CASEWORK IN A VETERANS' HOSPITAL

An Analytical Study of Referrals from Doctors Shaughnessy Hospital, 1953-4.

by

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Abstract

There is evidence that from the earliest days of recorded history man has been aware of a significant relationship between sound physical health and an harmonious social environment. Many physicians and hospital administrators today recognize that a complete program of medical care includes facilities for the treatment of patients' social and emotional problems. The Department of Veterans' Affairs has recently given recognition to this principle through the provision of medical social service as part of the Treatment Services program for veterans.

In the present study the medical social service program at Shaughnessy Hospital is examined in an attempt to show how the doctors use the new service and with what results. At the same time, an attempt is made to point out other potential areas of development for medical social service in this hospital.

The basic information for the study was obtained from an analysis of approximately four hundred social service records, representing new referrals by doctors to the department for the year 1953-54. In addition, approximately thirty doctors were asked, through the medium of a questionnaire and in personal interviews, how they were using social services to complement medical care, and what recommendations they might make for the fuller utilization of these services.

The findings from these two procedures were consistent. They indicated that there is a growing demand for social services in this setting, and that the potential demand is even greater. The services most widely requested were for the purposes of enabling medical diagnosis and treatment, and assisting the patients in discharge planning. On the other hand, there is as yet little recognition of social work as a method of treatment, complementary to the medical plan: this finding appears both in the classification of the services for which patients were referred to the Medical Social Service Department, and in the comments and suggestions made by medical personnel.

While recognizing the very real limitation of staff shortage within the Social Service Department, this study is primarily concerned with the need for continuous interpretation of casework services. Much can be done through the refinement of everyday practices, such as closer co-operation with the medical staff, more effective use of casework recording, and continued self-evaluation. These practices, together with the favourable attitudes toward social service already expressed by the medical staff, should enable the doctors to make the optimum use of the existing services available through the Medical Social Service Department, to the end of improving still further the overall program of care for the veteran patients.

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Acknowledgements

I should like to convey my sincere appreciation to the members of Shaughnessy Hospital who have made this study possible. In particular I should like to thank Miss Cecil May-Shaw, Head of the Social Service Department, for the suggestions and criticisms which she contributed as the study progressed. Special appreciation is due to Dr. G. Hutton, Head of the Neuropsychiatric Clinic for his criticism and guidance in formulating the questionnaire used as the basis for part of this study; to Dr. K.S. Ritchie, Assistant Superintendent, for his support of the project; and to all the members of the medical staff who participated in the survey.

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TABLE OF CONTENTS

Chapter 1. **Social Aspects of Medical Care**

Social component of illness. The concept of "Medical Teamwork"; the social worker's role. Four aspects of social work in a hospital setting. Beginnings of medical social work. A national program of medical care: the Canadian Rehabilitation Program for Veterans. Social Service in the Treatment Program. Development of social service at Shaughnessy. Aims of the present project. Special character of social work in a Veterans' Hospital. ........................................... 1

Chapter 2. **Case Referral to Social Workers**

Referrals to social service in relation to hospital population. Trends in referrals to social service. The sources of referral. Proportion of referrals by medical staff. The nature of these requests. Classification: Groups A, B, C, D. Study by groups. Social problems involved. Evaluation of the services rendered ....25

Chapter 3. **Social Service as Doctors See It**

Use of questionnaire as a measurement. Scope of the field covered. Findings of the survey: methods of referral; social information considered most useful; services requested most frequently; suggestions for improvement. Other recommendations made by medical staff ............................................49

Chapter 4. **Medical Social Work at Shaughnessy Hospital: Some Implications**

Retrospect and prospect. Implications: to social workers; to medical staff; to administration. Conclusion ...........................................67

Appendices:

A. Administrative chart of the Department of Veterans Affairs.
B. Departmental Hospitals and Institutions.
C. Table of Treatment Categories.
D. Statement of Departmental policy: "Function of Medical Social Service."
E. Questionnaire used in this study.
F. Excerpt from Intenue's Manual: "Medical Social Service."
G. Bibliography.
# TABLES AND CHARTS IN THE TEXT

## (a) Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Referrals to social service in relation to patient population</td>
<td>26</td>
</tr>
<tr>
<td>Table 2</td>
<td>Trends in referrals to social service</td>
<td>27</td>
</tr>
<tr>
<td>Table 3</td>
<td>Sources of referral to social service</td>
<td>27</td>
</tr>
<tr>
<td>Table 4</td>
<td>Age distribution of patients referred to the social service department</td>
<td>29</td>
</tr>
<tr>
<td>Table 5</td>
<td>Requests for social history and other services rendered</td>
<td>37</td>
</tr>
<tr>
<td>Table 6</td>
<td>Problems of anxiety, and services rendered</td>
<td>41</td>
</tr>
<tr>
<td>Table 7</td>
<td>Referrals for practical services</td>
<td>48</td>
</tr>
<tr>
<td>Table 8</td>
<td>Social information requested by doctors or considered most useful</td>
<td>57</td>
</tr>
</tbody>
</table>

## (b) Charts

<table>
<thead>
<tr>
<th>Fig. 1</th>
<th>Medical social services requested for patients</th>
<th>33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 2</td>
<td>Social services considered most frequently requested</td>
<td>61</td>
</tr>
</tbody>
</table>
CASEWORK IN A VETERANS' HOSPITAL

An Analytical Study of Referrals from Doctors
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CHAPTER 1

SOCIAL ASPECTS OF MEDICAL CARE

Current conceptions of health and disease rest on a broad basis. The World Health Organization, a specialized agency of the United Nations, defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." This statement implies that health can be achieved and sustained only in response to many favorable influences and forces, including economic, social, emotional, and physical. Medical care is not confined to the diseased organ but takes cognizance of the total person involved, and implies planning on a community basis, because complete rehabilitation requires many services. It might be added that health in this sense is much more than the product of physical medicine, but requires economic and social services, and the work of several professions.

This concept of the interrelation of social, emotional, and physical factors in the etiology and treatment of disease is not a new idea. In primitive form it might be said to be known to ancient Greek physicians who, like Plato and Hippocrates, emphasized that mind and body are inseparable. The old prophets of the Bible must have held it in strong belief also, for they wrote of strange miracles of healing

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and of the great power of prayer.

The technological and chemical discoveries of the eighteenth century opened up wide channels for research and investigation. Doctors could observe the human body with greater accuracy through its various stages of pathology in illness. So absorbing was this new interest that, for a time, medical study was focused almost exclusively on the diseased organ. This inevitably led to great advancement in knowledge of specific diseases and to the specialization and precision which have become the tradition in the science of medicine. More recently, with perfected tools of research and refined skills of treatment, new findings were brought to light, broadening the concept of disease and medical care. Of particular significance are the studies made by Cannon in the area of "physiological stress" and by Dunbar in the field of psychosomatic medicine, as they emphasize the concept of illness as a reaction of the whole organism to its environment.

Currently, the investigations of such leading physicians as Professor Hans Selye have helped to crystallize some of the thinking on the subject of the relation of mind and body in illness. Couched in clinical terminology, the

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basic ideas of "the adaptation syndrome" and "the stress concept" express the modern broad concept of disease and the significance of environmental conditions in the treatment plan.

In many respects, the general practitioner of medicine in his role of family doctor is at an advantage over the specialist in that he observes the patient's illness within a broad context of personal, social, and medical factors. The specialist in a large modern hospital, with its complex organization of specialized departments and services, shares the responsibility of formulating a diagnosis and effecting a treatment plan with any number of other specialists, either of his own profession or of ancillary professions and services, such as psychiatry, nursing, dietetics, physical and occupational therapy, vocational counselling, and social work. The problem then becomes one of delineating the specific services and co-ordinating them into an integrated treatment plan. Out of such an approach has evolved the concept of "medical teamwork."

The Social Worker's Role in Medical Teamwork

The role of the social worker in helping the hospital carry out its obligation of restoring the patient to maximal usefulness constitutes an integral part in a comprehensive program of medical care. Mrs. Minna Field in a paper presented at the International Congress of Hospitals in London, May, 1953, outlines the medical social worker's role in all
its facets. This includes four broad areas of activity: direct help to the individual and his family; interpretation to hospital personnel; research; and interpretation to the community.

In the area of direct help to the patient and his family, the medical social worker, as part of the professional team, brings the same techniques and skills that characterize social work in general. In essence, this direct help, or social casework, is directed towards preventing further social breakdown; restoring social functions; making life experiences more comfortable or compensating; creating opportunities for growth and development; and increasing the individual's capacity for self-direction and social contribution. It is based upon an understanding of the dynamics of human behaviour, upon the translation of this understanding as it applies to the patient, and upon special competence in guiding him toward maximal adjustment in the light of his illness.

The first step in such a helping process is a thorough understanding of the patient's inner and outer environment, for each person is unique in his personality configuration, his social and economic background, and in his reaction to a given situation. The combination of these variables determines the

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meaning illness will have to the patient and the areas in which he will need help. Thus, he may require assistance with concrete problems, such as financial difficulty, confronting him and his family during his illness, or he may be disturbed by deep emotional difficulties and interpersonal relationships which may react upon his medical condition. Frequently, the patient's illness creates imbalance not only within the patient himself, but within the family unit. Anxiety created by illness and separation decreases the capacity of the remaining members to handle added responsibilities. In the process of gaining an understanding of the patient's problem, the social worker senses the strengths within the patient himself and within the family group, and draws on these strengths as resources. Whenever possible, she will call upon additional resources within the community, as this knowledge is part of her professional equipment. Some of the ways in which the social worker can help reduce anxiety and enable the patient and his family in a constructive handling of problems created by illness are: clarifying medical procedures, referring to an appropriate community resource, helping modify the attitudes of relatives towards the patient, preparing the family for the patient's after care.

But this individualization is only one aspect of the casework process. The manner in which the help is given is of even greater importance, and it is here that the social
worker offers a unique service to the patient. Mrs. Field describes the casework approach as follows:

The social worker's approach differs from that of the other members of the professional team, his relatives, or his friends. While the very nature of their functions imposes upon the other members of the professional team the obligation to exercise authority, and while the attitude of the family members and friends may be colored by their own emotional reactions, the social worker can remain free from the need to prescribe any particular line of action and from emotional entanglement. Rather, the social worker's approach is governed by an attempt to see the problem as the patient sees it, to allow the patient to move at his own pace, and to make his own decisions toward a goal that he is helped to set for himself. Such an approach can be carried out only when it is rooted in a genuine appreciation of the intrinsic worth and dignity of the human being regardless of the stage of his illness or the degree of the incapacity it produces. For the patient such an approach assumes particular significance in the light of an illness that tends to undermine his feeling of usefulness and status. Experience has demonstrated that this approach, removing as it does the threat of control, compulsion, or censure, tends to minimize the patient's feeling of helplessness produced by the illness. It enables him to view his problems more realistically and to feel free to ask for help in its solution, convinced that he wants such help and that he will not be forced into a line of action contrary to his own needs and desires.

In the area of interpretation to hospital personnel, the social worker has the responsibility of helping the other professions gain an increasing awareness of the patient's total needs as a functioning, living being who has an existence and concerns beyond the hospital walls. This responsibility can be achieved only if the social service department is included in policy making and planning in the hospital. A well-rounded program of interpretation includes utilization

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1 Field, op. cit., p. 399.
of opportunity for day-to-day contacts with other hospital staff, supplemented by more formalized teaching.

In the area of research for improved medical care, the social worker can make a contribution by promoting an understanding of the social factors in illness so that provision might be made to meet the total needs of the patient.

Finally, in the area of community interpretation, the social worker must assume the responsibility of calling to the attention of the community the impact of substandard social conditions upon health, and suggesting ways and means of providing remedies. In this way channels will be opened for broad social policies designed to ameliorate and prevent such conditions.

