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The place of rehabilitation in the Home for Incurables : a study of one hundred patients in the King's Daughters' Home for Incurables, Louisville, Kentucky, December 31, 1947.

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THE PLACE OF REHABILITATION IN THE HOME FOR INCURABLES

A Study of One Hundred Patients
In the King's Daughters' Home for Incurables,
Louisville, Kentucky, December 31, 1947

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Gretna Lillian Brown

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TITLE OF THESIS: THE PLACE OF REHABILITATION IN THE HOME FOR INCURABLES

A Study of One Hundred Patients in the King's Daughters' Home for Incurables, Louisville, Kentucky, on December 31, 1947

APPROVED BY READING COMMITTEE COMPOSED OF THE FOLLOWING MEMBERS:

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NAME OF DEAN: Howell V. Williams

DATE:

ACKNOWLEDGMENTS

Grateful acknowledgment is made to Miss Esther Taylor, Executive Secretary, Family Service Organization, Louisville, and to members of the board and staff of the King's Daughters' Home for Incurables for their kind assistance in the preparation of this thesis.

TABLE OF CONTENTS

LIST OF TABLES

Introduction

Since 1909, the King's Daughters' Home for Incurables in Louisville, Kentucky, has provided institutional care for physically handicapped persons who are residents of Kentucky. A hospital survey done by the Kentucky State Board of Health in 1945-46 classified the Home as a "custodial-type institution", and did not include it in the survey, as it was not considered a hospital.[1]

Surveys on phases of the work of the institution were done in 1914 (Haven Emerson Survey) and in 1940 (Health and Welfare Council Survey) for administrative purposes. This year the work of the Home has provided the material for three theses in the Kent School of Social Work, University of Louisville. Mr. Clyde Van Metre has reported the history of the institution, and Miss Conder Lewis has studied applications for care at the institution during the Family Service Organization demonstration period of casework service (1946-47).

The subject of this thesis is, as the title indicates, the place of rehabilitation in the Home. No attempt was made to avoid overlapping with the other two studies because the difference in approach seemed to insure a difference in presentation and in selection

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[1]Statement by Mr. David H. Salyers, State Board of Health, personal interview.

of material. All of the information gathered for the three studies was regarded as timely inasmuch as the Family Service Organization of Louisville expected to evaluate its demonstration period of casework service this year, and some of the material presented will illustrate the need for a social worker in the Home and the qualifications of such a worker.

The question of the relation of rehabilitation to the program of the institution grew out of an interview with Miss Nettie Smith, a member of the board and social worker for the institution for many years. Her retirement in 1945 due to ill health left a serious gap which Family Service Organization has filled for a demonstration period on an out-post service basis.

Miss Smith deplored the loss of a worthwhile function in the Home when children under the age of eighteen were removed from the Home, following the Health and Welfare Council Survey of 1940. There had been a special wing in the institution for children, and special transportation was provided for them to the Kosair School for Crippled Children. After finishing at Kosair School, some of them went on to high school, and, lastly, when physical and mental abilities permitted, some of them received special training through the state vocational rehabilitation service and were placed in remunerative jobs. Since 1941 the patients in the Home had been increasingly the elderly, debilitated group, and the worthwhile function of rehabilitation in the program of the institution had been lost.

It seemed that the problem of rehabilitation for the adults in the Home was important enough to warrant special study. Several questions could be raised immediately in connection with this problem. Are there any patients in the Home at present who have potentialities for rehabilitation? If so, what proportion of the patient population do they represent? What is the extent of their physical handicap? Do they have other handicaps, emotional, mental, or social, in addition to the physical handicaps? Do some of them have interests or aptitudes they could be encouraged to develop? What facilities are there in the Home for furthering rehabilitation? What is the nature of the workshop program in the Home? Does it have a relation to vocational retraining or to rehabilitation? How would a program of rehabilitation for the younger adults be organized? Would it be feasible within the limits of the institutional program? What resources are available in the community for treatment, re-training and education of the physically handicapped? To what extent are these resources used?

Is the Home becoming largely an institution for the aged and chronically ill? What age groups do the patients represent? What proportion are more than 60 years of age? What proportion of the elderly group are able to engage in workshop activities or other useful activities?

What are the rules of eligibility for admission to the Home? What are some of the factors that may be influencing applications for admission? What function has the Home for Incurables?

Does the concept of rehabilitation have any place in the institutional program? Would such a concept fit into the philosophy and traditions of the institution?

It was believed that an answer to some of these questions could be found by studying the total patient population of an arbitrary date, such as December 31, 1947, as to age, sex, diagnosis, extent of physical handicap, length of residence, and present activities in the Home. By such a study it was assumed that any rehabilitation potentialities in the group might be noted.

The active card file at the Home was used as a base for the study. The file cards provided information as to age, sex, diagnosis, religion, date of admission, length of residence in the state, source of referral, names of living relatives, and burial, insurance and other financial data.

A file of more complete information about each patient was available in folders containing the signed application for admission to the Home, the referring physician's statement, and correspondence pertaining to the patient's admission to the Home, and conduct and condition following admission. Some of the folders contained little material other than the application form. Other folders were relatively voluminous, sometimes including psychological reports, social agency reports, and records of medical examinations and treatments along with letters from relatives of the patient and interested individuals.

The card file of 100 patients registered in the Home on December 31, 1947 was cleared with the records of the Family Service Organization pertaining to social studies of applicants to the Home. Forty of the 100 patients in the Home on that date had been known to the Family Service Organization. Thirty-six of the forty had been admitted during the agency's period of demonstration service to the Home. Four of the individuals, already in the Home, had been referred to the Family Service Organization for a particular casework service. The forty records at the Family Service Organization contained face sheets with identifying information and complete narrative recording of contacts. The records were notable for their presentation of personality and social factors in addition to describing the nature and extent of the handicap. A social study prepared for the Admissions Committee at the Home was included in the case record of all applicants admitted to the Home.

To confirm and clarify the written record, and to obtain information not available in the record, there were personal interviews with individual patients in the Home. For the six patients who were no longer in the Home, for the few who were mentally deteriorated or afflicted with aphasia, or about whom there was some question, the Superintendent or the Occupational Therapist of the Home was consulted. The Superintendent of the Home, a Registered Nurse, was consulted in regard to conflicting statements about a diagnosis, the extent of nursing care required, or the degree of incapacity. The occupational

therapist was consulted in regard to shop activities, attitudes, and interests.

Caseworkers at Family Service Organization who were currently responsible for casework service for any patients in the group studied were also interviewed.

Supplementary data was obtained through two important cooperating agencies, the Kentucky Crippled Children Commission and the Kentucky Vocational Rehabilitation Division. This information was supplied by Miss Mary Payne Marriott, Medical Social Consultant of the Commission and by Mr. Lindsey Allen, Director of the Rehabilitation Department. Thirteen of the hundred patients had been known to the Commission, and eight of these had received social, diagnostic, medical or surgical services. The five others were known to the Commission as crippled persons, but had received no special services. Of the seven patients known to the Vocational Rehabilitation, four had received rehabilitation services, and three had not as yet received rehabilitation services.

Data obtained from the study will be presented in tables with accompanying exposition. Brief case stories of patients will be given when they illustrate a need for casework service or a process of rehabilitation. The organization and history of the institution will be briefly related to provide background for understanding its traditions, its concepts of service and its structure. The material for this chapter was obtained by personal interviews with Mrs. E. P. Ernwine, President of the Board, Mrs. E. C. Kornfeld, Chairman of the Admissions Committee,

and from Miss Nettie Smith, Board member and former social worker, and from a copy of the By-Laws and Articles of Incorporation.

For better understanding of the problem under scrutiny a chapter will be devoted to the growth of the concept of rehabilitation and current thought regarding its principles and practice. The material for this chapter was gathered from the study of books and articles by authorities in this field. Special indebtedness to Michael J. Shortley and John Eisele Davis is acknowledged.

The following definitions are offered as basic to the understanding of the text of this study:

"Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."[1]

"Vocational Rehabilitation is a service designed to conserve the working usefulness of disabled human beings."[2]

"Physical Medicine includes the employment of the physical and other effective properties of light, heat, cold, water, electricity, massage, manipulation, exercise and mechanical devices for physical and occupational therapy in the treatment of disease.....Physical medicine is the more generic and more inclusive term and as defined

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[1]Symposium on the Processes of Rehabilitation, May 25, 1944 (New York: National on Rehabilitation, 1944), p. 5.

