A REPORT ON THE SURVEY OF CHRONIC ILLNESS ADMISSIONS FROM THE METROPOLITAN AREA OF HALIFAX TO THE PUBLIC WARDS OF THE VICTORIA GENERAL HOSPITAL

BETWEEN JANUARY 21st, 1957
AND FEBRUARY 28th, 1957

by

Mary Louise Courtney

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ABSTRACT

To consider the resources needed for the care of the chronically ill, a study of Chronically Ill persons admitted to the public wards of the Victoria General Hospital from the Metropolitan area of Halifax during a six weeks period from January 21st, 1957 to February 28th inclusive.

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CHAPTER I

INTRODUCTION

Since creation, sickness has plagued the foot steps of man and has been his constant companion. It has seen the passage of generations, indeed of centuries. The medical profession and its scientist have waged an ever ceasing struggle with illness. It has won many battles. Tuberculosis, a chronic illness, once a dread disease because of its high mortality rate, has been arrested and can be cured. The antibiotics or "wonder drugs" have been successful in controlling infection. Surgery, an essential branch of medicine, deserves much credit. Such operations as appendectomies and tonsillectomies have resulted in the healing of thousands of individuals who might have died unless such surgery was available to them.

Medicine still has a long road to travel. The chronic illnesses are now presenting themselves forcefully to society. They are more evident than ever because people are now living to an age where chronic illness might afflict them. The emphasis has been upon the infectious diseases common to all ages and now the emphasis is shifting towards chronic illness and its treatment and prevention. Chronic illness has been accepted by many as not treatable and this feeling could retard its treatment.

The social implications of the illness are varied and can be traumatic.

> The so-called Chronic diseases have become the chief causes of illness and death. Seventy-five years ago these diseases caused only one-fifteenth of all deaths; today they are responsible for as much as three-quarters. To an even greater extent they involve a tremendous volume of illness and invalidity. Whereas an acute infectious disease quickly results in recovery or death, death from a Chronic disease is preceded by years of sickness, so that the social significance of the Chronic diseases cannot be measured by mortality tables alone.[1]

Chronic illness must not only be considered in its medical sense but also in its complications involving the total person and other members of the family and community. This can be forgotten in the age of specialization which is being experienced in North America. Medicine has been greatly affected by specialization. There exist heart specialists, obstetricians, pediatricians, gynecologists, urologists and surgeons, to name but a few. It seems frequently that the emphasis could be upon the illness rather than upon the individual afflicted with the illness. This could result in the loss of dignity and respect which is due each individual as well as failure to treat effectively the illness itself. The chronically ill person could suffer more extensively from this focus, than the acutely ill patient, because of the long duration which characterizes chronic illness.

One cannot separate the illness from the individual if one is concerned with the attitudes and standards which

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[1] Ernst P. Boas, M.D."Chronic Diseases" - Medical Addenda (New York The Commonwealth Fund 1947) p. 127

each human being possesses. The social worker is vitally interested in the total person and his social relationships and environment. The chronically ill person should have his illness treated with this awareness. He does not live completely unto himself. He has a family or friends which affect his emotions, his personality and his character. The community in which he lives has its influence on him.

Is the chronically ill person going to return to his same job? How can he afford to face long term illness? Who is going to pay the hospital bills? How will he provide for his family? To what extent will he be incapacitated? Will he ever recover? These are just some of the questions which may cloud the mind of the chronically ill.

These are the social implications which concern the social worker and which in this survey the social workers should be competent to discuss.

Miss Pauline MacDonald, Director of the Social Service Department at the Victoria General Hospital, believed that a survey or study on Chronic illness by the second year students at the Maritime School of Social Work would be helpful to many connected with the problem of Chronic Disease. Chronic illness has not been adequately studied in its entirety. Only the surface has been touched. The surveys which have been conducted and the literature written on the subject have been limited in comparison to that on the acute diseases.

It seems probable that the community attitude which seems often to include resignation to the inevitability of the illness and the belief that is untreatable may account for the lack of anything like adequate coverage of the needs and resources which the chronically ill have and require. As a result of this lack and of the belief that a survey would be helpful in more clearly painting up the social implications, interest was stimulated in the subject. It was agreed that a study on chronic illness should be undertaken in partial fulfillment of the requirement for the Degree of Master of Social Work.

The first task facing the class was the finding of a proper limitation of the study upon which the research efforts of the class would be focused. The abstract which the class finally selected reads as follows: "To consider the resources needed for the care of the chronically ill, a study of chronically ill persons admitted to the public wards of the Victoria General Hospital from the metropolitan area of Halifax during a six week period from January 21st, 1957 to February 28th inclusive."

This abstract had the terms in it carefully considered and after much research a definition of chronic illness was finally decided upon. It is as follows: "Chronic disease, like chronic health is difficult to define precisely. The shortest inclusive definition is that it refers to disease which is not self limited in duration by its very nature, such as measles, pneumonia or a broken leg, but persists as either a continuous process or by producing, permanent, long term or recurrent disability or impairment of health."[2] The extent of the metropolitan area of Halifax can be seen in the appendix.[3]

Once the definition of terms in the abstract was reached by common agreement of the students, the class began conducting a more practical protion of the survey. The students made up a schedule consisting of many questions. In an effort to test its validity and accurateness a pre-test or a trial run was made. In this pre-test over forty patients were interviewed. The pre-test was conducted at the Victoria General Hospital. It was found, as a result of the pre-test, that many of the questions could be improved upon to make it more helpful to the patients in answering the questions and to give it greater usefulness. A revised schedule consisting of twenty-four questions and face sheet was agreed upon by the class members. Many time consuming hours had been spent on this schedule and the final revised schedule can be divided into three parts. The first division deals with accommodations or social resources and the two following divisions deal with economic and medical resources respectively. All three divisions were gear to obtain certain information which would give a clearer picture of chronic illness as it affected the total man and to come to some realization of the effect the illness had upon his life and the lives of others.

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[2] Morton L. Levin M.D. - "National Planning for Chronic Disease Control," Social Work in the Current Scene 1950 (New York:Columbia University Press, 1950), p. 107

[3] See apendix for Metropolitan area of Halifax.

In conducting the survey between the twenty-first of January 1957 and the twenty-eighth of February 1957 each student was assigned a different ward or wards. The wards were public. Many patients who could not afford more expensive hospitalization, if they could afford any at all, were hospitalized in these wards. There would be others as well who would be in these wards by choice. Many might enjoy the companionship derived from the presence of others. It was expected that the Tables would show for the most part people who were in the lower income brackets of society. There were some private patients interviewed on these public wards who might not have been admitted to the public ward if there had been room elsewhere in the hospital.

There were 171 patients admitted to the public wards with a provisional diagnosis of chronic illness, during the period of time in which the survey was conducted. However, of the 171 patients a total of thirty-nine schedules could not be used for the reasons listed in Table I. Six of the patients were discharged before interviewers were able to interview them. For the most part these patients had been hospitalized for a very short time before they were discharged from hospital. Ten could not participate because they were too ill to be interviewed. Fourteen patients or 8.2% of the total sample refused to participate in the survey.

TABLE I

NON-TABULATORY

REASONS FOR NON-PARTICIPATION OF PATIENTS

	TOTAL	SEX	
		MALE	FEMALE
Total	39	17	22
Discharged	6	4	2
Unable to Part. Because of Sickness	10	3	7
Language Barrier	2		2
Refused	14	5	9
Senility	3	2	1
Died	2	1	1
Transferred To Private Room	2	2	

All the patients included in the survey were given the opportunity to make their own decision as to their participation. The interviewers, as social workers, recognized the patients' right to self determination. This principle recognizes the individual should have a right to make his own decision. Unless the decision was his, the results obtained might not have been beneficial to the patient and might not have been helpful to the survey.