Formal Beginnings of Medical Social Work

Medical social work as a specialty of the social work profession can be traced to the work of lady almoners in English hospitals in the 1890's. Through the influence of the London Charity Organization Society almoners came to be appointed as part of the hospital staff, and their function evolved from the original task of checking abuse of medical charities, to a growing concern for the admission of suitable patients and their further help through social service in support of the doctor's plan for medical care.

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In the United States, social service departments in hospitals began to be established about 1905 with the growing recognition that adequate medical care must take account of social problems connected with illness. This conviction had been emphasized by visiting nurses who brought to the attention of hospital authorities the need to find some way of improving patients' home conditions and their understanding of medical prescriptions if treatment was to be successfully carried out. In addition, the inclusion of social work in the medical curriculum at the Johns' Hopkins Medical School, starting in 1902, emphasized the need for physicians to be well acquainted with the living conditions and habits of their patients, and to establish relationships of confidence and influence with them.

In retrospect, these developments can be seen as indicators of conscious effort within a changing social order to bridge the gap between the patient's physical disturbances and his social environment, so that he might be offered an integrated hospital service which would enable him to move toward restoration to health and participation in community life.

The Canadian Rehabilitation Program for Veterans

During recent decades, the concept of national responsibility for health planning and provision of medical services has gained wide support, as evidenced by the establishment of

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1 A history of medical social work in the United States and its place in the hospital is given in Dr. Richard Cabot's book, Social Service and the Art of Healing. Dodd, Mead and Co.; New York; 1928.
nation-wide health programs in the countries of New Zealand, Great Britain, the United States, and others. The experience of World Wars I and II underscored the fact that manpower is a nation's most valuable resource, and that unmet health needs create a heavy drain on the total economy. It was in the field of veterans' rehabilitation, however, that medical care programs were established on a national scale. In Canada such a program is set up under the Department of Veterans' Affairs as part of the total program of rehabilitation. This program has as its guiding principle the definition of rehabilitation adopted officially in 1946 at the National Conference on Rehabilitation in the United States:

Rehabilitation is the restoration of the disabled to the maximum physical, mental, social, economic and vocational capacity of which they are capable.

While it is recognized that vocational training, insurance and compensation provisions, and the other benefits provided under "The Veterans' Charter" are closely related in the rehabilitation of the veteran, for the purposes of this study emphasis will be on the treatment program of rehabilitation, as carried out by the Treatment Services Branch of the Department, with particular reference to the work of Medical Social Service.

The present system of medical services and hospital facilities has its origin in the rehabilitation program for veterans as provided under the Department of Soldiers' Civil

\[1\] A full description of this program is given in "Canada's Rehabilitation Program" by Walter S. Woods. Department of Veterans' Affairs Treatment Services Bulletin, May, 1948. V. III. No. 5. pp.3-12.
Re-establishment, a special Government department created in 1918 to deal with the demobilization of Canada's armed forces of World War I. With the near termination of the work of rehabilitation in 1928 the program was taken over by the Department of Pensions and National Health, and it was carried by this department until 1944 when the present Department of Veterans' Affairs was especially created to administer all matters pertaining to veterans. The medical services program is thus one part of a broad, comprehensive, co-ordinated plan designed to provide veterans the maximum benefit within the legislative framework.

The reorganization of the Treatment Services Branch at the end of World War II was based on long-term planning, although its immediate objective was to meet the tremendous task of emergency demobilization. It was necessary to utilize as far as possible the existing hospital facilities and the services of the practicing physicians of the country on a part-time basis, until the peak load of hospitalization was over. At the same time, however, certain principles considered essential in building up a treatment program of the highest standard were adopted as long-term policies. These included affiliation with Universities, the use of part-time specialists and internes instead of full-time salaried doctors, and the establishment of national and local advisory boards.

Complementing the high quality of medical staff, the Department has built up a system of hospital facilities that

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1 See Appendix A for administrative chart of the Department.
is considered unequalled. In addition to active treatment hospitals, many types of special treatment centres have been established to take care of special groups of veterans. These special services include treatment facilities for paraplegics, victims of severe poliomyelitis and arthritis, and for the ageing veteran who for physical reasons is unable to care for himself. Another type of institution is the Health and Occupational Centre, developed during World War II for the purpose of providing convalescent care to the veteran between the time he no longer needs to remain in an active treatment hospital and the time he is ready to return to the community.

The prime function of the Treatment Services Branch is the medical care of the pensioned veteran who is entitled to such care by virtue of his war service. In general, the pensioner is a veteran in receipt of financial allowance by reason of a service-connected disability or aggravation of a previously existing disability, either of which constitutes a vocational handicap as determined by the Canadian Pensions Commission. Treatment entitlement is also extended to non-pensioned veterans who may have a service-connected condition requiring medical treatment, and to the veteran in receipt of War Veterans' Allowance. Besides the veteran group, a number of other groups of persons are eligible for medical care in Departmental hospitals, notably those for whom the federal government has direct responsibility, including members of

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1 See Appendix B for a list of Departmental Hospitals and Institutions.
the Royal Canadian Mounted Police, Indians, Permanent Force and Active Service personnel, members of Overseas Auxiliary units, and others.

It has been estimated that hospital treatment for the disabled affects less than one per cent of those who served in Canada's fighting forces. But this proportion are cared for by extensive facilities and the amount of care per patient on the average is comparatively high. Hospital in-patient treatment strength has fluctuated between a high of 14,500 and a low of 9,000 but it has become stabilized at approximately 10,500. It is anticipated that the present hospital facilities will be needed for many years to come to provide for the care of the entitled veteran.

Social Service in the Treatment Program

At the present time, there are Medical Social Service units in fifteen Departmental hospitals or District Offices, comprising a total of 47 positions, one of which is that of central advisor. Medical Social Service was established in 1947 as part of the total treatment program. Prior to that, all social services of the Department were under the Social Service Directorate, a section of General Welfare Services. Medical social workers are administratively responsible to the Senior Treatment Medical Officer for services to patients.

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1 See Appendix C for Table of Treatment Categories.
2 Woods, op. cit., p. 10.
and to the Chief of Medicine for clinical matters. For technical and professional guidance, the Director of Medical Social Services, Ottawa, is consulted.

The need for social services within the treatment program for veterans was first recognized in 1918 when a "Social Service System" was set up within the Medical units and provision was made for ex-service nurses to take training in Mental Hygiene in order that they might render necessary "social services" to certain veterans. These services were seen to be such duties as follow-up of discharged veterans from hospital; investigation of home situation to assist in determining eligibility for certain benefits; and family services. A description of the services rendered by this group of social service nurses is given by Walter E. Segsworth, who had been for a time director of Vocational Training under the Department of Soldiers' Civil Re-establishment:

It may happen that the man is not making proper progress in retraining, although physical or mental examination does not disclose grounds for lack of progress. A trained social service worker who serves the Department is sent to visit his home, and it may be discovered that the lack of progress is due to financial embarrassment, sickness in the family, or various other matters. This social service nurse should be a graduate nurse of experience who has made a special study of social service conditions, and she is directed to ascertain the home surroundings of the man, offer kindly advice if required, and so to attempt to direct matters that all worries will be removed from the man's mind.2

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1 Canada, Department of Soldiers' Civil Re-establishment, Canada's Work for Disabled Soldiers, "The Medical Services: 'Social Service Workers,'" King's Printer, Ottawa, 1919. p. 27.

2 Segsworth, Walter E., Retraining Canada's Disabled Soldiers. King's Printer; Ottawa; 1920.
It is clear that the government recognized the need for social services within the treatment program, but the profession of social work itself was not yet recognized. Moreover, in the years following the establishment of the initial program, there was apparently little progress made in building up a permanent social service unit as an integral part of medical services. With the development of health and welfare programs throughout the country, many of the duties formerly carried out by the Department social service nurses were taken over by public health nurses and by provincial social welfare workers. Finally, in the 1930's, the Social Service System was merged with the Investigations Branch of the Department.

The problem of veterans' social needs came up again in the Government's reconstruction program following the outbreak of World War II. In accordance with the recommendations of the General Advisory Committee on Reconstruction, plans were made for a broad, comprehensive program of rehabilitation. One of the first services set up was the Casualty Rehabilitation program, designed to re-establish the disabled veteran in civilian life. To carry out this work, a staff of Veterans' Welfare Officers, recruited from returned service men, and given special in-service training, was built up to interview discharged members of the armed forces and advise them of their treatment rights and other benefits.

1 The Casualty Rehabilitation program is described fully in the Casualty Welfare Officers' Manual. King's Printer; Ottawa; 1950.
Meanwhile, Welfare Departments had been operating within the Armed Forces. These Welfare Departments had been created to deal systematically with cases of social difficulty, and were staffed with professional social workers whose chief social work function was that of a liaison service between the Armed Forces and the community social agencies. The success of this group had, no doubt, a favourable influence upon future planning for professional social services to discharged veterans.

Professional social workers came to be included in the rehabilitation program in 1945, with the establishment of the Social Service Directorate, a development arising from the recommendations of the Director of Social Science at National Defence Head Quarters, who had been requested to make a survey of the requirements of veterans for social services. Originally comprising three sections, Referral, Medical, and Investigation, the work of the Social Service Directorate was reorganized in 1947, when the Medical section became a separate department responsible to Treatment Services. The Referral section was retained within the Welfare Services Branch, and became the present Social Service Division. The Investigation section was also retained as part of Welfare Services, responsibility being carried by Veterans' Welfare Services.

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Officers. Both the Social Service Division, and the Medical Social Service units employ professional social workers as staff.

The inclusion of three separate groups within the Department of Veterans' Affairs, to deal with the social welfare of veterans, makes it necessary to have clear lines of responsibility and a close working relationship, so that a co-ordinated program of services to the veteran can be provided. The "division of labour" and co-ordination of activity among the three groups, outlined in the policy and regulations, and further developed through experience, has settled into a definitive pattern over the years. As a result, social work in this setting is of a somewhat unique character.

The limits of this report do not permit a precise definition of the areas of responsibility of the three groups concerned with the welfare of veterans, but a working definition can be obtained from a broad picture of the field. The Veterans' Welfare Officers, under the Director General of Welfare Services, have as their prime responsibility to ensure that every veteran is aware of all his rights and benefits to which legislation and regulations may entitle him. The Social Service Division, under the Director of Social Service within

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1 The accepted education for the profession of social work, as outlined in the University of British Columbia calendar, consists of a minimum of two university years of graduate study including lectures, clinical practice work in the field, and a research project or thesis, leading to the degree of Master of Social Work.
the Welfare Services Branch, exists primarily as a referral centre for veterans in the community to make available to veterans the same level of social services as exist for all persons within the community. This involves liaison and a close working relationship with community agencies so that duplication and overlapping of services is avoided.

Medical Social Service, under the Director, within the Treatment Services Branch, operates for hospitalized or outpatient veterans when social problems exist which affect their treatment. The function of Medical Social Service has been laid down by policy, and consists of five categories of service, as follows: (1) casework services to individual patients as part of the medical team of which the doctor is the leader; (2) medical social consultation service to others giving service to the veteran; (3) participation in the development of community understanding and aid to the sick and disabled; (4) participation in the teaching program of the hospital; (5) assisting in research projects which have medical social implications.

This review of the development of the social services program within the broad rehabilitation scheme indicates the significance of the contribution that professional social work can make in a comprehensive approach to social security. A relatively late comer to the medical treatment program,

1 See Appendix D for a statement of Medical Social Service function.
social work was, however, brought in in accordance with well-laid plans, and with a sound, advanced policy of function. The carrying forward of this policy offers a large potential of contribution to an already effective plan of medical care.