[2]Michael J. Shortley, "Vocational Rehabilitation" Social Work Year Book (New York: Russell Sage Foundation, 1947), p. 540.

herewith it embraces physical therapy, occupational therapy and the employment of physical agents for diagnostic purposes."[1]

Physical restoration - "any type of medical or related care..... for the purpose of reducing or eliminating a vocational handicap..... Services ...include medical, psychiatric, and surgical examinations and treatment, hospitalization, convalescent care, dental care, nursing care, physical therapy, occupational therapy, prosthetic appliances, medical supplies and drugs."[2]

"Occupational Therapy is any activity, physical or mental, prescribed by a physician and guided by an occupational therapist for the purpose of hastening recovery from disease or injury. It may be prescribed to restore the function of injured or diseased muscles and joints; to help control activity of nervous or mental disorders; to help readjustments following chronic diseases; to reduce permanent disabilities and to provide purposeful utilization of leisure time.

"Two of the main types of occupational therapy are diversional therapy and functional therapy.....It can play an important part in building a high morale, as well as maintaining general muscle strength."[3]

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[1] "The Future of Physical Medicine" Journal of the American Medical Association, CXXV (August, 1944), p. 1093.

[2] "The Doctor and Vocational Rehabilitation for Civilians" Pamphlet of the Office of Vocational Rehabilitation, Washington, June, 1947, p. 1.

[3] Florence M. MacLean, O.T.R. "Growing Old Gracefully", Public Welfare of Indiana, May, 1946, p. 9.

Medical Social Work - "The primary concern of the medical social worker is with social and emotional problems related to illness. Such factors as unfavorable home surroundings and inadequate diet, or worry and unhappiness, may contribute to the patient's illness or interfere with his recovery. Chronic illness involving long periods of limited activity and conditions resulting in permanent disability have many social and psychological complications. A large proportion of the patients referred to medical social workers have need of the whole range of skills and techniques of social casework if they are to gain the greatest benefit from medical care or make the best possible adjustment to a permanent handicap."[1]

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[1] "Medical Social Workers Needed" Pamphlet of the American Association of Medical Social Workers, Washington, D. C., 1945, p. 4.

CHAPTER I

THE KING'S DAUGHTERS' HOME FOR INCURABLES

A Brief History

The setting for this study is the King's Daughters' Home for Incurables which is a non-sectarian private institution operating with a public subsidy.

The Home is administered by an executive board, composed of members of the King's Daughters' Circles of the State of Kentucky. The Circles are a part of a fraternal order established in the late nineteenth century under the name of the International Order of the King's Daughters and Sons. The order was established for the primary purpose of providing Christian service in the community. Although the order is non-sectarian in nature and purpose, the motive of service was inspired by the Christian religion, exemplified by the motto of the order, "In His Name." In many communities the Circles were attached to churches, which were most frequently of the Presbyterian or Lutheran denomination.

One of the first community service projects of the King's Daughters' Circles in Louisville was a visiting nurse service for the "sick poor" of the city. The number of "hopeless cripples" found in

the homes aroused great sympathy in the nurses and consequently became a matter of deep concern to the Order. The presence of the severely handicapped in the home was seen to be a heavy burden to the family, resulting often in hardship or deprivation for other members of the family or in neglect of the needs of the invalid. Sometimes an immediate practical consideration was the need for the release of the relative caring for the invalid to remunerative employment.

Aspiring to meet this need, in November, 1908, the King's Daughters' Circles of the State of Kentucky began a fund raising campaign for an institution for the care of chronic invalids. One of the leaders in the campaign was Miss Jennie Cassidy, who was herself a cripple and bedfast. Members of the Circles voted that the institution should be located in Louisville, as the largest number of Circles were in this City.

In the spring of 1909, a house and grounds at the present site was purchased. On April 28, 1909, articles of incorporation for the "Home for Incurables" were filed at the Office of the Clerk of Jefferson County, Kentucky.[1] On July 2, 1909, the institution was opened with two patients, a woman sixty years of age and her invalid son. The mother entered the institution "to have some time to rest before she passed away," but lived for twenty years. The invalid son died eighteen months after his admission.

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[1]Articles of Incorporation, dated January 28, 1909, Office of County Clerk of Jefferson County, Kentucky.

For a year, the Home operated on funds raised by contributions from members of the Circles and by the proceeds from garden parties and other benefits. In 1910, the President of the Executive Board, Mrs. J. William Jefferson, went before the state legislature and obtained an appropriation of $10,000 a year for the institution. In 1918, the appropriation was increased to $22,000, reduced in 1920 to $18,000, and in 1922 to $15,000. The annual appropriation of $15,000 has been maintained continuously since 1922. This appropriation has constituted the public subsidy from the Commonwealth of Kentucky for the care of physically handicapped state residents at the "Home for Incurables."

When the Community Chest of the City of Louisville was organized following the first World War, the "Home for Incurables" was one of the original member agencies. Funds provided through this source ranged from about $10,000 the first years to approximately $35,000 a year at present.

Other financial resources have included bequests, contributions by member circles, and assignment to the institution of estates of permanent residents of the institution. In the last few years, operating expenses have included board payments by relatives and others in the amount of approximately $8,000 a year.

To summarize, the "Home for Incurables" is a private institution for the care of physically handicapped adults of the state of Kentucky. The building is owned by the King's Daughters' Circles of

The State under a charter of incorporation. Maintenance of the institution is largely obtained through the annual state appropriation and by a share in the Community Chest contributions of the citizens of Louisville and Jefferson County in the amount of approximately $35,000 per annum. Other sources of financial support vary from small contributions of member circles to bequests by interested individuals. A small amount of money is derived from the transfer of patients' estates to the Home. In recent years, board payments by relatives and from other sources have added a substantial amount to operating expenses.

Structure and Organization

The management of "The Home for Incurables" was vested in a Board of Directors in the original articles of incorporation dated April 28, 1909. The articles of incorporation were amended on November 6, 1931, and again on September 13, 1935, but the general structure of the organization remained essentially unchanged.

The following statement is a quotation of Article 7, Sections 1 - 3, of the Articles of Incorporation as amended on September 13, 1935:

> The affairs of this corporation shall be managed by a Board of Directors, composed of the officers of the Kentucky Branch of the Order of "The King's Daughters and Sons," the Leader and one representative from each Circle of "The King's Daughters and Sons" in the State of Kentucky, the Chairman of the Louisville City Union, and fifteen (15) additional members of the Order from the City of Louisville, Kentucky.

> The said Board of Directors shall be elected at the annual meeting of the Corporation and shall serve terms of one year.
>
> The officers of the Board of Directors shall be President, First Vice-President, Second Vice-President, Recording Secretary, Corresponding Secretary and Treasurer, each of whom shall be elected by the Board of Directors annually and shall serve one year or until their successors are elected and qualified.[1]

According to the By-Laws of the corporation, adopted November, 1941, the officers of the Board of Directors along with the chairmen of the elective and appointive committees, the Branch President, three members from the Board of Directors, the Custodian of Funds, and the Social Worker shall comprise the Executive Committee which shall have entire supervision of the affairs of the Home. The By-Laws provide that the Executive Committee shall authorize the expenditure and investment of all funds, and shall appoint the members of the Admission, House, Religious Work, Occupational Therapy, Finance, and By-Laws Committees. The Executive Committee employs the Superintendent, and, on the recommendation of the Admissions Committee, employs a Social Worker, and, on the recommendation of the Occupational Therapy Committee, employs a Therapist. The Executive Committee appoints a Staff of Physicians and a Medical Co-ordinating Committee.[2]

It is understood that the practical nurses, now nine in number, are employed by the Superintendent, who is also in complete charge of the attendants and housekeeping and maintenance personnel. There are now sixteen in the latter group.

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[1]Articles of Incorporation, as amended on September 13, 1935, Corporation Book, Office of the Clerk of the County Court, Jefferson County, Kentucky.

[2]By-Laws of the Home for Incurables, dated November, 1941, Section 5.

The members of the Executive Committees and the various auxiliary committees serve on a voluntary basis without pay. It is prescribed in the By-Laws that all members of the Board of Directors shall pay a membership fee of one dollar a year.

Eligibility for Admission

During the first year space was provided for twenty persons. When a wing was added, the number was increased to forty-six. In the Haven Emerson Survey of 1914, comment was made about the "elegant spaciousness" as inappropriate to an institution depending on public contributions for support. Additional beds were added in the rooms to bring the capacity to fifty-three. When further additions were built to the Home the capacity was enlarged to provide bed space for one hundred persons, which remains the present patient capacity.

At present three men have single rooms in the basement, and four women have single rooms on the second floor. There are three double rooms for women, and one double room for men. The dormitory rooms house from three to six persons in a room. Each person has one or more drawers of dresser space and a locker for clothing and personal belongings.