There were 132 patients who were interviewed in the survey. However, the face sheet information was available for use on all the admissions for chronic illness. Some of this information from the 39 patients who were not interviewed will be used in another chapter in this thesis. These will be referred to as the non-tabulatory interviews.

Between the period from January 21st to February 28th inclusive there were 389 admissions of all kinds to the hospital. A total of 171 of these were admitted for chronic illness. Chronic illness in the public wards accounted for 43.9% of the admissions to the hospital between January 21st and February 28th inclusive. It seems then that the survey covered an adequate sample for that period.

The Chronic diseases, tuberculosis, with the exception of one patient, and mental illness, were not included in the survey. These were not included because both these illnesses are receiving attention in hospitals other than the public wards of the Victoria General Hospital.

The survey did have limitations. It was only possible to interview patients who had been admitted with chronic ilness between January 21st and February 28th. As a result the chronically ill patients who might have been in hospital for a longer period were not interviewed. Many or all of the patients interviewed had been admitted to the hospital for at the most a week and usually one one or two days before they were seen by an interviewer. As a result many of the questions such as question 14 in the schedule ("Do you think your health will allow you to work again?") could not be answered accurately by some of the patients because they had not been hospitalized sufficiently long to have knowledge of the incapacitating factors of their chronic illness. The patients also could not answer this question adequately unless they were advised by their doctor as to the effect the illness would or might have upon the work picture. It was not possible for the interviewers to obtain this information from the doctors due to the limiting factor of time.

Unfortunately time did not permit the survey to be as comprehensive as it might have been. It would have been revealing and more meaningful if the patients interviewed in this survey had been followed up in their place of residence after their discharge from hospital.

It was also found that some of the questions asked on the schedule were loaded emotionally. The questions asked on finances often evoked emotional responses which were difficult for the patient to control. Some patients were not affected in this manner by the subject of finances. The standards of many individuals differ and there is a danger that one will superimpose his standards upon others.

Many of the feelings of inadequacy and the patients inability to manage independently of family or others came through in the financial division of the schedule. Perhaps some of these patients had been able to be financially independent of family or others for many years and finally reached the point when it was no longer possible for them to live without the financial assistance from external sources. One can realize the emotional disturbances due to loss of independence and feelings of shame and hostility which some of these patients might feel. Some patients have fears around their inability to pay hospital bills and treatment and fears that they must depend on others to pay. Others may feel proud that they have someone who is willing to pay for their hospitalization. They may possess the attitude that they have provided for their family for many years and therefore have no misgivings that their children or relatives are assisting them. Others, too, may feel that they have paid taxes and have a right to receive the financial support of society. It seems probable that every question or many of the questions, regardless of how well chosen, would cause some patient to have misgivings concerning his decision to participate in the survey.

The survey gave the students an opportunity to observe the chronically ill patients in the acute stages of their illness and were able to see many of the social implications which such illness carries.

The implications of the survey for social work are varied and emphasize the extent of the problems both tangible and intangible. The social worker focuses her attention upon the individual and his needs and resources. The survey has furnished further opportunity to do this as it relates to the chronically ill individual. Everyone of the patients interviewed had the problem of long term illness and its effect upon his life and upon the lives of others. This shows that the social worker has something of definite value to offer the chronically ill individual and the survey has pointed out to the author, the role of the social worker in the treatment of the chronically ill.

The following chapters concern themselves with the economic, medical and social implications of chronic illness. Chapter II studies the age, sex, marital status and living arrangements of the chronically ill patients included in the survey as they indicate the needs of the chronically ill. Chapter III is entitled, Health and Welfare, and studies the social implications of chronic illness. The fourth chapter concerns itself with the employment, occupation and income of the chronically ill and shows some interesting facts which seem to coincide with other studies on chronic illness. The final or fifth chapter gives the conclusions and recommendations which follow as a result of the preceding chapters.

CHAPTER II

AGE, SEX, MARITAL STATUS AND LIVING ARRANGEMENTS

This chapter deals with the age, sex, marital status and living arrangements of the chronically ill patients covered in the survey. The living arrangements whence they came before hospitalization and the living arrangements to which they feel they will be returning will be considered. However, the chapter only deals with these specifics in the social implications for the patient and his family or others associated in some way with him.

Before beginning the survey, many of the class members felt that chronic illness struck only the elderly citizens in society. The results from the survey did not support this belief. In Table II on page 14, 67 of the 132 tabulatory interviews show these patients to be between the ages of sixteen and fifty-five. Thirty of these 67 patients were between the ages of forty-six and fifty-five; of these 18 were females and 12 were males. Although there are 75 men in the sample and only 57 women, the women outnumber the men in the age grouping of forty-six and fifty-five by six. Sixty of the patients were between the ages of forty-six and sixty-five. As can be seen from observing this table, chronic illness strikes young and old of both sexes.

Neither youth nor old age has escaped from its influence. But the older members are strongly affected by chronic illness. At least this survey indicated this. Ninety-five individuals of the 132 were over forty-five years of age.

Chronic illness does affect all age groupings. Some of the chronically ill would be at the age where society might expect them to be helpful in contributing to society in the way of income tax and service. The elder chronically ill citizen might not have the number of dependents which the younger chronically ill person might have. In considering the age of the chronically ill, many problems for the individual and his family might arise. Their social needs can be best received from the position of the social worker. The family needs interpretation as to the meaning of the illness as it affects the patient. The social service department can be a resource for these patients in finding help with their problems. The attitudes of the patient can seriously affect his recovery. They can retard or exhilarate his progress.

The acceptance of chronic illness would be difficult for many. It would seem probable that many who had been very active in their life would find it difficult to live within the physical limitations which chronic illness might set. In the comparatively young person, this could induce great emotional hardships.

In the sample of 132 patients, 71 patients or 53.7% were married. Twenty-eight or 21.2% were single and twenty-one of these were men. Twenty-four were widowed or 18.1% and of the twenty-four, 18 were women. This emphasizes the known fact in society that women do live longer than men.

Sixty-one of the patients were either single, widowed or separated. This accounts for almost half of the total. How does marital status affect the lives of the chronically ill? The patient may have anxiety about his dependents, if he has any, around the manner in which he is going to continue helping himself and his family. If the mother in the family is stricken with chronic illness and rendered helpless, the welfare of her children may be one of her chief causes of concern. If the breadwinner is stricken, his concern might centre around provision of financial support for his dependents. The single members may have family members depending upon them for support. Single patients, unless they have some close ties with family or friends, may have acute emotional needs, which may be highlined by illness. All of these expected problems point to the need of an adequate social service department in the hospital which employs social workers equipped to deal professionally with these problems and others. The social worker can help the patient adjust his attitude to the incapacitating factors of his illness. She can also help in the adjustment of the attitudes of family and friends.

