report but it was omitted in the following years' reports. Meanwhile, in order to facilitate annual comparisons, the department continued to present its statistics in the hospital's annual report in the same form as was begun in 1938.

Although the American Association of Medical Social Workers had no active committee on statistics, the Committee on Functions did continue to try to define the purposes and methods of case work in a medical setting. It was this committee's material which was used as the basis for the book "Some Aspects of Social Casework in a Medical Setting" by Harriett Bartlett, which was published in 1940. She concluded that social casework is the central function of a social service department and that this is determined by the case-worker's ability to relate to the patient's needs and to the

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1 Massachusetts General Hospital, Social Service Department, Instructions on Statistics for 1940.

setting. She stressed the fact that it is the social worker's concept of social casework, its approach and methods and her ability to adhere to these which establishes the focus. Reflective of this emphasis, is the "Statement of Standards to be Met by Medical Social Service Departments in Hospitals and Clinics" adopted in May, 1936, revised in June, 1940, and published in its revised form by the American Association of Medical Social Workers in 1941. We read therein that:

> Medical Social Service has been developed in the hospital as a service to the patient, the physician, the hospital administration and the community, in order to help meet the problem of the patient whose medical need may be aggravated by social factors and who therefore may require social treatment which is based on his medical condition and care.[1]

Further, they define function as:

> 1. Practice of medical social case work.
> 2. Development of the medical social program within the medical institution.
> 3. Participation in the development of social and health programs in the community.
> 4. Participation in the educational program for professional personnel.
> 5. Medical social research.....[2]

And with regard to statistical reporting:

> .....The social service department should keep a statistical count of its recorded cases. For this there is strongly advised the plan outlined by the Committee on Statistics of the A.A.M.S.W. and the U. S. Children's Bureau. Other statistical material may be added in accordance with the special interests of the individual institution of which the social service department is a part.[3]

In its definition of medical social case work the preliminary

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1 A Statement of Standards etc., op. cit. p. 3.

2 Ibid. p. 4.

3 Ibid. pp. 4, 5.

reads:

> Medical social casework involves a study of the individual patient's social situation, interests and needs in relation to his illness, and the medical social treatment of the patient in collaboration with him and his physician, when those social needs and interests affect the physical and mental health of the patient.[1]

As we have seen, these statements did not alter the Revised H-4 because, while they appear in the revised edition of the "Standards", they are identical with the definitions in the 1936 "Statement of Standards". The only change made in the 1941 edition is the definition of Social Admitting which was made with the approval of the Committee on Functions. This reads as follows:

> The admission of patients to the in-patient or out-patient department of a hospital may be considered social admitting if:
> (a) the administrative policies of the institution permit reasonable exercise of medical social decision.
> (b) there is a study of the individual patient and his problem in relation to his medical social need.
> (c) this study is regarded as a first step in securing for the patient the medical social treatment which his total situation may necessitate.
>
> It seems increasingly evident that these last two points can be more adequately fostered and maintained if social admitting like social review and follow-up, is practised under the auspices of the social service department.[2]

Since these two studies referred to above were the most recent statements in the period under our present study, with regard to the Association's definition of Function, they remain for us a basis for evaluating ensuing schemes.

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1 Ibid. p. 4.

2 Ibid. p. 5.

It is now appropriate for us to turn to the work of a group of hospitals in New York City which we have chosen as an example of experimentation in the field of medical social statistical reporting. In 1943, in the hope of improving on the Children's Bureau plan for medical social statistics, the first use was made of a new method which had been developed as a joint project of the United Hospital Fund of New York and the Russell Sage Foundation's Department of Statistics. This project was undertaken at the request of the United Hospital Fund

> .....because it had not be successful in obtaining statistics of medical social work from the departments in hospitals served by the Fund.[1]

Concerning the purpose of the plan Dr. Hurlin has said:

> The purpose of the plan is to obtain measurement of the volume of casework service given by medical social work staffs without respect to its quality.[2]

And in an official statement regarding the purpose of the plan Dr. Hurlin says:

> It should be noted especially that the statistics are intended to relate only to the social casework of the respective medical social work departments rather than to the entire activity of their staffs.[3]

By definition, social casework is:

> Work performed by a social worker in which attention is given to a problem of a client for the purpose of assisting in solving it. The definition excludes activity that does not have the specific purpose of

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1 Letter to the writer from Dr. Ralph G. Hurlin, Director, Russell Sage Foundation, Department of Statistics, March 7, 1946.

2 Letter from Dr. Hurlin, June 19, 1944.

3 Statistics of Medical Social Casework in New York City, 1944. By Ralph G. Hurlin, Russell Sage Foundation, New York, 1945. p. 4.

> assisting in the solution of a problem of a particular client. Among services excluded are those that relate to the administration of the hospital or clinic such as the general management of a clinic, the keeping of clinic reports, the routine follow-up of patients for clinic attendance, and hospital or clinic admitting service.[1]

There are in this system two units of count: "case of service" or "the person in whose interest the work is done", and "casework interview" on cases receiving casework service. The casework interview is

> a personal contact by a qualified social worker with a person not a member of the casework staff, for the purpose of providing casework service.[2]

Routine interviews in order to ascertain whether a patient has a problem requiring social case work are not counted as "casework interviews" unless a problem is found and work initiated on it. Thus we have a new emphasis upon one of the techniques of social case work, perhaps the most used technique, for special count. This emphasis on the case work interview was believed by the committee to be an important index to the volume of medical social casework which had hitherto been overlooked.

> A "case of service" is counted when "the worker attempts to aid in coping with the problem of a patient, irrespective of the number of contacts that she anticipated, of the completeness of the service, or the probability of a positive result.[3]

The method is based on data accumulated by each worker on a daily tally sheet and at the end of the month reported by

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1 Ibid. pp. 4, 5.

2 Letter from Dr. Hurlin, June 1944.

3 Statistics of Medical Social Casework, op. cit. p. 5.

each department on a statistical form to the office of the United Hospital Fund. The Russell Sage Foundation makes monthly and annual analyses of the date reported by the Fund. The Monthly Statistical Form is comprised of four sections:

1. Cases receiving casework service;
2. Social service staff;
3. Casework interviews on cases receiving casework service;
4. Other interviews.

In order to obtain the required information three types of statistical forms are recommended for use by each case worker: 1. the medical social casework daily record; 2. the index card for alphabetical reference files; 3. the statistical case card. Within the category of "cases" a distinction is made between "Immediate Service Only" cases - "casework service given in an initial interview without plan on the part of the worker for any continuation of the service" and "Continued Responsibility" cases - "a person served in a first interview for whom the worker plans further casework service." Thus it is possible to compare the ratios of "Immediate Service" cases and "Continued Responsibility" cases to the total monthly caseload. The movement of caseloads of each worker is readily indicated and the movement of caseload for the department as a whole may be followed. This is a less simple form than that devised by the Children's Bureau but it serves a dual purpose of being useful to each department internally as well as to the Fund for inter-department comparisons.

The information acquired in Section 3. provides an index to the amount of interviewing and the proportion of this which is done by the worker with the patient or patient group, with the physician, with another social agency or with anyone else involved in the social casework plan. It also shows what proportion of interviewing is done by telephone. Section 4. makes it possible to compare the number of interviews held on cases receiving casework service with those on 'not counted cases' such as medical research, hospital admitting, etc. While this type of information may be useful locally for purposes of interpretation, community fund-raising, etc., it is difficult to understand what value it would have if the plan were used on a wider basis. Surely we have passed the era when it was of national significance to know what proportion of medical social casework interviewing was being done by telephone or by workers outside the office, in another agency's office, etc.

There is one basic criticism of the joint effort of the United Hospital Fund and the Russell Sage Foundation. We refer particularly to the definition of social casework therein used:

> Social casework is individualized study or treatment by a social worker of a problem affecting the well-being of a particular person for the purpose of assisting in solving the problem.[1]

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1 Ibid. p. 17.

Our criticism of this definition rests on the fact that it is not a definition of medical social casework. It completely overlooks the fact that social casework in a medical setting is influenced by that setting. In the first place, it ignores the fact that medical social work imposes on the caseworker the obligation to work within the framework of a medical institution, and under the leadership of a member of the medical profession. The social caseworker who can accept these facts sees them as strengths rather than as limitations and is enabled thereby to focus on her function as a medical social worker. The social caseworker who cannot accept them is so irked by these restrictions that she becomes full of anxieties about her own status as a professional person and impatient with regulations which, to her, seem meaningless and sometimes even contrary to her philosophy as a caseworker. In the second place, if medical social statistics are to measure volume of medical social case work, the definition ought to have indicated the particular focus of medical social work, i.e. "the patient whose medical need may be aggravated by social factors and who therefore may require social treatment which is based on his medical condition."[1] Miss Bartlett's study has shown clearly that the central focus of a medical social worker is social case work but that the setting requires

> .....additional qualities and capacities which have to do particularly with success in establishing and

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1 A Statement of Standards, op. cit. p. 3.

> maintaining a consistent focus within the realities of a medical setting.[1]

According to the definition of the United Hospital Fund plan we may imagine the medical social worker engaging in casework on any problem affecting her patients regardless of whether it has any direct bearing on the medical problem or its treatment. Because of its failure to be specific, this definition might lead one to believe that medical social workers perform the functions usually ascribed to family caseworkers, children's protection workers, child placement agencies, etc. Let us grant that case work is case work wherever it is performed and that the generic basis underlying all case work is fundamental to medical, psychiatric, child welfare, etc. Yet if we are going to try to measure the volume of case work done in a particular setting, that setting sets certain limits to the casework practised therein, and statistics of such case-work must be based on a clear definition of what it is we are measuring.

As we have seen, the 1936 "Statement of Standards" contained a definition of medical social case work which, in 1944 was still used by the American Association of Medical Social Workers. This definition [2] emphasized the fact that the focus of a medical social caseworker was on the illness situation and that medical social treatment was carried out "in collaboration with him (the patient) and his physician". It is the writer's belief that this definition of medical social case work is more specific than that of the United Hospital

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1 H. M. Bartlett, Some Aspects of Social Casework in a Medical Setting. Chicago, 1940. pp. 256, 257.