The second floor is reserved for women, and the men are housed on the first floor and in the basement. There is one dormitory room for women on the first floor. At present there is bed space for thirty-six men and sixty-four women. It is understood that more bed space is

available for women than men in the institution because the women applicants have always far outnumbered the men.[1]

The original Articles of Incorporation specified that "the object of this charity, which is non-sectarian, is to provide a home for persons who are residents of the State of Kentucky, who are afflicted with an incurable physical disability or disease."

The amended Articles of Incorporation, dated 1931, state:

> The object of this Corporation, which is non-sectarian, is to provide a home for destitute persons of good character, who have been residents of the State of Kentucky for at least one year prior to their application for admission into the Home, and who are afflicted with an incurable physical disability or disease. Provided, however, no applicant shall be admitted who is afflicted with a mental derangement, drug or liquor habit, or a contagious or infectious disease.[2]

No available official statement gives the date when pay-patients began to be admitted. This has been a development of the past few years. Free and pay-patients are given equal consideration.

Persons of all religious faiths are admitted and religious services are made available to each person. There is a large chapel provided for the services, and religious observations form an important part of the lives of the people in the Home. There is no arbitrary

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[1]Statement of Mrs. E. C. Kornfeld, Chairman of Admissions Committee, personal interview.

[2]Article 3, Amended Articles of Incorporation, dated November 6, 1931, Corporation Book 42, Office of the Clerk of the County Court of Jefferson County, Kentucky, p. 275.

limit set on the number from each faith who can be admitted to the Home, and again, as with sex, much depends on the constituency of the waiting list of applications.[1]

Since 1941, no person under eighteen years of age has been admitted to the Home, but there has never been a maximum age limit. It is understood that no person can be denied admission to the Home because of extreme age, but there are factors that do operate to control the number of admissions of bed-ridden persons needing complete nursing care. Primarily, the limit derives from the number of nurses and attendants that can be provided in the Home. Consequently, a semi-ambulatory or wheel chair patient, capable of self-care, may occasionally be admitted before an applicant who is bed-ridden or more seriously disabled. Similarly, an applicant who is senile, mentally deranged, incontinent, or affected with cancer, diabetes, or epilepsy may be denied admission, as the Home lacks the facilities and personnel needed to give proper care for such conditions.

To summarize the eligibility requirements, any white person over eighteen years of age with a physical handicap is eligible for admission, regardless of ability to pay, if he has been a resident of the State of Kentucky for the past year. There is no discrimination as to age, sex, or religious faith, but the applicant is expected to be of normal mind, not afflicted by cancer, and suffering from no contagious or infectious disease.

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[1]Interview with Mrs. E. C. Kornfeld, op. cit.

The Occupational Therapy Program

Miss Nettie Smith relates that the Board became interested in the possibilities of occupational therapy shortly after the close of the first World War. Since many of the patients "sat day after day with nothing to do," it seemed that occupational therapy might offer something to meet the need for directed, creative activity.

A graduate of the Boston School of Occupational Therapy was employed jointly by the Children's Free Hospital and the Home for Incurables, with the therapist dividing her time between the Hospital and the Home. At first the therapist taught the patients in the yard in the summer and in the hall in the winter. Eventually the workshop in the basement was established and provided with rug looms, hand looms, pedal looms, frames and material and equipment for basketry, leather work, cord knotting, chair caning, needlework, and wood work.

The crafts work was found to be important in terms of patient morale and productive of some income for the institution and the patient. A full-time, qualified occupational therapist has been employed by the Home for the past many years, and the workshop activities and achievements has long been one of the noteworthy features of the institution. As to its relation to rehabilitative procedures, the occupational therapist, Miss Flora W. Spurgeon, states that the work is not remedial in purpose (although sometimes the result may be remedial) and there is no special training directed toward the goal of self-maintenance.

Besides the intrinsic worth of useful and creative activity, there are other values in the workshop program. The patients work in groups, and real comradeship develops in the congenial atmosphere of shared, supervised activities. The role of the occupational therapist in creating and maintaining this harmonious atmosphere is very important. Her role is similar to that of the leader in a group work situation, who encourages the individual, and helps him with his relationships in the group. Skill in the teaching of crafts is only a part of the equipment and training of the qualified occupational therapist.

Some of the proceeds from the sale of articles produced by the patients was used to purchase a 16 mm film projector, and films are exhibited bi-weekly in the chapel for the pleasure of wheel chair and ambulatory patients. Miss Spurgeon believes that recreational opportunities for the patients as a group should be increased, and in line with this belief plans regular parties for the patients in addition to workshop activities.

There is a separate room in the basement that is known as the recreation room. Patients gather here to play games, work jig-saw puzzles, or to prepare a social cup of coffee. Shuffleboard is a favorite activity with a few of the patients.

There is little organized activity for the bedfast patients. An attempt to meet their need for some interest to lighten the monotony of their days seems to be provided by the visits of friends, relatives, and members of interested church groups, who visit and bring presents.

A member of the Junior League of Louisville, Mrs. Jasper Hagan, gives regularly a morning or two a week to the patients, teaching some of them simple activities, such as knitting, writing letters for disabled persons, and shopping for others. More of this kind of volunteer service would seem desirable, and would be an extension of the professional services of the occupational therapist.

Social Service

Miss Nettie Smith, board member and part-time social worker in the Home until the end of 1945, stated that she lacked one year of being a charter member of the Executive Board of the Home. She thus gave the Home many years of devoted service, both in the volunteer and paid capacity. Her duties are described thusly in the By-Laws of the Home:

> The Social Worker shall personally investigate all applications for admission, see that all application blanks are properly filled out and signed by the President. She shall attend to all business relations between the patients and the Home. She shall have charge of all papers belonging to the patients and shall render any other service desirable for the patient's welfare. She shall perform any other duties the Executive Committee may delegate to her. The Superintendent and the Social Worker shall prepare monthly and annual reports for the Board of Directors.

Miss Smith elaborated on her social work activities by stating that a large proportion of her work was concerned with the treatment, re-training, and rehabilitation of the children in the Home in cooperation with the Crippled Children Commission, and the Office of Vocational Rehabilitation. Miss Smith cited a number of cases of children who were rehabilitated and returned to the Community as useful and pro-

ductive citizens.

One of the cases cited, now a man of 56, returned to the Home last year after 27 years of remunerative work in the community as a bookkeeper. During these years he had been married and supported a wife and three children. Miss Smith recalled that when he was in the Home as a bed-ridden young man, he was something of a disciplinary problem. He had refused to string beads, as suggested. Later he became interested in a course of business training. When his condition improved and he became ambulatory, he was able to leave the Home, after five years of residence, on a self-supporting basis.

That the content of the social worker's job was very extensive was noted when a period of demonstration service by the Family Service Organization was under consideration. The board was interested in clarification of the responsibilities of a social worker as such confusion is not unusual in any medical setting where social work is first established. A job analysis was done by Miss Mathilda Mathisen, Associate Professor of Medical Social Work, Kent School, University of Louisville. Miss Mathisen analyzed the job as carried by Miss Smith from the standpoint of distinguishing between the clerical and professional activities. It was agreed that the Family Service Organization would undertake only the professional activities in connection with social investigations of new applicants and for case work service to an occasional patient already in the Home when there is need for a change of plan.[1]

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[1]Mimeographed Statement of Miss Esther Taylor, Executive Secretary, Family Service Organization, dated 2/19/46.

When the period of demonstration service by the Family Service Organization is completed, the Board expects to employ a full-time qualified medical social worker for professional service to the Home and its patients.

CHAPTER II

CHARACTERISTICS OF PATIENTS IN THE HOME ON DECEMBER 31, 1947

A study of all the patients in the Home for Incurables on a particular date was made for the purpose of determining rehabilitation needs and how they might be met within the limits of an institutional program.

A representative sample, selected by proper research methods and studied intensively, would have yielded the same results as the study of the patient population as a whole. The study of all the patients was undertaken, not because it was more valid, but because the results would be more readily understood by persons who might be unacquainted with research methods. It was anticipated that some of the information might also be useful for other study purposes or for administrative purposes.

It will be obvious from the study that the patient population is extremely varied as to age, diagnosis, length of residence and extent of mental and physical capacity. How to meet the needs of so heterogeneous a group does raise tremendous problems in administration. The data obtained by the study may

be useful to members of the Executive Board in charting their future course in regard to the selection of applicants for admission to the Home and in their planning for meeting patient needs by development of the services of the Home.