This may be more difficult as the family might not be as accepting as is the individual afflicted with the chronic illness. The social worker may have knowledge of resources in the community which might be helpful in relieving some of the stresses with which the chronically ill person is faced. There were no divorced patients in the survey but there were 9 or 6.8% separated. In observing the census figures for 1951, it is interesting to note that in the metropolitan area of Halifax with a population of 133,931, there were 68,626 or 51.2% single.[4] In the survey 21.2% were single. According to the census 58,964 or 44% were married and according to the survey 53.7% were married. There is quite a discrepancy between the numbers widowed. In the census report 5,976 or 4.4% were widowed and in the survey 18.1% were widowed. Two factors must be taken into consideration when observing these figures. The population of the metropolitan area of Halifax has increased to a total of 159,678 since 1951.[5] Also, the total population figures for the metropolitan area include children. In the survey on chronic illness which the students conducted at the Victoria General Hospital, all the patients were at least sixteen years of age. This may account for the discrepancies which exist when comparing the figures.

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[4] Canada, Dominion Bureau of Statistics, <u>Census of Canada, 1951</u> Volume 1.

[5] Canada, Dominion Bureau of Statistics, <u>Census of Canada, 1956</u>, Parliamentary Series #7.

TABLE IV

LIVING ARRANGEMENTS OF CHRONICALLY ILL ACCORDING TO SEX

TYPE OF LIVING ARRANGEMENTS	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Alone	7	1	6
Immediate family	90	46	44
Relatives or friends	8	6	2
Boarding and rooming houses	22	19	3
Nursing Home	1	0	1
Home for aged	2	1	1
City Home	1	1	0
City Prison	1	1	0

Table IV above shows the living arrangements from which the patients came prior to their admission to hospital. It was thought that more would have come from nursing homes or from rooming and boarding houses. But by far the greatest number, 90, had been living with their immediate family. (For the purpose of this thesis immediate family means husband, wife or children of patient). This seems significant and might indicate that these patients have not yet been affected by the breakdown of family living and urbanization which has affected other centres.

By far the majority of the patients partaking in the survey came from living arrangements where there were present other individuals such as family, friends or associates. This means that the patient would in all probability influence or be influenced by their presence.

There were 7 of 132 patients who lived alone prior to hospitalization. Six of these people were women. There were 22 living in rooming and boarding houses. These chronically ill people might suffer more because of the added fear that no one would be available to care for them if they were returning to these same living arrangements. If the chronic illness with which these patients were afflicted had incapacitated them, it would be difficult for them to look after themselves under those conditions. One chronically ill person had lived in a nursing home. Two had lived in a home for the aged and one had lived in the city home and one in the city prison. The patient who had come from the city prison expected to return to the prison and complete his sentence.

TABLE V

ANTICIPATED LIVING ARRANGEMENTS OF CHRONICALLY ILL FOLLOWING HOSPITALIZATION ACCORDING TO SEX

LIVING ARRANGEMENTS AFTER HOSPITALIZATION	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Same place	122	72	50
Different place	6	2	4
No place to go	0	0	0
Don't know	4	1	3

It was also asked of the patient the living arrangements to which they expected to return following their discharge from hospital. It is interesting to observe that 122 patients intended to return to the place whence they came. This shows optimism on the part of these patients or perhaps it might indicate their refusal to face or accept the reality that the same accommodations might not be available to them. Six persons thought they would be returning to a different place. It is encouraging to note that of the 132 persons interviewed, there was not one person who definitely indicated that he had no place to go. However, there were 4 patients who did not know what there living arrangement would be. Table V on page 18 does seem to indicate optimism on the part of the patients and perhaps also indicates some lack of realism.

CHAPTER III

HEALTH AND WELFARE

In considering chronic illness it is necessary to cover welfare aspects of the illness as well as the medical viewpoints and implications. The welfare of the patients is interwoven closely with the health aspects of the problem of chronic illness and cannot be separated. Both affect each other and so it is impossible to isolate factors unless the total picture is also considered.

A listing of the illnesses which are considered chronic must be given so that an indication of the seriousness of the problem of chronic illness can be given. Table VI on page 21 breaks down the chronic illnesses into twelve divisions and the chronic illnesses for which the patients were hospitalized fit under these divisions.

It is interesting to note that the patients admitted with a provisional diagnosis of cardiovascular disorder or cancer ranked first and second respectively in frequency. There were 33 patients given a provisional diagnosis of some cardiovascular disorder. Twenty-one were male and twelve were female. There were almost twice as many men afflicted as there were women and from observing

Table II on page 14 it can be seen that of the patients interviewed there were 57 women and 75 men. In other words, 56.8% of the patients interviewed were men. Twenty-six patients were given a provisional diagnosis of cancer. Thirteen of this number were women and thirteen were men. The cardiovascular disorders and cancer, taken together account for 59 of the 132 or 44.6% of the total.

TABLE VI

CLASSIFICATION OF CHRONIC ILLNESS ACCORDING TO SEX

DIAGNOSIS	TOTAL	SEX MALE	 FEMALE
Total	132	75	57
Gastro-Intentinal	14	10	4
Genito Urinary	5	4	1
Cardiovascular	33	21	12
Central Nervous	7	3	4
Locomotor	12	7	5
Pulmonary	15	6	9
Metabolic	13	5	8
Cancer	26	13	13
Tuberculosis	1	1	1
Cellulitis	2	2	0
Leukoplakia	3	3	0
Lupus Erythematosis	1	0	1

It has been stated in other studies on chronic illness that cancer and heart disease are the leading causes of death. "The death rate in the United States from cancer in 1940, was 120.3 per 100,000 population constituting the second leading cause of death; the first, heart disease, had a rate of 292.5."[6] The mortality figures are high for cancer and for heart disease. Although the survey does not indicate any mortality figures, it can be assumed that since such a high percentage of the patients had cancer and cardiovascular disorders in comparison to the other chronic illness, that the mortality rate would be comparatively high.

Chronic illness may produce fear and anxiety in many people. Those who have cancer may have their fears sharpened because of the attitude in society that such a diagnosis means a poor prognosis and that it most frequently results in death. The cancer patient may have delayed in seeking medical attention because of these fears. It is a disease which often discussed in pushed tones by the physician and others alike. Unless the patients know the diagnosis, it might be difficult for them to understand and accept the necessity for the medical treatment prescribed. The social worker must use discretion in discussing it with the patient and with the family. Often when the prognosis is very bad, it may not advisable to tell the patient. As in other casework situations, much depends upon the individual, his strength and limitations. The high incidence of cancer

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[6] Frances Upham, A Dynamic Approach to Illness (New York, Family Service Association of America. Copyright 1949),p.24.

shown in the survey indicates, possibly, the extensiveness of the problem and points up the need for further emphasis upon helping the patients understand the illness and in seeking early treatment. If a fatal prognosis is made, the family should be notified and helped to understand the implications for the patient so that he can receive the support and care which he might need very badly.

A cardiovascular diagnosis frequently means restricted activety in work, employment, recreation and in daily routine. Often these patients suffering from heart disease realize that their illness will cause death at some time. Often they are resigned, accepting and understanding of their illness. They know that they have limitations which cannot be exceeded without serious repercussion to themselves. Others are not as accepting and deny that they cannot perform duties and activities which could be done prior to the cardiovascular disorder. Many can continue living useful lives and perhaps live longer if they are helped to understand and accept the implications of their illness.

The disorders of pulmonary, metabolic and genito urinary systems in that order, follow cancer and cardiovascular disorders in frequency. The other chronic diseases in Table VII on page 24 did not occur as frequently as did the others which were mentioned above.

