

SOCIAL WORKERS' RECOMMENDATIONS
ON INSTITUTIONAL CARE
IN A VETERANS HOSPITAL

An Examination of the Factors Relevant to Social Workers' Recommendations as to the Necessity of Institutional Care for Married Male Veterans, with Special Attention to the Assessment of Marital Relationships: Based on Medical Social Service, Shaughnessy Hospital, Department of Veterans Affairs, Vancouver, B.C.

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"Consider and consider and always come back to what you said in a flash and to what you knew when you saw it."

Margot Ruddock

"One of the puzzling features that gradually came to light as the quantum theory developed was that electrons, which had always been regarded as particles, under some circumstances behaved as if they were waves; while light, which for nearly a century had been regarded as a form of wave-motion, under some circumstances behaved as if it were an aggregate of corpuscles. . . . that is to say, the location of a particle cannot be determined exactly at the same time as its momentum is exactly determined; and the more accurately the one is known, the less complete must be our knowledge of the other. This is known as the Uncertainty principle, or principle of imperfect specification".

Sir Edmund Whittaker
in the introduction to
Sir Arthur Eddington's
"The Nature of the Physical World"

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Abstract

Social Workers' Recommendations on Institutional Care in a Veterans Hospital

This study makes an examination of the factors involved in social workers' recommendations as to the necessity of institutional care for married hospital patients, a form of long-term care available within the general setting of a Department of Veterans Affairs Hospital. Attention is given to the reasons governing the "social recommendation" made by the social worker, when the decision lies between the granting of institutional care, or the patient's return to his home to be cared for by his wife.

The activities which lead to the social prognosis on which the recommendation is based in this special setting, are similar to those undertaken in various welfare agencies, where social workers assist families and doctors in decisions as to whether chronically ill persons may be attended to at home, or must be cared for in a nursing home or similar setting. In answer to the query as to what elements are considered in the formulation of a professional opinion, the importance of assessing the strengths and weaknesses of the marital relationship becomes a major theme of the study.

The method adopted in the study is (a) to single out a series of cases which indicate the range of problems considered to be typical in the hospital studies; (b) to present the recommendations made by the social worker and the reasons for them; (c) to specify as far as possible the services rendered by the social worker in these cases. Seven direct and six indirect services are distinguished. Attention is also given to the kind of facts which the social worker finds to be significant in assessing the strengths of a marriage, since the prognosis arising from these, and the outcome of the resultant "social treatment", frequently determine the recommendation.

In a final chapter, the assessment and modification of inter-personal relations between husband and wife and the family members are presented as the distinctive activity of the social worker in the hospital setting. The examination of this contribution, and others made by the social worker to the resolution of the types of problems under study, is not represented as exhaustive. It is set out as an initial descriptive account of the process inherent in the formulation of a professional opinion, an account which might be expanded in further research.

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I should like to thank my thesis adviser, Mrs. Mary Tadych, who created an atmosphere in which it could be felt that I had been helped to do better.

Last I should like to thank my children, whose concern for the progress of my thesis approached that felt for their own.

Errata

"therefor" should read therefore

"martialling" should read marshalling

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Chapter I

Generic Problems Involved in Helping Patients to Make Decisions

The care of the chronically ill person, old or young, who by the nature of his illness, requires considerable physical assistance, and, or nursing care, has always been one requiring special adaptations in the circle of those who remain well and active. This circle may be the small one of the immediate family, expanding by varied degrees to the larger kinship or clan group; it may include the unrelated stranger, moved by custom or pity, (the "Good Samaritan"); it may be an impersonal group entity charged with customary or legal responsibility to plan for the handicapped person. We find extremes: from that of the Eskimo, who, in times past, for reasons connected with the survival of the younger and ongoing group, exposed the ailing, the injured, or the old to hasten death;¹ to that of the French expedition who descended Annapurna, carrying the barely living, snow-blinded Lachenal, with rotting frozen extremities, down some 28,000 feet of mountain, from ice to jungle, saving him to climb again. At either extreme, the decision may be grounded in

1. Press notices in Canadian papers in December 1955 told of a recent legal case in the far North where a man was judged innocent of murder because he permitted his father to take his own life, in the manner dictated by this custom.

well thought out conviction, which has shaped a feeling of what is right to expect and right to do.

For any group there is the burden and the pain of the decision as to what disposal shall be made of the ailing person. In this he shares, his own common humanity reaching out tentacle-like to that of the group who also face his dilemma, regardless of the accepted cause of their degree of involvement.

In times past, the sick were cared for at home, if by home one may mean a house, a hut, a castle, an encampment round a fire; or people--a mother, a wife, a third cousin. As usual, the poet may have more to teach us than the sociologist. Robert Frost¹ in his "Death of the Hired Man" puts the following dialogue in the mouths of the farmer and his wife:

"Home is the place, where, when you have to go there,
They have to take you in.
I should have called it
Something you somehow haven't to deserve."

The pesthouse, the hospice, developed for the care of those who had no homes. Mixed motives may be ascribed to the founders--in part to remove infected and infecting bodies to where they would not pollute the whole, as well as basic concern for the suffering. Our civilization has moved on to the concept of a hospital or nursing care institution, giving care superior to that which can now be given in most homes. Times have

1. Frost, Robert, Collected Poems, "The Death of the Hired Man", New York reprint edition, Garden City Publishing Co. Inc., 1942, p. 53.

changed since those of the Elizabethan housewife¹ who "not only was expected to know what to do by way of immediate relief and later nursing, but, with no chemists' shops or rural clinics to help her, she had to produce from her own storeroom whatever cordials, medicines, purges, splints and bandages the occasion required." So far have we moved from the earlier idea of the home as the logical and best place to care for the weakened member of society, that we sometimes have difficulty in arranging for a patient's return to his home from the hospital.

Some have laughed at, as primitive, the Africans who brought their sick to be cured by Dr. Albert Schweitzer. They did not leave them in the hospital, detached from the family circle, but remained, crouched by the bedsides, to cook for and tend their sick. They had found a way of combining the virtues of family affection and scientific skills into an integrated service.

Cyril E. Waddilove, of the Society of Friends, (Quakers) speaking in Vancouver during the month of December, 1955, at a public meeting, told of this universal problem of the care of the sick, as he had observed it in a disrupted Korea, with hordes of refugees displaced by a North-South conflict, many urgently requiring skilled long-term medical care. There,

1. Hole, Christina, The English Housewife in the Seventeenth Century, Chatto & Windus, London, 1953, p. 79.

as in Africa, it had been customary for the family to accompany the ill person to hospital, but some had travelled so far that they not only had no immediate family, but no member of the large clan kinship system to offer such service. Nursing service had to be improvised to meet the need. It is of interest that, in planning for the future, despite the temporary arrangements that were necessary due to wartime family disruptions, they evinced a settled determination to return to the former system of family care for the feeding and nursing of the person in hospital.

Current Programs

We see that at varying times and places and in varying cultures the problem of the best care for the ailing has involved decisions, not only for the person in need of care, but for the family and the community.

On this continent there has been a reversal of the process referred to above, of the home people going to the hospital with the patient, in the "Montefiore plan" of hospital home care, where arrangements are made, in selected cases, for hospital services, medical, nursing, and ancillary, to be given to the patient in his own home.¹ The introduction of such a plan has been under discussion in Vancouver recently, by the Health

1. Bluestone, E.M., M.D., Minna Field, et al; Home Care--Origin, Organization and Present Status of the Extra-mural Program of Montefiore Hospital, Montefiore Hospital, New York City, 1949.

Division of the Community Chest and Council.

Throughout Canada, families request counselling as to how to plan for chronically ill or handicapped, old or young persons, whom it tasks the resources of the home to care for. The doctor; the clergyman; the public health nurse; the social worker in a referral centre, family agency, hospital or public welfare department all may be called on for advice in such situations.

In general, the alternatives to home care are infirmaries, rest homes and nursing homes. As the literature is reviewed, for example, the 545 precis detailed in "Chronic Illness", a publication of the United States Public Health Services, we find that the terminology varies in different states and provinces on this continent, but the resources may be similarly grouped. A check with those charged with the enforcement of the Welfare Institutions Licensing Act of the Province of British Columbia shows that they recognize only two types of care.

Private hospitals are licenced to provide care for medical, convalescent and chronic patients, and must have a graduate nurse in attendance at all times, as the patients admitted require skilled care. Boarding homes are also licenced under the provincial act; these may be known as nursing homes, or rest homes to the general public, and may have, but are not obligated to have a trained nurse on the staff. Practical nurses or skillful lay persons might give the sort of care which

is necessary for persons admitted, who are ambulatory, but may require considerable physical assistance.

In addition, certain boarding homes, licenced by the city as lodging houses, may offer a tray service or special service to older persons. Such institutions as the Marpole Infirmary and the Kamloops Home, are provincial institutions for the care of chronically disabled persons, and do not come under the Licensing Act. A Committee of the Community Chest and Council of Greater Vancouver, studying facilities for the care of the chronically ill in the area, has recommended a 500-bed institution for such patients.

As few families can afford the cost of privately arranged care on a continuing basis, to serve the needs of infirm persons, social workers in private agencies, municipal welfare departments and in the provincial Social Welfare Branch, in this province, are often approached regarding planning. Social workers and others acting as a resource to families in this dilemma must have medical information as to the kind of care required, as a basis from which to evaluate critically the resources of the family. From the large volume of literature about the medical problems of chronically disabled persons and the sorts of institutions required to meet their needs, it would seem that elsewhere in Canada and on this continent, much screening of applications is necessary, as insufficient beds are available to meet the need. Little is being written, however, about

the nature of the decision as to whether such applicants, if married men, may be cared for at home.

Social Workers in Hospitals

Professionally, the role of social workers in hospitals has been described as follows:

"... the medical social worker is a person with knowledge and understanding of the social services, of community and of human needs and aspirations, who through training has developed skills in helping people to live with themselves and with each other, and who brings this knowledge and skill into a setting where the primary function is the treatment of physical illness. The special contribution of the social worker is in the area of the patient's relation to society and particularly his family. The social worker is the person best equipped to assess the social environment of the patient, to understand the stresses in his life outside the hospital and what these may mean in relation to his illness and hospitalization. The social worker is qualified to diagnose the social problem, to make recommendations with regard to alleviation of stresses, either by helping the patient towards a better adjustment or by relieving environmental pressures." 1

This is a current statement on the present function of medical social workers in modern hospitals and clinics. Social workers have come into hospitals and institutions for the care of the sick, long after these establishments had been giving what seemed to be a rounded service. They came because existing services could not, in all cases, restore the sick to fullest function. Historians of the varying roles of social workers

1. From an address given by Miss Cecil Hay-Shaw, Head, Medical Social Service, Shaughnessy Hospital, to a Social Service Sectional Meeting, Division of TB Control, November 28, 1955, unpublished.

agree that medical social work in hospitals in the United States may be traced back to 1902 and in England to 1894. In parts of Canada, and notably in Veterans Hospitals in Canada after World War I, nurses were used to perform duties which are now usually viewed as proper to social workers. Social workers in other settings had been accustomed to approaching the evaluation of any individual's capacity for better functioning, by study of his family background and current personal situation as they illumined that capacity. Working in a hospital did not, then, call for a new approach to helping people. The ways in which illness could upset normal patterns, or further disturb already disturbed patterns of adjustment, called rather for heightening of existing skills already in use. The social worker learned that she,¹ must interpret her goals and procedures to those other members of hospital staffs who were sometimes impatient of the social worker's conviction as to the "client's right to self-determination,"² or of a slowness of pace in the social worker's efforts to catalyze changes desirable in view of medical diagnosis. The social worker must point out, as Lorna C. Brangwin has said with respect to social casework with unhappy marital situations:³

1. In Shaughnessy Hospital, medical staff may be male or female, as may social workers. For convenience of reference, in this thesis, social workers are referred to as she and doctors as he.

2. Canadian Association of Social Workers, B.C. Mainland Branch, Ethics Committee, March 29, 1954, Part II., i, (B).

3. Brangwin, Lorna A., "Marriage Counselling and the Viewpoint of the Caseworker", Social Casework, April, 1955.

"If we look only at the disturbance in the marriage, we are merely considering a symptom. If ways and means are prescribed to alleviate the symptom, without understanding the dynamic forces which have caused it and which operate in its current manifestations, then nothing of lasting value can be accomplished Many (such) marriages are adequately satisfying to the partners only as long as a kind of balance can be maintained in mutual gratification of emotional needs."

Those of other professional disciplines may be well aware of and grant to the body its right to slow rhythms of aberration and return to normalcy, in response to external and internal stimuli, but may feel that the social worker's function is to push or pull the psyche into patterns seen as desirable by those other than the patient. The social worker's role is not only one of direct service to her client, as patient, but of interpreting how the client's needs, other than the purely physical ones, can best be met, and at what pace.

The developing acceptance of the usefulness of the medical social worker in hospitals, both in direct service to patients and in consultation to other staff, is clearly stated in World Health Organization Technical Report Series, No. 22 of this series states that one medical social worker is required per 200 general hospital admissions or 2000 outpatients (per annum); and that two or three psychiatric social workers are needed to each psychiatrist or one per 500 outpatients (per annum).

In the "Standards for Hospital Accreditation",¹ the accepted basis for rating Canadian and American hospitals, social service is listed among "services which may be maintained." The standards are set out as follows:

"A. There shall be an organized department directed by a qualified medical social service worker, and integrated with other departments of the hospital.

B. Facilities shall be provided which are adequate for the personnel of the department, easily accessible to patients and to medical staff, and which assure privacy for interviews.

C. Records of case work shall be kept. Such records shall be available only to the professional personnel concerned.

D. Departmental and interdepartmental conferences shall be held periodically."

As earlier mentioned, especially trained nurses were the first social workers in Canadian Veterans Hospitals, operated after World War I by the then Department of Pensions and National Health. After World War II, in 1945 a survey undertaken at the request of the Department of Veterans Affairs resulted in the setting up of the Social Service Division within the Veterans Welfare Service Branch of the Department of Veterans Affairs, with the Director of Social Service responsible to the Director General of Veterans Welfare Services. At district levels, social workers responsible to the District Supervisors of Social Service were appointed to work either in departmental

1. Bulletin of the Joint Commission on Accreditation of Hospitals, "Standards for Hospital Accreditation", January 28, 1956.

hospitals, or in district offices.

In the spring of 1947, Medical Social Service was set up with Heads at local levels responsible to Superintendents of hospitals, but with professional responsibility also to the Director of Medical Social Service at head office Level. Close co-operation with social workers in district offices has continued, with a view to giving the best possible service to veterans and patients as they may shift from one category to another. Full details as to the initial and transition stages of the service and its status within Shaughnessy Hospital in particular have been set out in a recent thesis by Miss M. Clohosey, "Social Implications of Readmissions of Veteran Patients to Shaughnessy Hospital, DVA".¹

With respect to medical social work, as in other professional specializations, the goal of administration has been to set up for the veteran the most fully modern and acceptable treatment facilities.

Shaughnessy Hospital

Shaughnessy Hospital, a 1200 bed hospital situated in Vancouver, B.C., is administered by the Treatment Services of "Va" District, the Department of Veterans Affairs. Active treatment is offered to veterans of varied categories, to the Royal Canadian Mounted Police, to certain Indians and Mariners,

1. Master of Social Work thesis, University of B.C., 1954.

and to active serving personnel in the three armed forces.

"Institutional care", formerly known as Class 6 care, but now as Section 29 care,¹ is available to certain veterans. Without going into the intricacies of rulings on eligibility, it may be stated in a general way that veterans who have had service in a theatre of actual war, or who are in receipt of disability pension, may be eligible for this continuing type of care. If medical opinion shows that the patient's condition warrants it, this may be given in an active treatment bed, within the main permanent buildings of the hospital proper. If less close medical attention and nursing and orderly service is indicated, the patient may be accommodated in one of three facilities. The first group, commonly known as "the extension", is a number of army huts, on the grounds of the hospital proper. Some of the patients placed in these wards are fairly mobile, able to leave the ward and take meals in the attached dining room, to lounge in the recreation room, or go to the Red Cross Lodge on the grounds; others may be confined to bed. Hicroft, the former home of the late General Macrae, a handsome mansion set on sloping ground, within the city and close to shops and transportation, offers accommodation to more mobile persons who can manage to use stairs. The George Derby Health and Occupational Centre, in a

1. Office Consolidation; Regulations under the Department of Veterans Affairs Act; Veterans Treatment Regulations, 1955. See Appendix A for Excerpt re "Domiciliary Care".

wooded setting, in Burnaby, consists of detached huts, with central dining and recreation hall, adjoining workshops and other facilities. After World War II, this was used as a convalescent and re-training centre. Since, the need for this service has declined, but it is available to meet this need still, and so may house persons recovering from serious illness or injury, for brief stay, as well as those receiving institutional care.

Persons receiving institutional care are not necessarily old, but may be young veterans without possibility of home care, who are in such physical condition that they cannot be cared for in ordinary boarding homes. Nevertheless, the conditions leading to a need for institutional care are most apt to occur in the older age groups. As the veterans of World War I advance in years, many of them are potential candidates for continuing care.