It is suggested that the study may also serve to interpret the function of the Home for Incurables to the community. The function of the Home, and its place in the community, has never been too clearly defined. To some, it has represented a hospital; to others, it has been a nursing home for the chronically ill; and to others, it has seemed to be a home for the aged. That it is truly a "substitute-Home" for crippled and disabled adults of a wide range of ages and with a wide range of physical incapacity will be readily apparent.

Preliminary Study

As previously indicated,[1] the current active card file was used as the base for the study. Information given on each card included the patient's name, the birth date, the date of admission to the Home, the referring physician's name, the referral diagnosis, the religion, length of residence in the State, names and addresses of parents and other relatives, burial and insurance information, and pay arrangements, if any were made.

The number of persons in the Home on December 31, 1947 was 100, according to the registration book. By further checking

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[1] See <u>supra</u>., p. 4.

the registration book, it was possible to learn the names of persons who were admitted, dismissed, or who had died during 1948. The admissions since January 1, 1948 were excluded from the study, and six persons are included who were not in the Home in March, 1948, when the study was made. Three of these six persons died and three were dismissed.

Brief mention will be made of these six persons as they illustrate the patient turn-over in the Home, and show some of the problems that must be met in a custodial-type institution.

The first person was a woman with arthritis who, after twenty-five year's residence in the Home, developed active tuberculosis, and was sent to Waverly Hills Sanatorium. Although sent to the sanatorium in November, she was not officially dismissed from the Home until January 1, 1948.

Another woman, also officially dismissed on January 1, 1948, had been in the Home less than five months. She was accepted for the usual three months' trial basis, after considerable pressure from interested individuals for her admission. She was known to have a difficult personality and had been averse to entering the Home. She made a poor adjustment to the institutional routines and to the other patients and was dismissed when the social worker at the Family Service Organization found suitable accommodations for her in a nursing home.

In February, a third person was dismissed for transfer to Central State Hospital (state mental institution). This man was an ambulatory, post-encephalitic patient who had been in the Home a little more than a year. Although his mind was known to be somewhat impaired, he was accepted at the Home on a trial basis. When it became clear that he was too mentally disturbed for care in a Home intended for mentally normal persons, the patient's brother agreed to apply for his admission to the state mental hospital.

Besides the three dismissals, there were three deaths, one death occurring in January, one in February, and one in March. The person who died in January was a seventy-four year old woman who had been a resident of the Home for eighteen years. She was afflicted with atrophic arthritis, sometimes called arthritis deformans, and had been a bed patient requiring complete nursing care.

In February, a man of seventy years, resident for four months died. He was a bed-fast patient who had been admitted because of hemiplegia with arteriosclerosis and a hypertensive cardiovascular condition. In March, a woman of eighty, resident for two years, died. She, too, was a bed-patient, and had been admitted with the diagnosis of right hemiplegia and un-united fracture of the right hip.

Rate of Turnover

It seemed that it would be useful to determine the rate of turnover in the Home, as the data was available in the registration book. Accordingly, the registration book was studied for the past five years to determine the average number of patients received into the Home and the average number who died or were dismissed each year. The following table gives the results of the information gathered:

Table 1

Admissions, Dismissals, and Deaths, 1943-1947

YEAR	ADMISSIONS			DISMISSALS		DEATHS		Total Terminations
	Male	Female	Total	Male	Female	Male	Female	
1943	9	6	15	10	4	3	4	21
1944	13	8	21	4	4	6	4	18
1945	9	6	15	5	2	9	3	19
1946	9	16	25	3	5	6	6	20
1947	6	15	21	1	2	5	13	21
Total	46	51	97	23	17	29	30	99

It will be noted that terminations roughly average 20 patients per year over the five year period and that admissions approximate the same average over the same period.

It may be inferred from the rate of turnover that the patients in the Home on December 31, 1948 will be roughly 80% of the group that was there on December 31, 1947. Using the same process of deduction, the inference may be drawn that the

number in the Home on December 31, 1949 will be 60% of the group that was there on December 31, 1947, and at the end of the year of 1950, there will be 40% of the group. As will be indicated later in the study, much of the turnover occurs among the more recent admissions. From this information, the inference may be drawn that the results of the study may be regarded as representative, not only of the present group of patients, but also representative of the patient group for the next several years. If the study is not representative of the patient group five years from now the conclusion might be drawn that there had been some major changes in the policy of selecting admissions to the Home or there had been important factors in the community affecting the type of referrals.

Diagnoses of Patients

The first item selected for study was the diagnosis of the patients. In ascertaining the diagnosis, the statement of the referring physician was used when it was not contradicted by other medical information. Some lack of explicit diagnosis was found in statements from the referring physician which gave only a descriptive statement relating to the need for care in the Home. Examples are the statements "amputations of both legs," "semi-invalid," and "paralysis." When the physician's statements were not explicit, the patients were grouped in the "not classifiable" section.

The classification of diseases by diagnosis was made after consulting several general medical texts. The classification follows the outline that appeared most generally accepted. No attempt was made in the classification to account for persons who had two or more diseases or handicaps. When the diagnosis given was un-united fracture of the pelvis with glaucoma, only the orthopedic handicap was used for purposes of classification. When arthritis with pernicious anemia was mentioned, only the arthritis was noted in the classification. When right hemiplegia and un-united fracture of the pelvis was the combined diagnosis the disease noted first by the physician was taken as the primary diagnosis. This was done for the purpose of simplification.

In the group of 100 patients studied there were about 30 who were difficult to classify. There were four whom it was not possible to classify because of the lack of an explicit diagnosis, and two were difficult to classify because three or more disabling conditions were noted. Fifteen persons were found with two or more diagnosed ailments, and eight of them were found to have two disabilities, either one of which would make them eligible for care in the Home. There were eight persons for whom contradictory diagnoses were given by different medical sources, and some decision had to be made about selecting the most authentic source. For example, there was the patient who was admitted to the Home when seven years old with the diagnosis of infantile paralysis, but recent medical statements from both Louisville General Hospital

and Vocational Rehabilitation clearly establish the diagnosis as arthritis. This person was classified as an "arthritic."

The classification of patients by diagnosis and sex is presented herewith:

Table 2

Diagnosis* by Sex

Diagnosis	Sex		
	Male	Female	
Arthritis			
Chronic	4	16	
Chronic Hypertrophic	-	2	
Deformans (or atrophic)	-	3	
Osteo-arthritis	-	1	
Multiple Infectious	2	-	
Total	6	22	28
Paralysis			
Hemiplegia (right or left)	4	12	
Paraplegia			
From Birth (Spastic)	4	4	
Other Injury or Disease	5	1	
Total	13	17	30
Other Neurological Conditions			
Paralysis Agitans	1	2	
Post-Encephalitis	4	5	
Post-Poliomyelitis	1	3	
Multiple Sclerosis	2	-	
Total	8	10	18
Orthopedic Conditions			
Osteomyelitis	3	-	
Tuberculosis of Bone	2	1	
Un-united Fractures (or conditions following fractures)	2	6	
Total	7	7	14
Other Conditions			
Cardiac and Circulatory			
Arteriosclerosis	-	1	
Rheumatic Heart	-	1	
Muscular Dystrophy	1	1	
Not Classifiable	1	5	
Total	2	8	10
GRAND TOTAL	36	64	100

*Primary diagnosis

It is interesting to note that although this is a home for the physically handicapped, only a small proportion of the group have handicaps that can be classified as orthopedic, and that the largest proportion seemed to be the hemiplegic, paraplegic, and other neurological conditions. There is a considerable portion who have arthritis. As will be noted later under length of residence data, the group who has the longest residence in the Home is the arthritic.

Age of Patients

The next classification of patients was made according to age. Table 3 presents this data:

Table 3

Age by Sex

Age	Male	Female	Total
90-99	1	-	1
80-89	-	7	7
70-79	4	16	20
60-69	3	20	23
50-59	9	8	17
40-49	4	7	11
30-39	5	4	9
20-29	8	2	10
Under 20	2	-	2
Total	36	64	100

From this table, it was learned that there was a great dispersion in age, and that the range covered a span of more than seventy years. Actually, there were 51 persons over 60, and 49 persons under 60, although there has been the assumption that this is a home for the aged. The very large group of women between the ages of 60 and 90, however, was marked, as there was a total of 43 women in this age bracket, as compared to seven men. That there were 21 persons under 40, and that 15 of them were men, seemed especially significant in terms of the purpose of this study.

Length of Residence

Length of residence was next considered:

Table 4

Length of Residence by Sex

Years	Length of Residence		
	Male	Female	Total
0-4	20	36	56
5-9	9	12	21
10-14	1	2	3
15-19	4	6	10
20-24	1	5	6
25-29	-	3	3
30-34	1	-	1
Total	36	64	100

This table shows that slightly less than half remained more than five years. As indicated in Table 1, the departures were explained by both dismissals and death.

