MEDICAL SOCIAL SERVICE IN SHAUGHNESSY HOSPITAL OUT-PATIENTS' CLINIC

A Comparative Study

by

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ABSTRACT

Department of Veterans' Affairs hospitals and Out-Patients Clinics represent part of a comprehensive program of health and welfare for the war veteran. Although the services offered by these hospitals are available to a few classes of civilians, by far the largest number of patients are former service men. This study attempts to make an appraisal of the scope and level of medical social service presently being offered to patients in attendance at Shaughnessy Hospital Out-Patients' Clinic.

In order to accomplish this all available records for two separate groups of patients were surveyed. One group was made up of the total (84) referrals from Out-Patients' Clinic to Medical Social Service during a particular six-month period. The other group comprised an approximately equal number of patients not so referred. Besides background information, the main classification used included (a) medical diagnoses, (b) use of other D.V.A. services, (c) Social problems. In each case an assessment was made of the needs and the adequacy of the services given.

The findings of the study indicate that at present less than one per cent of out-patients are being referred to the Social Service Department, although a far higher percentage than this could probably benefit from such a referral.

The Medical Social Service Department has been aware of the possibilities for some time, and the present study was undertaken in order to gain facts and clarification, and make possible realistic plans for the future development of such service. Recommendations include (a) suggestions for improvement of recording, (b) the assignment of a social worker to the Out-Patients' Clinic, his services to be available to both physicians and patients, and (c) suggestions for further research.

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CHAPTER 1

THE BACKGROUND OF SOCIAL SERVICES IN OUT-PATIENTS' DEPARTMENTS

A brief sketch of the development in out-patient facilities from their earlier beginnings might underline the concept that social considerations in addition to medical, often play an important part in determining the progress of the patient. Unfortunately, historical information obtainable for this purpose is slight. One article of interest is that on the development of out-patient services by Maurice P. Macparland[1] in which he maintains that the essentials comprising out-patient departments have their origin in remote antiquity. Babylonians had the custom of laying the sick, without a physician, in the public square, where passersby could give advice. The sacred rite of incubation which involved the sick person sleeping in the shade of the temple so that the Gods might inform him as to what treatment to follow, is traced through Egyptian, Grecian, and into Roman history. Roman development of hospital systems was connected with military strategy, and archae-

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1 Macparland, M.P. Out-patient Departments through the Ages, Nursing Mirror and Midwives Journal, May 22, 1952.

logical excavations indicate that out-patient departments were maintained therein. The earliest known Christian institution to serve as a hospital was that of St. Basil, founded in Cappadochia in 369 A.D., where services were rendered primarily to non-resident patients. Charlemagne attached to monasteries and infirmaries special persons whose duty it was to insure the proper administration of funds for the destitute non-resident sick. From this practice the word "almoner" is said to have been derived, and the function of the almoner has persisted into modern times, although with considerable modification of meaning.

With the decline of monastic medicine in England, and the transition in the eighteenth century from privately endowed and maintained hospitals to voluntary public hospitals supported by the charitably inclined, dispensaries set up therein provided out-patient care for those in need of such attention. The need to prevent abuse of these free medical services led to an important development, the beginning of Medical Social Service in Out-patients' Departments. In 1895 the London Charity Organization Society under the leadership of Charles Loch, appointed, at the Royal Free Hospital of London, the first lady almoner with functions redefined to include, not only careful financial investigations, but also enquiries into the social condition of the patients, and, where needed, referrals to appropriate

charitable agencies.[1] It was not long before this new service became firmly built into the British hospital organization. Charles Loch's special concern over the professional practices of the almoner resulted in what was later known as the Institute of Hospital Almoners, which undertook the selection and training of suitable persons. From the beginning there has been a close professional tie between the English trained almoners and the American Medical Social Workers.

In America, as in Britain, at the beginning of the Twentieth Century hospitals still provided services primarily to the poor. Out-patient departments had become firmly established but among the physicians there was concern over the failure of many patients to return for treatment, especially where this failure endangered public health. Notable pioneers in investigating and attempting to alleviate problems plaguing many of these patients who were lost, were the women doctors of the period. With the growth of social work as a professional discipline it was recognized that a large portion of the social service performed by the medical profession could well be entrusted to professional workers in this field. The first organized hospital social service was inaugurated by Dr. Richard Cabot in 1905 at the Massachusetts

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1 Cannon, I.M., On the Social Frontiers of Medicine, Cambridge, Harvard University Press, 1952, p. 64.

General Hospital.[1] The social worker's functions were at first confined to the Out-Patients' Department, however doctors and other hospital personnel became increasingly aware of the value of medical social workers in dealing with social and emotional needs of patients. By 1923 there were approximately four hundred hospital social service departments in the United States,[2] and today they are an accepted part of most large hospitals and of many smaller ones in both Canada and the United States.

Distinguishing Contributions of the Medical Social Worker

Dr. Malcolm T. MacEachern when writing of the specialized services found within the structure of a modern Out-Patients' Department states "the Social Worker is the general practitioner among a group of specialists".[3] A medical social worker attempts to interpret and adjust in terms of each other, a patient's medical liabilities and his social assets. It is now realized that illness signifies more than a diseased organism in that it involves also the organism's reaction to the disease and to the total environ-

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1 loc cit.

2 Cannon, I.M. Social Work in Hospitals, New York, Russell Sage Foundation, 1930, p. 8.

3 MacEachern, Malcolm T., Hospital Organization and Management, Chicago, Physicians Record Company, 1947, p. 567.

ment. Ill health means different things to different people, the meaning depending on at least three factors.

(a) The nature and degree of the physical illness.

(b) The individual's personality structure.

(c) The environmental situation.

If we accept these dynamics of ill health, it then becomes evident that the professional services of more than one discipline are necessary in the successful treatment of disease.

The medical social worker has been able to establish his value on the treatment team of doctors, nurses, psychologists and sundry technicians largely because of the different approach which his position and professional training makes possible. This has been summarized by Minna Fields in her article on the Role of a Social Worker in a Modern Hospital.

> The Social Worker's approach differs from that of the other members of the professional team, the patient's relatives or his friends. While the very nature of their functions imposes upon the other members of the professional team the obligation to exercise authority, and while the attitude of relatives and friends can hardly escape being coloured by their own emotional reactions, the social worker can remain free from the need to prescribe any particular line of action and from emotional entanglement. Rather, the social worker's approach is governed by an attempt to see the problem as the patient sees it, to allow the patient to move at his own pace and to make his own decisions towards a goal that he has helped to set for himself. Such an approach can be carried out only when it is rooted in a genuine appreciation of the intrinsic worth and dignity of the human being regardless of the state of illness or of the degree

> of incapacity it produces. For the patient, such an approach assumes particular significance in the light of an illness that tends to undermine his feelings of usefulness and status. Experience has demonstrated that this approach, removing as it does the threat of control, compulsion or censure, tends to minimize the patient's feelings of helplessness arising from the illness. It enables him to view his problem more realistically and to feel free to ask for help, and that he will not be forced into a line of action contrary to his own needs and desires.[1]

This statement is, of course, generic and could apply to a caseworker in any setting. What, then, is the distinguishing feature of the medical social worker? What is it that enables him to serve on a treatment team and perform a particular function? In a hospital setting the medical social aspects of the situation become the focus of attention. A medical social problem exists when either the medical aspects in a case situation impinge on the social, or the social aspects impinge on the medical. Grace White in her analysis of the distinguishing features of medical social work states:

> The medical social worker's focus is on the interaction of the two more than on the totality of the medical or the social. This focus of the two is consonant with the purpose of the medical care program which establishes the boundaries of the medical social worker's function. In other words, social treatment is directed towards those social and emotional conditions which bear upon the medical condition or treatment of the patient. This calls for

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1 Fields, Mina, Role of the Social Worker in a Modern Hospital, Social Casework, Vol. 34, No. 9, Nov. 1953, p. 399.

> more technical knowledge than is often achieved by persons outside medical practice.[1]

Veterans' Hospitals

The war veteran[2] has long been recognized as having special problems and entitlements not commonly shared by his fellows. This recognition has traditionally taken the form of special legislation setting forth the rights and benefits to which it is considered military service has given entitlement. Previous to World War 1, the Canadian Government had confined itself to legislation covering pensions for disabilities directly attributable to war service, and to land grant legislation. However, in 1915 this recognition of need was expanded when a military hospitals commission was formed. Its duty was to provide special hospital accomodation which would be oriented towards the needs of the sick and disabled soldiers returning from Europe. A number of such hospitals were established across Canada,[3]

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1 White, Grace, "Distinguishing Characteristics of Medical Social Work" Readings in the Theory and Practice of Medical Social Work, Chicago, The University Press, 1954, p. 119

2 A veteran, as defined in the Statues of Canada, 1945, is

(1) a person who has been on active service in the Canadian forces or in receipt of active service rates of pay from such forces during the war...

(11) a person domiciled in Canada who served in the forces of (His) Majesty other than the Canadian forces and who was so domiciled at the time he joined any such forces for the purpose of war, and who has been discharged from such service.

3 For list of Veterans Hospitals see Appendix A.

both by this Commission and by its successor, the Department of Soldiers Civil Re-establishment. The work was expanded by the Department of Pensions and National Health which replaced the Department of Soldiers Civil Re-establishment and is being still further expanded by the present Department of Veterans Affairs.

Shaughnessy Hospital - The Introduction of Medical Social Service

One of these hospitals was that established to take care of the veterans in "VA" district.[1] Shaughnessy Hospital had its beginning in an eight ward, 250 bed establishment situated on the grounds of Vancouver General Hospital and operating as an annex to that institution. By 1919, this arrangement had become inadequate, and a large private school was acquired near the site of the present hospital. The building so obtained, together with several small huts surrounding it, served the needs of the veteran in British Columbia for many years. In 1941, the present hospital structure replaced it,[2] and together with the Jean Matheson Memorial Pavilion and the group of buildings formerly occupied

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1 "VA" district comprises British Columbia.

2 For a more complete and detailed history of Shaughnessy Hospital see, The Story of Shaughnessy Hospital 1916-1947, an unpublished account by E.M.K. Panton, R.N. former matron.

by the Vancouver Military Hospital, forms the present D.V.A. Hospital of some 1100 beds.[1]

Early in the history of special facilities for Canadian veterans it seems to have been recognized that there was a need for social services, although social work as a profession was not recognized. At that time it was felt that medical social work was a specialized branch of nursing activity, and the social service nurse, as she was called, was thought of as an attendant upon the sick, an educator and a reformer.[2] In 1919, two nursing sisters who had taken special training in psychiatric social work at the University of Toronto were assigned to Shaughnessy Hospital. Their duties involved follow-up of out-patients and of tubercular and mental patients on leave from institutions, as well as much work of an investigative nature. No case-work services, as that term is now understood, were offered save perhaps as incidental to other types of activity. These ladies did yeoman service for many years, and often saw needs which they were powerless to meet, as they were not allowed much latitude by regulations. As time went on, the number of those needing service increased to the point where much of the work had to be taken over by departmental investigators and outside Social Agencies. The activities of the social

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1 This includes all hospital beds except those in Geo. Derby H. & O. Centre, an additional 215. See Appendix A.

