CHANGING CONCEPTS IN THE CARE OF HOSPITALIZED PATIENTS*

By NEVA R. DEARDORFF

Health Insurance Plan of Greater New York

THESE are stirring times for health service and medical care. One picks up the New York Times and on a single page he reads that nutrition is the key to better health, that broad aid is urged for the handicapped, that cardiac conditions gravely affect social relations, marital relations and juvenile delinquency and that in New York City Bellevue Hospital is soon to get a new nurses' residence and school and, incidentally, that the extension of the boundaries of medical care into the field of preventive medicine will enlarge the role of the nurse.

One turns to a recent issue of the Survey and learns from Dr. Bluestone about home medical care for some patients who would otherwise have to be in hospital beds—a plan of service that, when it can be employed, is both better for the morale of the patient and less expensive for the hospital and the community on which the hospital depends for its support. The same issue of the Survey has articles on part-time mental clinics and on placement in nursing homes. A few months ago the Commonwealth Fund published the report of the Commission on Hospital Care, a 600 page volume, prepared with the very active cooperation and support of the U. S. Public Health Service. It has one chapter on hospitals and health departments and another on socio-economic factors.

More recently the Medical Annals of the District of Columbia opened its editorial columns to a presentation of the pressing need to give students in medical schools not merely an elective course on health economics but to require pre-medical education in the social sciences and to integrate the social, political and economic aspects of preventive medicine into "the fabric of every course we teach."

Two weeks ago at the National Health Assembly and the Family Life Conference, a month ago at the health section of National Conference of Social Work and now here at the National Conference of Jewish Social Welfare, this subject of planning for *health service and medical care as one, not two objectives,* stands out as a major theme. It is good to see all this rolling on.

At moments this idea of imbedding more deeply a positive health concept into the treatment of sick people seems new, but a little reflection will remind us that it has roots extending far into the past. Medical social service itself is evidence that for nearly 50 years a few minds associated with hospitals have been directed not only at the immediate treatment of the sick but also at keeping people well, even when this purpose expressed itself only in terms of obviating or postponing readmission to the hospital.

Clinic services also had begun at least two decades ago to operate in the field of prevention. It was in 1929 that Dr. C-E. A. Winslow wrote in the foreword to *The Health Inventory of New York City,* "Among the more general findings which emerge from the inventory as a whole, the important role played by the hospital in the development of clinic service of a preventive nature is highly significant."

Going directly to our subject, we shall treat it under the following three phases, which we conceive to be inextricably interwoven:

1. Our expanding concepts of health and the possibilities of its improvement.
2. New bases for the relation of the community to its hospitals and the health services that communities will expect of hospitals.
3. The reflection of these first two in relation of the hospital to its patients.

What health is conceived to be and what the community conceives as the duty of a hospital toward the health of its patients will in the long run determine what hospitals will be *enabled* to do. If snatching people from the jaws of death is all that the community expects of a hospital, that is all the average hospital will be able to do. But if the community wants hospitals to undertake programs that help people to be all that it is in them to be, then the community must make this clear in practical ways. For hospitals, like all other community facilities, live at the will of the community as that will comes to be expressed in the provision that the community makes for the moral and financial support of these facilities.

The members of Jewish communities do not need to be reminded of this fact of life. But Jewish communities, like the rest of the world, need to keep in mind that the community *will* and the community *deed* have to be constantly checked against each other, so that the will becomes more clear and informed, the deed more responsive and more intelligent in the expression of that will. Parenthetically, is not that process of checking and clarifying the business of community organization?

Our expanding concepts of health and the possibilities of its improvement.

And now this word about health. We have come a long way from the Victorian enjoyment of ill health and, if we may believe Victorian literature, the acceptance then of appallingly neurotic people as normal, or at least not in need of care in a mental hospital. We have now had enough experience to give us greatly heightened expectations about what can be achieved in health and about the practicable means of its achievement. We are now convinced that it is possible for people to acquire a keener sense of responsibility for their own physical and mental well-being, and for the cultivation of the mental health that grows out of sound social relations within their immediate sphere. We know that there are techniques for helping people, including ourselves, in these ways. Secondly, we know that by community action it is possible to modify most environmental conditions that can be shown to menace health and are not within the powers of individuals to change. We absolutely know these

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things can be done. And, thirdly, we have recently been amazed to see how human capacity in those who have suffered irreparable impairment of body and even damage to their mental abilities can be salvaged. The amazing advances that the last few years have brought forth in the conservation of powers in the physically handicapped and the chronically ill, truly deserve recognition as brilliant achievements in health, as well as entries in the separate set of books that we call "the rehabilitation of the handicapped." Would we not all agree, first then, that the relation of the hospital to its patients is being greatly changed by the rapidly rising concept of what it is possible to do to improve the health of almost everyone, including people suffering from conditions once thought hopelessly incapacitating.