Table 5

Length of Residence by Diagnosis and Sex

	Arthritis		Paralysis		Other Neurological		Orthopedic		Other		
Residence	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
0-4	2	11	9	9	4	6	3	5	2	5	56
5-9	2	3	2	3	3	3	2	2	-	1	21
10-14	-	1	1	1	-	-	-	-	-	-	3
15-19	2	2	-	1	-	1	2	1	-	1	10
20-24	-	3	-	2	1	-	-	-	-	-	6
25-29	-	2	-	1	-	-	-	-	-	-	3
30-34	-	-	1	-	-	-	-	-	-	-	1
Total	6	22	13	17	8	10	7	8	2	7	100

It will be seen that of the 23 who have been in the Home for ten or more years 10 of them have arthritis. It was interesting that the oldest resident in the Home, who had been there thirty years, had cerebral palsy (or spastic paralysis). He was a wheel chair patient, whereas two women "arthritics" and a "spastic" who had been there more than 25 years, were bed-patients.

Table 6

Age by Length of Residence

Years	0-4	5-9	10-14	15-19	20-24	25-29	30-34	
90-99	1	-	-	-	-	-	-	1
80-89	7	-	-	-	-	-	-	7
70-79	13	3	1	1	1	1	-	20
60-69	14	2	1	2	3	1	-	23
50-59	10	5	-	-	1	-	1	17
40-49	2	5	1	2	-	1	-	11
30-39	2	3	-	3	1	-	-	9
20-29	6	2	-	1	-	1	-	10
Under 20	2	-	-	-	-	-	-	2
Total	57	20	3	9	6	4	1	100

This table showed that the oldest residents are not the oldest in years. It was found that two of the group had entered the Home as children of seven years and two had been 12 and 14 years old, respectively. Five had entered the home when between the ages of 16 and 20 years of age. Two 18 year old males have been admitted in the past year through the Kentucky Crippled Children Commission.

Table 7

Extent of Handicap by Sex

	Male	Female	
Ambulatory			
Brace	-	1	
Cane	1	2	
Crutches	4	2	
Special Shoes	1	2	
Ataxia or Limp	3	4	
No Aid	-	-	
Total	9	11	20
Bedfast			
Complete	6	21	
Occasionally Wheelchair	2	5	
Total	8	26	34
Wheelchair			
Complete	18	24	
Also Cane and Crutches	1	3	
Total	19	27	46
GRAND TOTAL	36	64	100

The above table can not be accepted as absolute or fixed in any sense. Due to remissions and relapses, some of the ambulatory patients become bed-fast or in need of wheelchairs; some of the wheelchair patients become bed-fast, and some of the bed-fast patients may occasionally use wheel chairs as indicated. The number who are totally bed-fast and who have been invalids for many years, with no possibility of even a slight remission, are accounted for under the classification "Bedfast" and the sub-group "Complete."

It will be noted that there are twenty-seven out of the hundred in this category.

A little more than a third of the group are able to take their meals in the dining room in the basement. The remainder, some of whom are ambulatory and wheelchair patients are served in their quarters, because of some difficulty in managing the mechanics of the process. This may be due to excessive tremor in the hands, or blindness. A few of the former group must be fed by attendants.

Work Performance

Table 8

Work Performance by Sex

Type	Male	Female	
Work Shop	18	27	45
Chores for Other Patients	2	1	3
Radio and Electrical Repair	2	-	2
Receiving Special Training	1	-	1
Other	-	2	2
Total	23	30	53

Table 8 shows the work performance of the 53 persons of the group studied who engaged in some type of work in the institution. These are mutually exclusive groups by classification, but in actuality four women who work in the work shop also do chores for other patients. This work is not accounted for in the classification. The two men listed as doing chores for the other patients do not engage in work

shop activities. The person receiving special training is a 25 year old man who is receiving instruction at the Art Center, under Vocational Rehabilitation auspices. Of the two men listed as doing radio and electrical repair, one man has a basement workshop in the Home. The other man has had almost three years of private employment in that line, while boarding in the Home. Though temporarily not engaged in that work due to indisposition, he is listed because of his training and past record.

Two women are listed as engaged in "other work." One person, recently admitted, busies herself with making paper flowers at her own bed-side. Another woman makes scrapbooks, which she sends to hospitals.

Not listed is the interesting activity of one man in the Home, who manages the Circulating Library for the patients. He is not listed in a special category because he is counted in the number who engage in shop activities.

The Circulating Library consists of ninety books supplied by the Louisville Free Public Library. This group of books is returned and a new group substituted every three months. Requests for a particular book or for books on a particular subject are channeled through the Home Librarian.

Table 9

Shop Activities by Type

Type	Number of Persons
Weaving (rugs, luncheon mats)	11
Basketry	2
Art	1
Chair Caning	1
Needle Work	11
Threading	3
Woodwork	4
Weaving Potholders	5
Leather Work	2
Variety of Activities	5
Total	45

Most of the group go to the workshop to engage in their special activity. Some of them work regularly four hours a day, five days a week. Others are irregular because of indisposition. Several of the women help regularly with shop activities, but stay in their own quarters because of preference or incapacity. This includes one person who regularly cuts carpet rags for the rug looms, and several persons who embroider, knit, or do needle work of some kind. Two women expressed unhappiness about confinement to their

beds, and inability to go to the workshop. Several individualistic elderly women expressed a preference for working in solitary peace in their own rooms.

The person who does chair caning has been in the Home many years, and gains real satisfaction from his activity. One of the persons who does basketry is a paraplegic blind man, who has great skill in his basketry, and is noted in the Home for his friendly, outgoing disposition. The man who does the art work has multiple sclerosis, which is characterized by muscular weakness. This man is a graduate of an art school, and applied his training by doing lay-out and art work in an advertising department for many years before he was stricken.

All of these three men are late middle-aged, and are mentioned as representative of a group of middle-aged, severely handicapped men and women who have made a good adjustment to the Home, and to whom the activities in the workshop are as vital as the satisfaction of their physical needs for food and shelter.

In this connection, the words of John Eisele Davis, an authority on rehabilitation who emphasizes the psychic and spiritual values to the individual, may be cited: "Work is more than an activity; it is an emotional liberation - the thwarting of which may give rise to depression followed by apathy and, sometimes, by psychoneurosis or to restlessness and irritability."[1]

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[1]John Eisele Davis, "Principles and Practice of Rehabilitation," (New York: A. S. Barnes & Co., 1943), p. 14.

Table 10

Recreational Interests

Type	Number of Persons
Bible Study (in groups)	20
Bible Study (individual)	30
Card Games, checkers, other	26
Cinema	40
Letter Writing	15
Radio	60
Reading	
Avid readers	18
Occasional readers	28
Vacations	25

There is overlapping in Table 10 and no attempt was made to make mutually exclusive groups in order to arrive at a total. These figures are based on statements made during personal interviews with the patients, and as such are expressions of interest rather than verified interest.

It was learned that few of the bed patients had any interests or special recreational outlet. A great many of the chronic invalids had apparently lapsed into a vegetative existence in which satisfaction of their physical needs had become the prime motivation. Some discontent was manifested in the statements of some of them: "I just

sit here all day long;" "My only recreation is looking out of the window," and another who said, "It's a dull life." Some of the invalids had regular visits from close friends or relatives, and seemed to depend on this contact for most of their satisfactions.

It was noted that the younger group uniformly enjoyed the radio, and that most of them had special programs to which they listened with eager enjoyment. Some of them liked mystery stories and popular music, others liked the news broadcasts, and one person liked the sports news.

Several men patients like to play checkers and card games. One man, who as a crippled boy was taught by his father to play chess, is endeavoring to teach the game to a bed-fast younger patient.

Among the elderly group fewer interests were found, and most of them expressed a desire for quietness and rest. The radio, which can be used only at special hours, is regarded with aversion by many of this group who regard it as a source of noise and disturbance.

Some of the patients who have homes or close family ties, and who are able to travel by automobile or public conveyance, take vacations every year lasting sometimes from a week up to two months or more. For those who are able to take vacations, this is a source of great pleasure.

CHAPTER III

REHABILITATION AS RELATED TO THE HOME FOR INCURABLES

A Brief History of the Concept of Rehabilitation

Rehabilitation is a concept that has developed mainly in this century. It grew out of the Workmen's Compensation Laws in the first part of the century and gained impetus during and following each World War. The concept is closely related to the democratic ideal of guaranteeing to all persons the right of education, training and employment regardless of race, creed, color or state of physical handicap.