A recent annual statistical count shows an interesting trend:¹

"At midnight on 31st March, 1954, the Departmental Inpatient Census for the whole of Canada numbered 10,501 The patients ranged in age from 16 to 99 years with an average age of 56 and a median age of 60. The greatest number, 1,344 or 12.8 per cent of the total were in the 65-69 age group. Less than one-third were under 50 years of age; over one-quarter were 70 years of age or over.

1. Winfield, G.A. and Wellwood, L., "An Analysis of In-patients Department of Veterans Affairs at midnight, 31 March, 1954"; Canadian Medical Services Journal, Vol. XI. No. 7, July-August 1955.

The total figure is almost identical with that for 1950 (10,491). . . . The average age of patients shows an increase of four years and the median age of five years. In 1950, 38 percent were less than 50 years of age and only 17.1 percent were over 70."

The Department of Veterans Affairs' "Va" District, including the Victoria sub-office as well as the Vancouver office, has approximately 10,000 veterans in receipt of War Veterans Allowance.¹ These are veterans of certain service categories, if over 60, or younger if considered unemployable. These are eligible for treatment, including "section 29 care", if indicated. Others, in addition to these may be eligible, also. In the light of these figures, it is understandable that requests for such care must be carefully screened. If persons who are little handicapped or who could be accommodated outside are admitted, there will be no beds available for those who urgently require such care. The screening takes into account both the strictly physical condition of the patient and his social potential, since a knowledge of both is required in good medicine.

The Social Worker's Role

The nature of social workers' recommendations as to the necessity for institutional care in this hospital may be better understood if one looks initially at cases where the social worker is not asked to share in the decision.

1. Verbal information from clerical section.

Purely medical considerations may hold sway when the physical amount of nursing care is considerable, with frequent attention of the sort which cannot be given by an untrained person. Even then the patient may choose to return to his home, if he is able to procure nursing or orderly service. These are clearcut decisions.

Similarly, the social worker may not be called on to share in planning when it is obvious to nursing and medical staff that the man wishes to return home, and that he can receive adequate care there, despite continuing physical disability. Through contacts with the patient and perhaps his wife as well, the doctor often evaluated social considerations, such as level of housing accommodation, ability to follow diet, and the kind of care which can be anticipated at home.

There are, however, a number of types of situations, evaluation of which may culminate in the decision to give or withhold institutional care, where the social worker may be called on. At least four types may be distinguished, as follows:

A. In the group sometimes referred to as "hospital clearance", the patient no longer requires acute bed care; he may be refusing to return home; or he may be ready to return home, but his wife may state that she is unable to care for him. With the help of the social worker, the reasons behind these attitudes can be understood and a well-founded decision made.

B. Cases are referred to the social worker also, where a series of admissions have occurred with inadequate reason, from

the medical viewpoint, so that some social or personal reason is suspected as being the real cause. A solution is often found in institutional care, if changes cannot be made to permit the patient's acceptance at home.

C. Social workers are asked to evaluate personal attitudes and home conditions where the patient's health is such that it seems unlikely he could be cared for at home, but the doctor has not had the facts to form the basis of an opinion.

D. In some cases no formal referral may be made to the social worker, requesting participation in the decision as to the alternative of home or institutional care, because the social worker has earlier been involved with the patient or his wife, on account of problems, economic, personal or other. In the process of good normal co-operation between the patient, his relatives, nursing and medical staff, and on the basis of information about the home situation provided by the social worker, it becomes obvious in the pool of informed decision which is usually referred to as "teamwork", that the patient should go home, or that he should remain for institutional care. The propriety of the social worker's participation and the validity of the social worker's opinion are implicit in the whole process, and may be most respected when it has not been felt necessary to request them. In some such situations the social worker may incorporate in her written report a recommendation regarding the need of institutional care, even before the question is formally considered by medical staff.

Direct referrals of the above types of situations to the social worker may come from a variety of sources: the patient, or members of his family or circle of friends; medical or nursing staff; other ward staff; outside agencies. Referrals from persons other than doctors are cleared with medical staff before action is taken.

Referrals from doctors may originate on the services of medicine, surgery, psychiatry, or any specialized services. Prominent among the latter as a source of referrals to Social Service, is the Assessment and Rehabilitation Unit, (informally known as "A and R"), which had its origin in a Geriatric Research project set up as a pilot study in Shaughnessy Hospital in 1951. "A and R" has its own staff of consultants and its own interne, as well as a reception ward, but its services are available throughout the hospital. Its purpose is to stimulate the maximum of activity, social, economic, medical and personal, among older patients and those younger ones who are severely handicapped. Where the patient has limited remaining potential, social service is often called on to assess the social aspect of the situation. The information thus given is used as material in the decision as to whether institutional care must be offered.¹

1. For "A and R" purposes, five social categories have been established: Satisfactory family or friend relationships and accommodation available.

Unsatisfactory family or friend relationships but accommodation available.

Family, friends or landlord accept, but unable to or should not give care because of poor health or unsuitable accommodation.

Seasonal accommodation available with family or friends.

No family or friends or suitable accommodation.

Patients With and Without Families

In accepting referrals from any source, the social worker may be evaluating many factors, within the social and personal situation of the patient. There are no available figures as to the proportion of the general patient population who are married, or of single status, including widowed, divorced or separated; not does Medical Social Service itself keep figures which are segregated in this way. It is known that a considerable proportion of the patients for whom it is necessary to consider the possibility of institutional care, are of "single" status, that is they do not have a wife who is at present concerned in planning regarding them. Some of these, even men considerably handicapped, may go out to "batch" in their homes or in furnished rooms; some go out to private boarding homes; some to the homes of married brothers or sisters, sons and daughters. In the case of the latter group, special difficulties may arise which call for the services of the social worker, among these, feelings with relation to daughters or sons-in-law are prominent, as is the physical character of the accommodation available. Coloring attitudes to the patient and his illness are the longstanding feelings of the family, who may not see him as a person worthy of their sacrifice of convenience and privacy. There are many evidences that on this continent the circle of family responsibility has narrowed; occasionally a niece or nephew appears with a real sense of obligation to an

uncle, yet on the other hand in some families there may be very little acknowledgement of obligation to a brother or father. "Single" patients may need the social worker's help if they feel rejected by family and friends, so that they must accept institutional care, and their problems require the exercise of good judgement and skill.

It is, however, with the problems of married veterans who may require institutional care that the present study concerns itself. Social workers who have had hospital experience, are impressed by the quality of the enduring personal relationship between man and wife, as it affects the probability of the man's return to his home as opposed to his acceptance of institutional care. A man may be seriously handicapped, physically or mentally or both, to the extent that responsibility for his care in the home would be extremely onerous, and yet, where the relationship has been a rewarding one, his return home is welcomed. This is apt to be so, even if the wife is in frail health, or economically burdened. Conversely, the man may be very little handicapped, realistically speaking, as established by medical investigation, but if the relations are poor, the possibility of his return home will be called into question. His wife, or the patient himself, may be able to voice the real state of feeling, or may rather exaggerate the quality or degree of the patient's physical difficulties, or of his wife's health. Other "reasons" may be found why his return home is impossible, these being brought forward by

either partner. An attack may be made on DVA care or departmental regulations, as a cover. With married veterans, in short, it is frequently the degree of physical handicap, but also often the state of the marriage which determines the possibility of home care. The stereotype of the married state accepted in the community (even in these days of more ready access to hospitals) is that of the loving wife who awaits eagerly the return of the handicapped person, in order that he may be offered the comforts of home. It is therefore often with loss of face, and beclouded by rationalization and projection, that the persons whose feelings are so deeply involved can be brought to voice them. Will it be helpful or hurtful to assist them to "face the facts"? Have they sufficient strength and flexibility to accept help in changing their attitudes, especially when contending with some degree of illness or disability? These are the decisions the doctor asks the social worker to assist in.

Given a highly detailed diagnosis and prognosis on the physical state of the patient and perhaps that of his wife also, if her health has been called into question; given (if occasionally there is time to secure it) a quite full background regarding the patient and his wife, who would venture to predict the quality of the flicker of decision summarized as "Yes" or "No", that is generated out of the past relationships of man and wife? The decision may sometimes be unspoken, sometimes literally shouted, but out of what has it grown? Is it "Good

medicine", "good social work", good service to the patient to try to change the decision? If we try to change it, can we succeed?

These questions on social prognosis and the concerns which arise from it, formed the genesis of this study. In examining them, it is necessary to re-examine professional principles and literature, to re-test their validity and authority in this frame of reference.

Literature

"The Family Health Maintenance Demonstration, a controlled long-term investigation of family health"¹ sets out, as did the project centred in the Peckham Health Centre in England² to study health in normal, well families. The New York project utilized the services of a team of physicians, pediatricians, public health nurses, psychiatric social workers, a psychiatrist, psychologists and a consultant social scientist to study a group of families who were checked, eventually, against a group of pre-selected and untreated control families, Charlotte Stiber's chapter on the functions and findings of the social worker notes (Page 56) that

"The overall picture of relationship between husband and wife reveals much confusion, dissatisfaction, and resignation. Few of the adults appeared to be mature enough to support the demands of such a

1. "The Family Health Maintenance Demonstration, a controlled long-term investigation of family health", Proceedings of a Round Table at the 1953 Conference of the Milbank Memorial Fund, Milbank Memorial Fund, New York, 1954

2. Pearse, Innes, H., M.D. and Crocker, Lucy H. the Peckham Experiment, a Study in the Living Structure of Society, London, Allen & Unwin, 1943

relationship. Men were on the whole, passive, immature, undependable in an emotional sense. Women were more aggressive, immature, unable to accept the feminine role of wife and mother. Disappointment in their expectations of the possibilities of the relationship was common. The resignation comes, I believe, from some awareness which they have that some of the difficulty rests with themselves and that another or different partner would not bring about a different relationship."

" . . . because their own identifications are not well founded they cannot tolerate or tolerate uneasily the triple strain of being individual, spouse and parent."

This is from a study of normal, functioning families, chosen from a large random sampling. If these are the attitudes towards the rewards of the married state, what strengths are these to draw on when age and illness place additional burdens on the relationship?

R. Margaret Cork says of the wives of alcoholics:

"Typical of these women is the very dependent or immature wife who is married to a man with such great needs of his own that he is unable to meet hers. As a result, constant hurt and frustration is suffered by both partners and the basic or normal problems of married life are never grappled with."¹

A similar set of conditions is found where illness of a chronic or irreversible nature increases the dependency needs of one or both parties. A "dependent or immature" wife may have had a satisfactory relationship throughout her married life, but be unable to tolerate (if unhelped) the reversal of roles which develops if the husband becomes enfeebled due to age and illness. Correspondingly, the husband has a sense of

1. Cork, R. Margaret, paper "Casework in a Group Setting with Wives of Alcoholics", quoted in Concerning Families and Children, Vol. 4, No. 5, December 1955, the Family and Child Welfare Division, Canadian Welfare Council.

frustration, not only in his feelings of failure in being unable longer to be the strong man on whom his wife leans, but in his own unmet needs, in not having a strong, managing or even cooperative wife who can give him solace in his dependent state.

Even where there has been maturity, enfeebled health in both may produce in each the illusion that the other is fully incompetent and that he (or she) is the upholder; or alternatively may make tolerable an admission of the quasi-dependency of the self. Marked ambivalence may be notable in these situations: alternation of pride in being able to carry on, and of hatred of the obligation to do so, may produce marked mood swings. The man who must go home from hospital, not to be tended as an invalid, but to discharge the duties of a mother with respect to an ailing and childlike wife, needs the support of the social worker in the role, even though it be one the patient has freely chosen.

In a number of applications for institutional care, the social worker who is asked to make a social assessment observes some degree of "marital difficulty" as a factor.

Florence Hollis has said:

"The degree of conflict in marriage, in other words, is not an accurate measure of the fundamental dissatisfactions within the marriage nor of the wish to terminate it. Some marriages break up after relatively little overt expression of hostility, while others continue to exist through violent battles. In order to understand the dynamics of a given marriage adjustment, we must seek to understand the personalities involved

as well as situational factors that may be pressing. The more fully we understand personality development and these interlocking forces the more completely can we come to understand the stresses and strains that produce marital disharmony."¹

Whether or not the disharmony is marked, it is seldom that the patient or his wife ask overtly for help with this as such. If the situation is of the sort where the relationship is almost completely unrewarding, the possibility of institutional care because of the patient's health needs (like the separation involved in wartime service with the armed forces) would make a socially acceptable solution. It is, then, threatening to have the right to this solution brought into question.

In any hospital, a troubled wife, faced with participation in the decision as to whether or not she will take her husband home, may be pleased that someone, doctor or social worker, reaches out to learn how she feels about the problem. She may well, however, face the interview with fears that the hospital staff are "on the side of" the sick person. This fear may loom particularly large in a veterans' hospital, where the medical setting, inpatient or outpatient, forms part of a larger framework of services available to the patient as

1. Hollis, Elouence, Women in Marital Conflict
Family Service Association of America, New York, 1949,
pp. 18-19

a veteran. This larger setting may be the source of income, such as disability pension, Treatment Allowances, or War Veterans Allowance, so that fear of economic loss may further increase the burden. The wife or the patient may have been told by the Legion or regimental group that the patient has the "right" to continuing care, if he wishes it, and so may consider there is discrimination when the alternative of returning home is called into discussion.

Particular care in establishing a relationship may be needed, then, in the social worker whose particular goal is the easing of a marital difficulty, as she approaches the problem through participation in the decision of the patient and his wife and the doctor as to plans for the patient's future care.

The medical social worker does not have an easy entree to the treatment of a marital problem when it is tied to the threatening dilemma, "Will you or will you not care for your sick husband at home?" Resentment colours one answer and guilt the other, each calling up its defences and rationalizations. If the marriage has been markedly unhappy, the threatening death wish may be very near the surface. The medical social worker needs to be aware of how the fact of illness heightens what is already a problem. She needs also to be aware of the usual methods called into use by those of her profession in dealing with marital conflict, where the parties have voluntarily sought help.

In what way do social workers usually assist in the resolution or diminution of marital difficulties? Hollis "Women in Marital Conflict"¹ may be taken as a standard reference. In the chapter, "The Range of Casework Treatment" she suggests a classification of ways of helping "based principally on the means by which the change was brought about": modifying the environment; psychological support; clarification; insight; the client-worker relationship; and the differential application of these processes. These are brought into play as an effort is being made to find the roots of the disharmony. Miss Hollis says, (Page 14)

"Object love is that most essential of all capacities, the ability truly to appreciate and love other people, with concern not only for what the self can gain, but also for the well-being of the other person. To have that sense of fundamental well-being called happiness, the adult must be able to give love as well as to receive it."

The social worker's estimate of the strengths and weaknesses of the marriage, must then involve some minimum knowledge of the persons involved in it. The need for skill and rapidity of formulation are demanded by and inherent in the setting, where hospital beds must be kept for active medical treatment, not for the slow processes of change involved in dealing with friction-rubbing personalities.

Of the research project which formed the basis for her book, Miss Hollis says (Page 9)

1. Ibid.

"The overall impression left by the findings is that personality factors lay at the root of the marriage conflict in these families. An effort was made to identify insofar as was possible from the material, those personality factors particularly hazardous to comfortable adjustment. Not infrequently other factors, such as interfering relatives, certain cultural differences, and economic pressures contributed causally to the maladjustment and sometimes they played a major role, but more often they were either symptomatic of the personality factors or subordinate to them."

This is frequently borne out in hospital contacts.

Miss Lillian Carscadden in her thesis "An Evaluation of the Client-Worker Relationship" says:

"The selection of treatment methods is influenced to a large extent by the assessment made of the level of ability in relationship. The effectiveness with which these methods are used depends on the accuracy of the diagnosis made, and the equipment of the caseworker for using relationship in treatment."¹

As stated earlier in this chapter, social workers across the country, as well as medical social workers in DVA and other hospitals, are involved in casework handling of requests for deciding the question as to whether handicapped persons may continue at home, or must receive institutional care. Their common background of post-graduate training presumably leads to an approach to social diagnosis as a basis for social recommendations. The writer has not found, however, that social workers are writing out the recommendations in general, nor in particular about such recommendations as

1. Master of Social Work thesis, University of B.C. 1951

they embody an awareness of and adjustment of marital problems. It is necessary in the situations under study to apply as a yardstick normal practice in dealing with marital difficulties, illumined further by knowledge of the effect of illness and physical handicap on personality and ability to adjust.