2 Canada, Department of Soldiers Civil Re-establishment Annual Report, (1920) Ottawa, King's Printer 1921.

service nurses had, of necessity, to be confined to relief giving and acting as contact persons with outside agencies.[1] Times were changing, however, and it was being recognized that the professional social worker had something to offer. In 1945 social work was recognized as a profession by the D.V.A. and two fully qualified social workers were posted to the staff of the hospital. Further recognition came in 1947 when the Medical Social Service Department was organized as a separate department and recognized as part of the treatment service.[2]

Medical Social Service Today

At present the Medical Social Service Department staff is made up of a Department Head and six professional caseworkers with three stenographers. The Head of the Department is directly responsible to the Chief of Medicine in clinical matters, to the Senior Treatment Medical Officer administratively, and to the Director of Medical Social Services professionally. Case workers are allocated to specific Services, such as psychiatry, Assessments and Rehabilitation Unit, the Jean Matheson Memorial Pavilion, as well as to groups of wards in the hospital itself. They are responsible for the giving of casework service to the patients on the wards or Service to which they are assigned,

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1 While this was being written, Miss E.E.Lumsden, the only survivor of the social service nurses posted to Shaughnessy Hospital in 1919, died in this hospital.

2 For a statement of the functions of Medical Social Service, in D.V.A. Hospitals see Appendix "C".

and in consultation with the Head of Medical Social Service, for initiating any new or improved methods of service therein. The social worker is a member of a treatment team of which the patient's physician is the acknowledged head. This team is composed of doctor, social worker, nurses, physiotherapists, and such other members of the treatment services as may be active in the case.

Since one of the aims of Medical Social Service is the continual improvement of service, the staff undertakes a regular study of the program as a whole and of any part of it which may seem to require special consideration. It has been recognized for some time that the service offered to the Out-Patients' Clinic could perhaps be re-organized and augmented. It was also recognized that it would be necessary to make a careful study of the particular problems of the clinic before concrete suggestions could be advanced for the accomplishment thereof.

Focus of the Present Study

The purpose of the present study is to attempt to provide answers to the following questions:-

(a) What types of patients were referred to Medical Social Service from Out-Patients' Clinic; why were they referred and what was done?

(b) Were there a significant number of patients not so referred who might have derived benefit from such a referral?

Chapter Two includes a discussion of Out-Patients' Department, and of the Out-Patients' Clinic at Shaughnessy Hospital in particular. Chapter Three attempts to provide an answer to the first question by means of an analysis of the 84 cases which were referred to Medical Social Service from Out-Patients' Clinic. In Chapter Four an attempt will be made to provide an answer to the second question by reviewing one hundred cases chosen from Out-Patients' Clinic general intake during the same period of time as that which produced the previously mentioned 84 referrals. The final chapter of this study will be devoted to a summary of the services now being rendered by Medical Social Service to the Out-Patients' Clinic and to the suggestion of some improvements in the present methods of referral and of servicing the Out-Patients' Clinic at the social work level.

CHAPTER 2

THE WORK OF AN OUT-PATIENTS' DEPARTMENT

The Out-Patient Department of any modern general hospital is essentially an extension of medical services into the community rather than a place where the sick and injured poor receive attention. John K. McGibony in his book on hospital administration defines its function as:

> The provision of curative and preventive services with emphasis on the promotion of health through diagnosis, treatment, health education, research and after-care of patients discharged from hospital.[1]

Such services are generally free to those who can qualify and eligibility is often determined by some form of means test, (in Vancouver General Hospital, for example, income levels are fixed, ranging from $125.00 per month for a single person to $275.00 for a family of 7). The range of service offered is often wide and may include all of the medical and surgical specialties as well as general medicine, drugs, dentistry, prenatal and postnatal care and child care.

Social case work services are now widely offered through many Out-Patients' Departments and may be on an intensive and/or extensive scale. At one time medical social

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1 McGibony, John R., Principles of Hospital Administration, New York, G.P. Putnams, p. 502

service workers undertook to determine eligibility as one of their main tasks, but today this is often carried out by a clerical staff, leaving medical social workers to undertake the professional services to patients.

Briefly, the functions of an Out-Patients' Department may be summarized as follows:-

(a) To provide free medical care of all types to those of limited means.

(b) To make possible the maximum use of staff bed facilities by having all possible preliminary investigations done in the Out-Patients' Clinics prior to admission to the wards. This means that hospitalization can be delayed until actually necessary.

(c) To offer staff patients such post discharge care as may be deemed necessary by the staff member under whose service they were admitted.

(d) To provide a teaching experience for medical internes, social work students, nurses and dieticians.

The majority of patients in any Out-Patients' Department are referred to the department from various sources - doctors, nurses, social agencies, families and friends, and other interested persons. The provision of medical social services, both in number and extent, will vary in each hospital.

The Out-Patients' Clinic, Shaughnessy Hospital

In common with most hospitals, Shaughnessy seems to have had an Out-Patients' Clinic from its inception. At first, however, it was very small and its early history is rather difficult to ascertain in any detail. Most of what is herein set down derives from the personal communications of some of those closely connected with its early beginnings. From these accounts it would seem that, prior to 1919, such out-patient facilities as were required were provided by Vancouver General Hospital. When the Department of Soldiers Civil Re-establishment opened administrative offices in the heart of the city, a dispensary for the treatment of out-patients was included. Veterans seeking this type of treatment were by no means numerous and their care accounted for only a small portion of the physician's time. When the administrative offices were moved to Shaughnessy Hospital, the Out-Patients' Clinic moved also. At first the clinic was housed in an old army hut, but later it was moved into the west wing of the hospital. There the clinic remained for many years and, although the number of those seeking treatment was increasing, the clinic was still comparatively small and unimportant. Many of the patients treated there were hospital patients who had been discharged and referred for treatment on an out-patient level. The two factors which probably contributed most to the expansion of the Out-

Patients' Clinic were the depression and the introduction of the War Veteran's Allowance.[1] When the administrative offices were again moved downtown, this time to a new building at the corner of Bute and Haro Streets, a major portion of the Out-Patients' Clinic went with them. However, certain types of Out-Patients' treatment remained in the hospital. The reason given for the Out-Patients' Clinic being so closely tied to administration was that it was administration's job to decide as to whether or not treatment entitlement existed and it was also felt that having the out-patients' facilities under the same roof as the administrative offices was a convenience to the patient. It was gradually realized, however, that an Out-Patients' Clinic is an integral part of a hospital, and belongs with it. Consequently, the Out-Patients' Clinic was finally moved back to Shaughnessy Hospital and housed in the North Wing.

Eligibility for treatment in Shaughnessy Out-Patients' Clinic is the same as that necessary for admission to hospital and is carefully outlined in the various sections of the Veterans Treatment Regulations. The financial situation of the applicant has, in most cases, little significance and it is not always necessary that the applicant be a veteran. These treatment regulations outline some twenty-nine

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1 For a full explanation of war veterans' allowances and the pertinent legislation see Woods, Walter S, Rehabilitation, a Combined Operation, Ottawa, Queen's Printer, 1953.

different categories of persons who are entitled to be treated in a D.V.A. hospital. To be eligible, an applicant must have entitlement under one of them. Thus a person requiring treatment for a disability for which he receives a pension is entitled to treatment under Section 5, while a man in receipt of War Veterans' Allowance is entitled to medical treatment under Section 12.[1]

The present Out-patients' Clinic at Shaughnessy operates under its own medical director, and has its own staff of clerks. The various clinics of which it is composed are staffed largely by specialists employed on a part time basis, and the services offered cover most of the medical and surgical specialties. The specialists who act as consultants in general medicine work with teams of internes from the wards. These teams are changed every two months. The one nurse on the staff of the Out-Patients' Clinic attends the physicians when required to and gives injections and such other minor treatments as may be ordered. Few, if any, patients are now referred there upon discharge from hospital. Shaughnessy Out-Patients' Clinic differs from that of the Vancouver General Hospital in that there are no social workers attached directly to it. One of the principal reasons for this is probably the fact that eligibility for the service rests on a different basis from that

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1 For full details regarding treatment categories see Appendix "B".

obtaining at the Vancouver General Hospital, and is largely an administrative matter. If the examining physician considers that the services of a social worker might be of benefit to his patient, the patient is referred to the hospital Medical Social Service Department.[1](Hereafter referred to in this study as M.S.S.).

Referrals to Out-Patients' Clinic

Referral of patients to the Out-Patients' Clinic, (hereinafter referred to in this study as O.P.C.) may be made by any one who knows or suspects that the patient can qualify for treatment under one or the other of the numerous categories of entitlement.[2] By far the most common source of referral is the patient himself. As a rule, he knows that he has a treatment right or hopes to establish the fact that he has a just claim thereto. Some of the other more common sources of referral are physicians, friends, relatives, community organizations, and government bodies.

Referrals to Medical Social Service

Out-patients find their way to M.S.S. in almost as many different ways as they find their way to O.P.C. It

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1 Veterans' Welfare Services are also available to patients attending hospital. The Welfare Officers' primary responsibility being to make veterans aware of their rights and privileges under the Veterans' Charter. For veterans not under treatment there is also a District Social Service as well as welfare services in D.V.A. District Office and in the field.

2 See Appendix "B".

is not necessary for a patient to be referred from O.P.C. to M.S.S. in order for him to be given service. The most common source of referral is the examining physician; other common sources being friends, relatives, other D.V.A. personnel, community organizations, and, of course, the patient himself.

It is unfortunate (from the research worker's point of view) that Shaughnessy O.P.C. does not maintain its overall statistics in terms of individuals reporting to the general O.P.C., but rather in terms of visits, or treatment given. This means that in the general statistical returns it is possible for one individual to be counted several times. For example, in one day a patient might be seen in general medicine, the heart clinic and the arthritis clinic. He would be counted three times in the general returns. This makes an accurate count of individuals difficult if not impossible. During the six month period April 1st to September 30th, 1954, the six month period with which this study will deal, O.P.C. records show that 13,902 treatments were given. Senior members of the O.P.C. administrative staff, upon being consulted, gave as their opinion, based on years of experience, that the number of actual individuals involved would be about 60% of this figure. This means that about 8,341 persons actually reported to O.P.C. Of these 8,341 patients, a total of 84, or approximately 1% were referred

to M.S.S. by the examining physician. During the same period, a total of 86 patients, not necessarily in attendance at O.P.C. at the time, were referred from other sources. This group is not being taken into account in the present study as it is not pertinent. During the same period of time 596 patients were referred to M.S.S. from all sources, in-patient as well as out-patient. The 84 patients referred from O.P.C. represent, therefore, 14.14% of the total referrals to M.S.S. from all sources.

CHAPTER 3

AN ANALYSIS OF SHAUGHNESSY OUT-PATIENT CLINIC REFERRALS TO MEDICAL SOCIAL SERVICES BETWEEN APRIL 1, AND SEPTEMBER 30, 1954

In this study of the eighty-four cases referred to in the previous chapter (total referred to Medical Social Service from Out-Patient Clinic during the six month period mentioned) all the file records available were examined, the factual material tabulated and a final analysis made in three sections:

(a) How referrals are made.

(b) What records are actually used to obtain the necessary data.

(c) An analysis of the eighty-four cases in terms of the persons referred (age, marital status, treatment category, work record; and underlying and presenting medical problem), details of the problems for which they were referred to Medical Social Service, and what treatment plan was evolved. The final assessment of services rendered is dealt with in the fifth chapter.

How Referrals Are Made

It has already been mentioned in Chapter 2 that of the veterans seen in general intake at Shaughnessy

Hospital O.P.C. during the period April 1, to September 30, 1954, a total of eighty-four were referred to M.S.S. for further help.

The names of these cases were taken from a register in M.S.S., in which is kept a daily record of all new and re-opened cases and their source of referral. The register indicates the fact that the case was referred from O.P.C. but does not give the names of the O.P.C. doctors. Exceptions to this are those cases referred by O.P.C. to Psychiatric Services.