The democratic and humanitarian ideal in rehabilitation has been closely geared to the companion principle of increasing production by utilizing all available manpower in a socially useful way. The trend in rehabilitation has been away from the ideals of other centuries in which the cripples and afflicted were regarded as the natural recipients of charitable acts and good deeds.

Since rehabilitation in its practical aspects is linked to the economic picture, it is well to bear in mind that governmental activities in behalf of the handicapped grow in response to industrial

demands, and slacken when there is man-power surplus. Some efforts have been made by industry to mitigate this necessity by establishing a policy of hiring only handicapped persons for certain activities or in certain departments. This is an outcome of study and research in both industry and government of "fitting the handicapped to the job."

Another principle of rehabilitation was officially recognized in the Vocational Rehabilitation Act of 1943 - the principle of physical restoration, when medically feasible, before training or placement in a job. This principle was expressed in popular terms: "Never train around a removable handicap." The application of the principle recognized the use of medical advice as basic to any sound program of rehabilitation.

The number of persons physically capable of doing a job, but lacking in motivation, was early noted by vocational counsellors. Rehabilitation was seen to be something more than the application of education, retraining, and placement in a job. Recognition that the person to be rehabilitated was not a mechanical being, but a human person with hopes, fears and desires that had a real effect on a rehabilitation program, again broadened the base of the rehabilitation concept. Psychologists were used for testing interests and aptitudes, and psychiatrists were consulted for their opinions regarding the individual's state of mental health, his ego-strengths and his emotional stability.

After the human factor was recognized as important to successful rehabilitation, the social case worker was considered as an adjunct to the rehabilitation team who would be most likely to recognize and deal properly with emotional and social factors. The social worker was the expert with the techniques and understanding to help an individual to mobilize and make effective use of his capacities for change and growth.

Present-day authorities on rehabilitation uniformly agree that effective rehabilitation is an eclectic process involving the use of experts in medicine, surgery, psychiatry, psychology, vocational training and councelling, and social work. It is further emphasized by the National Council on Rehabilitation that the processes of rehabilitation are most effective when they begin at the time of injury or onset of the disease, and include, from the first, the concerted efforts of doctors, nurses, physicial therapists, occupational therapists, training instructors, recreational workers, and social workers - with all of them directing their energies toward the goal of rehabilitation.[1] This was the process used by the armed forces in the rehabilitation of the war injured, and recognized again that it was the man, and not merely an injured member of the body, who must be rehabilitated.[2]

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[1] Symposium on the Processes of Rehabilitation, Op. cit., pp. 1-31.

[2] W. B. Doherty and D. D. Runes (eds.), Rehabilitation of the War Injured, (New York, Philosophical Library, Inc., 1943), p. 425.

The application of this process to civilian life has been the project of the Baruch Committee on Physical Medicine, in New York City, which is encouraging communities to set up rehabilitation centers for the rapid re-training and rehabilitation of persons injured by accident or disease.[1] A corollary plan aims to promote the use of community hospitals as civilian rehabilitation centers, using the techniques of physical medicine to bring about complete physical restoration following surgery or medical treatment. "The hospital can thus perform its function of bridging the gap from the bed back to the job and can restore to usefulness many people who otherwise would be unable to support themselves and would therefore become public charges."[2]

Application of the Concept of Rehabilitation to the Home for Incurables

How, it may be inquired, do these interesting ideals and principles apply to the Home for Incurables, which is an institution providing care for severely handicapped persons with permanent disabilities of long standing? It is acknowledged that there is no immediate, direct connection between rehabilitation, as it has just been described, and the function of the Home.

Firstly, it is apparent, from material presented previously, that the purpose of the institution is the provision of care in a

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[1]The Baruch Committee on Physical Medicine, Report on a Community Rehabilitation Service and Center, (New York: Baruch Committee on Physical Medicine, 1946), pp. 1-24.

[2]Report of the Committee on Hospital Services, Community Hospitals as Civilian Rehabilitation Centers, (Harrisburg, Pa.: Hospital Association of Pennsylvania, 1946), p. 117.

"substitute-home." It has been established that the Home is classified as a "custodial-type institution," and is not a hospital.[1] It is clear that it is not a rehabilitation center, as there are no facilities for special training or development of work tolerance in preparation for remunerative work. Although there is an active and useful occupational therapy department, its main purpose is to provide occupation to maintain the morale of the patients rather than for retraining or the application of remedial activities.

Secondly, it is apparent from material presented in the study of patients in the Home, that a very small proportion of the group have any potentialities for complete vocational rehabilitation. To reiterate, at least half of the patients are aged and debilitated; another large group representing all ages are incapable of self-care and are dependent on the attendants for the satisfaction of every physical need; most of the younger adults who might be interested in training or some measure of physical restoration are incapable of travel by public conveyance, have no home in the community to which to return, and present complicated emotional problems in addition to severe physical handicap.

It may be stated that planning for rehabilitation has no place in the general program of the institution, and that, in particular, the concept of rehabilitation involving the goal of remunerative employment is totally unrelated to the purpose and

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[1]See Supra., p. 1.

program of the institution, or to the type of physically handicapped admitted there for care.

Although this conclusion is inevitable, because of the nature and purpose of the institution, it does not follow, that on an individual basis, some rehabilitative procedures are not, and can not be supplied, by agencies in the community to persons in the Home in the same manner as they are supplied to persons outside the Home. Examples of special training, vocational guidance, and physical restoration currently being received by patients in the Home will be given to illustrate the availability and use of community rehabilitation resources for some of the severely handicapped in the Home for Incurables.

Persons in Home Using Rehabilitative Procedures

The content of the case material used in this section was derived from case records and from interviews with institutional staff and social agency personnel. No attempt has been made to analyze any case situation, or assess minutely the individual's strengths or potentialities. Details given are with particular reference to rehabilitation and some of its processes and procedures.

Case 1 - Example of Special Training of Severely Handicapped within Home.

Mr. A, a 36 year old man who has been an inmate of the Home for 15 years has recently profited by special instruction in radio

and electrical repair given by a teacher who was sent to the Home once a week. This instruction was provided by the state office of Vocational Rehabilitation.

Previously, Mr. A's radio and electrical repair work in a shop in the basement of the Home had been largely a result of training through a correspondence course. It is understood that his repair work is limited to work that is done on radios and electrical appliances in the Home.

Mr. A is a severely handicapped person with osteomyelitis of 22 years duration. The condition is characterized by draining sinuses, and some nursing and medical care is regularly required. He has full use of his hands, and is considered in the Home an intelligent, stable person. He receives considerable recognition for the useful work he is able to do.

Although unable to walk, he is capable of self-care, and uses a wheel chair for circumambulation. He expresses satisfaction with his life in the institution, and regards it as his home. The presence of a sister and a brother-in-law on the staff of the Home doubtless adds greatly to his feeling of belonging.

Mr. A for a time considered the possibility of attempting to establish himself in a radio shop outside the institution. That he decided against the step and remained in the institution may be attributed to both reality and emotional factors. The reality of the cost of establishing a well-equipped radio shop, and the necessity of hiring an attendant to care for his needs, was the strong deterrent.

The emotional components of an attachment to the institution that had been his home for 15 years, and probable dread of the stress of a competitive life, can be reckoned as factors in his final decision.

Mr. A was able to use the help of a student case worker at the Family Service Organization in working through this problem and coming to a final decision.

Case 2 - Example of Need for Study.

Mr. B - This 22 year old boy came to the institution when he was 17 years old, following an injury in C.C.C. camp which resulted in osteomyelitis of the right femur. He was bedfast for some time, and his docile, sweet behavior was noted in a letter on file at the Home. During his five years at the Home he has received treatment at both the Kosair Hospital under the Crippled Children Commission and at the Louisville General Hospital. Following surgery in 1946, he was able to use crutches, and in the past year has improved so much that he is able to walk without crutches although he has a pronounced limp.

Although enjoying a vast physical improvement (how lasting is the improvement has not been medically verified), and an increased ability for locomotion such as is rare in the Home, Mr. B shows a discouraged, weary attitude and a spiritless dejection that would appear to be of psychic origin.

When interviewed in the Home by a representative of the office of Vocational Rehabilitation, Mr. B evinced no interest in a training program and indicated no special aptitudes and abilities. It is reported, however, by the occupational therapist that he has some skill in woodwork and has a real interest in working in the shop.

Not much is known about Mr. B, as neither the record at the Home nor the record at the Crippled Children Commission gave much social information regarding him. It is known that his parents are deceased, and that he has two half-brothers and a half-sister as his only living relatives. Mr. B mentioned a close tie with the married half-sister. Mr. B completed the sixth grade.