Social Service at Shaughnessy Hospital

Shaughnessy Hospital, located in the city of Vancouver, reflects the Departmental policy of concentrating its hospitals in the larger centres of population in order that patients might have the benefit of the services of leading physicians and specialists in all branches of medicine. Shaughnessy Hospital, Vancouver, and Veterans' Hospital, Victoria, constitute the main treatment centres for veterans in the Vancouver District.

Treatment facilities for service men in this area were originally established in 1916 under the Military Hospitals Commission, when an eight-ward annex (250 beds) was opened for military service patients, and administered by the Vancouver General Hospital. Under the Soldiers' Civil Re-establishment additional facilities were added, and the original Shaughnessy Hospital was established on the present site. Construction of the present modern building was started in 1939, and the building was officially opened in 1941, shortly after the beginning of World War II when hospital services were acutely needed for returning service men. The period 1941-47 witnessed a rapid development in hospital accommodation, with new buildings and
extensions being added, and old buildings being closed down. By 1947 the major reconstruction program was completed.

Shaughnessy Hospital, with a total bed-capacity of about 1500 contains separate facilities for active treatment, tuberculosis, convalescence, and domiciliary care. Active treatment is provided in the Main Building, a modern three-storey structure. Patients with diseases of the chest, and tuberculosis, are housed in a separate building also located on the hospital grounds, and known as the Jean Matheson Memorial Building, or more commonly, the Chest Unit. Convalescent care is provided at the George Derby Health and Occupational Centre in Burnaby. Domiciliary care is available in the Extension for bed-patients, while ambulatory patients requiring this type of care are accommodated at the Health and Occupational Centre, and at Hycroft, formerly a private mansion and now part of the Departmental facilities.

The Medical Social Service Department at Shaughnessy Hospital, established in 1947 in accordance with the Government's reorganization policy of social services for veterans, is accommodated on the second floor of the Main Building, within easy access of the medical staff. Additional offices are located in the Chest Unit, and in the Neuropsychiatric

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1 The Centre was named "George Derby" for the Department's Western Regional Administrator. It is located in a rural environment, on Lake Burnaby, and consists of eight separate dwelling units (Pavilions), plus two central buildings which contain the administrative offices, dining room and recreational facilities.
Clinic on the ground floor of the Main Building. With the exception of one worker who shares an office, the social service staff are provided with individual offices. The clerical office is a single room for the three staff members, and serves also as the general office for filing records. In addition, there is a large waiting room for the convenience of clients and visitors to the department.

At the present time the Medical Social Service Department at Shaughnessy comprises a staff of six full-time social workers, one of whom is the Head of the Department. Recently, after a lapse of one year, the department was re-established as a fieldwork agency for students from the University of British Columbia School of Social Work, and during the year 1953-4 three students received their fieldwork training here. Two of them trained under the interneship provision of the Department, a policy recently adopted in line with the general policy of the Government to maintain its medical services on a high level through affiliation with Universities.

The growth of the social service program at Shaughnessy parallels the growth of social services in the Department of Veterans' Affairs generally, and this has been reviewed. However, a number of points in the development of the program seem to be of particular significance to this study and will be noted here. The program originated with the establishment of the Social Service System of 1919 when four "social service nurses" had been placed in the Vancouver District. A remnant
of this initial program carried through until in the 1940's
two professionally trained social workers were taken on staff
to provide necessary services, chiefly to the Neuropsychiatric
Clinic. This was the condition that obtained in 1947 when the
present department was established.

The new Medical Social Service Department was
expected to develop a program of social services complementary
to the existing medical services, and forming an integral part
of the total hospital care. To initiate the new program, the
Government made ample provision for leadership and staff develop­
ment. The Director of Medical Social Service, Ottawa, acted as
consultant on all aspects of establishing the new department in
the hospital. The School of Social Work, University of British
Columbia, provided consultation as well as credit courses on
medically-oriented material. The medical staff of the hospi­
tal provided lectures for staff and in-service-training
internes. Clinics, ward rounds, and evening lectures for
medical internes were made available to the Medical Social Ser­
vice staff.

However, even with all these provisions, the new
department could not escape the difficulties of "growing
pains." It is a recognized principle that the strongest pro­
grams are those which are built up, not handed down. The
single concrete human situation is not to be discounted in
the development of any social program, for social work is not
a welter of activities but a professional discipline based on
an integrative approach to meet social need. In a hospital setting particularly, the method of social work and the contribution it can make to the medical care of the patient can best be appreciated through its effective use in individual situations. At Shaughnessy, the initial shortage of personnel to carry out and interpret the program proved a great handicap to the growth of the new service. More recently, with the greater availability of professionally-qualified personnel generally, the staff at Shaughnessy has been built up sufficiently to give the program a more secure footing, and to provide at least minimum coverage of social services for the hospital.

The Medical Social Service Department is now faced with the problem of expanding its services, so that a greater volume of services could be given, and so that services would be more readily available. At the same time, however, there is also need for evaluative research of the existing procedures and services, so that expansion might rest on a sound basis.

**Purpose of the Present Study**

All medical care and practice is aimed at returning the patient to an optimum state of health so that he can again be an effective member of his family, and of the community generally. In this sense the primary function of medical care is a social one. An increasing number of hospitals are including the professional services of social workers as part
of the total medical service because of the advantages of considering the patient as a person in his relationship to his family and his community. However, the responsibility of making social work an effective service in the hospital rests ultimately upon the mutual helpfulness and co-operation between the doctors and the social work personnel. It was an interest in developing such knowledge and understanding that gave rise to the present inquiry. How do doctors use the Medical Social Service Department as an aid to medical care of patients? What social services are given? What social services are requested most frequently? What areas of medical social work still remain to be developed in this hospital? These questions set the focus of the study.

Special Characteristics of Veterans as Patients

Certain special circumstances must, of course, be kept in mind in studying the nature of social services in a veterans' hospital and the use made of them. Veter"an"s are not a "normal" group of patients, such as one would normally find in an ordinary general hospital, so that the findings and implications of this study would have only limited application to hospital patient groups generally.

Since the primary responsibility of the Treatment Services Branch is for the pensioned veterans, that is, those with service-connected disabilities which constitute a vocational handicap, it is inevitable that the factors of chronicity and recidivism will be paramount characteristics of the
veterans' patient group. Those who need hospital care need a good deal of it. Another important characteristic of this group of patients is that a large proportion of them is in the higher age-group; naturally for them hospital care is complicated by all the impairments which accompany old age.

In such a setting, social work takes on a special character. Chronicity and recidivism in disease make for long-term and repeated hospitalization. Moreover, because of the provision of generous veterans' services, such as free medical care and full pension rates during the period of hospitalization, there is nothing to stop the veteran patient from returning to the hospital at any time. These conditions could mean long-term casework services. Another feature of social work in this setting is that the social worker is dealing with many elderly patients, and with an older group generally.

Finally, the presence of all these factors -- old age, chronic illness, free medical care and other veterans' services -- raises the question of dependency, and to what extent these conditions foster a pattern of dependency in the veteran patient group. The problem for social work, as for any other group involved in the treatment of these patients, is to work towards the patient's maximum utilization of his own capacities without playing into an existing or potential pattern of dependency.
CHAPTER 2

CASE REFERRAL TO SOCIAL WORKERS

To get a broad picture of the nature of social work in this setting, all the "new" referrals made by doctors during the year 1953-4 were earmarked for the study. "New" referrals mean those cases not previously known to the social service department, although the patients concerned may or may not have been previously hospitalized. The cases were drawn from the entries in the Case Registry of the Medical Social Service Department. Altogether, 371 cases were studied, representing 266 hospitalized patients and 102 outpatients.

The following figures, showing the movement of hospital patients and the referrals to social service, provide some indication of the relative size of the two programs at Shaughnessy, and suggest the representative nature of the group of cases selected for this survey. However, the two sets of figures preclude any precise comparison, since the statistics for the social service department include both in-patients and outpatients, while the hospital statistics apply only to in-patients. Nevertheless, the figures give sufficient detail

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1 It will be noted that there is some discrepancy between the number of new referrals listed in the Case Registry and that given in the Monthly Statistics of the social service department.

2 Statistics for the Outpatient Clinics were not available for this study, for although that department is located in the hospital building, it is not a part of the hospital itself.
to suggest the volume of the hospital service required at Shaughnessy. Although a seasonal fluctuation in patient population is evident, the total picture indicates that patient movement is largely determined by the number of beds available. Some suggestion of the chronic nature of patients' illness is indicated in the figures of average patient-days stay.

Table 1. Referrals to Social Service in Relation to Hospital Population

(Shaughnessy Hospital, 1953-4)

<table>
<thead>
<tr>
<th>Month</th>
<th>Movement of Patients</th>
<th>Social Service Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Admitted</td>
<td>No. Discharged</td>
</tr>
<tr>
<td>April</td>
<td>564</td>
<td>583</td>
</tr>
<tr>
<td>May</td>
<td>518</td>
<td>540</td>
</tr>
<tr>
<td>June</td>
<td>484</td>
<td>506</td>
</tr>
<tr>
<td>July</td>
<td>576</td>
<td>552</td>
</tr>
<tr>
<td>Aug.</td>
<td>554</td>
<td>556</td>
</tr>
<tr>
<td>Sept.</td>
<td>550</td>
<td>552</td>
</tr>
<tr>
<td>Oct.</td>
<td>587</td>
<td>539</td>
</tr>
<tr>
<td>Nov.</td>
<td>565</td>
<td>529</td>
</tr>
<tr>
<td>Dec.</td>
<td>512</td>
<td>610</td>
</tr>
<tr>
<td>Jan.</td>
<td>598</td>
<td>488</td>
</tr>
<tr>
<td>Feb.</td>
<td>556</td>
<td>549</td>
</tr>
<tr>
<td>March</td>
<td>535</td>
<td>603</td>
</tr>
<tr>
<td>Totals</td>
<td>6099</td>
<td>6617</td>
</tr>
</tbody>
</table>

Source: Compiled from the monthly statistics of Shaughnessy Hospital.
(a) Figure in brackets shows number of referrals by doctors.
(\*) Computed averages

The monthly distribution of referrals to the social service department shows a steady rise in the volume of work
handled by this department; and comparative yearly figures for the two previous years for which statistics were available indicate a general upward trend in the growth of the department.

Table 2. Trends in Referrals to Social Service
(Shaughnessy Hospital, 1953-4)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Caseload</th>
<th>New Cases</th>
<th>Referred by Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>1951-2</td>
<td>1885</td>
<td>822</td>
<td>372</td>
</tr>
<tr>
<td>1952-3</td>
<td>2730</td>
<td>847</td>
<td>524</td>
</tr>
<tr>
<td>1953-4</td>
<td>2935</td>
<td>1327</td>
<td>653</td>
</tr>
</tbody>
</table>

Source: Compiled from the statistics of the social service department, Shaughnessy Hospital.

It is significant that about half of all the referrals to the social service department each year come from doctors, although requests may also come from other sources. During the year 1953-4, the number and proportion of referrals from the various sources were as follows:

Table 3. Sources of Referral to Social Service
(Shaughnessy Hospital, 1953-4)

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>New Cases</th>
<th>Re-opened Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>519</td>
<td>57.10</td>
</tr>
<tr>
<td>Other hospital staff</td>
<td>152</td>
<td>16.72</td>
</tr>
<tr>
<td>Routine coverage</td>
<td>80</td>
<td>8.80</td>
</tr>
<tr>
<td>Patient</td>
<td>52</td>
<td>5.72</td>
</tr>
<tr>
<td>Relatives</td>
<td>21</td>
<td>2.31</td>
</tr>
<tr>
<td>Community</td>
<td>39</td>
<td>4.29</td>
</tr>
<tr>
<td>Other D.V.A. personnel</td>
<td>31</td>
<td>3.41</td>
</tr>
<tr>
<td>Other D.V.A. Hospital or District</td>
<td>15</td>
<td>1.65</td>
</tr>
<tr>
<td>Total</td>
<td>909</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Statistics of social service department, Shaughnessy Hospital (1953-4)
Without further elaboration of the statistical data, it becomes clear that the medical staff at Shaughnessy have a substantial interest in the services offered by the Medical Social Service department, and that there has been a steady demand for services from them. The way in which these services contribute to the well-being of the patients for whom they are requested is therefore a vital issue, not only from the standpoint of the particular patient, but also in the way social services will be utilized by medical staff in the future.