We who are here today may believe that to embrace these opportunities is the obvious and logical responsibility of hospitals, but does the average hospital believe it? As I have said earlier, that depends largely upon what the community looks to the hospital to do.

The Changing Relation between a Community and Its Hospitals

As you will doubtless note, I have rephrased this part of our subject from the "relation of *the* hospital to *the* community" to what I believe more accurately describes the situation in which hospitals now find themselves. Is not the definitive relation one between the community on one hand, and its aggregate of hospitals on the other?

In looking at this whole scene, it is necessary to examine the isolationism that until recently characterized the planning carried on by individual hospitals, and the factors that originally contributed to this intramural mindedness and the reasons for its impending decline. We should look at the ways in which central agencies approach planning problems and how issues of quantity and quality intertwine. Finally we come to the effect of all of these changes upon the kind, quality and amount of service that the individual hospital affords the individual patient.

There are many conditions to account for the isolationist psychology of many hospitals (Jewish hospitals seldom suffered from this in an aggravated form). It is that extreme individualism that has given rise to the present need for communities to make clear to hospitals what the new concept of the combined program of health service and modern medical care implies. Formerly the breathtaking advances in purely "somatic" medicine and the heavy expense in keeping up with these advances turned attention inward. The veiled but real competition between hospitals for paying patients was not a small factor. The uncontroversial nature of purely medical research and the backward state of the social sciences played into the picture. Perhaps the most important contributing condition was the arrangement by which the public hospitals were expected to take care of most of the people ill with diseases in which the social component both in etiology and treatment was obvious—the mental cases and many of the chronically ill. All of these and other conditions conspired to make it natural and feasible for the voluntary general hospital to be a little world in itself shut off from the rest of the community in which the treatment accorded the patients and the teaching and research conducted there were very largely on the hospital's own terms.

Hospitals without unit record systems practiced separationism not only from

the rest of the community but within themselves. And the manner of appointing professional medical staffs and the vesting of special rights and privileges in the visiting staff, tended to emphasize the closed character of the corporation.

But a good many of these features are disappearing. It was a proud era and one that produced many assets as well as very serious liabilities. We must now make sure that none of the real values are lost as we enter into new alignments of hospital services. But those liabilities surely must be attended to. One thinks of the long struggle with the problems in the care of the chronically ill, with many patients gravely needing hospital care and not getting it—those classed as "incurable"—others receiving extended care and not needing it, but needing instead a place to live. One suspects that hospital administrations with the intramural point-of-view little realized how poorly insulated they really were against the effects of the socio-economic problems of the community and how much in time, effort, and money might have been more constructively applied, had they more often joined forces with the rest of the community in an attack on those problems. That is why for years some of us have felt the great need for annual reports from hospitals that give more graphic accounts of the medical and the social reasons for the flow of patients through the institution.

I suppose the most powerful forces that are now battering down the walls of the isolated hospital are the graduated income tax and the decline of interest rates on the one hand and the advent of psychosomatic medicine on the other. The economic changes dictate new forms of community planning and new sources of financial support, specifically, financial federations and prepayment plans, which in turn mean new examinations of the community's total facilities to the end that they may be patterned better to meet its total needs. Expense per member of the community instead of per diem costs in one year in one institution is the true measure of cost.

Such inquiries by central agencies almost invariably start with questions about the provision of bed capacity, not in one hospital but in all of them and in related facilities. We have evolved ratios of beds to population, characterized in different ways—by age, sex, economic level and other demographic items. These ratios are based on past experience and represent the best that can be done at present. But we really have no way of knowing how those ratios would be modified, were it possible to operate the whole chain of services in very close integration and if in every part of the chain we were absolutely sure that all now known of preventive medicine, including active health education and mental hygiene had been put into full effect for the up-building of the health of every patient.