What social and emotional implications there are in Mr. B's attitude can only be guessed. It would appear that his attitude of dependency had lasted longer than the physical need for the dependency, and that possibly some fear of the return of a bed-ridden condition might be operating. How deeply rooted is his lack of self-confidence and how much his attitude is the result of earlier deprivations would need to be explored with Mr. B by an understanding and non-threatening case worker.

Thorough study of Mr. B's situation would involve primarily an understanding of Mr. B, of what he wants and of what he is capable. If medically and mentally he is recommended as capable of receiving retraining, the caseworker might be able to help Mr. B move in that direction.

Case 3 - Example of a Need for Follow-up.

Mr. C, a man of 27, entered the institution when he was 18 years old. He had been in bed six years with severe osteomyelitis of the right hip of long duration. He had been referred to the Home by the Crippled Children Commission who gave him an extensive program of treatment. He was enabled, through orthopedic surgery, to move about in a wheelchair and finally to walk with crutches.

In appearance, Mr. C was eager and alert, and talked freely of his efforts at self-support. With the help of the social worker in the Home, Mr. C was placed in the Kosair Brace Shop for apprentice training. This was discontinued after six months, as Mr. C found standing too fatiguing. After a few months Mr. C found work at an electrical appliance shop near the Home, where he worked for eight months without pay. For fourteen more months Mr. C worked for $21.50 a week, and paid board to the Home. His employment was terminated following an automobile accident in November, 1947.

Mr. C received compensation for damages in the accident, although he did not expect to have any residual damage. Mr. C is using his indemnity, with supplemental help from the Office of Vocational Rehabilitation, to establish a radio shop in a small town where he can make his home with an aunt.

Mr. C still receives some nursing care for his condition, and cannot completely dress himself alone. He has a artificial leg, and a brace, in addition to crutches, and experiences some difficulty in

locomotion. There was some considerable question among institutional people of Mr. C's ability to meet the demands of a competitive existence outside the institution.

How much Mr. C was over-compensating in an unrealistic manner is not known. It is understood that he used Vocational Rehabilitation services in only a superficial degree, and that most of the planning he undertook on his own initiative. He received no social case work service in his planning, as the situation was not known to the Family Service Organization.

Mr. C illustrates the need for follow-up in the community, as he will face many difficulties in his self-initiated program of rehabilitation. Follow-up by a rehabilitation agent, with encouragement and counsel, is probably essential in view of the many hazards Mr. C will face in adjusting outside the protective walls of the Home.

Case 4 - Example of Special Training Provided Outside the Home.

Mr. D, a 25 year old person who has been in the Home since he was 7 years old, was referred through the joint efforts of the Board and the Family Service Organization to the Art Center, where he has been receiving a regular program of student training for the past year. Payments for the lessons are provided by the Office of Vocational Rehabilitation. Mr. D, though a wheelchair patient and severely crippled by arthritis, has travelled daily by special conveyance to the school where he has taken a general art course of water color, modelling, pastel, life sketches, et cetera. He has shown ability in modelling,

and instructors at the School have been very encouraging about his progress. Mr. D has expressed special interest in hand engraving of jewelry as a remunerative occupation. How much Mr. D has been able to do with his severely crippled hands has been a matter of amazement to his instructors.

Mr. D may be an example of an over-compensating crippled person, with very slight possibility of placement in remunerative work outside the institution. The real value to Mr. D lies in the increased sense of personal worth that has come to him as a result of the recognition of his abilities in a special line.

Case 5 - Example of Use of Physical Therapy Aid in Re-training.

Mr. E - This 18 year old boy was referred to the Home by the Crippled Children Commission last summer, as a youngster in the cerebral palsy program, who was not receiving proper care in his home. The Commission also requested case work service through the Family Service Organization as an adjunct to further treatment and planning.

Mr. E is described as alert, sociable and cooperative. He completed the tenth grade in school, and has an excessive interest in reading. His condition is described as "very severe." Continued physical therapy treatments at the Commission Clinic, along with occupational therapy and possible later vocational training, have been recommended.

Transportation to the Physical Therapy Clinic has been provided for Mr. E by the student social worker at the Family Service Organization, and Mr. E has been enabled to continue with his program of treatment. The aim of the treatment has been to increase his ability for self-help in a wheelchair existence. It is expected that he can be taught to get into his wheelchair by himself. Although the retraining process for cerebral palsy patients is extremely slow, the increase of self-help in any degree increases the individual's self-reliance and enhances his feeling of worth.

Mr. E has seemed well-adjusted in the Home, and has been able to do some leather work in the shop. He can type also, and writes letters for less able patients.

Case 6 - Example of Restorative Procedures.

Mr. F is a 31 year old patient with arthritis. Because of limitations of muscles of the joints, this patient is also confined to a wheelchair. He has been in the Home on two occasions, with first admission when he was 23 years old. He left the institution for more than two years to live with a sister, but was glad to return. A letter on file at the Home expressed his desire to return to the Home "where people speak his language," and useful activity is available in the workshop to help pass the monotonous hours.

Mr. F has been receiving restorative treatment procedures for the past two years, which has included surgery followed by intensive physical therapy treatments at the Curative Workshop. Payment has been

provided by Vocational Rehabilitation with some financial supplement by Crippled Children Commission. Transportation to the Curative Workshop of the Kentucky Crippled Children's Society has been provided once weekly by a Counsellor from Vocational Rehabilitation. It is expected that there will be further surgery which has been undertaken with the aim of enabling Mr. F to walk in long-leg braces.

Throughout the period of application of restorative procedures, case work services have been provided by a social worker at the Family Service Organization, in whom Mr. F expresses great confidence. Mr. F has shown aggressive tendencies that have at times made him a disciplinary problem in the Home. By dealing with Mr. F's feelings around his handicap and his aggressions towards the Home, he has been enabled to make a more satisfactory adjustment.

All of these patients illustrate some phase of the use or need for rehabilitative processes available in the community. There are a number of others in the Home who might be referred for some phase of training if, after exploratory evaluation, it is found that they have the desire for the training and the capacity to absorb it.

In summary, it may be said that there is no direct rehabilitation service that can be provided within the Home. The Home provides shelter and care, but not rehabilitation. The practical function within the province of the Home is to help patients to obtain rehabilitative help in the community, as they evince interest in such help. It would be the responsibility of a social worker in the institution to help the

patient to understand his potentialities on a reality basis and to encourage him in making the effort to secure improvement.

Lack of transportation for trips to the clinic and training school could interfere greatly with an active program for the severely handicapped. Unless community or volunteer resources could be obtained to meet this need, many of the patients might be compelled to forego some treatment or training of great value to themselves, and to society. Although the Home does own a station wagon, which is primarily for the transportation of patients to the clinic or to the hospital, the schedule does sometimes preclude the giving of transportation on a regular, recurring basis for patients who are receiving special restorative treatments.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This study was done for the purpose of determining the place of rehabilitation in the Home for Incurables. The problem had been of concern to the social worker, who had been associated with the Home since its inception in the capacity of social worker-board member. An active program of education and special training, with final rehabilitation on a self-maintaining level for a few, had been possible when children as well as adults were admitted to the institution. It seemed that the Home lost a worth-while function when children under the age of eighteen no longer could be admitted.

Since it is expected that a full time social worker may be employed by the Executive Board when the Family Service Organization terminates its period of out-post demonstration service, some clarification of the role of the social worker in the home in relation to this important problem, and a presentation of the needs of the patient population in regard to rehabilitation seemed timely and valuable. It was hoped that, incidentally, the study might serve to clarify for the public the rules of eligibility for admission, and the function of the Home in the State and in the community.

The Home was founded by the fraternal order of the King's Daughters and Sons and has a history of nearly forty years of service. The order was religiously motivated and the Circles of the Order were sometimes attached to specific churches, but the purpose was broad community service on a non-sectarian basis.

The Home was established to provide care for the "hopeless cripples," whom visiting nurses had found in the homes of many destitute families. The purpose of institution was described in the articles of Incorporation, thusly: "The object of this charity is to provide a home for the physically handicapped." Residents of the State of Kentucky, whose physical handicap had been certified by a physician, were eligible for care. Selectivity was exercised by the Admissions Committee because of institutional limitations imposed by available bed-space, nursing personnel, and sources of support. For example, delay in acceptance may occur because of the lack of personnel to care for an additional totally bed-ridden person, or indefinite delay may occur before a bed for a state patient is available, because of the smallness of the state quota.