The Patients Referred

The general characteristics of the veterans' patient group, as outlined earlier in this report, were found to be typical of this specially selected group. Naturally, the amount of information obtained on each of the 371 persons was limited, not only by realistic standards, but also because many of the case histories themselves lack certain pertinent information, notably the medical diagnosis, a record of previous hospitalizations and illnesses, and the outcome of the case. Within these limitations, only a rough picture can be presented, but certain basic characteristics are no less evident than if more precise data were available. The features noted include old age, chronicity of disease (as indicated by the pension status of the veterans), and at least some indication of the economic status.
Of the 371 patients in the group, there were 359 men and 12 women, ranging in age from 18 to 89, with approximately 55 per cent of them over fifty years of age (Table 4).

Table 4. **Age Distribution of 371 Patients**

(Shaughnessy Hospital; 1953-4)

<table>
<thead>
<tr>
<th>Locale and Age</th>
<th>Number and Sex of Patients</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Hospital Patients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>44</td>
<td>8</td>
<td>52</td>
</tr>
<tr>
<td>30 - 49</td>
<td>61</td>
<td>1</td>
<td>62</td>
</tr>
<tr>
<td>50 - 69</td>
<td>92</td>
<td>2</td>
<td>94</td>
</tr>
<tr>
<td>70 and over</td>
<td>64</td>
<td>-</td>
<td>64</td>
</tr>
<tr>
<td><strong>Out-Patients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>17</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>30 - 49</td>
<td>35</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>50 - 69</td>
<td>36</td>
<td>-</td>
<td>36</td>
</tr>
<tr>
<td>70 and over</td>
<td>10</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total (a)</strong></td>
<td>356</td>
<td>12</td>
<td>368</td>
</tr>
</tbody>
</table>

(a) Ages not grouped, 3 patients.

Source: Compiled from records of social service department. Special count.

Some indication of the prevalence of chronic disease within the group was derived from an analysis of the Treatment Categories under which the veterans were receiving medical care at the time of referral to social service. However, since the case histories on outpatients did not always have this data, a complete analysis for the group could not be done. In the analysis of Treatment Categories for 254 patients, it was found that the largest proportion, about one-third, were under Treatment Category (12), or War Veterans' Allowance.
recipients. The next group in size, about 16 per cent, were Armed Forces personnel (Treatment Category, 18). Others of sizable proportion were: pensioned disability (Section 5), 15 per cent; marginal income (Section 13), 8 per cent; and patients under medical observation (Section 28), approximately 8 per cent. All these persons would be entitled to free medical care and the regular comforts allowance (about 7 dollars a month), and those under Section 5 would be drawing full pension rates during their period of hospitalization.

Additional information to suggest the nature of illness of the patients in the group under hospital care was obtained by reference to the particular ward from which the referrals came. It was estimated that approximately half of the patients were under general medical care, about one-sixth on psychiatric wards, and the remainder dispersed among surgery and the other services. The smallest group of those referred to social service were patients already under Departmental domiciliary care.

**Timing of Referrals to Social Service**

At what point in the course of medical treatment are referrals to social service most effective in meeting the social and emotional needs of the patient and preventing their adverse influence on medical planning? It is clear that the earlier the medical social worker arrives at her essential area of responsibility in collaborative medical-social planning with the physician, the more efficient and economical will the treatment
plan be. Because of the limitations of the social service records, in that they do not usually contain information regarding the date of discharge from the hospital of the patient, and because it was not within the scope of this study to seek this data from other sources, no conclusive observation could be made on the question of timing of referrals. However, some indication of timing was derived from reference to the date of patients' admission to the hospital.

Of the group of 371 referrals, approximately 29 per cent of the patients were referred from the Outpatient Department, that is, prior to admission to hospital. Of the group of 266 patients referred after admission to hospital, about 5 per cent were referred on the same day as admitted; approximately 29 per cent within one week of admission; just over 37 per cent in the period one week to one month after admission; and about 21 per cent were referred after at least one month of hospital care. (No information was obtained on the remaining 8 percent).

It would be risky to draw any specific implications from these figures, without obtaining further information on the nature of the social services requested. However, the importance of early referral to social service cannot be over-emphasized.

Nature of Referrals by Medical Staff

In an attempt to arrive at a working description of the multiplicity of social services requested in the 371 cases
studied the focus was deliberately set on the problem stated as the reason for referral. But even within these limits, the variation in problems was of wide range. Examination and analysis of the reasons for referral yielded four broad categories, which were adopted as a basis of classification. These four categories reflect the areas of social work services in this setting:

A. Social information as an aid to diagnostic and treatment planning by medical staff. This includes requests for social history, both for psychiatric use and for use in general medical treatment, as well as requests for social assessment of the patient's home conditions for a better understanding of the patient.

B. Direct assistance to patients with anxiety arising from illness, or as a result of unsatisfactory home conditions, or social relationships.

C. Social screening of home conditions to determine the suitability of the home, and the ability of the family in providing convalescent or domiciliary care for the patient, or alternately, to assist in locating of suitable living accommodation for the patient on his discharge from the hospital.

D. Practical services to patients or their relatives. This includes requests for financial assistance, assistance in finding suitable living accommodation, job placement, information about Departmental policy and regulations, etc.
MEDICAL SOCIAL SERVICES REQUESTED FOR PATIENTS

Social information for diagnosis and treatment planning

Assistance with problems of anxiety arising from illness or as a result of unsatisfactory social relationships

Social screening of home conditions for convalescent and domiciliary care

Practical services, such as financial assistance, job placement, locating suitable housing accommodation

Figure 1. Medical Social Services Requested for Patients
(Shaughnessy Hospital, 1943-54)
The differentiation between the types of services requested from caseworkers, and the grouping of these services into the four basic categories reveals that the majority of referrals are for facilitating services: diagnostic aids, (Group A); and aids in treatment planning (Groups A and C). A small proportion of requests is for practical services (Group D), and yet a smaller proportion for direct assistance to patients with problems of anxiety (Group B). A closer examination of these four broad categories should provide some solid material for an evaluation of the general nature of referrals, and of the services rendered by social workers.

**Group A: Diagnostic Aids**

The total referrals comprised 201 cases, of which 78 were from the Outpatient Department and 123 from the Hospital wards. The referrals were of three main types:

(a) Social history as an aid to psychiatric services  
(b) Social history for patients on general medicine wards  
(c) Social work assessment of patient's home conditions for a better understanding of the patient

About three-quarters of the requests were for psychiatric social history, while the remainder fell about equally between the other two types of service requested. The large proportion of requests for psychiatric social history points to the significance of the social worker's contribution in the area of diagnosis and treatment planning for the patient under psychiatric care. Referrals to Psychiatry from the Outpatient
Department are routed through the social service department as a matter of routine. Besides obtaining the required social history, social service staff are in a position to help patients accept the psychiatric service recommended.

History-taking calls for skill in interviewing, and a clear understanding of the purpose for which the information is required. The emphasis should be not so much on the details required, as on the skilled use of the worker-patient relationship to get the configuration of the life pattern, or portion of it, with as little distortion as possible. The style of recording social histories is determined by a number of factors, among them the nature of the content, the purpose to which the material is to be put, and the agency's policies. Material for social history is usually blocked out under topics for easy access by persons using it: but there is clearly a danger in conforming too rigidly to a preconceived pattern or outline, thereby losing the dynamic picture of the patient or client.

In the records reviewed for this study, the majority of social histories for Psychiatry were taken by the same worker, who is allocated to the psychiatric ward. As a consequence, these histories showed the same general pattern of writing and contained the same type of information.

It was noted that, in the taking of social histories, wide use was made of relatives as a primary or collaborative
source of information. This is encouraging for the practice of social work in this setting, for relatives can be an important link between the patient in the hospital and his outside concerns. The extent of contact with relatives and friends in obtaining social history information is about one in every two. (Table 5). It is to be noted, however, that in over two-thirds of them there is no further recorded contact with the patient or relatives beyond the initial social history. In those cases where further contact is recorded, there is evidence that follow-up services were directed toward stabilizing or improving the patient's social functioning, either through direct services, or by referral to an appropriate Departmental or community service.

The group of social case histories reviewed here provides a substantial sampling of the work done by medical social workers in this setting in contributing to medical diagnosis and treatment through preparation of social histories presenting the patient in his social functioning. The high proportion of requests for social histories indicates the significance of the work in this area. The findings on the services given, point up the need for a greater concern on the part of social workers for a continuing participation in the treatment of the patient, initially through a more dynamic interpretation of the patient's social situation as it is related to his illness, and subsequently, through continuing casework services to relatives where this seems indicated. Finally, from the research point of view, at least, it would be helpful for future
Table 5. Requests for Social History and Services Rendered
(Shaughnessy Hospital, 1953-4)

<table>
<thead>
<tr>
<th>Service Requested at Referral</th>
<th>Social History Rendered (a)</th>
<th>Direct Help (Patient or Relative)</th>
<th>Referral to Other Agencies</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social history as an aid to diagnosis and treatment (Psychiatry)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Information from patient only</td>
<td>50</td>
<td>1</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>b. From patient and others</td>
<td>53</td>
<td>23</td>
<td>19</td>
<td>95</td>
</tr>
<tr>
<td>2. Social history (General Medicine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Information from patient only</td>
<td>14</td>
<td>1</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>b. From patient and others</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>3. Social history with special emphasis on home conditions as they relate to patient's illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Information from patient only</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>b. From patient and others</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Totals</td>
<td>140</td>
<td>29</td>
<td>32</td>
<td>201</td>
</tr>
</tbody>
</table>

Source: Compiled from the social service records of Shaughnessy Hospital, 1953-4.

(a) Social histories are obtained in all cases: the first column therefore means that for these patients, no other casework services were rendered.
evaluations of this kind, if social service records showed the disposition of the case, whether or not continued services were given.

**Group B: Direct Social Work Treatment Services**

This group of 40 cases comprises the requests made for direct assistance to patients and relatives with problems of anxiety arising from the patient's illness or from unsatisfactory inter-personal relationships. This area of service represents one of the prime responsibilities that is the medical social worker's by tradition. The classification adopted for purposes of analysis shows two main types of problems in this group of requests:

(a) those arising from the patient's hospitalization or illness;

(b) those arising from patient's family and social relationships, and probably aggravated by his illness.

However, no classification can be so clear-cut that one category excludes the others; typically, problems of human relationship are complex.

Problems arising from the patients' illness or hospitalization included such referrals as the following:

a. Relatives are upset over patient's recent transfer to a closed psychiatric ward. Could social service help them accept the necessity of this move.

b. Patient is worried about lengthy separation from his family in the northern part of the province. Can social service help him?

c. Patient is to undergo surgery for gastric ulcer, and is worried about the family's reaction to this: Medical Social Service aid requested.
d. Reply needed to letter from patient's daughter inquiring about his illness. (Patient is on psychiatric ward).

