THE SOCIAL SERVICE DEPARTMENT OF THE VANCOUVER GENERAL HOSPITAL

Its History and Development, 1902 - 1949.

by

Elizabeth Anne Collier

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Abstract

This study portrays the Social Service Department of the Vancouver General Hospital from the first days of its institution under the Women's Auxiliary, through the course of its growth to the present time. The history has been divided into three periods; the first, under the Women's Auxiliary; the second, after integration into the hospital administrative structure, and the introduction of trained workers; and finally, the present organization. An evaluation and comparison by standards has been included, together with suggestions for improvement of existing services.

The Vancouver General Hospital has consistently maintained an "A" rating for medical service to patients. The Social Service Department is only one of the services offered by the hospital, and is not yet recognized as an essential component of the medical team. The study of its development explains the nature of the traditional ties from which the department is endeavoring to emancipate itself. The present policy is to build a gradually strengthening base upon which a truly professional service will be recognized, appreciated and sought.

In order to obtain a picture as complete as possible, early documents, reports, records and files, both from the Hospital and from the Women's Auxiliary, have been studied. Information was also secured from interviews with persons concerned with the department in the past and present. The existing department has been studied by personal observation and through contacts made while working in this setting.

Inadequacies and problems which hamper the service have been revealed in the study, but also, there is indication that the department is healthily aware of these, and is planning its future with care. There is room for much interpretation of the profession of social work to the medical and administrative staff, and to the community, in order that full understanding and support may be obtained. Likewise, doubled staff will be required before the department will be able to operate as it would wish. There is a cumbersome involvement with administrative and clerical duties, particularly in Outpatients' Department, which will need to be eliminated before the staff may be free to perform its casework function.

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I should like to convey my sincere appreciation to the members of the Vancouver General Hospital who have been of assistance in accumulating material for this study. In particular, I should like to thank Miss Olive Cotsworth, R.N., Director of the Social Service Department; Miss Eleanor Bradley, Casework Supervisor of that Department, and Mr. G.E. Masters, Assistant Director of the Hospital for the time and information which they generously gave.

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Chapter I

Development under the Women's Auxiliary (1902 - 1926).

The remark has been made that Vancouver must have had a healthy infancy, for there was no public hospital until 1888. Medical care, when required, was provided by the Canadian Pacific Railway, in its emergency building. As the population increased and multiplied, reaching five thousand in 1887, the need for a civic hospital was recognized, and the City Council authorized the erection of a building in that year on Cambie Street. This was to consist of a single ward of ten beds, for men only.

The city continued to expand, and by 1902 the population reached 30,000. Hospital facilities were inadequate for the growing community, and plans were begun for new construction at the present site in Fairview. In 1902 the hospital was incorporated, by an act of the provincial government, and its management was placed under a Board of Directors.[1] By concentrated work directed to the hospital construction, buildings were completed in 1906.

In these original buildings much of Vancouver's early history was developing. The Children's Aid Society, the University of British Columbia, the Old People's Home, the City Analyst, the Anti-T.B. Society and the City Relief Department each found quarters there in turn. There were many concurrent developments in the social field, including St. Luke's Home, which called itself "Vancouver's First Social Service Centre" (1888); the

1. The "Vancouver General Hospital Act" was drawn up under the provisions of the "Private Bills Act", and has been on the floor of the House for revision only twice. The second occasion was in February, 1950, when the Act was completely revised. The new Act has not yet been published, but it provides for a more flexible administration. The by-laws have been cut, and more power has been given to the Board of Trustees (formerly called the Board of Directors). The powers given to the hospital are contained within this act of incorporation.

Salvation Army Rescue Home for Girls (1888); the Young Men's Christian Association (1890); Alexandra Nursing Home (1892); St. Paul's Hospital (1894); the Local Council of Women (1894); the Young Women"s Christian Association (1897); the Children's Aid Society (1901); the Victorian Order of Nurses (1901); and the City Relief Department (1906), with some of its work done by the Friendly Aid Society. These were noteworthy community resources at the time when Vancouver General Hospital was newly born.

Vancouver had experienced a hectic phase of development in its brief history. The first decade of the century was one of intense depression, after the wild days of the gold rush era; facilities for social service were severely taxed by unemployment and destitution. Prosperity returned after 1908 and again the city took a new lease on life. It was in this community that the Vancouver General Hospital Social Service Department had its start.[1]

The Social Service of the Women"s Auxiliary.

Medical Social Service Departments usually grew from small beginnings. In Canada, many developed from the work of a nurse who became interested in the social needs of her patients; others developed under the nursing staff as such; others were established under the hospital administration directly; and still others grew from work initiated by volunteer groups interested in the work of the hospitals. The latter was the case with the Vancouver General Hospital, where, in 1902, the first Womens' Auxiliary was formed, under Lady Charles Hibbert Tupper. Finding increasing interest in their work, they continued their "Social Service Department" until it became an integral part of the hospital. At first they supplied and repaired linen and gowns, equipment and appliances, books and similar

No 1890

1. Much of the above material was taken from the interesting article, Vancouver"s Early Days and the Development of the Social Services. Lilian M. Nelson, (City Relief Department), Vancouver May 1934. (typescript).

'comfort', and performed other miscellaneous functions. They were an active body, and it was they who canvassed the city to get the voters to the polls to vote on the proposed new hospital in 1905. They conducted annual tag days for funds, and undertook much of their work in response to direct requests from the Board of Directors of the hospital. By 1910, however, the burden of work became too great for the volunteer group, and disbandment was contemplated. The Women's Auxiliary had been providing the hospital with supplies, had made loans to the Board, and had paid bills of some patients occupying endowed beds. In 1911 their financial position was precarious and they appealed for help. As the Medical Superintendent of the hospital did not wish to lose such valuable workers, funds were secured after careful investigation and information from other hospitals, for the commencement of social service work within the hospital. A share of the costs of the department were to be borne by the hospital, and the remainder by the Women's Auxiliary.

Early Social Service within the Hospital.

The year 1912 marks the beginning of the social service department within the hospital. Miss Macdonald, who had had experience and training in American cities was engaged as the 'social service nurse', and was supplied with an office and telephone in the hospital. Her salary was paid by the Women's Auxiliary from the proceeds of the tag days. Her duties included follow-up work in the homes after the patient's discharge - a car was provided - and attendance at the outdoor clinics. The case load increased steadily through the war years, and the Annual Report of 1914 states that the work increased 200 per cent.[1]

The "The general purpose of the Social Service Department is to investigate and to assist needy cases among the sick and convalescing poor of the city who have been patients in hospital. This assistance is first

1. It is not clear whether this was estimated on the cost involved or the number of patients served.

directed along the lines of improving the living conditions .... and, wherever possible, placing the needy ones in a position to become self-supporting."[1]

Here was some real recognition of the patient's need to help himself. The visits to the public wards are described where the nurse hears "many sad stories and finds opportunity to help .... the sick mother in very poor circumstances, who, besides combatting an illness, has the ever present anxiety regarding food and clothes for children at home. Sometimes we find both parents ill and temporary arrangements have to be made promptly for the care of the children." Particular concern is likewise expressed for the homeless man: "there is grave need in our city for a convalescent home, the public wards are so crowded that he is almost urged out in order to make room for a more needy one. Arranging for the care of such is no small part of our work. While the city relief office assisted with cases brought to their notice, it is difficult for these officers to know the actual needs of many patients leaving Hospital.... a personal interest in this work is necessary for its success."[2] Although emphasis was upon the philanthropic approach, there was also an awareness of social responsibility, noteworthy for the times. Regarding the volume of work, the statistical report lists 34 new cases, 71 home visits, 240 ward visits and 86 office interviews.