In recent years, a few patients have been admitted for whom pay for board has been provided by relatives or through other sources, but the majority are maintained largely through public subsidy (an annual appropriation of $15,000 from the state legislature) and from Community Chest contributions in Louisville and Jefferson County. Because of the sources of support, the number of patients from Louis-

ville and Jefferson County and the number from the state is fixed in proportion to the amount of support received from each source.

It has been stated that the purpose of the institution was the provision of a "home" for the physically handicapped. This purpose has been carried out in the fullest sense of the word. Not only has completely adequate nursing and physical care been provided, but the construction of the building with ramps and elevators contribute greatly to the convenience of the patients, who depend on wheelchairs or crutches for locomotion. Spiritual needs are carefully considered, and a chapel for religious services in a part of the building. The need for useful and creative activity for morale purposes was early recognized. An occupational therapist was employed, and a workshop equipped with looms, frames, and tools for woodwork was set up in the basement of the building. A part-time social worker not only investigated the applications, but attended to the personal and family problems of the patients in the Home. The intent of providing a "home" which would meet the various needs of the human personalities living under the roof of the institution was carried out thoughtfully and fully in all these ways.

The study of all the patients in the Home on a particular date was made for the purpose of understanding the program as a whole before determining the relation of rehabilitation to the program. The study showed the presence of a large group of elderly incapacitated women over sixty years of age, with relatively few men in this group. The larger proportion of the total number of men was found to be under the age of sixty, and many in this group were found to be active, useful

workers in the shop and elsewhere in the Home. Potential interest in, and capacity for, special training or rehabilitation, was found mainly among the male members of the group who were less than 35 years of age.

As to state of physical incapacity, a third of the patients were bed-ridden, and largely dependent on the attendants for total physical care. Only a small group, less than ten per cent, could be classified as ambulatory, and in this group were found ataxia, severe limping, or dependence on special shoes, braces, or crutches. The remainder were wheelchair patients, most of whom were capable of self-care. Perhaps less than half a dozen of the total group could travel readily by public conveyance. Generally speaking, the total number of patients in the home needed either the nursing or domiciliary care they were receiving, because of physical handicap or mental or emotional limitations in addition to the physical handicap.

Restorative or treatment procedures were found to be in progress for two persons, one through the Crippled Children Commission and one through Vocational Rehabilitation. Most of the patients were not eligible for the services of either the Crippled Children Commission or the Vocational Rehabilitation, and if any treatment were possible to alleviate or arrest the course of the condition, none would be available as there is no hospital unit for the treatment of chronic disease in the state of Kentucky.[1] The visiting physician prescribes drugs and

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[1]Report of Kentucky State Board of Health Hospital Survey, 1945.

treatment that is undertaken within the institution, and when care for acute illness is needed, refers the patient to the Louisville General Hospital.

The concept of rehabilitation, though current and vital, was seen as a democratic ideal that has not yet reached, in any degree, the severely handicapped of the general population in its practical application. The study of the institution, its purpose and function, and of the characteristics of the average patient population as to age, condition, and state of handicap indicated that there was no place for an active rehabilitative program within the confines of the institution. The function of the Home in relation to rehabilitation seemed to be the provision of case work service for the evaluation with the individual patient of his interest in some phase of rehabilitation service which might be available for him in the community. Potentialities for such service existed in perhaps less than ten of the hundred patients studied. Several cases illustrative of special rehabilitative procedures have been described individually. It was interesting to note that some of the less severely handicapped physically exhibited no interest in any form of re-training or rehabilitation, while some of the very severely handicapped, with little obvious potentialities, showed a tremendous drive, enthusiasm, and interest, and by some mechanism of over-compensation, were able to study and develop a special ability to an extraordinary degree. The value to all of these persons of case work service and counselling in initiating

and carrying out any special program of training or rehabilitation is apparent.

In conclusion, it is repeated that there is no place for rehabilitative procedures within the confines of the institution. If such a program were undertaken in future years, it would involve many organizational changes and a complete re-focusing as to the purpose and function of the institution.

Under the present structure of the institution, the administration can meet the rehabilitative needs of the patients by requesting case work services through Family Service Organization for any patient interested in rehabilitation or with potentialities for rehabilitation. When the Family Service Organization terminates its period of demonstration service, the responsibility for meeting the rehabilitation needs of patients will be centered in the social worker who will be employed by the Board. The complete cooperation and support of the Board and the staff in all individual rehabilitative plans will be vital to the success of the case work and rehabilitation process.

Although the value to be gained by training or restoration may seem to the average, normal person small and costly in time and money, the great meaning of even a small improvement to a severely handicapped person can hardly be over-estimated.

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APPENDIX

Schedule Date

Study of Characteristics of Patients in the King's Daughters' Home for Incurables, Louisville, Kentucky on December 31, 1947.

1. Identifying Information
   A. Name B. KDHI Case # C. FSO #
   D. Birth Date E. Sex: M F F. Marital Status: S M Wid. Div. Sep.

2. Social Information
   A. Source of Referral: Personal Individual Agency Relative Not given
   B. Living Relatives: Husband Wife Sons Daughters Mother Father Brothers Sisters Other None
   C. Contact with Relatives: Regular visitors Letters Vacation Other None
   D. Other Social Contacts (not institutional staff or patients)
      1. Friends before entrance into institution
         Church Other None
      2. Acquaintances since entrance to institution
         Church Other None

3. Employment
   A. Type of Employment
      1. Prior to handicap
         Professional Semi-professional Self-owned business Farmer Skilled Labor Semi-skilled and unskilled Seamstress Housewife Other None
      2. Subsequent to handicap
         Prof. Semi-prof. Self-owned business Farmer Skilled Labor Semi-skilled and unskilled Seamstress Housewife Other None
   B. Length of Employment
      1. Prior to handicap
         Less than yr 1 yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36
      2. Subsequent to handicap
         Less than yr 1 yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36

4. Physical Condition
   A. Admitting Diagnosis
      1. Arthritis: deformans hypertrophic other
      2. Paralysis: apoplexy birth injury other injury
      3. Orthopedic conditions: osteomyelitis tuberculosis of bone congenital deformity un-united fractures other
      4. Other neurological diseases: Post-encephalitis Parkinson's disease Post-poliomyelitis Multiple sclerosis Hydrocephalus Other
      5. Cardiac: arteriosclerosis hypertension
      6. Other: Spina Bifida Muscular dystrophy Undiagnosed Other
   B. Duration in years: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36
      1. Date of onset
   C. Status of Present Physical Condition
      1. Statis or arrested 2. Controlled 3. Progressive
      4. Improvable 5. Not classifiable
   D. If improvable, type of curative treatment in progress
      1. Operative procedures 2. Physical therapy 3. Occupational therapy (curative) 4. No treatment at present

5. Classification as to type of care required
   A. Hospital Type Care (both medical and nursing)
   B. Nursing Home Care
   C. Domiciliary or custodial care
   D. Physically capable of self-care outside institution
   E. Not classifiable

6. Extent of Handicap
   A. Use of Feet
      1. Ambulatory: no lower limb handicap special shoes braces crutches artificial limb other
      2. Wheel chair
      3. Bed-fast: paraplegia generalized disability debility other
   B. Use of hands
      1. Able to use both hands: with limitation without limit
      2. One hand only: left right
      3. Neither hand
   C. Other Physical limitation
      1. Blindness: total partial 2. Deafness: total partial
      3. Speech handicap: total partial 4. Cardiac 5. Other
   D. Mental and Emotional limitations
      1. Instability 2. Immaturity 3. Mental dullness
      4. Mental deterioration 5. Senility

7. Activities and Interests
   A. Passive-audience type
      1. Radio (music: light classic Drama: serial story classic Mystery: thriller detective News Other)
      2. Reading (comics, daily paper, magazines, novels, other)
      3. Cinema (comedy, musical, mystery, adventure, heavy drama, other)
      4. Other
   B. Active-participating type
      1. Undirected: art work collecting card-games other games Library work Radio repair Electrical work scrap books Chores for other patients Miscellaneous chores Typing Letter-writing Other None
      2. Directed: hand loom pedal loom chair caning knitting embroidery basketry art work other

8. Personality Traits
   A. Attitude towards handicap
      1. Realistic 2. Resistive 3. Over-compensating 4. Not classifiable
   B. Adjustment to institution
      1. Satisfied 2. Dissatisfied 3. Indifferent 4. Not classifiable

9. Length of Residence in Institution
   Less than yr 1 yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35

10. Self-maintenance
    A. Not a consideration: physical factors psychogenic factors both
    B. Possible consideration:
       1. Type: home-bound employment sheltered workshop self-employment industrial employment other
    C. Not classifiable

Remarks: