REHABILITATION OF ARTHRITIS PATIENTS

A Study of the Social Work Aspects, Based on Non-pay Patients of the Canadian Arthritis and Rheumatism Society (B.C. Division), 1949-52.

by

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ABSTRACT

In order to provide adequate treatment facilities, the B.C. Division of the Canadian Arthritis and Rheumatism Society made arrangements with the Western Society for Rehabilitation whereby twelve beds were reserved for the non-pay patients of the C.A.R.S. During the period of two years fifty-eight in-patients received treatment there. The relevance of casework for these patients is studied in the present thesis.

The in-patients came from all parts of British Columbia and were selected on the basis of low income, favourable prognosis and certain requirements set by the policy of W.S.R. Because of these factors, this study is limited to a carefully selected group, and does not include patients whose illness was far advanced.

Case illustrations are used to evaluate the effectiveness of services given. These also point up some of the special problems which this group has encountered. The nature of the illness and the need for a total approach in the rehabilitation process make it clear that the social worker is an indispensable member of the treatment team. This study shows also some of the factors which can hinder or prevent successful rehabilitation. Limitation in the physical setting, lack of funds, and lack of co-ordination of basic resources for treatment, re-education and follow-up, all detract from the potential effectiveness of the services so far available. Certain tentative recommendations are made on these points. Since arthritis is a condition about which medical science has not yet acquired a workable body of knowledge, this project must necessarily be somewhat exploratory. But the study leaves no doubt that the project undertaken by C.A.R.S. has made a significant contribution to the physical and mental well-being of the patients under treatment.
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TABLE OF CONTENTS

Chapter 1. Arthritics and their Rehabilitation


Chapter 2. Patients and their Problems

Non-pay arthritics. Problems arising out of lack of income. Personal and community implications of arthritis; situation in Vancouver and in the Province of British Columbia. ....................... 27.

Chapter 3. Treatment, Services, and Difficulties

Difficulties of the treatment; problems, possibilities; teamwork. Physical aspects of the treatment. Casework services; the social worker's goals. Interpretation and education in the field. .................. 40.

Chapter 4. Evaluation and Suggestions


Appendices:

A. Types of rheumatic diseases. ......................... 70.
B. Bibliography. ........................................... 72.
REHABILITATION OF ARTHRITIS PATIENTS

CHAPTER I - ARTHRITICS AND THEIR REHABILITATION

Arthritis is a term applied to a large group of conditions which give rise to aches, pains, and stiffness in muscles and joints. Arthritis, by medical definition, is any one of more than 200 varieties of disorders in which there is disease of one or more joints. The various rheumatoid diseases differ greatly in seriousness. Some are grave disorders which may lead to invalidism or total disability for the rest of the patient's life. The defect may become dynamic and progressive. On the other hand, the great majority of disorders termed arthritis by the layman are not likely to be anything worse than a mild form of rheumatism. However, the progressive and changeable character of the disease is its most striking feature, and represents the most important obstacle to successful rehabilitation. Although the joints are the seat of the disease, the whole body is involved. Obviously it is difficult to plan an integrated rehabilitation program for the people who are seriously affected; yet a large number can be successfully adjusted to their disability, and made partially productive.

Because of the chronic and unspectacular nature of the disease, it is difficult to ascertain the exact incidence of arthritis among the population. Some of the estimates place the number of Canadians suffering from arthritis at 600,000. It strikes the rich as well as the poor, mostly in their adult lives. In some cases the original disability has been prolonged by neglect; in others it has been so severe that even despite long and expert treatment it has left severe residual effects.
Facing the still obscure causes and cures of arthritis, physicians throughout the world emphasize the importance of prevention of crippling and the need for better attention to those already affected by the illness. Although responsibilities for the physically handicapped have been recognized in Canada fairly early, even so, we still lag behind most of the European countries in creating the social machinery for placing and accepting responsibility for hardships over which victims so often have very little, if any, control. The initiative taken by private organizations like the Canadian Arthritis and Rheumatism Society, often leaves them with an insurmountable task in their attempts to combat chronic and disabling diseases.

Arthritis, like any other chronic disease, profoundly affects the life of the individual patient and his family. If at one time the person had a good use of all his faculties and then was deprived of some of them by a disability, he finds it extremely hard to change his way of life to allow for the deviation. He must change all his previously formed ideas because of the newly acquired handicap. In order to do so, he desperately needs help in making an adjustment to life. The disabled individual has the same personal qualities and emotions as a normal person but, although similar opportunity for expression must be allowed for them, this is often made more difficult by his mental attitudes because of health and physical differences.

Chronic illness, like arthritis, can easily make the psychological or financial strain critical and may lead to economic and social catastrophe. Many families are gradually but inevitably pushed to destitution by the continuous financial
drain of chronic illness. Quite aside from the financial burden, the constant presence of an invalid, who may be querulous and exacting, and who must often be tended at night, is a constant drain on the vitality of the members of his family.

The ill effects of the illness are not confined to the patient and his family alone, but are a drain on the community resources as well. While this fact has been generally recognized, there are still many unhappy individuals suffering because of the lack of any organized attempt to help them improve their position. Recognition of the potentialities of the disabled, the early correction of physical defects, and complete physical restoration, are not enough. His residual physical and mental powers must be developed to the maximum if the rehabilitation is to be successful.

Evolution of Social Responsibility.

In the distant past, individuals with physical handicaps were not understood, nor was there much interest in them. It was a world of "survival of the fittest", in which physically disabled persons were eliminated either by the environment or by stronger persons. Gradually, protection in religious institutions insured survival for the physically afflicted. The attitude of the public toward the handicapped can be traced from downright superstitious neglect, through tolerance, to actual helpfulness at present. Increased knowledge has brought greater understanding, and, in enlightened communities, handicapped people are not only allowed, but encouraged to express themselves. To a degree, however, superstition is still present in the modern world. Superstitious resentment of the crippled is still alive
and people with physical defects often have been condemned as unproductive and socially useless.

Because of a combination of hereditary and environmental factors, as well as diseases, the population will always include many people with physical, mental, or emotional handicaps. This fact must be recognized and it must become the responsibility of others to help in an effort to minimize the impairment so that the handicapped person can live to the maximum of his capabilities.

Because of the sometimes serious emotional resistance that the term "cripple" evokes, a substitute-phrase, "physically handicapped", has come into use. This term certainly is more acceptable and does not have the malevolent features which still cling to the word "cripple".

It is a useful approach to the concept of "handicap" to recognize that almost nobody is completely free from handicap. It does not mean, however, that everybody has to seek help from the rehabilitation services. Only those who find their handicap too great an obstacle to living a satisfactory life in a competitive society need to be helped. Handicap does not mean only physical disability. It often includes many other things which may constitute a handicap in themselves or tend to aggravate the basic condition; age, lack of education, race, religion, cultural background, and various personality patterns are examples.

In order to gain clear understanding of the terms used in discussion of rehabilitation, some of them need to be explained. The terms "disability", "handicap", and "rehabili-
"litation" are popularly used to describe many different kinds of conditions and services, a situation which has resulted in considerable confusion.

The Baruch Committee on Physical Medicine has formulated a definition of rehabilitation which is now widely used. It postulates that

"The goal of rehabilitation is to achieve the maximum function of the individual and to prepare him physically, mentally, socially, and vocationally for the fullest possible life compatible with his abilities and disabilities."

This is more than a mere definition for it states well the objectives or goals to which a well conceived program must be directed.

The terms "disability" and "handicap" are often incorrectly interpreted as having one and the same meaning. They have, however, very different meanings, and a seemingly insignificant physical disability may cause a tremendous handicap. A simple example will illustrate this. If two men lose an index finger, the disability is not great, but the handicap may be great or small depending on whether the man is a violinist or a truck-driver.

One study which covers a good deal of experience in this field suggests the following definitions:

"A disability is a condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. It is essentially a medical thing".

"A handicap is the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level. It is an individual thing, composed of the barriers which the handicapped person must surmount in order to attain the 'fullest physical, mental, social, vocational, and economic
usefulness of which he is capable. 1.

As we come to understand clearly the meaning of the terminology used, we see that it is the "handicap" and not the "disability" that becomes the decisive factor in affecting the individual's attitude toward his future.

People are individuals who react differently in all life situations. Some find it easy to cope with certain situations; others have to give up. Some are able to adjust soon and well; for others, any required adjustment can easily mean a failure. The future possibilities of a handicapped person can be determined only by the person himself. What he is, what he wants to be, and what he possibly can be, are the things that can well foretell what his chances are. The person in a crippled body is the same person who was in the healthy body. The crippled body does not necessarily mean that the man is crippled too. Mental and physical skills and talents have re-created thousands of people into independent, happy human beings. In order to achieve this, however, every individual must make his own effort to take the offensive. It is always a hard-won decision to make some kind of a move and to undertake any kind of activity. As Edna Yost, in her book "Normal Lives for the Disabled", says, "these men have to give themselves their own 'kick in the pants', even if they have only two artificial legs with which to do it!"

Unless the handicapped person is prepared for help and wants

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it, any plan will fall through. Some persons are defeated by their handicap and become a permanent burden upon family, community, or friends. Others compensate for their handicap so successfully that they become outstanding in social and personal achievements.

Because every handicapped person reacts differently to his ill fate, any help has to be considered on an individual basis. Handicap, mental or physical, involves more than disability. It involves the total person, the man's whole make-up. In the same way, the treatment must be a total one.

In order that the services can be individualized to suit best every patient in question, his total personality must be understood. Rehabilitation then becomes a highly individualized process in which every person must be accepted as a separate entity and a separate plan must be made to meet his particular need. In order to meet the specific needs of the patients, rehabilitation implies the use of specific skills - medical, social, vocational, psychological. Through the use of these skills rehabilitation became a process in which the remaining capacities of a handicapped person are restored and developed to their highest efficiency.

The concept of total rehabilitation involves several definite steps, among which four important ones can be distinguished:

**A complete rehabilitation diagnosis.** The starting point in such a diagnosis is a thorough medical examination which reveals both the patient's limitations and his possibilities for improvement. The rehabilitation plan which is
based on the findings outlines all the services necessary for total rehabilitation.

Physical restoration through surgery or medical treatment. This is often the most important step in rehabilitation. Many persons are so completely incapacitated that any thought of employment or even self-care is out of the question unless physical improvement is effected.

Practical vocational training comes after the mental and physical rehabilitation. Employability is the common objective of all rehabilitation services, regardless of other goals. Having a skill serves to reduce the handicapping effect of the disability and puts the patient in a favourable position to compete with the non-handicapped for jobs.

Selective placement and follow-up are the final stages. The rehabilitation job is certainly not finished until the patient is working satisfactorily on a job in which he can work without danger to himself and others. The successful placement becomes then the measure of rehabilitation success. It has been said that rehabilitation does not mean a thing if it does not eventuate in placement of the highest quality which the patient's circumstances will permit. While this may be so in many cases, the ability to return to competitive employment should not be the sole criterion of success in rehabilitation. Many victims of chronic diseases, with help through physical or work therapy, could take a much more active part in normal living. Even being able to care for their personal needs would be a marked gain for many.
Institutions Helping the Arthritics.