Chapter II

Typical Situations Involving Marital Relationship Patterns

The records of the contact of medical social workers with patients in hospitals of the Department of Veterans Affairs are placed in folders held in locked filing cabinets of the Medical Social Service Departments. There is a normal distribution of three other copies. One copy goes to the ward or outpatient department where the patient is under medical supervision, to be placed on the chart. This copy, together with all other material on the ward chart; medical and nursing notes, opinions of consultants, records of special tests, etc., will later form part of the hospital file, which also holds records of previous periods of treatment. This file remains in the particular hospital where the patient is treated. One copy goes to the District Office file, where it forms part of a voluminous file containing many documents in addition to the medical ones; among these may be papers pertaining to service and discharge, special training, use of Re-establishment Credit, Pension and War Veterans Allowance investigations and rulings, aid in special problems given by Veterans Welfare Services, etc. This file moves from district to district, as may be necessary, so that, for example, if the veteran moves from Winnipeg to Vancouver, or back to Toronto, a complete record of medical treatment, and

other services which have been used in his interest, may be available to accompany him. The last file to which copies are generally distributed is the Head Office file, held in Ottawa. Where patients are known to the Neuropsychiatric Service of the hospital, a fifth copy of the medical social service case record is sent to form part of their file.

All five files, the medical social service, the hospital, the District Office, the Head Office and the Psychiatric, are held in locked cabinets. All employees of the Department of Veterans Affairs take an oath of secrecy, requiring that they not divulge information secured in the course of their duties. They may be suspended from the civil service if there is any breach of confidence in this respect.

Medical Social Service records are written primarily for the information of the doctor, in DVA hospitals as in other hospitals. In any hospital, some non-professional persons will have access to files in the course of clerical work. In the Department of Veterans Affairs, in the proper performance of their duties, many more non-professional people will have access to the reports of the social worker than in other settings. What the social worker knows and records as to a patient's earnings, his disposal of property, whether or not he is living with his wife, his ability to do casual or regular work, may affect his rights in connection with Pension, War Veterans Allowance, Re-establishment Credit, or other benefits. Intimate details of the

patient's way of living are of no concern to these other members of staff for their purposes, but do form a part of the record which is made as a part of the social worker's formulation of social problems of the patient as an aid to the doctor in furthering improvement or cure.

The rules of the Department of Veterans Affairs, which go back to the antecedent Department of Pensions and National Health, require that no secret files be held. All information and recorded thinking on the basis of information concerning any particular veteran, should be available on his file. This view is probably based, among other considerations, on the use of the file in hearings and appeals of the Canadian Pension Commission, which have some of the color of a court of law. A veteran may use, or have released to his lawyer, Legion secretary, veteran's advocate, or other duly authorized person, his file, in order to secure full information from the records, with respect to pension claim.

Rarely, Medical Social Service in this hospital follows the practice of notation on the records for general distribution, "Fuller detail is being held on MSS file", or "Fuller detail on MSS and NPC files." This is usually done where there is much detail of a sexual or other highly confidential nature, and is seldom resorted to. No confidential records are held without such a notation for the general file.

Medical Social Workers' Vocabulary

Because of the nature of the setting, and the number of persons who must see reports, there is undoubtedly a tendency to restrict their detailed content, over and above that usual to social workers' reports in any medical setting. It is acknowledged that medical social workers' case records are usually more concise than those, say, in family agency or protection settings, among others which could be named. Medical social workers' records tend to give less detail of the process on which their professional opinion is based, than do those of other social workers. This is because medical staff are interested in the social workers' net opinion, rather than in the means by which the findings have been reached. The doctor's time is at a premium, and the social worker's report is most useful to medical staff, if recommendations are concisely stated. Some process is necessary for the guidance of other social workers who may have to deal with the same patient in the future, but this is held to the minimum. Despite this pruning of factual matter, medical social workers have been criticized from time to time because records are held to be too voluminous.

Apart from omissions of the process, in all its detail, by medical social workers, they do not as yet have such a precise set of semantic tools for recording findings, as do the members of the medical profession. The "Physician's Pocket Reference"¹

1. "Physician's Pocket Reference to the International Statistical Classification of Diseases, Injuries and Causes of Death", Department of Trade and Commerce, Dominion Bureau of Statistics, Health and Welfare Division, King's Printer, Ottawa, 1950.

used as an aid in certifying causes of death, has major groupings from I to XVII, broken into 999 sub-groupings, exclusive of those listed as "Classification of Causes of Stillbirth". Of the 999 sub-groupings, each is further broken down. For example:

- XVI, 789, Abnormal Urinary Constituents of Unspecified Cause:
- 789.0 Albuminaria, unqualified
 - 789.1 Albuminaria, orthostatic
 - 789.2 Pyuria and bacteruria
 - 789.3 Chyluria
 - 789.4 Haematuria
 - 789.5 Haemoglobinuria
 - 789.6 Glycosuria
 - 789.7 Acetonuria

Medical Social workers in their basic training, and further in their experience in medical settings, must acquire a ready understanding of the doctor's vocabulary, in order to follow his thinking regarding the treatment needs of patients. The doctor is not obliged, by training, to acquire an understanding of the social worker's professional vocabulary, which includes many terms which may be readily acceptable to the psychologist or psychiatrist on the staff of the hospital, but which may be puzzling to the interne, or to the consultant in medicine or surgery. If the social worker were recording principally for another social worker, as in a family agency setting, or for a psychiatrist, as in a mental health clinic, it would be quite acceptable to refer in social diagnosis to a person "Suffering from unmet dependency needs", but this is unlikely to convey to some members of the medical staff all that

the social worker wishes to be understood regarding the patient. The social worker may thus resort to, as it were, translate the concept into other terms.

The point being made is a twofold one. In the first place the social worker does not have as well-defined and differentiated a diagnostic vocabulary in the complicated sphere of social diagnosis as does the doctor in the complicated physiological sphere. The social worker does not have an internationally or nationally accepted 999 and plus point classification to include such socially pertinent data as a conclusion that her patient is suffering from, let us say, excessive dependency, lack of masculine identification, unresolved feelings of guilt, or a poorly developed super-ego. In the second place, such general vocabulary as the social worker does have at her command, acceptable and understandable from one member of her profession to another, or from her to the psychiatrist, does not always serve as an aid in the doctor's understanding of the patient, so that the social worker may be obliged to state the definable concept in other terms, to translate it, as it were. There is a basic difficulty in communication. Doctors and social workers both profit from face to face discussion, but the written record is essential to the service expected.

It can therefore be seen, that, both on account of the purposes for which the records have been set up, and the nature of the vocabulary in which they are recorded, they do not

present ideal material from which to analyze the manner in which the social worker formulates social recommendations. They do, however, afford the best source available.

Brief Outlines of Cases

The social worker's insistence that all persons being helped must be viewed as particular individuals arises from the recognition that they can only thus be seen clearly. Nevertheless certain situations, or aggregations of personalities and problems arise repetitively. The cases chosen for presentation in this chapter are each "typical", in this way, of a large group of cases. No case presented has been put together of fragments from different cases. It has been necessary, however, for the protection of confidentiality, and in observance of the rules of the Department of Veterans Affairs, to alter some details, so that the situations from which they are drawn may not be recognizable. As the length of the records would, in any case, preclude the presentation of a full transcript for discussion, each case has been compressed for presentation here.

The cases chosen for presentation certainly do not comprise the total range. It is believed that they do represent a sufficient variety of commonly recurring situations to afford a basis for analysis of the typical activities of social workers in reaching a social recommendation. The necessity of institutional care has been called into question in all these cases. The cases are presented in order that an examination may be made

as to how the social worker formulates the answer to her share of this question.

A. Mentally Disturbed Patients

Decisions about the need for institutional care of patients who are quite clearly mentally disturbed, but not (at least for the present) committable, are of particular interest. Of such situations, three are chosen for brief review.

A (a) The confused and senile man may be brought to Outpatients or admitted to hospital because of his senile state, or because of some major physical difficulty. The physical complaint may give relatives courage to discuss the behaviour which has been troubling them for some time: memory loss; wandering and sleeplessness; careless behaviour in the management of stoves and taps; inability to carry out small errands; inattention to social taboos with respect to dress, bowel and bladder function; foul language; are among the complaints most often heard. Relatives may need to be helped with feelings that some stigma attaches to them, because of the mental state of the patient. They may not have had opportunity to observe such behaviour in others. One member of the family may have strong feeling that the family would be demeaned if the patient were institutionalized. The responsible member of the family, (perhaps a wife or son) then needs to be helped to feel secure that he is making a right decision in agreeing to the patient's removal from his home. The social worker's training and skill

must be put to full use in observation and awareness of the interactions of the feelings of different family members, so that all may emerge from the decision, in which all share, with some feeling of contentment, rather than the heightening of old rivalries. Such a feeling of right decision is of direct benefit to the patient, as improving his ability to "settle in". Sometimes several members of the family may be seen, sometimes only one, but in either case, the social worker will not be able to give a valid social recommendation unless she has real information as to attitudes of various members of the family.

In the case of A(a) it appeared that he had regressed to the level of early childhood for several years before he was brought to our attention. Latterly he had had no inhibitions as to bladder or bowel function, he wandered away from home readily and could not find his way for even a few blocks, to shops which had been familiar for many years. He could not be left alone for even a few minutes, because of his lack of regard for his own safety. His home was of modest economic status, but there was marked solidarity of family feeling. Young adults still resided in the home, and because of varying hours of work and study, had been able to assist the patient's wife considerably in sharing responsibility for his care. It seemed clear that this family had been able to tolerate the strain of caring for a senile person much longer than most families would have found endurable. The routines of patient's sons and

daughters were to change, and, in assessing the situation, it was agreed that the patient's wife could not carry the burden of his care along. The social worker's specific contribution, apart from the specific recommendation, from the social viewpoint, as to the necessity for institutional care, was in aiding the patient's wife to relinquish the care of the patient without guilt, as in his best interests.

A (b) The patient A(b) was full of fears, holding that his neighbours, and later the police, were seeking him out because of offences which actually he had not committed. If his wife left the house his fears built up increasingly, and he might phone to bring her back from casual employment, or from a visit to friends. She had considerable skill in standing as a buffer between him and his fears, but her patience and her vital resources wore thin under the continuing strain. She saw the loss^{of}/the patient's daughter in tragic circumstances, some years previously, as contributory to his condition; that it did not fully or satisfactorily afford her an explanation, her often-repeated "but why? why does he have to be this way?" bore evidence. With support from the medical staff and social worker, she was able to accept the patient's return home on three occasions. Then, as he became progressively more fearful, it became necessary to accept him in the hospital for continuing care, and later to commit him.

A (c) Physical and Mental Disabilities, wife is not

Helpful, Despite Her Affection. In the case of A (c), his wife, despite, or perhaps because of the quality of her affection and concern, was an enemy to his best mental equilibrium when at home. The patient had a history of back complaints, and a more recent physically disabling condition, but the focus of concern which brought him to hospital was his "nervousness". To the psychiatrist he admitted the increasing strength of his distaste for his wife, along with his desire, intellectually, to cope with the feeling. An effort was made by the social worker to assist Mrs. A(c) to react in a more relaxed way to the patient's difficulties. He could scarcely turn or sigh at night, but that she leapt up to light a fire and produce a cup of tea, making him more tense and restless in the process. She over-reacted to his every minor vagary of mood or physical condition, increasing his already debilitating consciousness of self. The physical situation of their home, remote from access to transportation or medical care, was an additional burden in the patient's difficulties. His wife had been dependent on the patient for business decisions in his days of strength and competence, and could not, even with help, move towards a decision on her own to move to city living accommodation. The patient's power of decision was enfeebled by his insight into the irrationality of his feelings against his wife, and his related fear of suggesting a move which might offend her. The weakness of each seemed to deepen the weakness of the other. Mrs. A(c) could not

be helped to develop strengths to compensate for those the patient had lost, although her devotion and affection were unquestioned. After several visits to the hospital and returns to his isolated home, the patient was accepted for continuing care. Had it been possible to further moderate his wife's reaction to his disturbed state, it might have been possible for him to manage at home for a longer period.

B. Speedy Decision around a Physically Handicapped Patient with a Reluctant but Dutiful Wife

This is an example of a case where a rapid social assessment was made. The hospital received a telephone call from a social worker of the Provincial Welfare Branch, in a rural centre, indicating that the patient's wife would not be able to care for him at home, and simultaneously the request was received from medical staff to assess the home situation. The patient had poor use of limbs and speech, following hemiplegia, being unable to walk without assistance. His wife was interviewed by the medical social workers, and it was learned that Mrs. B had known the patient in their early childhood in an Eastern city. She had come out to marry him after the death of her first husband. Accustomed to city living she had not adapted herself well to the countryside; her personal relations with this second husband had never been rewarding to her. She was not in the best of health. It was clear that she dreaded the possibility of the patient's return home and the responsibility for his care in a large and inconvenient farmhouse without close neigh-

bours, yet because of her strong sense of duty she would have undertaken the work. It was agreed that the patient could be offered institutional care, and this he accepted without discomfort, although initially he had indicated his wish to return home. Some continuing service was given the patient and his wife around certain business problems, and later the wife was referred for medical care and free legal aid. No detailed background information on either person was taken, no effort was made to modify attitudes, but support was given the wife in accepting a reasonable solution without guilt.

C. Loving Couple. Both in Physical Decline

Mr. C is typical of a considerable group of patients where both the patient and his wife have very real physical disabilities, but the strength of their feelings, the one for the other, made joint living possible for a considerable period, although institutional care had to be accepted in the end. Both the patient and his wife were of cultured Scottish background, the man tall and heavy, the wife tiny and frail. On several occasions the desirability of the man's return home was called into question, mainly because of the view of a private physician that his wife "needed a rest". He came in to the hospital from an upcoast resort where he had settled after retirement. The patient had a great deal of affecting for his wife, but little understanding of the physical strain he put on her, in expecting care in his own home. As soon as she had regained her strength,

the wife always wished "to try again". Eventually it became necessary to place the patient in institutional care. The wife first moved into living quarters in the city and later into a nursing home, secured with the co-operating of a provincial social worker. There was intermittent supportive contact with husband and wife, and some contact with family members. The transition from independent living was better bridged because the social worker understood and acknowledged the strength of the tie and the regrets when institutional care was found to be necessary.

D. "Feelings" Determine the Decision

Mr. D.'s situation typifies one of those where superficial information as to physical facts, without knowledge of the attitude of the man and his wife towards one another, and towards the facts, would give the impression that it would be categorically impossible for the man to return home. Yet he was able to be out of hospital for over a year after the diagnosis of carcinoma had been confirmed. The patient's equilibrium was affected, and later his speech. His wife's appearance was rather conspicuously odd; she was epileptic as well as of very limited intelligence, and was a regular visitor in the out-patient clinic at another hospital. This couple had one very attractive child of pre-school age, and lived in rented slum quarters where the landlord was fairly friendly. The social worker's home visits and contact with the wife disclosed that

the patient would be given adequate care at home. While poor and drab, his rooms were neat and warm, and a small balcony would give him an opportunity of being out of doors without encountering the danger of traffic. The patient was devoted to both his wife and his child. His wife wanted him at home. Her family who lived nearby, and were frequent visitors. The patient, at home would live in a climate of affection. The social recommendation was that a large, lurching man, with poor capacity to direct his movements should go to slum housing, to be cared for by a feeble-minded wife, subject to seizures. Follow-up home visits disclosed that the recommendation had been a sound one, its soundness resting on the feelings of the handicapped couple about one another and about their home.

Eventually, as the patient deteriorated, it was necessary to have him accept institutional care, and to support his wife in yielding up her responsibility for care, steeling her to refuse his hopes of returning home again. A community agency was drawn in with a view to ensuring the future welfare of the dependent child.

E. Repeated Admissions Arise from the Home Situation

The situation of Mr. E belongs to a group where attention is drawn to a difficult home situation by the patient's obvious reluctance to leave hospital on repeated admissions. The patient's condition was an obscure one, involving "dizzy spells" and "blackouts" vividly described by his wife as well as himself,

but never observed when he was in hospital.

The social worker's contact with him, intermittently as both an inpatient and an outpatient, helped him to admit, with somewhat lessened resentment, his frustration at having had to adopt a woman's role in housekeeping and caring for his wife, who had suffered a debilitating illness some three years previously. When in better health himself, he had enjoyed her dependence on him for physical care, and his ability to provide it; now the obligation became increasingly onerous. A home visit indicated that little could be expected in moderation of the wife's demands on him, but that he could be helped by the social worker to express to some extent his resentment of the situation, and by relieving his feelings thus, to tolerate it better. When the patient was hospitalized, his wife had financial and personal difficulty in securing temporary housekeepers; on one occasion she asked the municipality to secure her a nursing home bed. Because of her own fears regarding herself, she tended to be unduly alarmist over the patient's condition, thus reinforcing, rather than reducing his concern for his own health. It was necessary for the social worker to help her to understand the patient's condition better, so that she would not further his returns to hospital on the slightest pretext. The patient kept contact with the social worker on visits to the outpatient department, until his admission for what proved to be a terminal illness.

In such situations as this, the social worker's initial

formulation may not be stated as such on the record, but becomes implicit in the decision to work principally with one of the married partners, (in this case the patient rather than his wife), on the basis that the attitudes of the other partner are less susceptible of modification. Effort is made, however, to effect some change in both.