2 Supra p. 64.

Fund. If we accept the A.A.M.S.W. definition of function it follows, that the United Hospital Fund method of medical social statistics is not a reflection of function as we conceive it. On the other hand, if we accept the United Hospital Fund definition of social casework we can say that this plan does measure volume of social cases.

The United Hospital Fund method does not attempt to show volume of patients served who are "not counted as cases" although it does recognize that these "other services" are an element in the work of the medical social worker when it asks for a count of interviews on "not made cases". Since these are not considered casework interviews why count them at all, if the statistics are "intended to relate only to the social casework of the ... departments rather than to the entire activity of their staffs."[1] If these are included in the statistics in order to have some idea of the proportion of caseworkers' time being used for "other interviews" why was there no provision made for measuring the amount of time each consumed? The length of an interview may be only a matter of a few minutes or as much as an hour or more, therefore we consider a mere count of interviews has little significance.

Again, we have concluded that the 1941 revised standards is an acceptable criterion against which to measure the extent to which medical social statistics reflect function. In a statistical report, we therefore would look for some reference to Social Admitting. In its definition of social casework, the

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1 Statistics of Medical Social Casework, op. cit. p. 4.

United Hospital Fund excludes "hospital or clinic admitting service."

Admittedly the plan was still experimental and at the time the 1944 report was made some weaknesses had already become evident. Referring to our letter from Dr. Hurlin of March, 1946, we find that he considered that this method had done a great deal to focus attention

> .....both within the medical social work departments and elsewhere in the hospitals on the central function of medical social casework.....Probably the weakest point in the plan is its failure to insure comparability in identifying cases of slight service. This results in an important amount of incomparability in count. Our use of the 'immediate service only' category has not been successful, since some of the agencies definitely ignore its definition. I am convinced however, that some division of the case count is desirable, for internal use, even if it is not made uniformly by all participating agencies. If the same differentiation is not made by all of the agencies, however, we should of course, discontinue publication of the divided figures.

The writer's own impression, after having used this method of statistical measurement at the Royal Victoria Hospital, Montreal, for nearly two years, is that there is little to be gained by using this distinction between single interview cases and those for which longer service is planned. Dr. Hurlin's letter implies that the "immediate service only" case was a case of "slight service only". But, as every case-worker knows, a single interview may be a major service. The term "slight service" seems to belittle the quality of work involved, and if so, it is a negation of the original purpose of the plan "to obtain measurement of the volume of casework service...without respect to its quality." On the other hand, there are "cases" in which a service is offered and used which

may be terminated within a brief span of time but which could not be classified on either the basis of length of treatment or quality of service until terminated. This brings us back to the 1939 Revised H-4 and its optional classification of cases closed during the current month. But until there are some well-established criteria for classifying casework, we do not believe it worthwhile to subdivide total cases when volume of casework service is to be measured.

The writer's experience with the United Hospital Fund plan has also convinced her that the use of 'casework interview' as a unit of count for statistical reporting is of little practical value. Surely we can assume that social casework interviewing is taking place wherever casework is being practised. By this time medical social workers are making a unique contribution in the field of social work and it is the writer's belief that medical social statistics could enable them further to do so. Because of their focus on the ill person, medical social workers are in a position to learn what illness means to many types of people. The medical social worker, in collaboration with physician and patient, ought to be able to demonstrate what relationship, if any, exists between particular illnesses and concomitant social factors; medical social workers ought to be able to show scientifically the role of social and emotional factors in illness. Because of their close association with the medical profession, medical social workers can produce material reflective of this relationship which will contribute to a deeper understanding of the needs of people who seek help from a medical centre.

On the whole, if we compare the relative merits of the Revised H-4 and the United Hospital Fund forms against the Standards Committee's definition of Function, our conclusion is this. The Revised H-4 gives the better reflection of volume of medical social case work. Each plan might aid in the "development of the medical social program within the medical institution" by making it possible to compare ratios of case loads to numbers of workers and movement of case loads so as to gauge assignments, staff changes, etc. But neither plan succeeds in being a clear reflection of function in medical social work.

We have seen how, since 1930, the Children's Bureau of the United States Department of Labor carried responsibility for collecting and analyzing data on medical social statistics from those areas participating in the scheme. As of June 30, 1945, this responsibility was terminated "because of inability to obtain increased funds for strengthening and expanding the program".[1] At this time it was decided by the Community Chests and Councils Inc., that they would continue the Social Statistics Project and henceforth local supervisors in the Chest or Council have been collecting the data and sending an annual summary of the key items on each report form (Revised H-4) to the above-mentioned agency.

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1 "Children's Bureau Terminates Responsibility for Social-Statistics Project". The Child. Children's Bureau, Unived States Department of Labor. Vol. 10, No. 1, July 1945. p. 10.

> For the medical social service field we receive a summary of the patients accepted for service during the month and the patients served during the month. Additional information is available in the office of the local supervisor and may be obtained upon request.[1]

At the time this letter was written it was not known how many of the forty-three cities participating in the Social Statistics Project would report statistics for the medical social field since many did not have organized medical social service departments.

We cannot expect Community Chests and Councils to hold themselves responsible for stimulating the thinking of medical social workers who form only a small part of the social work group. It seems unfortunate, therefore, that there has been no further attempt on the part of the American Association of Medical Social Workers to sponsor a project in medical social statistics. If medical social statistics are to continue to reflect the professional concept of function, it behooves the profession to give the matter more serious consideration. Perhaps the Association will soon re-consider the importance of again giving leadership in this area.

Let us return now to study further developments in medical social statistical reporting at the M. G. H. During the years 1942, 1943 and 1944 the Social Service Department of that hospital continued to use Revised H-4 in co-operation with the Boston Council of Social Agencies and the Department

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1 Letter from Ruth Blumenthal, Community Chests and Councils Inc., New York, June 6, 1946.

presented its statistics according to its own 1938 form in the hospital's Annual Reports. The latter plan made it possible to make comparisons over a longer period. Since Social Admitting has not been a policy at this hospital, Section B. of Revised H-4 did not apply there. Gradually, however, the members of this department became less satisfied with Revised H-4. They became conscious that it did not fully satisfy the A.A.M.S.W. definition of function, i.e. that it did not adequately measure the significance of the work, it did not contribute to the department's participation in "the development of social and health programs in the community" nor did it provide material for medical social research. In 1944, the department began to consider how it might better meet these requirements and set out to find a solution to the problem. In the succeeding chapter we shall present a study of this method of medical social statistical reporting which was devised at the M. G. H. in response to these needs.

CHAPTER V

DEVELOPMENT OF A UNIQUE SYSTEM IN ONE DEPARTMENT: AN EVALUATION AND A CRITICISM

Beginning January 1, 1945, a new plan was inaugurated for gathering statistics concerning patients accepted for case work service by the Social Service Department of the M. G. H. This plan was the result of work done by a staff committee on statistics, and considerations by the whole staff, under the guidance and stimulation of its Chief of Social Service, Miss Ida M. Cannon. It was fortunate for the department that it had at its disposal the services of Mr. George Hogle, a member of the group of conscientious objectors assigned to the hospital. His grasp of the functions of the department and interest in the problem of medical social statistics was of inestimable value in developing the new project.

In order to understand the purposes underlying this new plan we shall quote from a statement made to the writer by Miss Cannon.[1]

Statistical evidence - a weakness in Medical Social Work.

> Medical social workers have attained a position where the modern hospital with high standards for care of the sick accepts their service as essential. The American College of Surgeons includes in its published Standards a statement for our services in regard to organization and function. We may well take some satisfaction in that our service has so far demonstrated its value as to warrant this

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1 October, 1946.

recognition. But such recognition on the part of those who are in the forefront of our rapidly evolving modern hospital with its growing sense of public service and community obligation, places upon us a serious responsibility to meet the test. Especially is this so for us who, in the complex hospital organization, stand for maintaining a close relation between the hospital and the community from which our patients come.

It behooves us to look frankly at our weaknesses. One of these is surely our failure so far to get any adequate means or method for measurement of our service. Our Association has had several committees in the past that have worked diligently to find a satisfactory statistical method for medical social service. I think we must honestly confess that we are far from attaining any adequate means of relating, by any careful measurement, our stated aims and our accomplishment. Our failure is the more obvious since we are so closely associating with a profession that has highly developed scientific tests for its accomplishments.

The Social Service Department of the Massachusetts General Hospital, has been a party to both the struggle to get at some suitable statistics and the failures that have to be faced. We came to realize that if we are to get an adequate measure of the significance of our work, we must come to some conclusion, even if tentative, of those items that we were to accept as units of count and then to make clear definitions of those items. We must recognize also that we must be always in a critical attitude in regard to our efforts. It was in this spirit that we decided in 1944 to try the experiment of using the punch card system to help us in analyzing the problems that our patients presented. Only when we recognize the social problems that complicate specific medical problems can we begin to study with any degree of accuracy our contribution to the care of the sick. Only as we get specific evidence of the significance of environmental conditions as related to sickness can we be really effective in changing adverse community conditions. We may theorize about the somatic effects stresses and strains in personal relationship for our patients, but where is our evidence? (sic) We are far, far from a scientific approach to social evidence. But that is more reason why we should work toward a means of testing our efforts in social treatment as it should be related to medical care.

Our task is now to examine this 'experiment' which

began in 1945, to consider whether it fulfils the purposes set forth above and to measure its purposes and results against the broader problem of this study. The new system was devised so that it could be adapted to the already-existing International Business Machine punch card system used by the administration of the M. G. H. for records of purchases, store, anesthesia and personnel. The method consists of a single form to be filled out by the case worker for each individual "accepted" case currently under care. As Miss Cannon has indicated:

> The emphasis in this statistical approcah is on distinguishing between problems presented, rather than on the measure of services rendered. Assuming ourselves to be professionally trained and adequate medical social workers, there is no need to justify and count the services we render. It is the analysis of our patients' problems and circumstances in which we are interested, and for the coming year the data itemized below will be collected by the workers on the statistical forms for every "accepted" case the general meaning of which has been somewhat changed. The criteria for an accepted case are as follows:
>
> 1. Whether the patient referred has need for assistance of a social case worker in a difficulty related to his illness, and
> 2. Whether the case worker accepts responsibility for helping the patient to meet, and the doctor to clarify, the problem. Acceptance of responsibility is implied if the following case work processes have been gone through:
>
> (a) The securing of significant data as basis for judgment of need.
> (b) The making of a judgment or evaluation as to the patient's problems in relation to the medical need.
> (c) The taking of some action in the light of medical judgment, even if it be a decision to cease further assistance, relative to helping the patient solve his medical social problem.
>
> In determining which cases are "accepted" ones, the length of time which a worker gives on one

> is not the essential factor. The important factor is in the uses of special casework knowledge, judgment and skills.[1]

The forms referred to above are printed cards, five inches by eight inches which call for identifying information concerning the patient.[2] Some of the items will remain constant such as name (except in cases of women who marry during their time of treatment), hospital unit number, date of birth, sex, color, etc. The form also asks for information which, during the period the patient is under treatment, may change. For example, medical diagnoses, medical social problems, worker, etc. Some of the information may be obtained from the patient's medical record and requires little interpretation on the part of the worker. Some items such as marital status, citizenship, religion, etc., might be filled in by a clerk. But the two sections devoted to "medical diagnoses" and "medical social problems" depend on medical and social data which the worker must supply. Thus under the heading, "medical diagnoses" the worker is instructed to select a maximum of three diagnoses.