TABLE VII

PREVIOUS HOSPITALIZATION FOR PRESENT CHRONIC ILLNESS

	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Previous Hospitalization	82	44	38
No Previous Hospitalization	50	31	19

TABLE VIII

PREVIOUS HOSPITALIZATION WITH OTHER CHRONIC ILLNESS

	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Previous Hospitalization	31	19	12
No Previous Hospitalization	101	56	45

The author can remember hearing a chronically ill person telling her that the difficulty which she found with chronic illness was its length and the fact that it did not cause death earlier. Thus one is able to see the misery that chronic illness carries. Its length often causes despair in the patient and some patients in the survey were heard to remark that they wondered if they would every be discharged from hospital. Some added to their answer on accommodation after discharge from hospital "if I don't die!"

Table VII on page 24 shows that 82 patients of 132 had been hospitalized previously with the chronic illness for which they were receiving treatment at the time of the survey. Fifty patients had had no previous hospitalization for that chronic illness.

According to Table VIII on page 24, 31 patients of the 132 had been hospitalized at a previous time for some chronic illness other than the one for which they were being treated at the time of the survey. There were 101 patients who did not have hospitalization with other chronic illness. It is interesting to observe that in the survey most of the patients had been hospitalized for one chronic illness and did not suffer from more than one. Yet 31 did have previous hospitalization with other chronic illnesses and it must be impossible to imagine the amount of suffering and disability either physical or emotional which many of the sufferers of chronic illness endure. The problem is extensive and heart breaking. It remains as one of the greatest battles which the combined force of society must wage.

TABLE IX

LENGTH OF PREVIOUS HOSPITALIZATION FOR ANY CHRONIC ILLNESS

	TOTAL	MALE	FEMALE
Total	98	55	43
Less than 3 Months	66	34	32
3 Months - 6 Months	20	13	7
Over 6 Months-9Months	4	1	3
Over 9 Months - 1 Year	2	2	0
1 Year and Over	6	5	1

TABLE X

LENGTH OF PREVIOUS HOSPITALIZATION FOR 6 WEEKS AND UNDER

BREAKDOWN FOR FIRST SIX WEEKS			
		SEX	
	TOTAL	MALE	FEMALE
Total	49	29	29
Less Than 2 Weeks	12	9	3
2 Weeks - 4 Weeks	25	15	10
Over 4 Weeks - 6 Weeks	12	5	7

Table IX on page 26 shows that 98 patients of 132 had been hospitalized with some chronic illness prior to their hospitalization at the time of the survey. (The length of hospitalization which they were undergoing at the time of the survey was not included). Sixty-three patients had been hospitalized for a total period of less than three months and 20 had been hospitalized for a total period between three months and six months. Six were hospitalized for a total length of one year or more.

It is interesting to observe in Table X on page 26 that each of 49 people out of 98 people hospitalized for any chronic illness, had been hospitalized for a period six weeks or less. This leaves the other 49 patients hospitalized for a total period of time over six weeks.

It has been determined from the material gathered from the survey that the 93 patients hospitalized had spent on the average of a total of seventy-five days each in hospital because of chronic illness. The average length of hospitalization at the Victoria General Hospital for acute illness was twelve days.[7] It was also thought that the average length of hospitalization for chronic illness was twelve days. However, the patient suffering from chronic illness comes in much more frequently. It is the feeling of some that the chronic patients' average stay is only twelve days because he is discharged when the acute stage of his illness has passed. This is done because the general hospital is not equipped to deal as fully as a hospital for the chronically ill to the needs of the chronically ill patient and as a result the chronically sick patient may return more frequently to hospital because of his unmet needs.

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[7] Annual Report of the Victoria General Hospital,1955-56, 89th Annual Report (Halifax, N. S. 1956).

It must be discouraging for the patient to return so frequently to hospital. Each individual is different and has developed his own methods of handling the long term problem of chronic illness. If a plan could be devised whereby these patients could receive adequate treatment in relation to himself, his family and community, the problem of chronic illness would be at least one step further on the road to eradication. Such a system could be a home care program.

In this program, the patient is treated as an individual with feelings, asperations, attitudes, treated in short as different from all other individuals. There may exist the possibility of emotional factors which must be considered in the treatment or in the helping of the chronically ill. Some will improve upon tangible assistance which they receive. Others suffer or have their chronic illness closely associated with complex and often neurotic attitudes, and can often be helped through skillful direction, understanding and support on the part of the caseworker.

The home care programs intergrates services to patients and includes medical, nursing and social services and drugs and supplies. There may be other services offered as well including physiotherapy, etc. The medical care the patient requires is considered in the light of the social implications with which the individual is often bound. The name "home care" means that the chronically ill patient receives assistance in a setting where his family or friends are present. Thereby, it is a more natural setting than the hospital. The fear the patient has or might have of loss, abandonment and separation might be at the least lessened and at the most eradicated, if the home care plan is found to be a feasible one for the patient and for his family or friends.

The social worker has a definite role in this program. She can interpret the illness to the patient and to his family and help them adjust to the social and emotional problems which might be involved in the home care of the patient. Many families might not be aware of the extreme importance which the emotional components of the chronic illness play in the treatment of the chronically ill. Their anxiety may exist around the fear that they are incapable of providing the proper medical care which the patient would require. The social worker's role is to interpret the meaning of the chronic illness to the family and to give encouragement and support to them in their ability to cater to the patient and in the importance which their presence and acceptance of the illness has upon the chronically ill family members.

The home care program is especially important to the chronically ill person in that he may need continued help and may not be in any financial of emotional position to provide it and the chronic illness often entails a permanent adjustment for those in the home as well as for the chronically ill member.

The home care program would not be operative unless the physical surroundings were such that the patient could return home without detriment to his physical condition. Table VI on page 21 shows that 122 patients of the 132 expected to return to the living arrangements which they had prior to hospitalization. Ninety of those patients hoped to be returning to their immediate family. A home care program might be operative then, in the metropolitan area of Halifax if those conditions mentioned above were present. Moreover, the patient and his family must be emotionally ready to accept the home care plan and the family must be able to assume the responsibility which such a program entails.

Ernst P. Boas M. D. in an article called "Chronic Diseases" states that a study by Jesin, Huskotten and Thomas at Syracuse University Hospital demonstrates the need and effectiveness of a home care program.[8] The study showed that with proper integration of various community and medical supervision emanating from the hospital can keep in their homes many chronically ill patients discharged from the hospital. They estimate that through their service, 165 discharged patients were saved 7,268 days of hospital care.

The various health organizations, perhaps, could be integrated to make the home care progfam as adequate as possible. Some of the health organizations service all the metroplitan area of Halifax while others like the Victorian

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[8] Ernst Boas M.D. "Chronic Disease, " Medical Addenda (The Commonwealth Fund, 1947) p. 140.

Order of Nurses service only Halifax, Rockingham, Bedford and Dartmouth. It is anticipated, however, that the Victorian Order of Nurses will extend their services to suburban areas just as soon as funds can be provided. The Halifax Visiting Dispensary also serves metropolitan area of Halifax.

The following quotation may indicate more conclusively the problem which exists around length of hospitalization.

> The burden imposed by chronic diseases is shown by the fact that although only one-fourth of the disabled persons and one-third of the hospitalized persons reported in the health survey had chronic illnesses, these cases accounted for over two-thirds of the total days of disability experienced by the surveyed population and four-fifths of the total days of hospitalization. Although only twenty-five per cent of the illnesses attended by physicians were chronic, fifty-one per cent of the physicians' annual services were received by the chronically sick.[9]

TABLE XI

LENGTH OF ILLNESS OF CHRONICALLY ILL

LENGTH OF ILLNESS	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
1 year or less	58	38	20
Over 1 to 2 years	14	6	8
Over 2 to 3 years	9	4	5
Over 3 to 4 years	4	1	3
Over 4 to 5 years	7	4	3
Over 5 years	40	22	18

[9] Ernst P. Boas, M.D. "Chronic Diseases," Medical Addenda (The Commonwealth Fund Copyright 1947), p.129.