F. Wife Whose Health Problems Include Emotional Factors

Captain F, a 79-year old patient, suffering from arteriosclerosis, with some minimal memory loss and mental impairment, was referred to Medical Social Service by the doctor, with the request for assessment of the home situation. On the ward it was learned that staff viewed the patient as difficult and demanding, and also that his wife and son had both advised that his wife would be unable to care for him at home, because of poor health. The patient stated that his wife was the best of women, in the best of health, and that he was going home.

When contacted, the wife spoke both of her poor health, and of her difficulties with the patient since his retirement. Her doctor corroborated her statements about her blood pressure which had been known to go "as high as 200", saying that it would be difficult for her to care for the patient, as she required rest, but could not say that it would be impossible. It seemed that the earlier years of the marriage had been tenable, because the patient had been much of his time away from home in the course of his business. Since retirement, Captain F was depicted as difficult and demanding to an increasing degree. He

had never at any time been known to do as much for himself as boil water to make tea. Nevertheless he maintained he was ready to go home and "do everything for himself".

Efforts to have the patient acquiesce to the proposal of institutional care were unavailing. The patient said that his wife's doctor was a fool and that he was no trouble to anyone at home. Explanation was given to his lamenting wife and to his repeatedly protesting son, that we had no right to compel the patient's stay. It was felt that they did come to accept, although they so regretted the necessity for our policy. Shortly after his return home, the patient was readmitted to hospital and died.

This seems typical of a group of cases where emotional problems are conspicuous in the wife's illness, which forms her stated reason for inability to accept the patient happily at home. The possibility of his being offered continuing care within the veterans' setting would offer a ready solution, in a separation. It would not then be necessary to admit the marital difficulties, which are not denied, but rather readily discussed by the wife, even on superficial contact. The family circle, (represented in this case by one son), attack the withholding of care, which they, too, see as a solution. The social assessment involves a balancing of values, an enquiry into varied solutions in the light of "Who would be hurt by this arrangement? Who by this?" In this case, as the patient had not initially presented as "likeable" on the ward, there was more sympathy for the wife's

dilemma, than for example, in case M (to follow) and the social worker had less to do in making it vivid to staff.

G. Patient and Wife Ambivalent Regarding their Relationship

The social worker in the family agency is thoroughly familiar with a group of clients who come voluntarily to the agency seeking help with a marital problem, returning at intervals of some months or years, usually with the same problem. They appear to seek the social worker as a person who will listen to their complaints, rather than as a means to a changed or improved relationship with the spouse. As might be anticipated, some persons caught in such situations are known to medical social workers assessing requests for institutional care. I have heard them referred to as "off again on again marital problems" and the name may be as good as any.

Mr. and Mrs. G showed such a pattern in our four-year intermittent contact with them. Mr. G suffered from chronic asthma and congestive heart failure, and had been temporarily living alone, apart from his wife, at the time when he was first referred to Medical Social Service with a view to securing an opinion as to the necessity for institutional care. At that time his wife was in another province but his sister and his daughters were concerned for his welfare, and a room was secured near his sister's home, so that it was not necessary to maintain the patient in hospital. In four months the patient came to our attention again, but there were more pressing medical reasons for

his stay in hospital for some time, and he was discharged to his home, this time with his wife in the picture, in a few months time. He was seen as an outpatient, and his marital difficulties came to the fore; the worker noted: "His domestic situation has been poor over a fifty-year period." It seemed probable that the patient should accept institutional care, because of the difficulties at home, but he refused to do so for financial reasons. A home visit disclosed that man and wife had not been speaking for over a year. His wife's complaints of his difficult disposition, hypochondria, and unreasonable demands for incessant service were substantiated by other members of the family as the reasons for the difficulties. Like "the boy who cried wolf", now that there was reality to his physical complaints, no-one credited him. Some five months after his last admission, the patient was again admitted to hospital, but left within four months, this time to live alone. Eight months later he was again admitted to hospital from a hotel room where he had been living alone. His wife's concern for him was reactivated, she began again to visit him and they were planning once more to set up a joint establishment, at the time of his death.

H. Patient and Wife both Handicapped; Family Involved in Decisions

Mr. H, an 82-year old patient and his wife were brought to the attention of Medical Social Service through an outside agency, to whom his son and granddaughter had gone for

advice in planning for the care of his 83-year old wife, whilst he was hospitalized. On discussion with medical staff, it was found that the patient was already under consideration for institutional care, although there was the probability that he could be discharged if suitable care could be provided outside. The patient had a difficult skin condition, bronchitis and emphysema. Some members of his family considered that he had been too heavy a drinker, but he was not in any sense of the word an alcoholic. He was somewhat rejected by his son, but viewed with affection by his granddaughter. They felt that they could perhaps make room for his wife, but not if it entailed the possibility of having to care for him. In their view patient had "spoiled" his wife, an obese, slightly confused old woman of whom he spoke in the most endearing terms. The feelings of the family were very fluctuating, even with regard to the possibility of caring for her. Some six weeks after the original contact, she was placed in a city boarding home. The patient was agreeable to this plan and contributed to her support from his pension. In the boarding home Mrs. H. was being encouraged to do more for herself. The patient, although he continued to be hospitalized, visited her regularly. Some three months after the original contact, the patient, with the help of the caseworker, was considering the possibility of taking a housekeeping room with his wife. Two months later his wife was very happily established with him. A follow-up home visit after the patient's

discharge showed both reasonably independent and contented, although the family were giving little assistance, now the patient and his wife were alone. Some five months after the patient's discharge, he was readmitted to hospital and died within a month. His son assumed a responsibility for the care of the patient's wife at this time. In accordance with family tradition, the social worker was asked to make a formal visit of condolence, prior to the funeral.

Case I. Situation Requiring Environmental Modification

This patient, suffering from a severe handicapping heart condition, was first brought to the attention of Medical Social Service in the fall of 1950. Five social workers have dealt with the patient and his family, and the case was almost continuously active until his death in the spring of 1956. It seems highly improbable that the patient would have spent any time out of hospital, had it not been for the efforts of Medical Social Service.

The patient was referred specifically with the query as to whether there were any possibility of his going home. "Home" consisted of a wife and two children of some ten and eight years of age, living in two housekeeping rooms in a tenement which bore a poor reputation. Physically, conditions would have been poor for the patient, it was necessary to climb stairs to get to the small wretched accommodation. It was learned that several social agencies had had contact with the family, and there

was indication of borderline neglect of the children. The medical social worker found that adjustment between husband and wife had never been of the best, the patient displayed no great anxiety to go home, and the wife made no movement towards securing quarters which would permit better physical living conditions.

After the passage of some three months, the patient was becoming dissatisfied with institutional care; his increasing concern for the welfare of the children was being fostered. Approximately one year after the referral the patient was making weekend visits to his home. Much of his dissatisfaction with conditions there was projected onto DVA and the treatment setting, he became a "difficult" patient. Some five months later his heart condition deteriorated and he again was placed on strict bed rest.

Again some four months later, the patient had made considerable physical recovery and the family had been assisted to move to a suburban house. The medical social worker remained in contact with the family, much detailed work being put in in getting household effects settled. There was some evidence of quarrelsomeness between man and wife, and indications that the wife was a poor manager. Nevertheless, with supportive contact the patient remained out of hospital until the following spring. The possibility of institutional care was again considered, but a strong social recommendation against such a plan was made. The patient was hospitalized briefly twice

between the spring and fall of this year. More suitable housing, still suburban to the city was found for them. The family were quarrelsome with neighbours and landlords. Despite these difficulties, and varied problems related to moving, the patient seemed at this time able to accept the necessity of recurring hospitalization and subsequent return home, without emotional upset. The family maintained a borderline social equilibrium, the wife writing to or contacting the medical social worker as various difficulties arose. The patient was again in hospital when the pipes of the small home froze in December, but the family accommodated themselves to his return home for Christmas.

In March the patient was hospitalized for the last time. The social worker, in the words of an interne "helped him worry" over some legal problems, his wife's health, and matters involved in his children's education. The patient died some two weeks after this admission.

J. A Dutiful Wife

Medical Social Service had had brief intermittent contact with this patient before the question of institutional care was indicated. In 1948 we assisted him with arrangements regarding glasses, and in 1951 he requested and was refused help to procure medications for a non-dependent daughter. Later in that year we were requested to secure social background information, because the patient was

displaying irrational behaviour, with some evidence that it might be due to barbiturate addiction. Mr J. was suffering from heart disease, urinary difficulties and a mild degree of diabetes. This was the first direct contact with his wife. The history secured from her indicated that he had formerly been accustomed to heavy drinking and had been physically abusive to his wife. There had also been evidence of liaisons with other women. His wife initially told medical staff that she could not accept him at home, even for weekends. The patient was temporarily placed on institutional care, but was soon making regular visits to his home, and then returned home fulltime. There was a brief stay in hospital a year later. After some seven months at home the patient was again admitted to hospital and his wife discussed (now with the third social worker to know this patient) her difficulties in caring for him at home. He was now confused and blundered about the house at night; he refused to bathe; she worried about his "taking pills". Some two months later, with supportive follow-up by the case-worker, she took the patient home.

A tiny, competent woman, Mrs J. nevertheless had health problems of her own and might easily have agreed dutifully, but very unhappily, to care for the patient. Because she had had the opportunity to ventilate her feelings and because she had been given the sense that someone was concerned about her as well as about the patient, she assumed the responsibilities cheerfully. The patient was seen occasionally

by the social worker when he attended outpatients.

Approximately a year later he was readmitted for control of his diabetes. His former difficult behaviour had vanished; he appeared to have regressed to the level of a good, clean, cheerful infant. His wife devoted herself to cleaning the house preparatory to a sale so that she might purchase a house in which the patient might more comfortably be cared for on one floor. She was unsettled at the suggestion that the patient might be discharged before this was worked out. With the assurance of the social worker that she was sincere and not "stalling", medical staff consented to delay the patient's discharge. The patient died about one month after his discharge. Mrs J. called later to share with the social worker details of his death, and has twice since requested the Department's help with problems of her own health.

It had never occurred to Mrs J. to separate from her husband because of his abusiveness or infidelity. To her a wife was a person who stayed with her husband. Nevertheless, at the beginning of our contact, without the help of the social worker for her, she would have insisted that the patient receive continuing institutional care. In the end she was left with an easy conscience because of her sense of "duty well done" in caring for her late husband, and she thought of the department as a continuing support.

K. A Patient Who Insists on Going out, Despite Medical Advice

Mr K. was first brought to the attention of

Medical Social Service in 1948. He suffered from a severe cardiac condition, as well as being disabled by arthritis. He has impressed various members of the staff as a person who was probably basically of limited intelligence and inadequate ability to adjust to life's pressures. Superimposed have been many situations which were anxiety producing. Latterly it has seemed probable there is some organic basis for mental confusion and deterioration.

Mr. K's first wife died in tragic circumstances. His second wife is fifteen years younger than he and has been intermittently hospitalized for mental illness throughout our contact. The patient's oldest son, born in 1944, has had to take responsibility above his years for the younger child, a little girl born in 1950.

Mr. K and his family have lived in slum housing, latterly of such a deteriorated type (two windowless basement rooms with only a tap) as to be condemned by civic authorities. As the patient has moved in and out of hospital, there have been worries over his wife, whether in mental hospital or at home. The patient's mother-in-law, whom he does not like, or his mother, who comes from out of town on the occasion, have sometimes looked after the children. The Children's Aid Society have been active over a period of years in a borderline neglect situation, and we have shared their concern over planning for the patient's children. Allegations regarding the

promiscuity of his wife have been a part of the picture.

When the patient was hospitalized here in the winter of 1952-1953 his wife was again in mental hospital, and medical staff again felt that his condition was such that he should accept institutional care. As usual, the patient refused, saying that he cared too much about his children, and needed to be at home when his wife was discharged.

Since then he had had his wife at home for a period. At present she is in the Provincial Mental Hospital, and could return home if he were able to offer her some stability. The patient has no insight into the abnormality of the home situation but does have a blind determination to remain out of hospital. No constructive change can be anticipated, and the social situation will remain a cause for concern on successive hospitalizations.

L. Housing Problems Add to Other Difficulties

In January, 1953, this 73 year old patient, undergoing treatment on the genito-urinary service, was referred because of his concern for his confused, nearly blind wife. He also worried about housing, as he and his wife were already paying half their small income in rent, and a change of landlords brought the possibility that notice would be given them to move. The patient's adult family were all out of the city. Mr. L. was assisted to make application to one of the low rental

housing projects in the city. Meanwhile he went out on pass, and sharing his wife's concern about the possibility of being evicted, took accommodation at a rental to some 70% of income. The patient was discharged from hospital some two weeks later. In March he returned to the social worker after attending outpatients. He expressed concern about the disreputable character of some of the other tenants in the building where he was paying such a high rental. His concern for his wife was mounting.

In May this couple moved into the low rental housing scheme to which we^{had} made representations on their behalf. Soon after the patient was readmitted to hospital, suffering from a heart condition. He was placed on the Seriously Ill List and became temporarily disoriented. The social worker helped by visiting his wife, about whom he expressed concern, because she was due to return to her eye specialist. In June the patient's well-to-do son from the East visited. The son talked of moving both the patient and his wife to the East, but no action was taken. During the latter part of June the patient was discharged to his home, where the social worker made a follow-up visit to the housing site. Very soon afterwards, we received a request for information from the psychiatric ward of another hospital where the patient's wife stayed some eleven days. Within two weeks' time, after her discharge, we were receiving a series of phone calls about the patient's wife and his ability to plan for her when she seemed

to be in a frankly delusional state. The patient was visited and given support in his current difficulties, culminating in his wife's committal to the Provincial Mental Hospital, and his return to Shaughnessy, where he was recommended for institutional care. After four months the patient was discharged to a boarding home. Some three months later the patient travelled East to make his home with his son. A letter of referral went forward to Medical Social Service in the DVA hospital there, as it was felt patient might need their service.

Some two years later the patient's son, who had come here for the funeral of the patient's wife, called at Shaughnessy to give the social worker details regarding the patient's death which had taken place earlier.

M. A Case Where the Social Situation Determines the Need for Institutional Care. THIS CASE IS GIVEN IN MORE EXTENDED DETAIL THAN OTHERS, IN ORDER TO GIVE SOME IMPRESSION OF PROCESS

The case of Mr. M may be cited as typical of those referred to in Chapter One, "Where the patient no longer requires acute bed care . . . he may be anxious to return home, but his wife may state that she is unable to care for him." This is further typical of a group of cases where the situation is brought to the attention of Medical Social Service intermittently, so that in the aggregate of contacts it becomes a "long-term case". Contact will, whenever possible, be renewed by the social worker who has known the family in the past, but sometimes by reason of case work considerations or sometimes because of change of

staff, a different social worker may enter. This case has been carried by two social workers, the first a student doing field work in the agency. It is given in greater detail than are other cases presented in this chapter, in order to give evidence of the kind of work done by the social worker, as a basis for the discussion in Chapter Three of the social worker's activity.

The patient was first referred in April, 1952. He was a man of 49 years; the medical opinion given with the referral was that he had made the maximum recovery following an accident. There was residual disability of one arm and leg. He was considered to be definitely unemployable from the physical viewpoint, and had thus become eligible for War Veterans Allowance, through the Department of Veterans Affairs. This form of continuing assistance, sometimes known as "the burnt-out pension", may be paid at single or at married rate, but no additional amount is paid on account of children. The patient had a son and daughter aged 11 and 9, by a wife 10 years younger than he. The purchase of their house had not been completed. Their economic situation would not be an easy one.

The patient had no thought but to return home, but his wife had been an infrequent visitor, and when the time of his discharge neared, said she could not give him the necessary care at home. She alleged her own poor health and the poor attitude of the patient towards herself when he had been capable of work, an attitude which she said had further deteriorated since his accident. She complained of the patient's foul

language when she visited, and of his previous brutality to her. On the ward, the patient presented as quiet-spoken, biddable, "no trouble to anyone". Medical and nursing staff were therefore not sympathetic to the wife, who was viewed as voluble and excitable. A check with a social agency which had at one time known the family showed that they viewed her as unstable and neurotic. The family doctor, contacted concerning the wife's health, expressed the same opinion, but also viewed the patient as a very difficult personality.

The wife was persuaded to permit the patient's ^{more} return home/on the grounds that there was categorically no further reason for his stay in hospital, than on any real acceptance of him as a sick person. Follow-up visits were made by the social worker, and the wife was given support in her view of herself as carrying out a very difficult task, since she indicated she was ailing, poor and forced to care for a difficult husband. Contact was closed after some six weeks.

The case was reopened about a month later when the patient was readmitted to hospital on the genito-urinary service. On review of the file it was felt it would be desirable to give further support to the patient as a basis from which an effort could be made to elicit his feelings about the home situation, with a view to possible modification of his behaviour. (It appeared clear, despite admission of his wife's tendency to self-pity and exaggeration, that the

patient's behaviour when at home, was actually most unpleasant.) Little rapport with the patient was established; he did not talk spontaneously, and his replies were almost always monosyllabic. It was difficult to judge whether the patient was the sort of person who might always have had such a response, or whether there was some deterioration in affect, incidental to his illness. Nothing of significance was elicited, apart from the fact that he had pride in his father, who had been a schoolmaster in Wales; and it was quite clear that he felt a man had an inalienable right to be cared for in his own home. He expressed no feelings about his wife or children. He never became involved with other patients on the ward. Apart from his reading of pocket thrillers, he appeared to have regressed to a sort of vegetable level of existence. There could be no firm opinion as to what extent the causation was physiological.