Because of a procedure instituted by the Chief of Service for Psychiatry, all cases referred to Neuro-Psychiatric Service are routinely directed by O.P.C. clerical staff to M.S.S. for social histories and for arrangement of appointments with a specific psychiatrist.[1] It is possible that the O.P.C. doctor may not be aware of this procedure and perhaps may not realize that his patient should first be seen by M.S.S. before he is given psychiatric assistance. It is also possible that a patient may be directed to M.S.S. having little or no idea as to why he is to go there. A note, together with the patient's district or hospital file is sent to the intake worker at the time of referral.

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1 Where the mental disturbance is considered severe enough to warrent an immediate appointment with the psychiatrist, this routine is not followed, in which case M.S.S. may or may not participate as a member of the treatment team at a later date.

The social worker at this time has an opportunity to interpret the reasons for referral and provide assurance of continued interest in the patients' welfare. Referral through M.S.S. also serves as a screening process as the social worker decides how soon the patient should be seen by the psychiatrist and whether additional information should be obtained from friends or relatives before the visit to the psychiatrist. In a few instances, after a social history has been taken and following a discussion between the worker and the referring doctor or psychiatrist it may be decided that the patient does not require a psychiatric interview.

Amongst the group of veterans referred by the O.P.C. doctor directly to M.S.S. are those considered by the examining physician to have social problems, or those who themselves have asked for specific services. There is often no way to determine who was responsible for the referral to M.S.S. as the doctor's comments seldom indicate whether the patient requested the services of a social worker. The examining physician is aware of the M.S.S. role from his contact with social workers on his hospital ward, as it is not practical for the social worker to be both attached to the ward and on intake at the time the ward doctor is in O.P.C., this doctor may not know the worker who deals with the referrals. The veteran, on referral, is usually escorted from O.P.C. to M.S.S. by a clerical staff member who also carries whatever personal file was available at the time of

examination. To this file is attached a doctor's brief note stating the reason for referral. Standardized referral forms are not used.

Details of Records Used in Obtaining Data

Records from three different types of files were used in obtaining pertinent data, the District Office file contains a complete documentary record of a veteran's contact with D.V.A. from the time of discharge. It includes copies of Case History sheets and Consultant's reports from D.V.A. hospitals. Copies of all M.S.S. records are also in this file except in cases where information obtained was of a certain confidential nature when a brief summary is placed on the district office and the hospital files. The Hospital file comprises a complete record of the veteran's medical documents and charts pertaining to hospitalization, plus copies of M.S.S. records. The M.S.S. file contains recordings of social workers' contacts with the veteran as either an in or an out-patient, plus all relevent reports and other necessary material from other departments.

Study of Eighty-Four Cases Referred from Out-Patients' Clinic

The eighty-four cases referred from O.P.C. to M.S.S. between April 1, 1954 and September 30, 1954, were studied in order to ascertain:

(a) Who was referred,

(b) What the problems were,

(c) What the treatment plan was.

The first step in this analysis was the examination of the files on the eighty-four veterans and the tabulation of such factual information as could be obtained. In some files the required information was inadequate. In sixteen instances the veterans' District Files had been transferred to other regional offices and were not available at the time of study, therefore the detailed case analysis was confined to the remaining sixty-eight cases. Each case was assigned a numerical code number in random order. Details tabulated relate to age, marital status, treatment category, underlying medical problems, presenting medical problem, reason for referral, presenting social problem, treatment plan, previous contact with months active with M.S.S. work record and reason for closure. The complete table is included in Appendix D and details are given in Appendix E of the abbrevations used.

Who Was Referred

This section contains an analysis and detailed discussion of the social factors of the sixty-eight cases tabulated in appendix D under the categories of age, sex, marital status, employment, treatment category, underlying and presenting medical problem.

Age: The age of the sixty-eight veterans under study ranged from nineteen to eighty-four years. Thirty-eight of these were under fifty years of age and thirty were over fifty. This grouping roughly separates the World War I and World War II veterans.

Sex: Only three of the group studied were female. It should be noted that this is considerably higher than the ratio of females to males obtaining in the general O.P.C. intake.[1]

Marital Status: At the time of referral from O.P.C. forty were married, fifteen were single, two were living in Common-Law relationships, four were separated, two had deserted their wives, and five were widowed.

Work Record: In order to further arrive at those who were referred to M.S.S. from O.P.C. because of employment difficulties, it was necessary to limit this classification to the veteran's employment situation at the time of referral: some of the records failed to provide sufficient data for full and reliable work histories. Such data as was obtained was tabulated in terms of full-time, part-time, spasmodic, and no employment. Employment was classified as full-time wherever records showed a consistent work history, even if seasonal (i.e. in such occupations as fishing and logging).

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1 Senior clerical staff gave as their opinion that percentage of females in the general O.P.C. intake would probably not be higher than 1/2% of the total.

Twenty veterans belonged to this classification. Part-time employment included all those on regular part-time weekly or daily employment. Of these there were two. A spasmodic work record was defined as one which showed an irregular pattern of employment and frequent job changes. Nineteen of the sixty-eight veterans worked spasmodically. Those shown as having no employment were veterans who showed a period of unemployment immediately before admission without prospects for immediate rehabilitation to jobs.

Treatment Categories: In order to be eligible for treatment at Shaughnessy Hospital as either an in-patient or an out-patient, a veteran must qualify under one of the treatment sections as outlined in the Veterans Treatment Regulations.[1] At the time of referral to M.S.S., nine of the sixty-eight veterans under review qualified by reason of a service disability (section 5), two received treatment for non pensionable disabilities which occurred within one year of discharge (section 10), five veterans qualified for treatment of a disability which had commenced within one year of discharge from the Regular Force (section 11), twenty-two were eligible as they were in receipt of War Veteran's allowance and three who were treated had no other entitlement but qualified because of inadequate income and resources (section 13). Four cases were considered likely to benefit by psychiatric treatment and were qualified under section 14. One veteran was treated for venereal disease

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1 See discussion in Chapter 4, pages 42 and 43 and details in Appendix B.

incurred while in the services (section 15). There was one case of a veterans' hospital employee, who contracted a communicable disease from a patient (section 17). Two who were members of the Royal Canadian Mounted Police qualified under section 19. The remaining nineteen veterans established eligibility under section 28 as they were examined at the request of the Department of Veteran's Affairs, Prosthetec Services, War Veteran's Allowance Board or for completion of examination for purposes of the Canadian Pensions Commission.

Underlying Medical Problems: Since the tabulation of the exact medical diagnosis would have been too elaborate and also unnecessary for purposes of this study, the various diagnoses were grouped under broad headings, i.e., psychiatric, referring to medically diagnosed disorders such as schizophrenia; orthopaedic, referring to such disorders as dislocations, fractures and bone grafting; neoplasms, taking in cancers and all forms of new growths; genito-urinary, referring to such ailments as prostatitis and kidney disorders; Cardio-Vascular, which included heart diseases and circulatory difficulties; gastro-intestinal, taking in ulcers and gastritis, and neurological, taking in organic disorders of the nervous system. Twenty-three veterans showed medically diagnosed psychiatric problems, eight had gastro-intestinal complaints, seven had cardio-vascular difficulties, five had gun shot wounds, four had neoplasms, four had orthopaedic disorders, three had

arthritic ailments, three had genito-urinary problems and three had neurological difficulties. The remaining eight had underlying medical problems which fell into a variety of other classifications in which there were no more than two cases in any one classification.

Presenting medical problems: A further tabulation was made of additional medical problems said to be present at the time of referral to M.S.S. where these differed from the underlying diagnosis recorded on the file. Of the cases of this type nineteen were medically diagnosed as having psychiatric problems, four had disabilities of an orthopaedic nature and seven veterans presented ailments of varied classifications. In thirty-five instances, no indication of a medical problem other than the underlying one was given by the examining O.P.C. doctor.

What Were the Social Problems

Under this heading two aspects have to be studied, the doctor's reasons for referral to M.S.S. and the veteran's problems as seen from the social diagnosis made in M.S.S.

O.P.C. Doctors' Reasons for Referral to M.S.S. It was found that the doctor's reasons for referral of veterans could be grouped into six general classifications, some of which are self-explanatory: i.e. for assistance with finances, accommodations, employment, and medical services for wives. A fifth group of referrals were those made for

psychiatric histories in cases where psychiatric examination was recommended. The background information obtained by social workers is of value to psychiatrists in making a diagnosis and following through with treatment. A sixth group referred were those with domestic problems. These problems related primarily to marital difficulties.

Problems as seen from the social diagnosis by M.S.S.

The problems as later seen from the social diagnosis made in M.S.S., fall into five classifications which are generally quite similar to the reasons for referral, i.e. problems relating to finances, accommodations, employment, domestic difficulties and veterans' social inadequacies. Problems classified as "financial" included those veterans who had a regular but low income and might have been able to cope with their own difficulties had further financial aid been available at the time. This category does not include those whose financial problems arose as a direct result of unemployment for veterans who were employable. The group with accommodation problems is restricted to situations in which social factors, such as age and illness created special needs. It does not include those with housing and rental problems which were due to ordinary financial difficulties. Employment, as the presenting social problem, was limited to employable veterans who, due to labour market conditions were unable to locate suitable employment. It should be noted that D.V.A. has two representatives placement officers with

the National Employment Service in Vancouver who will see veterans, either at the hospital on regularly scheduled visits, or at the National Employment Service office. The group seen as having domestic problems consisted, for the most part, of those showing various marital disharmonies. This classification however, does not include those situations where family or marital tensions arose as the result of veterans' personality disorders previously diagnosed as such by psychiatrists.

The classification "socially inadequate"[1] has been formulated to cover those veterans who were unable to cope with everyday pressures and required assistance with personal problems, (which had often been aggravated by these pressures). Usually this assistance was in terms of psychiatric treatment.

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1 The use of the term "socially inadequate" was decided upon, after discussion with M.S.S., as being the most apt for these cases and it is in this sense of inability to face everyday pressures of life rather than in terms of a medical diagnosis that the classification is used both here and in later discussions.

CHART 1 SHOWING REASONS FOR REFERRAL

Doctor's Reason for Referral	No. of Cases	Division of cases according to Social Diagnosis in Medical Social Service						
		Socially inadequate	Financial	Accomodation	Domestic	Employment	Not Known	Interview Refused
Psychiatry	42	37	2			1	1	1
Financial	12	2	7	1	1	1		
Accommodation	4		2	2				
Domestic	3				3			
Employment	3	2				1		
Treatment for Wives	4		4					
Total	68	41	15	3	4	3	1	1

In relating the social problems as diagnosed by social workers to the doctors' reasons for referral[1] it is seen that of the twelve referred for financial reasons, five were considered to have other primary social problems. These were as follows: two were socially inadequate, one had accommodation, one domestic, and one employment difficulties. Two of the four referred for help with accommodation had, basically financial problems. Of the three veterans referred to M.S.S. for employment, two appeared to be socially inadequate whereas one, due to labour market conditions, had a real problem in obtaining suitable employment. Four veterans were referred because medical treatment was required for their wives and in all cases, the need could be related to financial stringencies in the home. The social diagnosis made at M.S.S. of the forty-two referred for psychiatric treatment indicated that thirty-seven of these veterans were socially inadequate, two had, as their primary problem, financial difficulties, one had difficulty in obtaining employment, one refused to be interviewed and, in one case, a clear presenting social problem could not be ascertained from the records. Social workers' interviews with the three referred for domestic reasons confirmed the

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1 For a numerical correlation of reasons for referral with presenting social problems see Chart 1. These figures were derived from tabulations on Appendix D.

doctors' decision as to the nature of their underlying social problem. Summarizing the above it may be said that in fifty of the sixty-eight cases, the social diagnosis by M.S.S. was in similar terms to the reasons for referral given by doctors in O.P.C.

