PLANNING FOR CONVALESCENCE WITH GENERAL HOSPITAL PATIENTS

An analysis of the problems of patients requiring convalescence, and the social work services provided, based on a group of cases from the Vancouver General Hospital, 1954.

by

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Medical social workers, have, since the first decade of the twentieth century, been involved in helping general hospital patients to plan for convalescence when they are no longer in need of active hospital treatment. Recent advances in medical science, and changing attitudes about the role of the family in modern society, have brought about increased demands for social casework help for patients who must plan for a period of convalescence before returning to their former or optimum level of health. This thesis reviews the problems of convalescence as shown by a group of patients at the Vancouver General Hospital, who were referred to the Social Service Department of the Hospital, and analyzes the nature of the help with planning for convalescence which the patients received from social workers.

Schedules were used to collect data from the case records of these patients, and a questionnaire was used to obtain additional data from the social workers who worked with them. Information obtained included data as to age, sex, marital status, and occupation, together with an appraisal of the problems of these patients as they affected themselves, or involved their families and friends of the community. Information obtained from the questionnaire concerned the types of casework services offered in meeting the problems the patients presented.

The questionnaire was adapted from that developed by a previous research student, in studying casework services in a mental hospital. Whereas his study described, by "operational definition", the specific casework services offered by a social service department, this study attempts to describe, similarly, the specific services offered to meet one particular problem which confronts a social service department.

The study reveals that three main types of problems occur: (a) accommodation problems, (b) financial problems, and (c) psychological problems, and they confront (d) the patient; (e) his family and friends, and (f) the community. Specific casework services have been developed by social workers in dealing with these problems, and are rendered directly to the patient, or indirectly through his family and friends or the community. A considerable measure of appropriateness was revealed in the services offered to meet these problems.

The main results indicate that problems of accommodation far outnumber other problems that arise in convalescence; and that further research is needed to determine the effectiveness of services as they are, and how they might be improved.

Medical social workers have a three-fold responsibility to patients, to hospital, and to community. These responsibilities are recognized, and considerable efforts are being made to meet them. There is, however, a need for better and more comprehensive social work recording, in order that interpretation to hospital and community can be effectively carried out.
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PLANNING FOR CONVALESCENCE WITH GENERAL HOSPITAL PATIENTS
Medical social work is the practical application of the social work method in settings in which the primary focus is the prevention or treatment, of human illness, or the rehabilitation of patients who have been temporarily or permanently disabled by illness. Depending on the nature of the specific setting, the medical social worker may use any one, or all, of the social work processes of casework, group work, or community organization. Irrespective of the setting, however, the distinguishing feature of medical social work, as opposed to other applications of the social work method, is that it is practiced in conjunction with, and usually in collaboration with, the medical profession. Because the great bulk of medical social work consists of casework with patients in hospitals and clinics, the social worker has become a part of a multi-disciplined approach to illness. This approach, usually referred to as the team approach, is a method by which the special competence of each professional discipline is recognized and utilized under the advice and leadership of the doctor. Thus, the practice of medical social work involves not only a sound basic knowledge of the various applications of the social work method, but also, some awareness of the areas of competence of other disciplines that are involved in the treatment of the patient.

Medical Social Work in General Hospitals

In analyzing, at a point in time, any specific aspect of the practice of social work in a medical setting, it is helpful to see this process in relation to historical developments in order to understand

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something of the professional philosophy and method that has evolved.

Social work, although practiced in co-operation with medicine for barely more than half a century, has, in that short time, progressed through three distinct stages. Historically, the beginnings of organized medical social work are marked by the advent of the lady almoners to the charitable hospitals of England. Charles Loch, in 1895, was successful in having one lady almoner appointed to the Royal Free Hospital of London for the purpose of determining the eligibility of applicants for medical care, and of referring these applicants to appropriate social or medical agencies according to the needs that appeared. The primary function, of course, was that of determining eligibility for free medical care, since medical men and lay people were raising serious doubts about the integrity of many applicants who made use of free medical services. This study of eligibility, has gradually been delegated to clerical personnel as the contribution of the medical social worker has become more closely aligned with treatment. The lady almoners and doctors, in the early stages of medical social work development, soon found that an additional service was possible in the treatment of patients, if the doctors could know more about the patient's social situation, and could arrange for treatment of the social problems when these were adversely affecting the medical treatment programme.

This concept of social treatment marked the second stage in the development of medical social work. The concept gained impetus, when, in 1905, the first medical social worker in North America was employed at the outpatients' clinic of the Massachusetts General Hospital by Doctor Richard Cabot. Dr. Cabot, whose contribution to medical social work is appropri-
ately recorded by one of his first social workers,¹ saw social work as an important aid to more accurate medical diagnosis, and more effective treatment of the patient. The medical social workers and lady almoners of the early nineteen-hundreds, in attempting to make a fully effective contribution to the treatment of the patient, were confronted with two major problems of professional development. The first of these was a need for a basic philosophy of service, and a method through which service could be best implemented. The second was a need to receive, from medical practitioners, a recognition and acceptance of the unique contribution that social work could offer to medicine.

With regard to their need for a philosophy they were fortunate in being able to draw upon the experiences of charitable organizations which had been functioning for a number of years and were gradually evolving a philosophy of service. The Buffalo Charity Organization Society, for example, was established in 1877 and as a basic premise of service "declared itself to be impartial in its treatment of its cases. It made no distinction as to religion, nationality, or politics."² This philosophical social work concept has continued throughout the years to be basic to the practice of medical social work, as have many other social work concepts that had their origins in that period.

The early medical social worker's method of service, on the other hand, found many of its roots in the methodology of organizations and professions that were allied with hospital service. The Development


of programmes in England in the eighteen-seventies, for the after care of patients discharged from mental institutions, new developments in methods of nursing, both in the home and in hospitals, and programmes for training medical students, (by having them visit in the homes of indigent families for the purpose of understanding the social milieu of the poor and needy), all contributed something to the medical social worker's way of learning about, understanding, and helping the patient.¹ On this foundation of professional and non-professional experience, the medical social workers were soon able to gain the recognition and acceptance of medical men by demonstrating to doctors and hospital personnel that patients had social and emotional needs which could detract from effective medical care and treatment, but which could be treated by social workers, working co-operatively with other professional disciplines.

From these early beginnings, a rapid expansion in the development of hospital social service departments was seen. By 1913, there were approximately one hundred social service departments attached to hospitals in the United States, and by 1923, this number had increased to four hundred.² The year 1913, was also marked by the beginnings of medical social work with in-patients in hospitals. From this time, social service departments soon began to appear in special hospitals such as tuberculosis sanitoria, and military hospitals.³

³ Kurtz, loc. cit.
Since 1920, the medical social worker has been involved in the third stage of professional activity; that of prevention and rehabilitation. In the area of prevention, medical social work has gradually been assimilated into the fields of public health and public welfare, first in a consultative and educative capacity, and later in the area of direct service to communities and individuals. As awareness of the importance of rehabilitation has developed, the medical social worker has again been involved, but in this area the pattern has been reversed, in that the approach has been from service to individuals in hospitals, to community, and finally to national and international responsibilities.  

The three historical stages of development of medical social work, namely, eligibility, treatment, and prevention and rehabilitation, have led medical social workers to seek a clarification of their function in relation to patients, hospital, and community. In an effort to provide effective service, a professional association was created, and, in 1949, after many years of study, the association developed and adopted A Statement of Standards to be Met by Social Service Departments in Hospitals, Clinics, and Sanatoria. In 1950, the same association adopted a statement of Educational Qualifications of Medical Social Workers in Public Health Programmes. These developments took place in the United States, but influenced developments in Canada, where, in 1952, a group of medical and psychiatric social workers:

workers, functioning as a committee of the Canadian Association of Social Workers, (a national association for all professional social workers in Canada), developed a *Statement of Standards to be Met by Medical and Psychological Social Service Departments in Hospitals, Clinics and Sanatoria*.¹ This statement grew out of the work of the American Association of Medical Social Workers, and American Association of Psychiatric Social Workers.

Since this study is concerned with a Canadian hospital, the statement of the Canadian Association is considered to be the most useful. This statement of standards implies a tri-fold responsibility for the social worker practicing in a multi-disciplined agency. The responsibility is more clearly enunciated in the *Code of Ethics of the Association*,² which code recognizes that social workers have responsibilities to persons served, to the employing agency, and to the community. These responsibilities are inter-related, and interdependent on one another, and in a hospital setting must be constantly re-defined in relation to the contribution of other disciplines. The social worker, because he serves the hospital in part through contact with relatives and friends of the patient, and with individuals and agencies in the community, is able to effect an interchange of attitudes and opinions between hospital and community which should result in more adequate service in all three areas of hospital social work.

The social worker in a medical setting has as his first responsibility, the bringing of casework services to the patient, regardless of

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¹ *Statement of Standards to be Met by Medical and Psychiatric Social Service Departments in Hospitals, Clinics and Sanatoria*, Ottawa, Canadian Association of Social Workers, 1952.

economic status or nature of hospital service offered. This responsibility is met through the social work method of study, diagnosis, and treatment, in the areas of social difficulty. Effective study of the patient's problems involves an understanding of the patient's feelings and attitudes about illness, knowing whether these are the result of normal or abnormal responses on the part of the patient, and knowledge of the patient's past and present experiences, and of his future hopes and aspirations. From this study of the patient's total life situation, or more correctly, that part of his situation that it is necessary to know in order to help the patient, the social worker is able to develop a social diagnosis. This social diagnosis is developed through a process of acceptance and understanding of the patient's responses in relation to his feelings and attitudes, and his past and present experiences. With the social diagnosis, which will include the important factors in the medical diagnosis, the worker is then able to move toward planning and carrying out treatment goals.

"Social casework in a hospital,... is concerned with helping the patient with personal or environmental difficulties that predispose toward illness or interfere with obtaining maximum benefits from medical ... care. This service depends upon individualized study of the patient so that his medical or emotional situation, and its inter-relationship with his personal needs and problems may be understood. Sharing of information between the doctor...and social worker is basic to their individual understanding of the patient. With this understanding the social worker helps the patient to participate in a plan acceptable to him that is consistent with the medical...recommendation."2

1. Statement of Standards to be Met by Medical and Psychiatric Social Service Departments in Hospitals, Clinics and Sanitoria, Ottawa, Canadian Association of Social Workers, 1952.
2. Canadian Association of Social Workers, Statement of Standards.
the techniques employed in the social work treatment method are directed
toward modifying both internal and external stresses through the medium
of collaborative working with patient, doctor, and others in the treat-
ment team.

In addition to, and co-incident with, the responsibilities
which the social worker has to the patient are his responsibilities to
hospital and community. The social worker's first responsibility to the
active treatment hospital is to enable patients to leave when their peri-
od of active treatment is completed. The social worker, because of his
knowledge of community resources, and his understanding of the meaning
of illness to the patient, is able to bring to the treatment team sig-
nificant help with discharge and convalescent planning. At the communi-
ity level, he also has the responsibility of clarifying and interpreting
the active treatment hospital's function of treatment rather than custod-
ial care. At the same time, the social worker has the opportunity of
interpreting to community, gaps in service which may preclude the hospit-
al from carrying out this active treatment function. This, of course,
is a two way process, since the social worker, through his knowledge of
the community is in the best position to interpret to doctors and hos-
pital authorities, (both treatment and administrative), what limiting
factors exist in community resources.

The Modern Concept of Convalescence.

The present day socio-medical concept of convalescence has
its origins in at least three areas of social evolution. The first of
these, medicine itself, has, since the time of Hippocrates or earlier,
recognized that human beings require a period of recovery after illness,
during which time the individual regains his bodily functioning through
normal physiological and biological processes. What has been perhaps
less well recognized, is that the human psyche also needs this opportunity to move from what can be almost complete dependency on hospital personnel and facilities, to a psychological readiness to resume some measure of self sufficiency in the community. The exponents of psychosomatic medicine have put forward the concept that there is an inter-relatedness between physiological, biological, and emotional functioning which must be considered when treating illness and disease. This concept, termed homeostasis, is becoming better understood by medical men, and is, in a large measure, affecting newer trends in the treatment of disease. The concept has given rise to entirely new approaches to the medical management of the patient during convalescence, and has made it necessary for the medical profession to re-define its concept of convalescence. Dr. Kessler, in his book, The Principles and Practices of Rehabilitation, has defined convalescence as part of the total rehabilitation goal of the treatment team, and says:

"Today the term convalescence has taken on a new meaning, one identified with a dynamic programme of care which is not only concerned with the active treatment of the disease but also with the preparation of the patient for normal living after recovery."  

Frances Upham, gives a similar definition when she says that convalescence is part of one continuous process which, together with rehabilitation, is designed to restore the "individual as nearly as possible to his normal level of functioning and to help him achieve the maximum economic inde-

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3. Ibid, p. 36.
pendence within his capacity.* In either case, the definitions are broad enough to include, not only the techniques of physical medicine, but also the contribution that can be made by the social worker or other member of the treatment team.

However, before examining the social worker's concept of his role in convalescence, it would be well to consider the second area of social evolution which has contributed to the fuller understanding, and more comprehensive definition, of this period of recovery from illness. This second area concerns the contribution of the lay group - a contribution that has evolved through community usage, rather than through any defined philosophy of service. The lay group has traditionally identified convalescence with custodial care, such as might be provided for chronic or terminal illness. That aspect of convalescence which concerns the restoration of the individual to the community, has, for the most part, been assumed to be a family responsibility, and it is only in the last twenty-five to thirty years that this responsibility has become accepted as belonging to the community as well. The recent trends in family living, involving as they do smaller family units, and smaller homes, coupled with other socially disorganizing forces such as the increasing mobility of population, has meant that possibilities for convalescent care in the home are much more limited than formerly. Thus, while it is often possi-


2. Kessler, op. cit., p. 36.


ble for a patient to leave the hospital in the care of family or friends, it is not always possible for that patient to live for any period of time in the home of a relative or friend, nor is it always possible for him to assume full responsibility for his own management in his own home, at that particular point in his recovery. Nevertheless, he is no longer in need of acute hospital facilities, and is therefore faced with the problems of making alternate convalescent plans which quite often may be in direct opposition to his real desires to return to family and friends immediately. This happens at a time, when, as we have seen, the patient's emotional resources may also be weakened as a result of his illness, so that without understanding help, it could be an extremely debilitating experience for him.

To the medical social worker, these disorganizing social forces, which give rise to weakened family structure, insofar as the convalescing patient is concerned, present additional problems. One of the foremost of these is that the medical social worker's plan, in offering case work services to patients, generally stems from the basic social work philosophy that the family is the primary unit of society, and that social treatment of the patient must be focused, wherever possible, towards preserving this family unit, if the long term goals of the treatment team in the medical setting are to be realized. Thus, the third important contribution to the modern concept of convalescence has come from the social work profession, which has brought to medical settings this awareness of the importance of the patient's social situation, and its relationship to the patient's medical condition.

In the two definitions of convalescence which have been discussed, there would seem to be agreement as to the need for active medical treatment. There is also a suggestion that efforts must be made, during convalescence, to help the patient to achieve the best possible level of functioning as his illness abates. Because of the inter-relatedness of medical and social factors, the responsibility for carrying out much of this second part of the task lies with the medical social worker, who, over the years, has been able to contribute to the total understanding of convalescence an appreciation of the fact that illness cannot be viewed from its purely physical effects on the individual, but carries with it factors involving the family and the community. Therefore, while the social worker should accept the definition suggested by Dr. Kessler and others, he would see, in addition, some necessity to include a recognition of the necessity of enabling the family and community to participate in the convalescent programme.