In the Annual Report for the year 1918 an additional duty of the social service department may be noted: fifteen babies were "adopted into good homes and doing well." The adoption placements were made directly by the hospital worker. The Womens' Auxiliary was likewise concerned about

1. Annual Report of the Vancouver General Hospital, 1916. p. 20.
2. Ibid., p. 21

the "Drug Habit", which was brought to their attention by the social service nurse who suggested that the authorities should"take stringent measures." The worker and the Auxiliary were community-minded, and vitally interested in the field beyond the hospital walls. They provided for five mothers and seventeen children to go to Alexandra Orphanage Fresh Aid Camp.

In 1919 another development took place when the 'social service nurse' was allowed to make a survey of the Outpatients' Department, and subsequently took charge of that department. Although this might not have been a duty to be expected of a social service department, it would indicate that the social service was becoming a more integral and useful part of the hospital, in the eyes of the hospital authorities.

By 1920 the volume of work was so great that assistance was required. It was deemed advisable to reorganize the department and to coordinate the work with that of the hospital. For this undertaking, Miss E. Boultbee, who had taken a special course in social service work in New York and Boston, was placed in charge as Director of the "Social Service Department", under the direction of the Hospital Superintendent and the Director of Nursing. The reason for the tie with the nursing department is not explained, but was probably due to the fact that nurses were still performing the social service work. The department was reorganized along more modern lines, and its scope was expanded. Clinics were increasing in size, and constant adjustment became necessary to handle the top-heavy structure. Unemployment was a major concern in the city and, consequently, work in the Outpatients' Department increased rapidly. It was necessary to increase the staff to three, and a secretary was engaged to keep the records. The statistics for the year 1921 record 1549 ward visits, 1032 home visits, 12 children adopted, and a total of 4765 patients treated at

Outpatients' Department, which is atremendous increase since 1916.

Disbandment of the Women's Auxiliary.

During this period, the Women's Auxiliary was still supporting the social service work of the hospital, which it considered its chief concern. In addition, it continued with other work, which included providing hospital supplies and equipment, and conducting tag days to procure funds. However, receipts from the annual drives were becoming strained. By 1924 it was necessary to request the Hospital Board to share the salaries of the social service department, which it did. In 1925 the Women's Auxiliary was again able to pay the salaries, but, in 1926, re-appealed to the board for assistance. The board's response was that if it were to be responsible for the salaries in the social service department, "the control must be vested in the hands of the Board's Executive Officers, as the Directors were unable to delegate direction to other than its Executive Officers when assuming financial responsibility."[1] The social service department was thereby absorbed into the hospital on December 31st, 1926. On that date the impoverished Women's Auxiliary disbanded, after twenty-four years of effort concentrated chiefly on social service to the hospital.

The era during which the Women's Auxiliary maintained the social service department had been an important one in the development of the hospital. From a tiny beginning it had grown to a large organization and plans for extensions were still necessary. In 1906 when the hospital moved to its present location in Fairview it had a capacity of fifty beds; in 1926 it had nine hundred, with plans for construction already authorized to increase the capacity to fourteen hundred beds. Five buildings were in use in 1926: the Main Hospital, the Twelfth Avenue Annex; the Infants'

1. Annual Report of the Vancouver General Hospital, 1926. p. 18

Hospital, the Isolation Hospital and the Heather Street Annex. Construction of the Maternity Building and the Private Ward Pavilion had been authorized. When completed, this would extend the hospital area over four city blocks, spreading from Tenth Avenue to Twelfth Avenue; and from Heather to Laurel Streets. The numbers of inpatients served increased from 857 in 1903 and 8,713 in 1916 to 15,224 in 1926; there were 517 outpatients in 1916, and 4,515 in 1926, with accommodation still strained. Staffs, likewise had increased from 10 doctors, 26 nurses and one 'social service nurse', in 1916, to 17 doctors (11 resident, 13 consulting staff, 43 attending staff), 352 nurses (including 290 students) and two 'social workers' in 1926.

The social service department, although small, was by this time firmly established within the hospital setting. Its staff was not professionally trained in social work, and its service was on the environmental level. Its aim had been to keep the patient"s welfare constantly in mind. The interest of the Women's Auxiliary had been mainly philanthropic, and this approach was reflected in the service given.

The Women's Auxiliary to the Main Hospital was formed in 1930, and continues to-day as an active auxiliary body, cooperating with and assisting the social service department and the hospital as a whole. Responsibility for maintaining the social service department, which is rightly that of hospital administration, no longer rests with the Women's Auxiliary which is thereby able to function in an auxiliary capacity. Its services are concentrated in the Outpatients' Department and there is still room for increased volunteer activity in the various other departments of the hospital.

Chapter II

Development under the Hospital Administration (1927 - 1949).

Integration into the Administration of the Hospital.

The second phase of development of the Social Service Department, Vancouver General Hospital began with its integration into the hospital administration in 1927 and the disbandment of the Women's Auxiliary. At this time the staff consisted of two 'social service nurses' and a secretary to handle records. The function was not changed, and work carried on as before, chiefly in connection with the Outpatients' Department. This department was serving more patients than ever before, as would be expected during these years of economic depression.

By 1930, the year in which the Women's Auxiliary to the Main Hospital was formed, it was necessary to reorganize the Outpatients" Department. The 'social service nurse' was still responsible for admitting patients to this department. She interviewed each to establish eligibility and prepared medical charts for these patients. Some attempt was made to define the function of the social service department and to interpret its position to the other hospital personnel. The stated function was "to supplement medical treatment of a patient with social treatment, through clinic, ward or home, and aid the physician through a knowledge of the patient's home condition, or point of view which require adjustment, to make medical treatment more effective... Other services ... are included in activities which embrace a knowledge of community and medical resources, an understanding of the patient's medical and social needs, and the in-

terpretation of pertinent facts to the hospital, the patient and the community."[1] Services included boarding of children, infants, mothers and convalescents; adoption of infants (the procedure of the Children's Aid Society was followed); transportation from hospital; securing of material aids - braces, crutches, wheel chairs, or clothing - arranging blood transfusions for indigent patients, and supplying reports on patients to various organizations which required them. The department worked closely with other community agencies particularly in matters concerning medical reports to the City Relief Office; psychiatric reports to the Children's Aid Society, with reference to a child's adoptability; and arranging for accommodation or placement for indigent patients. There was close cooperation, as well, with other hospital departments when treatment was required for indigent patients.