The length of chronic illness is one of its major characteristics. From Table XI on page 31, one may observe that fifty-eight patients of the 132 had been ill for one year or less and of the remaining 74, forty had their chronic illness over five years. Chronic illness is a long-term problem and has furnished the medical researchers with a challenge, society with a serious problem, and the chronically ill person with many needs to be filled. This type of illness does not attack quickly but takes over insidiously and slowly.

In comparing the total length of illness, Table XI on page 31, with the total length of hospitalization, Table IX on page 26, one can observe that each of six patients was hospitalized for a period totalling one year and over and the number of patients who were chronically ill for over one year totalled 77. One can observe then, that as far as the patients interviewed in the survey were concerned, the length of time which the chronically ill person spends in hospital is but a small portion in comparison with the total length of the illness.

The use made of the health organization according to Table XII on page 34 might give an indication of the patients' knowledge or lack of knowledge of community resources. Fifty-one patients took advantage of the services of the health organizations. Many of these patients used more than one health organization and some patients had used five or six of them. Perhaps the most important fact in the whole Table is the large number of 81 patients who did not use any health organization. It is factual, however, from Table VII on page 24 that fifty people had not been hospitalized previously, for the chronic illness which they had at the time of the survey. Therefore, it is possible that the fifty of the 81 patients who did not use any health organization would not require those health services unless they had suffered from acute illness of some other chronic illness. However, there were 31 people who did not avail themselves of the health services who had been hospitalized prior to the time of the survey. There could be various reasons for this lack of use. The patients might have had no desire to use them or they felt they were able to carry on adequately without these services. It seems more likely, however, that many of the patients would not be aware of the existence or the location or eligibility requirements of the organizations. It would seem important for more adequate service to members of metropolitan area of Halifax that a referral centre be established so that information could be dispensed to the public for the purpose of helping them make best use of the health, welfare agencies which serve communities within the metropolitan area of Halifax. The service could be set up to refer persons to the proper social agency so that they could receive help with problems having social implications. The service could also refer to health organizations, those people seeking medical help. This service could be operated by the

TABLE XII

USE MADE OF HEALTH ORGANIZATIONS ACCORDING TO SEX

HEALTH ORGANIZATIONS	TOTAL	SEX	
		MALE	FEMALE
Total	176	86	90
Red Cross	9	3	6
Victorian Order of Nurses	13	4	9
Arthritis Rheumatism Society	1		1
Maritime Paraplegic Society	1		1
Halifax Visiting Dispensary	9	2	7
Dalhousie Public Health Clinic	20	5	15
Walter Callow Bus Service	1		1
Polio Foundation			
Any Hospital Outpatient Dept.	39	13	26
Cancer Society	2	1	1
Other	0	0	0
None	81	58	23

Halifax Welfare Council which is aware of the existing social agencies and health organizations in the metropolitan area of Halifax. The Welfare Council has on its board representatives from the city of Halifax who come from various walks of life and who are concerned with the health and welfare of their fellow citizens. As a result the Council is a meeting place where various problems and resources of the community are discussed and considered. Therefore, this seems an obvious starting point for such a referral service. Such a service would probably be helpful in relieving much anxiety and would give some security with the knowledge that such resources were available for use and the economic burden would be eased considerably for those partaking of the services as these organizations give their services freely or at a minimum rate.

It appears that the organizations which were used most extensively by the patients interviewed were the Dalhousie Public Health Clinic which was used by 20 patients and the hospital outpatient department which was used by 30 patients. It has been observed previously in this thesis that 75 men and 57 women were interviewed in the survey. However, according to Table XII the Dalhousie Public Clinic was used by 5 men and 15 women and the outpatient departments were used by 13 men and 26 women. There does not seem to be any reasonable explanation for this unless the men interviewed were not able to ask for help as readily as the women.

TABLE XIII

NUMBER OF PATIENTS BELONGING TO GROUPS ACCORDING TO SEX

GROUPS	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Belong	40	32	8
Do Not Belong	92	43	49

The social implications of Table XIII on page 35 are extensive. In that Table only 40 patients or 30.3% of the 132 patients interviewed belonged to a group. Ninety-two patients or 69.6% of the 132 did not belong to any kind of a group. By "group" the interviewers meant organizations exterior to the family where people gathered together for the purpose of attempting to satisfy certain interests of individuals belonging to the group. Such groups would be religious, professional, recreational or service clubs. The majority of the people interviewed in the survey did not belong to any such groups. There would be individuals who would have satisfying relationships in their family or with their friends. These people might not have any desire to belong to any such group. Allowances must be made for individual differences. However, it seems there would be many of the chronically ill who would benefit from membership in some organized group which would cater to their interests. Perhaps many existing groups, if they were willing and financially able, could arrange for the transportation of some of these patients to group activities. They could publicize their groups in such a manner as they thought advisable so that the chronically ill patients would feel wanted and would know which groups were available for their participation.

The health and welfare of patients are just causes for concern and the social worker can contribute much in helping the chronically ill patient to adjust to his illness, to his decreased capabilities and to the less active part which he may have to play in his family and in the community. In many hospitals including the Victoria General Hospital there exists a Social Service Department which concerns itself with the patients and their needs. This department also acts as an integrating and coordinating force within the hospital setting and helps the patient and the family adjust to illness. The chronically ill patients pose a problem in that it must be difficult to interpret to the patient and his family exactly the meaning of chronic illness and needs of the patient required. The Social Service Department at the Victoria General Hospital does attempt to go into the metropolitan area of Halifax to follow up the most serious cases. However, a more extensive and adequate service is not rendered because the Social Service Department like many other agencies do not have a sufficient number of social workers to carry out the service.

TABLE XIV

REFERRALS TO SOCIAL SERVICE DEPARTMENT AT VICTORIA GENERAL HOSPITAL

REFERRALS	TOTAL
Total	132
Yes	14
No	118

In conducting the survey, the interviewers found that fourteen patients asked assistance of some kind from the interviewer. It was not the function of the interviewer to perform the duties of the Social Service Department of the hospital. As a result the fourteen patients who requested assistance were referred to the Social Service Department at the Victoria General Hospital.

A social service department is essential in a hospital if its function is to provide the patient with the necessary assistance which he requires. The following quotation shows quite adequately the need for such a department.

> Because chronic diseases are complicated by many social and economic factors, adequate medical social service has been recognized as essential in a medical care program. Planning for the care and treatment of patients confronted with major adjustments as a result of partial or total disability requires skill and sound judgment which can be best obtained in a period of training under supervision of a school of social work. Unless adequate numbers of medical social workers are employed in hospitals, clinics and institutions for the chronically ill, the best type of service cannot be rendered.[10]

The function of the Social Service Department at the Victoria General Hospital is to help individuals with problems pertaining to their illness and to help the families of patients with the social problems which the chronic illness creates or problems which exist with the chronic illness. The social workers, who are professional people, help interpret the illness to patients and their families. They help the patients accept the illness, the hospital routine and the treatment prescribed. This department also makes many referrals to health and welfare agencies. The social worker in the medical setting works on a team with other professional people such as doctors and nurses. Many of these professional people, as well as the patients, are not aware of the function of the social worker in a hospital setting.