> Major diagnosis first. Add 2nd and 3rd diagnoses only when they are important ones in the whole medical picture, and not if they are minor complications of the major one or generally of little immediate consequence.[3]

Under the heading "medical social problems" the worker is instructed to enter a maximum of eight, "roughly in order of

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1 Massachusetts General Hospital, Social Service Department. Program for Statistics, December 10, 1944. p. 1

2 Appendix. p. 92.

3 Ibid. p. 94.

importance" (sic). The list is selective and is not intended to cover every possible medical social problem. The following criteria are established for entering a problem on the form:

> (a) That it be related to the illness situation.
> (b) That it be a problem regarding which it seems likely that patient or family may need some assistance and in relation to which the worker will assume some responsibility.
> (c) That as far as practicable the major social problems be entered first and the others following in decreasing order of importance.
> (d) That there be entered a maximum of eight problems.[1]

Each worker is supplied with a list of medical social definitions which were chosen as descriptive of the most common problems likely to be encountered.[2] The department spent some time working on this before agreement was reached that the terms chosen were most satisfactory, and even then it was understood that after a period of use the list would be reviewed and some items would be deleted or some added, if necessary. The committee studied available definitions of medical social problems, including those compiled by Gordon Hamilton in 1930. Finally the committee decided to develop its own definitions on the basis of five major groups:

1. Illness situation.
2. Attitudes toward illness.
3. Social situation.
4. Physical environment.
5. Personal characteristics.

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1 Ibid. p. 94

2 Ibid. p. 94

Each of these was subdivided into terms applicable to an individual patient's particular situation. For example, in the section 'Illness situation' there are eight terms, each defined in some detail as, Chronic illness -

> covers the whole problem of chronic illness, physical, mental or emotional and its care, in broadest sense, whether at home or in institutions, economic and psychological aspect.1

It is these subdivisions which are used when filling in the statistical form. In order to assist the worker and to establish uniformity in medical diagnoses, only terminology accepted by the Code Book, United States Public Health Service is used. Only by using accepted terminology is it possible to have any clear picture of the kinds of illnesses with which medical social problems tend to be associated.

During the first year of its use, the system of making a form for each accepted case required that the form be filled out as completely as possible at the time of acceptance. Workers were asked to submit them weekly. When the forms were assembled they were coded by the department statistician. The system of coding which was evolved in accordance with the International Business Machine punch card system, consisted of a series of code numbers that applied to each section of the form and that were filled into the alloted spaces in the lower section of the form.[2] When all the forms had been coded they were sent to the puncher who made a punch card for each form according to the code numbers thereon. The punch cards

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1 Ibid. p. 94

2 For purposes of uniformity in coding "Occupations" the coder uses the definitions of the United States Bureau of Census, Occupational Code.

were then filed for a permanent record.

Once a statistical form had been coded and a punch card made for it, the upper left hand corner was clipped by the coder and the form returned to the worker to be used for further reference and for the addition of information. When information was either added or changed, the worker drew attention to this by noting on the back of the form which item had been changed or added or, in the case of closing date, the date of closing and duration of the case was recorded. The form was then returned to the coder whose responsibility it was to see that the punch card was kept up to date and, for closed cases that the upper right hand corner of the form was clipped. In the case of 'closed cases' which were re-opened a new statistical form was made and a new punch card was filed with the old one. At the time of inauguration of this new plan, statistical forms were not made out for cases carried over from the previous year, but forms were to be made for cases re-opened in 1945 which had been closed in previous years. At the end of the year, December 1945, all forms were turned in for coding. Those ready for closing were coded and clipped accordingly, those to be carried over into 1946 were also coded and clipped. All cards were then returned to the respective workers.

At the end of the year the department statistician compiled an analysis of the data coded on each card and each worker was presented with an analysis of her own case load. It is to the summary of the year's analysis that we must turn to evaluate this new method of medical social statistical re-

porting.

According to the Statistical Analysis compiled by the department's statistician for the year 1945, there were 2,639 cards filed by the department. In some cases information was not given for each item, but we have a record of the number of patients for whom information concerning an individual item is missing. For example, from the 2,639 cards we have information about the ages of 2,612 patients according to ten year age groups. This is a significant total and from the statistics concerning this group we are able to obtain a picture of the trend of ages in the department's case load. In Figure 1. we have a graph showing the age distribution in ten year age groups.[1] According to the figure we see that in order of frequency, the 10-20 year span is the largest group of patients served by the department. The second largest group is the 50-60 year span and the next largest group is the 30-40 year span. As might be expected, the smallest group is that of the 90-100 year span. Thus, if we disregard for the moment the large group of children, we are impressed with the fact that there is a preponderance of middle-aged people being served by the Social Service Department at the M. G. H. One would conclude that the workers in such a department must be particularly aware of those problems peculiar to the middle-aged in the population and that as a result of their experience they might be well acquainted with resources for meeting these needs.

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1 See Figure 1. p. 84-B

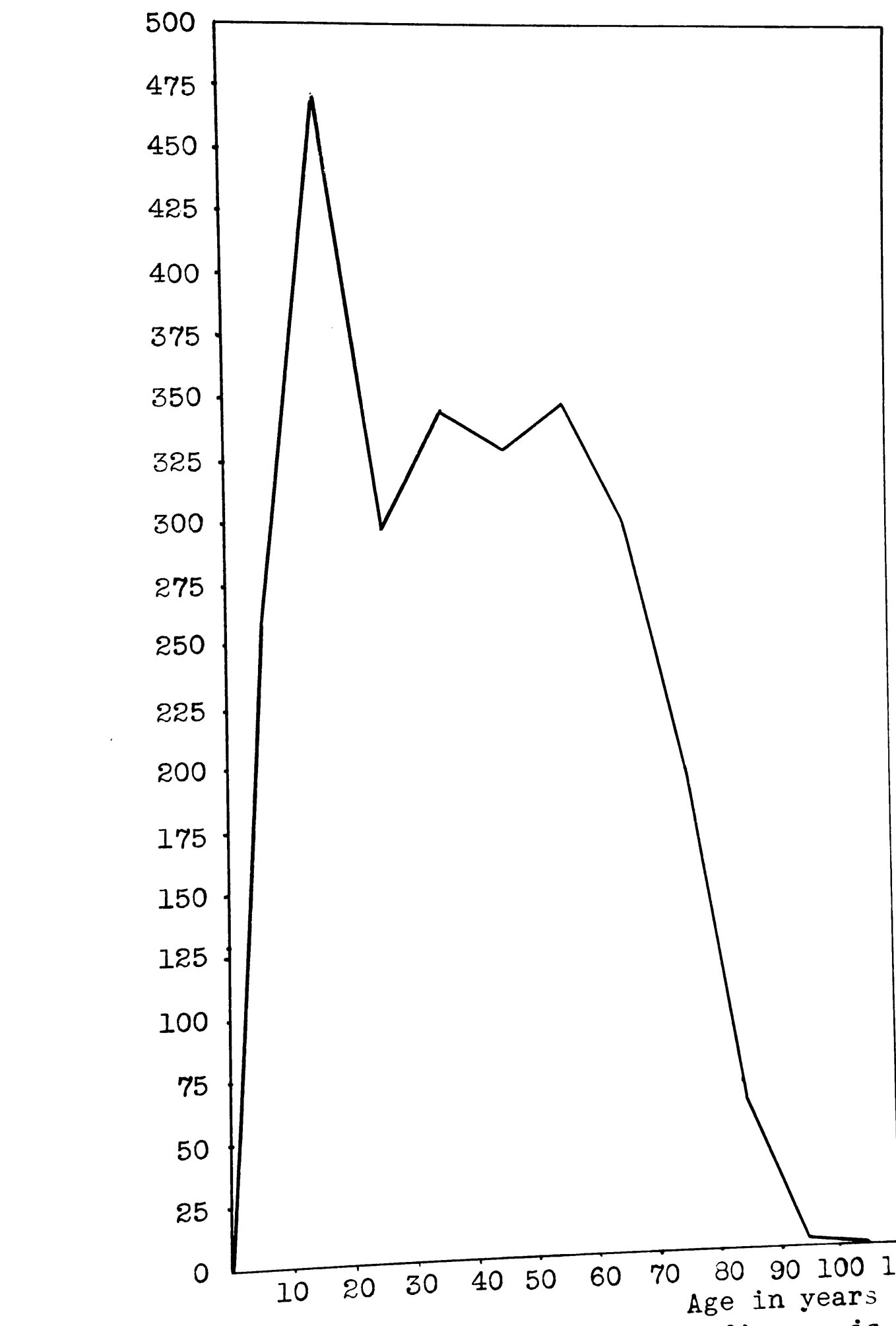
Table I Age Distribution of 2,612 Patients(a) at Massachusetts General Hospital, Boston, 1945(b)

Age in Years	Number of Patients
Total	2,612
0 - 9	261
10-19	473
20-29	296
30-39	346
40-49	327
50-59	349
60-69	299
70-79	198
80-89	58
90-99 and over	2

(a) Based on unpublished analysis of statistics concerning 2,639 persons referred to the Social Service Department. Note that information was lacking for 27 persons.

(b) All patients in the Children's Medical Clinic were interviewed by the social worker.