While in an ideal set-up the whole rehabilitation process is carried out in one place, there is no such institution in Vancouver. There are, however, several good resources, the combination of which can have a fairly effective program. Four in particular offer a great deal:

The Rehabilitation Centre, which has been planned and constructed according to the recommendations of the Baruch Committee on Physical Medicine and the experiences of the four Rehabilitation Centres in Canada operated by the Department of Veterans' Affairs. The Centre is not a hospital or a convalescent home, but a school for the "orthopedically disabled". Included in this medical categorization are paraplegics, polios with permanent paralysis, leg amputees, spastics, and kindred cases.

The whole establishment has been designed to take into account the special requirements of people who must move on wheels. All areas of the building are readily accessible to persons in wheel chairs. All bedrooms have adjoining baths and toilets which are designed for the convenience of the disabled, particularly those with paralysis of the lower body. The gymnasium is large and fully equipped for all the needs of physical re-education. The remedial walking pool and the Hubbard Tanks for horizontal hydrotherapy have also been specifically designed to permit wheel chair cases to enter and leave the pool unaided.

1. A thorough study of the facilities for the care of the chronically ill has been made by W. D. McFarland, MSW thesis, University of British Columbia, 1948.
The first unit of the Centre was built in January, 1949, by private funds raised by a group of citizens who saw the need for a place which is not a hospital, and where a patient could be trained for the business of daily living. The whole program is under constant medical supervision. The goal is to make the disabled person physically independent of others, to restore, if possible, his ability to get around by himself and to earn a living.

The Centre is, however, not designed to work miracles with people whose handicap has penetrated farther than its physical manifestations. But for those, who in the opinion of the medical director and family physicians, can benefit by its services, the Centre can hope to bring about a better co-ordination and thus a wider scope of physical activity, and a degree of psychological or emotional balance without which rehabilitation is meaningless.

The Special Placement Division of the National Employment Service, established in 1944, is, among other duties, concerned with the placement of handicapped individuals in industry. These applicants are, as a rule, in special need of occupational adjustments or readjustments and, of course, of special assistance in their search for suitable employment.

The Special Placement Division is interested primarily, not in a man's disabilities, but in his remaining work capacity and his "will to work". Placement of the disabled cannot be based on past performances or on sympathy. The applicant must be brought to realize, therefore, that what he has left, not what is gone, is the important consideration.
An "Appraisal of Physical Capacities" form, which has space for the evaluation for the forty-three physical activities needed for the performance of various types of work and thirty working conditions which cover practically every type of employment, simplifies the work of the employment officers. When this information is obtained from a handicapped individual seeking employment, the officer gets a reasonably complete idea of the possibilities of the individual and something definite upon which to base the search for suitable employment for him.

The will to work is all important because, if the handicapped person does not have this, he will not be successful. If he has, in most cases there will be found left to him some capacity to work which will be saleable to an employer. A successful placement of a disabled person in employment where the best use of his skills and abilities will be made, is the calculation of satisfactory rehabilitation.

**Vancouver General Hospital.** The Out-Patients' Department of the Vancouver General Hospital is one of the numerous resources making a fine contribution to the rehabilitation of handicapped persons. Although the origin of the department can be traced back to the year 1906, it was not until 1925 that medical services were taken over by the Vancouver General Hospital. At present, the department, through its diagnostic and X-Ray services, is of invaluable help in the total rehabilitation process. Very few patients could afford to go from specialist to specialist in an endeavour to clear away every
doubt before a final diagnosis is made. Here, in one department, are all the necessary specialists, and the patient is transferred from clinic to clinic until the doctors are satisfied that the diagnosis arrived at is correct. Many of the patients come from rural areas where diagnostic and X-Ray services are not available or they could not go to a specialist because of their financial situation. Yet we know today that an accurate medical diagnosis is the prerequisite of any rehabilitation program.

**Vancouver Vocational Institute.** The program of the Vancouver Vocational Institute states that it is designed to be a vocational training centre. This means that all the courses which are carried on in this school must lead to gainful employment in some occupation or other. In order to achieve this, the closest contacts are maintained by the Institute's administration with employer groups and labour organizations. In this way the Institute is constantly apprised of the employment demands and this may regulate the numbers it can enroll for training in specific occupations. There would be little point in training people for a trade in which they would find it hard to get a job. Where physical handicap is a problem, the Special Placement Division of NES is of particular help in determining the possibilities of both training and placement.

The Institute, built in October, 1949, is operated by the Vancouver Board of School Trustees, and its training facilities are open to anyone living in British Columbia. The policy of admission is that the person enrolled must have the
ability first to learn and second to take his place in a job. In general, students who will be admitted to the school must have had at least Grade X education.

The Vancouver Vocational Institute is of very great value in the rehabilitation process of handicapped persons. No one is more severely handicapped than the disabled person who must compete in the unskilled labour market. Therefore, skills must be developed in the most suitable occupational area, consistent with the rest of the rehabilitation process.

Workmen's Compensation Board. The Workmen's Compensation Board of British Columbia has qualified personnel for two types of rehabilitation - physical and vocational. The tremendous number of cases for which the Board is responsible makes it almost impossible for them to carry out an extensive continuous rehabilitation program. The restoration of function following an accident requires a fairly intensive program of physiotherapy and occupational therapy and needs a good deal of equipment which is not necessary in a physiotherapy program for other diseases. Although the majority of work has to do with injuries caused by accidents, the WCB is also concerned with arthritics.

The physical rehabilitation program is carried out in a separate Rehabilitation Centre, where an average of 490 cases a day are treated at the present time. As the Centre has its own X-Ray Department, it is possible to keep a very close check on the progress of every case.

Since the opening of the Western Society's Rehabilitation Centre, the WCB has enrolled in the Centre's rehabi-
ilitation program all industrial casualties suffering a spinal cord injury. Through this measure and the WCB's Rehabilitation Department, these industrial casualties are given every opportunity for rehabilitation.

Closely linked with physiotherapy is the Occupational Therapy Department, where every piece of equipment is designed for the same purpose - the restoration of function.

The Vocational Rehabilitation Department is located in the main building. Patients are referred to the Department when it is obvious to the medical staff that some permanent disability will be present and, because of it, a shift in the type of employment will be necessary. If a decision of re-training is reached, the Board finances services of the Vancouver Vocational Institute, secretarial schools, or correspondence schools. In some instances an apprenticeship can be arranged, where such training is indicated.

Canadian Arthritis and Rheumatism Society.

Private organizations have a long history of leading the field in trying to mobilize social action to assist in combatting chronic diseases. Encouraged by the effective war waged against tuberculosis and cancer, the Canadian Arthritis and Rheumatism Society tries to mobilize and canalize good public intentions into useful public action against rheumatism.

The history of the C.A.R.S. is relatively new. It was at the conference called by the Department of National Health and Welfare in November, 1947, that the formation of a national society was recommended. The Canadian Medical Association,
the Canadian Nurses' Association, the Canadian Hospitals' Council, and all Canadian medical schools and Provincial Health Departments were represented.

On March 15, 1948, the C.A.R.S. was incorporated as a national voluntary health agency, with divisions in British Columbia, Saskatchewan, Manitoba, and Ontario. A New Brunswick division was established in 1949; Nova Scotia and Alberta followed in 1950. Newfoundland and Prince Edward Island are still without organized Provincial divisions.

As the primary objective of the Society, the greatest possible reduction of death and disability caused by arthritis and other rheumatic diseases has been set. "The Society must continue and expand its nation-wide programme of research and education in rheumatic diseases to discover their causes and develop methods of prevention; promote locally the establishment or expansion of facilities for diagnosis and treatment of sufferers; and provide sufferers and the public with factual information." ¹

The establishment of an executive office and the initial organization of the Society's work was made possible through a grant of $10,000.00 from the Canadian Red Cross Society. The provincial governments contributed 1 per cent of their share of the Federal General Public Health Grant. The Province of British Columbia contributed an amount equal to nearly 5 per cent of its share of this grant. By the end

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¹ Objectives as given in the leaflet, Facts about Arthritis, 1951 Appeal, published by the British Columbia Division, C.A.R.S.
of March, 1949, the Society had over $65,000.00, which enabled it to pursue actively its objectives of organizing a truly national body. Since then, the finances have been provided by the means of government grants, annual public campaigns, and sponsorship by certain organizations.

In the Spring of 1949, the Medical Advisory Board was formed and was composed of thirty-seven physicians, surgeons, and scientists from across Canada. The Board established a Committee on Clinical and Scientific Research and a Committee on Professional Education. The funds for the maintenance of the research and education programs are provided by the Society's provincial divisions out of the proceeds of their annual financial campaigns. Under these programs, grants are made to existing university research departments and laboratories primarily to enable them to secure the services of technicians and the equipment necessary to carry out effective research in the rheumatic diseases. Research fellowships are available to those of proven ability in scientific research to enable them to carry on their work and their special skills.

The provincial divisions, including their own local branches, are the primary source of the Society's strength. Upon them devolves the application of general plans to local circumstances, with specific responsibility for all projects relating to the improvement of facilities for diagnosis, treatment, rehabilitation, and welfare, as well as for the financing of all the Society's operations.

The British Columbia Division was the first to be established, and its commencement of operations in September,
1948, actually preceded that of the National Office by several months. The pioneer work of this Division has been an inspiration to the Society across Canada.

In consequence of the magnificent gift of $27,500, made by the Associated Canadian Travellers in the Autumn of 1948, and generous financial assistance from the Provincial Government, a pilot arthritis centre was opened in March, 1949, in co-operation with the Vancouver General Hospital, and three mobile units were established in the Vancouver area. There has been a record of steady progress since that date, due to the energy of its leadership, the response of the citizens of the Province, and the support of the Provincial Department of Health and Welfare.

The Division has now thirteen active branches throughout the Province; eleven clinics are now operating in various well-equipped hospitals. Five mobile units serve Vancouver and district, and one mobile unit is associated with each of the other clinics.

The overall medical policy is governed by a special committee on arthritis and rheumatism of the British Columbia Division of the Canadian Medical Association. In each of the centres where a branch is active, the local Medical Society selects one to three physicians to serve for a term. These physicians are chosen because of their high professional standing and their particular interest in the work. The Division has appointed a part-time medical director and two assistant medical directors to give advise and guidance in medical matters.
The Division employs twenty-four qualified physiotherapists; two orthopaedic nurses specially trained in splinting, making casts, administering gold, and taking laboratory tests; two medical social workers; one medical secretary, and two stenographers.

In its efforts to improve the rehabilitation treatment of arthritics in British Columbia, the Society has made agreements with the Western Society for Rehabilitation whereby a certain number of arthritic patients may use its facilities, and certain of the Society's staff provide treatment there.

Facilities for Treatment and Rehabilitation of Arthritics.

Beds and physiotherapy facilities have been made available at the Centre to the C.A.R.S. for treatment of arthritic patients. In addition to resident patients, a certain number of out-patients can be treated. These are, of necessity, residing locally and generally can utilize the special treatment facilities.

The beds available for arthritics now number twelve. With this limited accommodation there is usually a waiting list. As there is no nursing care available at the Centre, the patients must be able to look after themselves; they must be able to dress and feed themselves, attend to toilet, get into the pool, etc.

The treatment and screening of patients is supervised by the medical staff, consisting of a medical director and two assistant medical directors. A two-year post-graduate training course in the leading centres of the United Kingdom
and the United States have specially qualified these doctors for their positions.

The physiotherapy treatment at the Centre is provided for the resident patients and for certain suitable cases of so-called "home-bound" patients who are brought to the special treatment centre. General physiotherapy treatment includes the use of warm pool and Hubbard tanks. The floor of the pool has been divided into eight lanes to permit walking on a level surface in varying depths of water. Two Hubbard tanks are designed for horizontal exercises.

The medical social service department plays an important role in the total treatment program. Actually, the Social Worker's contribution begins at the intake and selection of individual patients. The Social Worker helps the Medical Director to review the economic and social situation of patients considered for admission to the Rehabilitation Centre, and his responsibility is to point out any obstacles that may hinder the patient's rehabilitation. It is well known that stresses of a psychological nature play a considerable part in the flare-ups and perpetuation and possibly the causation of the rheumatoid process in some cases. The Social Worker can be of great assistance in helping the patient to understand and accept the illness and also to gather new strength to start a new life within the limits of the patient's disability. The individual patient needs help to enable him to sort out and to cope with the particular stumbling blocks that he has encountered in his effort to make use of medical resources in getting well.
Often, the trouble is not the lack of these facilities, but the patient's inability to make adequate use of them.

For a long time it has been felt that an occupational therapy is one of the urgent needs for the arthritic patients. An occupational therapy aims to aid and speed recovery through work activity. Doing something by one's own manual effort is the best way to spend part of every day, especially if those efforts tend to create something. "It is in permitting oneself to become interested in creating anything at all that curative value lies". 1.

The Arts and Crafts Work Shop, operated by the Red Cross at Shaughnessy Hospital, is available to patients in the Rehabilitation Centre. Special funds of the Women's Auxiliary are used for the purchase of material, and patients are encouraged to take an active interest in handicraft work.

Present "Case Load" at the Rehabilitation Centre.

As stated before, the C.A.R.S. patients have to comply with certain regulations set by the Western Society for Rehabilitation. In addition to these, the arthritics are admitted according to the policy of the C.A.R.S.

The C.A.R.S. moved into the Centre in March, 1951, and since that time the eight beds allotted to the Society have been in constant use. In addition to that, there has been an agreement worked out with the Provincial Government, which went into effect in July, 1951, by which nine beds

were given for low-income patients in the Centre. The Arthritis Society received four out of the nine beds.

The beds available for arthritics now number twelve, and, because of these rather limited facilities, the selection of the patients must be made very carefully. The final approval for admission is given by the Medical Director.

The usual requirements are that the patients must have arthritis, primarily from the rheumatoid group; they must be in the income group that is covered by free medical care; they must be able to look after themselves; they must be, in the opinion of the Medical Director, likely to benefit from the treatment.

Regarding the period of stay, there is no set limit, but the economic factors place some limitation; the average is three to six months - six being about the maximum granted to anyone.

In respect of financial arrangements, treatment in the Centre is not covered by British Columbia Hospital Insurance Service. There are three classifications for payment:

(a) Private Patients - whose admission may be arranged through the C.A.R.S. medical office but whose accounts are payable directly to the Western Society for Rehabilitation.

(b) Patients sponsored by the C.A.R.S. These are chosen from low and border-line income groups, (Out-Patients' Department level of income, approximately.)

(c) Patients financed by the Social Welfare Department and the local municipality, the administration being done through the Vancouver City Social Service Department.
category has been in existence since July, 1951. Although this constitutes a small quota at present, it is possible that there may be increased support for rehabilitation services if the results are indicative of such a need. Having this in mind, most cases being admitted in category (b) - i.e., paid by the C.A.R.S. - are being reported in the same manner to the provincial and the city authorities so that some idea of the needs may be given.

Also, at present some patients are elected as suitable by these authorities but are in excess of the quota beds. Such cases may be sponsored out of C.A.R.S. funds until a vacancy occurs on the Social Welfare Department quota.

All the arthritics at the Centre are social assistance cases, low income wage earners, pensioners, etc. Besides this, most of them show common patterns of behavior. The general personality structure of the arthritics is rigid and compulsive and they have a need to deny problems. These patients show strong control of all emotional expressions. Franz Alexander, in his excellent book "Psychosomatic Medicine - Its Principles and Applications" has made a study of psychodynamic findings. His conclusion is that the general psychodynamic background in all cases is a chronic inhibited hostile aggressive state, a rebellion against any form of outside or inside pressure, against being controlled by other persons or against the inhibitory influence of their own hypersensitive consciences. There is a predisposing personality factor which develops as the result of excessively restricting parental attitudes. They relate well superficially, but the relationship with the case-
worker often remains on an intellectual level only and sometimes it takes a very long time before real feelings are involved.

The referrals made to the Medical Social Service Department vary greatly. On one hand, there are minor time-consuming services which do not require the services of a trained person, and, on the other hand, there are problems requiring a high degree of professional skill and training. They range from an out-of-town request from an arthritic who wanted help with selling baskets he made, to a request from the doctor to assist in evaluation of the patient's personality and to help the patient with frustrations due to lack of improvement.

The most constructive kind of referral is one where the doctor has recognized the value of casework help to his emotionally disturbed patient and has prepared the patient for a positive approach to the use of casework service. Much depends on the nature of the relationship with the doctor and how he interprets the use of casework service to the patient. One of the difficulties is that the patient does not ask for help and is often not too receptive to referral to a caseworker. Since it is basic to casework movement that the patient should want to be helped, one can see the implications.

Purpose and Method of Present Study

The tendency at the present time to treat "the diseased individual" rather than particular manifestations of the disease has drawn attention to the social influences surrounding every sick person. This has led to renewed interest in situations and habits predisposing to disease and affecting the readjustment
of the sick person.

The purpose of the present study is to examine and describe the treatment given to a certain number of arthritics and to determine the significance of the existing program in relation to this group. The purpose is further to explore the implications of the illness, the patient's reaction to them, and their effect on his health. The study shows the social and emotional problems of patients suffering from arthritis. It aims, further, to point out the problems the disease creates for the patient, his family, and the community. It attempts to determine the role of each member of the professional team and especially the contribution of the social worker.

The absence of economic security of many patients is an important factor affecting their way to recovery. Often they have not prompt access to treatment and tend, therefore, to gamble with their health. Many of the patients become severely disabled before they come to the attention of the C.A.R.S.

In order to determine the effectiveness of present treatment and the best method to be used in dealing with the problem of non-pay arthritics, there is no better place to study the group than in the framework of the C.A.R.S. Although there are treatments given to those who can pay for them, the non-pay arthritics are actually the only group which the Vancouver Branch of the C.A.R.S. has attempted to rehabilitate. The final selection becomes even more restricted by the requirement that the patients must be able to take care of themselves and that there must be some likelihood of rehabilitation.

The importance of clinical teamwork and particularly of
social casework in the rehabilitation process indicates the considerable significance of social work as a treatment aid. The medical social worker is a rather new member of the treatment team of the C.A.R.S. His contribution has been examined in the light of his helping the individual patients to live more comfortably with their disabilities. The social worker has proven to be of indispensable help, not only to the patients but to the physician and other members of the professional team as well. Through regular case-conferences the social worker interprets his findings and helps in working out the best treatment plan for each individual patient.

The present study has been based on the observations of the Social Service Department of the C.A.R.S. in its main treatment centre, the Western Society for Rehabilitation. Casework services have been given to eighty-nine patients, and the illustrative excerpts of cases used in the study have been selected from this group. Patients who received treatment in the Society's branches throughout the Province and whose rehabilitation might have been undertaken by the Social Welfare Branch are not included. These patients become the sole responsibility of the Social Welfare Branch, and reports to the C.A.R.S. are not submitted unless specifically requested. Apart from the financial aspect, the problems of private and non-pay patients are essentially the same; therefore, as far as casework is concerned, all patients show the same characteristics. This study, however, limits itself to non-pay patients only.

It is important to remember that all the activities of the C.A.R.S. are still in the process of development. Rehabil-
citation, except in a few cases, cannot, therefore, be given as a model example. There is an enormous volume of pressing tasks to be dealt with before a complete program can be undertaken.

Although the number of suitable cases is limited, attempts have been made to determine as accurately as possible the adequacy of the patient's physical care, the amount of effort they had expanded to secure subsistence, and the attitudes they had towards the illness. Current ideas about rehabilitation have been reviewed as a background against which to evaluate the services.

Knowledge has been sought not only as a means for throwing light on certain phases of the medical problem, but also for evaluating the provision for medical care and the patient's physical and emotional needs.
CHAPTER II - PATIENTS AND THEIR PROBLEMS

To get an overall picture of the work done by C.A.R.S., some statistics for the two years of the Society's operation in the Western Society for Rehabilitation may be significant.

During this period, fifty-eight patients have been admitted to the Western Society for Rehabilitation. Of these, the majority were financed by the C.A.R.S. The Society was solely responsible for twenty-five patients; C.A.R.S. and C.S.S.D. were responsible for nine patients; C.A.R.S. and private financial responsibility handled seven patients; the C.S.S.D. was solely responsible for six patients; eleven patients were privately financially responsible.

The average length of treatment per patient in the Rehabilitation Centre has been 109 days. It is practically impossible to obtain the total amount of money spent on an average patient. Considering, however, only the cost of accommodation and physiotherapy, the cost is $9 per day, which mean $981 for the treatment period of an average patient. In addition to that sum comes the cost of special drugs and the salaries of the medical personnel.

Besides the 58 in-patients, there have been approximately 54 out-patients per month treated in the physiotherapy department at the Western Society for Rehabilitation. To show the work in the branches, the C.A.R.S. physiotherapists throughout British Columbia have given close to 90,000 treatments to 5500 patients in the 4 year period since the Society's inception.

These few facts indicate the job involved in the program
undertaken by the C.A.R.S. The Society has assumed financial responsibility for a major part of the cost of caring for arthritics throughout British Columbia. The Society's 22 mobile units, combined with careful management by the patient's physician and the Social Welfare Branches, offer to thousands of arthritics, who are unable to obtain the needed hospitalization, the best available substitute care.

Problems Arising out of Lack of Income.

Generally speaking, medical treatment is lagging far behind medical knowledge due to economic factors. Potentially, many people could be helped by treatment, but there are not sufficient resources to help them. A great many of the benefits of modern medicine, particularly preventive care, are lost to people who do not have prompt and ready access to needed services. A serious situation arises, particularly for the needy sick. There are some services, but prolonged treatment is available for the most part only to those who can pay for it. It is true that doctors attend many people who cannot pay, and hospitals conduct clinics and provide care financed by taxes or public subscription; nevertheless, it is generally true that most of the people who cannot pay for services go without them, partly or entirely.

Not enough attention has been given as yet to the social implications of chronic illness as well as to the close relationship between chronic disease and poverty. Aside from the emotional and mental maladjustments brought about by chronic illness, there are, inevitably, far-reaching economic problems to cope with. The illness has become a social hazard, like death or unemployment in that it cannot be adequately provided for by the individual,
When the wage-earner, himself, is ill, the main income is lost to the family, and, if there are no savings, complete dependency soon follows. Relatives can help in emergencies, but rarely can such assistance be extended over long periods of time. Usually other members of the family, or relatives, are forced into a situation that may easily mean a threat to the whole family. Consider, for example, the case of Miss G., a girl from the Okanagan, now 21, who has had rheumatoid arthritis since she was 15.

The family had spent a great deal of money not only on their daughter's illness but also on illnesses they had themselves. Miss G's mother has had difficulty with ulcers for the past 18 years. The father needs an operation for a triple hernia, but, as he said, he cannot afford to take time out because of his responsibilities at home and because of the expenses connected with his daughter. When a period of treatment at the Rehabilitation Centre was recommended, the Social Welfare Branch felt they could not sponsor the treatment. They were of the opinion that Miss G. was not eligible because her parents had a house, an old model car, and Mr. G. had a steady job. Under these circumstances the family should continue to pay for whatever medical care their daughter needed.

When the C.A.R.S. reviewed the whole situation, it was considered that, unless something was done to relieve the tension in the household, the whole family would soon become a charge on the community. Selling the house in order to provide funds for treatment would not be a sound decision in the long run, and it was, therefore, decided that the C.A.R.S. would take the financial responsibility for Miss G.'s treatment.

To many people, the only alternative to exhausting their savings or to incur heavy debts is public care. Faced with this, many people tend to gamble with their health. They delay the needed medical attention and hope that the pain or weakness will disappear itself. They go on working, without realizing that the work accelerates the disease and soon may lead to total disa-
Mr. C. and Mr. H., whose stories will be discussed later in this chapter, were other examples of people who have made great effort to go on working in spite of their pains. They were unable to face the fact that they might have to depend on public funds. They were concerned about their families, whom they did not want to be unfavourably affected by losing their jobs.

Mr. C. struggled hard until, as he said, "he could not hold the hammer any longer". As a result of his struggle, Mr. C. may never be able to work again.

Mr. H. had also been trying to fight the disease by working whenever he was discharged from the hospital. After several periods of hospitalization and work, he had to give up and seek treatment. His prognosis is somewhat better than in Mr. C.'s case. There is a chance that Mr. H. will be able to do some light work again.

The lower down he is in the economic scale, the harder do the problems press upon the sick individual. When the day comes that he is really sick and cannot go to work, the patient will refuse the doctor, since the doctor costs money. A nurse will not be thought of - she would cost a fortune. A little something from the drug store will help things along unless it is an acute attack. When the resources of legitimate medicine have failed, the unfortunate individual, in a desperate attempt to get better, often readily becomes a victim of quacks who exploit him ruthlessly.

Insufficient or insecure income affects certain patients; it may be the cause of emotional tension, malnutrition, or fatigue from striving to secure means, and it becomes clear that the economic insecurity has unfavourably influenced the patient's attitude, both preceding and following the development of ill-health. The restriction which inadequacy of income places on
the receipt of medical care has serious implications, arising from the fact that its medical needs exceed those of families at higher economic level.

Dr. E. P. Boas, in his book, The Unseen Plague - Chronic Disease, suggests that the incidence of chronic illness found by the Massachusetts survey was 50 per cent higher among the "poor" than among those who were better off. Since the chronically ill can contribute only little, if anything, to the cost of care, it becomes increasingly difficult for voluntary agencies to assume financial responsibility for them. If the individual cannot pay, then, to the extent that needed services are available to him, they are supplied by the community at large - the local, provincial, or national community, or all three together. Besides providing the needed medical care, for many disabled persons, some form of support must be provided. This often means public assistance not only for the ill individual but also for his family, with the burden falling on the local community. The amount of money that has to be invested in some of the permanently disabled patients can reach very high figures. It is the cost, however, that society has to pay for its inability to provide, at an earlier stage, organized care, suitable facilities for treatment, properly supported laboratories for the investigation of disease, and the education of physicians which is necessary to form the best method of prevention of chronic disease. The care of those of the sick who did not have the opportunity of being economically self-sufficient and who, therefore, cannot purchase the needed medical care, becomes a direct responsibility of society. The care of the chronically sick cannot be left to the accident of
philanthropy.

The public has been slow in realizing that taking care of a disabled individual and providing him with the needed medical attention is in most cases a profitable undertaking. There is a strong economic justification for rehabilitation, aside from humanitarian consideration and the recognition that manpower is an indispensable national resource. Money spent for rehabilitation makes an economic return to society.

**Personal and Community Implications.**

From the dawn of the history of mankind to modern times, people have been devastated by all kinds of pestilential disease. The terror inspired by these plagues led to vigorous, although initially ineffectual methods of control. Gradually, however, legal and moral authority given to public health officials allowed them to apply new and more effective scientific knowledge in the extermination of these diseases. With the progress of medicine the acute infectious illnesses have been either wiped out or brought under control.

The victory over most of the acute diseases did not bring the relief people hoped for. A new plague, in the form of chronic diseases, has emerged. While a person, ill from an acute infectious disease, has only two alternatives - quick recovery or death, a chronically ill person may suffer for years. Most people who are chronically ill do not constitute a menace to society. Their prolonged suffering does not attract much attention. Their increasing disability and indigence is hidden and unspectacular. Should death from a chronic illness occur, it is usually preceded by years of disability.
The social significance of chronic diseases cannot, therefore, be measured by mortality alone. It is its effect on the individual, his family, and the community that is so fearful and has such dreaded consequences. In any illness which results in physical disability, there are bound to be immediate and obvious emotional disturbances which are secondary to the illness. These may result from the loss of earning capacity, interruption of schooling, severe restriction of activity, as well as from the pain and discomfort of the disease itself. These are the practical and real results of any disabling disease. Anyone who has had personal experience with people disabled by chronic illness is aware of their physical and mental suffering, and knows, further, how the presence of a chronic invalid affects the life of the whole family. The disease can cause psychological disturbances severe enough to break up a home. It places a serious strain on family finances, especially if the wage earner is stricken, although disease strikes the rich as well as the poor. "Statistics show that chronic illness occurs almost half again as frequently among the lowest income groups as among those in even slightly higher brackets."¹ This is reflected in the fact that families are frequently reduced to dependency on public funds as a result of such sicknesses.

The case of Mr. C. illustrates the effect of chronic illness on the life of the whole family. Now 47, Mr. C. had always led a happy life with his family. He loved his three young sons

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and provided them with everything they needed.

Mr. C. worked hard as a carpenter in the mines so that his family could some day have a small house of their own. After years of hard work, his wish finally came true. One day in 1946, however, he felt strong pain in his hands. He did not suspect it was anything serious and continued working. He tried to ease his pain by using various pills. As they did not seem to have any result, Mr. C. consulted a doctor, who broke the news to him that he had acute rheumatoid arthritis. The doctor recommended cortisone. Mr. C. began to buy the expensive drug, which eased his pains but did not improve the condition. Several periods of hospitalization drained heavily on the family's resources, and Mr. C. was finally compelled to sell his house for which he had worked so hard. The family moved to the farm of Mr. C.'s uncle and had to apply for social assistance. The C.A.R.S. physiotherapist and the S.W.B. brought Mr. C.'s case to the attention of the Medical Director of the Society, and a period of treatment in the Rehabilitation Centre has been arranged. After 7 months of treatment, Mr. C.'s prognosis is not a favourable one. Mr. C.'s ability to resume work will be very limited and the whole family may have to remain on social assistance.

Mr. H. has had a similar fate, although his and his family's future seems somewhat brighter. Mr. H., 36, has two young children, and his home is in a small town in the Rockies.

Mr. H.'s work history shows that he had always worked hard as a driller in the mines, at building bridges, and with the CPR. He became ill in 1949, and until 1952 he was continually in and out of hospitals. When out of the hospital he always managed to work for a few weeks until he had a flare-up and again had to seek treatment. Over this period of 4 years, the family's financial expenditures have been extremely heavy, and they became dependent on social assistance. Mr. H. has been approved for treatment at the Rehabilitation Centre and, in the opinion of his doctor, Mr. H. should recover to the extent that he will be able to do some light work. Through the initiative of Mr. H.'s wife, the family is planning to start a small coffee shop in their home town after Mr. H.'s return.

Although there is a good chance that the family may regain independence, they would not be able to manage without the help of public funds.

It is impossible to estimate how many people met the same fate as Mr. C.'s and Mr. H.'s families have. Accurate figures on
the prevalence of chronic diseases are not as yet available. Mortality figures tell only a small part of the story because most deaths follow years of disability. Exact information regarding the actual prevalence of chronic illness could be obtained only by a most intensive medical survey of large population groups. A given chronic disease may have varying significance in terms of prevalence, disability, and mortality.

Rheumatism, the most prevalent chronic disease, is second as a cause of disability and fourteenth as a cause of death. It cripples far more than it kills. It is a far more important cause of invalidity than cancer. It has recently been estimated that about 600,000 Canadians suffer from rheumatic diseases, 100,000 being totally or partially disabled, 15,000 being confined to bed or wheel chair. Eighty per cent of the victims of its most serious form - rheumatoid arthritis - are between the ages of 20 and 50 at the time of onset, usually under 40. Rheumatic fever is the second leading cause of death among children between the ages of 5 and 15, and is the basic cause of a large proportion of all heart disease. Each year arthritis and other rheumatic diseases cost Canadian business nine and one-half million workdays, and Canadian workers lose $54,000,000 in wages alone. This does not include those so disabled that they cannot work at all. Cost of medical care or social assistance are extra, borne by the sufferer and the taxpayer.

These few figures are very impressive in their indication of the problem placed on society by the rheumatic diseases alone. What opportunity has a chronically ill person today to obtain

1. Facts about Arthritis, a leaflet published by the B. C. Division, C.A.R.S., 1951 Appeal.
adequate treatment of his sickness and to receive suitable institutional care if the need for it should arise?

The vast majority of the chronically sick cannot remain self-sufficient in seeking health; they must turn to the community for whole or partial assistance. Using the actual needs of the people as a gauge, the conclusion is inescapable that our resources, and the way in which services are distributed, are in many respects totally inadequate to meet the requirements of the nation's tens of thousands of chronically ill citizens. There has been some recognition of the need to offer medical treatment to individuals stricken with a chronic illness; but the needs of the chronically ill have not been met in any community, although the problem touches on almost every aspect of community life. The present rather chaotic conditions will be well illustrated by a quotation from a well-known authority on chronic illness.

"The existing facilities for the care of the chronic sick person present a very confused picture - patients at home who should be in hospitals, patients in homes for the aged that are not prepared to minister to their wants, patients in convalescent homes occupying beds needed for another purpose; a mad confusion of patients and institutions - the patients scrambling to find refuge wherever they may, the institutions admitting them grudgingly, and having admitted them, not providing the care they need. It is a scene of great disorder. Public and private hospitals, homes for the aged, convalescent homes, nursing and visiting doctor services, after-care agencies, agencies for sheltered work, medical social service departments, family service agencies; every one of them accepts with reluctance the burden of the chronic sick, and tries to shift responsibility to another agency which is not better prepared for the task". 1.