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[10] *Control and Treatment of Chronic Illness in St.Louis and St. Louis Co., Missouri 1946* (St. Louis:Social Planning Council of St. Louis and St. Louis Co., Missouri, 1946)

As a result the social worker does much interpretation of her functions.

TABLE XV

PATIENT'S PARTICIPATION IN SURVEY

TYPE	TOTAL
Total	132
Very Cooperative	122
Cooperative	9
Unable to Participate but Information Obtained	1

Table XV above presents a very encouraging picture for researchers who might follow the foot steps of the students who undertook this survey. The patients who were interviewed showed extremely good cooperation. There were 122 who were very cooperative and 9 who were cooperative. One patient was unable to participate but the information was obtained from other sources. This might indicate also the sociability of these chronic patients and their desire to have contacts with others and their desire to be of assistance to the interviewer and to themselves. It is possible also that many of the patients have become resigned to the fact that they are required to give information of themselves to the staff in the hospital setting from their admission to their discharge. Perhaps the interviewer mistook submission for cooperation. But it seems that if the patients answered the questions because of this, the interviewers would have catgorized them under "cooperative" rather than under "very cooperative."

CHAPTER IV

EMPLOYMENT, OCCUPATION, INCOME

> The National Health Survey (1935-1936) showed that in urban areas, the disability rate from diabitis among families receiving public assistance was four times as high as among families with incomes of $3,000. or more a year, the rate of orthopedic disabilities and the disability rate for rheumatism were both more than three times as high in the public assistance group. The same survey revealed that the chronic disease disability rate varied from 2.87% among families with incomes of $1,500. to $2,000. per year.[11]

The incidence of chronic illness appears to be greater among the lower income groups. However, it is difficult to know whether people who are chronically ill have low incomes because of their reduced ability to earn, or whether it is the lower income groups which chronic illness attacks most because of emotional or other factors. Also the people interviewed were on the public wards where one would expect to find mostly low income groups.

As mentioned in the introduction of this thesis, there were 389 admissions of all kinds to the hospital during the period in which the survey was conducted. Of this number, 171 patients were admitted to the public wards with chronic illness. This was 43.9% of the total admissions then admitted to the public wards. This might indicate that chronic illness might afflict those in the lower income levels who are least able to afford chronic illness.

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[11] Frances Upham. A Dynamic Approach to Illness (New York, Family Service Association of America, 1949) p. 87.

A total of 38 patients were receiving incomes under $1,000 a year. Five of these 28 received their income in kind.

One of these people was a woman twenty-eight years of age. She was admitted with a provisional diagnosis of arthritis. This woman was separated from her husband and had received ten dollars a month from him up until one month prior to her hospitalization. This woman also had children to support. She did receive food and board for herself and her children in return for the housework which she does for her employer. She seemed very despondent and indicated by her attitude that there was nothing to look forward to in the future.

TABLE XVI

INCOME OF ONE PERSON AND TOTAL INCOME OF HUSBAND AND WIFE

INCOME	TOTAL	INCOME OF ONE PERSON	TOTAL INCOME OF HUSBAND AND WIFE
Total	132	100	32
$ 0 to $999	38	26	12
$1000 to $1999	30	29	1
$2000 to $2999	27	21	6
$3000 to $3999	20	14	6
$4000 to $4999	9	7	2
$5000 to over	3	2	1
Don't know	3	1	2
Refused to tell	2	0	2

These poor are the individuals who can least afford to be afflicted with chronic illness. Considering the cost of living, it is indeed amazing that these people are even able to exist on such inadequate incomes. Twelve people in the $0 to $999 category said that their income included that of their wife or their husband. Most of these were married couples who were eligible for old age assistance or old age security and according to the patients that was the only source of income.

Thirty people received yearly incomes between $1000 and $1999. A total of 68 of the 132 or 51.5% received incomes under $2000 a year. Forty-seven patients or 35.6% of the total of 132 received yearly incomes between $2,000 and $3,999. There were only 12 patients or 9% of the total who received $4000 and over as yearly incomes. It must be remembered also that many of the patients who gave high salaries as their income were private patients who were on the public wards because there was no available space in other non-public wards or private rooms. But for the most part the patients interviewed were on the public wards because it was the cheapest way to receive treatment and hospitalization. It certainly is evident from the above discussed incomes that a national hospital insurance plan financed by taxation would certainly be in order and would relieve much of the worry which chronically ill persons usually have when they cannot pay their way. The tax burden would be distributed and the chronically ill would not be required to pay in a lump sum. The anxiety and emotional upset which might be constant companions to the chronically ill in the low income groups would be considerably eased. Many of the people interviewed were concerned about their financial position and the hospital bills which were yet to be paid.

TABLE XVII

HEALTH INSURANCE

TYPE	TOTAL
Total	144
Blue Cross	21
Blue Shield	2
Maritime Medical Care	16
Other Health Insurance Plans	8
None	97

Table XVII above indicates another reason why the patients interviewed would have further good cause to be concerned about their financial position. Thirty-five people of the 132 had some kind of medical coverage and it is apparent that some of these patients were covered by more than one plan. Frequently, those who carry Blue Cross carry Maritime Medical Care. There were 97 patients or 73.4% of the 132 patients interviewed who had no coverage whatever. This meant that these patients were required to pay their expenses from the low incomes which they received.

If they did not have the money to pay the hospital expenses and could not receive financial assistance from their family or friends they would probably be considered as indigents and the municipality and the hospital would be required to pay the hospital bills. Lack of health coverage resulted in feelings of insecurity. The author felt this keenly when interviewing patients. Many said that their families were helping to pay expenses but some of the patients were not accepting of their help. This hurt some of the patients as they had been independent of their families previous to hospitalization, for financial support. There would, of course, be some patients who would feel secure in knowing that they had their families or friends who could pay their hospital bills.

Table XVIII on page 45 shows that 47 patients expected to receive family support when and if they were discharged from hospital. Some patients who partook in the survey were despondent and felt that they might never be leaving hospital and would die there. This feeling might result from the fact that acute patients were probably near them and recovered more rapidly than the chronically ill. Moreover, it would be depressing when an acutely ill patient died. Individual differences, capabilities and limitations can be the only real basis for predicting the effect of this situation or others upon the chronically ill patient. A total of 31 patients gave more than one means of support and hence the reason for the total of 182. Some of the

TABLE XVIII

MEANS OF SUPPORT FOLLOWING HOSPITALIZATION ACCORDING TO SEX

MEANS OF SUPPORT FOLLOWING HOSPITALIZATION	TOTAL	SEX	
		MALE	FEMALE
Total	187	113	74
Salary	39	34	5
Family Support	47	14	33
Personal Insurance	9	8	1
Company Pension	16	14	2
Rentals	5	2	3
Savings and securities	15	10	5
Old Age Security	31	16	15
Old Age Assistance	1	1	
Mothers' Allowances	1	1	
Disabled Persons Allowances	3	3	
Blind Persons Allowances	1	1	
War Veterans Allowances or Assistance	2		2
Workmans Compensation	4	4	
Unemployment Insurance Benefits	3	3	
No Income	10	2	8

patients who listed old age security gave no other means of support. This means that some of the patients intended to exist on forty dollars a month upon discharge from hospital.

Fifteen patients gave social secutity benefits as their expected means of support following hospitalization. In order to be eligible for many of these social security benefits the patients could not be making over a specified amount of income and this would be small. Thirty-nine patients expected to receive their salaries upon discharge from hospital as means of support. Some of these people expected to receive payment in kind for their services rather than cash.