This great variety of tasks assumed by the social service nurse was possible only because service was still on an environmental level, and because assistance was available from the Women's Auxiliary volunteers.

By 1931 the full impact of the depression was being felt and work doubled in the Outpatients' Department with 15,412 consultations recorded for the year. Mrs. Rae Gordon (R.N.) was in charge of the social service department, and Miss O. Cotsworth (R.N.) was placed in charge of the Outpatients' Department. These nurses expressed much concern about the fact that patients were increasingly from the younger groups. In the Annual Report for the year the remark is made that "six or seven years ago the majority of patients were those who were too old to work. At present ... (they are) young or middle age, and their presence here (Outpatients' De-

1. "Personnel and Function of the Social Service Department combined with Out Patients' Department, Vancouver General Hospital." Mimeographed material, 1930.

partment) is due to their inability to obtain work."[1] About two-thirds of the patients were certified as indigent by the City Relief Department, and as all these were necessarily checked by the 'social service nurse', the Report stated there was urgent need for the addition of trained full time social workers.

The Report for 1932 emphasized concern for the careful handling of individuals applying for admission. "It is only natural that many of our patients are distressed as they approach the admitting nurse.. (who can) do much to allay their emotions by a kind and sympathetic understanding of their problems. All cases not admitted should be given instruction in regard to where to apply for help. No patient should be rejected without an effort being made to see he is directed to and a contact made with the best source of assistance."[2] This commendable concern for the individual as a person seems to prevail throughout the work of the department during this period. The worker also began to try to follow up outpatients who failed to return for treatment in the belief that "a client's illness is often related to his social problems, and is becoming more so."

Also in the year 1932 there were two interesting departures from the conventional work in the department. Lectures on social service were given to the public health nursing students at the University of British Columbia, with the intention of interpreting the functions of social service and increasing the mutual understanding between the two professions. Also, in connection with the university, the first social work student to receive field work at the hospital was placed there during the summer.

The pressure of work was becoming increasingly great, and, in 1933,

1. Annual Report of the Vancouver General Hospital, 1931.
2. Annual Report of the Vancouver General Hospital, 1932. p. 47

a second public health nurse was added to the social service department, attached to the admitting office. A new ruling was made regarding admissions, whereby no patient could be admitted without a note from a doctor requesting aid in diagnosis or treatment. This reduced the volume of patients by one-third, and freed the workers for more time on other matters.[1]

The Introduction of Trained Social Workers.

The year 1934 was a milestone, for the first trained social worker, (Miss Helen Sutherland) joined the staff. She was appointed to take over the work in the Outpatients' Department and to supervise the volunteer group who were again active. The Annual Report for this year conveys a greater understanding of the profession of medical social work: "to further the medical care of the patient by a method of social case study and treatment .... after which a patient is able to work out his own plans. Often, too close supervision and intensive follow-up will rob a patient of his self reliance, and make him wholly dependent on others. A Social Service Department should know when to be content with pointing the way, and allowing the patient to develop his own initiative." It was hoped to develop this service "year after year by an increased staff". Social service investigation and follow up work were considered to be "the greatest unsolved problems in the clinic." This self-evaluation indicated a healthy awareness of the inadequate service available, with the probability that future growth would be in the direction of modern standards of medical social casework.

During the year, 5,091 new cases were attending Outpatients' Department and a total of 36,263 consultations were made. At this time, too, the social service department was able to decentralize some of its work

1. There is no record of what happened to the ineligible applicants.

and to avail itself of the willing assistance offered by the Women's Auxiliary. This busy group consisted now of 357 members, and had a membership committee for the purpose of interesting people in their work. There were twelve committees in all, and through them the group offered to assist every branch of social work in the hospital. Their work consisted mainly of providing transportation, visiting, supplying soup to clinics, and appliances and clothing to patients in need, work formerly attempted by the social service department, but more properly a task for a volunteer group. The volunteers felt that their visiting service was particularly valuable, and commented, in the Annual Report of 1935: "We can help to break down the ignorant prejudices against the hospital which quacks are encouraging for their own ends. In this we have much more influence than a paid worker, for they know we are not paid, and our judgment is unbiased." By this reorganization of work, the social service workers were enabled to focus their efforts towards more adequate professional social service. The year 1935 marked the end of adoption service given by the hospital social service department, as this function was taken over by the Superintendent of Neglected Children for the province of British Columbia. Correspondence is still occasionally received requesting information about children placed for adoption by the hospital.

The social service department set up its own records section at this time, which was a valuable service for gathering social information from hospital records. To prevent overlapping in record giving, policy was defined "by a definite understanding of the responsibility of each department; information of a social nature, or affecting a social condition (was)

recommended as ours to give or discuss."[1]

By 1937 the hospital had expanded and included the following: Main Building, Private Ward Pavilion, Maternity Building, Infectious Diseases Hospital, Tuberculosis Hospital, Heather Street Annex, Infants' Hospital, Subsidiary Hospitals and Outpatients' Department. In spite of this, the demand for accommodation exceeded capacity and the General Superintendent stated in the Annual Report that the hospital authorities were faced with the most serious and urgent hospital problem in Canada, and were actually refusing emergencies. To help ease the situation, arrangements were made with Vancouver City Social Service Department to place patients, who no longer needed active care, in homes outside the hospital. A social worker, trained in Montreal, was appointed to correlate this work. As a result, Glen and Grandview Hospitals, Bayview Hospital and private nursing and boarding homes were made available, which facilities are still in use.

In this year, also, a study was made of the entire administration and accommodation of the Outpatients' Department. The social service director presented a formal plea to the board of directors for increased staff of trained social workers. As a result, one trained worker was added and others were to be employed as they became available.

Changing trends

An internal adjustment was made within the social service staff, relating to the distribution of work. As a new departure, definite duties on certain wards and clinics were assigned to each worker. This gave the

1. Annual Report of the Vancouver General Hospital, 1935, p. 53

worker a particular section of the hospital as her individual responsibility, which facilitated work with the patients and with other hospital staff. It was not possible to assign workers to all wards or clinics although service was available upon request. The addition of another trained worker in 1938 made some extended service possible, but the staff was still "woefully inadequate" in quantity. Volunteers from the Women's Auxiliary were giving what assistance they could. Nine social work students from the University of British Columbia received their field work training this year which, it was hoped, might interest some in future employment at the hospital.

Conferences were held with other city welfare agencies to clarify and outline inter-agency policy, and to enable more uniform service and proper referral. In defining which agency should assume responsibility for a case, the policy stated "referral should be made only after all agencies interested had discussed the case." The social service department was given the authority to notify outside municipalities on advice from the Inspector of Hospitals (Provincial Office), regarding responsibility for cases requiring boarding home care.