Referrals requesting assistance for patients with problems of inter-personal relationships included such referrals as the following:

a. Patient has bleeding peptic ulcer. He has indicated that there are domestic difficulties in the home. Can social service help him.

b. Patient is an alcoholic. It is indicated that marital relationships are poor. Wife may benefit from Medical Social Service help.

c. Domestic problems. Patient is anxious to have estranged wife return. There are three young children.

An analysis of the type of problems referred, and the frequency of the various services given, is summarized in Table 6. It is significant that the highest frequency of services rendered was in the areas of direct casework treatment and referral to community agencies.

"Direct casework treatment," as it is used here, is that definition given by Gordon Hamilton, meaning therapeuting interviewing carried on for the purpose of "inducing or reinforcing attitudes favourable to maintenance of emotional equilibrium, to making constructive decisions, and to growth or change."

The extent of this type of service is difficult to measure in any setting, for it requires process recording of the interviews, or at least a summary of the social worker's active

1 Hamilton, op. cit., p. 249.
participation in enabling the client to become keenly aware of his reality situation and of his part in it. Direct therapeutic treatment usually requires a series of interviews over a long period of time, for the growth process is slow.

From the records studied, it would seem that the extent to which this type of service is practiced in this setting is very limited. The majority of case histories consist of only one, or at most, several, interviews. Moreover, because the general style of social work recording in this setting shows little of the worker's participation it is difficult to draw any precise conclusions about the nature of the relationship between worker and patient, and its effect on the latter.

Referral to an appropriate community resource is another important service that the social worker in a hospital setting can provide. Frequently an appropriate service can be initiated by the social worker in the hospital but its effectiveness would be lost if it were not continued on the patient's discharge. In the cases studied, referrals were frequently made to such agencies as the Family Welfare Bureau, Provincial Welfare Services, and to social service departments in other hospitals if the patient had to be transferred there.
Table 6. Problems of Anxiety Referred to Social Service

(Shaughnessy Hospital; 1953-4)

<table>
<thead>
<tr>
<th>Problem at Referral</th>
<th>Services Rendered and Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cases (a)</td>
</tr>
<tr>
<td>1. Anxiety arising directly from patient's illness or hospitalization</td>
<td></td>
</tr>
<tr>
<td>a. Patient's concern over his illness</td>
<td>11(3)</td>
</tr>
<tr>
<td>b. Relatives' concern about patient's illness</td>
<td>6(1)</td>
</tr>
<tr>
<td>c. Family services required due to patient's separation from family</td>
<td>5(0)</td>
</tr>
<tr>
<td>2. Anxiety related to family and social relationships (existing prior to illness)</td>
<td></td>
</tr>
<tr>
<td>a. Marital difficulties</td>
<td>7(0)</td>
</tr>
<tr>
<td>b. Other domestic troubles</td>
<td>6(2)</td>
</tr>
<tr>
<td>c. Alcoholism</td>
<td>5(0)</td>
</tr>
<tr>
<td>Totals</td>
<td>40(6)</td>
</tr>
</tbody>
</table>

Source: Compiled from social service records of Shaughnessy Hospital, 1953-4.

(a) Figure in brackets represents the number of outpatients in the group.

Perhaps the most significant finding from the analysis of these cases lies in the limitations of recording, already noted. To quote Gordon Hamilton again, "the main considerations in recording are: the need for sufficient factual material, both social and psychological; the worker's professional analysis
of the situation; the formulation of diagnostic and treatment evaluations; the preliminary outline and step by step reports of the treatment which is made available, and the final outcome of the case." It is recognized that case recording is partly determined by the setting and the administrative practices, according to the use made of it. However, the question of concern here is not contrary to administrative purposes. The effectiveness of the social work method is a matter of vital concern to administration, and social work stands to benefit by a clear interpretation of the approach caseworkers use.

**Group C: Assessment of Home Conditions**

The patients in this group presented varied degrees of physical incapacity, and required temporary or permanent nursing care. Many had physical disability complicated by memory defects and senile deterioration, which made it essential for them to have constant supervision. Most of the patients in this group were older veterans whose problems were a complexity of chronic disease, infirmity of old age, and lack of family or friends to care for them. The problems as stated at referral fell into two main types, according to the nature of the service requested by the medical staff.

(a) Those where social screening of home conditions was required to determine decision on institutional care consideration (Treatment Section 29). This includes cases where application for institutional care was made by the patient or relatives, as well as those cases where such consideration was initiated by the medical staff.

(b) Requests for assistance in discharge planning following a period of hospitalization, where further convalescent care was required.

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Typical referrals in this group included such requests as the following:

a. Patient hemiplegic. Check capability of family to care for him at home. If not, Section 29 to be considered.

b. Carcinoma terminal. Social screening is necessary to determine family's interest and wishes in regard to interim care.

c. Patient considered capable of taking insulin treatment for his diabetes. Is former boarding home suitable living accommodation?

Evaluation of applications for permanent institutional care is a critical one for the applicant and for the Department. Admission practices and selection skills have to be of the highest order to ensure that the present Departmental facilities will be utilized to the best advantage. Medical staff must consider the patient's need for institutional care on the basis of medical, social, economic, and personality findings. In order to classify difficult cases with ease and efficiency, the Assessment and Rehabilitation (A & R) Unit was established within the Department. The A & R Unit represents a team approach to the patient who presents a disposal problem, and is concerned with ensuring that the man is functioning up to his fullest capacity. This is determined through a total assessment of medical, psychological, social, and economic aspects, each of which is the special contribution of the respective member of the A & R team: medical man, psychologist, medical social worker, and Veterans' Welfare Officer. The immediate purpose is to determine which candidates will require Departmental facilities, and which might better remain at home or seek other assistance in the community.
From the social work standpoint, the decision to recommend institutional care is easy in many cases when the needs of the patient and the facilities of his home and of the community are kept in mind. Thus, acutely disturbed or disoriented individuals, and aged persons who have reached a stage of apathy so that their growing need for the physical aspects of care could not be served appropriately at home, are acceptable for institutional care when there are no friends or relatives able or willing to care for them.

Among those not able to care for themselves outside the institutional setting are some whose problems lie in their upset psychological and emotional reactions to living, and this includes abnormal family and social relationships. The solitary hermit who has always refused help from neighbors, the alcoholic, the quarrelsome grandfather who makes his home with relatives of a younger generation, all these present problems of disposal when chronic illness and the infirmities of old age overcome them.

In all cases where the elderly or physically incapacitated person presents a disposal problem to the hospital staff, in order to effect a suitable plan, the man's motivation and his remaining capacities must be known and considered. Has he the capacity to maintain himself in the community? Are there suitable facilities in the community for his use? These are the questions about which the social worker, as part of the hospital team, must be vitally concerned.
In the 82 cases reviewed, the services rendered by the Medical Social Service staff may be summarized as follows:

a. Referral to Veterans Welfare Services, or to an appropriate community service, 9 cases, or just over 10 per cent. The chief services requested were: finding living accommodation, housekeeping services, and budgeting assistance.

b. Discharge recommended, in approximately one-third of the cases. For the majority of these patients, it was found that relatives or friends were prepared to care for them. A smaller group seemed capable of making their own plans. Others simply planned to return home.

c. Institutional care consideration recommended, in about ten per cent of the cases. These recommendations were found to be based on such reasons as: no relatives, or friends, or suitable accommodation; illness of relatives; relatives or friends unable to give patient the nursing care he requires; or a combination of these.

d. Extension of hospitalization recommended, about ten per cent of the cases. This was usually as a transition to other plans, such as temporary illness of relatives, or other plans of patient's own making.

e. No decision reached by social workers, just over ten per cent of the cases. Decisions were sometimes deferred because patient was placed under further medical observation. In a number of other cases it was stated that further contact with relatives was planned.

In this group, as in the other groups discussed earlier, it was found that in the majority of cases the social worker's recommendation was formulated on the basis of a very brief contact with the patient or his relatives, frequently after one interview. This is often necessitated by a demand from the medical staff for an early report of social findings, particularly during periods of acute pressure for hospital accommodation. An early referral to social service would give the worker a better opportunity to explore the social resources within the
community and to mobilize these resources on behalf of the aged or incapacitated patient.

One more point deserves attention. With rare exceptions, social service records do not show whether or not the recommendations made by the workers were carried out by medical staff. This information, if it were readily available, could be very valuable in evaluating the contribution of medical social work in this setting.

Group D: Practical Services

The administration of a practical service is one of the oldest and best known ways of helping. In Departmental hospitals, it is usually the Veterans' Welfare Officers who administer the bulk of "practical services" in their responsibility of making veterans aware of their rights and benefits under veterans' legislation. Locally at least, Welfare Officers have also largely assumed the responsibility for helping patients in finding suitable living accommodation, job placement, etc. However, a fair proportion of referrals to social service are for this type of services.

The appropriate use of a practical resource in serving the need of the patient may be one of the most valuable contributions. From the social work point of view, the worker's professional responsibility goes beyond doing things or giving things to the client or for him; the social worker has a professional obligation to determine the best source of help and to enable the client to use it constructively. Granting the destitute man an emergency loan may be vital to the man's
immediate need, but, in itself, it may not be the most effective way of meeting his basic need. The use of practical resources should not be an end in itself. The person seeking help must be individualized, the nature of his need clarified, and the practical resource, if it is to be used, must be so employed as to motivate self-help, self-awareness, and responsibility in the client, so that he can mobilize his own capacities and resources in the solution of his problems.

The disposition of the 48 cases referred to Medical Social Service for practical services is summarized in Table 7.

From the analysis of the cases in this group, the significance of the Medical Social Service Department as a referral and liaison centre for veterans' patients becomes very clear. Another feature of importance is the large proportion of outpatients who are being referred to social service. In many of the case histories it was indicated that veterans coming to the Outpatient Clinic are frequently more in need of practical services than of medical attention. This condition suggests that a greater availability of social work services in the Outpatient Clinics would be not only desirable, but vitally important as an addition to the existing Departmental services.
Table 7. **Referrals for Practical Services**  
*(Shaughnessy Hospital; 1953-4)*

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>No. of Cases (a)</th>
<th>Frequency of Services Rendered</th>
<th>Patient able to do own planning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>At Source</td>
<td>On Referral to Community (b)</td>
</tr>
<tr>
<td>1. Financial assistance</td>
<td>14(8)</td>
<td>3</td>
<td>15(8)</td>
</tr>
<tr>
<td>2. Help in finding living accommodation</td>
<td>8(2)</td>
<td>2</td>
<td>5(1)</td>
</tr>
<tr>
<td>3. Job placement</td>
<td>7(2)</td>
<td>-</td>
<td>5(1)</td>
</tr>
<tr>
<td>4. Referral to community resource or service</td>
<td>9(5)</td>
<td>-</td>
<td>8(1)</td>
</tr>
<tr>
<td>5. Miscellaneous (Housekeeping services, clothing, etc.)</td>
<td>10(3)</td>
<td>7</td>
<td>3(2)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>48(20)</strong></td>
<td><strong>12</strong></td>
<td><strong>36(13)</strong></td>
</tr>
</tbody>
</table>

Source: Compiled from social service records, Shaughnessy Hospital.

(a) Figure in brackets refers to number of outpatients in each group.

(b) Figure in brackets indicates number of referrals to Veterans' Welfare Officers.

Note: Patients discharged before any services given by Medical Social Service, 2.
CHAPTER 3

SOCIAL SERVICE AS DOCTORS SEE IT

To obtain information about the degree of participation of the medical staff in the social service program of the hospital, and to get some material from the personal experiences of doctors in utilizing social services as an aid to medical treatment, a questionnaire was formulated. It covered four aspects of hospital social service: the method of referral preferred by doctors; the kinds of social information found to be most useful by medical staff; the kinds of social service most frequently requested by doctors; and, suggestions for improving the work of the social service department. Each question contained a check list of possible answers, and there was a space provided for alternatives. The purpose of the project was outlined in the opening paragraph of the question sheet, and it was also explained in further detail where it was feasible to see each doctor personally. Doctors answering the questionnaire were not required to identify themselves on the form sheet, but a number of them did so.