What Was the Treatment Plan

The purpose of this study as was outlined in Chapter 1, is to survey the extent of services rendered to O.P.C. through M.S.S. by analysing the referral of veterans over a six month period and, further, to review certain of non-referred cases[1] to ascertain whether referral to M.S.S. might have benefited any of these veterans. In this chapter the study is confined to the first group i.e. those veterans referred from O.P.C. to M.S.S. In order to ascertain the nature of assistance provided by M.S.S., the analysis of records included a tabulation[2] of the treatment plans arranged for referred veterans by social workers. This study is not a case analysis of techniques applied in dealing with the individual situations presented by veterans, but case illustrations are given at the end of this chapter to outline some of the casework services given to out-patients referred to M.S.S.

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1 See Chapter 4

2 See Appendix D

CHART 2 SHOWING TREATMENT PLAN MADE BY MEDICAL SOCIAL SERVICE IN RELATION TO SOCIAL DIAGNOSIS

Treatment Plan Made	No. of Cases	DIVISION OF CASES ACCORDING TO SOCIAL DIAGNOSIS IN MEDICAL SOCIAL SERVICE						
		Socially inadequate	Financial	Accommodation	Domestic	Employment	Not Known	Interview Refused
Carried by Medical Social Service	47	39	3	1	4			
Referred to Welfare Services	12	2	7	1		2		
Referred to District Social Services	1		1					
Referred to Community	4		4					
None and not known	4			1		1	1	1
TOTAL	68	41	15	3	4	3	1	1

The treatment plans as put into effect for the sixty-eight veterans studied could be enumerated under the following four broad headings: treatment rendered directly by M.S.S., treatment rendered through referral to Veterans' Welfare Services, treatment through referral to the District Social Services; treatment rendered by referral to other community organizations and social services agencies.

Social Workers in M.S.S. dealt directly with forty-seven of the veterans referred. In thirty-nine instances, the service rendered was primarily that of preparing social histories for psychiatrists. In preparing these histories, case work services given include preparing veterans for further examination and treatment. Relatives, if interviewed, may be assisted towards a better understanding of the veteran's illness or of other social problems which might present themselves during the course of the interview. Services by M.S.S. for this group of veterans are usually not continued after the social history has been taken as the psychiatrist takes over the active treatment of the case. In some cases, however, casework service may continue during the course of psychiatric treatment. In the four cases where the presenting social problem was domestic, and for one of the three cases where the problem was one of accommodation, M.S.S. provided the required help. Hospital Superintendents assistance fund has been made available, through the Hospital Auxiliary, for emergency

grants usually not over ten dollars for any one veteran or veteran's family. All grants made through this fund are administered by M.S.S. and must be shown to directly benefit the veteran. Further material aid for veterans, e.g. clothing, may be obtained on emergency by social workers from the Shaughnessy Hospitals Pack Store through the Hospital Administrative Office.

Thirteen of the sixty-eight veterans studied, were referred to Veterans Welfare Officers for help in making application for financial aid from the Army, Naval and Air-force Benevolent Fund and, also, for help with employment and accommodations. The four referrals to community organizations and agencies were for financial aid i.e. the fourth treatment plan classified. These referrals for material aid may have been directed to any one of a variety of resources such as the Returned Soldiers' Club Poppy Fund; the Canadian Legion, for emergency aid; the municipal or the city authorities for social allowance and to the Vancouver General Hospital Out-Patients', e.g., for treatment of veterans' wives where lack of finances was a factor. Although, of the group of veterans studied, referrals to community groups were confined to financial problems, it is quite possible to make referrals for assistance with domestic, housing and accommodation problems.

Without a follow-up study of the patients after their return home, a full assessment of the value of Medical

Social Service services cannot be made for the sixty-eight cases. However, the following case histories do illustrate what progress may be made and how full use of Medical Social Service may be of benefit to the patients.

The Case of Mr. A:

This fifty-one-year-old patient with many long-standing complaints of hernia difficulties was referred to Medical Social Service from Out-Patients' Clinic for medical social history prior to psychiatric interview. District File indicated nil disability for hernia condition. History information revealed a worried, anxious man, vague in his information re his background and particularly about a first marriage when following divorce proceedings he was granted custody of an only son. His second marriage he claimed to be happy, but, again, he was vague and somewhat confused about his wife's sickly condition. The twenty-three-year-old son was at home with little ambition to seek employment. He was a worry to the wife and an added burden financially. Patient had been employed intermittently and stated that each job, e.g. mail sorter, janitor, was too heavy and caused him considerable pain. The wife, when interviewed subsequently, stated that she and patient both thought that at this time he should have a thorough physical examination. She indicated her previous illness of T.B. which was completely cured, also her present menopausal state which she denied contributed

to any of patient's worries and stated their marriage was a satisfactory one. Discussion was held around some of the emotional factors possibly contributing to pain and patient's complaints, thus necessitating psychiatric interviews, and the wife given some understanding in this regard. Even though the patient discontinued psychiatric contacts, the wife for the first time had an opportunity to gain insight into the emotional factor of the long-standing complaints and was thus better equipped to cope with the difficulties presented by the husband at home.

The Case of Mr. B:

This forty-one-year-old patient with disability pension for multiplesclerosis was referred to Medical Social Service from Out-Patients' Clinic because of existing marital difficulties; also, the doctor believed the wife required more interpretation of patient's condition. The stage of development of the patient's disease indicated that the patient would tend to be inadequate in certain areas such as the taking of initiative and responsibility at home and in the obtaining of employment or remaining at a job for any length of time. He would also probably be impotent. Both patient and his wife were interviewed several times. Interviews with patient centred around giving of support and allowing him to ventilate his feelings about his handicaps. He was also reassured that he could do an adequate job in employment with less responsibility even though he had

previously accustomed himself to more responsible positions. He was encouraged to take an interest in things at home, his children, the garden and his workshop and was helped to understand that his wife indicated there could be more to their marriage than sexual relations. Interviews with the wife were centred around helping her to make a decision about continuing her marriage or separating from patient. She gave history information that patient had come from a home where financial difficulties arose constantly, where patient was over-protected and was never required to take responsibility. She thought his changing of jobs and inadequacies at home were largely due to his home upbringing. She did not wish to accept interpretation of patient's illness and felt guilty when she tried to formulate plans to separate from a sick husband. She became quite hostile to the worker, wished to break the contact herself and was contributory to patient's keeping appointments only spasmodically. Although the wife became hostile because of her guilt feelings and discontinued interviews, sufficient relationship was established between the social worker and the patient to enable him to return for help when under stress. His illness is such that his inadequacies will form a chronic pattern, but it was noticeable that he did respond to the support and help given to him.

The Case of Mr. C:

This thirty-six-year-old patient suffering from severe varicose veins was referred to Medical Social Service because of his home financial situation together with a large debt structure. Patient was attempting to obtain a pension for his condition, thus, in this case, was not entitled to financial help through D.V.A. His wife and two children, living in meagre conditions in an auto court, were referred for social assistance. It was learned that she applied in her own right as a single person as she and patient were not legally married. Patient indicated in subsequent interviews that his wife had other men visiting her and he felt unwanted at home. History information revealed patient's inadequacies throughout his life, particularly in forming relationships and in obtaining steady employment. Supportive help was given him around retraining for further employment in which he showed some real interest; also, help around giving him some understanding of his social inadequacies and psychiatric assessment was offered to him.

Without elaboration of the case histories given above it is not possible to illustrate fully the complexity of factors in each of the cases. Indeed, the physical disability was only one. The service given by M.S.S. made it possible to uncover and discuss the importance of the factors some of which had not been recognized by the patient; this materially added to the rehabilitation of the patient both physically and in his social environment.

CHAPTER 4

A REVIEW OF CASES DRAWN FROM GENERAL ADMISSIONS TO COMPARE NEEDS AND TREATMENT PLAN WITH THOSE WHO WERE REFERRED TO MEDICAL SOCIAL SERVICE

A. Selection of Cases for Study

It will be remembered that during the period April 1st to September 30th, 1954, the total intake at O.P.C. consisted of approximately 8341 patients. The obvious query at this stage is, of course, centred about the number of these, apart from the 84 cases already studied, which might have benefitted from referral to M.S.S. and whether or not it is possible to say what type of cases should have been referred.

Ideally, such information could only be obtained after a complete study of the 8341 cases, since the cases were so heterogeneous that a small sample would be inadequate for such a study. Since this was not possible, owing both to the time factor and to the fact that the records would have needed considerable revision before such a study could be made, it was thought that a review of approximately the same number of cases as that studied in Chapter 3 might furnish certain pertinent information which would form the basis for further work. After discussion with Dr. Marsh, it was decided to draw one hundred files at random from

O.P.C. records and to study these in detail, tabulating such information as seemed relevant. Commencing at an arbitrary file number, (the actual number used was 223) this and every fifth file thereafter were drawn until a total of one hundred files had been obtained.

A separate case was made out for each file giving details of age, marital status, treatment category, medical diagnoses, work record, and record of other services used besides those provided in O.P.C. Some difficulty was encountered in that every record did not contain the same information or give full details on certain points (for instance work records were sometimes either missing altogether or very incomplete). The completed cards were assigned code numbers on a numerical basis, after having been sorted according to marital status rather than placed in alphabetical order. All information was then tabulated and appears as Appendix F to this study.

B. Discussion of Certain Aspects of the 100 Cases

It is proposed to consider the 100 cases, tabulated briefly in the preceding pages, according to sex, age, marital status, treatment category, medical diagnoses, work record, other services used besides those provided in O.P.C., and whether or not the case was known to neuropsychiatry.

Sex: Of the 100 cases being reviewed, 99 of them were males. Case number 19 was the only female. This is believed to be a somewhat higher percentage of females than is generally found in the O.P.C. intake,[1] although here again accurate figures are difficult to obtain.

Age: The group was found to range in age from 19 to 86 years. The 19 year old, number 35, offers the only example encountered of a non-veteran receiving treatment in O.P.C., a Mounted Police officer-in-training. Six of the group were under thirty years of age, twenty-two were between the ages of thirty and forty-nine, while the age group seventy and over contained thirty-three individuals. If age fifty is taken as an arbitrary dividing line between the veterans of the First World War and those of Second World War, 72% of the total group may then be said to be World War 1 veterans.

Marital Status: Fifty-nine of the 100 cases were married men living with their wives, twenty-one were single, eight were widowers, four were divorced, and eight were legally separated. The lone woman in the group was one of the eight legally separated.

Treatment Category: As will be remembered, treat-

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1 Senior clerical staff gave as their opinion that the percentage of females in the general O.P.C. intake would probably not be higher than 1/2% of the total.

ment categories were mentioned in Chapter 2 and it was stated that in order to be eligible for treatment in a D.V.A. hospital, at either an out-patient or an in-patient level, a person must come under one or the other of the various sections. The legislation which lays down the treatment regulations obtaining in D.V.A. hospitals, gives a list of the circumstances under which a person may be treated. These are divided into some twenty-nine sections, the more commonly used of which may be found in Appendix B to this study. Of the 100 cases under review, 17% were found to be receiving treatment for their pensionable disabilities at the time the case was reviewed. These veterans are shown in the tabulation as under treatment category No. 5; 53% of the cases found to be receiving treatment under Section 12, that section which authorizes treatment of those in receipt of War Veteran's Allowance; 11% of the group were receiving treatment under Section 13, since they did not have entitlement under any other section and were veterans adjudged to be in the group whose income was inadequate for the provision of needed medical service; 1% were receiving treatment under Section 16, which means that they were suffering from a non-pensionable service disability about which there was some question, while 1% appeared under Section 27. He was undergoing examination at the request of the Canadian Pensions Commission. 9% were receiving treatment under Section

28, as some competent D.V.A. authority had requested it, while 1% were receiving treatment under Section 11, being treated for a condition present at time of discharge from the regular forces. One of the group, a member of the R.C.M.P. was being cared for under Section 19; 4% were receiving treatment under Section 18, as they were serving members of the armed forces, and one individual was being treated under Section 29, as he was in D.V.A. Domiciliary care.[1] One per cent of the cases were receiving attention for a non-pensionable disability present at the time of discharge from the special force raised for the war in Korea. This would mean that they were being treated under the authority of Section 9.