Figure 1. Age Distribution of 2,612[a] Patients at Massachusetts General Hospital, Boston, 1945[b]



(a) See Table I for figures on which this diagram is based. p.84-A.
(b) All patients in the Children's Medical Clinic were interviewed by the social worker.

Again, from the punch cards we have information regarding the sex and colour of 2,634 patients and we find 1,354 white, female patients, and 1,242 white, male patients as against 14 black, female patients, and 21 black, male patients. We also have information regarding the clinic or hospital service in which 2,553 patients were being treated at the time of referral. Of these, 1,414 cases were "in the house" (General Hospital, Baker Memorial and Phillips House) and 1,139 were in the clinics. Of these 366 patients "in the house" were on the Medical Service, and 210 were on the Surgical Service. It is also possible to make comparisons between the medical social case loads in the specialized services such as Arthritic, Thyroid, or Diabetic. In the Out-Patient Department, the service having the largest number of cases is the Children's Medical with 208 patients, while the Neuro-medical is the second largest service with 164 patients. Medical and Surgical Outdoor services had 141 and 52 cases respectively. Of the 2,584 cases where information is given regarding the individual or the agency which makes the referral, 2,137 were referred by a physician, 129 by an outside agency and 95 by the patient himself. Information regarding the patient's marital status, citizenship, religious affiliation, occupation, education and household data such as residence, type of dwelling he occupies and with how many people he shares it, is also available. In closed cases information is available as to duration of the case from one day to twelve months; two months is the most frequent period for the 1945 case load.

The unique contribution which this type of statistical

reporting makes to the field of medical social statistics is, that for the first time data are available concerning patients from two points of view. That is, we now have easily accessible social data such as age, sex, marital status, occupation, medical social problems, etc., for a large number of patients who present a wide variety of co-existent medical diagnoses. It now becomes possible to correlate medical diagnoses and medical social problems. This would be the logical next step. It was the hope of those who devised the method that this form of tabulation would stimulate both medical social workers and physicians to use it for research purposes. In order to see these possibilities more clearly let us now examine more closely the analysis of the first year's statistics.

Some of the most interesting facts that this method of medical social statistical reporting reveals, are those concerning the medical social problems of patients receiving the services of the Social Service Department. Table II and Figure 2.[1] illustrate the percentage distribution of the fifteen most prominent medical social problems during the year. Of the 2,554 patients about whom medical social data are given, 1,072 cases or 17.3 per cent presented problems of Chronic Illness. Next in order of frequency are the 587 patients or 9.5 per cent for whom Convalescence was a problem which needed the help of a medical social worker. Third in order of frequency are the 544 cases or 8.8 per cent who had problems

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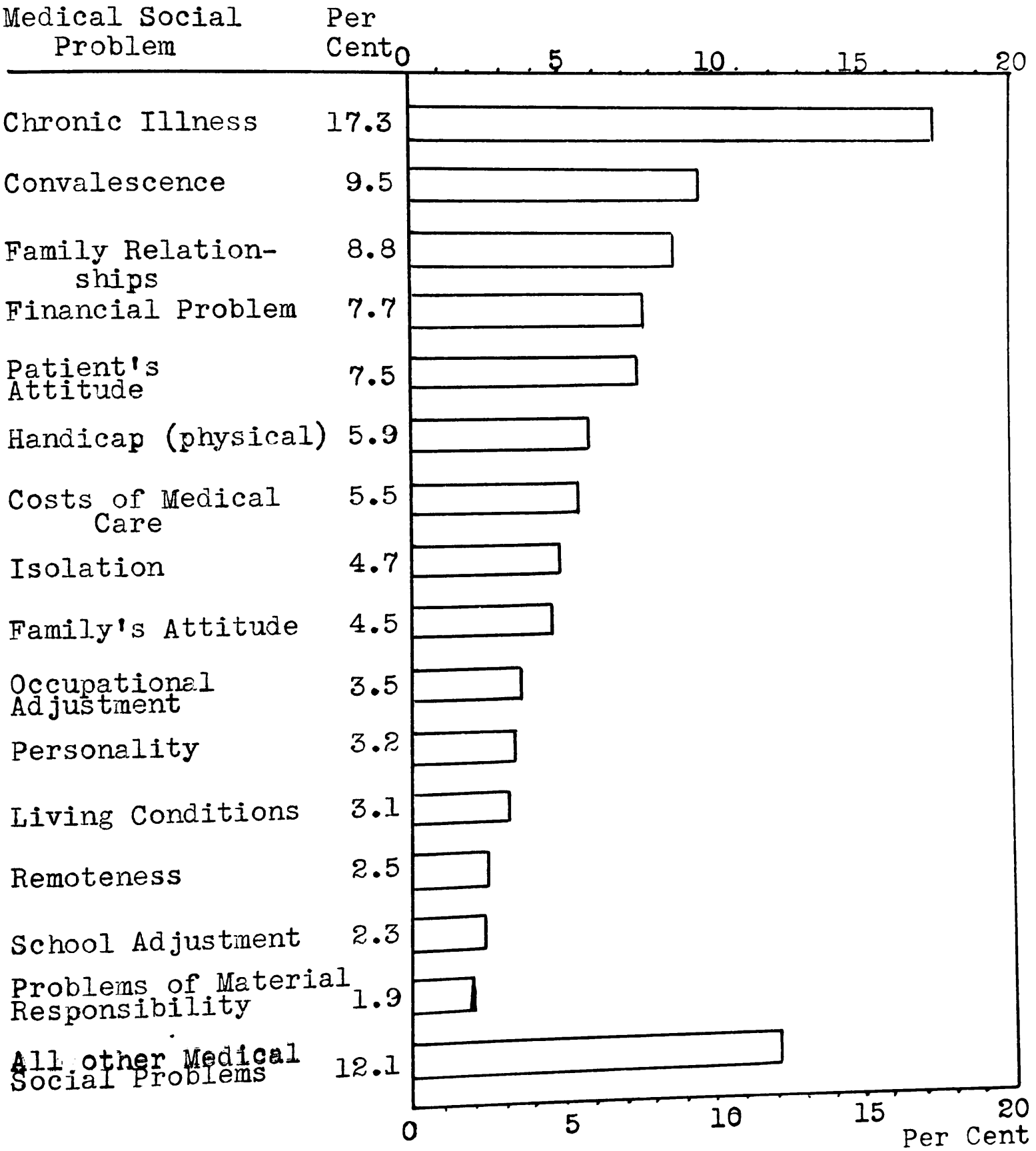
1 See pp. 86-A, 86-B.

Table II Percentage Distribution of The Fifteen Most Common Medical Social Problems Observed at Massachusetts General Hospital, Boston, 1945(a)

Medical Social Problem	Frequency of Problem	Per Cent of all Problems
Total	6,209	100.0
Chronic Illness	1,072	17.3
Convalescence	587	9.5
Family Relationships	544	8.8
Financial Problem	476	7.7
Patient's Attitude	463	7.5
Handicap (Physical)	368	5.9
Costs of Medical Care	343	5.5
Isolation	290	4.7
Family's Attitude	277	4.5
Occupational Adjustment	220	3.5
Personality	198	3.2
Living Conditions	192	3.1
Remoteness	158	2.5
School Adjustment	140	2.3
Problems of Material Responsibility	115	1.9
Other Medical Social Problems	766	12.1

(a) Based on a study of 6,209 Medical Social Problems in 2,639 cases referred to the Social Service Department. Note that an optimum of eight problems could be used for each case.

Figure 2. Percentage Distribution of The Fifteen Most Common Medical Social Problems(a) Observed at Massachusetts General Hospital, Boston, 1945(b)



(a) See Table II for figures on which this graph is based. P. 86-A.
(b) Based on a study of 6,209 Medical Social Problems in 2,639 cases referred to the Social Service Department. Note that an optimum of eight problems could be used for each case.

of Family Relationships. As might be expected, Financial Problems form the next group, while Patient's Attitude, Handicap, Costs of Medical Care, Isolation, Family's Attitude, Occupation, Personality, Living Conditions, Remoteness, School Adjustment, and Problems of Material Responsibility follow next in rank of importance. Figure 2., the bar diagram, makes it possible to visualize the rank order of the frequency of any one of these problems. For example, the problem of Chronic Illness is almost ten per cent more prevalent than problems centering in the patient's attitude. The original figures assume a new importance when we see their relative values in this way.

Now let us turn to the tabulation of medical diagnoses made of the year's case load. Table III and Figure 3.[1] show the percentage distribution of the eight most frequent medical diagnoses appearing in the case load of the Social Service Department of the M. G. H. during 1945. This group comprises fifty-four per cent of the total 3,231 diagnoses out of a possible 7,917 diagnoses, i.e. allowing a maximum of three diagnoses for each statistical form. The largest diagnostic group in which medical social problems are present is Carcinoma. This group of 431 cases, or 13 per cent of the total 1945 case load, includes cancer of the buccal cavity, the pharynx, of the digestive organs, of the respiratory system, of male and female genitalia and other specified forms of cancer. Second in frequency of diagnosis is the group of 246 Cardiac Diseases, 7.6 per cent of the year's case load.