Though we often refer to quality and quantity as if they were antitheses, we can't be really sure of *quantity* of the facilities needed until we are sure of *quality* of the service rendered. I recall an incident that will explain this point a little further. A few years ago when I was at the Welfare Council of New York City a committee from the board of an institution for convalescent care of children came in one day. The interest of the agency was known to extend only to the provision of bed and board in the country, and its institution was half empty. Yet its board of directors thought that maybe the place should be enlarged and this committee came to ask me flatly how many convalescent beds

were needed for New York City children and how many were in operation. If there were a deficit in beds, expansion would be indicated. I tried to explain that there was no such thing as an unqualified demand for beds into which to put children who had been sick, and that the measurement of demand could be made only in terms of much more specific description of what might be offered. It seemed to me obvious that if half the beds were empty, if what they were then offering was not being utilized by their colleagues in medical social service departments and child care agencies, their chance of filling the beds they already had lay in enriching their program, not multiplying their beds. I have since doubted that I made myself clear to the committee but I am sure you understand the issue that this situation presented.

This brings us back to the issue of the kind of care that the community is coming to expect the agency or the institution to give its patients and to our third section on changing concepts in the care of hospitalized patients.

Changing Concepts in the Care of Hospitalized Patients

On every hand one sees evidence that the medical world is now accepting for practical working purposes the concept so well expressed by Dr. William A. White in 1926—"The oneness of body and mind, the organism-as-a-whole concept, and the interrelations between the organism and its environment, particularly the social environment, constitute an irreducible minimum of consideration that must be borne in mind if we are to arrive at any comprehensive idea of the patient and his illness."

This is too great a subject for me, a layman, to try to discuss with you in any specific detail, but as a layman I can see that it brings a mighty change in the relation of the hospital to its patients and to the community.

Even a partial and fragmentary application of that concept sweeps away the older intellectual walls of the hospital and forces it to look outward to see what brings all of its different patients to it and what forces in the patient himself, his home and his community, will either help him to hold the gains in health that he has achieved with the aid of the hospital or will undermine and destroy those gains.

It is the simultaneous outside demand for better health service and the inside gravitation toward psychosomatic medicine that really underlies the changes in the relation of the community to its hospitals and of the hospitals in turn to their patients. It is coming to be seen that a hospital which cannot practice medicine in those terms ceases to be truly a *general* hospital and has to be classed as a special hospital, quite as much as those institutions that in the past have limited their programs to a procedure such as the removal of tonsils, or to service for patients with a selected disease.

What this expansion in the concept of the practice of medicine in hospitals will imply in the way of staff personnel beyond the present complement of physicians and technicians, nurses and social workers, we do not yet know. But we can be sure that the necessity for additional personnel will be greatly modified, first by the degree to which the existing personnel use their powers of perception to integrate these new concepts into their day-to-day work; secondly by the degree to which a hospital can develop effective working relations with other social and health services, public and voluntary, in the community, and third, most importantly, by the degree to which better health services ultimately cut down the total demand for services. It may well be that in given cases initially a greater investment of service will be made but that in the aggregate and in the long run, the need for service will actually be reduced.

Closely correlated with this merging of health service and medical care into one concept and that one with a strong admixture of psychosomatic medicine, are three developments of great significance to the future expression of it in specific programs and activities.

Number One relates to the community hospitals as proposed in the Master Plan of Hospitals for New York City. These are not merely hospitals *without* means for the care of rare specialties. In these hospitals lie the hope of services which are sufficiently close to people that they can put into full effect and sustain over a period of time these newer concepts of hospital care that knows the social background of patients and can serve in the training of medical personnel and the conduct of research based upon these concepts. These hospitals should, therefore, be regarded as the bulwark of the Master Plan not only for the maintenance of health and the care of most of the sick but also for the training of internes in the practice of *general* medicine (not the *general* practice of medicine) and for all kinds of post graduate educational services for the practicing physicians in the hospital's own community, for studies in the socio-economic factors in illness and for experimentation with efforts toward the control of those factors. The community hospital will be the place where the new socio-psychosomatic medicine can really be practiced on a continuing basis.