Ten people indicated to the interviewers they expected to have no visible means of support following discharge from hospital. The feeling and anxiety which existed in some of these people must have been extreme. Some patients would deny the social implications which lack of financial support would have for them. Some would be optimistic and would feel that they have been capable of supporting themselves and would be able to do so following discharge from hospital. It is difficult to imagine the torture which many must have experienced. This feeling would be heightened if possible, if they were expected to provide for any dependents.

TABLE XIX

EMPLOYMENT ACCORDING TO SEX

EMPLOYMENT	TOTAL	SEX	
		MALE	FEMALE
Total	132	75	57
Number Employed	65	52	13
Number Unemployed	67	23	44

on page 47, 52 felt that they would be returning to the same kind of work. There were 3 patients who had no job in view and if they did have a job in view it would be different from the one they held prior to hospitalization.

TABLE XXII

CLASSIFICATION OF THOSE NOT GAINFULLY EMPLOYED

JOB TYPE	TOTAL	SEX	
		MALE	FEMALE
Total	67	25	42
Housewife	27		27
Student	2	2	
Retired	25	19	6
Other	13	4	9

In Table XXII a breakdown is shown of those not gainfully employed. Of the 67 not gainfully employed, 27 were housewives, 2 were students, 25 were retired. There were 13 in the "other" category. Table XIX on page 46 shows as unemployed 67. In Table XXII these 67 were not gainfully employed and the same Table seems to indicate that there were few persons available for the labor market.

The employment tables do present an optimistic picture for these patients. It shows their desire to return to work and their belief and optimism in hoping that most would be returning to the same kind of job they had before hospitalization. However, these employment tables present an unrealistic picture. It hardly seems probable that so many would be returning to the same kind of work done before hospitalization. If the doctor had not advised the patient as to his degree of disability and the work, if any, he is c capable of doing, he could not be sure that he would be returning to the same kind of work done before hospitalization. The patient might have denied the possibility that he might not be returning to the same kind of work. He might have felt that if he admitted the possibility that he would not be returning to the same kind of work, in front of the interviewer, he could not control his emotions.

In Table XXIII on page 50 the only really significant figure is in the category referred to as Service, Personal. There are 20 of a total of 65 in this category. Most of these patients would be domestics, gardeners, handy men. This seems to be the type of employment which pays least and the category into which 30.7% of the employed patients in the survey are placed.

TABLE XXIII

OCCUPATION ACCORDING TO SEX

TYPE	TOTAL	SEX MALE	 FEMALE
Total	65	52	13
Proprietary or Managerial	4	4	
Professional	1	1	
Clerical	5	3	2
Agricultural	1	1	
Trapping, fishing, hunting, logging	2	2	
Mining and quarrying			
Manufacturing and Mechanical	9	9	
Construction	6	6	
Transportation and Communication	11	11	
Commercial Financial Trade	2	2	
Service Personal	20	9	11
Protective	2	2	
Other	2	2	

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The emphasis of this thesis has been upon the resources which are available and could be available to the Chronically ill patient. The role of the social worker in the treatment of the chronically ill has been stressed.

It has been indicated in the survey that since so many expected to be returning to their families following discharge from hospital and because of the frequency of hospitalization and the length of the chronic illness, a home care program might be feasible. Such a plan would reduce costs and would see the patient treated among those who would be vitally interested in his welfare. This home care program is recommended by the writer as giving better service to the physical and emotional needs of the patient. As in Chapter III a team consisting of doctor, social worker, nurse, and physiotherapist and others would be providing this home care service if the physical surroundings were such that the program would be operative. In addition, the family and the patient must be willing to accept this plan. It is the social worker's role to evaluate the home, interpret the illness to the family and to the patient and to help them accept the illness and the responsibility it entails. The social worker helps with the social problems.arising as a result of the illness and coincidental to it. She is concerned with the individual and his relationship to problems involving other people and other things.

The patient is the focal point of the home care program. As a result the social worker acts as a coordinator in the program. She helps the program run smoothly and considers the role the patient plays or can play in his family and with others. She can be creative in helping the patient accept treatment and in developing new interests which the patient wants to do and is capable of doing.

In observing the medical resources used by patients in this survey, it is interesting to observe that so many had not taken advantage of the services which the health organizations render. If they were better known, more benefits could be derived by a greater number of the chronically ill. A health and welfare referral service, operated by the Welfare Council of Halifax, would be helpful in making the resources better known and more readily available to the chronically ill. These referrals might be more easily and adequately handled by the Welfare Council than by any other agency. It has knowledge of the welfare and health agencies which exist because the Welfare Council does concern itself with the problems and resources in the community.

One of the functions of the Social Service Department of the Victoria General Hospital is to refer patients to the agency which could best fulfill their needs. These referrals are only made for the benefit of the hospitalized patients, and the Social Service Department does not serve those chronically ill in the community who are not hospitalized.

There were a great number of chronically ill patients in the survey who did not have any medical coverage and many had low incomes. Many were not in any financial position to pay for their hospitalization. The National Insurance Plan will, in all probability, be put into operation at some feasible time in the future when there are sufficient hospitals and medical staff to provide such a service. The financing of such a program will probably involve increased taxes which will effect all people. However, the cost will be spread out and the chronically ill with low incomes will pay little, if anything, for their hospitalization. They can then feel that through a lifetime of paying taxes they have paid in advance for services.

The Social Service facilities at the Victoria General Hospital are being taxed to the limit at the present time. The social workers on staff are only able to do follow-up work with patients in the metropolitan area of Halifax, who are in serious need of such service. If the Social Service Department could employ more workers, the service could be increased and a fuller coverage could be given patients after their discharge from hospital and their return to their community. Since a shortage of workers does exist, it seems probable that additional workers would be required in the event of home care development.

The social worker, as a caseworker, helps to restore the health of the patient in helping him meet the problems which arise in the patient or in his family as a result of the illness. This really means the rehabilitation of the patient. The social worker helps the patient to use the medical care as constructively as possible. She encourages and helps the patient to understand his illness and the implications which it has for him. In so understanding, the patient is in a better position to be more accepting of his illness and his problems and it follows that he can then move, with the help of the social worker, towards dealing with them in a constructive manner.

It was surprising to the interviewers to observe a great number of patients in the survey who did not belong to any group. Some of these patients may have been so incapacitated that it was not possible or feasible for them to leave their own homes and join groups. Others might not have wished to join groups and found satisfying relationships with their own family or friends. Some might not have been aware of the existing groups which they could join. As stated in Chapter III, groups mean organizations exterior to the family where people gather together for the purpose of attempting to satisfy certain individual needs or interests. These groups could have been recreational, professional, religious groups or service clubs. If those chronically ill patients interested in participating in the group could be become more aware of existing groups, through community interest and publicity, the community would be contributing materially to the good mental health of many of its citizens.

The study has proved to be an interesting one and shows the need of recognizing the chronically ill person as an individual whose illness cannot be treated separately from the total person. The demand for improve and additional resources to meet more adequately the needs of the chronically ill has been shown in a limited way. Further study should be made of these chronically ill people. Through such a study, the homes of these people might be visited by other interviewers and additional or supportive evidence of their needs would probably ensue.

APPENDIX I

FACE SHEET

ocial Research
M.S.S.W.

Chronic Illness Survey
Victoria General Hospital

January -
February, 1957

ame:..

dress:..

ex:........................... Marital Status: ☐ Married
☐ Single
☐ Widow(er)
☐ Divorced
☐ Separated

ge:...........................

evious Admission(s) ☐ Yes
☐ No

ovisional Diagnosis:..

arest Relative:...

dress of Nearest Relative:..

lephone of Nearest Relative:..