There seemed to be no entree to case work with the patient and it was therefore decided to work with the wife. Home visits were made, in deference to her stated condition of health and in view of her home responsibilities. Some personal history was obtained. She had been an only child. Her first knowledge of the patient was as a visitor to the home of childhood playmates. Later, as a young working woman, upset by the breaking off of an engagement, she became aware that the patient was forming an attachment to her. His first wife had died, living only long enough to present him with a son who was 12 years of age when he became engaged for the second time. Flattered by his

attentions, although he was not favoured by her parents, she married. She stated that from the earliest days of the marriage it brought her no happiness. The patient was depicted as a man who saw a wife as a provider of clean clothes, food and household care, and as a bedmate, all solely at the level of his convenience. He did offer her some social life, but this involved beer parlours and heavy drinking, neither of which she would tolerate. She described in detail incidents involving his drunkenness, vile language, and physical abuse.

Since his illness she stressed that there had been further physical deterioration in the patient. After his first return home from hospital he had poor urinary control; not only were there problems of bedwetting and dribbling, but he would wander about the house, despite the presence of visitors, clad only in a pyjama top. He called her foul names and berated her, regardless of whom might be present. He demanded frequent attendance upstairs; he could not be kept on the main floor because the bathroom was upstairs. (Mrs. M, because of her own feelings, seemed unable to tolerate any such expedient as his use of a bottle) Mrs. M had great need to have the children "on her side", magnifying to them every defect in the patient's history and behaviour. She did not respond to the worker's efforts to have her gain some acceptance of the patient's behaviour as being the outcome of his state of health, nor was there any moderation of the heat of her reaction, in the interests of more tranquil home life for the children. She continued to

be a meticulous housekeeper and a good manager on limited income.

The social recommendation was made that the patient could not be cared for at home. This recommendation was acceded to, but never well accepted by medical and nursing staff, to whom Mr. M continued to present as "a good patient". He was reclassified to section 29, but remained on the active treatment ward.

Contact was maintained in view of the sympathy aroused in the nursing staff because the patient's wife and children did not visit him. Again Mrs. M's inability to present the patient in any tolerable light to the children was noted. A Christmas visit home was arranged. The wife's account was that the patient used the occasion to berate her for leaving him in hospital "to rot"; the patient's realistically based sense of rejection had been hoarded up and given full expression. The patient's wife now took in boarders, she stated from economic necessity. It appeared that she could tolerate the strain of providing for stragglers, but not for the patient. Further urinary difficulties and the fact that the patient was now on catheter gave more medical reason for his retention in hospital. Mrs. M throughout this period was under medical care at the Outpatient's Department in another hospital, to which we had referred her.

A visit from the patient's brother from the East, whom he had not seen for many years, brought need for careful ex-

planations from the social worker, when he wondered why his nephews did not visit the patient, and why he could not be cared for in his own home, when he so actively expressed the wish to be out of hospital.

The case was closed to Social Service and reopened after seven months. The patient had gradually improved to the extent of becoming more ambulatory, and was to be moved from the ward he was on. He refused to be shifted, announced and carried out his intention of returning home. At this point his wife telephoned first the doctor, and, at his suggestion, the social worker. Her protests were very heated. She said that she had fallen in assisting the patient to get to the bathroom, as he could not walk upstairs alone. As she herself had been sleeping on a cot, to yield up bedroom space to the boarders, she had to give the cot to the patient and share a bed with her daughter. Mr. M had kept the family and boarders awake all night by pounding the floor with his cane demanding attention when he could not open doors. She said that his urinary urgency made him "impossible" at home. His language was worse than ever. She had been in touch with a lawyer even before she did accept from us explanations that we had no right to force the patient's return to hospital. (The assumption by wives that we can compel a patient's actions is a frequent one, and doubtless arises from recollection of earlier authority exercised when the patients were in the armed forces. It would seem that they

wishfully deny the civilian status of patients). Mrs. M threatened retreat into illness, and legal separation from the patient. The patient's need of institutional care seemed now to lie in abeyance until some further deterioration in health should take place, to force his return, or the wife carry out her threats. However, a few days later he was admitted again to hospital, saying only that home conditions (stairs, etc.) were too difficult for him.

As earlier stated, each of the cases presented in precise form in this chapter has been chosen as representing typically a problem recurring frequently in many cases which come to Medical Social Service. The range of cases does not pretend to be exhaustive, but it is believed, does present a sufficient base from which to procure material which will permit analysis of the activity of the social worker in moving towards a social recommendation.

Although these cases already represent groups of typical situations, it might be possible to group them further--for example, by the end-product of the recommendation FOR or AGAINST institutional care; according to the strength of the marital relationship; or according to the social diagnosis of the nature of the whole problem involved. As they do not necessarily represent the full range of problems, such further grouping would appear irrelevant to the purpose of the study. The intention in presenting cases is to offer cases which are typical, and which display at least a considerable view of the range of activity of the case worker.

Chapter III

Social Work Services in the Cases

Having examined in Chapter One the universality of the problem under study, its nature in the particular setting, and the usefulness of the professional literature in resolving our difficulties; having in Chapter Two presented some cases chosen as typical; it is now proposed to examine the nature of the social worker's activity in making the social recommendation for or against the necessity of institutional care. How does the social worker approach the problem? What are the services she gives, directly and indirectly, in the service to the patient?

Certainly it is not always possible to secure all the background information that might ideally be desired, if the situation of the patient and his wife are to be understood. It is only on the basis of such knowledge of their feelings about one another, and the patient's illness, as it affects that feeling, that the social worker can truly see their situation in the light of the sea anemone-like slipping, sliding, folding, unfolding fact that feelings are; and, having seen, decide whether it will be necessary to accept, or desirable to endeavour to alter existing attitudes. In some cases the decision to alter may be made and the effort pursued, whether successfully or unsuccessfully. The availability of time in which to carry off the

effort will have an effect on the apparent justice of the social prognosis. If a man and wife approach a family agency about a marital difficulty, they may spend six months or two years in sorting matters out. If a man enters hospital, he does so for the treatment of his heart condition or his hemiplegia, let us say--he is not asking for social treatment of his marriage difficulty, even though medical staff may see it as clearly contributing to failure to make the maximum recovery from the physical disability. If the patient gives his consent, fully, rather than grudgingly, there is usually not any lengthy period available in which he can use the skilled help of the social worker to achieve some amelioration of the personal situation. There are often sound medical and administrative reasons for pressure on the social worker to come to a firm prognosis and make a firm recommendation, within a timespan, which, in any other setting, would be considered to offer too brief a base from which to come to sound conclusions.

The medical social worker must then bring to her client the soundly-based conviction that she has as much right to probe, skillfully and purposefully (although sometimes at the cost of temporary pain) as has the doctor. The justification can only be the same as that which justifies the physician's approach to the more purely physical difficulties, the most informed direction of skill to produce better function, or at least to avert further loss of function, whether social or physical. The social

worker in the hospital setting needs confidence in her skill and needs warmth of approach in order to enter successfully into her difficult task in the brief time allotted.

Because of the time factor, a full social study is not always completed, as a service to aid in the understanding of the patient's problems. The services which are rendered have been grouped for discussion into direct and indirect services. I believe that the considerable variety of tangible and less tangible services given by social workers in veterans hospitals can be fitted, without too much warping or bending, into the classification of services offered below. It is proposed to discuss these in relation to the "sample" cases which were set out in compressed form in Chapter Two.

Services Rendered Directly to the Patient and His Wife

1. Identifying the Nature of the Inter-personal Relations

When the social worker becomes involved in the decision as to whether a married patient should return to his home or may require continuing care, her first task is to identify the nature of the relations that exist between him and his wife, with later attention to these as they are affected by the attitudes of children of the marriage or other relatives. The social worker is required to form a judgment. Initially this may be crude, based on the observation of the most obvious facts, and may be stated in the simple opinion: relations are good, relations are bad. Skilled attention to the next question, - why?

may show that "good" is not necessarily as helpful as it first presents itself, and that "bad" may be susceptible of change. Persons with "good" relationships may still need assistance in facing the situation, encompassed in illness, age, and limited economic resources.

In the three cases of "A Mentally Disturbed Patient", in (a) and (b) relations were warm and supportive and helpful to the patient concerned. In (c), however, although there can be no question that the patient had a loving wife, her affection and concern took forms that were deleterious, rather than helpful to his recovery. The wife did not respond to the social worker's efforts to secure a change in her ways of expressing her concern for the patient's welfare.

B and J are situations where the marriage had been to a large extent unrewarding to the wife, or where it had at least brought a full measure of pain and disappointment. In B the social worker felt that the wife should not be burdened with the care of the patient. The degree of his physical handicap entered into the recommendation, but so also did the degree of "sacrifice" that would have been expected of the wife, if called upon to care for him at home. In J the social worker came to the opinion that the wife could, with adequate support in her difficult role, undertake the care of the patient, and this she proved able to do for a considerable period, despite her initial refusal.

In C and D are examples of truly affectionate couples,

of very different social backgrounds, the one an officer and his lady, the other a labouring man and his feeble-minded wife. In both situations, however, because of the mutual warmth of feeling, the patient was enabled to be longer at home than might have been predicted, on the basis of his physical condition alone.

In such a case as that depicted in F, there is a basically good relationship, but one barely having the strength to endure the strain of the wife's long dependence, which left the patient's own similar needs unmet.

In F and M, whatever the wife's initial entree into the marriage (in the earlier case there is little information, in M more), her feelings at the time the patient is brought to attention are akin to hate and fear. These feelings, once admitted, bring guilt and defensiveness in their train. In the M case an effort is made by the social worker to assist in working through these feelings, and the effort fails.

In H, of interest are not only the relations of the patient with his wife, but those with his son and granddaughter, their feeling towards his wife, and the interactions of these. Initially, the "family" ask outside help in planning for his wife, they seem to be somewhat rejecting of him but say they are willing to care for her; they then proceed to place her, with city help; later when the patient and his wife again set up joint housekeeping, the family do not visit; in the end, after

the patient's death, they accept responsibility for his wife. It is necessary for the social worker not only to be aware of the shift in feeling, but of their impact on the patient and his plans. The patient's life has always consisted, not just of him as an individual, but one who is a member of a family. It is easier in a hospital than in some other settings, to ignore, if care is not exercised, the shifting ferment of family feelings as they impinge on the patient and his changing situation. The social worker is there to assess the quality and effect of these social factors.

2. Furthering Understanding of and Adjustment to Illness and Prescribed Regimen

It must be admitted that none of the cases chosen for this study illustrate particularly well the sort of direct service that medical social workers in hospitals are often called on to give. The feelings of patients and their families about prescribed diets, their misunderstandings about the nature of an illness, or the effects of prescribed treatment, may be dealt with initially by the doctor, the dietician, the physio-therapist, the X-ray technician or some other member of staff. The social worker may be called on to reinforce the patient's understanding of the information already given, but in particular to understand the origin of and to deal with the emotions that are blocking a genuine acceptance of treatment necessities, and ability to put them to good use.

Where some of this activity has occurred in the cases chosen, the extent of the activity has to some extent been obscured by the omission of detail in the reduction to precis. For instance, in the case of Mr. J as it is presented, there is reference to his "suffering . . . from a mild degree of diabetes". This presented a problem in his return home, at one point, On account of some visual disability he could not administer his own insulin. His wife declared, almost with terror, that she could not "stick a needle into" him. Because of a knowledge of the earlier difficulties in the marriage, the social worker felt that this represented a real emotional block to the wife and she was not pressed to change. The patient made his own arrangements to have his daily doses given at a small private hospital near his home.

In the situation of Mr. E one of the specific reasons for a home visit was to give his wife a better understanding of the nature of his illness. Because of her fear of being left alone, without the patient to care for her, she panicked when he had one of his dizzy spells, thereby reinforcing his concern and fears about his own condition. She was helped to understand that it was not necessary to rush him to hospital each time he felt dizzy. The visit was necessary as she was confined to the house and could not visit hospital. It assisted in postponing the patient's return for treatment.

In A (c) an effort was made by the social worker to

further adjustments in the attitude of the patient's wife. Her way of reacting to the patient's physical and mental disabilities actually resulted in their exaggeration. Because she could not be helped to adjust and the patient's condition deteriorated, his admission for continuing care was necessary.

3. Supporting the Patient's Right to Self-Determination

The proposed code of ethics of the Canadian Association of Social Workers¹ states (Part II, 1 (B)): "The social worker should recognize and accept the right of persons served to make their own decisions and to act for themselves unless they freely give this authority to the agency, or unless the agency must act in a protective role in order to safeguard the persons served or the community."

Social workers have been trained in the light of this principle. A hospital can become an acid testing ground for its application. The "right to self-determination" can become at times the right to self-destruction, or to destructiveness of the rights of others. What can be done is to give the patient a full understanding of the materials from which his decision must be made, and full support in our subscribing genuinely to his right to do his own deciding. Only if he is senile, psychotic or temporarily not in full control of his faculties, may

1. Canadian Association of Social Workers, B.C. Mainland Branch, March 29, 1954, material received from the National Committee on Ethics, "Proposed Code of Ethics for C.A.S.W." Mimeographed.

we properly decide for him. By the exercise of the skills of the case worker, understanding past experiences which have made it difficult for the patient to come to wise decisions, we may sometimes assist him to adopt more fruitful courses of action than he might accept, unaided.

As in F, where "repeated admissions arise from the home situation", there are many cases where the patient is saying in his actions, and can be persuaded to say in words, that he finds it painful and difficult to leave the hospital for his home. The stereotype of the hospital seen by the community and sometimes also phantasied by the hospital staff is that of the patient grateful for his cure or remission of symptoms who returns to a welcoming family. This does not always hold true; he can return to the burden of cares, rather than to the pleasures of convalescence. It is a matter of skilled professional judgment, within the competence of the social worker, to decide how much of the feeling regarding the care it is safe to siphon off, as too much release will arouse feelings of guilt which will only add to the patient's discomfort. In F, given help to express his feelings, and some continuing intermittent supportive contact, the patient was enabled to make his own decision that he would be most comfortable in returning home to care for his wife.

In C, the patient exercised his privilege of returning home, despite the information that it was too much

for his wife's health to provide the sort of care he needed. It was difficult for her to express this to the patient, because of her affection for him and her wish to care for him if at all possible. Had she lived in the city, where the medical social worker might have dealt with her directly rather than through intermediaries, an earlier decision might have been arrived at. In the end the patient did accept that he must be cared for in the institutional setting, but he required support after his decision was made. The activity of the social worker in mobilizing community resources to provide care for his wife, after he had come permanently into our setting, helped him to feel that he had made the right decision.

In F, the patient did not accept efforts to have him alter his decision to return to his home. This was a borderline case where one felt that his judgment was somewhat impaired, and yet not to a degree where there would be justification for exercising authoritative control. The social worker's role lay, then, in maintaining acceptance from his wife and son of his right to self-determination, even when it so sadly affected his wife's physical condition.

In K, where the patient insisted on going out to his psychotic wife and neglected children in slum housing, despite the opinion of the medical staff that from the strictly physical viewpoint he required our care, the social worker was unable to effect any change in the patient's decision.

The consequences for the children also caused community concern which was not shared by the patient. We still had no right to exercise restraint. The social worker's role therefore lay in part in gaining acceptance by staff and the social workers of an outside agency, that we could not detain the patient, even in what appeared to be his own best interests and those of his children.

4. Giving or Reinforcing Understanding of DVA Regulations

As said in number 2: "Furthering adjustment to illness and prescribed regimen", cases chosen for presentation cannot illustrate equally well all the services given by the medical social worker. Those which illustrate particularly well some services may show less well others, which in actual day to day work are frequently given.

This is true of the social worker's responsibility to give explanations of departmental regulations. Actually, this is not, per se, a primary responsibility of the social worker, but falls strictly within the province of the Veterans Welfare Officer. (See III. Indirect Services, 3.) However, the social worker may often initiate such discussion, or respond to the patient's questions in a broad way, with details to be filled in later by the Welfare Officer. Or the social worker may be called on formally, or drawn in informally, to the necessity of dealing with the patient's feelings as they arise around the regula-

tions. "The Veterans Charter"¹ contains some thirty Acts, outlining the rights and privileges of veterans. Many of these, as with legislation governing the affairs of those other than veterans, are supplemented by copious regulations, frequently renewed and revised. In the nature of a reward for the discharge of patriotic duties, involving risk to life, and physical and other changes to the person, the veteran's privileges are felt by him to be rights. Essentially, and also because there are active pressure groups in the Canadian Legion and other service men's organizations, pushing for change, and building on any existing sense of injustice, much emotion attaches to the interpretation of legislation. Deductions from War Veterans Allowance on account of hospitalization; the granting or withholding of Treatment Allowances, depending on medical opinion as to whether or not a patient is being treated for his pensionable disability; pension rates; opinions as to whether an Allowance may be paid at the married or single rate--about such rulings patients may have feelings quite passionate in their intensity, none the less so because a source of income may be involved.