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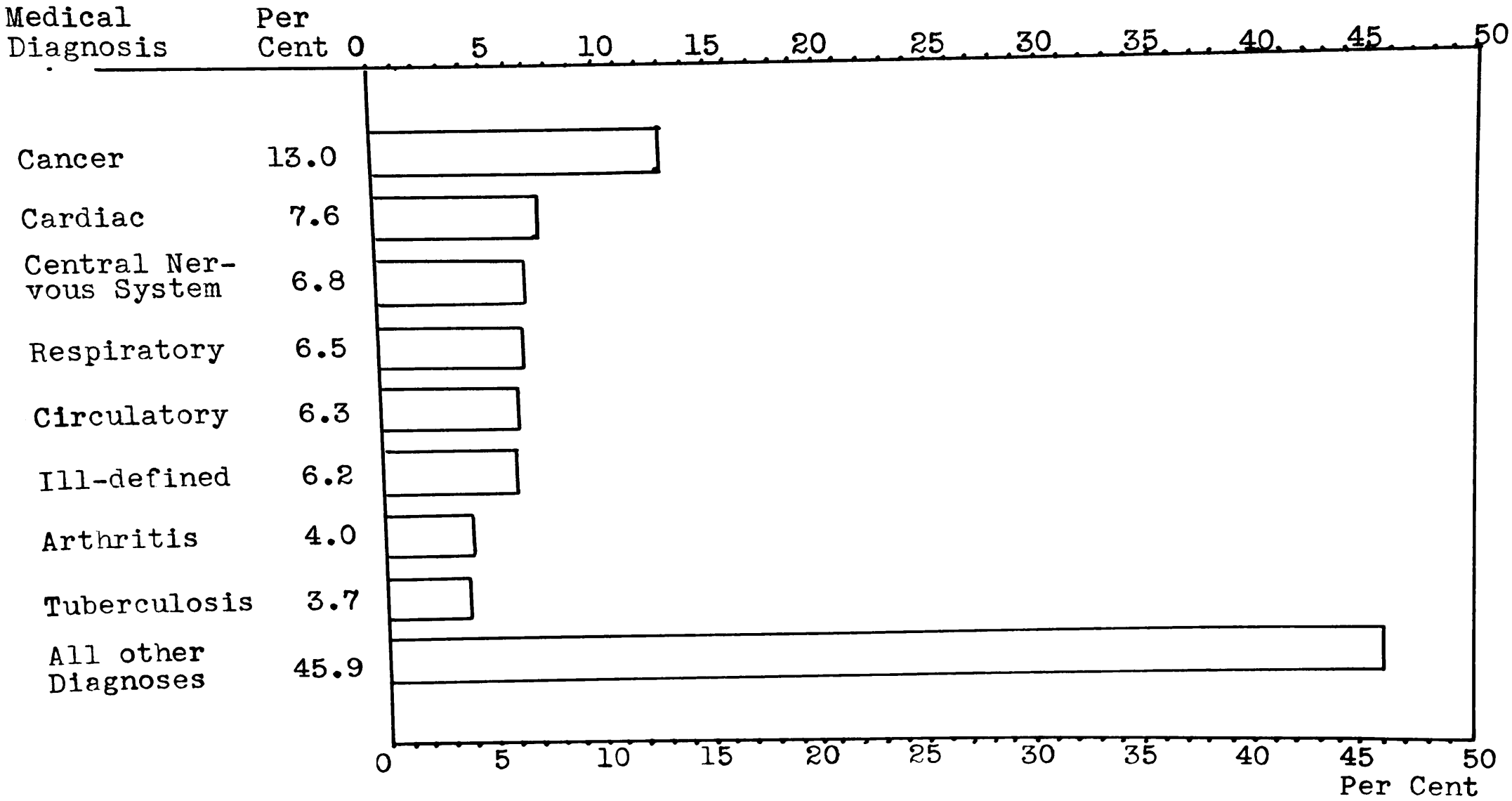
1 See pp. 87-A, 87-B.

Table III Percentage Distribution of Eight Most Frequent Medical Diagnoses Appearing in Caseload of Social Service Department, Massachusetts General Hospital, Boston, 1945(a)

Medical Diagnosis	Frequency of Diagnosis	Per Cent of all Diagnoses
Total	3,231	100.0
Cancer	431	13.0
Cardiac Diseases	246	7.6
Central Nervous System Diseases	220	6.8
Respiratory System	210	6.5
Circulatory System	203	6.3
Ill-defined Diseases	139	6.2
Arthritis	129	4.0
Tuberculosis	119	3.7
All other diagnoses	1,534	45.9

(a) Based on an analysis of 3,231 diagnoses occurring in 2,635 cases. Note that a maximum of three diagnoses could be used for each case.

Figure 3. Percentage Distribution of Eight Most Frequent Medical Diagnoses[a] Appearing in Caseload of Social Service Department, Massachusetts General Hospital, Boston, 1945[b]



(a) See Table III for figures on which this diagram is based. P. 87-A.
(b) From an analysis of 3,231 diagnoses occurring in 2,635 cases. Note that a maximum of three diagnoses could be used for each case.

These include rheumatic heart disease, the largest of the group, hypertensive cardio-vascular disease and other heart diseases. The third largest group of diagnoses or 6.8 per cent are those of the Central Nervous System. This group, 220 in all, includes central nervous system inflammatory diseases, intercranial lesions and a large group of other central nervous system diseases such as epilepsy, reading disabilities, etc. The next group in order of frequency is Diseases of the Respiratory System, exclusive of the common cold. The 210 cases in this group, or 6.5 per cent of the total case load include diseases of the pharynx and larynx, bronchitis, pneumonia and other respiratory diseases. Hypertensive vascular disease and "other diseases of the arteries, varicose veins, and haemorrhoids, etc.", make up the group of 203 cases of diseases of the Circulatory System. This is 6.3 per cent of the total. The Ill-defined Diseases totalling 139 cases or 6.2 per cent, ranks sixth in order of frequency of medical diagnosis. This is a surprisingly large group and of greater significance socially as well as medically than we might have expected. The group covers those "ill-defined diseases" which are sometimes termed psychogenic. A glance at the diagnostic classification of the patient load of any large medical institution might suggest their significance to the medical profession from the point of numbers alone. These represent the patients whose complaints seem to have no physical basis but whose personal problems are focussed on physical symptoms. Since the hospital is the logical place to which these people turn for help, it behooves

the hospital to provide the means of securing that help. It may be that the physician is not the person nor the clinic the most appropriate place in which treatment should be given. This is exactly where joint consideration by the physician and the medical social worker in collaboration with the patient is needed. The medical social worker's training has taught her how to give help, either by assisting the patient to accept her own case work skills or by facilitating his referral to the appropriate resource in the community. The patient thus helped is prevented from exploiting the medical center and is offered the assistance which he really needs. The group of 129 Arthritis cases ranks next in numerical importance with Tuberculosis, respiratory and other types combined, coming close behind with 119 cases.

It should be noted that in tabulating the incidence of medical diagnoses, no distinction was made by the statistician between primary diagnoses and other accompanying diagnoses, at the point of referral. Thus we cannot say that the 431 cases of cancer represent 431 cases accepted by the Social Service Department whose major medical social problem was focussed on this diagnosis. But we can say that 431 cases accepted by Social Service for social case work had this diagnosis. Similarly, for each of the other diagnostic groups, we can only say that these numbers represent the frequency with which a given diagnosis occurred among the patients receiving medical social case work. When viewed alongside of data on medical social problems, however, we begin to see a possibility of a correlation between diagnostic groups and the co-existing medical

social problems.

By using Figure 2. and Figure 3. it is possible to compare the distribution of the two sets of problems, medical and social. It is important, of course, to be aware that correlation does not imply causal relationships. If this were the case, we would find ourselves saying, 'why, yes, of course a high cancer rate would naturally be correlative with a high incidence of problems of chronic illness.' Equally false, yet apparently sound conclusions may be drawn by attempting to see causal relationships between other diagnostic groups and correlative medical social problems. For example, the two sets of bars follow much the same pattern except that the frequencies of medical diagnoses are lower all along the line than those of medical social problems. But one might be inclined to conclude that because Tuberculosis and Isolation are each in eighth position they may have a cause-effect relation to each other. Yet there is no evidence in this material to bear this out. It might however, suggest a need for research on the question. According to the medical social definition, 'isolation' means; 'separation from family and intimate group, homelessness, lack of "primary group", broken home.' Again, we find skin diseases and problems of school adjustment ranking fourteenth on each scale. Yet we cannot, without further evidence say that most skin diseases cause or are related to problems in school adjustment or conversely, that most school adjustment problems cause or are related to skin diseases.

Naturally, the greatest value of these statistics depends on the manner in which they are used and care should be

taken to avoid making 'sweeping generalities' such as the above examples. On the other hand, it will be possible to sort out the punch cards according to the diagnostic groups in which any given medical or social problem exists and study the matter in detail by referring to the case material about each patient thus represented. Only thus will it be possible to ascertain whether there is a causal relationship between the two. For instance, it is possible to select, for any given period of time, all the cases in which Rheumatoid Arthritis was a diagnosis and in which there existed problems of the Family's Attitude. We might then examine the case material corresponding to each punch card and determine in which of these cases Arthritis was the major medical problem and whether there is a relationship between the major medical and social problems. We might wish to make a study of the cases in which problems of Chronic Illness were co-existent with Financial Problems or with problems created by the Costs of Medical Care. The ways in which problems of Chronic Illness are complicated by Financial Problems might well be demonstrated by such a study. The question of the need for the community to finance plans for the care of the chronically ill might be evaluated against other findings, e.g. adequacy of facilities even if financing the plan were no problem.

A study of the housing of patients would be possible from the point of view of any of the other problems or facts on the cards. For instance, it would be possible to select the number of patients living in overcrowded households, i.e. more than one person per room, and of this group to select

those with a diagnosis of Rheumatic Fever for whom convalescent plans had to be referred to the medical social worker. Another such study might be made of the incidence of problems of occupational adjustment in patients with Rheumatic Heart Disease.

In addition to the above-mentioned information, we have a means of knowing more about the patient group according to their cultural backgrounds (depending on the nationality of the mother), birthplaces, and residence.[1] Thus of 2,597 patients having birthplace reported, 1935 were born in the U.S.A. or in U.S. territory; the next largest group were born in Italy, while 127 were born in Canada (English) and 27 in Canada (French). Comparing national backgrounds, we find 2,492 reported - 1,136 U.S. and U.S. territory, 335 Italian and 182 Canadian (English) and 71 Canadian (French). As for residence, we find 2,632 reported with 1,257 from Metropolitan Boston, exclusive of Municipal Boston, 822 from Municipal Boston and only 16 with foreign residences.

The accumulated statistics also give us an opportunity to analyze the occupations of patients as well as the industries in which they are employed. In 1945 there were 2,221 occupations reported. This total includes 117 pre-school children, 518 students and 504 housewives. The largest occupational group was that of "Operatives and Kindred Workers" which includes 22 chauffeurs, 14 welders, and 10 dressmakers. These are the first three sub-groups in order of frequency.

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1 See Appendix pp. 115, 116.

"Clerical, sales and kindred workers" is the second largest group. The three largest sub-groups are: 59 clerical workers (not elsewhere classified), 24 stenographers, etc. and 22 salesmen. The third largest occupational group is "Service workers - other" i.e. exclusive of domestic service workers and protective workers. The three most frequent sub-groups of this category are 29 servants, exclusive of private families, 27 waiters and waitresses, and 17 janitors or sextons, making a total of 156 workers.