Examination of the situation in British Columbia shows that many of the "scenes of great disorder", so aptly described by Dr. Boas, are evident here. Two of the arthritic patients who

1. E. P. Boas, The Unseen Plague-Chronic Disease, New York, 1940, p. 75.
had to go through the ordeal are good examples:

Mr. D., now 35 years old, a married man with 4 children, has had rheumatoid arthritis for 5 years. During an acute flare-up, Mr. D. was hospitalized at St. Vincent's Hospital and was attended by a private doctor. After a period of several weeks, the doctor referred Mr. D. to the City Social Service Department as the patient could not stay in the hospital any longer. Attempts were made to place Mr. D. at the Vancouver General Hospital, Shaughnessy Hospital, and the Western Society for Rehabilitation, but none of these institutions would accept him. Finally, Mr. D. was admitted to Heather Annex, a section of Vancouver General Hospital for the care of the aged. Following the patient's referral to the City Social Service Department, there was considerable correspondence between the Department of Veterans' Affairs, Ottawa, and the patient's doctor re Mr. D.'s status in respect of treatment at Shaughnessy Hospital. Also there were numerous discussions between the Medical Section of C.S.S.D., Department of Veterans' Affairs doctors, and the patient's doctor, so that much time was lost trying to arrange for treatment. Mr. D. remained in Heather Annex for 6 months.

Although he was promised active treatment and cortisone, none of these promises materialized during that period. Finally he was moved to the Rehabilitation Centre through the efforts of the Medical Director of C.A.R.S. On admission, intensive treatment was given, and the patient improved tremendously. After three months of treatment, Mr. D. was considered well enough to be admitted to Shaughnessy Hospital and continue his treatment there.

Lack of proper facilities severely aggravated the condition of another patient, Mr. O.

Mr. O., 71 years old, married, has had rheumatoid arthritis of four years duration, with heavy involvement of knees, hips, and left shoulder. After a short time he became almost completely crippled. He had been attended by a private doctor, who admitted Mr. O. in an acute flare-up to hospital for a period of six weeks. While in the hospital Mr. O. was on cortisone therapy and improved to the extent that he could get around on crutches. As Mr. O. could not stay in hospital any longer, admission to the Rehabilitation Centre was recommended and approved. When Mr. O. arrived at the Centre, his condition was much worse and he could not manage on his own. As there are no nursing facilities at the Centre, Mr. O. had to be sent home the same day. He does not get proper care at home as his elderly wife, herself, is not well and has arthritis in her hands. At present Mr. O. is again completely bedridden, and there is little hope for improvement as the hospital care he needs is not available.
The fact is that there are thousands of persons like Mr. D. and Mr. O., who are disabled or on the way to disablement by chronic disease. Yet there are not sufficient facilities and no overall program in British Columbia to care for the chronically sick who cannot any longer function independently. Chronic illness cannot yet be prevented, but every effort must be made to prevent, postpone, and arrest the disabilities that result from it. This can often be done only after prolonged treatment and, in most cases, lengthy hospitalization. If the sufferer from chronic disease does not receive the care he needs, in the course of a few years he becomes an unemployable invalid; specialized care has to be provided at this stage, and the cost is high.

Although there are numerous excellent rehabilitation resources in British Columbia, - some of them have been described in Chapter I, - there is no co-ordinating body to arrange them into a program. Taking them at large, the resources are excellent. We are not, however, making full use of them. As a result of this, large numbers of the chronically ill are being accommodated in general hospitals, whose facilities are designed primarily for the care of acutely ill patients whose stay is relatively short. The acute hospitals, particularly in the larger centres, are overcrowded. In Vancouver, for instance, it is not easy to get a bed in the Vancouver General Hospital even if the case is emergent. Besides lack of space, most of the acute hospitals have not the medical staff nor the facilities to handle chronic diseases. Not only is the care provided unsuited to the needs of the chronically ill, but it is more
expensive than it would be in institutions with appropriate facilities.
CHAPTER III - DIFFICULTIES OF THE TREATMENT

As in many other forms of chronic diseases, there is not much known yet about the cause and treatment of arthritis. Despite the intensive investigation and research of recent years, the many and different theories have not as yet yielded positive results. The absence of specific drugs or means of prevention does not mean, however, that there are no effective measures of treatment. In spite of the vast amount of crippling and deformity to which rheumatoid arthritis may lead, the prognosis is by no means as unfavourable as is generally supposed. More frequently the process becomes arrested or quiescent at some stage in its course and the patient is able to carry on activities with only a small amount of difficulty. In many cases there is a tendency for rheumatoid arthritis to go away by itself for no known reason. After ups and downs, with periods of welcome relief, alternating with months of swollen painful joints, the disease may simply stop and never return.

What is important is that, as in other diseases, early diagnosis is the key to successful treatment. The earlier arthritis is diagnosed and treated, the better the results. Mr. L.'s case is a good example. Mr. L., a 40 year old man, had a widespread arthritis involvement for about 2 months when his case was brought to the attention of the C.A.R.S. Social Service Department.

Although Mr. L. had been attended by a private doctor and the C.A.R.S. physiotherapist, he had great concern over his financial situation. He had spent all his money and was considering the selling of his car to obtain the funds for the treatment he needed. The referral to the CSSD had been for exploration of the possibility of obtaining treatment through the Department of Veterans's
As Mr. L. was found to be not eligible for treatment at Shaughnessy, it was decided to admit him to the Rehabilitation Centre under the auspices of the C.A.R.S.
After a period of three months of concentrated treatment, Mr. L. was discharged. About a month later, he was working full time as a mechanic on a night shift. His physical condition seems to have improved a great deal, and his doctor considers Mr. L. has made an excellent recovery.

In the case of Mrs. M., early diagnosis and treatment helped not only her but the whole family to lead a satisfactory and happy life. Mrs. M., a 34 year old married woman with two children, developed rheumatoid arthritis involving nearly all her peripheral joints in the Fall of 1951.

At that time she was living in an isolated rural area, where she was treated by a local doctor. As her disease was progressing, she was admitted to St. Paul's Hospital in Vancouver in the Spring of 1952. While in hospital her arthritis improved and she was admitted to the Rehabilitation Centre under the auspices of the C.A.R.S. She responded very satisfactorily and, when she was discharged to her home in the Fall of 1952, her arthritis had almost completely subsided. She was able to establish a home, care for the children, and do her own housework.

Obviously, it is easier to prevent a disability or deformity than it is to correct it. Even if at present unable to cure the disease, modern medical treatment concentrates upon the prevention of disability and deformity. The basic program of treatment for rheumatoid arthritis involves a properly balanced combination of rest and therapeutic exercises. These measures are, however, not dramatic in their results, and may have to be carried on for many years.

Although the basic treatment program seems to be very simple, there are numerous serious problems involved in it. The need for early diagnosis is recognized more by the professional people working with the chronically ill than by the general public. The tendency to delay the seeking of medical services for personal or economic reasons has already been discussed. The belief that
a chronic ailment is incurable and that medicine has nothing to offer is shared too frequently by the patients. The general public also has developed the idea that rheumatoid arthritis always goes on to severe crippling. It is the sense of hopelessness about the treatment of chronic disease, a feeling too often shared by doctor and layman alike, that is responsible for a state of affairs which delays progress in the treatment and prevention of arthritis.

Rest is an essential measure in the treatment of the disease. It is not only rest for the body that is required; rest for the mind is just as important as it is for the body. The patients need as much freedom from responsibility and anxiety as possible. While rest for the body is, in most cases, not difficult to obtain, rest for the patient's mind poses a great problem for everyone working with him. The strong feelings of insecurity, hopelessness, fear, and worries are often too overwhelming and prevent the patient from co-operating in his treatment. Unless the patient's security is restored, he cannot benefit from the facilities made available to him.

It has been recognized that emotional stress plays a large part in arthritis, both in the onset and in recurrences. The person will improve more rapidly if he can avoid worry and despondency and can set himself confidently to the job of getting well. The patient must be given a thorough understanding of his disease. He must face the facts, accept the possibility that a

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1. A study of social and emotional problems in rheumatoid arthritis has been made by H. P. Mickelson, M.S.W. thesis, University of British Columbia, 1949.
long period of treatment may be necessary, do his best to co-operate with his doctor, and follow the treatment plan, although it may mean unwanted restriction.

The patient is very seldom able to do these things by himself. He must be helped by every member of the professional team to clear his way to recovery so that he can make the fullest use of the help offered to him. The nature of the illness implies that no single person can do a good job in rehabilitating an arthritic patient. Considering the problem of rehabilitation of an individual, it becomes clear that there is a twofold effort involved: on the one hand, to lessen and minimize the person's physical handicap through medical treatment, and, on the other, to help him develop his strength and his abilities so that he is better equipped to meet and live on comfortable terms with able-bodied people in the community. The nature of the problem is such that a total approach is necessary: the consideration of the patient's total situation, his finances, his job, his home, his disease, and his future. While the members of the professional team have their specific tasks to perform, they all should have one thing in common — whether it is the doctor, the physiotherapist, or the stenographer, they all must have the basic realization that they are dealing with the whole individual and not with his disease. It is in the focus on the person as a whole that the doctor, physiotherapist, nurse, occupational therapist, social worker, and other personnel work together as members of the professional team. Each member should be clear not only as to his own functions but should also have a good understanding of the functions of other members. C. H. Elledge, in her book,
The Rehabilitation of the Patient, says that teamwork cannot be produced by virtue of the fact that various experts are housed under the same roof. It is created by mutual understanding of persons offering different, though related, services to the individual with the physical impairment.

When an individual is under active medical care, the physician assumes the leadership of the team. He makes the decisions affecting the total treatment plan and delegates certain responsibilities to different members of the team. In regular staff conferences the patient's capabilities are evaluated, treatment plans discussed, and information regarding his medical and social needs considered. Recommendations are then based upon the joint thinking of the group and are carried out by those responsible in their particular area.

The following case illustrates how working together assists a patient.

Miss A., aged 22 years, with rheumatoid arthritis, was referred by her private doctor to the Society, for physiotherapy treatment. Miss A. had been ill for 6 months and had little use of her hands and arms. As the physiotherapist proceeded with treatment, she found Miss A. listless, apathetic, and not too interested in carrying out the suggested exercises. As the physiotherapist was concerned about the patient's attitude, she discussed Miss A. with the caseworker. The conclusion was that the patient needed help, and that the physiotherapist would discuss the problem with Miss A.'s doctor. This was done and a referral made to the caseworker. The caseworker found that Miss A.'s problem centred around an overprotective and dominating mother and rivalry with an older sister, who was more attractive, successful in business, and who had recently married. Miss A.'s illness occurred at the time of her sister's marriage and the loss of a clerical job. It was obvious that she was reacting to failure and pressure from her parents by withdrawal into illness.

Through the use of an accepting relationship with the caseworker, understanding and encouragement from the physiotherapist, and, in addition, to developing confidence in
her doctor, Miss A. gradually gained some sense of personal worth. She had enough inner strength to respond favourably, as did her mother, who came to recognize the cause of some of the problems. Miss A. showed remarkable improvement. Upon sharing the information with the doctor, long range planning with Miss A. was begun. The ultimate result was a receptionist's course, upon completion of which Miss A. obtained employment.