There are many ways of dealing with anger; often in the hospital the social worker's way has come to be respected, because it is found that it is helpful to the patient. The person less skilled in understanding and dealing with emotion may say "it is wrong to feel like that", or "you mustn't talk

1. "The Veterans Charter", King's Printer, Ottawa.

like that". The social worker, from training and experience knows that with one person the expression of feeling may most wisely be encouraged, but that with another it is imperative it be dammed back. Dealing with departmental regulations is not just a matter of reciting or reiterating facts, but of gauging the reasons for reactions to them. This an area where the social worker is properly called on for service.

In cases such as A(b), the patient "full of fears", the family often experiences a great sense of relief when institutional care is offered to a person who is mentally disturbed and therefore a burden in the home. Sometimes, as with A(b), after a period on our psychiatric ward, or the ward in the Extension where disturbed cases are segregated, it becomes clear that our facilities are not adequate to care for the patient, but that committal to the Provincial Mental Hospital is necessary. It is often necessary in these situations for the social worker to explain and re-explain why the patient cannot continue to be cared for by the Department. In the case of Mrs. A(b), there were no prolonged protests, but these are sometimes forthcoming, even from very well adjusted persons, who may feel that the Department of Veterans Affairs has an obligation to provide any sort of treatment needed by the veteran.

As in H, departmental care for the aged and somewhat ailing person would often seem to offer "an easy way out" of

further obligation by the family. Why the hospital staff would prefer to see the patient outside the hospital walls requires a good deal of explanation to the family, not because of the facts themselves, but because of feelings which have been generated over a lengthy period in many lives.

5. Arranging for Utilization of Community Resources

Among the duties of medical social workers listed for all grades, in posters of the Civil Service Commission advertising vacancies in various establishments, is: "Duties: Under the direction of the Head of the Medical Social Service Department, and in close collaboration with the medical staff . . . to co-operate with community health and welfare organizations in the interest of such patients." A knowledge of appropriate community resources is relatively readily acquired, even though new agencies are continually forming and old ones changing their policies. At the level of mere knowledge of policy, it may not always be too readily determined, for instance, whether a person should be sent to the Family Service Agency, to the Family Court, or to Free Legal Aid, if the presenting problem seems to be one of marital difficulty or securing maintenance. Should the Alcoholic be sent to Alcoholics Anonymous or to the Alcoholism Foundation, or rather be treated on our own psychiatric ward? Could the Salvation Army best help him? Should he and his wife together go to the Family Service Agency? These are questions involving a knowledge of agency policies. They are also pre-eminently questions involving a good understanding

of the person requiring the service.

Sometimes there is no difficulty in deciding that there is only one agency which can meet the client's need. He is temporarily unemployable and without funds, and his wife can get help only in the form of social assistance. The well adjusted person, mature and competent, may have even more difficulty in accepting this resource than the immature, dependent person. How can the patient and his wife be helped to use the only resource available? This is a matter of understanding why they feel as they do about it. Is there an unwonted need to assert independence? an old history of "relief" during the depression? are there questions about the ownership of property, the status of the marriage, or some other matter, which they dread to answer?

To make "a good referral" for a more intangible service is not easy, although it may be easy to see the patient's need of the service early in the medical social worker's contact. If one does not carry the patient's understanding of the problem far enough, he will not make the contact; if one carries it too far, he will return to the referring social worker, as the one with whom he has established a warm relationship, rather than to the social worker in the new agency.

In the cases cited, community resources have been widely drawn on. After World War II the Department of Veterans Affairs stressed to its staff that there should be no duplication of existing community services. The veteran is primarily a

citizen and retains the rights of any citizen. The pattern is therefore well established of drawing on existing sources of help, available to all citizens.

In A, the cases of mentally disturbed patients, it is noted that DVA patients move on to the Provincial Mental Hospital where that type of care is indicated. Reference has been made above to problems in having relatives accept the necessity of that sort of care. In B, medical care at the out-patient department of another hospital was arranged, and Free Legal Aid was secured for advice in business difficulties.

In C, reports on the patient's home situation; later planning for the move of his wife to Vancouver; and finally the provision of nursing home care for her; were provided by workers of the Provincial Social Welfare Branch. This resource is often used, and in British Columbia we are particularly fortunate in having this unified service to which referrals can be made. Patients' permission to give medical and other personal information is of course secured before contact is initiated. In D, where the patient and his wife both had physical and mental handicaps, we see the use of a community agency to ensure better planning for their pre-school aged child. Had this patient lived elsewhere than in greater Vancouver or Victoria, the Social Welfare Branch might have been called on to assist in this situation.

In E, the patient's wife herself called on a municipal

agency to assist her, by requesting nursing home care. It was found, however, that her request had its origin in her exaggerated view of our patient's condition. With a better knowledge of his condition, and with our support to him in his role of offering her care on his return home, our service consisted, in effect, of helping the patient's wife NOT to use the community agency. Its services became unnecessary, because of service given from the veterans hospital. Again in H, we find the patient's wife's family calling on municipal service to provide boarding home care for his wife. This was used for a period, until the patient was brought to the point where he and his wife could again live together. We see that in such co-operative work, Medical Social Service is not only effecting a saving in treatment costs in our setting, but is relieving the community of the necessity of providing care for the patient's wife.

In the home situation of K, it has been necessary to co-operate with the Children's Aid Society from time to time with regard to plans for care of the patient's children, and also to direct complaints to that agency as the one competent to act, when we did not have statutory authority. Some contact with medical social workers at Essondale has also been necessary in the situation. At times it may be suitable to act as go-between between the patient and the community agency, at times it may be desirable, with the permission of the patient and medical staff, for a social worker of the community agency to

contact the patient directly. Good planning in the best interests of the patient and his family in these situations will depend on a proper understanding of what the community agency can and cannot do in his interests. This helps to keep his demands realistic and places him in a better state to benefit from treatment.

In the case of L a housing problem is one of several difficulties. This is a difficulty which frequently causes concern, as so many of the patients are on limited income, most frequently some combination of Old Age Pension, War Veterans Allowance and disability pension; the basic married War Veterans Allowance rate being \$108 monthly for man and wife, but this may go to \$120 monthly. Those who own their own small homes may be in difficulty with rising taxes, fuel costs, etc. Those who must rent, especially if in the city, must usually pay more than they can afford for self-contained accommodation, or shift to the rooming-house level of amenity. Because of the lack of low-rental housing projects, despite the existence of a number of organizations in the city furthering such development, we are not frequently able to receive favourable consideration for our patients. This is certainly not because of any discrimination, but because of the pitiful lack of housing being made available to meet the needs of the low income group. When we do succeed in securing a favourable reply, as in the L case, we share the delight of the new tenants to the full. The availability of such accommodation may at times swing the

balance as to the necessity of institutional care. In general it may be stated, however, that in the area of housing there are not sufficient resources with which to co-operate.

In the M case Mrs. M was referred to the outpatient department at another hospital, not only so that she might have necessary medical care, but to obtain some factual information on her claims that she was physically unable to care for her husband, although she could provide for boarders. Referrals for medical care of patient's wives are of so frequent occurrence that they are discussed in a section apart, below.

6. Modifying Environment

Some of the medical social worker's work ~~in~~ modifying environment has already been discussed under the previous heading of "utilization of community resources", (as for example in connection with housing). This is because much of our ability to effect changes in the more external factors of the patient's situation depends on the use of community agencies used by others than veterans.

We do have, however, within our own setting, considerable flexibility in the regulations which affect the economic circumstances of patients in the receipt of pensions and allowances. The social worker often takes note of changes which might be arranged in the patient's interest and asks the Veterans Welfare Officer to look into the details. Here, in line with the usual acknowledgement of competence in the area

of "feeling", care must be taken that the patient's hope not be set on "a sure thing"; he is warned that time may elapse before a ruling is secured, and that the nature of the ruling cannot wisely be predicted.

There are also funds provided by the Auxiliary to Shaughnessy Hospital and other sources, set up as "the Hospital Superintendent's Fund" and disbursed by Medical Social Service. This is used to meet special emergency situations, sometimes for patients leaving hospital until a continuing resource can be drawn on, sometimes to meet special needs of bed patients and their families.

At times, as in case I, the environmental changes are secured as needed to benefit the patient, by mobilizing the family to act on its own. Mrs. I had remained for years in sub-standard housing of a physical nature such that the patient, because of his physical condition, could not return home. With the help of the social worker, although change came about slowly, Mrs. I herself secured suburban housing, better suited to the needs of the children, and such that it formed no barrier to the patient's return home. Later she moved to more suitable accommodation. Initially she had seemed immobilized and helpless. Because of the first changes which the wife was enabled to make, the patient again became an active participant in family affairs and a real father to his children, despite the necessity of recurrent returns to hospital.

Our lack of resources to secure adequate housing for patients has already been discussed.

7. Arranging to Meet Wife's Health Needs

The service of arranging to meet the health needs of patients' wives is to be discussed separately, rather than under 5: Utilization of community resources, because it is a specialized service, which is frequently called for. Elderly patients with limited economic resources are often found to be worrying about the health of their wives, who are without the means to secure medical care, at a time when the needs of the patients themselves are being adequately met. The social workers are therefor often asked to discuss these situations with patients, whether or not the question of institutional care for the patient, should his wife not be able to care for him, is involved.

Our usual resources, for patients who live in greater Vancouver, are the outpatients departments of the Vancouver General or St. Paul's Hospitals. For other centres in the Province, we have no direct resources. If the needs of children, as well as the wife, are involved, or if there is something exceptional in the situation, the Social Welfare Branch may be called on, with a view to their drawing on local resources in the home community.

In situations where institutional care is under consideration, a referral for outpatient care for the wife may some-

times, as in B, be given as merely incidental service. This form of assistance often brings out the warmest expressions of gratitude. Health needs have frequently been unmet for extended periods, due to persons not being aware that help was available. Wives seem particularly touched to know that there is concern for their health, as well as that of the veteran patient, even though we cannot offer direct service within our own setting.

At times, as in the D case, where both the patient and his wife had considerable physical handicap, the wife is already receiving necessary service, but contact with the medical social worker in the other setting means that each hospital better understands the needs of the other party to the marriage, and so is better able to serve its own patient.

The extent of the interaction between man and wife and their illnesses is well illustrated in case E. We did not at any time have a direct medical report on Mrs. E, but she was known to have had a stroke. An exacerbation in the physical difficulties of either one produced an exaggeration in the symptoms of the other.

At times the well-adjusted wife, who has accepted our support in the difficult task of caring for a husband who would otherwise have required institutional care, turns to us later for advice in health problems of her own. This was so in the case of Mrs. J.

In some situations, as the cases of Mr. H and Mr. L, the patient's wife may be receiving care from a private physician, on the basis available to old age pensioners, holding the provincial "blue medical card". Our medical staff or the patient may be helped by factual information on the true medical condition of the wife, so that we take action in the light of that knowledge.

In cases like that of Mr. M, where the wife alleges her health as one of the principal reasons for being unable to care for the patient, a referral to the outpatients department, in part for the purpose of securing an opinion, may be helpful to all concerned. In this case a knowledge of the facts concerning the wife enabled us to focus on the real difficulty, which was a marital one of long standing.

Indirect Services

1. Securing detail, ranging from selected facts to full social histories, as required by medical staff, as an aid to diagnosis and treatment.

The securing of a social history is well known to professional staff, and well accepted by lay persons, when it is to be used as a part of the material on which a neuropsychiatric diagnosis is based. Of our three cases of mentally disturbed patients cited in II, A, social histories were secured on two, (b) and (c). The time and critical judgment put to use by the medical social worker in securing information from the patient

and, or his wife, enable the time of the neuropsychiatric staff to be put to its most highly skilled use, rather than in the winnowing of facts.

In Shaughnessy Hospital, in line with a routine practice instituted at the request of the Neuropsychiatric Service, medical social workers see the great bulk of the patients who are referred from outpatients, before a psychiatric appointment is made. It is left in the professional discretion of the social worker whether a fully detailed social history is secured, or whether merely a few details are taken on the current situation. Social workers are also expected to exercise judgment as to whether an appointment is urgently and immediately required, or whether several days may pass before an appointment, without further deterioration of the patient.

On other services, the social worker is increasingly requested to secure information on the patient's background, or his behaviour when at home, as an aid in diagnosis. The usefulness of such information can readily be seen in a case such as that of Mr. E: "Repeated Admissions Arise from the Home Situation", where medical staff had a much better understanding of the nature of his "blackouts" after the social worker's interviews with the patient and his wife.

In case J, where there was some question of barbiturate addiction, the knowledge, secured from the wife, that the patient was taking "pills", was of assistance to medical staff.

in confirming their suspicions. Information as to the patient's confused behaviour, his night wandering etc., was also of assistance to medical staff in presenting a clear view of the patient. Sometimes in the controlled atmosphere of the ward, under the authority of staff, and following patterns adopted by others on the ward, patients appear much less disturbed than in their norm. The social worker can take time to judge whether the wife's account is an exaggerated, or a factual one.

Such histories are valuable in the treatment setting, not just as the procuring of collections of facts, although that in itself may be important. They are also helpful because the social worker's contact conveys to the wife the valid conviction that someone attached to treatment services respects her observations and cares how she feels about the facts. This may have a highly therapeutic effect on the quality of her relationship with the actual patient. It is undoubted, (is usually expressed in behaviour, but sometimes even in words) that a wife may feel a sort of jealousy of the person comfortably hospitalized (as she views it) while she continues to bear the burdens of daily living. Good history taking, while focussed on the patient, will thus be of considerable assistance to the wife.

2. Furthering Understanding of Social Pressures on the Patient, by medical, nursing and auxiliary staff.

To the writer's way of thinking, the furthering of the real understanding and acceptance of the patient, as a person,

seen in relation to others--his wife, his family, his employer, his neighbours, along with his economic situation, etc., is one of the most valuable services given by the social worker.

The interne who writes on the ward chart "patient may be discharged to his home today", doubtless visualizing a comfortable middle class home, when actually the man's wife and even children are unprovided for in Quebec, and he has neither a room nor a job to go to here, is not practicing good medicine. (An exaggerated, but, alas, not an imaginary example is chosen.) The role of the social worker in teaching an understanding of the patient as a person rather than as a disease, deserves stress. This is not done by the standing up and delivering of lectures, but by day to day contact on the wards. It is interesting that the particularly sensitive interne, who himself is capable of securing a good picture of the patient's social situation, is often the one who earliest comes to make good use of the social worker, not only as a means to secure a fuller picture of his patients, but as the professional person within the hospital setting who is best equipped to help the patient with the many personal difficulties which often have a direct effect on the course of his illness. The social worker may be asked to help in a particular way, or may be given a free hand to proceed as her competence dictates.

The patient will be given more sympathetic acceptance and handling by nursing staff, if they are aware of the pressure

of the home situation. In such a case as E, we see a good example. The history secured is not only of value to medical staff, as discussed in Indirect Services, 1, above, but is helpful to the nurses. This patient's particular need was for remission in his unceasing task of being leaned on by his physically handicapped and dependent wife; he himself needed to lean, we may say. Without a knowledge of the home situation, ward staff might well say of patient's frequent admissions, "I don't know why he comes in all the time; he talks about those black-outs, but you never see anything wrong with him while is is on the ward." With the knowledge that he has been caring for some years for his invalid wife, he is given more acceptance and sympathy when he enters hospital and this assists in meeting his need.

We may have similar resistance, but to the patient's wish to go out, as in K, where medical staff felt that from the physical viewpoint institutional care was necessary. In many senses his return home seemed foolish, or wrong; but with a knowledge of his home situation, his concern for his mentally ill wife, his affection for his children, his need to do so could be better tolerated.

Intrinsically, of course, in every request for institutional care of a married veteran, home background, a "history" is required. As already stated in Chapter One, VI, the necessary information may be known to the doctor, and a request for investigation is certainly not necessarily referred to the

social worker. Proper decisions around this question can only be made as the home situation is clearly envisaged and understandingly dealt with. This may result in recommendations which on the surface appear extraordinary, as we see in contrasting D and M. In one it seemed initially clear that the man should not go home, in the other that there was no adverse reason; yet the social recommendations ran exactly counter, and were accepted as valid by medical staff.

In the case of M, where he presented as a "good" patient on the ward, although his behaviour in the home was so difficult and anti-social, the social worker's report was accepted as factual, but gained no sympathy for the situation of the wife nor the dilemma of the children in so disturbed a home situation.

The understanding of the social worker's ability to help patients has developed far when all grades of staff feel free to make referrals of patients who are disturbed. I recall, although not in connection with any of the cases cited, an orderly who told of a patient: "He wanted me to call the Legion for him, but I knew you were the one he should talk to."