The early war years brought no decrease in the number of patients being served, and again the volunteers from the Women's Auxiliary were required to provide additional service. In order that services might not overlap, the policies of both groups were better defined, to provide "a much wider scope (to) the work, and .. more concerted action ... a wider understanding of each group's place in the welfare work of the hospital." Volunteers were able to assist the staff with patients, files, and cards; to check attendance at clinic, and to visit patients not attending. The

social service staff assumed extra duties in the admitting service of the Outpatients' Department by interviewing the patients and preparing the credit cards which intitled them to service (eligibility was established according to a means test). This relieved the main admitting office staff, but caused the social service director some concern. She stated in the Annual Report (1939) "I am still doubtful ... that the latter work is one for our department, as it seems a credit department could .... carry this work .... and relieve the social service staff for more direct social work." This duty, assumed as an emergency measure bytthe social workers has persisted since this time and has been the subject of much controversy. However, the social service department had become such an integral part of the hospital that the Medical Director of Outpatients" Department noted in the Annual Report: "There is a tendency to forget the patience, tact and thoughtfulness they display .... it must be pointed out that the quantity of clerical work performed by our trained workers prevents them from applying their special knowledge to the problems at hand." The social service director was likewise aware of this frustrating situation and expressed the hope that "the workers will have more time to help the patients more with their immediate problems .... than act as emergency stop-gaps for patients being discharged."[1]

As the war progressed, changes in the client group were noticed. Whereas, in 1936, the hospital patients had been 40 per cent 'pay', 60 per cent 'staff' (non-pay), in 1941 the percentage had become 70 per cent 'pay'. The number of patients at Outpatients' Department was steadily falling off, but, because of increased case work, and the extra work entailed in the closure of the City Nursing Home, the social workers were as busy as ever. The social service director was particularly interested in

1. Annual Report of Vancouver General Hospital, 1940. p. 37

the problem of care for the chronically ill and the older age group whose pension or assistance was inadequate. She wrote that "one cannot help but feel that the medical care and housing are .... inadequate", and recommended some type of national health insurance and contributing old age pension scheme. In order to prevent duplication of services, further conferences and meetings were held with the City Social Service Department. In addition, a revised scale of eligibility for admission to Outpatients' Department was drawn up which reduced the numbers of patients.

By this time (1941), there were nine workers, and a clerical staff of three employed in the social service department, with offices in both the Main Hospital and Outpatients' Department. Two workers were required to care for the chronic and aged patients in the subsidiary hospitals and boarding homes, because of the emergency nature of this work resulting from pressure to release hospital beds. The aim of the department was to assist the patient to deal with his problems, to cooperate with the medical and other hospital staff, and to assist in community programmes for the betterment of specific conditions.

The social service director explained that a study of the social work services revealed that assistance was more frequently required in cases of recurrent and chronic illness, physical handicap and invalidism rather than those of acute illness. For this reason, the greater proportion of work was attempted with these groups. Major problems encountered included financial difficulties, mental or emotional instability, family or marital friction, maladjustment to medical treatment (such as cancer, venereal disease or major operations), poor home environment, placement following illness, and unmarried motherhood. In all cases there was to be "consider-

ation for the patient's wish and his willingness to accept assistance; there should be a cooperative effort on the part of the patient, doctor, nurse and social worker."[1] In this may be seen a striving to incorporate more modern standards and concepts of social case work into a system which had operated for so many years on a superficial level.

This attempt to clarify function and policy of the social service department continued during the succeeding years, and was necessary because of the difficulty of breaking loose from traditions established before the advent of trained workers. The statements of policy emphasize more and more the need for interpretation of social work to the patients and to the other hospital staff. The tendency was still for the hospital staff to refer to social service only for environmental problems of patients, and there was no general awareness of the deeper potentialities of the service. Moreover, service was still considered a need exclusively of the non-pay patients, and not required for private patients. The social workers were under constant pressure of work of a routine nature, and interpretation was a difficult task.

Improved economic conditions had greatly reduced the number of outpatient consultations, but the increased work attached to providing boarding or nursing home care for chronic or convalescent cases fully occupied the workers responsible for this service and for the discharge of patients. The director stated in 1942 that "there is too much pressure from the hospital to perform miracles and get patients out." This was a natural result of the pressure upon the hospital to provide medical care beyond its capacity, and every department reflected the strain. In 1943 the new Semi-Private Pavilion was opened, and Outpatients' Department (together with the social service offices) was quartered in the ground

1. Cotsworth, O.V., "Medical Social Work in a General Hospital", a paper prepared October 1941, p. 5.

floor of this building, where it remains today. Even this increased capacity did not relieve the strain sufficiently, and work continued under pressure.

By 1944 the social service department was laboring under a load too great for its limited staff. Its responsibilities included the admitting service to Outpatients' Department (3,929 patients interviewed), and placement of discharged patients; which might not be justified services for a social service department, but nontheless occupied a large portion of the workers' time. Fifty beds were made available in the Heather Street Annex for placement of chronically ill patients, but these were not sufficient for the demand. The department was also attempting to provide more casework service, and records of 2,374 cases were added to the files. These records do not reveal sustained casework, nor any of a therapeutic nature, but do indicate greater use of social service in the preparation of social histories for the physicians, particularly for the psychiatric clinics. Likewise, as a new departure, requests were being received for service to private patients. Although these were chiefly for placement, it was the first real introduction to the private patient group and, therefore, a significant advance.

The end of World War 11 brought with it the problems of peace, including housing, employment, security for young and old, and the amplification of medical care. All hospital records for consultation and treatment were broken and all departments were worked to capacity. The growing importance of psychiatry had resulted in the opening of ward 'R' for psychiatric cases. Cases from this ward, together with those from the psychiatric clinic, which were automatically referred for social histories, necessitated the assignment of a full time social worker. This duty, however, was welcomed by the social service department, for it was considered to be a valid function of trained medical social workers. Moreover, psy-

chiatrists have been aware of the consultative service which social service departments may offer, and have been in the habit of using the social worker's service to a greater extent than is usual in general medicine. The psychiatric clinic provided an important advancement for the social service department.

There was increasing concern about the distribution of work and about unnecessary services performed by the social service department. The director's report (1946) states: "In recent years it has been recognized that there should be definite planning of activities of workers in a Medical Social Service Department, and while the worker should have a place in the administration of the hospital admitting services, this is only part of her function. Her main one .... a case worker with the interest of her patients first .... (is).. looking after the social needs of sick persons or helping the patient to adjust to any problems that may arise due to his social situation or his personality." The staff was composed at this time of the director, seven trained workers and three clerks, and there was the feeling that, although a complete casework service could not be offered, the workers could be used to greater advantage if relieved of the accumulation of other duties.

In 1947 a casework supervisor, with experience in the field of child welfare, was added to the staff. Her duties included supervision of staff social workers plus the yearly quota of students from the University of British Columbia. Her interests were also directed towards rearranging staff activities, and more efficient use of personnel, and, although progress was necessarily slow, the change was imminent.

One important development occurred in 1948 with the opening of the new Health Centre for children in one of the old buildings on Tenth Avenue renovated for this purpose. A social worker was appointed to the staff of the Centre, directly under the supervision of the case work super-

visor. This was the first time a separate department of the hospital had opened with a social worker on staff, and the immediate integration of the social service into the medical structure was an indication of what might be expected in the future.

This second phase of development has traced the growth of the social service department from the time of its integration into the hospital administration, through the introduction of the first trained social worker, through the growing but gradual struggle to emancipate itself from the traditions of years, to the point where it is still handicapped by lack of personnel and general acceptance, but is ready for its concerted effort to establish itself as a recognized part of hospital treatment on a consultative level.

Chapter 111

The Social Service Department To-day

The expansion and development which have characterized the Social Service Department and the Vancouver General Hospital as a whole throughout its history are still apparent to-day. Changes of staff, of policy, of procedure and of even the hospital buildings are presently occurring, and any description given will not necessarily be valid for long.

Organization

At the time of writing, the social service department, which is only one of many departments, fits into the complex administrative structure of the hospital under the authority of one of the five assistant directors. The Director of the social service department is responsible to the Director of the hospital through this assistant director; thence to the Board of Trustees and to the Governors. The line of authority for administrative purposes is direct; the social service department, as a hospital service, is in a staff position to the medical services.

Within the social service department itself, administrative authority is in the hands of the director, who is responsible for her department. Below the director, the line of authority divides; one branch is to the assistant director, the other to the casework supervisor. The assistant director is a caseworker, with her own case load; but with no staff under her; in addition, she carries responsibility for part of the administration of the subsidiary hospitals used for chronic and convalescent care. The casework supervisor is directly responsible for the casework services of the professional and student workers, (the latter in collaboration with the University of British Columbia). The social case

workers are in line positions below the casework supervisor. Clerical staff are in a staff position, responsible to the director of the department.

The director, assistant director and the casework supervisor together formulate policy and procedure for consideration by their superior authority. Expansion of service or staff requires considerable foresight in planning, because the rigid system of budget control, which is necessary in the financial operation of the hospital, permits no expenditure not budgetted and approved in advance.

Location.

Geographically, the social service department is located in five different hospital buildings, but its activity is concentrated in the Outpatients' Department. "Main Social Service" offices are in the old "Main Hospital" building, close to the front entrance to the building. Here, in three offices, are the director, assistant director, one social worker and two clerical workers.

The Semi-Private Pavilion, which houses Outpatients' Department, contains the offices of the casework supervisor, two workers assigned to social admitting services, and two other workers. The social service in the Maternity Building is performed by a "social service nurse", who has office space in the Outpatients' Department of this building. Beyond, in the newly-renovated Health Centre for Children, are offices shared by three workers. Student workers, placed at the hospital during their field work training, are housed in two offices in an old nurses' residence, "West House."

The Department, therefore, is located in more or less strategic positions in various sections of the hospital. The responsibility for buildings and the allotment of office space is not in the hands of the

department, but is controlled by the various assistant directors of the hospital.

Function.

As outlined by the director, the function of the department is "an aid to the medical and social treatment of patients requiring this service ... (and includes aid) ... in the medical, administration and other departments of the hospital, and to other community health and welfare agencies." The workers' job is "casework with patients requiring assistance; that is, a study of the patient's background and environment, personality and emotional reactions; also his ability to help himself ... if unable to do so, assisting him to use the various agencies who might help him with his particular problem."[1]

These services are available to patients in the wards and to outpatients. Although workers are not assigned to private wards, they are on call for private patients whenever necessary. Because of the limited staff and the great number of patients it is not possible to cover the entire hospital (7,549 inpatients and 33,618 outpatients were served by the hospital in 1948). Therefore, only a few wards have workers assigned specifically to them.

Referral Procedure

Two social workers are responsible for the admissions to Outpatients' Department where eligibility is established according to a means test. The large number of patients receiving admitting service to the clinics (6,838 in 1948) means that admissions occupy most of these two workers' time. They in turn, make the referrals to other workers who are responsible for particular clinics and who carry the patients for casework service.

1. Cotsworth, O.V., Memo prepared for the Medical Interne Staff. Vancouver General Hospital, Vancouver B.C. Revised 1948.

Clinic service, plus the miscellaneous other routine services for which the workers are responsible, occupy most of their time. The individual workers have correspondingly little time for ward services, and even less time to seek expanded services to private patients. Nonetheless, this service is offered, and given upon request.

Service may be requested for patients by referral to the social service department or to the individual worker attached to the wards and clinics. Referral may be made by the attending doctors; nurses, or other hospital staff; by the patient himself; or by friends, relatives or other social agencies on his behalf. The department, however, prefers referrals to come from the medical staff, or, at least, to be made with the doctor's knowledge and consent. Under the most recent policy, referrals to social service are to be made by the doctor on a specific referral sheet. However, many doctors are not yet aware of this system; and are under the impression that social service is already acquainted with the problems of the patient, as workers were formerly in attendance at all clinics. The present situation is therefore one of transition, and cases are accepted by the department from other sources of referral. In all cases, the workers act in conjunction with the medical staff. Should they be unable, at the time, to discuss the patient with his doctor, the worker is able to add her comments to the patient's medical chart, which is always available to her, and which will be seen by the doctor upon his return visit to the patient. Former practise was for workers to add their remarks directly below the doctors' comments on the medical record, using the same sheets. In February, 1950, however, new social service forms were introduced, which are to be placed separately on the medical records, directly in front of the forms used by the doctors. These records will be ready reference for the doctors and for the workers, and will constitute a permanent part of the patient's medical chart.

Personnel and their Duties

The duties of the social service workers are many and varied, but include a good deal of routine as well. Casework services are ostensibly foremost, and the aim is to provide this service according to the individual patient's need. Unfortunately, the volume of work does not permit as much casework as the workers themselves would wish. Admitting services to the Outpatients' Department, which are actually an administrative function, take a good deal of time. In addition, there are numerous routine services, such as rechecking eligibility, writing charts, preparing credit cards, supplying transportation, etc. These are being transferred gradually to clerical staff, but are still time-consuming. Other duties include ward and home visits, attending clinics, preparing social histories, procuring appliances, dentures, and clothing, and so on.

As has been indicated, the fact that social workers are responsible for admitting patients to Outpatients' Department, and the large case load in that Department, has necessitated the concentration of duties there. This will explain the distribution of duties described below.

The director of the department, who has been with the hospital since 1937, is chiefly concerned with administrative duties such as meetings, reports, budgetting and so on. In conjunction with her assistant and the casework supervisor, she prepares suggested new or altered policies for presentation to the assistant director of the hospital. She presents cases referred for assistance with appliances, dentures, etc., to the Womens' Auxiliary Social Service Committee. In addition, she carries a small case load.

The assistant director joined the staff in 1941 and has been in her present position since 1945. She has supervision of Glen and Grandview Hospitals, which are private hospitals from which accommodation is purchased for chronic or convalescent cases; she likewise supervises Heather

Street Annex, in which convalescent placements are made through arrangements with the City Social Service Department. In addition, this worker takes calls from the Private Ward Pavilion, the Semi-Private Building and the Emergency Wing. Her duties are chiefly concerned with placement. She works closely with the City Social Service Department on cases to be placed by mutual arrangement in Heather Annex.

The casework supervisor joined the staff in 1947 to fill this particular position. Formerly she was a casework supervisor for the Children's Aid Society of Vancouver. She is responsible for supervising the staff of social workers, to assist them in their professional development toward a higher standard of casework service. In addition, she gives intensive supervision to the yearly quota of students from the School of Social Work, University of British Columbia, who are receiving their field work training at this hospital. She also carries a small case load, assists the director to formulate policies, supervises the staff of Outpatients' Department and performs routine duties when required by staff shortages.

The programme of clinics at the Outpatients' Department is too comprehensive for the limited social service staff to be assigned to every clinic. At present, there are ten medical clinics, six surgical clinics and at least six others, not including the expanding programme of the Health Centre for Children. Likewise, the wards in the various hospital buildings are too numerous for individual coverage. For this reason, the remainder of the social workers have been allotted to selected wards and clinics. Calls for service from other wards or clinics are referred to workers through the casework supervisor.

One worker is assigned to the neurology, neuro-surgery and psy-

chiatric clinics, and to the corresponding hospital wards. In the month of October, 1949,[1] her caseload was 265 (112 clinic, 153 ward) of which 187 were discharged during the month. She made seventeen ward visits and conducted fifty-four office interviews.

One worker is assigned to a large group of clinics and wards (arthritic and genito-urinary clinics, men's orthopaedic, women's surgery, men's surgery, paraplegic, post-polio, and infectious diseases wards) plus calls from two wards set aside for Workmen's Compensation Board cases. In addition, she has been assisting with admitting services at the maternity clinics. Her case load for the month included 48 cases, 30 'admits' to hospital, 77 ward visits and 49 office interviews.

Another worker is assigned to the medical, cardiac and gastro-intestinal clinics, and to the medical and eye, ear, nose and throat wards. In the month she handled 21 cases plus 20 admits, made 76 ward visits and held 92 office interviews. In November, 1949 she assumed a new duty, that of conducting a survey on poliomyelitis.

The two workers performing the admitting service to Outpatients' Department have duties of a different nature. These include social admitting services, referrals, appliances and other routine duties which come to the attention of the department. More specifically, the admitting service includes admissions, re-admissions, financial rechecks for eligibility, and dealing with ineligible applications. Referral service includes referring patients for social assistance, accommodation, or other needs which require service from a community resource; and, likewise, taking referrals from outside agencies, which involves procuring relevant information,

1. For purposes of comparison, caseloads for the various workers are all for the month of October, 1949.

giving initial verbal reports to the doctors, setting up a record, and then transferring the case to the responsible clinic worker. Other routine duties which come to the attention of these workers include grievances regarding appointments, requests for information, and so on. In addition, the admitting workers carry certain cases which have indicated casework services at 'Intake', and which are not the responsibility of other workers. In all, during the month, there were 249 patients admitted to Outpatients' Department, and 87 re-admitted. Each of these was interviewed by one of the admitting service workers. They also gave service to a total of 125 clinic cases.

The Maternity Building is separate, and its clinics are operated apart from the Outpatients' Department in the Semi-Private Pavilion. Social service here had been performed alone by a 'social service nurse', but recently one of the social workers has been assigned part-time to the maternity and gynaecology clinics. Most cases from this department are short term contacts which frequently include referral to the Children's Aid Societies or other community agencies. These cases do not usually receive service beyond the hospital setting. The case load for the month totalled 85, with 189 ward visits and 11 office interviews.

The Health Centre forChildren, opened in 1948, is operating at an ever-increasing tempo. Until November, 1949, one social service worker handled all the admitting services, which averaged 160 new case interviews per month. In addition, she took referrals for casework from the children's wards and the Infants' Infectious Diseases Hospital; she attended pediatric ward rounds, prepared social histories and assumed responsibility for follow-up. A new distribution of work has been possible, however, by the recent addition of two workers, one of whom attends three days per week, the other full-time.

At present the two full-time workers share the admitting service every morning. One of these workers is responsible for regular ward visits to the infants' and pediatric wards, and for referrals from the Infectious Diseases Hospital. She gives casework service to cases already known to the Health Centre and is responsible, after consulting with the casework supervisor, for assigning new cases. Also, she is responsible for the weekly behaviour clinic. That is, she makes appointments, assigns cases for a social history, and arranges the conferences which are attended by school teachers, public health nurses from the Metropolitan Health Units, social workers from the hospital or outside agencies, the psychologist and the psychiatrist. The purpose of these clinics and conferences is to try to work out a plan of treatment which will be followed by all those concerned with the patient. The social worker is the coordinator, acting in an administrative capacity, but, if the case were one which she herself carried, she would likewise act as social consultant for the conference.

The other full-time worker has been responsible for the feeding clinics, including casework service and follow up. At present she has not been on the wards, but will be assuming this duty after her orientation period.

The third worker is functioning in a special capacity and is on call only, for the admitting service. She is responsible for the allergy clinics, and others as her case load permits; she is likewise responsible for follow-up, for re-appointments and for the semi-annual reports for the psychiatric clinic, unless other workers are already active on these cases. She follows cases carried cooperatively with other community agencies, unless other workers already have these cases; and she participates in any special organizing or other jobs which arise.

These three workers at the Health Centre for Children are temporary employees only, at present. The worker who was appointed to the single social work position at this unit is on educational leave of absence, attending Smith College on a scholorship provided by Dominion grants.

Added to the professional staff are the student social workers from the University of British Columbia. They help by carrying some cases, which are carefully selected by the casework supervisor to give as wide an experience as possible in casework. These students attend two days each week and average about ten cases per month, chiefly from the Health Centre for Children and from the Outpatients' Department. Most of the home visiting is done by the student workers, as the full-time staff workers are generally confined to the hospital by pressure of work.

The figures quoted in the preceding paragraphs give only slight indication of the constant pressure which seems to be inherent in the clinic and hospital setting, where so much of the service is of an emergency nature, and matters of life and death are a constant reality. The composite statistics of the activity of the social service department record a total of 662 patients served during the month selected. Of these, 371 were in clinic, and 291 on the wards; ward service included 415 visits, 45 office interviews and 2 home visits; clinic service included 275 office interviews, 18 home visits and 3 home interviews. During the year 1948 there were 7,549 patients attending Outpatients' Department, of which 6,836 received admission service and 4,449 casework service from the social service workers.

Although the social service is necessarily concentrated in the Outpatients' Department at present, increasing numbers of cases are being referred from the hospital's large inpatient population. During the year 1948, there were a total of 33,618 inpatients, averaging 957.4 patients

daily. The hospital is one of the largest institutions in Canada, in size and capacity, and averaged 1186 beds for the year 1948. Several hundred additional beds will be included in the new buildings presently under construction. However, the social service staff will not be able to expand its service a great deal unless new workers are added. Having evolved historically with the Outpatients' Department, social service remains concentrated there.

The clerical staff is small, and likewise under a great deal of pressure due to the volume of work to be done. There are two clerks in the main social service offices, one of whom acts as bookkeeper and receptionist as well as typist. In the Outpatients' Department, the clerical staff is assigned to this department and not to social service and does not assist by typing social service histories. Records for the Health Centre for Children are typed there, and the clerks are assisted by volunteers from the Women's Auxiliary. Because of the limited clerical staffs, most dictation must be written out in longhand by the workers, which is a time-consuming process.

There is a place for volunteer workers in most agencies serving the public. The Vancouver General Hospital avails itself of services of workers from the Woman's Auxiliary in several departments, particularly Outpatients' Department. The social service department utilizes these services too, and volunteers are able to supply much needed assistance, particularly with clerical duties and driving patients to and from clinics. In addition, the "Social Service Committee" of the Women's Auxiliary works with the social service department to provide appliances, dentures or other extras which are not included in hospital service.

Facilities

As with most departments in the hospital, space is at a premium, and offices are small and few in number. There are four small offices for the social service staff in the main building. The director occupies one of these; another is shared by the assistant director and one worker; the third is shared by the two clerks; and the fourth contains filing cabinets for the social records.

In the Outpatients' Department, social service has six small offices; in the Maternity Building there is one; the Health Centre for Children workers use one office with others available at certain times. The students from the University of British Columbia are housed in two large rooms in "West House", but conduct their interviews in the other offices described above.

All these offices are equipped with desks and telephones, but not all are suitable for interviews.

Records

The social service workers have free access to all hospital records, including medical charts. The records section of the hospital is housed in the basement of the old main building, and is presently in the process of reorganization. It is planned to house the social service records with the other hospital records, but at present they are filed in one of the offices in main social service, with the exception of Health Centre for Children charts, which remain separate in that building.

The social service histories on file date back to the 1920's but are not numerous until the late 1930's. Charts are filed according to name and number, and a complete card index is maintained. In instances when minor service is rendered, but no case is made, a record is kept in the index on a buff-colored card, which indicates "no case made." If a case

is made, a social history is completed and the buff card is transcribed to a white one. The case history is allotted a number and is then filed numerically in special envelopes according to blocks of years. These charts vary from a single page of information to lengthy histories, and contain the complete record of the patient as known to the department. A summary of the medical information from the medical chart is included, plus the particulars obtained from the Social Service Index. The recording is, as much as possible, process recording, depending, in a great measure, upon the time the worker had available.

The records in the Maternity Department are medical records, plus a social service card index. Any cases made into social service records are filed with the above-mentioned in the main social service records office.

The Health Centre for Children, operating as a separate unit, has its own facilities for filing charts, which are maintained in the Health Centre Building. The social service histories are listed alphabetically on a card index, allotted a number, and the histories themselves are filed numerically.

The confidentiality of the records is guarded and the histories are available only to the social service staff (including clerical staff concerned).

The foregoing description of the social service department of the Vancouver General Hospital can only be considered a tentative one, as the department is in a state of alteration. Several changes in the division of work have already been made during the year, as a result of an experimental survey conducted by the casework supervisor. A report containing suggestions and proposals for further changes in the allocation of duties has also been submitted to the hospital administration for consideration be-

cause it was felt that, although complete casework services could not yet be offered, the available services could be more efficiently used. At the time of writing, these proposals are still under consideration, and no definite action has been taken by the Board, but is anticipated. These proposals, if accepted, would relieve the professional staff of some of the routines which hamper their work and would free them to perform a more efficient and higher standard of casework service.

The next aim of the department is toward increasing staff and expanding services. With each increase of qualified staff, the department feels that it will be able to demonstrate its service to a broader area of the hospital; and by so doing, it will create greater demand for social service and thereby a need for still more staff.

Chapter IV

An Evaluation by Standards

"Social Service, a professional service to patients, physicians in hospital administration and the community, has been developed in hospitals and clinics to help patients with environmental and personal difficulties related to their illness, recovery, and preservation of health."[1] In order to guide hospitals and clinics in organizing and improving their social service departments, the American Association of Medical Social Workers has prepared a statement of standards which has been approved by the American Hospital Association (1949). These standards form a basis for analytical evaluation of the social service department of Vancouver General Hospital.

A. Organization

In accordance with the Standards of the American Association of Medical Social Workers, the social service department of Vancouver General Hospital is an integral department in the hospital and includes all social workers within the institution. Its director is responsible only for this department, is directly responsible to the assistant director of the hospital, and, through him to the director and the board of trustees. There is a close planning relationship with the administration, and with the other professional departments up to a point. There has been a tradition, set in the past, to look upon the medical social service as only a facility for benevolent services to patients, and not to recognize its potentiality for valuable consultation. However, this attitude is being overcome gradually, and there is a growing recognition of medical social service on a more direct level

1. A Statement of Standards to be met by the Medical Social Service in Hospitals and Clinics, The American Association of Medical Social Workers, Washington 5, D.C. 1949. p.3.

with medical service. The department is aware of its position, and is prepared to progress slowly toward further recognition.

"The financial support of the social service department should come from the hospital. When it is advisable or necessary to use other than hospital funds such funds should become a part of the hospital income and the expenditure charged to the social service account."[1] At Vancouver General Hospital the director of the social service department prepares her budget, which is then incorporated into the hospital budget; this policy is in accordance with the approved standard and is necessary in order to comply with the hospital's rigid system of budget control. There is one deviation from the standard procedure, however, with respect to procurement of appliances, dentures or special equipment for certain patients. These are not provided for in the hospital budget, and it is necessary for the department to apply to the "Social Service Committee" of the Women's Auxiliary in each case. This committee meets weekly, and obtains its funds for such equipment from the Women's Auxiliary funds and the Vancouver Community Chest allotment. Although such requests are generally granted upon the recommendation of the social service department, the routine procedure is cumbersome, and not in accordance with the accepted standards.

B. Personnel

"The minimum requirement for any staff member should be the completion of the full graduate curriculum in social work in an accredited school of social work. Qualifications for each position in the department, including training and experience, should be clearly set up with the approval of the executive head of the institution. Minimum qualifications for director and supervisor should include supervised casework experience in which skill has been demonstrated in a recognized social service department in a hospital or clinic; the director should also have had experience in

1. ibid, p. 7

direct supervision. Administration and case supervision are separate functions and in general should not be performed by one individual. However, the director may carry supervisory as well as administrative responsibility when the department is small or newly organized, if the combination of duties does not impair the quality of service."[1]

At present, only one of the members of the social service staff possesses the desired qualifications in accordance with prescribed standards for medical social casework. One other staff worker is on leave of absence for the purpose of completing her formal training and is expected to return at the end of the current term. One of the workers has partially completed her second year of graduate study, and several of the remainder have one year credited training, before or after the degree course was offered at the University of British Columbia. Although the first Master of Social Work degrees in Canada were granted in 1947 at the University of British Columbia, there have been two year training programmes in some universities for many years. Qualified workers probably could have been procured had the hospital made its positions attractive enough, by adequate salary and opportunity for advancement.

Moreover, qualified supervision has only been available at the hospital since 1947. This is limited so far as staff workers are concerned, because of strenuous demands upon the sole casework supervisor's time. There has been no attempt to build up a supervisory staff from within; nor has there been sufficient pressure or inducement for partially-trained workers to complete their training and advance into supervisory work.