Number Two relates to prepayment plans. Their amazingly rapid acceptance by the public is giving at least a part of the answer to the question as to where the money will come from in the future to finance good health and hospital services. It will come straight from the people who understand what they are buying and who wish their service to come, not as a charity but as something for which they are paying. In essence, hospitals are public utilities—utilities that deal in matters other than transportation or electric current, it is true—but utilities in the sense that they must be organized and operated to provide services unfailingly when, as, and if they are needed. We know that utilities can be satisfactorily operated under voluntary or public auspices, given a source of income sufficient to buy what is needed and sufficient freedom to inspire operating personnel to do its best. It is entirely within the realm of possibility that public as well as voluntary hospitals will have *paying* patients; some county infirmaries in upstate New York have such service now. All of the patients at a hospital will be paying patients—some from their own and their family resources, acquired either currently or through insurance and other savings, and some through public assistance. To the hospital it should make no difference who pays the bill, so long as it is properly met. The hospital's interest in the patient's economic condition can thus become diagnostic rather than contractual.

When we reach the point of having the group practice of medicine in close alliance with a hospital and the patients covered by insurance which pays both medical and hospital expense, we can begin to give philanthropy its real opportunity to push forward the boundaries of human welfare through experi-

mentation and the special supplementation of a substantial program that is not dependent upon charity.

Point Number Three relates to the larger aspects of city and regional planning. Once hospitals begin to relate themselves more specifically to socio-medical problems and to community health services, they will be forced to ask—what community is it that this hospital is expected to serve and with whom must we work. In many places the community can be defined, but in many other places it is still very difficult, if not impossible, to give the answer. And that is because we have not yet attained much proficiency in the broader phases of city and regional planning. Our community is amorphous both in terms of a land and a population base. Each agency and each institution may have set itself boundaries, but no two are the same.

Until we can get more common planning into the provision and operation of our social and health services, again both public and voluntary, for geographically defined groups of population, each agency and each institution is confronted with a peculiar and needlessly confusing scene, a condition that not only is a source of administrative waste but also adversely affects what can and will be attempted for individual patients. At least as much as other community facilities, hospitals need more systematic and integrated planning for neighborhoods, communities, metropolitan areas and regions, as the foundations upon which to rest their individual plans for the care of their patients.

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The changing concept of the care of hospitalized patients reaches back into new concepts of health itself, new concepts of the content and practice of medicine, new concepts of the relations of a community to its hospitals, new concepts of the economic foundations of medical and hospital services and new concepts of the total configuration of communities themselves. To carry through on these is a tough assignment for the leaders of any community but not nearly so bad as trying to operate obsolete forms of medical care in social chaos.

MEDICAL SOCIAL WORK AND THE COMMUNITY*

By EDITH SELTZER

Director, Special Services and Consultant on Medical Social Service of the United Hospital Fund of New York

A SURVEY of the topic "Medical Social Work and the Community" is far beyond the possibility of achievement in this brief paper. An attempt to write that resulted in what might be the outline of a book. Out of the many topics that correctly belong in such a discussion, I have selected a few that seem to me to be more specifically related to this program and that have come to my attention as being of interest to many communities across the country.

For purposes of further brevity, I have limited my comments to relationships between hospital social work and the community. I have not attempted to discuss the relationships of medical social work in the equally important fields of public welfare, public health, and community organization. Relevant as their aspects are, it is impossible to do more than mention them.

Medical social service in hospitals and medical care agencies has as its primary purpose the provision of social case work service to individuals who have social and emotional problems associated with illness. To carry out this function, the social service department must be highly adaptable and flexible in its program, its tempo, and its emphasis with recognition that it is part of a team and that its program is predicated upon the total program of the hospital.

The unique position of this field in the constellation of social work arises from its dual affiliations—on the one hand, an alliance with doctors, clinical medicine, hospitals and hospital administrative policies; and on the other hand, a vital and necessary affiliation with the cooperating social services in the community. While the former—the medical and hospital affiliations—provide the particular setting in which this specialized field of case work functions, the latter—the community agencies—offers a main resource for obtaining the enormous service needed to help the sick.

The social service department of a hospital has the interesting, if complicated, problem of maintaining its own integrity in meeting the social work responsibilities within the hospital and also in developing effective methods of channeling out to the community agencies those patients or their relatives who need additional or different social services. Encouraging greater use of the services of the community agencies to the hospital's patients and their relatives is important in order to broaden and lengthen the totality of the community's rehabilitative resources.

Awareness of this need of interrelatedness of hospitals and community agen-

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