3. Co-operation with Veterans Welfare Officers in putting Departmental Resources to the Patient's Best Use.

Under II, Direct Services, 4, Giving or Reinforcing Understanding of DVA Regulations, a good deal is covered of what also belongs in this section under Indirect Services to Patients. Because of changing staff, referrals of certain

sorts of problems may be made indiscriminately to either VWO's or social workers in the hospital. Where referrals are initially made directly to the appropriate one, it may be found that there are areas of concern which could best be dealt with by the other. The usual basis of co-operation works extremely well: VWO's are expected to deal with matters of departmental legislation and benefits available to the veteran; Social workers make referrals to outside sources of assistance, and deal with situations where the feelings of the patient or his family are greatly involved. Unless each pays deference to the areas best served by the other, the patient will not receive the fullest extent of service to which he is entitled. There, therefore, take place discussions of situations, on a consultation basis, where the social worker never sees the patient, and the Welfare Officer continues to carry on direct contact, or where a referral has been made to the social worker, but it is felt best to have the situation handled by the Welfare Officer. Discussions and referrals also flow in the opposite direction.

4. Sharing in Public Relations for the Setting

Out of whatever mysterious fabrics the morale of the many employees of a large institution is created, two factors may be seen to be prominent: harmonious working relationships and mutual respect of various levels of staff; and the sense that the institution bears a good reputation with the public, because the harmonious working relationships have resulted in good service

to the patients. Medical social service staff share in these satisfactions.

In such a case as L, the son returns to the hospital some two years after our last contact, in part to stop to talk with the social worker about the manner of our former patient's death which took place in a different DVA hospital. This is done because the son thinks of the medical social worker as someone who is not a mere functionary, but who saw his father, the former patient, as a person, rather than a cipher; as someone, too, who found the means of lightening some of the patient's difficulties. In the J case, the patient's widow, after his death, retained a similar feeling about the medical social worker, and came to her for counsel regarding personal health problems. The feeling of satisfaction with the service of the hospital, which is expressed in such contacts, diffuses in an atmosphere which reaches other patients, building their confidence, and making them more accessible to help. It also reaches the public and affects their attitude towards the institution and its services.

In another area the medical social worker is in a position to gain improved acceptance for the institution. We receive many enquiries from private persons and outside agencies as to certain veterans' eligibility for treatment or other benefits. It is not the function of medical social service to rule on eligibility, and appropriate authorities within the

department will be consulted, but the social worker serves as a useful channel for outside enquiries. We are thus placed in a position where we can deal with the feelings aroused by unfavourable rulings, or explain the reasons behind complicated legislation.

The situations in which we cannot give information often arouse considerable adverse feeling, but with suitable explanation persons can usually accept why we cannot give information without patient's consent.

In cases such as F, where the health problems of his wife included emotional factors, and where our decision to offer institutional care to the patient would have offered a socially acceptable basis of separation, the handling of our refusal is very much a matter of public relations. The frustrations and difficulties of the personal situation are so great that the parties to them wish to deny all contributory responsibility. It is easy for them to say that the Department of Veterans Affairs is entirely or largely responsible, so that the hate and rage which properly attach to the personal situation become attached to us. However, if persons in the situation of Mrs. F sense our sincere concern and sympathy for their dilemma, and our real regret that we cannot offer the desired solution, much less adverse feeling is attached to our refusal.

In assessing applications for institutional care, situations around which clusters so much feeling on the part of the

patient and his family, careful handling with understanding of and respect for the feelings engendered is particularly necessary. It is therefore especially useful, from the viewpoint of public relations, to have the social worker involved in the necessary recommendations.

5. Co-operative Work with Administration: while accepting administrative pressures, furthering social goals.

It is necessary in any setting that professional staff accept the propriety of the policy they are called upon to assist in furthering. As for social workers, the obligation recommended is:¹

(H) The social worker should carry out agency objectives and policies as prescribed to the best of his capacities and according to his code of ethics, working continually through agency channels to improve his services and personnel practices.

(I) If agency policy or procedure violates professional standards the social worker should

The social worker who cannot herself fully accept the rightness of rulings regarding institutional care, is unlikely to be able to help such a troubled person as Mrs. F to accept the fact that the patient, her husband, cannot be given continuing care, even though Mrs. F and her son feel that this is the only solution. The two social workers who worked initially with cases H and I strongly shared the conviction implicit in administrative policy, that it is important for every person

1. "Proposed Code of Ethics for CASW", *ibid* cit., p.2.

who can achieve any degree of independence outside hospital to be helped to do so. Social workers who could not accept this policy could not have carried to completing the lengthy case work process which was necessary to resolve these two difficult situations and get these two patients out of hospital.

The social worker is able to undertake such a vigorous, longterm kind of activity in selected cases, respecting the goals of administration, because she works in an atmosphere where the goals and opinions of the social worker are reciprocally respected. As an example we observe the M case, where the social worker's recommendation that the patient should not return home was approved, despite early minimal physical findings on the patient's degree of handicap.

6. The Social Worker's Broad Professional Responsibility to Others than the Patient

One of a social worker's most basic ways of working is in the necessity of seeing a wider circle of persons whose interests interrelate with those of the client. The focus on the individual client is usually set by the agency within which the social worker operates: for example, a child, if a Children's Aid Society; a wife or husband if a Family Court; a patient if a hospital. The social worker will be exercising her professional function probably in very close proportion as she focuses on others than the client, seeing the periphery equally clearly with the center of interest. The degree of this

diffusion is in contradistinction to the function of the lawyer or doctor, whose skill must be directed to secure the greatest direct benefit for his client or his patient.

The social worker's approach becomes noticeable in planning for the continuing care of patients: who will be hurt by this plan? who will gain by that plan? what may on cursory observation appear to be beneficial to the patient, may be seen to be potentially detrimental when one is in possession of a clearer social picture. The patient's greatest comfort may develop if he is assisted to accept some hurt in order that others may be hurt less. He may require such help because age, illness and resultant dependence impair his social judgment. This may be so, especially if he is taking into account the wishes of a wife similarly impaired, with whom relations have been uneasy for years. The patient is really seen as himself only when it can be seen how his decisions impinge on the lives of others. The United Nations definition of a social worker states this:¹ ". . . the well-trained social worker makes the nearest possible approach to full and constant awareness of the interplay of social, economic and psychological forces in the lives of the troubled people who come to him for assistance."

The development of this sense of responsibility in

1. Quoted in mimeographed material distributed by Dr. L.C. Marsh from "Training in Social Work, an International Survey", New York, United Nations, 1950.

action is seen in such situations as the K case and the M case, both of patients with children. In these there is the obligation of concern for what will be the impact of decisions around institutional care, as it affects the children. In one case the Children's Aid Society is active; in the other an effort is made to enlarge the wife's sensitivity to the effect of the situation on the children.

In all cases, in the nature of the problem under discussion, there is concern for the wife, directly as a person, as well as for the patient. In cases such as E and F we see the effect of fluctuations in the patient's health and mental state as they affect the health of the wife. The question then becomes, who has the primacy in the status of patient? The ideal answer is neither.

Even in a situation where the wife has good physical health and real maturity, as in A (a) and A (b), two cases of mentally disturbed patients, it is of help in the decisions which must be made for her to feel that the social worker is interested in her (the wife) as well as the patient. In one case it was necessary to bring the patient into care immediately and the wife required support in the decision. In the other case the wife took the patient home three times after successive admissions to hospital, in part because of this breadth of focus, which saw her difficulties and responsibilities with respect and concern, and which offered her continuing support in carrying

them, so that she did not feel isolated from the assistance the hospital could offer.

In case D the mother of the patient's wife, and the patient's sister-in-law as well, were involved in giving support to the wife, which in part made it possible for the patient to be at home for a while, before institutional care became necessary. Both were seen by the social worker. The wife's mother, in particular, was helped by the knowledge that someone stood by to assist in planning.

Chapter IV

How Can the Best Service Be Given?

At the outset of this study it was envisaged that it might be possible to set up an exhaustive schedule for analysis of case records. It was thought that large numbers of records might thus be analysed and so it might become possible to say what were the qualities of a good marriage; that is, if a good marriage were to be defined as one where a wife was willing and able to take home from hospital and give good care to a veteran who would otherwise require long term institutional care. To this end, "An approach to analysis of case records was set up" (see Appendix D).

It was discarded as a tool of the study, because while the data, though even more extensive than that offered, would still not yield the means to forecast what might be the answer of a particular patient and a particular wife to the question: Shall this man go home? Yet, to a degree, asking the right questions does help towards the right answers. It is therefore useful to look at the discarded schedule as an example of the kind of approach social workers, in or out of hospitals, can make to diagnosing the special quality of a particular marital problem.

The collection of the sort of data referred to in the analysis is difficult because it requires the assessment of many variables. There are many stages between the positive and negative pole of each variable. Where does the middle ground lie? Where does good or favourable begin, and bad end, as we look from one pole to the other? Social workers are accustomed to working with such data, and are expected to be able to do so, without coming to moral judgments, or condemning their clients because of the observed quality of the clients' feelings or actions. They are expected, despite the slippery quality of the data with which they work, to be able to come to some sort of "social diagnosis". In the setting of Shaughnessy Hospital and other veterans hospitals, they are expected to be competent to make a social recommendation as to the necessity of institutional care.

Formulation of Social Recommendations

Although other social workers, in hospitals and varied settings, are concerned with similar decisions, nothing has been found written directly to the point. Medical social workers must therefore be guided by what they have learned about the effect of illness on normal persons, and the professional approach to helping with the marital problems of those who are not ill. The normal pace of case work, as determined by the strengths of the clients concerned, may have to be modified by the exigencies of illness, and the pressures of other than

social aspects of treatment. The process of formulation of sound recommendations is one which deserves constant critical assessment and review, in order that it may be more soundly based in understanding of the patients who are in need of help.

How, then, does the social worker come to the social recommendation? In the first place, facts such as those martialled in the schedule in the Appendix need to be observed. The securing of these is not a separate process, but is part of the social treatment. The distorting, magnifying or diminishing microscope of the patient's way of feeling about facts is often more important than the facts themselves. Both Mr. E and Mr. F have wives who are in poor health. Mr. E cares for his wife, but having done so willingly in the past, he now does so with intermittent reluctance; Mr. F, seeing only his own needs, denies that his wife has any health problems at all. So we might run through other categories of fact referred to in the schedule, recognizing that what is significant is not the fact, but the feelings that cluster around it. We may run through economic problems, by some viewed with grief, by some with philosophical calm; through vagaries of behaviour of the spouse, by some viewed with rage and rejection, by some with tolerance and helpfulness, the conclusion is the same: the "fact" is not the important weight in the balance, the feeling "right or wrong", "reasonable or unreasonable", soundly or shakily based, can outweigh the fact; it is the feeling that counts.

The basic, irreplaceable skill of the social worker is that of estimating the quality of feelings attached to particular variations of possible solutions. The social worker must be aware of norms of feeling, just as the physician is aware of norms of pulse or reactions to drugs. Aware of norms, and evaluating the particular situation in their light, weighing the strengths and weaknesses of the parties, the social worker may decide that the feeling can be changed in tone. We have seen the successful results of such a case work effort based on such a prognosis, in A (b) and E. We see unsuccessful effort in M. In other situations, such as D, where the social worker recommended that the patient might return home to a beneficent atmosphere, or F where the social worker reported that it was useless to endeavour to restrain the patient from returning home, no effort was made to induce any change in feeling tone. Such decisions rest on the social prognosis that the feelings of the persons concerned are sound and mature, despite the disturbing intrusion of illness; or that they are so deeply rooted in immaturity that they seem unlikely to be susceptible to change in the time at our disposal.

What is being said is that the most important of the services of the social worker, the one on which rests the crux of the social recommendation, is that discussed in Chapter Three, "identifying the nature of the interpersonal relations." The camper sees clearly, if he is no tenderfoot, that from bone-dry pitchwood of cedar stump, quick-leaping flames will follow

the match; but from barnacle-covered, sea-sodden hemlock picked from the water's edge, scarcely even smoke can be expected. So the social worker, from the collation of such facts as listed in the schedule in the appendix, with the addition of the minutiae discernable to trained observation, and with skilled judgment of the areas of feeling involved, comes to a clear picture of probabilities, technically called the social diagnosis. From this material, and ideally with the fullest participation of the parties concerned, a social recommendation is made, on the question of home or institutional care.

A competence to understand and to work with the feelings of patients and their families comes best from a real knowledge of the history of past feelings in the person being helped. What were his earlier, if not his earliest relationships? What was his expectation of the relationship of marriage? To what degree has it been met or to what degree has it been unrewarded? All of the materials, or even the most desirable materials on which to base a judgment, may not be available. But from the facts, feelings and relationship discernable on brief contact, the social worker is usually able to make a helpful recommendation.

The existing records, which must be used in an effort to understand better the process by which the social worker comes to the social recommendation, do not necessarily afford us complete material for understanding of that process. This is as it should be: the records are not set up as an explanation

or justification of the social worker's detailed activities. The function of the records is to inform the doctor of the social worker's conclusions and recommendations as they affect the patient's better welfare. While it has been possible in this study, to break down the services given, directly and indirectly, there is seldom detailed material available on which to base an analysis of the methods by which the social worker approaches what has been described, earlier in this section, as "the crux of the social recommendation--identifying the nature of the interpersonal relations."

Relevance of the Work to the Purposes of a Hospital, to the Basic Needs of Patients

The function of hospitals is to assist their patients in making the fullest recovery from illness. Because it was increasingly realized that recovery depended not solely on physical factors, but on the whole adjustment of the whole person, medical social workers have become a standard part of the professional staff of modern hospitals.

In the hospital which forms the setting for this study, medical social workers are frequently called on to make social recommendations on the desirability of the institutional care of patients. This is because the social worker's ability to assemble the sort of factual information detailed in the schedule in the appendix, and the superimposed ability to assess the feelings of the parties concerned, do result in recommendations which are useful to medical staff.

In the hospital setting, the doctor takes responsibility for the marshalling of the resources appropriate to the differential treatment of each patient. In the assessing of the desirability of institutional care for patients, social factors weigh strongly for all patients, but especially so for married men. It is appropriate that the social worker, skilled in assessing relationships, be called on to assist the doctor in these situations.

Areas for Further Research and Recommendations

1. The "typical" cases chosen for presentation in this study have been used merely as a stepping-stone to the analysis of the kinds of services given by the social worker in the process of coming to a social recommendation. Starting from this tentative thinking on the kind of process used, and having set up for discussion a list of services, it would be of considerable interest to use these as a method of studying a large group of cases. Are many services being given which do not fit into the pattern which has been here set up? The writer's acquaintance with many other cases suggests that the pattern is¹ an adequate one, but it would be of interest to make an objective test, and to explore the possibility of analytical classification.

2. Breakdown of Medical Social Service Cases by Problems:

As earlier stated in Chapter One¹ Medical Social

1. See also Monthly Report form in Appendix B.

Service statistics do not require any categorization of the types of problems met in the cases being served, although they are broken down in other ways. Methods for such breakdown by problems, and a follow-up of the block of cases involving decisions on institutional care, would yield material for further interesting study.

Early in this study it had been planned to canvass other local social workers, in such settings as the Vancouver General and St. Paul's Hospitals; Medical Section, City Social Service; and the Social Welfare Branch; with a view to securing information as to the methods by which they proceed to the decision whether clients must be given nursing or boarding home care, at personal or public expense, or whether they may be cared for at home. In fact, some tentative conversations took place, along these lines. Apart from the particular interests of the clients concerned, these decisions involve much "public relations" and much expenditure from the public purse. It was of interest that the problem suggested for study was immediately apprehended as an entity by those to whom it was broached.

This problem is of general interest and concern to social workers. It is hoped that this study may stimulate further interest and study of the decisions as they are approached in other settings. Such exploration might include practice in other Department of Veterans Affairs Hospitals.

On review of this study, the writer does not see it as leading to sweeping recommendations for change. It has examined the basis of work of medical social workers in a hospital where social service meets with a wholesome measure of acceptance, so that methods of co-operation with medical staff are always in a fluid condition, with minor progressive changes shifting into improved practice. These are not always reflected in the individual records of cases, but in growing mutual respect of the varied professions serving the patient, so that relationships are easier, referrals more informal and service to patients better. Monthly reports reflect such changes. In a teaching hospital, with a substantial new group of internes moving into the hospital annually, changes develop throughout the year in the doctor's ability to use the social worker in the service of the patient.

It would not be out of place however, to reiterate some of the annual or more frequent cautions which are signposts on the road to better co-operation.

Social workers stress the need of early referrals, particularly in cases of married veterans who may require institutional care. An early social assessment will permit time for the gathering of facts, the observation of feelings and a sound recommendation. If the social worker is called in on the last day of the patient's stay; on the basis of "this man does not appear to need continuing care, but his wife will not accept

him at home"; or "this man's health is such that he could remain in care, but he demands to return home", the social recommendation can scarcely be as sound as if more time had been allowed for its formulation.