Among the 682 reported industries, the largest number of patients, a total of 230, are in the manufacturing group. The three largest sub-divisions are: 34 ship-builders, 18 electrical workers, and 13 printing workers. The second largest group of patients are those 115 in Trade. Among these, employees of eating and drinking places, food, except dairies, and wholesale trades form the largest sub-divisions. The third largest group of patients which totals 86 persons, comes from the professional services. These include medical services, educational services, charitable and religious work.

One of the advantages of the punch card system lies in the speed and exactness with which the cards can be sorted.[1] It is thus possible to sort the whole group of cards for one year very quickly in terms of any combinations of categories desired. Thus if it seems wise in the interests of administrative policy, to discover how many 'accepted cases' in the department were men over 65 years of age who came from outside

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1 They can be sorted by the machine at the rate of 400 cards per minute.

Metropolitan Boston who had problems of convalescence, this information could readily be obtained. The cards might first be sorted on the basis of residence, then in terms of medical social problems, then according to age, sex, etc. Or, if we wanted to know how many were married women under 35 years of age, having a medical diagnosis of Functional Digestive Disturbance and a medical social problem of making plans for the care of dependent children, the same ease of selection would be assured. It would be equally easy to discover from which municipalities we have the largest number of patients and upon this basis work out a plan for division of case loads among the workers. Or, if the problem of relationships between the Social Service Department and other community agencies were to be studied, there is material available concerning sources of referrals i.e. outside agency, patient himself, physician, nurse and data concerning communities from which patients come. Such a study as this might bring out the fact that a large number of patients using medical social case work come from a certain community. This information could then be used to point out the need for closer working relationships with agencies in that community or it could be used as a stimulus for seeking improved facilities in that community.

Perhaps the most fruitful type of research will be based on information about medical diagnoses and co-existent medical social problems. We know as yet relatively little about medical social problems. At least a degree of uniformity is achieved by having a set of definitions to which the worker can refer in order to have consistent terminology on

the statistical forms. As we have seen, the list of medical social problems is not exhaustive and there is adequate space for additions to be made. On the whole, the workers have expressed general satisfaction with the definitions and, as they have become more familiar with them they have tended to use them with greater ease.

There is always a danger that the 'filling in' of forms will become perfunctory, that because there is a 'must' involved, workers who feel pressed for time will make hasty and unsound judgments regarding the classification of their patients' medical social problems. If we were to evaluate the validity of the definitions, a study might be made of a sample group of each worker's forms. Recorded material for each case thus represented could be used as the basis for checking the judgments made about each medical social problem. Should it be discovered after analysis of a sample of recorded cases that markedly different results of medical social classifications were produced, several conclusions might be reached. In the first place, inadequate definitions of medical social problems might account for differences between the original classification and that made by the research worker. In the second place, if, as we have suggested, hasty judgments had been made, poor use of the definitions might also lead to inconsistencies in classification. In the third place, if case recording has been inadequate to give a clear picture of the situation, this might account for discrepancies. By the time this method has been in use for two or three years it should be evaluated. Unless those who use it can see that it is

producing significant results, a lack of interest in using it may become a very real hazard. We have to see to be convinced. We cannot expect workers to be enthusiastic about a project in which their efforts are merely a means to an uncertain end.

Some student theses have been based on material involving this method of statistical reporting and the conclusions of these ought to be made known to those whose work made the studies possible. The practical use of this method must be demonstrated if the plan is to fulfil the intentions of those who originally devised it. Perhaps in the near future it will be possible to have a member of the Social Service staff assigned to a study of some of the data in order to bring it to the attention of the members of the department, to other hospital personnel and particularly to those of the medical staff who are most closely related to the medical problems.

Although one of the factors influencing the development of this plan was that the International Business Machine punch card system was already in use at the M. G. H., the success of the method is not dependent on it. It is conceivable that a modified form of this method of medical social statistical reporting might be adopted elsewhere without sacrificing its fundamental principles.[1] This would make possible more widespread use of the method. One can foresee possibilities of joint planning among the medical social workers in a community where each department used this method. Some of the studies

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1 Punch cards are made for the registers of State Crippled Children's programmes in the United States, but selection is done in a simple way by running a knitting needle through the holes made for the required code number.

already suggested as possible for one department would be immensely more valuable if they were based on findings from a group of hospitals. If one hospital can say that the most frequent medical social problems associated with the diagnosis of cancer are defined by the term Chronic Illness and if several hospitals in the same community made the same report, surely this would be an indication of the need for a study of existing facilities to meet the needs of the chronically ill. Similarly, physicians who are interested in problems related to the care of patients in any one of the diagnostic groups might ask for a study of these with a view to increasing their understanding of the needs of these patients, to making better use of facilities for meeting these needs, and, in the long run, to improving the over-all care of their patients. It is encouraging to find in this method of medical social statistical reporting, a means to some objective evaluation of the theories concerning the cause-and-effect relationship between disease and social problems. One of the beliefs concerning Rheumatic Fever is that it generally occurs among people who live in over-crowded, damp homes, i.e. that poor housing generates Rheumatic Fever. By using the punch card method it would be possible to make a study of the relationship between poor housing and Rheumatic Fever and thereby either substantiate or disprove the above-mentioned theory.

Although the material for this study is limited to statistics for the year 1945, it may be helpful to note subquent changes which have been made in the method. As the plan

was first developed, each worker was to fill out a form for each accepted case at the time when the case was accepted and the form was to be coded "not later than one month after the 'date of referral'". During the first year of its use, it became clear that it was often impossible to secure all the data within this time, and that to save both the worker and the statistician it might be better not to code any of the forms until the case was closed. At that time all the available information could be filled in and only one coding would be necessary. There is however, a possibility that by postponing the filling-in process until closing the worker will omit some of the earliest diagnostic or medical social problems which during the time the case has been open have been modified or ruled out. It would seem as important for the social worker to record these early impressions as it is for the physician to record his 'impressions' in the medical record.

Again, when the 1945 plan was inaugurated at the M. G. H., it was assumed that an annual report of the actual number of patients receiving case work service would easily be obtained from the count of each worker's statistical forms. In addition to this, a count of 'not made cases' would be available through each worker's Intake Book. But decision as to status of a case cannot always be made in one interview. For this reason forms were not always turned in at the beginning of case work service and the monthly count of each worker's forms was an unreliable indication of her case load.

It was therefore decided that, beginning January 1, 1946, each worker would turn in a statistical form for each

accepted case within one month from the date of closing. Each worker would also report on her monthly turnover of cases and on the number of 'not made cases'. For the purpose of this count a uniform report form was devised. This report form comprised nine sections. According to the clinic or hospital service in which the patients were receiving treatment at the time of referral, the case count was to show the following facts: the number of cases carried over from the previous month; the number of new cases; the number transferred from other workers; total cases handled during the month; the number of cases closed; the number of cases transferred to other workers and the total number carried over to the next month. The number of Intake Only or 'not made cases' was also requested. This means that now there is a count of actual numbers of patients to whom medical social case work is being offered, and the number of patients otherwise served by the department. In addition, there are medical social data concerning the 'accepted cases' which has hitherto been lost in the mass of case material and never before available with such ease and uniformity.

On March 17, 1947, the following bulletin was issued to the staff of the Social Service Department, at the M. G. H. as a result of the work of a staff committee on statistics:

> In order to make the present system more effective the Statistics Committee makes the following recommendations to the staff for their approval:
>
> 1. The co-operation of each worker in closing cases promptly is essential. The case load should be reviewed at the end of each month to determine which cards should be closed and handed in. We suggest that a case be 'closed' when the social worker has

decided to take no further responsibility for casework activity unless a new problem arises.

2. When a worker transfers a case, the statistics card should be handed to the second worker at the time she is asked to accept the case.

3. The following items should be filled in before a card can be coded: name, unit number, birth, date or age, sex, color, referral data, date of referral, status of case, worker, residence, diagnosis and medical social problems. As many of the other items should be filled in as possible.

4. The Statistics Committee plans to revise definition of "medical social problems". Any suggestions will be welcomed. Criticisms of the monthly report sheet are also invited.[1]

On April 3, 1947, the Statistics Committee reached the following conclusions:

It was decided that the monthly report form is satisfactory except that the column for new cases should be divided to separate 'cases re-opened for second time this year' from all other cases.

The definitions of Social Problems were reviewed for the purpose of eliminating as many as possible. The following recommendations were made:

1. Dietary Problem could be eliminated since the social aspects of this problem are also included under some other heading such as Financial Problems.

2. Pregnancy could be eliminated since this is really a diagnosis. Special problems related to prenatal care could come under some other category.

3. Problems of Material Responsibility could be changed to Problems of Family Responsibility. Illness in the Family could then be included under instead of in, a separate category. (sic)

4. Borderline Psychiatric Problems could be eliminated and included under Personality.

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1 Letter to the writer from Miss Joan Pinanski, Chairman, Staff Statistics Committee, Social Service Department, Massachusetts General Hospital, May 17, 1947.

> 5. Remoteness should be changed to Transportation. Other problems of remoteness usually come under Isolation. It was felt that transportation is such an important problem that a separate heading should be provided for it.
>
> 6. Disfigurement or Permanent Impairment could be eliminated and included under Physical Handicap. This category is used less frequently than any other.[1]

So far as the writer has been able to learn, there have been no further changes in this plan.

In view of the fact that one purpose of the new method of medical social statistical reporting was to provide a means of recognizing 'the social problems that complicate specific medical problems', we make the following suggestions: that a change be made on the statistical form so that it becomes possible to indicate which medical social problem is related to each medical diagnosis. Thus, if cancer of the breast is the major medical diagnosis, there ought to be some indication of the medical social problems which are related thereto. At present the statistical analysis of the year's case load shows only the frequency of diagnostic problems but it does not indicate the frequency of major diagnostic problems. For example, we know that in 1945 the Social Service Department of the M. G. H. accepted 431 patients for case work service in which cancer was a medical diagnosis, but as we have seen, there is no way of knowing whether this was a major diagnosis in each instance. Therefore, if our material is to show the relationship of social problems to <u>specific</u> medical problems, we must be specific as to which medical problem is of major

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1 Ibid. p. 2.

importance.