In this part of the study, several factors had to be kept in mind, not the least being that the questionnaire would have to be brief, concise, and practical, in order to get the fullest co-operation from the medical staff, who have a great deal of "paper work" in the ordinary course of their work. Another point of importance was that, since this was the first
time such a project had been carried out, the questionnaire was so constructed that it might also contribute to the interpretation of hospital social services, rather than simply surveying the uses that medical staff are making of them in this setting. For this reason, only those things which would normally fall within the function of a medical social service department were included, although provision was made for additional or alternative suggestions, to be offered by the doctors themselves.

In interpreting the results, it is relevant to remember that the inquiry was carried out at the end of the training year for the medical internes, who have most of the direct responsibility, in consultation with resident staff and part-time specialists, for the actual services to the patient. Since the internes had had a year's opportunity to become acquainted with the work of the social service department, they would probably have a wider appreciation of it than a group of internes just beginning their training period.

Altogether, approximately 80 per cent of the doctors who were requested to participate in the survey completed and returned the question forms. The discussion of their responses below is not intended to provide a comprehensive review of how

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1 It would be worth while for the reader, at this point, to turn to Appendix E and see the questionnaire used in the study.

2 Appendix F contains a transcript of the information on the Medical Social Service Department from the Interne's Manual.
doctors use the social service department in this hospital, nor of what the potentialities of the department might be from the point of view of the medical staff. The 25 questionnaires reviewed here serve to bring out enough of the doctors' experience and thinking to suggest what aspects of social work are already accepted and utilized, and what areas require further development.

**Method of Referral to Social Service**

The majority of doctors who answered the questionnaire stated that they did not find the practice of writing requisitions a convenient method of referral to Medical Social Service. Actually, the written requisition, although a requirement, is little used, and a large number of referrals are simply telephoned in by the doctor and received by the social worker on intake duty. The written requisition, which is the normal procedure when doctors are requesting consultation or special tests, such as x-ray, is desirable in medical requests for social service in that it facilitates the work of the medical social service department since the assignment of cases and initiation of action by the social worker can be carried out more readily when the patient's social problem is indicated and his medical condition is made known. These doctors who did not approve of written referrals were ready in every instance to suggest alternatives, either the ones listed on the form, or others of their own.

The method of referral most widely favoured by these doctors was a preliminary referral by telephone, followed by
discussion with the worker who would be taking the case. One doctor stated that sending the patient to the social service office, after a telephone referral might be satisfactory in some cases. Another suggested the use of a modified form of written requisition, requiring only the basic identifying information about the patient. This could be written by the nurse or ward clerk, and forwarded to the department. The case could then be assigned, and the worker in charge could discuss it in detail with the doctor. This particular doctor stated this type of requisition would be less time-consuming than the regular consultation form, and that the social problem could be defined in conference with the social worker. Actually, this could be done, and is being done, even with the present form of written requisition, which is not a rigid requirement, and which allows the doctor to give only as much information as he thinks is necessary at the time. In every instance where the doctors did not approve of the written requisition, the main reason given was that it was time-consuming, and that a duplication of work was involved, since the doctor usually discusses the case with the worker anyway.

Of those doctors who considered the written requisition a convenient method of referral, two indicated no alternatives; three specified that it should be supplemented by discussion with the social worker in charge of the case; and four simply checked discussion with the worker as an alternative, without making any comment.
It would seem from the doctors' overall responses and from their comments that, as a group, they are well aware of the need for a close working relationship with the social service staff; and that they are desirous of an early conference on the case, either as a supplement or as an alternative to the initial requisition for social service, and prior to the social worker's contact with the patient. Such a discussion could serve two main purposes: clarification by the doctor of the reason for the referral, which would include the patient's medical condition and his response to the treatment plan; and, clarification by the worker of her role in the case, so that an integrated plan of treatment could be assured. The need for close co-operation with the medical staff is, of course, recognized by the Medical Social Service staff, and is part of this department's policy. However, in view of the doctors' emphasis on the need for close co-operation, and since social service records do not always show the extent of such co-operation, it would seem desirable to investigate this area further through closer examination.

Social Information

Because social information is so complex and may easily follow in many directions, medical social workers in any setting have to discipline themselves in the selection and condensation of social information which they make available for the use of medical staff. Another point of considerable relevance is that many doctors, accustomed to medical abbreviations,
will not take the time to examine long social entries, even if they were desirable. The question of what information workers should place on the medical file, in this setting, is therefore a very important one.

In the present survey the items included as social information were as follows: patient's family and social relationships; employment history; economic status; patient's plan on discharge; his reaction to his illness; and, home and community resources for his use.

The results indicate that the doctors, as a group, were discriminate in their rating of the comparative value of the different items. Out of the 25 doctors who answered this section of the questionnaire, only three checked all the items, and two of them marked the items by numbers, in the order in which they found the information most useful. The majority checked two or three items; three checked only one item; only one did not check any. (Table 8).

The item of social information most frequently checked was information on the patient's family and social relationships, with 21 out of 25 doctors stating this as one of the most useful areas which they look for in social service reports. Second in frequency on the list was information on home and community resources available for the patient's use, with 17 out of 25 doctors marking this as one of the areas they consider most useful. The items least frequently checked
were employment history, and patient's plan on discharge. Items in the range of "middle frequency" were, the patient's reaction to his illness, and his economic status. If economic status could be considered as part of the patient's home resources, and patient's plan on discharge as part of the total rehabilitation plan, then the item on patient's illness emerges as the area of information doctors ask for least frequently. This is referred to further, below.

Other items specifically added by the doctors, and the frequency of requests for them, were as follows:

a. Family's reaction to patient's illness (2)
b. Wife's attitude towards helping patient, and her ability to do so (1)
c. Friends' or neighbors' opinion of the patient (1)
d. Patient's motivation for rehabilitation (1)
e. Early developmental history (1)
f. The supportive value of social worker's interest, and the patient's response to such help (1)

A number of doctors stated in additional comments that the item "patient's reaction to his illness" was not a social problem, but a medical one, and therefore it was primarily the doctor's responsibility to obtain this information from the patient. On the other hand, the additional suggestions received from the doctors point clearly to the same area of information; for example, the patient's motivation for rehabilitation would surely imply taking into account his reaction to his illness. Similarly, early developmental his-
tory, family reactions to the patient's illness, and the other areas mentioned, cannot well be isolated and considered apart from the patient's reaction to his present difficulties.

On the whole, these responses suggest that there is a wide variation as to the kind of information about patients which doctors expect to get from social workers. Some feel a keen responsibility for obtaining the information themselves; others see the social worker as a valuable resource in their medical planning for the patient. In future research it would be well to explore this area more intensively.

Reason for Referral

The reasons for which doctors most frequently make referrals to Medical Social Service were also developed in a carefully considered list; with provision for other comments. The list contained seven types of services usually performed by medical social workers in a hospital setting:

a. obtaining social history
b. assistance in planning convalescent care
c. helping relatives towards a better understanding of the patient's illness and his needs
d. helping ameliorate patient's anxieties and fears
e. helping patient towards rehabilitation planning
f. assisting patient with financial difficulties
g. helping patient modify unfavourable attitudes
Table 8. Social Information Considered Most Useful
(Analysis of 25 questionnaires, May 1954)

<table>
<thead>
<tr>
<th>Number of Items Checked</th>
<th>Number of Doctors</th>
<th>Information Requested (Frequency)</th>
<th>Total Items Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a  b  c  d  e  f  g  h  i  j  k  l</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>3</td>
<td>3  3  3  3  3  3 - - - - - 1</td>
<td>18</td>
</tr>
<tr>
<td>One</td>
<td>4</td>
<td>3 - 1 - - - - - 1 1 1 -</td>
<td>7</td>
</tr>
<tr>
<td>Two</td>
<td>5</td>
<td>3  2 - - 2 3 - - - - -</td>
<td>10</td>
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<tr>
<td>Three</td>
<td>10</td>
<td>11 1 6 1 5 9 1 - 2 - - -</td>
<td>36</td>
</tr>
<tr>
<td>Four</td>
<td>1</td>
<td>1 - 1 1 - 1 - - - - -</td>
<td>4</td>
</tr>
<tr>
<td>Five</td>
<td>1</td>
<td>1 1 1 1 - 1 - - - - -</td>
<td>5</td>
</tr>
<tr>
<td>Total (a)</td>
<td>(25)</td>
<td>22 7 12 6 10 17 1 1 2 1 1 1</td>
<td>81</td>
</tr>
</tbody>
</table>

(a) One doctor only listed no items as required.

a – f. Items listed on questionnaire:

a. patient's family and social relationships
b. employment history
c. economic status
d. patient's plan on discharge
e. his reaction to his illness
f. home and community resources for his use

g – l. Additional items listed by doctors:

g. early developmental history
h. patient's motivation for rehabilitation
i. family's reaction to patient's illness
j. friends' or neighbors' opinion of patient
k. wife's attitude towards helping patient, and her ability to do so
l. the supportive value of social worker's interest, and the patient's response to such help
There was a wide variation in the responses in this section of the questionnaire, both in the number of items checked by doctors as well as in the particular items checked. This variation seems to indicate that this group of doctors use the Medical Social Service Department for a variety of services; also, that individual doctors make referrals for different services. The doctors were selective in specifying the reasons for which they referred patients to Medical Social Service; only one doctor checked all the items listed, and he marked them in the order of frequency in which he used them as the basis of referral. In this particular list, the item "social history" came first. The majority of doctors specified two, three, or four reasons. In addition, several doctors offered other reasons, not listed on the question form, namely, casework with family, supportive therapy, and job placement.

The highest frequency among the reasons for referral was in the area of discharge planning and convalescent care, with items (e) and (b) most frequently checked. The use of medical social services as a means of facilitating diagnostic and treatment planning was reflected in the frequency of item (a), which came second. It is significant that this area also came first in the analysis of the case records (Chapter 2), with over 50 per cent of the referrals requesting social history. The slight discrepancy may be explained in part by the fact that most of the referrals for social history come from the psychiatric ward, where the number of doctors is com-
paratively small; the results obtained from the analyses of case records and of the questionnaire would not necessarily be the same, since no weighting was given to the responses from the different Medical Departments.

It is significant that items (c), (d), and (g), which together might be considered representative of "direct social work treatment," as contrasted to "facilitating" service, rated a comparatively low frequency. At the same time, a number of doctors commented on these items, the general opinion expressed being that this area is primarily the responsibility of the physician, or that it is best done by the doctor. A few stated that the services listed in these items were definitely not the responsibility of the social worker. One doctor specified that some direct service to patients on the psychiatric ward might be appropriately done by the social worker, but on the general medicine wards this is primarily the doctor's responsibility. Because this particular section of the questionnaire evoked considerable comment, there is some question as to the meaning that the statements might have implied; that is, was the distinction between giving treatment, and aiding the giving of treatment made sufficiently clear by the question, and was it fully understood by the medical staff.

The area of practical services was probably not given sufficient consideration in the formulation of the questions; only one item, (f), can be said to be exclusively in this area. However, the frequency rating for it was approxi-
mately 17 per cent. In addition, one doctor listed as another reason for referral, helping the patient to obtain suitable employment. It should be emphasized again that social work in this setting is in some ways unique. The division of labour between Veterans' Welfare Officers and Medical Social Workers almost inevitably places much of the responsibility for practical services to patients upon the welfare officers. In mental hospitals, and in general hospitals, this responsibility for helping patients with housing accommodation, finding jobs or training for them, financial assistance, and so forth, would fall largely on social workers.