With respect to the records of the social service department, set down at whatever time in the hospitalization the social worker is called on for help, it is probable that continued departmental self-study and self-criticism could lead to their improvement. Without producing social service reports so detailed and unwieldy as to be an obstacle rather than a help to busy doctors, it should be possible to refine or winnow the data set down in support of the social diagnosis. Such data should not only indicate why the social worker sees the problems as she represents them in her area of responsibility, but should explain why the social treatment/^{is}undertaken and foreshadow the results. If the later the results are not as anticipated, the reasons for the variation from the prognosis might be considered and added if possible.

Such succinct procedures, concisely formulated, meet the special needs of recording in a medical setting, as primarily a report to the doctor. They would also further the purposes of further medical social work research, not only in the many aspects of the current study left barren and uncultivated, but in the many other problems which await our professional self-criticism.

Appendix AOffice Consolidation Regulations
under the Department of Veterans Affairs Act
Veterans Treatment Regulations, 1955Domiciliary Care, Section 29

Domiciliary care, and treatment when needed, while receiving such care, may, at the discretion of the Department having regard to his circumstances, be given to a veteran described in subsection (1) of section 12 or to a veteran or other person described in paragraph (a), (b), (c) or (d) of subsection (1) of section 13, subject to the following conditions:

- (a) that the veteran or other person is totally disabled;
- (b) that he shall, if the Department so directs, assign or pay to the Department for administration any or all of his income and resources and, in accordance with a scale set by the Department may, after providing for his dependents and a trust fund and comforts and clothing, apply towards the cost to the Department an amount not exceeding \$120 a month, provided that any pension paid to the Department in respect of dependents shall be used for the benefit of such dependents; and
- (c) that treatment required while receiving domiciliary care shall be given under this section; provided that, when treatment which may be given under section 5, 6 or 22 is required for a continuing period of three months or longer, it may be given under such section.

Sub-section (1) of Section 12: Subject to subsections (2) and (3), treatment may be given in Canada to a veteran within the meaning of the War Veterans Allowance Act, 1952, whose service and limited income and other circumstances entitle him to be a recipient under the Act, or to such veteran who would be a recipient if the pension under the Old Age Security Act received by him or his spouse or both were deducted from his income.

Paras. (a), (b), (c) and (d) of Sub-section (1) of Section 13.
Subject to subsection (2), treatment may be given to:

(a) a veteran who

- (i) is receiving pension for a disability related to the service which qualified him as a veteran, or had overseas service and was honourably discharged, or
- (ii) served in World War I, and in World War II on or before August 15, 1945, and was honourably discharged;

(b) a person who served

- (i) in World War I, or in World War II, in any of His Majesty's forces other than those of Canada, or in any of the forces of His Majesty's Allies or of the Powers associated with His Majesty, and who was resident or domiciled in Canada or Newfoundland on August 4, 1914 if service was in World War I, or on September 1, 1939, if service was in World War II, or was not so resident or domiciled but has resided in Canada or Newfoundland for a total period of at least twenty years and who, in any case, is receiving pension for a disability related to such service, or had overseas service and was honourably discharged, or
- (ii) in World War I in any of His Majesty's forces other than those of Canada and who was domiciled in Canada or Newfoundland when he became a member of such forces, or who served in World War I in any of His Majesty's forces other than those of Canada or in any of the forces of His Majesty's Allies or of the Powers associated with His Majesty and has resided in Canada for a total period of at least twenty years and, in any case, was a veteran who served in World War II on or before August 15, 1945, and was honourably discharged;

- (c) a person who was recruited in Newfoundland in any of the forces raised in Newfoundland by or on behalf of the United Kingdom for service in World War II and who is receiving pension for a disability related to such service, or who had overseas service and was honourably discharged;
- (d) a person who served as a member of a Canadian contingent in the zone of the military operations in South Africa in which the forces of the United Kingdom were engaged prior to June 1, 1902, or any former member of His Majesty's forces, other than Canadian forces, who served in that zone during the South African War and was domiciled in Canada or Newfoundland immediately prior to October 11, 1899, or was not so domiciled but has resided in Canada or Newfoundland for a total period of at least twenty years, if in any case he landed in South Africa prior to June 1, 1902;

NUMBER OF INTERVIEWS

NUMBER OF CASES											NUMBER OF INTERVIEWS										
IN-PATIENTS	General		A. & R.		D.N.D.		Research		Total		General		A. & R.		D.N.D.		Research		Total		Total
	In-act	act	In-act	act	In-act	act	In-act	act	In-act	act	In	Out	In	Out	In	Out	In	Out	In	Out	
Medecine	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Surgery	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Psychiatry	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
P.B.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Section 29	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
TOTALS																					
OUT-PATIENTS																					
C.P.C.	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
GENERAL OPD	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
FOLLOW-UP	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
STAFF	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
OTHER HOSPITALS	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
TOTALS																					
GRAND TOTALS																					
	Total Case Load										Other Interviews										
											Total Interviews										

SOURCE OF REFERRAL OF NEW & REOPENED CASES:

	<u>NEW</u>	<u>REOPENED</u>	<u>TOTAL</u>
(a) Doctor	_____	_____	_____
(b) Other Hospital Staff	_____	_____	_____
(c) Other DVA Hospitals or Districts	_____	_____	_____
(d) Other D.V.A. Personnel	_____	_____	_____
(e) Patient	_____	_____	_____
(f) Relatives	_____	_____	_____
(g) Community	_____	_____	_____
(h) Routine Coverage	_____	_____	_____

NUMBER OF CASES CARRIED FROM PREVIOUS MONTH _____

TOTAL CASE LOAD _____

CASES CLOSED

1. No further action needed. _____
2. By referral to (a) Other DVA hospital _____
(b) Welfare Services _____
(c) Community _____

TOTAL NUMBER OF CASES CLOSED _____

NUMBER OF CASES CARRIED FORWARD _____

Head of Medical Social Service Dept.

Q.M.V.H. #704/54

Appendix C

Incidence of Cases
Medical Social Service
Shaughnessy Hospital
January, February, March, 1956

	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Total</u>
1. No. of cases involving alternative of return home or institutional care.	21	8	5	34
2. No. of these cases where man has wife.	12	3	4	19
3. No. of these cases which were specifically referred re possible institutional care.	11	1	3	15
4. No. of these cases known to Assessment and Re-habilitation Unit.	6	1	4	11
5. Overall Departmental Case-load including these and all other cases.	197	190	173	560

Appendix DAn Approach to Analysis of Case Records

I. Questions to be Answered for Both Man and Wife

A. Physical Health:

1. Actual diagnosis and prognosis of physical disability.
2. Attitude to disability--is it or can it become realistic and constructive?
3. Long or recent onset of handicaps?
4. Nature of care required.
(for man--is disability pensionable?)

B. Mental Health:

Questions 1 to 4 as above.

II. Marital Data:A. The Marriage:

1. Former unions of wife; any children?
2. Former unions of man; any children?
3. Status of current union--legal, common-law, etc.
4. History of infidelity since current union.
5. Disparity of age.
6. Sexual adjustment.
7. Ethnic, cultural and religious backgrounds for both.

B. Attitudes to the Marriage:

1. Happy now? formerly happy? never happy?
2. Is there open quarreling? armed peace with tension? violence? bad language? excessive drinking?
3. Do the partners have common amusements? similar feelings about the house or home, sympathy for differing interests, common friends?
4. What was the man's ideal of a wife?
5. What was the woman's ideal of a husband?
5. Is there co-operation in the approach to children, whether adult or minor?
6. Dominance.

III. Economic:

1. Man's former employment, present source of income.
2. Wife's former employment, present source of income.
3. Special burdens on income: completing home ownership payments; high rental; debt; children; wife's health needs, etc.

IV. Attitudes of Others:

1. Attitude of children of any union: will they magnify or moderate any existing difficulties? Do they live near?
2. What are the attitudes of other relatives of both parties?
3. What are the attitudes of neighbours, and of persons in groups to which the parties are attached? What is the attitude of the community?

V. Resources:

What resources are available in the community to meet special needs? as housing, health needs, problems of children, part-time housekeeping, etc.

Appendix EBibliographyBooks

1. Breckinridge, Love, Little and Manning, Community Services for Older People--the Chicago Plan, a Wieboldt Foundation Project, Wilcox and Follett Co., Chicago, 1952.
2. Cabot, Richard, Social Service and the Art of Healing, Dodd, Mead, New York, 1928.
3. Calnan, Wilfred Michael, The Effectiveness of Family Case Work, Master of Social Work thesis, University of British Columbia, 1948.
4. Cannon, Ida, On the Social Frontier of Medicine, Harvard University Press, 1952.
5. Carscadden, Lillian, An Evaluation of the Client-Worker Relationship, Master of Social Work thesis, University of British Columbia, 1951.
6. Clohosey, Mary Edward Annie Bradley Elizabeth, Social Implications of Readmission of Veteran Patients to Shaughnessy Hospital, Department of Veterans Affairs, Master of Social Work thesis, University of British Columbia, 1954.
7. French, David G., An Approach to Measuring Results in Social Work, Chapter 4, "The Logic of Evaluative Research", Columbia University Press, 1952.
8. Goldstine, Dora, ed., Readings in the Theory and Practice of Medical Social Work, University of Chicago Press, Chicago, 1954.
9. Freud, Sigmund, Inhibitions Symptoms and Anxiety, The Hogarth Press Ltd. and the Institute of Psychoanalysis, London, 1948.
10. Hamilton, Gordon, Theory and Practice of Social Case Work, Second Edition, Revised, New York School of Social Work, Columbia University Press, 1951.
11. Hole, Christina, The English Housewife in the Seventeenth Century, Chapter V "On Sickness and in Health", Chatto and Windus, London, 1953.

12. Hollis, Florence, Women in Marital Conflict, Family Service Association of America, New York, 1949.
13. Jensen, Frode, M.D., and Weiskotten, H.G., M.D., and Thomas, Margaret A., M.A., Medical Care of the Discharged Hospital Patient, New York, the Commonwealth Fund, 1944.
14. The Family Health Maintenance Demonstration, Milbank Memorial Fund Proceedings of a Round Table at the 1953 Annual Conference, Milbank Memorial Fund, New York, 1954.
ed.,
15. Lewin, Kurt, Resolving Social Conflicts, selected papers on group dynamics, Part II 6, "The Background of Conflict in Marriage", Harper and Bros., New York, 1948.
16. McKenzie, McQuarrie Bruce, The Care of an Aging and Disabled Group in a Veterans Hospital, Master of Social Work thesis, University of British Columbia, 1950.
17. Pearse, Innes H., M.D., and Crocker, Lucy H., The Peckham Experiment; a Study in the Living Structure of Society, Allen and Unwin, London, 1943.
18. Richardson, Henry B., Patients Have Families, Commonwealth Fund, New York, 1945.
19. Robinson, George C., The Patient as a Person, Commonwealth Fund, New York, 1939.
20. Turner, Violet B., Chronic Illness, Digests of Selected References, Federal Security Agency, Public Health Service, United States Government Printing Office, Washington, 1951.
21. Woods, Walter S., Rehabilitation (a Combined Operation), published by authority of the Minister of Veterans Affairs, Ottawa, King's Printer, 1953.

Periodicals

22. Brangwin, Lorna A., "Marriage Counselling and the Viewpoint of the Caseworker", Social Casework, Family Service Association of America, Albany, New York, April, 1955.
23. Fahrni, Brock M., et al., "The Functioning of an Assessment and Rehabilitation Unit", Department of Veterans Affairs Treatment Services Bulletin, Ottawa, July-August, 1953.
24. Goldberg, E.M., "Some Developments in Professional Collaboration and Research in the U.S.A." based on a talk given to the Department of Psychological Medicine, Glasgow University, February, 1954, The British Journal of Psychiatric Social Work, Number 11, Spring, 1955.

25. Goldmann, Franz, M.D., "Home Care for the Needy and Medically Needy", Journal of the American Medical Association, March 29, 1952, Vol. 148.
26. Goodman, Anne, "Medical Social Work with the Aged in a Public Institution", Social Casework, Vol. XXXVI, No. 9, November, 1955.
27. Harvie, Henrietta A., "The Intake Interview in Marital Counselling", The Social Worker, Vol. 24, No. 3, February, 1956.
28. Konopka, Gisela, "Changing Definitions and Areas of Social Work Research", Social Work Journal, Vol. XXXVI, No. 2, April, 1955.
29. Rusk, Howard A., M.D., and Dacso, Michael M., M.D., "The Dynamic Approach to the Care of the Chronic", Hospitals, The Journal of the American Hospital Association, Vol. 29, January, 1955.
30. Sacks, Patricia, "Establishing the Diagnosis in Marital Problems", Journal of Social Casework, Vol. XXX, No. 5., May, 1949.
31. Scherz, Frances H., "Criteria for Defining Program and Emphasis in the Family Agency", Social Casework, Vol. XXXII, No. 3, March, 1951.
32. Shedlov, Abraham, et al., "Medical-Social Screening of Applicants to a Domiciliary Unit", Social Casework, January, 1954.
33. Simcox, Beatrice R., "Diagnostic Process in Marital Problems", Journal of Social Casework, Vol. XXVIII, No. 8, May, 1949.
34. Towle, Charlotte, "The Client's Rights and the Use of the Social Service Exchange", The Social Service Review, March, 1949.
35. Winfield, G.A., and Wellwood, L., "An Analysis of In-Patients, Department of Veterans Affairs, at Midnight, 31 March, 1954", Canadian Medical Services Journal, Vol. XI, No. 7, July-August, 1955.
36. Yahraes, Herbert, "Something Can be Done about Chronic Illness", Public Affairs Pamphlet, No. 176, New York, 1951.
37. Yommans, John B., M.D., "The Place of Medical Social Service in the Hospital", Hospitals, the Journal of the American Medical Association, Vol. 28, December, 1954.

Miscellaneous

38. Bain, T.D., M.D., Superintendent, Shaughnessy Hospital, "Geriatrics", mimeographed, undated.
39. Bartlett, Harriet M., "Some Aspects of Social Casework in a Medical Setting". The Committee on Functions, American Association of Medical Social Workers, Chicago, Illinois, 1942.
40. Burns, Faye B., "Operation--Social Research in a VA Hospital Setting Long Beach VA Hospital". Mimeographed, Social Service Unit, Long Beach Veterans Administration Hospital, February, 1953.
41. Guillot, Ellen Elizabeth, Ph.D., "Person and Situation: a Study of Medical Social Casework in a Cardiac Clinic", Community Studies Inc., publication 90A, Kansas City, Missouri, March, 1955.
42. Bulletin of the Joint Commission on Accreditation of Hospitals, "Standards for Hospital Accreditation, Chicago, Illinois, January 28, 1956.
43. Community Chest and Council of Greater Vancouver, Report of the Special Committee Studying the Inadequacies of the Hospital Facilities for the Chronically Ill in the Vancouver Area, mimeographed, undated.
44. Community Chest and Council of Greater Vancouver Social Planning Section, "A Suggested Plan for Hospital Home Care Services for the City of Vancouver", mimeographed, May, 31, 1955.
45. Commission on Chronic Illness, National Conference Care of the Long Term Patient, mimeographed, March, 1954.
46. "Concerning Families and Children", the Family and Child Welfare Division Canadian Welfare Council, Ottawa, review of "Casework in a Group Setting with Wives of Alcoholics", paper presented by Cork, R. Margaret, Vol. No. 5, December, 1955.
47. "Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel", World Health Organization Technical Report Series, No. 22, Geneva, December, 1950.
48. "Home Care--Origin, Organization and Present Status of the Extra-mural Program of Montefiore Hospital", Montefiore Hospital, New York City, 1949, Bluestone, E.M., M.D., Minna Field, et al.

49. Interim Report of Research Project No. 54-51, Shaughnessy Hospital, Department of Veterans Affairs, mimeographed, Vancouver, B.C., July-November, 1941.
50. Physicians' Pocket Reference to the International Statistical Classification of Diseases, Injuries and Causes of Death, Department of Trade and Commerce, Dominion Bureau of Statistics, Health and Welfare Division, King's Printer, 1950.
51. "Planning for the Chronically Ill", Joint Statement of recommendations by the American Hospital Association American Medical Association, American Public Health Association, and American Public Welfare Association, reprinted from American Journal of Public Health, vol. 37, No. 10, New York, October, 1947.
52. Ethics Committee, B.C. Mainland Branch Canadian Association of Social Workers "Proposed Code of Ethics for CASW", mimeographed, March 29, 1954.
53. "Solving the Problems of the Aged", unsigned, Saskatchewan News, Vol. 6, No. 21, July 24, 1951.
54. "The Veterans Charter", Acts of the Canadian Parliament to Assist Veterans, King's Printer, Ottawa, 1947.
55. "Weyburn, Saskatoon Homes for Aged Planned with Provincial Assistance", Saskatchewan News, Vol. 8, No. 22, August 18, 1953.
56. Workshop Report "Educational Aspects of Field Supervision", Section 1: The Content of Field Work. Annual Meeting January 24-27, 1951, Toronto, No. 2131, American Association of Schools of Social Work, New York 16, N.Y., mimeographed.