A clearer understanding of the community's responsibility in convalescence might be gained by examining some of the factors that influence convalescent planning generally. As has been noted, it is only in the past twenty-five to thirty years that convalescence has been seen as a community problem. This movement from family responsibility to community responsibility has paralleled to some extent, advances in medical science, such as the discovery of insulin, improved surgical skills, modern antibiotics, and early ambulation, which have all had their effect in prolonging the life expectancy of Canadians. At the same time the acute phases of many illnesses have been reduced, while the necessity for convalescent care has increased. Early ambulation in particular, has

1. Hyman, loc. cit.
reduced the necessity for care in acute hospitals, however, this does not mean that more rapid recovery and return to normal functioning can be effected at home, merely because the patient is permitted to walk, soon after major surgery. In fact, the placing of excessive physical or emotional demands on a patient at this point in his treatment, may bring about complications rather than recovery. The use of antibiotics can create similar misunderstanding in the minds of lay people, often with unfortunate results. Antibiotics aid the physician, not by reducing the duration of illness, but in reducing the acute phase of the illness by assisting the human organism to combat infection. The result is that patients who have been treated with antibiotics may feel quite capable of performing at a normal level, even though, from a clinical point of view they still require a period of convalescence.

However, the fact that many of these advances in medical science have been successful in reducing the acute phase of illness, has meant that hospitals have come to see their role as one of active treatment, while the problems of convalescence are becoming more and more, the responsibility of the community. This in turn has created problems for the patient who is faced with the necessity of leaving hospital when his doctor tells him he is no longer in need of active treatment, but at the same time is not ready to resume normal living. Many communities have dealt with this problem by providing facilities for those persons unable to avail themselves of family or private nursing resources. But even where such resources exist, the patient will often need the skillful help of the treatment team in order to make the best

use of them. To the medical social worker falls the task of understanding the needs of the individual patient in relation to his medical and social situation, and his total rehabilitation goals, and of enabling him to use whatever resources are available to him in the community.

Medical Social Work at the Vancouver General Hospital.

The Vancouver General Hospital has, since 1926, offered amongst its treatment services, the facilities of a Social Service Department. The Department endeavours to offer services to patients and hospital through the maintenance of sound casework practices, and indirectly, as a result of this offers medical social work services to the community as well. More direct services to community are also developing as the staff of the department becomes more active in health and welfare committees in the community.

As the department is presently structured, its Director is responsible to an Assistant Medical Director who has administrative responsibilities for treatment and is also the co-ordinator of the educational programme in the Hospital. The department offers services through two main sections, namely, outpatient clinics, and in-patient hospital facilities. Casework services are offered in each section by professional social workers who have responsibilities for specific in-patient wards, or outpatient clinics. Standards of service and of personnel practice are comparable to those set by the American Association of Medical Social Workers and the Canadian Association of Social

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1. This concept of the medical social worker's three fold function to aid patient, hospital and community, through sound casework practices is developed more fully in a recent publication of the Eastern Canada District of the American Association of Medical Social Workers, entitled, "Teamwork in the Medical Setting", Institute Proceedings. It is specifically discussed by Barbara M. Allan, under the heading, "The Role of the Social Worker in the Rehabilitation Clinic", pp. 14 - 19.
Workers. The hospital, in addition to offering the City of Vancouver and the Province of British Columbia general and specialized "acute hospital" facilities, also performs a teaching function in the community. The social service department, in conjunction with other departments, has played an active role in developing and carrying out this teaching programme, both in respect to social work students, and students in other professions.

Because of the teaching programme, and because of the progressive administration of the hospital, the modern approach of the medical team\(^1\) has been embraced by the various departments.

"Medical teamwork - the co-ordination of services in the interest of the patient and his family has come to be accepted as the only valid approach to the complex problem of maintaining and restoring health."\(^2\)

This team approach involves participation of all professional disciplines in the hospital, including nursing, physical therapy, dietetics and social work, under the leadership of the physician. It depends, however, on the additional factor of relationship with the patient for the purpose of lending "strong personal support at the time of illness"\(^3\) to enable the patient to utilize the helping efforts of each discipline. The concept of relationship is one that is well understood by social workers and physicians, and one that has been effectively utilized by other professions such as nursing and physical therapy. Because relationship is one of the basic tools of social work, however, the social worker in the medical team assumes the additional responsibility of effecting

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1. A full discussion of the medical team in the Vancouver General Hospital is to be found in Mary Frew Bowkett's, *The Social Worker in the Treatment Team*, Master of Social Work Thesis, University of British Columbia, 1951.


inter-professional relationships which will have value in achieving the healing goals of the total team. This requires on the part of the social worker, confidence in his own skill, and an ability to co-ordinate the efforts of key people, both lay and professional, in bringing their contributions to bear on the welfare of the patient. The medical social worker at the Vancouver General Hospital is frequently one member of the medical team, and to a large extent is able to perform the dual function of an integrative and enabling person in bringing his special body of knowledge into the total treatment programme.

The Discharge Problems of Vancouver General Hospital Patients.

Patients admitted to the Vancouver General Hospital present a wide and varied range of medical problems. The period of their hospitalization may extend over a few hours in the emergency ward, or over several years in wards such as the polio wards. The average stay in an "acute hospital" in British Columbia, however, ranges from six to twelve days, with the Vancouver General Hospital generally having the higher average mentioned.

For purposes of efficient medical management, patients are usually domiciled according to the chief medical service required. Thus, orthopaedic patients will usually be found in one section of the hospital, surgical patients in another, and general medicine patients in a third. Similarly, patients suffering from genito-urinary disorders will be accommodated according to the specific medical service required, as will maternity patients, and patients suffering from infectious diseases. Nevertheless, regardless of the service offered, most patients are faced, ultimately, with the necessity of making discharge plans. The greater number of them are, of course, able to make such plans without assistance
from outside sources, but there are always certain patients who require professional help in planning for discharge. Generally speaking these latter patients fall into four groups, whose problems are to some extent similar, in nature, but, nevertheless, must be distinguished from one another for purposes of analysis. These problems are defined as follows.

1) **Problems of post discharge accommodation.**

Patients affected by these problems fall into two groups. The first are those who have had to give up former accommodation because of the financial problems that their illness has created for them, while the second are those who, because of their illness, must change their accommodation in order to cope with physical or environmental situations that the illness has created. For example, patients who have become paraplegic as a result of illness may be successfully retrained in many ways, but usually will have to be accommodated in facilities that have elevator service, or a minimum of stair climbing. As a rule, however, patients whose problems are primarily ones of accommodation, are able to function in the community once this need has been met.

2) **Problems of Convalescent Care.**

As pointed out above, many patients are ready for discharge from active treatment hospitals before they are ready to resume their former level of functioning, and must make plans for a period of convalescence. The majority of these patients will ultimately

(1) This division of discharge problems is the writer's, and should not be construed as an indication that the Social Service Department makes such an arbitrary division of its services. The services of the Department are offered to all patients on the basis of their individual needs, and the implication here, is, that from a research point of view, patients planning for discharge tend to fall into one of these broad groupings.
resume some level of self sufficiency, but there is a smaller group of patients whose illnesses are of a chronic nature, occasionally marked by acute episodes which make hospitalization necessary. These patients frequently require a period of care in a specialized convalescent home before being able to return to a less dependant form of care at home or in an institution.

3) Problems of Chronic Care.

Patients whose medical conditions create the need for some of the provisions of nursing care over an extended period of time, with very little hope of achieving a more independent level of functioning, are usually described as chronic patients. Although these people may be accommodated in their own homes, or in institutions in the community, the thing that distinguishes them from other groups of patients is the fact that they are, because of some residual of their illness, in need of some nursing care to fully meet their basic needs.

Generally speaking, these patients will require only a minimum of medical care for the condition that has become chronic, but they will require, over an extended period, nursing help that will permit them to enjoy a maximum of satisfaction commensurate with the limitations imposed by their illness.

4) Problems of Terminal Care.

Patients requiring this type of care outside an acute hospital, differ only slightly from those requiring chronic care. One difference is in the duration of time that specialized care will be required, since terminal illness does not usually extend over lengthy periods. In practice, it would be possible to group chronic and terminal problems together for purposes of administration, however,
it has been found that patients requiring terminal care must often be considered on a more purely emotional basis than the long term chronic patient, because of the effect that such a diagnosis may have on family, friends, and community.

The Social Service Department at the Vancouver General Hospital is frequently asked to offer casework services to individuals whose discharge needs fall into any one of these categories. Various methods have been devised, and various resources have been developed to deal with these problems, but in discussions with the social service staff members, significant lacks have been described in the availability of resources to help the second group, namely, those requiring convalescent care. In this study, therefore, it is proposed to examine the problems of this group of patients, and the existing methods and resources used by the Social Service Department in helping these patients make convalescent plans.

Before considering specific convalescent problems, some mention should be made of the sources of referral of these patients to the Social Service Department. As a general rule, the majority of referrals come from the doctors, but some may come from other members of the treatment team, from other hospital staff, or from relatives or friends of the patient. In any event, the referral is always discussed with the patient's doctor as soon as possible, in order that both doctor and social worker can share their knowledge of the case, and reach a decision as to the most suitable type of social service to offer the patient. If the referral originates with the doctor he will usually have formed some impression of the nature of the problem that confronts the patient, and the way in which the social worker may help.
In order to facilitate the handling of referrals, the doctors are asked to complete a special form which, in addition to providing identifying information, lists eight types of problems which appear to be most common to hospital patients. "Appendix "A", shows the referral form presently used by the doctors in requesting services from the Social Service Department. It will be noted that the category headed Discharge Plans is broken down into four sub-headings as follows: Nursing Home, Boarding Home, Institution, and Home. In practice it has been found that, although referrals are made for one or the other of these types of discharge plan, it is often the case that when the social diagnosis has been formulated, some modification of the original plan has to be made. For example, the patient who is referred for nursing home care, may, upon further social assessment by the social worker and the doctor, be discharged to his own family, because of cultural or psychological factors, even though the medical diagnosis indicates that a good deal of nursing care will be needed. Also, it occasionally happens that patients referred for other reasons will ultimately require help in making convalescent plans as well. This is partly explained by differences in definition of reasons for referral between doctors and social workers, and such cases are usually solved by individual discussion with the doctor concerned.

In the main, when a referral has been made, and the need for help with convalescent planning has been agreed upon by doctor and social worker, the problems that confront the patients referred fall into the three categories of accommodation, financial problems, and psychological problems. The actual methods of helping the patient to deal with these problems will be dealt with more fully in the ensuing chapters, however, it should be mentioned at this time, that these problems often involve
the patient's family and friends and the community, as well as himself.

Focus of the Study.

In attempting to confine the scope of this study, certain limits were set. The first of these is that the study was restricted to in-patients of the hospital, up to the point of their discharge. The second is that the total in-patient population referred to the Social Service Department was considered, with the exception of referrals from the maternity wards, and the Health Centre for Children. Maternity ward referrals were deleted from the study, because, at the present time, the services offered to these patients are largely in the nature of referrals to other community agencies that provide a specialized form of convalescent care based on the special needs of maternity patients. For the same reason, referrals from the Health Centre for Children were not dealt with since the problems of convalescent care for children differ greatly from the problems presented by other acute hospital patients, as do methods employed by social workers in dealing with them. In addition, the record system of the Health Centre for Children is not fully integrated into the total record system of the hospital at this time, therefore, specialized research methods would be required to extract and standardize the data in these records.

The month of September, 1954, was chosen as the most representative month from the point of view of referrals to the Social Service Department, for several reasons. The first of these is that the department, in January, 1954, began to use a comprehensive type of monthly statistic sheet, and by September, most of the difficulties of this changeover had been overcome. The second reason is that the question of elective surgery must be considered in order to avoid unnecessarily
weighting the group to be studied. Persons admitted for this type of
service during the month of September are not usually influenced by such
factors as summer holidays, or the Christmas season, consequently, hospital
authorities consider that the most representative group is admitted during
this month. Some seasonal differences occur, however, during this month,
in relation to specific illnesses such as poliomyelitis, and from this
point of view, September is frequently a month in which increased admis­
sions occur in these categories. This problem did not appear to be sig­
nificant in September, 1954, since illnesses which often attain epidemic
proportions in British Columbia in the month of September, did not create
unusual demands for hospital facilities during September, 1954.

The study itself consists of an examination of thirty-two
patients that were referred to Social Service Department during the month
of September, 1954, according to their age, sex, marital status, and fin­
ancial status, following which these patients' convalescent problems are
examined and compared on a statistical basis. The study is then expanded
to include an examination of the direct and indirect services offered by
social workers in the hospital to these patients, in respect to the con­
valescent planning problems that were presented.

Essentially, the study attempts to answer the questions of; who
were the patients studied, what convalescent planning problems did they
present, what social services did they receive, and were such services
appropriate to the problem of convalescent planning?
Methods and Procedure

In order to assess the role of the medical social worker in helping patients with convalescent planning, it is necessary to understand what types of patients are referred, and what types of problems they present. Since the term convalescent planning holds various shades of meaning for individual social workers, and since patients receiving this type of service are referred to the Social Service Department under a number of different headings on the Department's referral form, certain problems arise in attempting to select the cases involving convalescent planning. It was thought at the outset, that the case records for all referrals for the month of September, 1954, should be read, and those dealing with the problem of convalescent planning studied. This plan, however, was abandoned when it was realized that many cases reported in the social worker's monthly statistics were not recorded in detail elsewhere. Therefore, since it was important to know what percentage of the total caseload was receiving convalescent planning service, an alternate method of obtaining this information had to be devised.

As noted in Chapter I, the study has been limited to in-patients and the services offered them up to the point of their discharge from the hospital. The Maternity wards, and the Health Centre for Children have been deleted from the study for the reasons mentioned previously, which leaves, for purposes of study, most of the general and specialized medical and surgical wards in the hospital. These wards are served by five medical social workers, each of whom has responsibilities for specific wards, and

1. See Appendix "A", and the discussion in Chapter I, p. 20.
offers services to all patients referred from those wards. During the
month of September, 1954, these five social workers reported that social
services were offered to a total of two hundred and sixty patients. This
figure represents the total case load of the five social workers, as it
appeared on their monthly statistic sheets. Subsequent adjustments had
to be made for the purposes of this study since several of the social
workers carried some cases in the Outpatients' Department as well as on
the in-patients wards. The monthly statistic sheets break down the gross
total into "ward" or "Clinic" cases, therefore, the "clinic" cases were
subtracted from this gross total. This left an adjusted total of two
hundred and thirty-three cases to consider.

In order to determine which of these two hundred and thirty-
three cases involved problems of convalescent planning, the five workers'
monthly statistic sheets were again examined. Information contained in
these sheets includes a section headed "Reason for Referral," which is
subdivided into eight columns that are identical to those listed on the
Department Referral Sheet. (See sample in Appendix "A"). A random
sample of cases in the Social Service Department files revealed that
most convalescent planning problems were referred under one of the fol-
lowing sub-headings: Rehabilitation Plans, Discharge Plans, (Nursing Home,
Boarding Home, Institutional Care, or Home,) or Other. Therefore, a
schedule (a copy of which is inserted as Appendix "B"), was devised in
order to collect the required information from these statistic sheets.
The information sought in this schedule included the patient's name,
the hospital unit number assigned to the patient, and the reason for
referral, under one of the six sub-headings above. Cases referred for
reasons other than those six were not listed on this schedule. Of the
two hundred and thirty-three cases reported on the monthly statistics
sheets, one hundred and sixty-three appeared under the sub-headings on this schedule. The distribution of these cases was - Rehabilitation, nine: Nursing Home, ninety-one: Boarding Home, twenty-three: Institutional Care, ten: Home, sixteen: and Other, twelve. These figures indicate that the majority of referrals for the month of September, 1954, were made for Nursing and Boarding Home placement.