From the overall responses obtained in this question, it would appear that doctors are keenly aware of the contribution that the social service department can make in the area of diagnostic and facilitating services, such as obtaining social histories, assessing home conditions to determine their suitability for the patient's convalescence, and generally assisting the patient in rehabilitation planning. In the area of interpreting illness to the patient and relatives, however, the doctors show surprisingly little inclination to request this service from the social service department. Again, the question is raised as to whether the distinction between giving treatment, and aiding the giving of treatment has been made sufficiently clear.
### SOCIAL SERVICES REQUESTED BY DOCTORS

(Frequency of Reasons for Which Referral made to Social Service Department: 25 doctors)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Reason for Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Social history</td>
</tr>
<tr>
<td>10</td>
<td>Assist in planning for convalescent care</td>
</tr>
<tr>
<td>15</td>
<td>Help patient towards rehabilitation planning</td>
</tr>
<tr>
<td>20</td>
<td>Financial assistance</td>
</tr>
<tr>
<td>25</td>
<td>Job placement</td>
</tr>
</tbody>
</table>

**DIAGNOSTIC AID**

- Social history

**FACILITATING SERVICES**

- Assist in planning for convalescent care
- Help patient towards rehabilitation planning

**PRACTICAL SERVICES**

- Financial assistance

**DIRECT TREATMENT SERVICES**

- Help ameliorate patient's anxieties and fears
- Help patient modify unfavourable attitudes

<table>
<thead>
<tr>
<th>Number</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Case work with family</td>
</tr>
<tr>
<td>10</td>
<td>Supportive therapy</td>
</tr>
<tr>
<td>15</td>
<td>Listed items (questionnaire)</td>
</tr>
<tr>
<td>20</td>
<td>Additional items listed</td>
</tr>
</tbody>
</table>

**Figure 2.** Social services requested by doctors.
Suggestions for Improvement

Five possibilities for changes in the present establishment of the social service department were listed as considerations towards making the work of the department more effective from the point of view of the medical staff. These suggestions were based on observation of the existing methods of organization and functioning of the Medical Social Service Department at Shaughnessy and comparison with the practices of comparable departments in other hospitals. The aspects included only those changes which might be in the realm of possibility, so to speak, for the particular setting. Is there a need for more information available about the services of the department among medical staff? Do the medical staff see a need for a closer working relationship between the two services? Would it be desirable to have a social worker allocated to each hospital ward for greater availability of social service? Is it desirable to have a social worker available in the Out-Patient Department? Should social workers participate in daily ward rounds? These were the specific suggestions listed for consideration.

About half of the doctors included in the survey indicated that the availability of a social worker in the Out-patient Department would be a practical improvement from the medical standpoint. In the Outpatient service of the Neuro-psychiatric Clinic this service already exists, and the medical staff from this Department were alert to point this out. Second highest in acceptance was the suggestion about closer
co-operation between Medical Social Service staff and doctors, just over one-third of the doctors checking this item. While it is recognized that there are variations in the degree of co-operation between the social service staff and doctors on the individual doctor-worker relationship basis, it is significant that the doctors, as a group, are asking for closer co-operation between the two services. (This request was also made in the area of methods of referral, above, where the medical staff requested discussion with the worker following referral of the case).

Two other suggestions which gained wide support from the medical staff were: making more information available about the services of the Medical Social Service department, particularly in the first week of the medical internes' training program (this aspect was not included on the questionnaire, but was mentioned in the additional comments offered by doctors); and the allocation of a social worker to each ward. It is significant that the first point should have gained such wide support, since the survey was done at the end of the internes' training period when they had already had some opportunity to learn about the work of the social service department. It is well to remember, however, that the only "formalized" orientation these doctors receive concerning the work of the Medical Social Service Department is the information contained in the Interne's Manual, referred to earlier, above. The Interne's Manual, compiled in 1950, contains a section on the work of the Medical Social Service Department. This brief account is directed mainly at giving
some guidance to the beginning doctor in recognizing superficial signs of anxiety in the patient, and stresses the importance of early referral of such patients to social service. In view of the growth and development of the Medical Social Service Department in recent years, it would seem desirable that this section of the *Interne's Manual* be revised and brought up-to-date to give a more adequate interpretation of medical social work.

The idea of a social worker allocated to each ward was seen by some doctors as a definite improvement, in that the worker would be more readily available to the doctor on the ward; also, because it would be the same worker at all times, she could have a greater opportunity of interpreting the service of the department on the wards for which she was responsible. On the other hand, some doctors stated that this would be a definite liability to the medical service, since certain social workers appear to have a better approach to certain types of patients and use should be made of this rather than use of one social worker for all the patients on the ward. Again, there is room for more research which would interpret the various applications of these ideas.

Doctors, generally, disapproved of the idea of social workers participating in daily ward rounds, and only two indicated this as a possible means of improving the work of the department. From personal conference with a number of doctors who did not approve the suggestion, it was learned that the main reason for this is that these rounds are already attended
by a number of medical personnel, and the inclusion of the
social worker would probably only add to the patient's anxiety
and bewilderment at such a "grand parade."

A number of individual recommendations to improve the
work of the Medical Social Service Department were made by the
medical staff. One of these was that social service reports
to doctors should be made at more frequent intervals when dealing with a case, rather than reporting when the case is closed. Another suggestion was a request for social service weekly conferences available to medical staff, and particularly to the doctor in charge of the case to be discussed. Case conferences in the social service department are already a regular feature of the weekly staff meetings, but this is not generally known among medical staff, as indicated in this survey. The inclusion of medical staff in these discussions is a feature worthy of consideration by the administration of the Medical Social Service Department, and by Hospital administration generally.

Yet another recommendation made was in the area of helping relatives take greater responsibility for the care of the patient, particularly wives caring for their husbands at home, when the period of active treatment was completed and further hospital care was not indicated. The doctor stressed the invaluable service the social worker could give in helping the patient's relatives -- particularly the closest ones -- to gain a sense of appreciation of the patient's need to be
part of the family, and his sense of rejection at being "abandoned" by his family if he is merely left in the hospital. The other factor stressed was that convalescent facilities for the chronically ill are so limited even with the ample provisions of the Department of Veterans' Affairs; consequently, the social worker by helping the family accept the patient at home could make the facilities of the Hospital more available for the active convalescent patients and for those patients who require institutional care on medical grounds.
CHAPTER 4

RETROSPECT AND PROSPECT: SOME IMPLICATIONS

In the preceding chapters of this study an attempt has been made to examine the character of social work at Shaughnessy Hospital against the background of developmental history. At the same time, considerable interpretation of medical social work method and function, as it has developed in the broader field, has been given. Throughout the study, those areas of social work that are extensively utilized in this setting have been pointed out through an examination and analysis of case records, and through a survey of doctors' opinions of the existing program of social service; at the same time, potential areas for further development of the program have been cited. It would be neither practical nor appropriate to recapitulate the findings: they have been presented precisely and elaborately, if somewhat critically. But there are some obvious implications arising from the findings, with specific interest for the three groups of personnel most directly concerned with an effective medical social work program: social work practitioners, medical staff, and administration.

Implications for Social Workers

The immediate responsibility of the social worker, as a practitioner, lies in bringing to the patient group the
most effective service possible, even within the existing limitations, of which he may be well aware. The lack of adequate numbers of personnel does not preclude the professional obligation of continuous evaluation of existing procedures and practices, and the refinement of these practices to the end of serving the patient group in an ever-increasingly effective manner.

Specific areas for desired improvement have been suggested by the findings presented in this study. The recommendations below are based on these findings, and bear directly on the very core of social work:

(a) There is a need for improvement of recording techniques in this setting. This includes more dynamic case histories which show the worker's active participation, his diagnostic assessment of the situation, and the plan of treatment. A systematic reviewing of case records by the individual worker can serve a useful purpose in checking the need for continuous services and follow-up of recommendations made to medical staff. Finally, the value of recording the disposition of the case cannot be too strongly emphasized: whether continued casework services can be given or not, it is the social worker's professional responsibility to record this in the file with the reasons for his decision clearly indicated.

(b) Closer co-operation with medical staff is encouraged. This recommendation arises primarily from the suggestions made by medical staff, since the degree of co-operation which already exists could not easily be determined from an analysis of case
records, and since it was not the central focus of this inquiry.

(c) If social workers are not to restrict their services to an environmental level, and to go beyond the specific request made by the doctor at referral, increased interpretation to the medical staff of medical social service will be necessary. The patients' problems being what they are, as shown by some of the material assembled in previous chapters, it is clear that some patients need extensive or continued help, and much could be done on the individual doctor-worker basis to gain a wider appreciation of such needs.

Implications for Medical Staff

The recent inclusion of social service programs in Departmental hospitals is intended to improve further the quality of medical care for veterans, by relating social factors to the illness, and by treatment of particular social problems connected with medical care. While it is recognized that the work of making the particular services of the Medical Social Service Department known to the hospital staff is primarily the responsibility of administration and of the social service staff, the extent to which these services are utilized in behalf of patients depends directly upon the medical staff, who have overall responsibility for treatment.

At least one point of importance emerges from the material presented in this study: there appears to be some question as to whether social workers in hospitals concern themselves with the giving of treatment, or aiding in the giving of
treatment. There is surely no doubt about who is giving, or directing, the treatment. But, from the social work standpoint, it is important that doctors, in their treatment plans for patients, make the fullest use of available social work services to the maximum benefit of the patient, who is, after all, not merely "a white male" with a diseased organ, but a human being -- an anxious father whose illness imposes economic dependency on his family, an elderly hermit whose pattern of self-sufficiency is threatened by infirmities of old age, a young sailor who has found the discipline of service life too great a strain and who has sought escape by self-destruction. These problems are not left behind when the hospital doors close upon the "patient," as doctors are well aware. Social workers cannot solve all such problems, but they can assist in solving those that are brought to their attention, by a careful investigation of the social and personality factors in the particular situation, by an application of special skills and knowledge of the dynamics of human behaviour, and the appropriate use of available community resources.

A second, and more specific recommendation, lies in the area of timing referrals to the social service department. If social work services are to be most effective, referrals must be made as early as possible by the doctor in charge of treatment, so that the social plan may be made on a sound basis, and so that it might be integrated with the total treatment plan.
Implications for Administration

The greatest impetus to the development of the medical social service program within the Treatment Services Branch of the Department of Veterans' Affairs was the recognition of the service at top levels of administration; it is ultimately at this level that further improvements can be implemented. In the course of this report many lines of direction have been indicated for the overall future development of the medical social service program at Shaughnessy Hospital. Some of them deserve special emphasis:

(a) Continued support of the program for staff development.

(b) Extension of social service to the Outpatient Department on a full-time basis, as soon as there are sufficient personnel.

(c) Inclusion of social service staff in the orientation program of medical internes, so that they might be helped to become more aware of what social workers are doing and what they can do.

(d) Revision of the section on Medical Social Service in the Interne's Manual.

(e) Support and encouragement of experimentation and pilot research, particularly in the areas of more dynamic recording, and in the allocation of social work personnel.

(f) Continued support of close working relationships between the social service personnel and doctors, and among the various professional bodies and services in the hospital generally: at the same time, there is a need for closer examination
of the possibilities for greater co-ordination of efforts of the treatment team.

Conclusion

The social service department at Shaughnessy Hospital has maintained a continued program of medical social casework services through its early years of development, and has made steady progress in the expansion of services to all parts of the hospital. This progress has been made possible through the combined efforts of administration, and medical and social service staff. The medical staff at Shaughnessy show a continuing interest in the new service, and are using it to complement the medical care of patients when they recognize the existence of social problems as obstacles to the medical treatment. Because of the special characteristics of the veterans' patient group, some types of service of the department are used more widely than others, and social work has developed in these areas of service to a greater extent. The greatest use that has been made of social service to the present time, is as a diagnostic aid and as a facilitating service to medical treatment, but there is much room for the development of social work as a direct treatment service.