APPENDIX II

Social Research

Maritime School of
Social Work

CHRONIC ILLNESS SURVEY

VICTORIA GENERAL HOSPITAL

SCHEDULE

January -
February, 1957

1. In what community were you living before you came to hospital? ____________________

2. What were your living arrangements before you came to hospital?

- ☐ A. by yourself
- ☐ B. with immediate family
- ☐ C. with relatives
- ☐ D. with friends
- ☐ E. in a boarding house
- ☐ F. in a rooming house
- ☐ G. in a hostel
- ☐ H. in a nursing home
- ☐ I. in a home for the aged
- ☐ J. in a City or County Home

3. How long have you been living there? ______weeks; (or) ______months; (or)_____yrs.

4. When you leave hospital where do you plan to live?

- ☐ A. the same place
- ☐ B. a different place
- ☐ C. no place to go
- ☐ D. don't know

5. Do you know many people in this area where you plan to live? ☐ Yes ☐ No

6. Do you belong to any groups?
☐ church groups ☐ social ☐ service clubs ☐ recreational ☐ other ☐ none

7. Have you any (other) hobbies or interests? ____________________
(Take first three named) ____________________
____

Transition: (something like) "Now we'd like to talk about your work before you got sick."

8. Were you employed before you came to hospital? ☐ employed ☐ unemployed

9. Were you employed on a ☐ full time, ☐ part time, or ☐ seasonal basis?

0. What kind of work were you doing before you came to hospital?

- ☐ A. proprietary or managerial
- ☐ B. professional
- ☐ C. clerical
- ☐ D. agricultural
- ☐ E. fishing, hunting, trapping
- ☐ F. logging
- ☐ G. mining and quarrying
- ☐ H. manufacturing and mechanical
- ☐ I. construction
- ☐ J. transportation and communication
- ☐ K. commercial, financial and trade
- ☐ L. service)
  - ☐ personal
  - ☐ protective
  - ☐ other

Not gainfully employed -

- ☐ M. housewife
- ☐ N. student
- ☐ O. retired

1. Is your husband (or wife) working? ☐ Yes ☐ No

12. What was the total yearly income?
(If husband and wife were working add income together)

☐ $ 0 to 999
☐ 1000 to 1999
☐ 2000 to 2999
☐ 3000 to 3999
☐ 4000 to 4999
☐ 5000 and over

13. Were you able to manage on this? ☐ Yes ☐ No

14. A. Do you think your health will allow you to work again? ☐ Yes ☐ No ☐ Don't know
B. If yes, do you plan to return to the same kind of work? ☐ Yes ☐ No
C. If B is no, do you have another job in view? ☐ Yes ☐ No
D. What kind of job is it? OR What kind of job do you think you'll be able to do?
____

15. What means of support will you have when you leave hospital?

☐ A. salary
☐ B. family support
☐ C. personal insurance
☐ D. company pension
☐ E. rentals
☐ F. savings or securities
☐ G. Old Age Security
☐ H. Old Age Assistance
☐ I. Mothers' Allowances
☐ J. Disabled Persons Allowance
☐ K. Blind Persons Allowance
☐ L. War Veterans Allowance or Assistance
☐ M. Workman's Compensation
☐ N. Unemployment Insurance Benefits
☐ O. no income

16. Do you have Health Insurance?

☐ A. Blue Cross
☐ B. Blue Shield
☐ C. Maritime Medical Care
☐ D. Other Health Insurance Plan
☐ E. None

17. How long have you had this illness? ______ months; ______ years

18.AHave you been in hospital before with this illness? ☐ Yes ☐ No; with other Chronic illness? ☐ Yes ☐ No
B. If yes, how many times? ______ times
C. How long were you in hospital each time?

First:	______	weeks or	______	months
Second:	______	"	______	"
Third:	______	"	______	"
Fourth	______	"	______	"
Etc.	______	"	______	"

Preamble

19. Have you used any of the following health organizations?

☐ A. Red Cross Society
☐ B. Victorian Order of Nurses
☐ C. Arthritis and Rheumatism Society
☐ D. Maritime Paraplegic Association
☐ E. Halifax Visiting Dispensary
☐ F. Dalhousie Public Health Clinic
☐ G. Walter Callow busses
☐ H. Polio Foundation
☐ I. Any hospital outpatient dept.
☐ J. Other (specify)______________
☐ K. None

APPENDIX II

0. Were you satisfied with the help which you received from this (these) organizations?
☐ Yes ☐ No

1. A. Was there some medical help which you needed and did not get? ☐ Yes ☐ No
B. What was it? ______________________________

2. When you leave hospital what medical help do you think you will need?

☐ A. Doctor's care
☐ B. Nursing care
☐ C. Drugs and dressings
☐ D. Special diet
☐ E. Homemakers' service
☐ F. Physiotherapy
☐ G. Medical appliances and equipment
☐ H. Don't know

3. <u>Interviewer's Comments</u>

A. Patient after leaving hospital needs -

☐ a. Doctor's care
☐ b. Nursing care
☐ c. Drugs and dressings
☐ d. Special diet
☐ e. Homemakers' service
☐ f. Physiotherapy
☐ g. Medical appliances and equipment
☐ h. Don't know

B. Degree of Disability -

☐ a. Chair bound
☐ b. Bed bound
☐ c. Other

C. Is job retraining necessary or feasible?
☐ necessary ☐ unnecessary ☐ feasible ☐ not feasible

D. Patient was
☐ very co-operative
☐ co-operative
☐ refused to participate
☐ unable to participate but information obtained from auxiliary sources
☐ unable to participate and no information obtained

4. Refer to Social Service ☐ Yes ☐ No

APPENDIX III

LIST OF COMMUNITIES - METROPOLITAN AREA

Armdale
Bedford
Birch Cove
Boulderwood
Burnside
Cole Harbour
Dartmouth
Eastern Passage
Fairview
Ferguson's Cove
Halifax
Imperoyal
Jollimore
Kline Heights
Lakeside
Melville Cove
Millview
Port Wallis
Prince's Lodge
Purcell's Cove
Rockingham
Spryfield
Tuft's Cove
Westphal
Woodlawn
Woodside

APPENDIX IV

CLASSIFICATION OF DIAGNOSIS

GASTRO-INSTESTINAL SYSTEM

Rectal abscess

Caecostomy

Ulcerative Colitis

Dyspepsia--functional

Hernia

Ulser--peptic and perforated

GENITO URINARY SYSTEM

Nephrolithiasis

Acute retention

Undescended testicles

Uraemia

CARDIOVASCULAR SYSTEM

a) Cardiac

Cardiac disease

Cardiac infarction

Congentive heart failure

Coronary thrombosis

Hypertension

Myocardial infarction

Rheumatic heart disease

b) Blood diseases

Hemophilia

Leukemia

Sickle cell anemia

PULMONARY DISEASE

Asthma

Bronchiectasis

Pulmonary oedema

Lung abscess

METABOLIC DISEASES

Addison's disease

Diabetes

CENTRAL NERVOUS SYSTEM

Glaucoma

Cerebral Vascular Accident

LOCOMOTOR SYSTEM

Fractured hip

Polyarthritis

Varicose Ulcer

Arthritis

OTHERS

Cancer

Tuberculosis

Cellulitis

Leukoplakia (skin)

Lupus erythematosis

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