The information contained on the schedules at this point did not give the required data regarding cases needing help with convalescent planning, therefore, it was necessary to submit the completed schedules to the social workers concerned to obtain this additional information. A separate column was added to the schedule, and the social workers were asked to indicate which of the cases listed had, as the main problem, a need for help with convalescent planning. The social workers were asked to consider as convalescent planning cases, those in which a period of specialized care was required before the patient could resume either his former level, or his most satisfactory level of functioning. When this information was tabulated, it was found that out of the total of one hundred and sixty-three cases listed on the schedule, eighty-six were considered by the social workers to have, as their main problem, a need for help with convalescent planning. Thus, of the total in-patient population appearing on the case load of the Social Service Department during the month of September, 1954, fifty-three point eight per cent were referred for help with convalescent planning.

Having isolated the cases in which convalescent planning was the important factor in casework treatment, it was then necessary to

1. In the ensuing discussion in this study, the masculine gender will be used to define patients of either sex unless the context otherwise indicates.
determine how many of these cases had social service records in the Social Service Department files. This was accomplished by checking the names on the schedules against the card index of the Department's files, since every case record that is set up in the Department is indexed alphabetically in a separate card catalogue. By using this device, it was found that thirty-two cases, out of the total number of eighty-six that received help with convalescent planning, had social service records available.

Thus, having determined which cases had convalescent planning as an important factor in the casework process, and having selected those cases for which social service records were available, it was then possible to proceed to extract the required data that was available in the case records. This was accomplished by reading each file and collecting the required information on a second, but more comprehensive, schedule. (see copy at Appendix "C"). This schedule was divided into four main sections. In the first section, the patient's name and hospital unit number was entered to facilitate drawing the files. This material was taken from the original schedule, which contained the complete list of patients referred for discharge planning. The second section was arranged to collect routine data from the face sheet of the file. Factors of sex, age, religion, marital status, occupation, financial assistance, type of medical care offered, (staff or private doctor's service), and admission diagnosis were obtained in this manner. The third section of this schedule was constructed in a manner to permit the tabulation of information pertaining to the convalescent problems affecting the patients, or involving their families or friends of the community. These problems were grouped broadly under the headings Finances, Accommodation, or Psychological
problems. Finally, a column was used for general remarks about each case studied, and about special factors, where these seemed to need further clarification.

Who are The Patients Referred For Convalescent Planning?

In analyzing the statistical data concerning the thirty-two patients referred for convalescent planning help, certain factors appeared to be particularly pertinent to problems of convalescence. These were age, sex, marital status, and financial status. At the outset, it was thought that medical diagnosis might be significant also, however, on examination, factors of diagnosis covered such a wide range of medical problems, that no valid observations could be made in this small group of patients. It was noted, however, that cardiac conditions occurred in nine cases, involving four men and five women or twenty-eight per cent of the group of thirty-two patients. This pattern tends to be common in general hospitals in British Columbia where cardiovascular disorders account for about twelve per cent of the total patient days spent each year in general hospitals, including maternity wards.\(^1\)

Factors of occupational status were also examined, but were not thought to be representative of any large universe because of the limited size of the study group. Seventeen patients were classified as retired, and five were shown on the face sheets as unemployed at the time of admission to hospital. Some explanation of this becomes evident in the examination of age factors in this group, since the majority of the patients were over forty years of age, and over fifty per cent of the group were over sixty-five.

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Of the thirty-two patients studied, it was found that there were sixteen men and sixteen women in the group. One of these was a four year old boy, and the remaining patients ranged from twenty-one years to eighty-eight years of age. For purposes of analysis, the age factor was studied under three broad groupings, namely, thirty-nine years and under, forty to sixty-four, and sixty-five and over. This breakdown was decided upon on the basis that the incidence of financial dependency increases at the age of forty, when employment possibilities become fewer because of age,\(^1\) and again at sixty-five when the provisions of Old Age Assistance, and of most superannuation plans become effective.\(^2\)

In the under thirty-nine group, five men and three women were listed, in the forty to sixty-four group three men and four women appeared, while in the over sixty-five group eight men and nine women appeared. Thus, fifteen patients studied were under sixty-five, and seventeen were sixty-five or over. This would appear to be a normal distribution of hospital patients according to age, since the incidence of degenerative diseases is usually higher in the over sixty-five group. The interesting feature about these findings, is not that these older persons are in hospital, but that they are so frequently referred to the Social Service Department for help with convalescent planning, rather than for help with planning for chronic care.

\(^1\) A recent study of one thousand five hundred and twenty unemployed persons in the City of Vancouver reveals a very marked increase in unemployment at age forty. This study was conducted by the Social Planning Council of the Community Chest and Council of Greater Vancouver and is entitled, Report on Registration of Unemployed, Feb. 23, 1955.

\(^2\) In British Columbia, Old Age Assistance, a Dominion-Provincial income security programme, is made available to persons sixty-five years of age and over, on proof of eligibility. Old Age Security, a universal pension scheme, is available to Canadians at age seventy.
Marital Status

Information concerning the marital status of the group was collected under the headings, single, married, widowed, divorced, or separated. Of the total number of thirty-two patients, ten were listed as single, six married, fourteen widowed, two divorced, and none separated. From this it can be seen that twenty-six of the patients studied were dependent on persons other than a spouse, for help with convalescent planning. Sixteen of these were in the over sixty-five group, which further complicates their situation in that they are not likely to have parents or siblings who are able to assist them, and their own children, if any, probably have personal family responsibilities which do not permit them to assume much responsibility for older relatives. This factor, together with the financial problems that frequently beset older people, explains in part why patients sixty-five and over account for slightly over fifty per cent of this group, which required help with convalescent planning.

Table I, (overleaf) classifies marital status by age groupings and sex of the thirty-two patients studied. It will be noted that in the thirty-nine and under group, five men and three women, or a total of eight patients are shown. Of these, three men were single, two men were married, and the remaining three were married women. In the forty to sixty-four group, there were three single men, two women who were married, and two women who were divorced. In the sixty-five and over group, there were three single men and one single woman. Only one patient, a woman, was married, but five men and seven women were widowed. From this it can be seen that the largest number of referrals for convalescent planning in this group were for men and women sixty-five and over, and widowed, being thirty-seven-and-one-half per cent of the total, while single men in
all age groups constituted the second largest group of referrals for convalescent planning services.

Table I

Comparison of Age, Sex, and Marital Status of Thirty-two Patients Referred to the Social Service Department for Help with Convalescent Planning.

(Vancouver General Hospital, Social Service Department, September, 1954.)

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
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<tr>
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<td>40 to 64</td>
<td>65 and Over</td>
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<td>3</td>
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<td>-</td>
<td>-</td>
</tr>
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<tr>
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<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Records selected from files of Social Service Department, Vancouver General Hospital.

The absence of persons whose marital status is described as separated, and the low incidence of divorced persons in this study, requires some further comment. First, these statistics are compiled from face sheets which are exact copies of the admission sheets used by the hospital, and it is quite possible that many people are reluctant to discuss their marital status with the admission clerks, particularly at a time when illness has probably lowered their emotional defences, and they are anxious to create an acceptable impression in the eyes of those who are in a position to make medical treatment available to them. Secondly, where marital problems
do exist, and appear to be affecting the course of treatment, these patients are often referred to Social Service on the basis of emotional problems, rather than for convalescent planning, and convalescent planning may then be of secondary importance in the social casework treatment of the patient's problems. Normally, where convalescent planning is a factor in such cases, some evidence of this should appear on the worker's monthly statistics sheet, however, it frequently occurs that, in the process of helping the patient with the emotional problem affecting his illness, the problems of convalescent planning resolve themselves.

Financial Status

Information concerning the financial status of the patients is the group studied was also collected from the face sheets of the Social Service records. The information available indicates if the patient, at the time of admission, is in receipt of Social Assistance, Old Age Assistance, Old Age Security, War Veteran's Allowance, Workmen's Compensation, or Other. Information is also given, as to whether a patient is to be under the care of a staff doctor or a private physician. Usually, patients who are in receipt of public assistance or who are unable to afford private doctor's services, are admitted as staff patients.

Patients receiving Old Age Security are not necessarily in receipt of public assistance, since this is a universal form of income security made available to Canadians who are seventy years of age or over, regardless of their financial status. Consequently, these patients cannot be classified as one group but must be broken down into two groups, those who receive additional financial assistance from public funds, and those who are financially independent. This division was accomplished by cross classifying those patients in receipt of Old Age Security with the type.
of physicians services, either staff or private, and then checking this information against the Social Service records which invariably contain additional data on financial status.

From this it was found that fifteen patients, seven men and eight women, were in receipt of Old Age Security, and that seven men and four women were classified as staff patients. When the records were studied further it was found that these eleven staff patients were all in receipt of additional public assistance, and the four remaining patients were financially independent. It should be noted, however, that financially dependent patients are not always listed as staff patients, since this division of patients is made at the discretion of the doctors. Nevertheless, it is very unlikely that a financially independent person would be admitted to hospital as a staff patient.

Of the total group studied, there were sixteen patients admitted to hospital while in receipt of some form of financial assistance. Thirteen of these patients, including the eleven patients receiving Old Age Security and Supplementary Allowances, were receiving financial assistance from two sources. The distribution of these patients according to type of assistance received was, Social Allowance, one man and one woman; Old Age Assistance, one man; Old Age Security and Supplementary Allowance, seven men and four women; War Veterans Allowance, two men; Workmen's Compensation, one man; and Other, one man. Sixteen patients were not in receipt of public assistance, however, of these sixteen, two men and two women were listed as staff patients, which suggests that their financial status was marginal.

From these figures it can be seen that twenty cases out of the thirty-two studied were living on low or marginal incomes. This would.
suggest that the Social Service Department is more frequently involved
in cases where financial problems are a factor in convalescent planning,
than in cases where financial independence occurs. One possible explana-
tion for this is that patients who have financial resources are usually
able to make convalescent plans on their own and while there may be
emotional problems present when such patients are faced with the need to
make convalescent plans, they may conceal these from the doctors and
consequently not be referred for help from the Social Service Department.

This large group of financially dependent patients in the Social
Service case load does not agree statistically with the figures for total
admissions to the hospital. It has been noted for some time that admis-
sions are fairly consistently in the ratio of one staff patient to six
private patients.¹ Unfortunately, data is not collected according to
type of assistance for the total hospital admissions, therefore exact
comparisons cannot be made, but, of the group studied here, seventeen
patients were staff, and fifteen patients were private, a ratio of
slightly more than one staff to one private patient. This fact seems to
corroborate the observation that patients in marginal financial circum-
stances are referred to the Social Service Department for help with
convalescent planning more frequently than patients who are financially
independent.

What Are The Problems of Patients Referred for Convalescent Planning?

As discussed in Chapter I, when a patient is referred to the
Social Service Department for help with convalescent planning, three main

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¹ From information obtained in an interview with the Chief Medical
Records Librarian, Vancouver General Hospital, January, 1955.
areas of patient needs are presented. These are, problems of finances, problems of accommodation, and psychological problems which arise because of the need for convalescence. These problems appear in the social worker's dealings with the patient, with the patient's family and friends, and to a lesser extent with the community to which the patient must ultimately be discharged. In order to ascertain the incidence of such problems in the cases studied, separate columns were included in the second schedule, (Appendix "C"), for the purpose of noting what type of problems occurred in each case. Three subdivisions were necessary in order to collect this information. The patients' problems were first divided on the basis of involvement of patient, family and friends, and community, then each subdivision was further divided under the headings, finances, accommodation, and psychological.

To collect the required information in this manner, however, some frame of reference was needed that would make possible a reasonable degree of consistency in definition of these terms. This was necessary because the case records were completed by different social workers, all of whom have different techniques in recording, and in describing, the problems of patients. Consequently, two sets of definitions were needed, the first concerning who was involved in the problems, and the second concerning what those problems were. The final definitions are discussed below and in the following pages, in order to lend some clarity to the findings of the study.

A) Problems affecting the Patient.

All problems of convalescent planning that were discussed between social worker and patient were included in this category. Occasionally, a patient is too ill to enter into his own planning, and the social worker must make an
assessment on the basis of other information than that given by the patient, in which case those problems were not listed under this category.

B) **Problems Involving Family and Friends.**

Persons directly related to the patient, or persons having other than a professional interest in the patient's welfare, were considered under this heading. Usually, such people are involved in planning at the instance of the patient, although they may often approach the social worker on their own, to make inquiries, or to offer services. These persons may also be involved in planning as a result of the social worker's intervention, after such action has been discussed with the patient and has received his endorsement.

C) **Problems Involving the Community.**

This category was included, because the medical social worker, in offering convalescent planning services, must frequently make use of community resources, or of professional persons not affiliated with the hospital. Accordingly, it includes the personnel of community welfare and health agencies outside the hospital, and the personnel of such private agencies as licensed nursing or boarding homes. Also included here are the personnel of special convalescent centres such as the Western Society for Rehabilitation,¹ and provincial health institutions.

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¹. The Western Society for Physical Rehabilitation, a private health agency in Vancouver, offers in-patient and outpatient physical rehabilitation services to the orthopaedically disabled in British Columbia.
The headings "A", "B", and "C", above were further sub-divided according to the nature of problems that occurred in convalescent planning. It was found that the same three sub-headings could be retained in the three areas of social service help, viz, direct help to patient, or indirect help through family and friends, or through community agencies. Therefore, the definitions given below will apply to all three of the headings listed above.

A) Financial Problems.

Convalescence is often a very costly problem for patients and their families, and because of this various resources have been developed in the Province of British Columbia to assist persons who are unable to finance a period of recovery from illness. The problems that most frequently occur are, loss of income or dissipation of savings because of illness, a need for routine convalescent care which the patient is unable to finance, or a need for specialized care which may be unusually costly. In addition financial problems may arise in relation to the purchase of special appliances which the patient requires to assist in his rehabilitation plans.

For the family, there are frequent problems of loss of income during the patient's convalescence, as well as the problem of providing costly care and equipment for the patient. An additional problem that may involve both patient and family is that of providing transportation expenses, in order that the

1. At the present time the average per diem charge for nursing home care is approximately six dollars and fifty cents, but many nursing homes charge as much as ten or fifteen dollars a day. Boarding home care is usually cheaper, but averages from ninety dollars to one hundred and twenty dollars per month on a private basis.
patient may attend treatment centres such as the Vancouver General Hospital's Outpatients' Department, or in order that patient-family relationships can be maintained.

Financial problems that involve the community, are primarily those of providing financial aid through public or private resources, when the patient, his family or friends, or the medical social worker request such aid.¹

B) Problems of Accommodation.

Patients referred for help with convalescent planning may, for a number of reasons, require help with making arrangements for accommodation when they leave the hospital. The foremost of these reasons are reasons defined by the medical profession in consultation with the medical social worker, and would concern the need for special types of care. In addition, problems may arise around the need to change accommodation in order to be closer to medical service, or to avoid the necessity of climbing stairs or overworking the body in other ways during the period of convalescence. Finally, many patients require help in finding accommodation by reason of the fact that they have lost their former accommodation because of their period of hospitalization. This may mean that relatives or friends are no longer able or willing to care for them, or it may mean that they have been unable to maintain their former accommodation because of reduced income during the period in hospital.

¹ Most cities and municipalities in British Columbia make use of private nursing and boarding homes and assist patients with financial costs through social assistance funds. Patients receiving this type of help usually receive nursing or boarding home care at a lower rate than private patients would.
In problems of accommodation, the medical social worker may frequently make use of family or friends or community agencies in planning with the patient. Family and friends may be consulted on the basis of finding or providing accommodation, when such a plan appears to be in the interests of the patient, or they may be involved in order to help them understand why a specific type of convalescent care is recommended. The community, of course, also assumes some responsibility in convalescent planning, by making convalescent facilities available to the public. For the purposes of this study, community was considered to be involved, when either the patient or the social worker enlisted the assistance of some community agency, in order to arrange accommodation for the convalescing patient about to be discharged from hospital.