It would obviously be desirable to have the medical social service department used in all capacities. This is being gradually realized as the staff of the department is increased to make services more available generally, and as there is greater interpretation of the existing and potential services that medical social workers can give. But there is plenty of
room for further interpretation, sharing in planning, possible research or experimentation projects for the development of new areas of social services in this hospital, and research which will further clarify some of the pros and cons of existing services and the opinions of the various professions and practitioners in the veterans' hospital teams. It is reasonable to hope that some of these areas and possibilities have been opened up by the present study.
APPENDIX A: LINES OF PROFESSIONAL RESPONSIBILITY
TREATMENT SERVICES BRANCH, DEPARTMENT
OF VETERANS AFFAIRS

Minister
Department of Veterans' Affairs

Deputy Minister

Director General
Treatment Services

Director
Medical Social Services

OTTAWA

SHAUGHNESSY HOSPITAL

Senior Treatment Medical Officer
(Hospital Superintendent)

Hospital Administrator

Research

Assistant Superintendent

Education

Auxiliary Services

CLINICAL SERVICES

Medicine
Surgery
Radiology
Dentistry
Pathology
Anesthesia
Eye, Ear, Nose and Throat Services

Internal Medicine
Int. Med. (T.B.)
Dermatology
Neurology
Psychiatry
Physical Medicine
Medical Social Service
<table>
<thead>
<tr>
<th>Type of Hospital and Location</th>
<th>Operating Capacity</th>
<th>Social Work Staff (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Active Treatment Hospitals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp Hill Hospital, Halifax, N.B.</td>
<td>9082</td>
<td></td>
</tr>
<tr>
<td>Lancaster Hospital, Fairville, N.B.</td>
<td>550</td>
<td></td>
</tr>
<tr>
<td>Veterans' Hospital, Quebec, P.Q.</td>
<td>450</td>
<td></td>
</tr>
<tr>
<td>Queen Mary Veterans' Hospital, Montreal, P.Q.</td>
<td>275</td>
<td></td>
</tr>
<tr>
<td>Ste. Anne's Hospital, Ste. Anne de Bellevue, P.Q.</td>
<td>700</td>
<td>8(1)</td>
</tr>
<tr>
<td>Sunnybrook Hospital, Toronto, Ont.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westminster Hospital, London, Ont.</td>
<td>1650</td>
<td></td>
</tr>
<tr>
<td>Deer Lodge Hospital, Winnipeg, Man.</td>
<td>1522</td>
<td>4(3)</td>
</tr>
<tr>
<td>Veterans' Hospital, Saskatoon, Sask.</td>
<td>850</td>
<td>3(1)</td>
</tr>
<tr>
<td>Colonel Belcher Hospital, Calgary, Alta.</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>Shaughnessy Hospital, Vancouver, B.C.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans' Hospital, Victoria, B.C.</td>
<td>1100</td>
<td>7(1)</td>
</tr>
<tr>
<td><strong>2. Active Convalescent Facilities</strong></td>
<td>365</td>
<td></td>
</tr>
<tr>
<td>Ridgewood H &amp; O Centre, Saint John, N.B.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans' H &amp; O Centre, Senneville, P.Q. (Ste. Anne's)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rideau H &amp; O Centre, Ottawa, Ont.</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Divadale H &amp; O Centre, Leaside, Ont. (Sunnybrook)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans' Convalescent Hospital, Calgary, Alta. (Colonel Belcher)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Derby H &amp; O Centre, Burnaby, B.C.</td>
<td>215</td>
<td></td>
</tr>
<tr>
<td><strong>3. Special Institutions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans' Hospital, St. Hyacinthe, P.Q.</td>
<td>200</td>
<td>2(1)</td>
</tr>
<tr>
<td>Western Counties Veterans' Lodge, London, Ont. (Westminster)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Institutions Designed Primarily for Veterans' Care Cases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Red Chevron, Toronto, Ont.</td>
<td>327</td>
<td></td>
</tr>
<tr>
<td>Bellvue Veterans' Home, London, Ont.</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>Veterans' Home, Winnipeg, Man. (Deer Lodge)</td>
<td>30</td>
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</tr>
<tr>
<td>Veterans' Home, Regina, Sask.</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>Veterans' Home, Edmonton, Alta.</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Hycroft, Vancouver, B.C. (Shaughnessy)</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9774</td>
<td>42(8)</td>
</tr>
</tbody>
</table>

(a) Vacancies at this date shown in brackets

★ The Operating Capacity for these institutions is included in the figures for the Hospital shown in brackets

★★ H & O: Health and Occupational Centre

Source: Compiled from D.V.A. Head Office Monthly Statistics Reports.
### APPENDIX C. D.V.A. TREATMENT CATEGORIES (As at April, 1953)

<table>
<thead>
<tr>
<th>Section</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Pensionable Disability - Active Treatment</td>
</tr>
<tr>
<td>5</td>
<td>Sequelae of Pension - Venereal Disease</td>
</tr>
<tr>
<td>6</td>
<td>North West Field Force - 1885</td>
</tr>
<tr>
<td>6</td>
<td>Pension Section 48 or 49 of the Pension Act</td>
</tr>
<tr>
<td>6</td>
<td>Pensionable Disability - Newfoundland</td>
</tr>
<tr>
<td>6</td>
<td>Merchant Seamen, Auxiliary Service Personnel, Fire Fighters (Overseas), Air Raid Wardens, Voluntary Aid Detachment Personnel, Civilian Government Employees (Wartime)</td>
</tr>
<tr>
<td>6</td>
<td>Special Operator (Overseas Air Crew)</td>
</tr>
<tr>
<td>6</td>
<td>Injured on Flight Duty</td>
</tr>
<tr>
<td>6</td>
<td>Red Cross and Welfare Workers in the Far East</td>
</tr>
<tr>
<td>6</td>
<td>Non-Permanent Active Militia and Reserve Army Personnel</td>
</tr>
<tr>
<td>7a</td>
<td>Newfoundland Special awards</td>
</tr>
<tr>
<td>7b</td>
<td>Permanent Force and R.C.M.P. for Poor Condition</td>
</tr>
<tr>
<td>8</td>
<td>Hospitalization for Pensioner in Jail</td>
</tr>
<tr>
<td>9</td>
<td>Treatment within 30 days of Discharge: Disability existing at that time</td>
</tr>
<tr>
<td>10</td>
<td>Trainees</td>
</tr>
<tr>
<td>11</td>
<td>Permanent Force: Disability existing at time of Discharge</td>
</tr>
<tr>
<td>12</td>
<td>War Veterans' Allowance Cases requiring active remedial treatment</td>
</tr>
<tr>
<td>13</td>
<td>Veteran earning less than $900 (single); $1800 (married)</td>
</tr>
<tr>
<td>14</td>
<td>For Psychiatry</td>
</tr>
<tr>
<td>15</td>
<td>Institutional or Custodial Care of non-pensionable Venereal Disease</td>
</tr>
<tr>
<td>16</td>
<td>Pensioner when uncertainty exists on Diagnosis</td>
</tr>
<tr>
<td>17</td>
<td>Staff - Infectious Disease Case</td>
</tr>
<tr>
<td>18</td>
<td>Persons referred by the Department of National Defence</td>
</tr>
<tr>
<td>19</td>
<td>Persons referred by the Royal Canadian Mounted Police</td>
</tr>
<tr>
<td>20</td>
<td>On request by financially responsible authority</td>
</tr>
<tr>
<td>21</td>
<td>On request of any department of the Government of Canada</td>
</tr>
<tr>
<td>22</td>
<td>At the request of Imperial or other Allied Government</td>
</tr>
<tr>
<td>23</td>
<td>Under Provincial Hospital Insurance (Veterans only)</td>
</tr>
<tr>
<td>24</td>
<td>Too ill to turn away. Admitted and charged.</td>
</tr>
<tr>
<td>25</td>
<td>In hospital. Diagnosis changed to non-eligible condition</td>
</tr>
<tr>
<td>26</td>
<td>Hospitalization for Research Purposes</td>
</tr>
<tr>
<td>27</td>
<td>Pensions Medical Examination - for observation</td>
</tr>
<tr>
<td>28</td>
<td>Quarters and Rations for Pensions Medical Examination; for D.V.A. examination in reference to prosthetic appliance; for examination required by War Veterans' Allowance Board; for examination of Prisoner of War</td>
</tr>
<tr>
<td>29</td>
<td>Institutional Care</td>
</tr>
</tbody>
</table>

Source: Compiled from D.V.A. Treatment Regulations as contained in The Veterans Charter and Amendments.
APPENDIX D. FUNCTION OF MEDICAL SOCIAL SERVICE IN D.V.A. HOSPITALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

USE OF MEDICAL SOCIAL WORK SERVICES
SHAUGHNESSY HOSPITAL

In co-operation with the Medical Social Service staff I am studying a group of cases in which social services were requested as an aid to the medical care of patients.

It would be very helpful to have some suggestions from the medical staff as to what aspects of social services are most useful in facilitating medical care. Your answers to the following questions and any other comments you might make will provide a valuable source of reference for my study.

A.N. Barsky
U.B.C. School of Social Work

1. Do you find the writing of requisitions a convenient method of referral to Medical Social Service? Yes____ No____

As an alternative, do you prefer any of the following?
- telephone
- discussion with the social worker
- sending patient to the Social Service office

Other

2. What kinds of social information do you find most useful?

- patient's family and social relationships
- employment history
- economic status
- patient's plans on discharge
- his reaction to his illness
- home and community resources for his use

Other

3. For what reasons do you most frequently make referrals to Medical Social Service?

- social history
- assistance in planning convalescent care
- helping relatives towards a better understanding of the patient's illness and his needs
- to help ameliorate patient's anxieties and fears
- helping patient towards rehabilitation planning
- for financial assistance
- helping patient modify unfavorable attitudes towards the community on his return home.

Other

4. What suggestions would you make to improve the work of the Medical Social Service Department?

- more information available about the services of MSS
- closer co-operation between MSS staff and doctors
- a social worker allocated to each ward
- a social worker available in O.P.D.
- participation by social worker in daily ward rounds

Other

Other Comments (Please use reverse side if necessary)

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APPENDIX F: SOCIAL SERVICE INFORMATION FOR MEDICAL INTERNES

(As given in the Interne's Manual, Shaughnessy Hospital, 1950).

Medical Social Workers assist patients and their families to develop and use their personal capacities to deal with problems in their social environment. They work as part of the treatment team with the physician as its leader.

Referrals to our Department may be instituted by anyone but medical social case work service is never commenced prior to consultation with the doctor in charge of the patient.

Our Department is primarily concerned with what the patient's illness and its implications means to him and his family and ways in which they may be helped to work through their feelings about it.

The following are a few examples of patients exhibiting types of behaviour which could be referred:

(1) The tense, anxious, bewildered or even the "good" patient, who is not responding to treatment.

Such people may be disturbed about -- their own particular illness...home worries...prolonged hospitalization with all its implications...crippling or disfigurement...surgery...their family's or the community's attitude toward them with their illness...fear of leaving the protective environment of the hospital...death.

(2) The belligerent patient who persists in going A.W.L., indulges excessively in alcohol...refuses to co-operate...disregards regulations...will not adhere to his diet.

Referrals may be made by completing a blue form located on all wards, the 514A, or, in case of emergency, a telephone call to our offices.

An early referral is appreciated in order that we with you, and possibly one of the community agencies, may assist the patient to work through his anxieties to the point where he once again may accept and benefit from medical services provided for his treatment and convalescence.
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