The writer also suggests that further consideration be given as to the possibility of eliminating some data from the statistical forms. During the first year of their use certain items on the forms were omitted with such frequency that one is inclined to question the validity of continuing to use them. Of the 2,639 forms turned in, 1,558 lacked information as to the number of rooms in the household; 1,396 lacked information as to the education of the patient and 682 lacked information as to the number of children in the household. Likewise, there was no information concerning the type of dwelling and number of members in the household on a considerable number of forms. It is the writer's opinion that if these items continue to be frequently omitted, the department ought to consider the possibility of discarding these terms altogether.

In addition to these changes, a further change in the definitions of medical social problems might make for greater clarity. The frequency with which the writer has encountered marital problems co-existent with illness situations has led her to the conclusion that a separate heading is needed in order to record it adequately. At present the term 'family relationships' must be used but one has the impression that this is too general a term for such a specific problem. The term 'chronic illness' is not clearly defined as a medical social problem and this vagueness leaves too much scope for disparity in interpretation.[1] Since the problem of the care

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1 Supra. p. 82.

of the chronically ill is becoming the concern of many people in the community as well as of medical social workers and physicians, it is particularly important to establish a definition of the term 'chronic illness' which will be generally acceptable. The present definition fails to set limits on this term from the point of view of time. In other words, we do not know what a chronic illness is.

The whole problem of the use to which all the data are put is a serious one. In the first place, before trying to interpret the findings, we must realize that the material was collected under different conditions. For example, our analysis shows that during the year 1945 a total of 2,639 cards were filed, representing roughly the same number of people. Of this number 473 were young people between the ages of 10-19 years, i.e. about 17 per cent of the total patient load of the department. At first glance this would appear to be an unusually large proportion for a general hospital, but when the figures are read in the light of the fact that the policy in the Children's Medical Clinic during this period was for 100 per cent coverage, one realizes at once why the case load for young people of this age is larger than for any other age group. Again, if ome compares cases only on the basis of their source of referral, the neuro-medical clinic seems to be the source of referral for the second largest group of clinic patients. Once again, however, a knowledge of the administrative policy of this clinic tempers the conclusions that one would otherwise be tempted to make. During 1945 there was 100 per cent ~~cost~~ coverage by the medical social worker in this clinic

also. Because the largest age group is 10-19 years, one would be inclined to assume that the most frequent diagnostic group would be among the diseases common to young people. This is not the case, however, and we can understand it only when we remember that the table of medical diagnoses is compiled from a total of all three possible diagnoses for each patient.

A further problem concerning the use of these data is created by the circumstances of their origin. The medical social statistical plan now used at the M. G. H. was undertaken by the Social Service Department rather than by the Department of Medicine or by the administration of the hospital. There is therefore, a possibility that the material may not be used by other hospital personnel, unless an effort is made to acquaint them with it. In order that the Social Service Department may fulfil its function in the medical setting, medical social workers must take a further responsibility. If these statistics are to contribute to medical as well as to social information, they must be made known to the medical as well as to the medical social work group. And if medical social statistics are to become a vital part of the contribution of the social service department to the care of patients in a medical institution, the institution must be given an opportunity to use them. These problems are not insoluble and do not affect the potential values of this method. Any statistics may become just so much 'dead wood' unless they are vitalized by being put to good use. The most important matter is that this method of medical social statistical reporting has

potentialities far beyond any other medical social statistical method so far developed.

We have shown how this method may be used to measure the volume of 'accepted cases' over a twelve months' period and how, by a very simple procedure, monthly volume of work may be measured in relation to this basic scheme. We have also suggested how the material collected by this method may be used for research purposes in a truly medical social capacity. It may be used by medical social workers, by community councils, etc. It also has possibilities for use by the medical profession. Finally, it is obvious that one of the most desirable outcomes would be for it to be used as the basis of a research project sponsored by a hospital administration or by a group composed of physicians and medical social workers.

Our conclusions as to the permanent value of the method of medical social statistical reporting currently in use at the M. G. H. are dependent on one major fact. It cannot be reiterated too often that the ultimate value of these statistics depends entirely on the use to which they are put. To the best of the writer's knowledge, this method is the only one as yet developed which meets the basic requirements of a medical social statistics project namely, measurement of volume and carefully classified material for social research. If the statistics thus acquired are not used for anything more than an annual report, they will become 'dead wood'. If they are filed away for some vague 'future use', no matter how carefully each year's analysis is made, they will not justify the time and

expense involved in securing them. A statistically valid analysis of patients' medical social problems and circumstances is now possible. Let us hope that medical social workers will accept the challenge which it presents. May they have the courage to draw from it the conclusions which may prove to be essential to the health and welfare of those whom they serve.

CHAPTER VI

SUMMARY AND CONCLUSIONS

There are two significant results of this study which are, of course, related to the original purpose. In the foregoing chapters we have seen how medical social statistical methods have changed as the function of the medical social worker has become more clearly defined. We have also seen how, as they became more conscious of their responsibilities as professional people, medical social workers in at least one department, namely that at the M. G. H., have developed a method of medical social statistical reporting which has enabled them to fulfil the function of participation in social research.

In the early days, medical social workers were particularly conscious of being more or less 'tolerated appendages' to the medical institution and because of this they felt they had to justify their presence there. In addition to this, medical social work was a new specialty of the social work profession, which in turn, was only beginning to develop the concept of social case work.

Octavia Hill first gave expression to the basic concept of social case work as we now know it. Speaking in 1869 before the Social Science Association in London, she drew attention to the importance of knowing about a man's hopes, his history, his dreams, past experiences and how to "move, touch, teach (him)".[1] Social case work had progressed since that time

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1 Quoted by Mary E. Richmond in Social Diagnosis, New York, 1917. pp. 29-30.

but it is important to recognize that by 1905 when medical social work began, the philosophy of social case work, its techniques and practices were still in the process of being formulated. Social case workers in hospitals not only felt that they had to justify their existence, but they also had to learn to adapt themselves professionally to the institution and to the older professions of medicine and nursing which were basic to it. They were members of a newly-organized profession and in addition, they were responsible for developing its special application to the medical setting. As Mary Richmond said, in 1917, "what Dr. Cabot had in mind in bringing trained social workers into the dispensary...was not a mixture of medical and social work but their chemical union."[1]

Thus, in the beginning, medical social statistics had a tendency to try to show how busy medical social workers were and at what they were so busy. But by the year 1933, many developments had taken place in organized social work and in the theory and practice of social case work, particularly as it applied to the problems of the sick person. By this year also, the American Association of Hospital Social Workers had made a study of medical social statistical methods. Bearing in mind what was then conceived to be the function of the medical social worker, the Association made its first attempt to encourage medical social workers throughout the country to use a uniform method of statistical reporting. Throughout the

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1 Ibid. p. 35.

years 1933 to 1939 the American Association of Medical Social Workers, as the Association came to be called, made changes in its methods of statistical reporting which were consistent with changes in the concept of function in medical social work. In the present study, it has been evident that this 'chemical union' did not take place overnight but occurred only when each profession began to recognize its need of the other. Only as medical social workers came to see the broadest implications of their function, has it been possible to claim that they are at last within sight of that goal so clearly established for them in the beginning.

As we have seen, none of the methods devised by the professional organization has ever been completely satisfactory from the point of view of the purposes of medical social statistics nor have they succeeded in enabling medical social workers to fulfil all aspects of their function. In other words, the methods designed by the Association have succeeded in establishing, more or less satisfactorily, a basis for measuring volume of medical social case work. But this is not enough. These methods have not enabled medical social workers to produce any large body of material which would be useful for social research.

Fortunately, medical social workers have not been content to let their professional organization have the last word in regard to either their concept of function or their methods of statistical reporting. The Social Service Department at the M. G. H. has always maintained that progress springs from a constant awareness of one's short-comings and it has inspired

its workers to discover ways and means of mastering weaknesses. Perhaps this was because one of the founders of medical social work, Dr. Richard Cabot, was a physician at that hospital and because its first Chief of Social Service, Miss Ida M. Cannon, was a particularly objective person. One of the results of this attitude has been that in the area of medical social statistical reporting the M. G. H. Department of Social Service has constantly striven to improve on its own methods and on those recommended by the professional organization. Nor has it been indifferent to methods developed elsewhere. Before launching into a new project of statistical reporting in 1945, careful consideration was given to current methods in other departments. In the study we have just completed, we have examined the plan developed for the United Hospital Fund of New York City. We have seen that it emphasizes the case work interview because, as a major aspect of social case work, the volume of interviewing was considered to be an important index to the volume of case work. The writer has indicated that while information concerning case work interviewing may be valuable from the point of view of administrative policy, it does not make a unique contribution to our body of socially useful knowledge. Nor does it make socially useful material available for medical social research.

The Social Service Department at the M. G. H. undertook its new plan of statistical reporting in the hope that it would enable the medical social workers to analyze the problems which their patients presented. It was also hoped that the medical social workers would thereby be enabled to study their

contribution to the care of the sick. We have seen how this department has succeeded in meeting the need to keep a count of volume of work by using "the patient served" as its basic unit of count. But the new plan inaugurated in 1945 made it possible for the medical social workers to use a new classification of the types of social problems which confronted their patients, and of the environmental and personal factors related to the illness situation. This method of statistical reporting which fulfils the purposes of medical social statistics, namely, measurement of volume and provision of socially useful material, has other advantages as well. It makes use of the punch card, a modern technological device, which is used in many hospitals for other statistical purposes. But it might be mentioned in passing, that the method may be adapted to institutions not having an International Business Machine punch card system. Above all, it makes it possible for medical social statistics to reflect the current concept of function in medical social work.

It may seem surprising that medical social workers should have been so slow to develop medical social statistics which could be useful for research, particularly when their work has been so closely related to that of the medical profession. One reason for this may be that not all schools of social work require their students to undertake original research projects. And without some training it is difficult for the amateur to feel competent to undertake such a project independently. Furthermore, among those who are fully qualified, according to the requirements for membership in

the A.A.M.S.W., not all have been graduated from professional schools of social work where standards have been such as to offer any training in research methods. And finally, until recently the educational requirements for social workers have lacked uniformity. There are still many workers who have never had any formal training in either social case work or in the practice of case work in a medical setting. And for those practising in the medical setting, there has been the additional conflict over their status in that situation. There is no need to assume that we must wait until there are sufficient workers to enable us to 'spare' some for research purposes. Medical research has proceeded in spite of the fact that the number of skilled practitioners has been disproportionate to the need. Medical social workers must have the courage to acknowledge their weaknesses and the foresight to promote ways and means of overcoming them. As long as medical social workers fail to produce conclusive evidence of their contribution to the care of the physically handicapped, the chronically ill and the acutely ill, they are failing in their responsibility not only to their own profession but also to the profession with which they are allied and to the community which each is seeking to serve.