C) Psychological Problems

The meaning of illness to the patient, his family and friends, and the community, is a matter of special concern to both doctors and social workers. Illness may, to the patient, have both positive and negative aspects. To many patients it can mean, perhaps, the realization of a desired dependent state, while to others the enforced dependency created by illness may be a source of anxiety and conflict. Similarly, impaired functioning, as in amputation cases, may carry with it certain satisfactions, or conversely, it may appear as a threat to the patient's basic feelings about himself as a person.

Patients who require a period of convalescent care may be confronted, not only with problems concerning the psychological implications of the illness itself, but also with problems
of accepting or rejecting the suggestion that they need a period of convalescence. To some, the stage of convalescence may mean the giving up of a dependency state that has been quite acceptable, while at the same time, this relinquishment of a satisfying form of adjustment may carry with it a sense of being rejected by those who have been caring for the patient.1 To others, factors of concern about family finances, or about having to rely on others for care during convalescence, may make them quite resistive to the suggestion of further inactivity.

With the patient's family and friends, psychological problems often occur in relation to accepting the need for convalescence when the patient appears to be well, or again, problems may be deeply rooted in these peoples' underlying feelings about the patient and his illness. If these feelings are negative, the resultant responses of relatives and friends can be quite detrimental to the patient. Such responses as overt rejection of the patient, or an overprotectiveness,

1. Case #27, that of a seventy-four year old English woman, demonstrates how some psychological problems can present major difficulties in the medical management of a patient. This patient was admitted with a coronary disease, from the home of a former employer. She expected to return to his home on discharge, (culturally this attitude was quite justifiable), but when he refused to take her back because of the extra care she would need, her medical progress came to an abrupt halt. Her physical condition made her a candidate for Boarding Home care, but when she learned that she could not return to her former home she became extremely dependent on hospital personnel. Therefore it was agreed by patient, doctor and social worker, that she should go to a nursing home for a period of several weeks. The opinion of the doctor and social worker was that she should relinquish gradually some of her dependence, as her own confidence in her physical abilities improved. This plan was carried out, and in six weeks she was transferred to a boarding home where she continues to make satisfactory progress.

However, it is safe to assume in this case that if the boarding home plan had been embarked upon without recognizing and dealing with her dependency needs she would soon have been readmitted to hospital.
stemming from guilt feelings that have been aroused by the patient's need for care can frequently act as subtle obstacles to good convalescent planning.

Psychological problems which occur in relation to the community, generally involve broad problems, such as community apathy about patients' needs in relation to convalescence, but also they may include problems that develop around the specific patient's social situation. For example, patients who have histories of aggressive criminal behaviour may not immediately receive the full co-operation of the community, unless some clarification of the patient's underlying socio-medical problem is offered. Similarly, patients with unpleasant medical conditions such as neurodermatitis in a seemingly chronic form may not be readily placed in the community without some additional interpretation being given to the people who will have to deal with the patient.

The Patient's Problems.

The three problems which involved the thirty-two patients studied, their families and friends, and the community, are shown in Table II, (overleaf). Each patient was given a code number, and the patient's sex, age, marital status, and occupation were shown, following which the incidence of problems concerning his convalescence are shown.

Of the sixteen men studied, problems of accommodation appeared most frequently, involving the patients in thirteen instances, the family and friends in four cases, and the community in two. Case number 1, that of a four year old boy, was seen as a problem affecting only the family and friends, because the primary problem, accommodation, was not shared
Table II: Showing The Three Problems of Convalescent Planning Affecting Thirty-two Patients, and Involving Their Families and Friends, And The Community.

(Patients tabled in Sex groups, and in ascending order of age)

<table>
<thead>
<tr>
<th>Code</th>
<th>Sex</th>
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<th>Occupation</th>
<th>Problems Affecting Patients</th>
<th>Problems Involving</th>
<th>Community</th>
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Source: Vancouver General Hospital Social Service Records

(a) Finances (b) Accomodation (c) Psychological.
by patient and social worker. Problems of finance occurred as the second most frequent group, involving patients five times, family and friends three times, and community four times. Psychological problems occurred with patients in six cases, with family and friends in three, and not at all with the community.

With the sixteen women studied, the pattern was similar, although the incidence of problems was more frequent. Thus problems of accommodation occurred in all sixteen cases with patients, in nine cases with family and friends, and in five cases with the community. Problems of finances occurred seven times with patients, three times with family and friends, and five times with the community, while psychological problems occurred in nine instances with patients, five times with the family and friends of the patient, and not at all with the community.

From these figures then, it can be seen that problems of accommodation were the most frequent, occurring in twenty-nine of the thirty-two cases studied. The explanation for this is not immediately apparent, but it would seem from examining Table II, and from the discussion in Chapter I, (see page 12) that sex, age, and occupation may have some bearing on the frequent need for help with accommodation when planning for convalescence. The breakdown according to sex shows that all the women studied presented accommodation problems, and all but three of the men presented this type of problem. Of the three men who did not present problems of accommodation, two were under forty years of age, and one was of pre school age. Ruling out for the moment, the latter, (case number 1), because of its special circumstances, the remaining two males were married, and both had held responsible jobs before admission to hospital. Eighteen patients were listed as retired, (ten women and
eight men), and four patients were unemployed. Thus twenty-two of the thirty-two patients studied were not gainfully employed at the time of admission, and all of these patients presented problems of accommodation.

The problems that involved the families and friends of the patients were fewer in number than those involving the patients themselves. This is partly explained by the age range of the patients studied, since over fifty per cent of them were over sixty-four. People in this age range are not likely to have many resources in terms of family and friends, and this is particularly true when many of them are either widowed or single. Problems involving family and friends occurred with greater frequency with the women studied than with the men, and the majority of problems involving the families and friends of the women patients centred on accommodation.

The problems involving the community occurred least frequently, and were reported in the Social Service records as problems of finances or accommodation only. With the men these problems affected only those over sixty-four years of age, while for women problems involving the community occurred most frequently in the under forty group. Since problems involving the community are primarily those of providing finances and accommodation, it seems unusual that there is not a more consistent distribution of these problems according to the age range of both men and women. However, one explanation of this is that public assistance had already been granted to a number of patients prior to their admission to hospital, and of the total group of thirty-two patients only seven were finally placed in accommodation that was provided by public funds.

1 See discussion on p. 28.
Further examination of Table II, reveals that twelve of the patients had problems which concerned themselves only, ten patients showed problems affecting themselves, and involving their families and friends, and ten patients had problems that affected themselves, and involved their families and friends, and/or the community. These groups of patients, and the problems that appeared in their case records are shown in Tables III, IV, and V, below.

In Table III, (overleaf), the patients whose problems concerned only themselves are listed according to code-number, and are cross-classified by age, sex, marital status, and occupation, and by problems of convalescent planning. Of these twelve patients, the records of two show that all three problems of convalescent planning were present. These were cases number seven, and twenty-two. Four patients, numbers six, eight, twenty-six, and thirty, showed two factors, three of which were accommodation and psychological, and one of which was accommodation and finances. The remaining six patients, numbers two, three, thirteen, fifteen, twenty-nine and thirty-two, showed only one factor, which in five instances was accommodation, and in one instance was finances. In this group then, the problem most often encountered, either alone, or in combination with other problems, was that of accommodation, occurring a total of eleven times. Psychological problems occurred five times, and problems of finances occurred four times.

Table IV, (following page 44), is constructed in a similar manner to Table III, except that it is expanded to include the problems as they appear to involve the patient's family and friends as well as himself. Again, ten patients appeared in this grouping, and of these, six showed problems of accommodation involving the patient and his family

(Patients tabled in Sex groups, and in ascending order of Age.)

(Vancouver General Hospital, September, 1954.)

PATIENTS IN GROUP "A"

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<th>(c)</th>
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Source: Group of thirty-two patients, selected from Vancouver General Hospital Social Service Department Records.

# (a) Finances
(b) Accommodation
(c) Psychological
and friends. Two showed problems of accommodation affecting the patient only, while only one case showed the problem of accommodation involving the family and friends, but not the patient. Only one case in this group did not present accommodation as a problem.

An examination of the total incidence of problems in each case in this group shows that four problems occurred in one case, (number twenty-one), three problems occurred in five cases, (numbers four, five, twenty-three, twenty-four, and twenty-five), and two problems occurred in four cases (numbers one, twelve, fourteen and thirty-one). None of the cases in this group presented problems in all areas involving themselves and their families and friends, and only one showed three problems involving himself.

Table V, (immediately following Table IV, overleaf), shows the remaining group of ten patients, whose problems of convalescent planning concerned themselves, their families and friends, and the community. Three of these ten patients, numbers seventeen, eighteen, and nineteen, showed problems of accommodation affecting the patient, his family and friends, and the community. Three others, numbers ten, eleven, and twenty-eight, showed problems of accommodation affecting the patient and his family and friends, while four patients, numbers nine, sixteen, twenty, and twenty-seven, showed accommodation problems affecting the patient and the community.

Other problems of convalescent planning which occurred in varying combinations in this group were noted in the following frequencies. Two cases, numbers seventeen and eighteen, showed a total of seven problems. Two patients, numbers twenty and twenty-seven, showed six problems, while two others, numbers sixteen and nineteen showed five. The remaining four patients showed less than five problems each, with numbers nine and eleven
Table IV: The Three Problems of Convalescent Planning, Which Affected Patients, and Involved Their Families and Friends.

(Patients tabled in Sex Groups, and in ascending order of Age.)

(Vancouver General Hospital, September, 1954.)

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Source: Group of Thirty-two patients taken from Vancouver General Hospital Social Service Records.

#  
(a) Finances  
(b) Accommodation  
(c) Psychological
Table V: The Three Problems of Convalescent Planning, Which Affected Patients, and Involved Their Families and Friends, and the Community.

(Patients tabled in Sex groups and in ascending order of Age.)

(Vancouver General Hospital, September, 1954.)

PATIENTS IN GROUP "C"

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Source: Group of Thirty-two patients taken from Vancouver General Hospital Social Service Department Records.

# (a) Finances
(b) Accommodation
(c) Psychological
having four, and numbers ten and twenty-eight having three.

It is of interest to note that in Table V, under the section dealing with problems involving the community, there were no problems of a psychological nature reported. Such problems were considered, by definition, to be primarily problems of interpretation to personnel in community agencies, about medical-social difficulties presented by the patients, and while discussion with the workers at the General Hospital indicated that these problems often arose, there was little indication of this in the recording.

This question of brevity in the case records created an additional problem in this study, since the material available in the records lends itself most readily to a strict quantitative analysis of the type of patient served by the Department, and the nature of problems presented by patients. While it might be assumed, that when problems were described in the records, appropriate services were rendered to deal with these problems, there is a further need in this study to know specifically what the nature of these services might be. This is particularly true when it is recalled that the social worker in the hospital setting has responsibilities not only to the patient, but also to the hospital and the community. Thus there is a need for more detailed information about the casework services offered to the patients studied in order to evaluate the extent to which the social worker's responsibilities are being met, and since this information was not available in the records some alternate method of obtaining it had to be devised.

A similar problem was encountered by Ernest Schlesinger in a study of casework services in a mental hospital,¹ and he had devised a

questionnaire for the purpose of obtaining this information from the social workers who had dealt with the cases being studied by him. Mr. Schlesinger's study concerned the total services offered by caseworkers in a mental hospital, consequently the data he sought in his questionnaire was much broader in nature than the data needed to describe casework services in a specific area such as convalescent planning. However, his basic method involved examining the services from the points of view of direct services to patients, and indirect services rendered through hospital staff, family and friends, and community. Since this approach seemed to apply equally well to this present study, Mr. Schlesinger's basic method was adopted, and a questionnaire was developed which sought information about the direct and indirect services rendered to patients in need of social work help with convalescent planning in a general hospital. This questionnaire was circulated to the five social workers involved in this study, and the results of this enquiry are incorporated in the discussion in Chapter III.
CHAPTER III

THE MEDICAL SOCIAL WORKER'S ROLE

This chapter describes and analyses the nature of the social casework services provided by the Social Service Department, in dealing with the problems of convalescent planning which were discussed in Chapter II. On the basis of discussion with the social workers involved in this study, together with some modification of a method developed by Mr. Schlesinger,¹ a questionnaire, (which is attached as Appendix D), was developed. The questionnaire was used to obtain information regarding the type of casework service offered to the thirty-two patients studied.

The questionnaire, which lists five questions regarding direct services to patients, and seven questions regarding indirect services, was constructed in a manner that permitted the quality of the service to be described in each question. Answers could then be checked by the social workers concerned, under one of the following headings; "yes", "no", or "uncertain". Thirty-two questionnaires were circulated among the five social workers, and all thirty-two were completed and returned. The workers did not consult the records in completing the questionnaires, nevertheless, all questions were answered in either the negative or the affirmative. In no case were the workers uncertain of the services rendered, therefore, the tabulation of results was greatly simplified.

The Nature of Casework Services in Convalescent Planning.

In formulating the questionnaire, consideration had to be given to the basic casework techniques used by social workers in helping patients to plan for their own convalescence. These are, of course, techniques which are basic to all casework, but which, when applied to one specific type of problem encountered by caseworkers, can be defined spec-

¹ See discussion in Chapter II, p. 45.
ifically, in relation to that problem.

The basic techniques employed in helping patients to plan for convalescence, are, according to the social workers involved, those described by Florence Hollis as environmental modification, psychological support, and clarification. Working definitions of these techniques are set out below.

a) **Environmental Modification.**

This technique involves the steps taken by the worker to change the environment, through direct action in the client's favor. It includes the usual tasks of meeting material needs such as food, clothing, and shelter, but in addition may involve modifying attitudes and feelings of other people in order to enable the client to make a satisfactory adjustment to his environment.

b) **Psychological Support.**

Psychological support is the process of helping the client to express his feelings, reassuring the client as to his own worth, and his ability to deal with his problems and life situations, and expressing an understanding and acceptance of the client and his problems, together with an expression of a desire to assist the client, and of confidence that his difficulties can be overcome.

c) **Clarification.**

Clarification is the technique of helping the client to understand himself, his environment, and his associates.

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and to see these in relation to their effect on the problems that confront the client. This technique is an intellectual and emotional process which deals with the client's conscious thoughts, feelings, and attitudes.¹

In attempting to be more definitive in analyzing the casework services given to patients, planning for convalescence, these broad techniques were incorporated in the actual description of services as they appeared in the questionnaire that was circulated to the social workers. It will be noted that these techniques may be employed directly with the patient or indirectly on behalf of the patient. Accordingly, the questionnaire was divided on this basis, and the questions were evolved on the basis of the following definitions.

I. Direct Services.

Direct services to patients are those services which the worker offers in a face-to-face relationship with the patient, and which involve direct action on the part of the worker in solving the problem.

a) **Enabling patient to accept the need for convalescent care.**

Helping the patient to overcome his initial resistances to the suggestion that he will need a further period of recovery from his illness after his stay in the acute hospital, is frequently the first task of the social worker in dealing with the problem of convalescent planning. These resistances may have their basis in purely environmental conditions such as concern about where personal effects can be stored, or at

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¹ These definitions are paraphrased by the writer from Hollis, *op. cit.* pp. 413-421
the other extreme, they may be the result of psychological needs of the patient which will not permit him to accept the necessity of convalescent care. In either case, the social worker's task is to enable the patient, if possible, to see the causes of his resistances, and to assess these in relation to his future well-being. When this is not possible, the worker may find it necessary to act on behalf of the patient, in modifying factors that may be contributing to the patient's resistance.

b) Supporting patient around anxieties relating to his family, friends, and/or personal affairs, in his planning for convalescence.