Medical Diagnoses: The various medical diagnoses given were, for purposes of the study, grouped in the same manner as were those in Chapter 3. A full explanation thereof will be found on page 28. In this chapter the diagnosis chosen as the first one represents the disability for which the individual was receiving treatment at the time his file was reviewed. In some cases, this was the veteran's pensionable disability. Where the medical documents gave a history of more than one disease or disability, then the predominent one was shown as the second. It was found that in

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1 This appears to have been a patient at Geo. Derby H. & O. Centre who was seen in one of the special Out-Patients' Clinics.

the column marked "1" 3% of the 100 cases were suffering from various neurological conditions, 15% from trouble in the gastro-intestinal tract, 19% from respiratory troubles, 28% from various cardio-vascular diseases, 5% from various glandular troubles, 4% from some type of neoplasm, 18% from one of the arthritic conditions, 6% from some disability referrable to the field of orthopaedics, 1% from genito-urinary diseases, and 1% from the effects of severe malnutrition. In Column 2 it was found that 4% of the group were suffering from respiratory diseases, 12% from disorders of the cardio-vascular system and 7% from glandular disorders of various types. Six per cent were suffering from some type of arthritis, 5% from diseases of the genito-urinary system and 5% from some disorder in the field of orthopaedics. Fifteen per cent had a psychiatric diagnosis while neoplasms accounted for 2%. The remaining 26% of the group had apparently never been treated for more than the one illness.

Work Record: As mentioned earlier, work records were often very difficult to assess from the information on file. In only one instance, however, (case No. 66) was the available information of such a contradictory nature as to make any evaluation impossible. Unless there were clear indications to the contrary, a person was considered to have a good work record. Any work history subsequent to age 60 was disregarded. Assessed in this way, 64% of the group under review were adjudged to have a good work record, 21%

to have a record of part time work, and 13% to have a record of sporadic work. Part time workers were thought of as those whose work pattern was that of accumulating a stake and then spending it before going back to work. Sporadic workers were considered to be those whose history showed them to have been out of work more often than in work and to have been relief recipients at least part of the time. The remaining 2% of the group, although seemingly able to work, never seem to have done so, but to have subsisted on handouts of one kind or another. An examining doctor wrote concerning one of them, "This man appears to have retired in 1919" (No. 18 in the tabulation.)

Other Services Used: Seventeen of the group under review were found to have had contact with M.S.S. at one time or another. Some of the contacts were on an in-patient basis, some on an out-patient basis. None of the group, however, were active with M.S.S. during the period which this study covers. Eight of the group had had contact with District Social Service, while 48 had had contact with Veterans' Welfare Officers in other than a purely investigative capacity. Eighteen had been in contact with more than one of the above mentioned services, while three had been in contact with them all.

Thirteen members of the group under review had been seen by psychiatry at least once. This represents 81.3% of those cases having a psychiatric diagnosis. Of

the thirteen cases known to psychiatry, five were known to M.S.S. also, one was known to D.S.S., and seven were known to V.W.O. Five of the cases known to psychiatry do not appear to have had contact with any of the services mentioned.

The Social Situation

As the group of files were being reviewed a careful note was made of anything which might prove of value in making an assessment of the probable social situation. Major reliance was placed on the medical documents on file and on what the physician did not say as well as on what he did say. In 61% of the cases, namely case numbers 1,2,3,4, 6,8,10,11,12,13,14,15,16,17,18,20,23,24,25,26,28,29,30,32, 33,34,36,38,42,44,48,49,50,52,53,54,55,56,57,58,59,60,63, 66,68,69,70,74,75,76,77,78,79,82,86,91,92,93,94,96, and 98, it was felt that the records indicated some degree of social maladjustment. The degree varied from that seen in the case of Mr. A. to that seen in the case of Mr. B. or of Mr. C.

The Case of Mr. A.

Mr. A., age 27, married, discharged from the navy in 1945. His work record both before and after enlistment appears to have been good. First appearance in O.P.C. was in January of 1946 with vague wrist and throat complaints. After careful examination, the physician was obliged to record "no apparent disease." He next appeared in October of 1947 complaining of vague low back pain. Again the

physician recorded "no apparent disease." In 1951 Mr. A. was back again, this time complaining bitterly of low back pain accompanied by sick headaches, for which he had been receiving treatment from a chiropractor. Once more he was subjected to a thorough physical examination, the physician's report being "no apparent disease." In May of 1954, he was back once more. This time his complaints were numerous and his tone hostile. Again he was examined, the physician being forced to record that "no physical basis for this man's complaints can be found." There is no record of Mr. A ever having had contact with either M.S.S. or D.S.S.

Mr. A. was, without doubt, suffering from everything of which he complained, and since careful examination failed to disclose any sort of adequate physical basis for his complaints the question arises - was there something in Mr. A's social situation with which he was unable to cope, and which was forcing him to seek refuge in aches and pains?

The Case of Mr. B.

Mr. B., age 73, married, retired on a small pension after thirty years service with one firm, applied for War Veterans Allowance in 1949. This was granted. Later on, both he and his wife were granted Old Age Security, at which time the War Veterans Allowance was terminated. Mr. B. was not in receipt of a disability pension and his appearances in O.P.C. dated from his receipt of War Veterans

Allowance, and were few and short. Suddenly Mr. B. began to be seen frequently in O.P.C., exhibiting a morbid fear of prostatic carcinoma. The first visit of this type occurred in October of 1952, at which time he was carefully examined and assured that his fears were groundless. The medical record states that the "patient was given reassurance and aspirin and appeared grateful." During casual conversation with the physician, Mr. B. mentioned that his wife planned to visit the Old Country in the very near future. Mr. B's next appearance at O.P.C. was in July of 1953. He was still worried about prostatic carcinoma; his wife was still visiting the Old Country. This time the patient was given "reassurance and phenobarbital", the physician adding that the patient was "very tense and anxious." At this time the patient mentioned that he had a daughter in Ontario whom he would very much like to visit if the doctor thought such a visit would be medically advisable. He was assured that such a visit would be quite alright. In September, 1953, Mr. B. was back once more. This time his worries were centred about his bowels and their action. He was carefully examined and reassured. In April of 1954 patient appeared once more in O.P.C. where examination disclosed that he was suffering from a gouty arthritis. This condition cleared quickly under treatment. June of 1954 saw Mr. B. back with more complaints. After careful examination, the doctor recorded his inability to find any definite physical basis

for the patient's complaints. In passing, it was noted that Mrs. B. had undergone surgery a few days previously. There is no record on file of this patient having had contact with either M.S.S. or D.S.S.

Since careful physical examination failed to disclose an adequate basis for this patient's recurrent worries about his physical condition the question again needs to be asked - was there something in his social situation with which he needed help?

The Case of Mr. C.

Mr. C., age 65, married, veteran of both World Wars, a steam engineer by trade. Work history was excellent until his discharge from the service after World War 11. At that time Mr. C. was awarded a small pension for Marie Strumpel's disease.[1] Subsequent to discharge, Mr. C. took up twenty acres of land in the Fraser Valley. He applied for and was granted War Veterans Allowance. The medical history shows that Mr. C. was much troubled by his disability. Despite this very considerable handicap, Mr. C. managed to expand his farming enterprise to the point where he was threatened with loss of the Veterans Allowance. His physical condition thereupon became much worse, and he reported to O.P.C. The doctor reported that apart from the Marie Strumpel's disease, positive findings were quite limited. In October

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1 Rheumatoid Ankylosing Spondylitis, or Bamboo Spine. A form of arthritis attacking the spinal column.

of 1953 the patient appeared in O.P.C. once more. This time he was admitted to hospital and placed on active treatment for Marie Strumpel's disease and a mild anaemia. It is of interest to note that in July of 1953 the patient had lost his entire flock of three hundred pullets due to contamination with Newcastle disease. During this period of hospitalization, Mr. C. became known to the social worker assigned to his ward. It was found that Mr. C. had numerous problems with which he felt unable to cope. The loss of virtually his entire flock of poultry had been a severe financial blow to him and he felt that it would necessitate his sixteen year old son leaving school as Mr. C. could no longer afford to finance the lad's education. The patient was given supportive casework help, and the appropriate machinery set in motion to obtain financial assistance for the son so that he could continue in school. Upon the occasion of Mr. C.'s last appearance in O.P.C. his complaints were minimal, and his response to treatment much better than his physician had expected it to be. Contact with Mr. C. had been maintained by M.S.S. after his discharge from hospital and it was learned that his son had been granted financial assistance through the Soldiers Dependent Children Fund and was going to be able to continue at school.

Mr. C. was having a difficult time in meeting the ordinary demands of life in the face of a very real disability. Any additional burdens were more than he could cope with.

Social Problems and Age

A detailed breakdown of the 61 cases where the records seemed to indicate the probable existence of a social problem, showed that three of them were in the under 30 age group, 16 were in the 30-49 age group, 23 in the 50-69 age group, and 19 in the group 70 and over. It was observed that the cases where alcohol seemed to be a major factor were much more numerous in the 50-69 age group than in any other, while those cases where the suspected social problem was a domestic one tended to be most numerous in the age group 70 and over. The usual story was that of an old man who had become difficult to look after. This was causing a breakdown in family relationships, and the man was no longer wanted at home.

Social Problems and Work Record

Of the 61 cases where there was felt to be evidence of the existence of a social problem, thirty-six had a record of full time employment. In other words, 56.2% of those whose work record was adjudged good were felt to exhibit evidence pointing to social maladjustment. There were 12 such in the part time employment group or 57.1% of the total number in that group. In the group of sporadic workers there were 10, or 76.9% of the total number in that group. The two individuals whose work record added up to nothing were both adjudged to be socially maladjusted.

Social Problems and Treatment Categories

Am examination of those cases where it was felt some type of social maladjustment might exist shows that 32 of them were being treated under the provisions of Section 12. This represents 60% of the total number in the group under review who were receiving treatment under that section. It will be remembered that this is the section which authorizes treatment for those veterans in receipt of War Veteran's Allowances. Persons in receipt of this are considered to be in receipt of an inadequate income.[1] Six of the group where social problems were felt to exist were receiving treatment under Section 13. This represented 54.5% of the total number receiving treatment under this section. In the light of the explanation given earlier with regard to the meaning of this section, it will be seen that these people may also be considered as being in the inadequate income group.

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1 Since this was written, legislation has been passed which increases the amount of War Veterans Allowances.