A large part of the success in this case was due to the physiotherapist's ability to recognize the patient's poor attitude toward recovery and to do something about it. It is obvious that the close working relationship and the sharing of the problem with others interested played an extremely important part in this patient's recovery. Miss A.'s case illustrates not only the need for early referral to the caseworker but the need for an understanding and an acceptance of the role and function of each person working with the patient. This includes, as stated previously, an appreciation of the essential skills of each profession.

Physical Aspects of Treatment.

Although there is no specific cure at present, it is often possible to control arthritis or improve its clinical course. One thing must be always remembered, however, that arthritis is a systematic disease; the patient must be treated as a whole rather than with local therapy to the joints alone. It is impossible to forecast the turn of events in an individual patient. In the most favourable cases a severe relapse may occur at any time; while, on the other hand, the most malignant example of the disease may suddenly become arrested.

The principles which underlie modern treatment of rheumatoid arthritis are simple. "First, advantage is taken of the disease's natural tendency to improve by encouraging improvement through rest, sometimes supplemented by the use of gold salts
and hormones. Second, the disease's natural tendency to damage joints and limit their movement is discouraged by therapeutic exercises". 1. It will be obvious that success in treatment depends largely upon the patient's understanding, determination, and morale. Every patient must follow faithfully the basic program of rest and exercises prescribed for him by his physician.

Difficulties of the treatment dependent on the patient's attitude have been discussed previously. It seems necessary, however, again to emphasize this fact. Although some workers are chiefly concerned with the physical well-being of the patient, they must never at any time forget that on the part of the patient a healthy mental attitude toward the treatment is essential if any results are to be expected. The physical therapist must often work with patients who feel their treatments are useless and bothersome. Unless the physiotherapist understands that such a patient is often unable to co-operate because of his deep emotional regression, she is apt to lose her patience and become annoyed with him. In such a case the sensitive patient may interpret her attitude as rejection and further regress into his dependency.

Specifically, the physiotherapist is concerned chiefly with general body alignment, management of currently inflamed joints, and correction of such contractures as might have occurred. Treatment aims at the maintenance of joint motion and muscle strength and at the prevention of joint damage and deformities. While the physiotherapist who work in the Rehabilitation Centre have all the modern equipment and give treatment according to a regular daily schedule, the mobile physiotherapists 1. Quoted from the pamphlet, Rheumatoid Arthritis - A Handbook for Patients, published by the C.A.R.S., 1952.
have a much more difficult task to perform. They bring physical therapy for the purposes of prevention of deformity and maintenance of muscle power to those physically unable to attend the Centre or their physician. The part the physiotherapist plays is that of an instructor who carefully explains the exercises and other treatment, and then checks up periodically on the patient's progress. The patient is expected to carry on his own exercises after they are explained to him.

The mobile physiotherapist comes across all kinds of patients. Some of them want to "keep going" at all costs and finds it extremely hard to conform to the requirements of bed rest and mild exercise. They become frustrated by the slow progress. The physiotherapist needs to gain the patient's confidence and understanding of what is involved in having arthritis. She has to try to enlist the co-operation of the patient's family and eventually the other members of the professional team. Unless the patient's co-operation is secured, the "keep going at all costs" may well end in permanent disability. On the other hand, the physiotherapist has to combat the dependency of those who simply go to bed and stay there. Such patients must be convinced that increased activity is desired, even though it makes them uncomfortable.

In conjunction with the basic treatment program, various other forms of treatment may sometimes be employed, such as gold salt injections, cortisone, and ACTH,1 plasters and splints, and certain surgical procedures. However, it must be realized

1. ACTH (adrenocortico-trophic hormone) is an extract made from a tiny gland which is situated in the pig's brain; it takes 400,000 of these pituitary glands to make 1 lb. of this material. This substance produces its effect by stimulating the supra-renal glands to produce their own cortisone.
fully that the drugs do not bring a complete cure and should be used only as an addition to the basic treatment, not as the only treatment itself. While these drugs are capable of suppressing the symptoms of rheumatoid arthritis during its active stages, they do not alter the course of the underlying disease process, and the symptoms usually return when the drug therapy is stopped.

Until recently, research has largely been sponsored through the national office of the C.A.R.S. and confined to the larger Eastern centres. During the past two years, however, active clinical research has been going on in British Columbia to try and evaluate, on a long-term basis, the newer hormonal and other agents that may be so beneficial in certain types of arthritis.

On the Rheumatic Fever Project there have been sixty children with acute rheumatic fever. Although a few of their parents contributed toward hospitalization, practically all the children were non-pay patients as far as cortisone was concerned. One of the purposes of the R.F. Project was the survey to determine the percentage of chronic heart cases. There will be an annual re-examination for all the children.

The Rheumatoid Arthritis Project has now been completed. There were fifty low-income patients on the project. The research project seems to be one of the reasons why the C.A.R.S. has confined itself to the rehabilitation of non-pay patients. While close supervision of private patients was hardly possible, the non-pay arthritics were all concentrated in the arthritis clinics of the Vancouver General Hospital and St. Paul's Hospital. The
necessary follow-up was carried out in the hospitals, and the results of the drug-therapy were regularly checked. Cortisone has been used as an adjunct to routine treatment, such as physiotherapy, casework, bed rest, etc. Because two years ago, when the project was started, the effects of the drug were not well known, all patients had first to give their permission in order to be placed on the project.

The clinical research was sponsored solely by the CARS - British Columbia Division, at a cost of $15,000. The Society also supplies cortisone, Compound F and ACTH on compassionate basis to those who cannot pay for it.

Casework Services.

Although it is at present a well-accepted fact that the medical social worker can offer a valuable service as a member of a professional team, it still requires an intensive and continuous interpretation and demonstration as to his role. A completely different situation was evident a generation or two ago. Complete medical care was given by the family practitioner. His position as friend of the family, his familiarity with all its members, his knowledge of their life histories, their strengths and their weaknesses, physical, mental, and emotional, enabled him spontaneously to treat both the disease and the patient. With the growing depersonalization of medicine and the increase of specialization, the physician has become more and more a highly skilled medical technician, with less attention given to the patient as a person.

Initially even social workers, themselves, had little concept of the proper function of medical social service. They
were engaged in admitting patients to hospitals, in determining how much they should pay, and in giving relief to families. They patronized charitable endeavours of hospital visitors. Only rarely did they work out, in co-operation with the physician, a well thought out plan for rehabilitation of the patient, with the employment of their knowledge of the social, economic, and emotional factors that condition illness.

It was not until the medical men accepted the importance of social and economic factors involved in the illness that the medical social workers obtained their present status. The medical social worker of today has taken on some of the functions of the general practitioner. He does not treat disease, but deals with the sick person as an individual. The main function of the social worker became, then, to aid the physician in the treatment of the ill, focusing on those social and emotional problems related to the illness and the patient's recovery.

The social worker, as an associate of the physician, works with him side by side in trying to help the sick individual. It is not rare any longer for the physician, after appraising his patient from the point of view of his social as well as medical needs, to call in the aid of the social service department whenever he finds it necessary. This has become particularly frequent when working with patients who are chronically ill.

The social worker is concerned in all his contacts with the psychological effects produced upon the patients by the change which the illness causes in their life situations. This is very evident in patients who are afflicted with arthritis and are thus confined for longer periods of time in such treatment centres as
the Rehabilitation Centre and who, often, because of the pro-
gression of the disease, leave the place incompletely cured.
The patient's reaction to his circumstances, his disease, and
the limitations are of special importance as no specific remedy
for the disease is known and the patient must, himself, be res-
ponsible for carrying out most of the therapies prescribed to
protect already damaged parts.

In the treatment of patients with arthritis, every worker
is constantly confronted with the problem of the patient's reac-
tions to his illness, and to the unfavourable prospects for his
future. Such reactions may not only influence the course of the
illness but may also determine whether or not the patient will
co-operate in achieving his recovery. In fact, the reactions are
often of greater importance than the actual disease because it
depends on them whether the patient gives up or makes a satis-
factory adjustment in life.

The following case shows the importance of helping the
patient with his attitudes and reactions to illness.

Mr. K., single, 51 years old, has been referred for case-
work to help him with frustrations due to lack of improve-
ment. At the time of admission, Mr. K. was sceptical
about treatment. "He would have to see improvement before
he would believe it". He was feeling that cortisone was
being denied to him because he no longer had money to pay.
Although there were contrary indications medically, and
this had been discussed with him, the patient was unwilling
to believe that this was true. "As long as I had
money I got cortisone; when I had no money it stopped".

Mr. K. is an intelligent, highly intuitive person, whose
outward hostility concealed real sensitivity of feeling. He
presented himself as a "strong, hard man, who could
do anything for himself except for his arthritis". Ex-
treme fear of dependency resulted in his exaggerated
drive, (always getting to the top; having to do every
job perfectly; his contempt for people who "work 20 years
in the mine and never known anything").
Mr. K.'s ego strength showed his capacity to use casework service on a supportive basis and moving toward tentative clarification of his defence mechanism. Mr. K. used his casework relationship initially to express general hostility toward anyone, moving from this to a relationship almost on a transference level.

At the time of his discharge, Mr. K. was able to accept the slow progress of his illness. His generalized suspicion towards the treatment has disappeared. He has learned to be more accepting and tolerant of other people.

Mr. K. has needed considerable support in his adjustment to living outside the Centre. He missed the stimulation of the group living, and became quite depressed for some time. Physically, Mr. K. has shown considerable improvement, and he will be able soon to return to some kind of light work.

The chronicity of the disease brings innumerable social and economic complications, and gives rise to problems that are most difficult to solve. These problems are further aggravated by complex emotional personality traits which illustrate the difficult task with which the social worker has to deal.

One study of emotional factors in rheumatoid arthritis says that,

"All of these patients manifest extreme degrees of emotional insecurity, and dependence, marked feelings of inadequacy, and inferiority, plus a tendency toward a high degree of emotional isolation. They appear to have marked difficulty in their relationships with other people. There is a high degree of blocking of free outward expression of feelings. Very frequently they are inclined to be overactive, physically, intellectually, or both. They are prone to have been overly conscientious and to have driven themselves too hard. They tend toward overwork and often tend to take on more responsibility than they can handle. Usually they are extremely sensitive and are highly perceptive of others' feelings, especially if these be hostile or unfriendly. They dislike being under obligation and could prefer to be strongly supported by others without any demands being made upon them in return. This results from their dependent need which often is so great that they court the support and affection of others by being unduly obliging and too ready to do favours for them. Thus they allow themselves to be imposed upon rather than to risk offending and thereby losing the regard of others. They seem to be in almost desperate need of comfort and
emotional support". 1.

The most outstanding features in the emotional characteristics of arthritic patients are their feelings of insecurity, inadequacy, sense of failure, strong dependency. Some tend to deny problems and repress hostility, while others express it outwardly. The above-mentioned personality traits of arthritic influence the direction of the caseworker's service. He discovers and interprets the social and economic factors involved in the illness and tries to modify them so that they will favourably influence the outcome of the illness. Equally important, he helps the patient to make an adjustment to his illness and to his environment. In order to achieve this, the social worker cannot depend solely on his skill. It requires a close co-operation on the part of the patient himself to make the best use of the facilities made available to him. The patient must use all the resources within himself if he wants to play an active part in the relationship which is the basis of professional casework. In some instances the patient's inability to use services may be due to deep-seated personality problems which the caseworker is unable to handle without psychiatric consultation.