The necessity for convalescent care can raise many problems for the patient in relation to his family and friends, and his personal affairs, and the resultant anxiety may motivate him to act in an ill advised manner in making plans. However, the skilled social worker is usually able to recognize these problems, and to work out, with the patient, ways of dealing with them, in order to avoid unnecessary conflicts arising for the patient, at this crucial period of his recovery. For example, a patient who is concerned about the fact that his business affairs are not being attended to during the period of his illness and convalescence, may refuse to proceed on a convalescent programme because of a wish to return to his business. The social worker, through discussion and planning with the patient, may be able to help him work out a method of dealing with this problem without having to forego the convalescent period. Such service can only be given, however,
if the worker is able to help the patient express his problem and recognize that alternative methods of dealing with it exist.

c) **Enabling patient, through supportive and/or clarifying techniques, to arrange for his own convalescence.**

To many patients, accepting the necessity for convalescence is not as difficult as making arrangements for it, yet, it is basic to the practice of social work that the patient be given the right to determine and carry out, to the fullest degree possible, the methods of solving his problems. The social worker's responsibility in such cases is to estimate the patient's ability to act on his own, and to strengthen this ability, wherever possible, through making available to him, information which will be helpful to him in planning, and through expressing confidence, when it is warranted, in his ability to carry through on his own plans.

d) **Direct action on behalf of patient regarding his personal affairs.**

Direct action on behalf of the patient follows only after it has been established by the worker that it is more advisable to take such a course than to have the patient take action himself. Usually such action is not taken unless the patient, by reason of his illness, is unable to act on his own, or the worker has more ready access to resources in the hospital or the community than the patient has. Such matters as communicating with business associates, or arranging for the storage of personal effects might appear in this category of service.

e) **Arranging on behalf of patient for financial assistance and/or accommodation in relation to his convalescent needs.**
At the Vancouver General Hospital, this category of service covers two distinct types of problem for the social worker and patient. One group of patients is unable, because of physical or emotional factors, to make such arrangements on their own, but a second, and larger group in the Social Service caseload are unable to make their own arrangements because of administrative techniques that have been developed to facilitate inter-agency handling of convalescent problems. Patients who require convalescent care away from their own homes, and who are unable to finance such care, usually must be referred to the local public assistance agency for financial aid. In practice, the medical social worker in the hospital obtains the required eligibility data from the patient, and forwards it to the appropriate agency for consideration. If the agency is prepared to assume financial responsibility for the case referred, it becomes that agency's responsibility to provide the type of care that is required. In the past the practice has generally been to arrange for placement of the patient in the first suitable vacancy that occurs.

If a patient is able to make his own financial arrangements the local welfare authority has no responsibility, legally, to find accommodation for that patient, and if the patient is unable to act on his own behalf, and has no family or friends to act for him, the medical social worker then has the responsibility of arranging a suitable placement for him. This, of course, is done in co-operation with the patient whenever possible, since the social worker has the additional
responsibility of protecting the patient's right to determine and carry out his own plans insofar as he is able.

In examining these direct services to patients, it will be noted that they appear to be focused toward meeting the problems discussed in Chapter II, namely, finances, accommodation, and psychological problems. Therefore, it is possible to compare, to some extent, the two factors of problems presented, and services rendered in convalescent planning, on the basis of the individual cases studied. It is also possible to obtain from this comparison, some indication of the suitability of social services offered.

II. Indirect Services.

The indirect services in this study are seen as those in which the worker, using basic casework techniques, acts on behalf of the patient, through the medium of family and friends, the personnel of community agencies, and the personnel of the active treatment hospital. To some extent these services can also be equated with the problems discussed in Chapter II, however, those which concern other hospital personnel do not readily lend themselves to this method of approach, because the summary type of recording does not usually include reports of discussion of the patient's problems with these people.

f) Enabling patient's family and friends to accept the need for convalescent care.

The patient's family and friends may, in the same manner as the patient, present resistance to the need for convalescence. Insofar as this may be impeding the patient's planning, the social worker will find it necessary to help these persons to understand and accept this need, in order that they may be able to
participate in helping the patient effect the most satisfactory convalescent plan possible.

g) **Enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence.**

The enlisting of help from interested persons is usually done in co-operation with the patient, but it may, at times, be necessary to approach such people without the patient's permission, if his illness prevents him from participating fully in his own planning. In either case, the more important aspect of this service is that of enabling these people to avail themselves of hospital and community resources, and to participate to the fullest in the patient's convalescent planning. The social worker must, however, maintain his own focus of helping the patient, and any services he renders to interested friends and relatives must be limited to achieving that goal, and not to treating social problems that have no bearing on the patient's socio-medical needs.

h) **Giving Direct Services to patient's family and friends to reduce patient's anxieties in planning for convalescence.**

The principles expressed in "g" above would obtain in this service also, and the nature of services offered could involve any of the usual services offered through casework agencies.

j) **Conferences with patient's doctors regarding patient's convalescent plans.**

Although, by definition, this service is always offered to patients by medical social workers, it must be included in
any discussion of services to patients, since it is basic to the practice of medical social work in an acute hospital. This service includes discussions about the nature of the patient's illness, the medical, psychological, and social implications of convalescence for the patient, and clarification for the medical staff about the availability of resources in the community which might be helpful in convalescent planning.

k) **Conferences with other hospital staff regarding patient's convalescent plans.**

These include conferences with nursing staff, dieticians, accounting personnel, and others, for the purpose of obtaining information which will be helpful in working with the patient, or for the purpose of helping other staff members to understand the problems that are occurring in convalescent planning. It frequently occurs, also, that such conferences are held to enlist the help of other personnel in assisting the patient in his planning.

m) **Conferences with Community Welfare Agencies.**

It will be noted that this service is sub-divided in the questionnaire into two headings, namely, Administrative, and Interpretive, and that the same division occurs in service "n". Although these two services are frequently utilized by social workers in dealing with problems of convalescent planning, they tend to receive very little mention in the case records. In Chapter II, it will be recalled, problems that involved the community appeared only as problems of finances and accommodation, and psychological problems did
not appear. In discussions with the social workers, however, it was learned that psychological problems did occur with the community, consequently, this aspect of the services offered required some further clarification. Conferences dealing with administrative matters, therefore, were considered to be concerned with the routine arranging of financial help, and/or accommodation, while interpretive conferences were seen as those in which factors about the patient's medical or social situation required careful clarification in order to have the patient's convalescent needs satisfactorily met by the community agency.

Conferences with Community Welfare Agencies might include such agencies as the Vancouver City Social Service Department, the Vancouver Children's Aid Society, or the Salvation Army.

n) Conferences with Community Health Agencies.

In the area of convalescent planning, Community Health Agencies are an extremely important resource for the social worker. These agencies exist under public or private auspices, and for the most part are organized to meet a specific need. Broadly speaking, they can be divided into two groups, those that are organized to provide accommodation, and those organized to provide specialized services such as home nursing care. In addition, there are a few health agencies organized to meet both types of convalescent need.

Of the first group, those designed to provide accommodation, a very full description has already been given.¹ For the most

part, these agencies provide accommodation, not only for convalescent patients, but also for chronic and terminal patients, and, at the present time, these facilities are taxed to the maximum. This group of agencies includes the private nursing and boarding homes in the community, and a few homes operated by governmental agencies.

The second group of Community Health Agencies are those which offer services such as home nursing care, provision of special equipment or appliances, or rehabilitation services. These would include such agencies as the Metropolitan Health Committee, the B. C. Polio Fund, or the Canadian National Institute for the Blind.

Agencies which carry out both functions, are those in which the patient must live on the premises while receiving special convalescent care. The Western Society for Physical Rehabilitation, and the Canadian Cancer Society are examples of such multi-function agencies.

The Casework Services Offered in Convalescent Planning.

In analysing the services given to patients, it was decided to retain the patients in the groupings that appeared when their problems were examined in Chapter II. In this way it was possible to compare the services given each patient with the problems which arose in his convalescent planning, and to make some assessment of the frequency in which services were offered when problems affected the patient alone, (Group "A"), when they affected the patient and involved his family and friends, (Group "B"), and when they affected the patient, and involved his family and friends, and the community, (Group "C"). Consequently
tables were developed which would cross-classify the services given by the social workers, with the problems presented by the patients in each group. It was also felt that these tables should be constructed in a manner that would permit some comparison of direct and indirect services as well, therefore, the completed tables have been constructed with two sub-divisions on the basis of these two main divisions of service.

In order to make the cross-classification, however, it was first necessary to tabulate the total services rendered, according to the code numbers of the patients that received these services. These tally sheets are shown as appendices E, F, and G, and show the total services rendered to the patients in each group. These were then summarized on tables which also listed the problems presented. These tables are inserted at appropriate positions in the following pages, and are discussed on the basis of the groups into which the patients fell. In reading these tables, the following points should be noted, with respect to the codes used:

1) The first column lists the code numbers of the thirty-two patients studied.

2) Under the heading "Problems Presented", the figure 1 represents problems affecting the patient, 2 represents problems which involved the patients and their families and friends, and 3 represents problems which involved the patients, their families and friends, and the community.

3) Under the headings "Direct Services" and "Indirect Services", the code letters in the columns represent types of casework services offered as discussed in pages 49 to 57.

4) At the head of each column in the tables, one of the letters F, A, or P, appears. These represent the problems presented by the patients studied, and the letter F is the code used for financial
problems, A for accommodation problems, and P for psychological problems.

GROUP A: Patients Showing Problems Affecting Themselves Only.

(Twelve cases, as tabled and discussed in page 43.)

A summary of the problems presented by the patients in Group A, and the details of the services which, according to the questionnaire completed by the social workers at the Hospital, were rendered in dealing with these problems, are shown in Table VI, (overleaf). In the following analysis, these direct and indirect services are discussed and compared on the basis of the problems presented by these twelve patients.

Financial Problems.

Table VI, shows that four patients, numbers three, seven, eight, and twenty-two were reported to have financial problems affecting themselves only. The service most frequently offered to meet this problem directly was that of arranging on behalf of the patient for financial assistance, and/or accommodation, in relation to his convalescent needs. This service appears in the table as service "e", and it will be noted that patients number seven, eight, and twenty-two received this service in dealing with their financial problems.

Patients in Group A did not present problems which involved their families and friends, or the community, however, indirect services through family and friends or community were offered to some of these patients. Enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, is the service most frequently offered indirectly through family and friends in dealing with financial problems. This service appears as service "g" in the table, and it will be seen that one patient, number twenty-two, received this service. Conferences with community welfare agencies on administrative
TABLE VI  Showing the Problems Presented by Patients in Group A, with Details of the Casework Services Offered to Meet These Problems.

(Patients tabled by code numbers as they appeared in Group A, Table III, and services tabled by letter, as they appear in the discussion on pages 49 to 57.)

(Vancouver General Hospital, September, 1954)

<table>
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<tr>
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<th># Indirect Services Through Community Relating To</th>
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Source: Questionnaires completed by five social workers at the Vancouver General Hospital Social Service Department.

# Refer to page 58 in the text for explanation of code numbers.
matters is the indirect service most often used to deal with financial problems that involve the community. This appears on the tables as service "m 1", and five patients, numbers two, six, eight, thirteen, and twenty-six, received this service.

From this analysis of the direct and indirect services offered to meet financial problems, it can be seen that only one patient, number three, did not have his problems met. An examination of his case record reveals that he was still in the hospital at the time of this study and his financial problems would not likely be dealt with until a discharge date was set for him. It should also be noted that four patients received, indirectly through the community, services related to financial problems, although they did not have financial problems reported in their case records.

Accommodation Problems.

Table VI, shows that all the patients in Group A, with the exception of patient number three, were reported to have accommodation problems affecting themselves only. The services most frequently offered directly to deal with these problems are; enabling the patient, through supportive and/or clarifying techniques, to arrange for his own convalescence, (service "c"), and arranging on behalf of patient for financial assistance and/or accommodation, in relation to his convalescent needs, (service "e"). One or both of these services were offered to seven patients, numbers two, seven, eight, twenty-two, twenty-nine, thirty, and thirty-one.

Although patients in Group A did not have problems reported as involving their families and friends or the community, some indirect services were rendered through family and friends and community. Service
that of enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, was the service most frequently offered indirectly in dealing with problems of accommodation. Three patients, numbers two, twenty-two, and thirty, received this indirect service through family and friends. Service "n i", that of administrative conferences with community health agencies was the one most frequently offered through the community in dealing with problems of accommodation. Five patients, numbers two, eight, fifteen, twenty-two, and twenty-nine, received this type of indirect service through the community.

Therefore, although patients number six, thirteen, fifteen, and twenty-six, had problems of accommodation reported in their case records as involving themselves only, they did not receive direct services to meet these problems. However, patients number six, and fifteen, received indirect services in meeting this problem. This leaves only patients number thirteen and twenty-six who did not receive services in relation to their accommodation problems. The records on these two cases reveal that patient number thirteen was still in the hospital at the time of the study, and patient number twenty-six had made accommodation plans on his own, without the aid of the social worker.

Psychological Problems.

Table VI, shows that five patients, numbers six, seven, twenty-two, twenty-six, and thirty were reported as having psychological problems affecting themselves only. The direct services offered most frequently by social workers in meeting these problems were; enabling patient to accept the need for convalescent care, (service "a"), and supporting patient around anxieties relating to his family, friends, and/or personal affairs, in his
planning for convalescence, (service \textit{"b"}). One or both of these services were offered to eleven patients in Group A, with patient number two being the only exception in this group.

No psychological problems were reported to involve the family and friends of the patients in this group, nor was the community reportedly involved by these patients' psychological problems. However, indirect services through family and friends and the community were offered to several of these patients in dealing with the psychological problems that were presented. Enabling patient's family and friends to accept the need for convalescent care, (service \textit{"f"}), and giving direct services to patient's family and friends to reduce patient's anxieties in planning for convalescence, (service \textit{"h"}), were the services most frequently offered indirectly through family and friends and in dealing with psychological problems. Four patients, numbers two, three, twenty-two, and thirty received one or both of these indirect services. Interpretive conferences with community health and welfare agencies, (services \textit{"n ii"} and \textit{"m ii"}) were the casework services usually offered in dealing indirectly with psychological problems which involved the community. Three patients numbers two, three, and six, received one or both of these services.

Thus, of the twelve patients in Group A, only five presented problems of a psychological nature, but all patients in the group received direct or indirect services designed to meet psychological problems.

\textbf{Group B: Patients Showing Problems Affecting Themselves, and Involving Their Family and Friends.}

(Ten cases, as tabled and discussed in page 43. )

A summary of the problems presented by the patients in Group B, and the details of the services which, according to the questionnaire completed by the social workers at the Hospital, were rendered in dealing
with these problems, are shown in Table VII, (overleaf). In the follow­ing analysis, these direct and indirect services are discussed and com­pared on the basis of the problems presented by these ten patients.

Financial Problems.

Table VII, shows that three patients, numbers five, twenty-one, and twenty-four, were reported to have financial problems affecting themselves only. The service most frequently offered to meet these problems directly, was, it will be recalled, that of arranging on behalf of the patient for financial assistances, and/or accommodation, in relation to his convalescent needs. This service appears in the table as service "e", and two patients, numbers twenty-one and twenty-four, received this direct service in dealing with financial problems.

Two patients, numbers four and five, presented financial problems which involved their families and friends. Service "g", that of enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, was the service most frequently offered to deal with financial problems that involved the patient's family or friends. Only one patient in Group B, patient number four, received this service.