CHAPTER 5

SUMMARY AND RECOMMENDATIONS

In discussing medical education in the book, The Hospital in Modern Society, Dr. Willard C. Rappleye compares the characteristics of current medical practice with those of contemporary industrial life. He says:

> Considerable emphasis is being placed upon organizations as a means of providing mass production in medical services. Efforts are made to standardize procedures partly as a reflection of the methods in the field in industry. The methods are based in many instances upon the fundamental fallacy that the human being, who is the unit of medical service, can be regarded as a uniform, standardized organism. The contrary is known to be the case inasmuch as no two individuals are alike, and no two, even with the same disorder, react in exactly the same way. Sound medical practice requires careful study of the health needs of each individual - physical, psychic and social.[1]

When a Shaughnessy Out-Patients' Clinic physician sees a patient, the relationship between them is not quite parallel with the relationship existing between a family physician and his patient. In a D.V.A. hospital, the patient is on treatment by reason of eligibility under regulations rather than because he is on the doctor's private practice, as is the case of a patient in a general hospital. In nearly all cases, the D.V.A. doctor has available to him

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1 Rappleye, Willard C., The Hospital in Modern Society, Cambridge, Harvard University Press, 1943, p. 33

some type of a file on his patient. This file may be in several volumes and cover as much as a thirty-year period in fair detail. Usually this file gives the patient's health history, and if the family has ever undergone an investigation as the result of having applied for an allowance, it will probably give some picture of the family constellation and the way it operates. It may even give some clear indications as to the patient's work history. From the material contained in this file, it is frequently possible to obtain a reasonably accurate picture of the type and complexity of the problems which the veteran and his family have encountered, and of the degree of success with which they have been overcome. This is, of course, what was studied in Chapters 3 and 4. Investigation disclosed that although patients come to the O.P.C. to obtain treatment for some particular complaint, they are frequently referred to M.S.S. for reasons in no way connected therewith. An average staff of twelve doctors see approximately one hundred and sixty-five patients daily whose district or hospital file must be reviewed either in whole or in part. This is in addition to the considerable number seen on routine matters which require little, if any, reference to material on file. This means that, in addition to his other duties, a doctor in O.P.C. is required to review better than thirteen files a day. Because of this pressure on the doctor, it frequently devolves upon senior members of the clerical staff to arrange

for many of the referrals to M.S.S. which are presently being made. This, of course, is done with the full knowledge and authority of the doctor concerned.

What the Research Indicated

In Chapter 3 it is noted that, of the twenty-nine cases referred to M.S.S. from the O.P.C., twenty-one were later referred to other services for help with such things as financial difficulties, the finding of employment, and the locating of living accommodation. This group, together with the forty-two cases referred for the taking of a social history prior to psychiatric assessment, emphasizes the fact that much of the work performed by M.S.S. is in the nature of assessment and referral. This service is diagnostic and involves something more than clerical skill. In this screening process, the social worker uses his professional skill to help the veteran to accept the necessary referral or treatment. The need for speedy intake and referral services is frequently seen when, for example, a patient is to be seen immediately by psychiatry. The patient may not realize why he is coming to M.S.S. and often does not differentiate between the social worker and the psychiatrist. It is the social worker's responsibility to help the patient work through his feelings of confusion over being transferred from one source of help to another. A speedy decision to refer a patient to another source of help may

have the effect of making him feel that he is being given what he would probably refer to as the "run around". As a result of this feeling, the patient then approaches the new service with feelings of resentment and hostility, carrying over to the second person the anger he felt towards the first. It requires a high degree of casework skill to properly prepare such a patient for referral to other services.

As stated in Chapter 1, and outlined in Chapter 4, a further study was undertaken to ascertain whether or not a significant number of patients reporting to the O.P.C. might have benefitted from a referral to M.S.S. as did the group studied in Chapter 3. Although the number of cases reviewed in Chapter 4 was not large enough to be more than indicative, the information obtained seemed to point to the fact that there were some who could have benefitted from casework help. Even after making allowance for the fact that closer investigation might have disproved the presence of significant social maladjustments in a proportion of the cases, the pattern exhibited by Mr. A. or Mr. B. could have been duplicated many times. It is fully realized that, as a rule, the physician is quite cognizant of the fact there are probably strong emotional factors behind his patient's medical complaints. However, as was pointed out earlier, the physicians in the O.P.C. are under considerable pressure, and at the present time do not have

easy access to the aid and counsel of a professional social worker.

Recommendations

A. Staff Allocation: The services offered by Shaughnessy Hospital O.P.C. form part of a wide D.V.A. health and welfare program. Medical Social Service is part of this program. It is felt that the presence of a Medical Social worker in the O.P.C. would contribute materially to the effectiveness of the services presently being offered there. In many cases, treatment of the social factors would probably diminish or obviate the need for prolonged hospitalization or medical treatment on an out-patient basis. The veteran would also be receiving more adequate help, and it is considered that the cost of such a service would, in time, be more than offset by the saving in other services which are now necessary. It is recommended, therefore, that a qualified social worker be allocated to the O.P.C. staff on a full time basis.

B. Recording: One of the important functions of M.S.S. is that of co-ordinating the services available to patients. Because these services involve so many members of the treatment team, the M.S.S. records must be written in such a form as will make them of the greatest use to all who have reason to consult them. This means that the emphasis has to be placed on facts, and these facts must be presented in such a way as to be intelligible to persons not

trained in social work skills or the professional language of social work. M.S.S. records may be used by Medical Records personnel, physicians, administrative and other staff, both here and in Ottawa. Hence, process recording such as is normally used in a casework agency has to be modified, and the resulting records do not lend themselves readily to an assessment of the actual casework processes and techniques employed in reaching a social diagnosis, nor in assessing fully how the treatment plan was evolved. The case records reviewed in this study did not show clearly all of the work which had been done nor the specific results accomplished by it. This information had to be obtained by discussing the case with the social worker concerned. In order to justify itself a newly instituted service must be ready to prove its worth. One of the ways of accomplishing this is by keeping adequate records. It would be essential, therefore, that an improvement be made in case recording. It is recommended that in future, casework records have the social worker's evaluative impression or social diagnosis, clearly stated, and the treatment plan adequately outlined.

C. Further Research: The O.P.C. of Shaughnessy is a large and important segment of the service offered by that hospital to the veterans resident in "VA" district.

At the present time, very little is known to M.S.S. of many aspects with which they should be familiar in order to plan for maximum effectiveness of the service offered. Perhaps one of the first studies which might be undertaken is a detailed and scientifically valid study of the types of social problems commonly found among O.P.C. patients, and the frequency with which they appear. Another area for fruitful study centres about the effectiveness of casework services as measured by the client's improved ability to function. Yet another price of research which might yield worthwhile results is a study of the type and severity of social maladjustment found in O.P.C. patients suffering from various physical or mental disabilities.

In conclusion it may be said that the present study has demonstrated the value of the service offered by M.S.S. to veterans in Shaughnessy Hospital, and has indicated other areas where a full time social worker might prove helpful.

APPENDIX A

D.V.A. HOSPITALS AND INSTITUTIONS

Name and Location of D.V.A. Hospitals and Institutions	Operating Capacity
1. Active Treatment Hospitals	**9082**
Camp Hill Hospital, Halifax, N.B.	550
Lancaster Hospital, Fairville, N.B.	450
Veterans' Hospital, Quebec, P.Q.	275
Queen Mary Veterans' Hospital, Montreal	700
Ste. Anne's Hospital, Ste Anne de Bellevue, P.Q.	1,135
Sunnybrook Hospital, Toronto, Ont	1,650
Westminster Hospital, London, Ont.	1,522
Deer Lodge Hospital, Winnipeg, Man.	850
Veterans' Hospital, Saskatoon, Sask.	125
Colonel Belcher Hospital, Calgary, Alta.	425
Shaughnessy Hospital, Vancouver, B.C.	1,100
Veterans' Hospital, Victoria, B.C.	300
2. Active Convalescent Facilities	**365**
Ridgewood H & O Centre,** St. John, N.B. (Lancaster)	*
Veterans' H & O Centre, Senneville, P.Q. (Ste. Anne's)	*
Rideau H & O Centre, Ottawa, Ont.	150
Divadale H & O Centre, Leaside, Ont. (Sunnybrook)	*
Veterans' Convalescent Hospital, Calgary, Alta. (Colonel Belcher)	*
George Derby H & O Centre, Burnaby B.C.	215
3. Special Institutions	**200**
Veterans' Hospital, St. Hyacinthe, P.Q.	200
Western Counties Veterans' Lodge, London, Ont. (Westminster)	*

APPENDIX A (continued)

Name and Location of D.V.A. Hospitals and Institutions	Operating Capacity
4. Institutions Designed Primarily for Veterans' Care Cases	327
The Red Chevron, Toronto, Ont.	165
Bellvue Veterans' Home, London, Ont.	30
Veterans' Home, Winnipeg, Man. (Deer Lodge) †	
Veterans' Home, Regina, Sask	62
Veterans' Home, Edmonton, Alta.	70
Hycroft, Vancouver, B.C. (Shaughnessy) †	
Total	9,774

† The Operating Capacity for these institutions is included in the figures for the Hospital shown in parenthesis.

†† H & O: Health and Occupational Centre

Source: Compiled from D.V.A. Head Office Monthly Statistics Reports.

APPENDIX B

D.V.A. TREATMENT CATEGORIES

GUIDE TO AND SYNOPSIS OF MOST COMMON TREATMENT SECTIONS

PENSIONABLE DISABILITIES

Section 5 Treatment of a veteran for a service disability.

Section 6 Treatment of a person for a disability for which pension is paid by reason of service in the Red Cross and other non-military organizations.
a. Allied Pensioners.
b. South African, Fenian Raid and North-West Rebellion Veterans
c. Civilian war pensioners from various auxiliary services.

Section 7 Treatment for a disability for which pension is paid under Newfoundland Special Awards, or for a service disability incurred in the regular forces of Canada or the R.C.M.P.

Section 8 Treatment of a veteran for a service disability while undergoing imprisonment.

NON-PENSIONABLE DISABILITIES

Section 9 Treatment of a veteran for a disability present at the termination of his service in the Special Force.

Section 10 Treatment of a veteran for any non-pensionable disability within one year of his discharge or while he is undergoing an approved course of training under the Veterans Rehabilitation Act.

Section 11 Treatment of a disability present at the time of discharge from Regular Forces, provided that it is commenced within one year of the date of discharge.

Section 12 Treatment of veterans in receipt of War Veterans Allowance.

APPENDIX B (Continued)

Section 13 Treatment of a veteran who has no other entitlement and qualifies because of inadequate income or resources.

Section 14 Treatment of a psychiatric disability when such treatment will assist in his rehabilitation.

Section 15 Treatment of veneral disease, or its sequella, if it has been ruled that it was incurred during service.

Section 16 Examination and treatment of a service disability where there is uncertainty as to the need for treatment in hospital or as to the primary condition for which treatment is needed.

Section 17 Treatment of an employee who contracts a communicable disease as a direct result of his attendance on patients.

Section 18 Treatment of service personnel at the request of the Department of National Defence.

Section 19 Treatment of members of the R.C.M.P.

Section 20 Treatment of a person at the request of a responsible body, politic or corporate, where facilities are not available elsewhere.

Section 21 Treatment of a person at the request of any department of the Government of Canada.

Section 22 Examination and treatment of an allied veteran at the request of the Government concerned.

Section 23 Examination and treatment of a veteran for a non-entitled condition where he guarantees payment of the hospital account and is personally responsible for payment of medical services.

Section 24 Treatment of any emergency condition where the patient cannot qualify in any other class and cannot be transferred to another institution by reason of his critical condition.

APPENDIX B (Continued)

Section 25 Treatment of a veteran or other person who no longer qualifies for treatment but cannot be discharged or transferred.

RESEARCH

Section 26 Examination or treatment of a veteran or other person, with his consent, for research purposes.

EXAMINATION

Section 27 Examination of a veteran or other person, at the request of the Canadian Pension Commission.

Section 28 Examination of a veteran or other person at the request of the Department, Prosthetic Services, War Veterans Allowance Board, or for completion of examination for the purposes of the Commission.

DOMICILIARY CARE

Section 29 Domiciliary Care, and treatment needed, while receiving such care. Subject to both total physical disability and financial agreements.

Source:- Compiled from veterans treatment regulations made by Order in Council P.C. 1954-1933 dated December 8, 1954, as amended by P.C. 1955-102 dated January 20, 1955, effective January 1, 1955.

APPENDIX C

FUNCTION OF MEDICAL SOCIAL SERVICE IN D.V.A. HOSPITALS

(As stated in D.V.A. Treatment Instruction Letter No.1 1949)

(A) i) To provide social casework services to individual patients as part of the medical team of which the doctor is the leader.

ii) To provide medical social consultation services to others giving service to the veteran.

iii) To assist in the development of community understanding and aid to the sick and disabled.

iv) To participate in the teaching program of the hospital.

v) To assist research programs which have medical social implications.

(B) Because of the diversity of the services within the department it seems advisable at this time to outline specifically to whom and under what circumstances such casework service may be given.

(C) Individualized service, (including casework with the patient and/or his family, preparation of social histories, securing of other pertinent information, referral to the community for service) may be given, under medical direction, to the following:

i) any patient, veteran or non-veteran, under departmental medical care in hospital or as an outpatient whose personal or social problems are related to his illness or disability.

ii) any person referred to Treatment Services for medical assessment, diagnosis or treatment, where the doctor desires social information or where he requests that casework service be provided.

APPENDIC C (continued)

iii) patients discharged from Hospital or Out-Patient care where requested service has not been completed or where, in the opinion of the doctor concerned, continued service will add to the efficacy of the treatment given, or materially lessen the likelihood of recurring illness.

iv) veterans where the follow-up care, or securing of medical social data, is requested by Treatment Services in connection with some special study or research project.

(D) It is understood that the medical social worker will call on the assistance of other departmental and community services in meeting the needs of the patient and his doctor, when, in the opinion of the doctor concerned:

i) the value of the requested service will not be materially lessened by channeling through someone else, and

ii) the service requested is in line with the policy and function of the department or community service to whom the request is made.

APPENDIX D

TABULATION 1

TABULATION OF DATA FROM EIGHTY-FOUR CASES REFERRED TO M.S.S. FROM O.P.C. APRIL 1, 1954 - SEPTEMBER 30, 1954

Case No.	Age	Mar. Stat	Work Rec.	Tr. Cat.	Medical Und.	Problem Pres.	Reason for Ref.	Present-ing Soc.Prob.	Treat-ment Plan	Months active	Reason Closed	Prev. Cont.
1	42	Mar.	F.T.	28	Psych.	Psych.	Psy.Hi.	So. In.	MSS	7	Cont.	No
2	41	Des.	SP.	28	Psych.	Psych.	Psy.Hi.	So. In.	MSS	3	L.C.	No
3	59	Mar.	F.T.	19	Orth.	Psych	Psy.Hi.	So. In.	MSS	1	T.C.	No
4	34	Sin.	N.E.	5	Neuro.	N.G.	Psy.Hi.	So. In.	MSS	1	Ref.	No
5	64	Sin.	N.E.	12	Psych.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
6	33	Sin.	SP.	28	Psych.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	Yes
7	40	Mar.	SP.	5	Psych.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
8	38	Des.	SP.	28	Psych.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	No
9	33	Sin.	SP.	15	N.Y.D.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
10	31	Mar.	F.T.	28	C.V.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
11	60	Wid.	N.E.	12	Neop.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
12	37	Mar.	F.T.	11	Psych.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
13	54	Mar.	F.T.	14	Psych.	N.G.	Psy.Hi.	So. In.	W.S.	1	Ref.	No
14	46	Mar.	F.T.	5	G.S.W.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	No
15	30	C.L.	Sp.	28	Maln.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	No
16	34	Mar.	F.T.	28	Psych.	N.G.	Psy. Hi.	So. In.	MSS	1	T.C.	Yes
17	36	Mar.	Sp.	28	Psych.	C.V.	Emp.	So. In.	W.S.	1	Ref.	No
18	30	Mar.	F.T.	28	G.U.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
19	54	Mar.	F.T.	28	G.I.	N.G.	Emp.	So. In.	W.S.	1	Ref.	Yes
20	29	Mar.	F.T.	28	G.I.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
21	68	Mar.	N.E.	12	G.I.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
22	28	Mar.	F.T.	14	Psych.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	No
23	65	Sep.	Sp.	12	Psych.	Neuro.	Psy.Hi.	So. In.	MSS	1	T.C.	No
24	38	Mar.	F.T.	14	Psych.	N.G.	Psy.Hi.	So. In.	MSS	1	T.C.	No
25	19	Mar.	Sp.	11	Psych.	N.G.	Psy.Hi.	So. In.	MSS	3	T.C.	No
26	35	Sin.	PT.	28	Psych.	N.G.	Psy.Hi.	So. In.	MSS	1	L.C.	No
27	47	Mar.	Sp.	28	Psych.	Ortho.	Psy.Hi.	So. In.	Com.	1	Ref.	No
28	30	Mar.	F.T.	10	G.I.	N.G.	Psy.Hi.	So. In.	MSS	5	L.C.	No
29	55	Mar.	F.T.	17	Psych.	Psych.	Psy.Hi.	So. In.	MSS	1	T.C.	No
30	63	Mar.	F.T.	3	Neop.	Psych.	Psy.Hi.	So. In.	MSS	1	L.C.	No
31	23	Sin.	Sp.	11	Arith.	Psy.	Psy.Hi.	So. In.	MSS	1	T.C.	No
32	40	Mar.	F.T.	28	G.I.	Psy.	Psy.Hi.	So. In.	MSS	1	T.C.	No
33	27	Mar.	Sp.	10	Psy.	V.D.	Psy.Hi.	So. In.	MSS	1	T.C.	Yes
34	44	Mar.	Sp.	5	Psy.	Arth.	Psy.Hi.	So. In.	MSS	1	T.C.	Yes
35	63	Wid.	N.E.	12	N.K.	Psych.	Psy.Hi.	So. In.	MSS	1	Ref.	No.
36	36	Mar.	Sp.	14	Neur.	Psych.	Psy.Hi.	So. In.	MSS	1	L.C.	No
37	60	Wid.	N.E.	12	Orth.	Psych.	Psy.Hi.	So. In.	MSS	1	L.C.	No
38	46	Mar.	Sp	5	G.I.	N.G.	Fin.	So. In.	MSS	1	L.C.	No
39	29	Mar.	F.T.	28	Psy.	N.G.	Psy.Hi.	So. In.	MSS	1	L.C.	No
40	34	Mar.	N.E.	28	G.S.W.	N.G.	Psy.Hi.	So. In.	MSS	3	L.C.	No
41	40	Mar.	P.T.	5	All.	Ortho.	Fin.	Dom.	Com.	2	Ref.	Yes
42	70	C.L.	N.E.	12	G.S.W.	N.G.	Dom.	Dom.	MSS	1	L.C.	Yes
43	32	Mar.	F.T.	13	Psy.	N.G.	Dom.	Dom.	MSS	1	L.C.	No
44	74	Mar.	N.E.	12	C.V.	C.V.	Dom.	Dom.	MSS	1	T.C.	Yes
45	28	Mar.	Sp.	5	Psych.	N.G.	Fin.	Emp.	W.S.	1	Ref.	Yes
46	62	Mar.	Sp.	13	Arth.	N.G.	Emp.	Emp.	W.S.	1	Ref.	No
47	24	Sin.	Sp.	11	Psych.	N.G.	Psy.Hi.	Emp.	N.K.	1	N.K.	Yes
48	68	Mar.	N.E.	13	G.U.	Ortho.	Psy.Hi.	Fin.	MSS.	1	T.C.	No
49	41	Sin.	Sp.	19	Neuro.	N.G.	Fin.	Fin.	Com.	1	Ref.	Yes
50	45	C.L.	Sp.	5	Mala.	N.G.	Fin.	Fin.	MSS	1	Ref.	Yes
51	47	Sep.	N.E.	28	Ortho.	Psych.	Fin.	Fin.	W.S.	1	Ref.	Yes
52	52	Sin.	F.T.	5	C.V.	Der.	Fin.	Fin.	W.S.	2	L.C.	No
53	63	Sep.	N.E.	12	E.N.T.	Sinu.	Fin.	Fin.	W.S.	1	Ref.	No
54	64	Wid.	N.E.	12	E.N.T.	Neuro.	Tr.Wi.	Fin.	Com.	1	Ref.	No
55	74	Sin.	N.E.	12	G.S.W.	N.G.	Fin.	Fin.	W.S.	1	Ref.	No
56	69	Sin.	N.E.	12	C.V.	N.G.	Acc.	Fin.	D.S.S.	1	Ref.	No
57	68	Sin.	N.E.	12	Arth.	Psych.	Fin.	Fin.	W.S.	1	Ref.	No
58	82	Mar.	N.E.	12	Neop.	C.V.	Acc.	Fin.	W.S.	1	Ref.	No
59	62	Mar.	N.E.	12	G.L.	N.G.	Tr.Wi.	Fin.	Com.	1	Ref.	No
60	70	Mar.	N.E.	12	Orth.	N.G.	Tr.Wi.	Fin.	W.S.	1	Ref.	No
61	71	Mar.	N.E.	12	Neop.	N.G.	Tr.Wi.	Fin.	Com.	1	T.C.	No
62	64	Mar.	N.E.	12	C.V.	Psych.	Psy.Hi.	Fin.	MSS	1	T.C.	No
63	39	Mar.	Sp.	11	Diab.	S.I.	Psy.Hi.	N.K.	W.S.	1	Ref.	No
64	60	Sin.	N.E.	12	C.V.	Psych.	Fin.	So. In.	W.S.	1	Ref.	Yes
65	31	Mar.	F.T.	28	G.S.W.	N.G.	Psy.Hi.	I.R.	None	1	H.R.	No
66	74	Sin.	N.E.	12	G.I.	N.G.	Acc.	Acc.	None	1	L.C.	No
67	76	Sin.	N.E.	12	C.V.	N.G.	Fin.	Acc.	MSS	1	L.C.	Yes
68	69	Wid.	N.E.	12	Arth.	Ortho.	Acc.	Acc.	W.S.	1	Ref.	No

Note: 1 Cases 69 to 84 inclusive were not reviewed as the District Files were not available for study. - See Chapter 3 p. 25.