An example of a patient who was unable to benefit from casework was Mrs. F.

Mrs. F., 44 years old, was referred for clarification of home and financial situations. Mrs. F. had been in general ill health for years, and the family was in poor financial standing because of the long history of medical expenses.

Mrs. F. was a neurotic woman, with "martyr" complex of long duration. Defences she had erected, her illness, her martyrdom, and her suffering were precious and necessary to her. She was happy with her illness and obtained

an adequate satisfaction from going over her sufferings in casework interviews. It was felt that to continue with the accepting and supporting relationship was playing into the unhealthy part of her personality. Mrs. F. put all her complaints on a physical basis and was quite unable to face the fact that her difficulty may be tied up with a personality problem.

Because it was felt that Mrs. F.'s neurotic patterns were well established, treatment was concentrated on building her up physically, to the point where she could return home.

At the time Mrs. F. was discharged from the Centre, she was in reasonably good physical condition, though she had not arrived at the point where she could undertake a job. Her future seems, however, to be questionable. It is anticipated that she will probably regress into illness and become totally dependent.

It is obvious that casework, however skillful, cannot always help a patient to change his inadequate personality. Often contacts have to be terminated without any noticeable improvement. Mr. R., a 47 year old married man, was referred for help in obtaining sedentary work. He had been employed at heavy labour, mining, and shipyards, and was apprehensive about a change.

Mr. R.'s inadequate personality, with marked lack of capacity to relate, showed anxiety and tension about returning to work. He was over-conscientious and had an exaggerated sense of responsibility towards the C.A.R.S. Casework aimed toward reducing Mr. R.'s feelings of failure and discouragement because of his long illness, which showed no improvement, and toward his acceptance of his fear and anxiety about returning to work.

Mr. R. found it difficult to use a casework relationship on any basis at all, although he did progress to the point where he could confess to feelings of inferiority and failure, and seemed to obtain some relief from the worker's acceptance of his inability to take a job. He made no real response to any form of treatment, and, at the time of discharge from the Centre, he was no better than when he was admitted.

Mr. R. had strong feeling about authority: "If the doctor says I am ready to go to work, I must be." He
was concerned over the reversal of roles in their family, where his wife was the bread-winner and he was completely dependent. Focus in casework centered around an attempt to help Mr. R. to accept his illness on a more realistic basis rather than "tomorrow I'll be better".

Because it was felt that Mr. R. was unable to use a casework relationship on a constructive level without a psychiatric appraisal, contact was terminated except on the basis that the patient would get in touch with the worker when he needed it.

The purpose of casework is to help those who are capable of self-direction to think through some of their personal problems which are related to the illness. In order to help an individual in his feelings of adequacy as a person, it is often also necessary to bring his family along in their ability to recognize the patient's strengths and capacities and to lose some of their fear of his disability. The patient and his family are helped to work through those social and emotional problems that revolve around his disability and that influence his attitudes and those of his family's toward the illness and himself.

It can be said that the main function of the caseworker is to aid the physician in the treatment of the ill person. Through special training in understanding the deeper underlying cause of people's problems; through sensitivity, awareness, warmth, and honesty, the caseworker assists the patient to use the help offered to him. He helps the patient to fortify himself against discouragement; he helps divert his aggressiveness that is stimulated by frustration; he helps him accept the reality of limitations. In other words, he tries to lessen the tendency toward disillusionment, depression, and periodic feelings of helplessness.

The final goal of the caseworker appears to be identical
with the goal of rehabilitation; restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.

A case history from this study has been selected to illustrate how casework helped to successfully rehabilitate a patient. Mr. G., 23 years, who developed acute rheumatoid arthritis in 1951, was referred to the caseworker after about a month's treatment at the Rehabilitation Centre. Mr. B. needed help in becoming orientated to change of occupation and in making an adjustment to his family situation. Mr. B.'s social diagnosis indicated that he was an intellectual, immature, and somewhat dependent young man, with a strong drive toward achievement. His conflict centered around his relationship with his parents and marital difficulty. Personality structure indicated strong super-ego, somewhat rigid and repressive. There was a good capacity to relate, and evidence of good ego-strength. Because of direct relationship between emotional disturbances and the onset of illness, it was felt that prognosis was good, provided Mr. B. could work through his psychological conflict.

Onset of illness had followed his wife's decision to leave him, taking their 14 months old son. At the time of referral Mr. B. was ready to be discharged from the Rehabilitation Centre. He was much improved and was ready to consider some type of training, with a view to more sedentary employment than truck driving.

Upon referral, Mr. B. showed an eagerness to use casework help on a supportive level in relieving his feelings of irritation and frustration arising out of his dependent situation at home, to the point where he could sustain a period of training in a field entirely new to him without regression. Over a period of a year he showed good capacity to move toward self-awareness and some understanding, mostly intellectual, of his relationship with his parents. He was able to relate anxiety and tension to emotional stress. (Flare-ups were associated with pressure from his mother and wife and worry...
in about nine months, Mr. B. had moved to the point
where he was aware of the rigidity of his pattern -
"I don't bend enough" - and was asking for psychiatric
help as a positive step in resolving his unconscious
conflicts.

The psychiatrist diagnosed Mr. B. as psychoneurotic,
with good assets for use of psycho-therapy. Physi-
cally, Mr. B. responded well to bed rest and cortisone.
He had maintained a full day of training over the
period of half a year. He has now successfully com-
pleted an X-ray technician's course and is steadily
employed. At his own request, Mr. B. is still having
psychiatric treatment. Casework goals were fully
achieved with Mr. B. when he, himself, stated, "If I
had not had casework help I might have got better for
awhile, but I would soon have gone back to my old ways
of driving myself and I would have broken down again."

Interpretation and Education in the Field.

All the physically handicapped have great problems to
meet as they attempt to adjust their limited physical equipment
to the demands of living in a social environment. It has been
customary to regard the physically handicapped person as a dis-
tinct personality type, with traits, qualities, and impulses,
fixed and irreversible, that set him apart from others. The
total personality pattern, however, is not a series of loose and
unorganized values. The physical disability is only one facet
of that problem. It is a mistake, therefore, to think of the
handicapped as a personality type, seclusive and withdrawn.

The idea that many handicapped people can be rehabilita-
ted as productive members of their communities has only recently
been developed. Today we know that, with intensive treatment
and with adequate organization of medical and rehabilitation
services, many lives can be restored to usefulness.

An examination of the problems of the handicapped has
revealed their importance in the national economy. It shows
not only that rehabilitation is a duty of the community but that it is profitable to the individual and to society. Statistics have been used to show the relation. For example, in the United States some idea of the loss of earning power can be gained from a study made by the Office of Vocational Rehabilitation.

"In the fiscal year 1946, 36,106 physically handicapped persons were rehabilitated. Sixteen per cent had never worked before, while 75 per cent were unemployed when rehabilitation services were begun. The total earnings of these persons before rehabilitation were over eleven million dollars; after rehabilitation they were fifty-six million dollars. This result was secured at a cost of three hundred dollars a person". 1.

Calculations like these should be convincing even to people who claim that rehabilitation is expensive and a burden upon the taxpayer. Interpretation and public education should be carried further, however, in order to ease the burden of social prejudice that hinders the adjustment of handicapped persons. The most difficult is the adjustment to hostile social forces. It is an individual and collective reaction of hostility toward the disabled, who are condemned as an unproductive and useless burden. This attitude on the part of society is the greatest hurdle that the disabled person is called upon to surmount. The physically handicapped person then bears a double burden, his actual disability and the social restrictions it causes.

As the psychosocial prejudice is frequently rationalized on economic grounds, interpretation in this area becomes a major function. It is necessary to demonstrate that it is good business to hire the handicapped; to show that they produce;

that they are steady workers; that their employment is not more costly to the employer and is, therefore, not an act of charity.

Far too many communities are not as yet prepared to offer the disabled either maximum medical, social, or economic opportunities which would enable individuals to re-establish themselves. Education must be accompanied by community organization toward the creation of an informed public opinion. A constructive program is dependent on the community's attitude to the problem, and upon its willingness to spend and to ensure that the program is good. The public attitude also has its effect upon the recipients and upon those who hesitate to apply—upon their self-respect and their morale; upon their ability to recognize and perform their rights and obligations as citizens.

An educational campaign needs to show the extent of disability among the population, the suffering and economic loss entailed and the potentialities of handicapped people for being restored to more rewarding and productive lives. These facts are, unfortunately, not generally understood among the public, nor among the rank and file of the medical and other professional groups. Because the success of a rehabilitation program requires the closest teamwork among physicians, social workers, public health workers, teachers, employers, and the public at large, great effort must be made to clearly understand each other's function as well as the problems involved.

The physicians dealing with the chronically ill could well direct an educational program toward a better understanding of the handicapped. Preventive measures, however, other than those against infectious diseases, are largely untried and
unexplored. The average physician to date has been rather bewildered by the problems he is confronted with in the field of rheumatic diseases. He has had little experience with the treatment of the rheumatic patient under ideal conditions and is, therefore, pessimistic because his drug therapy is rather ineffective when used alone. An educational campaign to prevent rheumatic diseases would, obviously, be futile because there is no known method of preventing those diseases whose causes are unknown. Educational methods looking toward prevention must, for the present, be directed largely to physicians, teaching them how to recognize and treat these diseases and minimize their effect.

Although much has been accomplished through interpretation and education, much more must yet be done. The available supply of specially skilled persons in the medical and allied fields could be employed much more effectively if there was a broader understanding of what rehabilitation means, and what it can do in the communities. Increased public as well as professional understanding of the medical, social, and economic implications of chronic disease would help the handicapped individual to become an active contributing member of society, of which he becomes a definite part.
CHAPTER IV - EVALUATION AND SUGGESTIONS

Rheumatic diseases remain one of the most important unsolved problems which disease presents to society. Their seriousness is due to the large numbers of people affected, to the pain and disablement involved, and to the vast economic loss caused. These conditions are a great destructive force in society. They may be the cause of employment loss, destitution, neglect of home, neglect of children, disorganization of family life, and dissipation of community resources. With the exception of rheumatic heart disease, the rheumatic diseases do not cause many deaths, yet they rank second only to mental illness as a cause of human incapacity.

Incomplete knowledge of causes results in incomplete knowledge of the best means of treatment and prevention. There is a good chance, however, that the cause of rheumatic diseases will soon be discovered in view of the great amount of research work being carried on, which was started following the discovery of how helpful cortisone can be in certain cases. Even in the present state of incomplete knowledge, there are already efficient treatments which can relieve the pain and lessen the degree of disablement. Further, it may be said that, if all cases of arthritis were diagnosed early enough and promptly submitted to treatment, very often the condition could be arrested completely, even with the methods medical science possesses at present. It is only at a very much later stage, when the joints have become severely crippled and the disease more-or-less "burned out", that rheumatoid arthritis is said to be incurable. Even at that stage, however, quite a lot can often be done with time and care,
although it may no longer be possible actually to "cure" the sufferer. If only more hospital beds could be put aside for the care of the chronic, it would be of great help to these sufferers.