Although patients in Group B were not reported to have problems which involved the community, one patient received indirect service through the community in dealing with his financial problems. Administrative con­ferences with community welfare agencies is the indirect service most frequently used to deal with financial problems that involve the community. This appears on the table as service "m i", and patient number four re­ceived this type of help in dealing with financial problems.

From this analysis of the direct and indirect services offered to meet financial problems, it can be seen that only one patient, patient
TABLE VII

Showing the Problems Presented by Patients in Group B, With Details of the Casework Services Offered to Meet These Problems.

(Patients tabled by code numbers as they appeared in Group B, Table IV, and services tabled by letter as they appear in the discussion on pages 49 to 57.)

(Vancouver General Hospital, September, 1954)

<table>
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Source: Questionnaires completed by five social workers at the Vancouver General Hospital Social Service Department.

# Refer to page 58 in the text for explanation of code numbers.
number five, presented financial problems which affected himself and involved his family and friends, but did not have these problems dealt with in the usual manner. An examination of this case reveals that the patient was still in the hospital at the time of this study, and the date for his discharge had not been set, therefore his financial problems had not been dealt with at that time.

**Accommodation Problems.**

Table VII, shows that eight patients in Group B were reported to have problems affecting themselves only. Patients numbers one, and five, did not present accommodation problems affecting themselves. As noted earlier, the services most frequently offered directly to deal with these problems are; enabling the patient through supportive and/or clarifying techniques, to arrange for his own convalescence, (service "c") and, arranging on behalf of patient for financial assistance and/or accommodation, in relation to his convalescent needs, (service "e"). One or both of these services were offered to seven of the patients in this group, with patients numbers one, five, and twenty-three not receiving this type of direct service.

Seven patients, numbers one, fourteen, twenty-one, twenty-three, twenty-four, twenty-five, and thirty-one, had problems of accommodation which involved their families and friends. Service "g", that of enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, was the service most frequently offered indirectly in dealing with problems of accommodation when they involved the patient's family and friends. Eight patients, (numbers five and fourteen excluded), received this type of service in dealing indirectly with accommodation problems.

Problems of accommodation which involved the community were not
reported for any of the patients in Group B, but two patients received indirect services through the community in meeting this type of problem. Service "n i", that of administrative conferences with community health agencies, was the one most frequently offered in dealing indirectly through the community with accommodation problems. Patients number five and twenty-four were the two patients in Group B who received this type of service.

Therefore, all the patients in Group B, who presented problems of accommodation affecting themselves, or involving their families and friends, received appropriate direct and indirect casework services in dealing with these problems.

Psychological Problems.

Table VII, shows that four patients, numbers four, five, twenty-one, and twenty-five, were reported to have psychological problems affecting themselves only. The direct services offered most frequently by social workers in meeting these problems were; enabling patient to accept the need for convalescent care, (service "a"), and supporting patient around anxieties relating to his family, friends, and/or personal affairs, in his planning for convalescence, (service "b"). One or both of these services were offered to all the patients in Group B, with the exception of patient number twenty-three.

Three patients, numbers one, twelve, and twenty-three, presented psychological problems which involved their families and friends. Enabling patients family and friends to accept the need for convalescent care, (service "f"), and, giving direct services to patient's family and friends to reduce patient's anxieties in planning for convalescence, (service "h"), were the services most frequently offered indirectly
through family and friends in dealing with psychological problems.

Seven patients in Group B, (numbers twelve, fourteen, and twenty-five, excluded), received one or both of these indirect services.

Problems of a psychological nature which involved the community were not reported for any patients in Group B, but two patients received indirect services through the community, to meet such problems. Interpretive services with community health and welfare agencies, (services "n ii" and "m ii"), were the casework services usually offered in dealing indirectly with psychological problems that involved the community. Patients number five, and twenty-four, were the two patients who received these indirect services.

Therefore, on examining these psychological problems and the services rendered to meet them, it will be seen that patient number twelve was the only patient that presented psychological problems and did not receive the usual services for these problems. This patient's psychological problems involved his family and friends, and he received direct services in dealing with these problems. An examination of his record revealed that his family and friends could not be contacted, since they lived in a remote part of British Columbia, therefore, services were rendered directly with the patient in helping him accept this limitation of service to his family and friends.

**Group C: Patients Showing Problems Affecting Themselves, and Involving Their Families and Friends and the Community.**

(Ten cases, as tabled and discussed in page 44.)

A summary of the problems presented by the patients in Group C, and the details of the services which, according to the questionnaire completed by the social workers at the hospital, were rendered in dealing with these problems, are shown in Table VIII, (overleaf). In the
TABLE VIII

Showing the Problems Presented by Patients in Group C, With Details of the Casework Services Offered to Meet These Problems.

(Patients tabled by code numbers as they appeared in Group C, Table V, and services tabled by letter as they appear in the discussion on pages 49 to 57.)

(Vancouver General Hospital, September, 1954)

<table>
<thead>
<tr>
<th>Code No.</th>
<th># Problems Presented</th>
<th># Direct Services to Patients</th>
<th># Indirect Services Through Relating to</th>
<th># Indirect Services Through Relating to</th>
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<td>- - e</td>
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</tbody>
</table>

| TOTAL    | 5                    | 10    | 9    | 2     | 10    | 9    | 7    | 4    | 6 |

Source: Questionnaires completed by five social workers at the Vancouver General Hospital Social Service Department.

# Refer to page 58 in the text for explanation of code numbers.
following analysis, these direct and indirect services are discussed and compared on the basis of the problems presented by these ten patients.

**Financial Problems.**

Table VIII, shows that five patients, numbers sixteen, seventeen, nineteen, twenty, and twenty-seven, were reported to have financial problems, affecting themselves only. The service most frequently offered to meet these problems directly was that of arranging on behalf of the patient for financial assistance, and/or accommodation, in relation to his convalescent needs. This service appears in the table as service "e", and all five patients received this direct service in dealing with financial problems.

Two patients, numbers eighteen and nineteen, presented financial problems which involved their families and friends. Service "g", that of enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, was the service most frequently offered to deal with financial problems that involved the patient's family or friends. Both of the patients that presented these problems received this indirect service.

All of the patients in Group C, with the exception of patient number nineteen, presented financial problems that involved the community. Administrative conferences with community welfare agencies is the indirect service most frequently used to deal with financial problems that involve the community. This is shown in Table VIII as service "m i", and seven patients received this type of help in dealing with financial problems. Three patients, numbers ten, eleven, and nineteen, did not receive this service.
Therefore, this analysis shows that two patients, numbers ten and eleven, presented financial problems involving the community, but did not have these problems met through the usual casework services. An examination of their records, however, shows that patient number ten had his financial problems met through accommodation services, while patient number eleven had his financial problems met through his family and friends. In all other cases in Group C, when financial problems occurred, they were met with the casework services usually employed to meet such needs.

**Accommodation Problems.**

Table VIII, shows that all the patients in Group C were reported to have accommodation problems affecting themselves only. It will be recalled that the services most frequently offered directly to deal with these problems are; enabling the patient through supportive and/or clarifying techniques, to arrange for his own convalescence, (service "c"), and, arranging on behalf of patient for financial assistance and/or accommodation, in relation to his convalescent needs, (service "e"). One or both of these services were offered to all patients in Group C.

Six patients, numbers ten, eleven, seventeend, eighteen, nineteen, and twenty-eight, had problems of accommodation which involved their families and friends. Service "g", that of enlisting the help of, and enabling family and friends to participate in planning for patient's convalescence, was the service most frequently offered indirectly in dealing with problems of accommodation when they involved the patient's family and friends. All of the patients in Group C received this type of indirect service in dealing with accommodation problems.
Seven patients, (numbers ten, eleven, and twenty-eight, excluded), had problems of accommodation which involved the community. Service "n 1", that of administrative conferences with community health agencies, was the one most frequently offered in dealing indirectly through the community with accommodation problems. Four patients, numbers ten, sixteen, seventeen, and twenty-eight, received services of this nature through the community.

Thus, of the seven patients that presented problems of accommodation involving the community, five patients, numbers nine, eighteen, nineteen, twenty, and twenty-seven, did not receive service through the community in dealing with these accommodation problems. All of these five patients, however, received either direct services themselves, or indirect services through family and friends in dealing with problems of accommodation. In all other cases in Group C, when accommodation problems were presented, appropriate casework services were rendered in the usual manner.

Psychological Problems.

Table VIII, shows that seven of the patients in Group C had problems of a psychological nature which affected themselves only. Patients number eleven, nineteen and twenty-eight, did not present this type of problem. The direct services offered most frequently by social workers in meeting these problems were; enabling patient to accept the need for convalescent care, (service "a"), and supporting patient around anxieties relating to his family, friends, and/or personal affairs, in his planning for convalescence, (service "b"). One or both of these services were offered to all the patients in Group C. Five patients, numbers eleven, seventeen, eighteen, twenty,
and twenty-seven, presented psychological problems which involved their families and friends. Enabling patient's family and friends to accept the need for convalescent care, (service "f"), and, giving direct services to patient's family and friends to reduce patient's anxieties in planning for convalescence, (service "h"), were the services most frequently offered indirectly through family and friends in dealing with psychological problems. All the patients in Group C, with the exception of patient number nine, received one or both of these services.

Problems of a psychological nature which involved the community were not reported for any of the patients in Group C, however, six patients received indirect services through the community to meet such problems. Interpretive conferences with community health and welfare agencies, (services "n ii" and "m ii"), were the casework services usually offered in dealing indirectly with psychological problems that involved the community. Patients numbers sixteen, seventeen, eighteen, nineteen, twenty, and twenty-seven, were the six patients that received these indirect services.

Therefore, all the patients in Group C, who presented psychological problems received appropriate direct or indirect services to meet these problems, and nearly all the patients in the group received additional psychological services, even though problems were not reported in the case records.

The fact that psychological problems do not appear in the recording when they involve the community, requires some further explanation. It is possible, that social workers are reluctant to record incidents that occur in relation to other agencies, when such recording might be construed as criticism of the other agency, however,
it is more probable that inter-agency interpretation is a continuing process which normally does not concern one patient, but rather involves the total working relationship of both agencies, consequently, the social workers do not record these interpretive services unless special problems occur in relation to a certain case.

In the direct services to patients, one category of service, that of taking direct action on behalf of the patient in regard to his personal affairs does not seem to have any apparent relationship to the main problems presented by the patients. In actual fact, however, this type of service is one that is frequently offered in helping a patient to overcome resistance to convalescent planning as well as in reducing anxiety for the patient who must make such plans. In this respect then, it might well be considered a service designed to cope with psychological problems which arise in convalescent planning.

In the three groups of patients studied, it will be seen by Appendices E, F, and G, that this type of service (service "d"), was offered to nine patients out of the total of thirty-two. Of these nine patients, only four were reported in the case records as presenting psychological problems, while the remaining five had problems only in relation to finances or accommodation. This would suggest, therefore, that the social workers consider these services either as incidental to the problem of convalescent planning, or of minor importance, in relation to other psychological problems, and consequently, they do not include them in the case records in every case.

Tables VI, VII, and VIII, do not show all the indirect services offered to the thirty-two patients studied, and an examination of Appendices E, F, and G, will show that two types of indirect ser-
vices were not discussed in relation to the problems presented.

These remaining indirect services which are offered to patients planning for convalescence, concern those services offered through consultation with hospital doctors and other hospital personnel. These appear in Appendices E, F, and G, under items "j" and "k". As would be expected, consultations were held with doctors on behalf of all thirty-two patients studied, since successful convalescent planning requires the advice and leadership of the doctor in the treatment team. Nevertheless, it is important to include this service in any specific analysis of medical social work, in order to demonstrate, to some extent, that social work, in that specific setting, meets with accepted standards.

Consultation with other hospital staff regarding patients' convalescence, (service "k"), occurred in twenty-one of the thirty-two cases studied. The fact that not all patients received this service requires further explanation, since it would, on first examination, seem that nursing, dietetic, and other staff could offer valuable information in relation to the patients' physical needs during convalescence. While this is true, such information is frequently obtained from the doctor directly, and it is only when the patient presents special nursing, dietary, or other needs that direct conferences with these other staff people are necessary.

The Suitability of Services in Convalescent Planning.

The relationship of the casework services rendered, to the social problems presented by the thirty-two cases studied, gives some indication of the value of such services to patients and to hospital. It will be recalled that by far the majority of problems that appeared
in the analysis in Chapter II, were concerned with accommodation. Twenty-nine of the thirty-two patients studied showed problems of accommodation affecting themselves, thirteen patients showed accommodation problems involving their families and friends, and seven patients showed accommodation problems involving the community. Financial problems occurred with a frequency of twelve times with the patients themselves, six times with family and friends, and nine times with the community.

Direct services focused on meeting these two problems of accommodation and finances were offered to twenty-seven patients, while indirect services directed toward these same goals were offered to twenty-one patients.

Psychological problems occurred directly with patients in fifteen cases, and indirectly involved the family and friends of patients in eight cases. Services designed to meet these problems were offered directly and indirectly to all fifteen of these patients and their families and friends. In addition, services which focused primarily on psychological problems were offered indirectly through casework with the community in eleven cases, although problems of this nature were not reported in the case records.

These factors, however, point up the fact that in every instance where specific problems arose, appropriate casework services were offered, or a suitable explanation of why such services were not offered was readily available and in most instances was reported in the case record. Moreover, it has been noted that other services were offered in most cases even though the problems, as reported, showed no indication of the need for such services. From this then, it appears that suitable casework services are being made available to
patients requiring help with convalescent planning.

The effectiveness of such services, unfortunately, cannot be determined in this study, since any appraisal of the effectiveness of casework services would require follow up assessments of these patients, after they had left the hospital, and after their period of convalescence was completed.
CHAPTER IV

CASEWORK AND CONVALESCENCE

An attempt has been made in this study to provide answers to several questions relating to the social worker's role in convalescent planning. Questions raised included queries about the types of patients studied, the convalescent planning problems they presented, the social casework services offered to them, and the appropriateness of such services. Although these questions at first appeared to be broad questions that are common to the problem of defining social work in any setting, it was found, on further analysis, that there were certain specifics in casework with convalescents, in the Vancouver General Hospital. In order to demonstrate this it is necessary to briefly review the findings of the preceding chapters, following which the significant material in the study can be discussed.

The Findings of The Study.

In this study, thirty-two case records were examined, and the findings were first analyzed on the basis of the patients' ages, sex, marital status, and financial status. The patients' problems were then analyzed according to the manner in which these problems affected the patients themselves, involved their families and friends, or involved the community. The selection of this study group was made somewhat difficult because of a lack of suitable case records, and because of this the final selection had to be made on the basis of records available, rather than on a standard sampling basis. The final group selected were patients who received convalescent planning services through the Hospital Social Service Department during the month of September, 1954.
In the study group there were sixteen males ranging in age from four years to eighty-seven. Only one of these was in the four year group, and the remaining fifteen ranged from twenty-one to eighty-seven. There were sixteen females in the group, ranging in age from thirty to eighty-eight, therefore the total age range for the thirty-two patients was four years to eighty-eight years. Twenty-four of the total group were over forty years of age, and seventeen patients (slightly over fifty per cent) were sixty-five or over.

The distribution of the thirty-two patients by marital status showed that nine men and one woman were single, two men and four women were married, five men and nine women were widowed, and two women were divorced. None of the patients studied showed their marital status as "separated". Only six of the thirty-two patients had marital partners to whom they could look for help with convalescent planning, and over half of the group, because of age and marital status, were unlikely to have near relatives who could offer help during this critical period of their rehabilitation.