2 The only female veterans in this group were Nos. 11, 13, and 22.

APPENDIX E

A GUIDE TO ABBREVIATIONS USED IN TABULATION

Column No.	Abbreviation	Details
3	Mar. Stat.	Marital Status
	Mar.	Married
	Sin.	Single
	C.L.	Common Law
	Sep.	Separated
	Div.	Divorced
	Wid.	Widowed
4	Rec.	Record
	F.T.	Full Time
	P.T.	Part Time
	Sp.	Sporadic
	N.E.	No Employment.
5	Treat.Cat.	Treatment Category
6	Und.	Underlying
	Pres.	Presenting
	Psych.	Psychiatric
	G.S.W.	Gun Shot Wounds
	C.V.	Cardio Vascular
	Neop.	Neoplasm (New growths)
	Ortho.	Orthopaedic
	Aller.	Allergies
	Diab.	Diabetes
	Neuro.	Neurological
	G.U.	Genito-Urinary
	Arth.	Arthritis
	N.Y.D.	Not Yet Diagnosed
	Mala.	Malaria
	N.G.	None Given
	Ref.	Referred
	T.C.	Treatment Completed
	L.C.	Lost Contact
	Cont.	Continuing
	H.R.	Help Refused
	Derm.	Dermatitis
	Maln.	Malnutrition
	E.N.T.	Eye Nose & Throat
	G.I.	Gastro Intestinal
	Gland.	Glandular
	Resp.	Respiratory

APPENDIX E (Continued)

Column No.	Abbreviations	Details
7	Ref.	Referred
	Psy.Hi.	Psychiatric History
	Fin.	Financial
	Acc.	Accommodations
	Dom.	Domestic
	Tri.Wi.	Treatment for Wives
	Emp.	Employment
8	Soc. Prob.	Social problem
	So. In.	Social Inadequacy
	I.R.	Interview Refused
	N.K.	Not Known
9	MSS	Medical Social Service
	W.S.	Veterans Welfare Services
	DSS.	District Social Services
	Com.	Community Agency
11	Cont.	Continued
	L.C.	Lost Contact
	T.C.	Treatment Completed
	Ref.	Referred
	N.K.	Not Known
12	Prev. Cont.	Previous Contact.

TABULATION 2 APPENDIX F

TABULATION OF PERTINENT FACTUAL INFORMATION

ON REVIEW OF 100 CASES AS OUTLINED IN TEXT

Case No.	Age	Marital Status	Treat. Cat.	Medical Diagnosis 1	2	Work Record	Seen in Psych.	Other Services Used MSS/1	MSS/2	DSS	VWO
1	51	Wid.	5	G.I.	Neuro	FT	No	Yes	No	No	No
2	60	Wid.	12	Resp.	Psych	FT	Yes	No	No	No	Yes
3	70	Wid.	12	C.V.	N.G.	FT	No	No	No	No	Yes
4	80	Wid.	12	C.V.	Neop.	FT	No	Yes	No	No	Yes
5	67	Wid.	13	C.V.	Arth.	FT	No	No	No	No	No
6	70	Wid.	12	C.V.	Gland.	FT	No	Yes	No	No	Yes
7	74	Wid.	12	Gland.	C.V.	FT	No	Yes	No	No	Yes
8	78	Wid.	12	C.V.	Arth.	FT	No	No	No	Yes	Yes
9	72	Div	12	C.V.	Neuro	FT	No	No	No	No	No
10	46	Div	5	Resp.	Ortho	FT	No	No	No	No	No
11	33	Div	13	G.I.	Psych	SP	Yes	No	No	No	No
12	65	Div	16	Resp.	Gland.	FT	No	No	No	No	Yes
13	60	Sep	12	C.V.	Arth.	PT	No	No	No	No	No
14	44	Sep	13	G.I.	N.G.	FT	Yes	No	Yes	No	Yes
15	52	Sep	5	Resp.	G.I.	PT	No	No	No	No	Yes
16	76	Sep	12	C.V.	N.G.	PT	No	No	No	No	Yes
17	55	Sep	12	C.V.	Psych.	PT	No	No	No	No	Yes
18	65	Sep	12	Resp.	G.I.	NE	No	No	No	No	Yes
19	65	Sep	12	C.V.	Psych.	PT	No	No	No	No	No
20	69	Sep	12	Neop.	Arth.	FT	No	No	No	No	Yes

APPENDIX F (continued)

Case No.	Age	Marital Status	Treat. Cat.	Medical Diagnosis 1	2	Work Record	Seen in Psych.	Other Services Used MSS/1	MSS/2	DSS	VWO
21	82	Sin	12	C.V.	N.G.	FT	No	No	No	No	No
22	55	Sin	5	Arth.	N.G.	FT	No	No	No	No	No
23	63	Sin	12	Arth.	Psych.	SP	Yes	No	Yes	No	No
24	46	Sin	27	Gland.	Psych.	FT	No	No	No	No	Yes
25	46	Sin	13	G.I.	Neop.	SP	No	No	Yes	No	Yes
26	44	Sin	5	Arth.	Resp.	SP	No	No	No	No	No
27	53	Sin	5	C.V.	G.U.	SP	No	No	No	No	No
28	33	Sin	28	Gland.	Ortho.	FT	Yes	No	No	No	No
29	60	Sin	28	Arth.	N.G.	PT	No	No	No	No	Yes
30	33	Sin	11	Ortho	Psych.	FT	Yes	No	No	No	No
31	53	Sin	5	Resp.	Resp.	PT	No	No	No	No	Yes
32	69	Sin	28	Resp.	Psych.	SP	No	No	No	No	Yes
33	74	Sin	12	C.V.	G.U.	PT	No	No	No	No	No
34	76	Sin	28	G.I.	Gland.	SP	No	No	No	No	No
35	19	Sin	19	Resp.	N.G.	FT	No	No	No	No	No
36	59	Sin	12	C.V.	G.I.	NE	No	No	No	No	No
37	55	Sin	13	C.V.	G.U.	FT	No	No	No	No	Yes
38	29	Sin	5	G.I.	Psych.	SP	Yes	No	Yes	Yes	Yes
39	65	Sin	12	G.I.	Gland.	FT	No	No	No	No	Yes
40	76	Sin	13	C.V.	Gland.	SP	No	No	No	No	No

APPENDIX F (continued)

Case No.	Age	Marital Status	Treat. Cat.	Medical Diagnosis 1	2	Work Record	Seen in Psych.	Other Services Used MSS/1	MSS/2	DSS	VWO
41	62	Sin.	12	Arth.	Neuro.	PT	No	No	No	No	No
42	73	Mar	12	Arth.	G.L.	FT	No	No	No	No	No
43	38	Mar	28	Ortho.	N.G.	FT	No	No	No	No	No
44	70	Mar	12	Arth.	N.G.	PT	No	No	No	No	Yes
45	77	Mar	12	Resp.	C.V.	FT	No	No	No	NO	No
46	74	Mar	12	C.V.	N.G.	FT	No	No	No	No	No
47	33	Mar	5	Resp.	N.G.	FT	No	No	No	No	No
48	66	Mar	12	C.V.	G.U.	FT	No	No	No	No	No
49	24	Mar.	18	Gland.	N.G.	FT	No	No	No	No	No
50	70	Mar	12	G.I.	C.V;	FT	No	Yes	No	Yes	Yes
51	34	Mar	28	Resp.	Ortho.	FT	No	No	No	No	Yes
52	44	Mar	13	G.I.	Psych.	FT	No	No	No	No	Yes
53	72	Mar	12	Ortho.	N.G.	PT	No	No	No	No	No
54	67	Mar	12	C.V.	G.I.	FT	No	No	No	No	No
55	75	Mar	12	Neop.	G.U.	FT	No	Yes	No	Yes	Yes
56	65	Mar	12	Arth.	G.V.	FT	No	No	No	No	No
57	70	Mar	12	Arth.	N.G.	FT	No	No	No	Yes	Yes
58	66	Mar	5	Resp.	G.U.	PT	No	No	No	No	No
59	60	Mar	12	Neop.	G.I.	PT	Yes	No	No	No	Yes
60	63	Mar	12	C.V.	N.G.	FT	No	No	No	Yes	Yes

APPENDIX F (continued)

Case No.	Age	Marital Status	Treat. Cat.	Medical Diagnosis 1	Medical Diagnosis 2	Work Record	Seen in Psych.	Other Services Used MSS/1	MSS/2	DSS	VWO
61	26	Mar	18	G.U.	G.I.	FT	No	No	No	No	No
62	32	Mar	5	Resp.	N.G.	FT	No	No	No	No	Yes
63	62	Mar	12	G.I.	Resp.	PT	No	No	No	No	Yes
64	70	Mar	12	C.V.	C.V.	FT	No	No	No	No	No
65	62	Mar	13	C.V.	C.V.	PT	No	No	No	No	No
66	27	Mar	5	Ortho.	N.G.	?	No	No	No	No	No
67	71	Mar	12	Neop.	G.I.	FT	No	No	No	No	Yes
68	70	Mar	12	Resp.	C.V.	FT	No	Yes	No	No	Yes
69	72	Mar	29	Arth.	Gland.	FT	No	Yes	No	No	Yes
70	71	Mar	12	Resp.	Arth.	FT	No	No	No	Yes	Yes
71	63	Mar	13	Gland.	G.I.	FT	No	No	No	Yes	Yes
72	79	Mar	12	Resp.	G.I.	FT	No	No	No	No	Yes
73	65	Mar	12	Arth.	Ortho.	FT	No	No	No	No	No
74	40	Mar	5	Arth.	N.G.	SP	No	No	No	No	Yes
75	73	Mar	12	G.I.	Neuro.	FT	No	Yes	No	No	No
76	63	Mar	12	C.V.	C.V.	FT	No	No	Yes	No	Yes
77	38	Mar	5	G.I.	G.I.	FT	No	No	No	No	Yes
78	67	Mar	12	C.V.	C.V.	PT	No	No	No	No	No
79	38	Mar	5	Resp.	Ortho.	FT	Yess	No	No	No	No
80	55	Mar	12	C.V.	Resp.	SP	No	No	No	No	No

APPENDIX F (concluded)

Case No.	Age	Marital Status	Treat. Cat.	Medical Diagnosis 1	2	Work Record	Seen in Psych	Other Services Used MSS/1	MSS/2	DSS	VWO
81	83	Mar	12	Resp.	G.I.	FT	No	No	No	No	No
82	34	Mar	28	Maln.	Psych.	FT	Yes	No	No	No	No
83	29	Mar	18	Resp.	N.G.	FT	No	No	No	No	Yes
84	65	Mar	12	C.V.	N.G.	PT	No	No	No	No	No
85	86	Mar	12	C.V.	C.V.	FT	No	No	No	No	Yes
86	38	Mar	13	Arth.	Gland.	FT	Yes	No	Yes	No	Yes
87	39	Mar	18	Arth.	N.G.	FT	No	No	No	No	No
88	73	Mar	12	Arth.	N.G.	PT	No	No	No	No	Yes
89	70	Mar	12	Ortho.	C.V.	PT	No	No	No	Yes	Yes
90	32	Mar	9	Neuro.	N.G.	FT	No	No	No	No	No
91	74	Mar	12	Arth.	Psych.	PT	Yes	No	Yes	No	Yes
92	75	Mar	12	Neuro.	G.I.	SP	No	No	No	Yes	Yes
93	38	Mar	28	G.I.	G.I.	FT	Yes	No	No	No	Yes
94	66	Mar	5	Neuro.	Psych.	FT	No	No	No	No	No
95	62	Mar	12	G.I.	N.G.	FT	No	No	No	No	Yes
96	57	Mar	5	Ortho.	Psych.	FT	No	No	No	No	Yes
97	72	Mar	28	G.I.	N.G.	FT	No	No	No	No	Yes
98	42	Mar	13	Arth.	Psych.	FT	No	No	Yes	No	No
99	68	Mar	12	Arth.	N.G.	FT	No	No	No	No	N1
100	59	Mar	12	C.V.	Arth.	FT	No	No	No	No	No

Note: See following page for guide to abbreviations used in above.

Source: - Department of Veterans Affairs District Office files.

Treat. Cat. - Treatment category. For further explanation see Chapter 4, page 42, also Appendix B.

Psych: - Psychiatric Service

MSS/1 - Medical Social Service on an in-patient level.

MSS/2 - Medical Social Service on an out-patient level.

DSS - District Social Service. For explanation see Chapter 2, page 18 footnote

VWO - Veterans Welfare Officers. For explanation see Chapter 2, page 18 footnote

For explanation of abbreviations appearing in body of tabulation see Appendix F.

APPENDIX G

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