C.A.R.S. - The Pioneer.

While it has been recognized that medical science knows how to prevent a very great part of the disablement, the fruits of this knowledge are not, however, at present available to any substantial number of Canadians. Only a comparatively few can benefit from the existing facilities because they have not a ready access to them. In view of the suffering, invalidism, and economic loss caused by rheumatic diseases, it is surprising that they have not earlier been the subject of an intensive study and of co-ordinated effort, both by medical science and society generally. It was not until the Canadian Arthritis and Rheumatism Society was formed that an attack upon rheumatic diseases was undertaken. In preparing the attack, the C.A.R.S. has been conscious of the magnitude of the problem which arthritis presents. It refused to accept, however, the pessimistic attitude of the average physician and emphasized that a great deal could be done to relieve both the suffering of individuals and the drain on the nation's economy. The Society recognized that a problem so extensive could be solved only through many years of tireless effort and through the effective co-operation, interest, and participation of many agencies, groups, notably the medical profession, health and hospital authorities, medical schools, and the general public. The volume of effort now being directed against rheumatic diseases falls far short of
that which is necessary. Yet results already achieved give cause for confidence that these diseases will be conquered when the attack is developed on a scale commensurate with the actual problems.

The B. C. Division of the C.A.R.S. endeavoured from the beginning to assist the family physician in the diagnosis and treatment of the rheumatic diseases and also to encourage research into the various aspects of their obscure nature. In order to achieve this, the Society provided physiotherapy facilities, staffed with personnel trained in the management of arthritis, in all the major centres throughout the Province. This has proven to be of great significance and help for the thousands of patients who, because of their inability to pay, were often left untreated. Further, the Society maintains medical offices, physiotherapy and social service departments, which are housed in the Western Society for Rehabilitation. Twelve beds are maintained in the building for those requiring intensive treatment and who could not afford to obtain it otherwise. The treatment facilities are also made available to patients on an out-patient basis.

The in-patients who have been the subject of the present study came from all parts of British Columbia. The selection for admission to the Rehabilitation Centre has been made on the basis of their low income as well as their suitability for undertaking their rehabilitation. They were housewives, skilled and unskilled workers, patients with arthritis of short or of many years' duration. Onset of arthritis generally followed many years of the cumulative stress of drive, with little relaxation.
Although it is difficult to generalize, some common patterns of behaviour have emerged. There were some patients who handled their dependency needs by regressing into severe illness, while others tended to conceal from others and even from themselves the extent of insecurity manifest in their use of illness as a support, and presented a front of adequacy to the world - "I'm getting along fine. I can solve my own problems", was a common expression. All patients showed a high degree of emotional immaturity present long before the onset of illness.

As far as physical improvement of the in-patients is concerned, a recent survey, made by the Medical Director of the Society, seems to indicate the need for longer treatment periods. Patients whose improvement has been classified as "marked" had an average stay of 139 days in the Centre, as compared to 70 days of those who had only "minor" improvement. Figures like these, however, cannot be considered as having more than limited validity because of the complexity of problems of each individual patient.

The Value of Casework.

A chronic disease like arthritis, which imposes prolonged or permanent handicap on the patient, usually requires him to make radical adjustments to his social and physical environment. Adjustments may be so profound and difficult that they may interfere with his response to medical treatment. In order that the medical treatment may be as effective as possible, it is important that it be supplemented by the services of social workers trained and experienced in medical social casework. During the time of rehabilitation, the patient is
almost sure to need major help in his emotional readjustment. Whether they are private patients or patients sponsored by some social agency, they all have fears and doubts that are more likely to bring about the failure or defeat of the rehabilitation efforts than is the actual physical condition. The motivation to get well depends on many factors, but most of all it depends on the realistic encouragement of those who are trying to help the patient and who work with him professionally. The patient's treatment cannot be separated from his total personality pattern. "He is not merely a man with a stiff arm, but a man who comes from a small Western town who has had two years of high school, who has worked in mines for 15 years, who is married and has a family, who has abilities and aptitudes, interests, hopes and dreams of the future."  

Having the patient's total personality constantly in mind, casework service is pointed toward reducing pressures in the environment, relieving of anxiety, discouragement, self-blame, distrust, with a view toward reducing tension. It is important to help the patient to accept limitations and to gain a feeling of confidence and worth as a person.

Patients expressed their understanding of the use of casework in varying terms. A difficult patient, with little or no capacity to relate, progressed from: "I guess it's got to be done" to, at the end of a year: "You just get to know someone, and then they go away". A woman patient, with a family

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problem, who insisted that "everything is fine" could accept help in regard to her own inadequacy as a person: "I felt like a nickel with a hole in it; getting somebody else's viewpoint made things look different. I feel better now". A child-like, immature woman of 50, with strong feelings of guilt and failure in regard to her role as wife and mother, said: "You've been like a good neighbour, only better". The response from patients to casework has indicated, without question, the need for and the value of such services.

**Difficulties in Rehabilitation of Handicapped Persons.**

Handicapped persons fail for all kinds of reasons to achieve rehabilitation. In some instances the failure may be attributed to the fact that disabling conditions were not found early enough. In other cases funds, facilities, or personnel may have been the difficulty in obtaining effective service. Evaluation of existing services shows that, although much has now been done, there is still much to do. One major problem is those patients who require long periods of hospitalization. Long-term hospitalization is extremely expensive and is not generally available, therefore, to people of limited or modest means who suffer from arthritis. Physicians and other professional people may know that their patients need long-term hospitalization, but at present such hospital accommodation is almost totally nonexistent. Too often patients in this class reach and continue to live in a state of hopeless invalidism without ever having received proper treatment. General hospitals under the British Columbia Hospital Insurance Service are only entitled to care for chronic patients with acute conditions for
thirty days, but the majority may need three to four months in bed. This phase of treatment is extremely important as, if adequately carried out, the disease may become quiescent and deformity be prevented.

The need for early referrals cannot be over-emphasized. Patients should be referred for treatment in the first stages of the disease rather than when their condition becomes chronic. Treatment of the patients who have been arthritics for years is palliative rather than curative. While realizing this, the problem of lack of treatment facilities emerges again. The almost ideal facilities of the Rehabilitation Centre can be made available to a limited group of patients only. Because of the great number of sufferers involved, and the consequent impossibility of providing a specialist or special hospital care for each one, most of the services were instituted as a stop-gap to assist the family physician in providing adequate diagnosis and treatment in the hope that, through education, the hospitals and communities would soon absorb or provide adequate therapeutic facilities. The Society's projects are devised to meet the most pressing needs which are practical within the financial limitations imposed upon any voluntary agency and, above all, which will encourage and make possible the ultimate participation of other authorities or groups concerned. The arthritis out-patient clinics at the two large hospitals are largely staffed without charge by the Society, and, as they are rendering a valuable service to the community, they should be absorbed by the hospitals and financed under BCHIS.
Another sorely neglected phase of a complete program is obtaining employment for patients who are fit for part-time work or employment in a protected environment. Most of the arthritic patients are unable to return to their previous employment, and attempts have to be made to find them a new and suitable place in the industry. Usually this is a hopeless task because both employers and unions are reticent to accept the partially disabled. As a result of this, the partially disabled in effect becomes completely disabled, his self-confidence and pride are destroyed, and he and his family become a charge on the community. However, the problem of job-finding for the partially disabled who can regain some economic independence is not a problem of arthritics alone; this situation applies to many other types of handicapped people. Thus it becomes obvious that a united community effort is necessary to correct the deficiencies.

A large part of the burden of rehabilitation still is being carried by voluntary agencies, financed by public subscription and private philanthropy. From a small beginning, The B. C. Division of C.A.R.S. now has a greatly expanding organization, with an increasing number of personnel and an annually increasing budget. It is obvious that the Society cannot continue to expand at this rate even if such was advisable. All that the C.A.R.S. can do still falls short of the need, and only a small portion of those who require rehabilitation services are receiving them. The time has come when constructive measures should receive the financial support of business, the people, and the Government. Plans cannot be
transformed into realities without adequate funds. On behalf of those who may need long-term treatment for the prevention or correction of disabilities, the Society might well join in the promotion of measures of public medical care designed to make adequate treatment more generally available to them. The physically handicapped require special legislation for their protection and for the provision of those services which can contribute to their full rehabilitation, but even the most progressive government can do little in this direction without the intelligent support of the general public. An essential feature of a program must, therefore, first include the adoption of such measures of general education as will assist government in raising public opinion to the point at which such legislation becomes both possible and practicable.
APPENDIX A

Types of Rheumatic Diseases.

The various conditions included under the broad term "rheumatism" may be roughly divided into three main groups: arthritis, non-articular rheumatism, and rheumatic fever (including rheumatic heart disease).

Rheumatoid arthritis is a disease of the entire system, producing inflammation of the joints and often involving various other tissues - for example, those of the muscles. Despite the intensive investigation and research of recent years, the causation of the disease has not been determined. Some known facts are that "it has a slight tendency to be familial; the sex incidence in peripheral rheumatoid arthritis is three women to one man, and 80 per cent of the cases occur between the ages of 25 to 50, with the peak at 35 to 40". 1.

Of all forms of rheumatism, rheumatoid arthritis, if neglected, is capable of producing the greatest crippling and disability.

Rheumatoid spondylitis, also known as Marie Strumpell disease, is by many regarded as rheumatoid arthritis of the spine because it affects mainly the joints of the spine. About 90 per cent of the victims of this disease are men, usually young men.

Osteoarthritis, the most common disorder of the joints, is a disease of middle or old age. It is essentially a wearing-out process of the weight-bearing joints, such as the spine, hips, and knees. In certain cases of osteoarthritis, injuries may be responsible for the changes in the joints. Physical defects which put an unequal pressure on a particular joint may also contribute.

Non-articular rheumatism is a general term used to describe rheumatic diseases which do not affect the joints. These forms of rheumatism are more prevalent than actual arthritis. Although they may be very painful, they are less serious than arthritis because they do not lead to any serious disability or deformity.

Rheumatic fever and heart disease. While rheumatic fever usually occurs in childhood, its effects persist throughout life. Typical rheumatic fever is characterized by severe pain, redness, swelling and stiffness in one or more joints. The joint pain disappears usually completely within a few weeks.

to a few months. Rheumatic fever is a very serious disorder, not only because it causes more deaths than any other disease in children of school age but also because a proportion of cases develop complications in the heart which may cause serious disability later in life. The heart is involved in all cases of rheumatic fever. Dr. P. H. Spohn, in a recent lecture on rheumatic fever in children, stated that 50 per cent of patients suffering from an attack of rheumatic fever will eventually develop an organic heart condition.
APPENDIX B

BIBLIOGRAPHY

Books


Gillin, J.L., Poverty and Dependency. The Century Co.; New York; 1926.


Boas, E.P., The Unseen Plague - Chronic Disease. J. J. Augustin Publisher; New York; 1940.

Dexter, R.C., Social Adjustment. Alfred & Knopf; New York; 1927.


Articles, Reports and Essays.


Canadian Arthritis and Rheumatism Society, National Office,