The analysis of the financial status of these thirty-two patients revealed that twenty patients were living on low incomes at the time of admission. Sixteen patients, (fifty per cent), were admitted to hospital in receipt of some form of public assistance. Thirteen patients, were receiving financial aid from two sources. This high degree of financial dependency in this study group further emphasizes the seeming lack of social resources available to many of the patients referred for help with problems of convalescent planning.

The problems of patients planning for convalescence were seen as those of finances or accommodation, and those involving psychological
factors. Examination of the social service records, and discussions with social workers involved, revealed that these problems affected the patients directly, but also, frequently involved the patient's family and friends, and the community, particularly the community health and welfare agencies. As might be expected, the majority of convalescent problems affected patients directly, amounting to fifty-six problems affecting the thirty-two patients. The family and friends of the patients studied were involved in convalescent problems twenty-seven times, and the community only sixteen times. Problems of accommodation occurred with the greatest frequency, affecting patients twenty-nine times, family and friends thirteen times, and the community nine times. Financial problems affected patients twelve times, involved family and friends six times, and the community nine times. Psychological problems were presented by the patients fifteen times, and involved the family and friends eight times. No psychological problems involving the community were reported.

Problems affecting patients, or involving their families and friends, or the community, occurred with slightly greater frequency with women than with men, but no significant differences in the nature of the problems that affected men and women were reported in the records.

On examining the problems of patients, it was noted that problems affecting the patient, but not involving his family or friends, or the community, occurred in twelve cases. Problems which affected the patient and involved his family and friends occurred in ten cases, and problems that affected the patient, and involved his family and friends and/or the community, occurred in ten cases. Thus only ten patients of the thirty-two studied were reported to have problems which involved the community. This suggests, that despite the high degree of social
dependency evidenced in this group, resources other than those of the community were available to many of these patients.

The recording done by members of the Social Service Department is largely of a summary nature, consequently, the nature of services offered is not always fully defined in the records. Because of this, it was necessary to devise some method, other than the usual case analysis approach, of determining what particular types of service were rendered in planning for convalescence. Therefore, a questionnaire was developed, and completed by the social workers who dealt with the cases studied. Services were noted to be rendered either directly to the patient, or indirectly through his family or friends or the community. It was found that there were five direct types of service, and nine indirect types of service that were commonly used in offering convalescent planning help.

All the patients studied received either direct or indirect services, focused on meeting the convalescent problems they presented. Direct services were given to all but one patient, and indirect services were given to all patients. Where problems of finances, and accommodation occurred with patients themselves, it was noted that direct services designed to meet these problems were provided in nearly all cases. The few instances in which such services were not offered were explained mainly on the basis of timing, in that the patients were not ready to deal with such problems, because of medical or social reasons. Patients presented psychological problems in fifteen cases, and all fifteen of these patients received direct services focused on meeting such problems. In addition, fourteen other patients, who did not have psychological problems reported in their case records, nevertheless received direct services related to psychological problems.
Problems of finances or accommodation which indirectly affected the patients by involving their families or friends, or the community, occurred in twenty-one cases. Indirect services designed to meet such problems were offered to these twenty-one patients, and to several others who had not had these problems reported in their case records. Psychological problems were reported to involve the family and friends of eight patients, and indirect services designed to deal with these problems were offered to these eight patients. No psychological problems were reported to have involved the community, but indirect services focused on meeting such problems were offered in eleven cases. In one other case services of a psychological nature were offered to the patient's family and friends, although problems of this nature were not reported in his case records.

The Implications of the Study.

The findings of this study tend to highlight several features of convalescent planning, and of the social services offered to deal with problems of convalescent planning. Of particular significance, from the point of view of social work generally, is the fact that the study has described and defined most of the types of service offered to patients when convalescent planning problems arise. One is immediately impressed with the fact that the specific services offered in convalescent planning reveal a common base with casework services generally, and retain the generic social work base of study, diagnosis, and treatment. The evidences of this have been discussed fully in the preceding chapters,¹ and it is not proposed to enlarge on this evidence here. Rather, it is felt

¹. See discussions in Chapter I, page 6, and in Chapter III, page 48.
that the implications of this study which require further comment are those which relate to the problems of the patients studied, and the specific ways of helping such patients.

In examining the tables in Chapter II, one is immediately struck by the fact that twenty-nine out of thirty-two patients presented problems of accommodation, when faced with the necessity for making convalescent plans. To social workers employed in the hospital, this does not come as a surprise, since it bears out what is already acknowledged by the Social Service Department, and by hospital authorities generally; that community resources for dealing with the problem of convalescence are extremely inadequate at the present time. The surprising fact is that social workers are able to help patients make use of other resources with such regularity. It will be recalled that only ten of the patients studied presented problems that involved the community, and these problems were either problems of finances or accommodation. The remaining twenty-two received help in dealing with their problems either on their own, or with the assistance of family and friends. In considering this factor, it should be borne in mind, also, that over half of the patients did not have close relatives who could be of assistance in their planning.

The importance of the patient's family as a social resource in convalescent planning cannot be overlooked, however, the nature of cases referred to the Social Service Department indicates that the community must assume some responsibility for patients who have no family resource, or else the hospital must re-define its function to include convalescent care as well as active treatment. At the present time this would appear to be an economically unsound plan since the
facilities of a convalescent centre, including the necessary staff and equipment for a physical rehabilitation programme, are not as costly as the facilities and staff required to equip an active treatment hospital. As has been noted, the facilities available in the community for convalescent care are, for the most part, those designed to provide nursing care, and these facilities are primarily designed to provide accommodation for chronic patients. Undoubtedly, this factor alone creates many problems of a psychological nature for the convalescing patient, since, to the lay group, the very mention of nursing home care frequently brings forth feelings and attitudes about the function of these homes in providing chronic care. While this is not necessarily an insurmountable problem for the social worker, it is quite conceivable that some patients are never able to accept clarification about such problems, and are therefore, unable to make the best use of the care provided.

This problem is further complicated by the fact that many patients referred for help with convalescent planning are in the older age groups, and probably expect to be grouped with the chronic patients rather than with those in need of convalescent care. To these patients, the necessity for even temporary nursing care can be extremely difficult to accept, whereas, if homes designed to meet the needs of convalescing patients only, were available in the community, many of these difficulties might be overcome.

The fact that so many patients in the older age groups appeared in this study reveals an interesting trend in modern thinking on the question of convalescence. The increasing incidence of older persons in the population, and the advances being made in medical science has meant that some of the earlier concepts affecting the care of the aged
have had to be revised. Health and Welfare officials are particularly concerned in the matter of rehabilitating older persons who have received active treatment for their illnesses, since this group could create a continuously increasing demand on chronic care facilities in the community, if efforts are not expended to keep them in a reasonable state of self sufficiency in the community. Medicine has made an important contribution to the solution of this problem by developing techniques for treating the acute phases of many illnesses common to the aged, but the total rehabilitation of these patients requires the co-operative skills of many disciplines, including medicine, nursing, physio-therapy, and social work, and the community must be prepared to make such services available to the aged, if for no other reason than that of economy. Some beginnings have been made in this area of making community resources available for convalescent programmes, but for the most part medical social workers are faced with the problem of finding resources that will meet this need, even though the resources were not designed for such purposes.

The problems involved in helping patients make convalescent plans appear to be particularly time consuming for the social workers, and this is especially true when community and family resources are limited. It will be recalled, that eighty-six patients out of a total case load of two hundred and thirty-three, were referred for convalescent planning help in one month, and thirty-two of these eighty-six patients received a total of ninety-one direct services, and one hundred and forty-nine indirect services related to convalescent planning. The analysis of these services in Chapter III indicates that very little

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1. A pilot study is presently being conducted under Federal Health Department auspices, at two private hospitals in Vancouver, where patients in the older age groups are receiving multi-disciplined convalescent and rehabilitative services, under the medical supervision of The Vancouver General Hospital.
duplication of service occurred, (as for example the small number of conferences with other hospital staff personnel, when the doctor was able to provide the necessary information), which suggests that these services are rendered in an efficient manner on the part of the social worker. If any deficiency exists in the area of convalescent planning services by social workers in the Vancouver General Hospital, it appears to be not in the area of the three-fold responsibility of the social worker to the patient, the hospital, and the community, but rather in the area of recording.

For the month of September, 1954, only thirty-two "convalescent planning" cases out of eighty-six had case records set up in the department's files, and of the records that were available, very few contained full reports of the problems presented or of the services rendered. This is further emphasized when one considers that a number of casework services were offered to patients when no problems had been reported in the records. The problem here does not appear to be one of lack of skill on the part of the workers in recording, but one of lack of time to record fully. However, the importance of recording in convalescent planning should not be underestimated, since the problems that confront the department in relation to community resources must be interpreted to the Director of the Department, and through him to the community, if the workers, who must deal with these problems, are to play an effective role in bringing adequate convalescent facilities to their patients. This can only be done through the medium of recording, which medium provides a permanent record of the trends in patients' needs and in the community's ability to meet these needs, thereby giving the hospital authorities factual evidence with which to interpret gaps or duplications in service to patients.
It has been suggested in Chapter I, that interpretation to the community and to the hospital is not purely an administrative function, and that social workers carrying cases on the hospital wards have responsibilities in the area of interpretation, on a case by case basis, of the hospital's role in the community, and of the resources in the community which are available in helping the hospital carry out its function. The study has given ample evidence that the social workers are meeting this responsibility at the case carrying level, and unless the problem of recording can be overcome, it does not seem likely that a more complete method of interpretation can be utilized by the department at this time.

Limitations of the Study.

In a study of this nature, conducted over a brief period of time, and dealing with a small group of patients, one would expect to find many deficiencies and statistical inaccuracies which tend to limit the value of the study insofar as broad trends and patterns in convalescent planning are concerned. The most obvious of these limitations, of course, are those that appear in the statistical method of approach. Because of the difficulties encountered in finding suitable case records, it was impossible, in the limited time available, to obtain a true sample of the in-patient population of the hospital, consequently, there is no valid evidence that the group studied is a representative group that would show any positive index of association with the total population of the hospital. By the same token, the data collected from the records and by the questionnaire method were valid only for the patients studied, and could not be considered to be representative of the total caseload of the Social Service Department. Therefore, any trends that might be
apparent in such a study could only be interpreted in their broadest
terms, and only when they tended to compare with well known facts
about convalescent planning.

The method employed to equate problems of convalescent plan-
n ing, and casework services, also shows limitations in terms of compar-
is on and cross-classification, and while it is relatively effective in
a study of a small group of patients, other modifications would have to
be employed if larger groups were to be analyzed. While the method
employed does serve to show some of the relationship between the two
factors of problems and services, it must be remembered that the problems
were grouped under three broad sub-headings, and that each of these sub-
headings could be further broken down to include a number of specific
problems. This observation also applies to the division of casework
services, which, while more descriptive than the division of problems,
is nevertheless a broad classification. A more comprehensive study of
the same question of convalescent planning would of necessity, require
more comprehensive description and measurement of both problems and
services.

The interesting feature of the method employed is that is has
made possible some statistical presentation of the involvement of the
patient's family group, and of the community, in the matter of conval-
escent planning, and it has, to some extent, depicted the myriad of
services offered to patients, their families and friends, and the com-
munity, when a referral for help with convalescent planning is made to
the Social Service Department. Unfortunately, this method of study does
not bring out fully the effectiveness of the services rendered, since
this could only be done on the basis of follow-up assessments some time
after the patients had been discharged from hospital. This deficiency in the study, however, may have advantages in pointing up the need for further specialized research in the whole field of social work and convalescent planning, with particular reference to questions of patients' readmissions to hospital, or return to a satisfactory level of self sufficiency. These indications for further research are evident in other parts of the study; and bear some further discussion at this time.

Indications for Further Research.

The fact that this study was focused on describing the common characteristics of a group of thirty-two general hospital patients who were referred to a social service department, for help with convalescent planning, does not imply that the whole question of convalescent planning has been fully dealt with. In actual fact, this study represents only the beginning of exploration into a problem which is essentially part of the larger problem of rehabilitation of the patient. The study has attempted to deal with only one aspect of convalescent planning, namely, the nature of problems that arise for patients requiring a period of convalescent care, and the services that the medical social worker offers these patients before they leave the active treatment hospital. In order to present the total problem of convalescent planning, and the medical social worker's role in such planning, several other studies would be necessary.

The first of such studies might well be concerned with the problem of available resources, both in the family and in the community. This study has pointed up some of the difficulties that confront patients whose family resources are, because of age, marital status, and changing
concepts about the role of the family, no longer as helpful as they might have been thirty years ago. Social scientists have, for a number of years, shown concern about the changing status of the older person in the community, and the changing role of the family in respect to older persons. To some extent this trend in respect to the aged seems also to be affecting those who are temporarily or permanently disabled, and there are indications that the community is being called upon, more and more, to assume many of the traditional family responsibilities. To what extent this trend is affecting attitudes about convalescent planning and convalescent care, is not immediately clear, but it would seem that some further study in this area would be most helpful in clarifying present attitudes about family and community responsibility for patients whose needs are for convalescent care apart from the active hospital.

The second area of study which would be helpful in understanding the total problem of convalescent planning would be an evaluative study of community resources that are presently used, and an assessment of how effectively these resources are used. This study has highlighted to some extent, the fact that social workers must be extremely resourceful, and must spend a good deal of time, in finding ways of helping patients to deal with their problems of convalescence. There seems to be little doubt that the resources used are often decided upon on the basis of necessity rather than suitability, since resources within the community do not seem to be designed to meet the convalescent problems of patients as frequently as they are designed to meet the chronic care problems of patients. To some extent, a study of this type might also point up some of the psychological difficulties that confront patients when they are asked to make

1. See discussion in Chapter I, page 10.
use of inadequate resources in planning for their own convalescence. The
analysis in Chapter III, of services offered by social workers indicates
that much time is devoted to dealing with psychological problems that the
patients present, and many of these problems seem to be related to environ­
mental difficulties such as making financial arrangements, or making plans
for accommodation.

Any evaluation of community resources, however, would require
very careful consideration, since many of the resources used in the com­
mmunity at the present time, are provided under commercial auspices.
Nursing and boarding homes, for instance, are usually privately owned
businesses, and while there is no doubt that these homes meet legal re­
quirements as to minimum standards of physical accommodation and nursing
services, any attempt to evaluate other services offered by these agencies
would require the full co-operation of the people who earn their liveli­
hood from these business ventures.

A third type of study is also indicated in attempting to describe
and evaluate the total programme of convalescent planning and care avail­
able to patients in the active treatment hospital. As has been mentioned,
some appraisal is needed of the effectiveness of social services in helping
patients to make a satisfactory adjustment to their illnesses and to be­
come as self sufficient as their illnesses will permit. This extremely
important study is perhaps the most difficult to conjecture upon, since
it would require the development of some standard of measurement of move­
ment in the casework relationship, and would also need to contain some
method of assessing the degree of importance that should be placed on
medical factors in the patient's adjustment, or his failure to adjust.
Such a study would also need to standardize the measurement of the effec­
tiveness of casework with the patient's family and friends, and of use
of community resources, and the effects of these two types of service on the patient's ability to make and carry out convalescent plans.

Unfortunately, in carrying out this latter type of study, many of the difficulties that have been encountered in this study would again become apparent. The problems that are inherent in the summary method of case recording, when such recording is used to obtain research data, become considerably magnified in attempting to analyze movement in social casework. Also, the fact that case records are not available for all patients served, raises the inevitable question of selection of a study group of patients. At the present time, problems of obtaining valid samples of the patients referred to the social service department of the Vancouver General Hospital are extremely difficult to cope with, however, this does not preclude the possibility of conducting further studies into the field of convalescent planning. If the importance of such research is apparent, however, the methods used to carry it out might well be on the basis of a random sampling of referrals to the department, together with the establishment of a control group of patients, the whole of which might then be observed by the researcher throughout the various stages of medical and social treatment.