In this study we have cited examples of isolated projects in medical social statistics which have sought to aid medical social workers in the performance of their job. There are other examples of research projects which have been carried out by individual medical social workers, by groups of medical social workers and by medical social workers and physicians.

But the profession as a whole has not placed sufficient emphasis on this aspect of its function. We regret that the A.A.M.S.W. has not seen its way clear to undertake any study of the problem of medical social statistical reporting since 1939. It is the writer's opinion that the method currently in use at the M. G. H. is an important step towards providing material for social research. But this is only a beginning. If the A.A.M.S.W. is to provide leadership to professional medical social workers it must be prepared to stimulate an interest in this as in other areas of their work.

We conclude therefore, that medical social statistics have, during the past forty years, been an index to current concepts of function; that as the function of the medical social worker has become more clearly defined, these methods have undergone constant change. Not all these changes have been promoted by the professional organization of medical social workers, and where changes have occurred in individual departments or in certain centres, they have not followed the same pattern. But in at least one medical social service department, namely that of the M. G. H., where it was recognized that medical social workers could accumulate a body of material which would lend itself to medical social research, a means of doing so has been developed. After forty years, the central function of medical social work which is the practice of social case work in a medical setting, has risen to the top like cream to the top of the bottle. But there would be no cream had the milk not contained the constituents of cream in the first place. Medical social workers have at

last found a quantitative scientific method for increasing their own understanding of the stresses and strains which complicate the lives of sick people. They have also in this statistical method, made it possible to locate case material which will in turn contribute to the understanding of other members of the medical team as well as others in the community. Let us hope that the leadership which the M. G. H. has so often given in the past in the field of medical social work, will again have far-reaching results.

APPENDIX

CODING OF ITEMS ON STATISTICAL FORM

A. Name of Patient (not coded)

B. Unit number and Social Service number (Be especially careful to have the unit number accurate, as it is the only coded means of identification.)

C. Date of birth (Month, Day and Year)

D. Age (In months for babies under 1 year. All others by years.)

E. Sex and Color

1. White Male	5. Yellow Male	
2. White Female	6. Yellow Female	(These two items
3. Black Male	7. Other Male	are combined for
4. Black Female	8. Other Female	punch card purposes)

F. Birthplace (Use world conditions approximately as of 1934.)

G. National Background
(By country of parents. Example: a person born in Turkey of Greek parents would have a Greek National background. Where mother and father are of different national backgrounds, the mother's should be entered.)

H. Clinical Source of Referral

I. Source of Referral to Social Service
1. Physician
2. Administrator
3. Nurse
4. Patient himself
5. Family or friends
6. Outside social or public health agency
7. Social review
8. Other

J. Date of referral (Month, Day and Year)

K. Date of closing case (Month, Day and Year)

L. Duration of case (Difference between dates of referral and closing)

If the duration is:
under 1 week, give figure in days
under 1 month, give in weeks only (nearest)
under 1 year, give in months only (nearest)
over 1 year, give in years only (nearest)

M. Status of case (As to contact with Social Service)
   1. New
   2. Carried over from last year (as of January 1)
   3. Reopened - from prior year
   4. Reopened - 2nd time this year
   5. Reopened - 3rd time this year
   6. Etc.

N. Case Worker's name and number
   (If case is transferred to other workers, there are two additional places on form to show such transfers consecutively.)

O. Marital Status
   1. Single
   2. Married
   3. Separated, voluntarily without legal action
   4. Separated, legally
   5. Divorced
   6. Widowed

P. Citizenship
   1. Citizen
   2. Alien - 1st papers
   3. Alien - no papers

Q. Religion
   1. Protestant
   2. Catholic
   3. Jewish
   4. Other
   5. None

R. Occupation and Industry (Specify each whenever possible. Code of the U.S. Bureau of Census used.)

S. Education (When filling in the form, state simply years of schooling finished, plus any other pertinent information, such as degree, etc.)
   1. Less than 4 years grade school
   2. More than 4 years grade school but not completed
   3. Grade school completed
   4. High School but not completed (includes junior high)
   5. High school completed
   6. College, but not completed
   7. College, completed with degree
   8. Technical training with or without college
   9. Professional training after college
   10. Other

T. Residence
   (Address, municipality and state, or foreign country. Special code is used for Welfare Sections of Boston; municipalities of Massachusetts; States; and outside U. S.)

U. Patient's Status in Household
1. Living with spouse
2. Living with children but without spouse
3. Living with parent or parents
4. Living alone
5. Other

V. i. Number of members in Household (including patient)
ii. Number of children in Household (of all children under 18 years, including patient if a child)

W. Number of Rooms in Use in Dwelling
(If a person has a single room in a boarding house, he would be living alone in one room and have only one member in the household. Also any rooms which may be closed off and not used are not counted.)

X. Type of Dwelling
1. House (includes 1, 2, or 3 family house)
2. Multiple dwelling (includes tenement and apartment houses)
3. Boarding House
4. Institution
5. Hotel
6. Other

Y. Medical Diagnoses (including Psychiatric)
(Maximum of three to be entered. Major diagnosis first. Add 2nd and 3rd diagnoses only when they are important ones in the whole medical picture, and not if they are minor complications of the major one or generally of little immediate consequence.)

Z. Medical Social Problems

The following list of problems is selective and does not attempt to cover every possible medical social situation. The criteria for entering a problem are:

a) that it be related to the illness situation
b) that it be a problem regarding which it seems likely that patient or family may need some assistance and in relation to which the worker will assume some responsibility
c) that as far as practicable the major social problems be entered first and the others following in decreasing order of importance
d) that there be entered a maximum of eight problems.

Illness Situation:

1. Chronic Illness: Covers whole problem of chronic illness, physical, mental or emotional, and its care, in broadest sense, whether at home or in institutions, economic and psychological aspects.

2. Convalescence: Insofar as it enters into the situation as a problem affecting the patient or his family, whether at home or in an institution, brief or long. As compared with chronic illness, the emphasis here is on the special problem of convalescence whether or not connected with a chronic disease. (Usually shorter term care and cure.)

3. Costs of Medical Care: The emphasis here is on the various costs which arise from an illness, which place upon the patient or family a burden beyond their capacity, with resultant strain and usually some need for outside assistance.

4. Dietary Problem: Diet may have contributed to the present illness or may appear as a difficulty needing adjustment only after diagnosis of the illness.

5. Handicap (Physical): Permanent and irreversible physical damage, which calls for a revision in the patient's pattern of behaviour.

6. Handicap (Mental or Emotional): Presumably permanent and irreversible damage of a mental or emotional nature which calls for a revision in the patient's pattern of behaviour.

7. Industrial accident or Disease: In the strict sense, such as accidents occurring while on the job, or diseases arising from working conditions, resulting in poisoning, silicosis, etc. Problems beyond the injury or disease are intended - insurance, legal aspects, etc.

8. Pregnancy: Problems relating to pre-natal care, etc.

9. - 19.

Attitudes Toward Illness:

20. Patient's Attitude: Where there is a subjective emotional reaction to the illness situation, physical or mental, in which there is a real need for adjustment by the patient.

21. Family's Attitude: Where a problem arises because of emotional or other strong reactions of any members of the family towards the patient's illness, mental or physical.

22. Misinformation: A problem arising in attitude toward illness by either the patient or his family on the basis of being wrongly informed regarding the illness, or its significance.

23. - 29.

Social Situation:

30. Cultural (or Ethnological) Problem: As to language, attitudes, or failure to assimilate American culture, as in some immigrants.

31. Family Relationships: Problems of personal relationship within the patient's family group, for example, unusual tensions, overt disruption of family ties, conflict over emotional dependence or independence, emotional or tangible; in other words, when there is a problem of inter-relationships centered in the family group and not necessarily in the illness. (If the problem is centered within the patient, it should be entered under the section Personal Characteristics.)

32. Financial Problems: Inadequate income, financial strain, budgetary problems, aid from public or private agencies. As distinguished from Costs of Medical Care, this item is concerned with general family finances.

33. Illegitimacy: Problems associated with the pregnancy of an unmarried woman, abortion of such, or of an illegitimate child and its effect on the future of the child and the mother.

34. Isolation: Separation from family and intimate group, homelessness, lack of "primary group", broken home.

35. Occupational Adjustment: Whether physical or psychological, paid job or home activity. Includes problems of vocational guidance, rehabilitation, unemployment, unemployability, etc.

36. Problems of Material Responsibility (in family life): For instance, unusually large family, care of old age, necessity for special care for children, difficulties that arise from combined households.

37. Recreational Problems: Problems to do with recreation, and other non-vocational outlets.

38. School and Educational Adjustment: May be physical or psychological.

39. Societal Factors and Community Problems: Includes problems of larger sociological nature, such as housing shortage, lack of resources, technological unemployment, strikes, war regulations, living in deliquency area or backward community.

40. - 49.

Physical Environment:

50. Living Conditions: Problems of physical environment, inadequate or unsuitable shelter, clothing, furniture, sanitation, transportation facilities, etc.

Personal Characteristics:

60. Borderline Psychiatric Problems: Includes problems of mental or emotional instability which are potentially pathological but not yet diagnosed.

61. Destructive Habit: In a child - deliquency, tantrums, lying or pilfering, other evidences of habitual disturbing conduct. In an adult, alcoholism, drug addition, prostitution, sex perversion, other self-destructive or anti-social behaviour.

62. Disfigurement or Permanent Impairment: When preceding present illness and not requiring medical care.

63. Low Intelligence: Where there is a problem because of limited mental capacity. There may or may not be a diagnosis of mental deficiency.

64. Personality: Problems relating to traits of personality and individual patterns of behaviour, such as eccentricities, childishness, irritability, lack of initiative, hyper-independence, etc.

65. - 99.

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