Recommendations.

Although the focus of this study has been limited to a small group of patients, selected through a process of elimination of cases which would not lend themselves to simple classification of data, it is possible, nevertheless, to make some general observations about convalescent planning, and its importance in the medical social worker's job in an active treatment hospital. In this study, certain problems have proven to be of particular concern to patients planning for convalescence, and certain types of services have been shown to be appropriate to the task
of helping these patients with their problems.

In the analysis of the patients and their problems, several factors occurred with sufficient frequency to be considered as denoting trends in convalescent planning, and on this basis it is possible to offer specific proposals in respect of these trends.

As has been noted, the first important feature that one sees in analyzing the problems of patients is that nearly all patients presented problems of accommodation. In view of this, it would seem that the Social Service Department might profit by a thorough examination of this problem in relation to resources available, and to the economical use of social workers in meeting the problem. A beginning has already been made in this, in that the workers are, during the month of March, 1955, conducting a time study of the total medical social work job in the hospital. Once this has been completed, it will be possible to move towards a more comprehensive description of each job that is being done in the hospital by social workers, and those workers whose cases frequently present problems of convalescent planning will be better able to evaluate what proportion of their time is spent dealing with this problem of finding and arranging for accommodation for patients. Having established this, it would then seem possible to evaluate whether or not the existing resources are satisfactory, both qualitatively and quantitatively, and if they are, to determine if the methods employed by the workers in making use of these facilities, are satisfactory from the point of view of the patient, the hospital, and the community, or if more effective methods of dealing with the problem of accommodation might be employed.

The second important trend that was noted in examining this group of thirty-two patients was that of age. It will be recalled that
a large number of these patients were in the older age groups, yet were considered as candidates for convalescent care, rather than chronic care. The medical social worker, dealing with problems of convalescent planning is in a unique position to observe such developing trends, and to interpret these to the hospital and the community. This would appear to be one of the functions of a hospital social service department, and although the community is doubtless aware of the many problems that are arising as a result of the increase of aged persons in the population, it is only the medical social work department that can interpret this specific aspect of the total problem. By the same token, the hospital social service department is the only one that can offer the special consultative services needed by the community in planning ways of coping with these changing trends. The hospital social service department, because it enjoys a close liaison with the medical treatment team, is in a better position than any other community social agency to know what the changing needs of older patients are, and to know what medical science prescribes and recommends, in terms of the medical and social treatment of such patients. On this basis then, it would seem that the Social Service Department of the Vancouver General Hospital should continue to offer leadership in the community, in planning for the total needs of the increasing group of older patients who require some form of convalescent care in the community, rather than in the active treatment hospital.

To carry out this function, however, requires that the Department be able to speak with authority on matters relating to convalescence, which points up the need, (already discussed), for further research in the areas of available community and family resources, and in the area of effective casework services to patients. This can only be effected by full application of the social work method in the cases carried by the
department, and such an application would include careful consideration of the research implications of each case. Thus thought might well be given to the need to record more fully and inclusively, and to include in the recording a full description of the social problems that require treatment, a standardized description of the services utilized to treat such problems, and a statement of the effectiveness of these services at the point of termination of contact with the patient. This whole question of recording has received a considerable amount of attention in the past by staff committees in the department, and the recommendations of these committees have been incorporated in the policy of the department. Since the medium for effective recording already exists, the problem appears to be one of determining how such recording can be done by workers who are already finding it difficult to record fully on a limited number of cases. Undoubtedly, the workers are motivated by their desire to serve the patient, and as a result recording does not always receive a high priority on the worker's timetable, however, if the Department is to meet its interpretive responsibilities to the hospital and the community, in bringing effective services to all patients, the basic tools of the social work method must not be neglected.

Conclusion.

This study has attempted to describe a group of thirty-two patients referred to the Social Service Department of the Vancouver General Hospital, together with the problems of convalescent planning that these patients presented, and the casework services that were offered to them in dealing with these problems. The study has revealed a common group of problems arising for convalescing patients, and it has shown that high standards of medical social work are maintained by the Department.

Some questions have been raised in the study about the Depart-
ment's need to assume leadership in the area of interpretation to the community, of trends in convalescent planning, but the indications are that the Department is well aware of its responsibilities in this area. As the Department becomes more clearly defined in the total treatment constellation of the hospital, it seems likely that it will be able to meet these responsibilities in a more concerted fashion than is possible at present.

The study was undertaken for the purpose of describing one aspect of the total problem of rehabilitation of patients in general hospitals, and from this it has developed that further research is indicated in order to complete this description of the problems of rehabilitation of the patient. Convalescent problems have been seen in this study, as involving the patients themselves, their families and friends, and the community, consequently, the indications for further research involve these three aspects of the patients' social situations.

The method employed in this study to collect and analyze the data available has been reasonably satisfactory, in that a small group of patients was studied. However, if further research is undertaken in this area of convalescent planning with Vancouver General Hospital patients, it would seem advisable to utilize a controlled observation method rather than the case analysis method, unless more suitable cases records are available.

The role of the medical social worker, during the past sixty years, has changed from that of simple eligibility study to active participation in the total treatment of patients. New knowledge, and changing concepts, both in medicine and in social work, have brought about sweeping changes in attitudes about convalescence, and its importance in the return of the patient to an optimum level of health after illness. Much of the responsibility for planning and carrying out
convalescent plans with patients has been assumed by medical social
workers. This study has indicated that this responsibility has not
been poorly placed, since the philosophy, methods, and the techniques
of social work lend themselves well to the modern multi-disciplined
approach to healing the sick.
Appendix A Referral Sheet used by THE VANCOUVER GENERAL HOSPITAL

NOTICE OF REFERRAL TO THE SOCIAL SERVICE DEPARTMENT

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
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<table>
<thead>
<tr>
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</thead>
<tbody>
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</tbody>
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<table>
<thead>
<tr>
<th>Clinic</th>
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</thead>
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<tr>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
</tr>
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<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**REASON FOR REFERRAL:**

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>✔</th>
<th>✔</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affecting Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assistance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Nursing Home</td>
</tr>
<tr>
<td>(b) Boarding Home</td>
</tr>
<tr>
<td>(c) Institutional Care</td>
</tr>
<tr>
<td>(d) Home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**REMARKS:**

Doctor

Social Worker
Appendix B: Sample of schedule used to isolate cases having Convalescent Planning as the main problem.

<table>
<thead>
<tr>
<th>NAME</th>
<th>UNIT NUMBER</th>
<th>REHABILITATE</th>
<th>NURSING HOME</th>
<th>BOARDING HOME</th>
<th>INSTITUTION HOME</th>
<th>OTHER</th>
<th>REMARKS</th>
<th>RECORD AVAILABLE CONValescent PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Sample of schedule used to collect data on the convalescent problems of the thirty-two patients studied.

<table>
<thead>
<tr>
<th>REMARK</th>
<th>PROBLEMS WITH</th>
<th>CASE</th>
<th>FACE SHEET DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>JMS WITH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JMS WITH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JMS WITH</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| NAME | NUMBER | SEX | AGE | MARITAL | OCCUP | FIN MD | DIAG | SP | M | W | D | S | A | B | C | A | B | C |
|------|--------|-----|-----|---------|-------|--------|------|----|---|---|---|---|---|---|---|---|---|
| S | M | W | D | S | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |
| S | M | W | D | S | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |
| S | M | W | D | S | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |
| S | M | W | D | S | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |
| S | M | W | D | S | A | B | C | A | B | C | A | B | C | A | B | C | A | B | C |

A - FINANCES
B - ACCOMMODATION
C - PSYCHOLOGICAL
S - STAFF
P - PRIVATE
S - SINGLE
W - WIDOWED
S - SEPARATED
M - MARRIED
D - DIVORCED
Appendix D: Sample of Questionnaire used in Study.

Did you offer the following casework services in convalescent planning with #

<table>
<thead>
<tr>
<th>I. Direct Services to Patient</th>
<th>yes</th>
<th>no</th>
<th>uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Enabling patient to accept the need for convalescent care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Supporting patient around anxieties relating to his family, friends, and/or personal affairs during his period of convalescence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Enabling patient, through supportive and/or clarifying techniques, to arrange for his own convalescence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Direct action on behalf of patient, regarding his personal affairs. (e.g. Arranging storage of personal effects.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Arranging on behalf of patient for financial assistance and/or accommodation in relation to his convalescent needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Indirect Services to Patient</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>f) Enabling patient's family or friends to accept the need for convalescent care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Enlisting the help of and enabling family and friends to participate in planning for patient's convalescence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Giving direct services to patient's family or friends to reduce patient's anxieties in planning for convalescence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Conferences with patient's doctors regarding patient's convalescent plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Conferences with other hospital staff regarding patient's convalescent plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Conferences with Community Welfare Agencies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Administrative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Interpretive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n) Conferences with Community Health Agencies. Include public and private nursing and boarding homes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Administrative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Interpretive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from a questionnaire developed by Ernest Schlesinger for Casework in the Mental Hospital, Master of Social Work Thesis, University of British Columbia, 1954.
Appendix E: The Direct and Indirect Casework Services Offered to Ten Patients Whose Convalescent Planning Problems Concerned Themselves Only.

<table>
<thead>
<tr>
<th>SERVICES TO PATIENTS</th>
<th>PATIENTS IN GROUP &quot;A&quot;</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 3 6 7 13 15 22 26 29 30 32</td>
<td></td>
</tr>
<tr>
<td>DIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a)</td>
<td>- - 1 1 1 1 1 1 1 1 1</td>
<td>10</td>
</tr>
<tr>
<td>(b)</td>
<td>- 1 1 - 1 - 1 1 - 1 1</td>
<td>8</td>
</tr>
<tr>
<td>(c)</td>
<td>- - - - - - - 1 - - 1</td>
<td>2</td>
</tr>
<tr>
<td>(d)</td>
<td>1 1 1 - - - - - - 1</td>
<td>4</td>
</tr>
<tr>
<td>(e)</td>
<td>1 - - 1 1 - - 1 - 1 1</td>
<td>7</td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>2 2 3 2 3 1 2 3 3 2 3</td>
<td>31</td>
</tr>
<tr>
<td>INDIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>1 - - - - - - 1 - 1</td>
<td>3</td>
</tr>
<tr>
<td>(g)</td>
<td>1 - - - - - - 1 - 1</td>
<td>3</td>
</tr>
<tr>
<td>(h)</td>
<td>1 1 - - - - - 1 - 1</td>
<td>4</td>
</tr>
<tr>
<td>(j)</td>
<td>1 1 1 1 1 1 1 1 1 1 1</td>
<td>12</td>
</tr>
<tr>
<td>(k)</td>
<td>1 - 1 1 1 1 - 1 - 1</td>
<td>7</td>
</tr>
<tr>
<td>(m) i</td>
<td>1 - 1 - 1 1 - - 1 -</td>
<td>5</td>
</tr>
<tr>
<td>(m) ii</td>
<td>1 - 1 1 - - - - - -</td>
<td>3</td>
</tr>
<tr>
<td>(n) i</td>
<td>1 - - 1 - 1 1 - 1 -</td>
<td>5</td>
</tr>
<tr>
<td>(n) ii</td>
<td>1 - - 1 - - - - - -</td>
<td>2</td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>9 2 4 4 3 2 6 1 4 4 1</td>
<td>44</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11 4 7 6 7 4 4 9 4 6 7</td>
<td>75</td>
</tr>
</tbody>
</table>

Source: Questionnaires completed by five social workers at the Vancouver General Hospital, Social Service Department.
Appendix F: The Direct and Indirect Services Offered to Ten Patients Whose Convalescent Planning Problems Affected Themselves and Involved Their Families and Friends.

<table>
<thead>
<tr>
<th>SERVICE TO PATIENTS</th>
<th>PATIENTS IN GROUP &quot;B&quot;</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 4 5 12 14 21 23 24 25 31</td>
<td></td>
</tr>
<tr>
<td>DIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a)</td>
<td>1 1 - 1 1 1 - 1 1 1 7</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td>1 1 1 1 - 1 - 1 1 1 8</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td>- 1 - 1 1 - - - 1 - 4</td>
<td></td>
</tr>
<tr>
<td>(d)</td>
<td>- - - - - 1 - 1 - - 2</td>
<td></td>
</tr>
<tr>
<td>(e)</td>
<td>- - - - 1 1 - 1 - 1 4</td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>1 3 1 3 3 4 7 4 3 3 25</td>
<td></td>
</tr>
<tr>
<td>INDIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>1 1 - - - 1 1 1 1 - 1 6</td>
<td></td>
</tr>
<tr>
<td>(g)</td>
<td>1 1 - 1 - 1 1 1 1 1 1 8</td>
<td></td>
</tr>
<tr>
<td>(h)</td>
<td>1 1 1 - - 1 1 1 1 - 6</td>
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</tr>
<tr>
<td>(j)</td>
<td>1 1 1 1 1 1 1 1 1 1 10</td>
<td></td>
</tr>
<tr>
<td>(k)</td>
<td>1 - 1 1 - 1 1 1 1 - 6</td>
<td></td>
</tr>
<tr>
<td>(m) i</td>
<td>- - - - - - - - 1 - 1</td>
<td></td>
</tr>
<tr>
<td>(m) ii</td>
<td>- - - - - - - - - - -</td>
<td></td>
</tr>
<tr>
<td>(n) i</td>
<td>- - 1 - - - - 1 - 2</td>
<td></td>
</tr>
<tr>
<td>(n) ii</td>
<td>- - 1 - - - - 1 - 2</td>
<td></td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>5 4 5 3 1 6 6 7 2 3 42</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 7 6 6 4 10 6 11 5 6 67</td>
<td></td>
</tr>
</tbody>
</table>

Source: Questionnaires completed by five social workers at the Vancouver General Hospital, Social Service Department.
Appendix G: The Direct and Indirect Casework Services Offered to Ten Patients Whose Convalescent Planning Problems Concerned Themselves, Their Families and Friends, and the Community.

<table>
<thead>
<tr>
<th>SERVICES TO PATIENTS</th>
<th>PATIENTS IN GROUP &quot;C&quot;</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9 10 11 16</td>
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</tr>
<tr>
<td>DIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a)</td>
<td>1 1 1 1</td>
<td>8</td>
</tr>
<tr>
<td>(b)</td>
<td>1 1 1 1</td>
<td>9</td>
</tr>
<tr>
<td>(c)</td>
<td>- 1 - 1</td>
<td>5</td>
</tr>
<tr>
<td>(d)</td>
<td>1 - - -</td>
<td>4</td>
</tr>
<tr>
<td>(e)</td>
<td>1 1 1 1</td>
<td>9</td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td>4 4 3 4</td>
<td>35</td>
</tr>
<tr>
<td>INDIRECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>- 1 - 1</td>
<td>8</td>
</tr>
<tr>
<td>(g)</td>
<td>1 1 1 1</td>
<td>10</td>
</tr>
<tr>
<td>(h)</td>
<td>- 1 1 1</td>
<td>9</td>
</tr>
<tr>
<td>(j)</td>
<td>1 1 1 1</td>
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Source: Questionnaires completed by five social workers at the Vancouver General Hospital, Social Service Department.
APPENDIX H

BIBLIOGRAPHY


American Association of Social Workers, Educational Qualifications of Medical Social Workers in Public Health Programmes, Chicago, 1950.


Canadian Association of Social Workers, A Statement of Standards to be Met by Medical and Psychiatric Social Service Departments in Hospitals, Clinics and Sanitoria, Ottawa, 1952.