In addition, there has been a tendency to place nurses in social work positions. Regardless of how well-intentioned or conscientious these

1. ibid., p. 8

personnel might have been, they could not justly be expected to raise the professional standards of social casework.

The tendency has been, in the past, to make the best of the available staff and facilities, rather than to impress upon the hospital administration the importance of improving standards. The administration, in turn has lacked understanding of the potential value of a truly professional social service department, and has not, therefore, been aware of the need for professionally qualified workers. As a natural consequence, progress has been slow and difficult. The professional staff is too few in number for the quantity of work to be done. Before standards can be raised or service expanded, it will be necessary to increase the number of workers, and to insist on qualified, trained personnel. Moreover, every encouragement should be given for staff members to complete their training, in order to instill the desired standards throughout the department.

"In order to carry out the responsibilities of the department, the staff must be adequate in number and in qualifications. In establishing or reorganizing a social service department, the size of the staff should be decided in advance by the hospital administrator and the head of the department, and insofar as possible, provision should be made for proportionate increase in staff as the services of the department expand."[1]

Recently, in an attempt to compare the social service staff with other hospitals in Canada and the United States, the casework supervisor sent a questionnaire to a representative group of hospitals. The replies received indicated that at least double staff would be the minimum required to serve the present patient accommodation; when the buildings now under construction are completed, this will again be too few. This estimate might provide valuable guidance to the hospital administration for future planning

1. ibid.,p. 7

and reorganization. Under the existing circumstances, the social service staff is unable to expand to other clinics and wards, and, naturally, for lack of demonstration, many doctors and patients are not familiar with the department as a resource. Even if a greatly increased demand for social service should arise, the department will not be able to meet it unless increased numbers of qualified personnel are forthcoming. New workers entering the field will not be attracted to the hospital service unless there is greater inducement for them to add to their present skills and knowledge, and to find, likewise, an opportunity for advancement.

"Appointments to and dismissals from the social service staff should be made by the director of the department according to standards of performance and qualifications which have been accepted by the administration as policies for the department. Consultation should be held with the hospital administrator of the institution when appointments or dismissals are considered which deviate from these standards."[1]

Appointments to and dismissals from the social service staff are made through the hospital personnel department, under a similar policy to other staff. The personnel officer is guided in his decisions by the recommendations of the director of the social service department. The personnel department uses a system of rating which lists a job evaluation for each position in the hospital. These are contained in a job manual, which lists one hundred and seventy-six "titles"; like titles receive like salaries, and are based upon points in accordance with specified requirements (educational qualifications, training, experience, and skills). Social work positions are on a level with senior nurses, but the manual shows little understanding of the profession as such. For instance, the social worker is required to be able to perform admitting services and discharges, to arrange transportation and placement, but no mention is made of casework as a pro-

1. ibid., p. 8

fessional service. An extra point, which provides for a higher salary, is given for the second year of training. It would seem that the listing for social workers should be re-described and re-evaluated in the job manual.

"Personnel practices which compare favorably with those of other well organized social agencies in the community and similar departments of social work in other hospitals are essential to attract and retain qualified personnel."[1]

Although salaries are not out of proportion with other agencies in the community, the social service department is only one of many in the hospital, and its position is not yet properly recognized. It is not enough for the department to understand its own function, for, unlike other social agencies, a medical social service department must convey this understanding to the other professions.

There is need, too, for increased clerical staff. The staff at present is overworked, and any increase in the volume of work would be impossible for them to assume.

In the past, the service of the Women's Auxiliary has been important, and willingly given. At present their duties are chiefly involved with the Outpatients' Department, where the organization is extremely confused. Consequently this volunteer group is still performing duties which they assumed in the past, and which are not necessarily justly delegated to volunteers. However, if the distribution of duties and function of the various groups could be clarified, the social service department might well benefit by the extended use of selected and supervised volunteers.

C. Function 1. Practise of Social Casework

(a) Nature of Social Casework: "Social Casework in a hospital or

1. ibid., p. 8

clinic is concerned with helping the patient with personal or environmental difficulties which predispose toward illness or interfere with obtaining maximum benefits from medical care. This service depends upon individualized study of the patient so that his medical situation and its interrelationship with his personal needs and problems may be understood. Sharing of information between the doctor and the social worker is basic to their individual understanding of the patient. With this understanding the caseworker helps the patient participate in a plan consistent with medical recommendations and acceptable to him."[1]

The social service department is aquainted with this function, and makes every endeavour to carry it out in practise. The patients are worked with individually, and there is close consultation with the doctor. Because emergency action is frequently necessary, either to bring a patient to hospital, or to arrange his discharge, much of the conferring and referring is done by telephone. A satisfactory policy has evolved, and, in many cases, a well-established routine may be followed, such as referring a patient to the City Social Service Department for emergency assistance, or to Provincial Medical Service for transportation out of the city. These referrals are then followed by letter by way of confirmation, and the arrangement seems to work smoothely.

Frequently, as would be expected in a hospital setting, the workers have only short term contacts with the patient. The attempt is made to encourage the patient to be able to use his own resources as much as possible. If the patient remains dependent upon the social worker or a community resource, follow-up work is done. When a patient is already an active case of another agency, or referral is being made, this is explained to the

1. ibid.,p. 3

patient in order that he will be aware of the transfer and accepting of it. The policy of referral and responsibility for a case has been gradually worked out in conference with other agencies. If responsibility for a case is doubtful, a conference is called on an individual basis. The patient's welfare is considered to be the deciding factor and a plan which will benefit him most, and be acceptable to him, within the framework of agency limitations, is the aim of the conference. The agencies work cooperatively and promptly in these instances and, although an ideal solution may not be possible, the limits are due to agency or legal regulations and not to lack of cooperation.

In order to prevent duplication of coverage of clients, the department makes use of the Social Service Index in every case which comes to their attention. Cases are registered automatically at intake, and workers are then responsible for clearing with the Index for other registrations. If the case is currently active, the worker exchanges information, and if necessary, reports, with the agency concerned. The relationship with outside agencies and private organizations in the community is well established, and cooperation is apparent. This is an important factor in medical social service, for the constant pressure due to the need for hospital clearance, makes reliance upon community resources essential. The social service department constantly utilizes these resources for referral of unmarried mothers, babies for placement, boarding or nursing home care for chronic or convalescent patients and other such situations. Private organizations such as the Kinsmen Club,(which has a special interest in poliomyelitis), group work agencies, family court and others are always needed resources for the department. The workers must be, and are, acquainted with the resources available, and alert to new opportunities which may assist the patients concerned.

"The quality of casework service is measured neither by its duration nor its complexity but by the evidence of recognition of human beings as individuals, each reacting to a given situation according to his own needs and with a right to determine for himself the solution to the problems it may present for him."[1] The department has not been able to give sustained casework except in selected cases, and has also been limited in the treatment aspect of service. In order to reach further into this area, increased interpretation of medical social casework will be necessary to the medical staff and the community, and has already begun. Likewise, additional staff will be needed if the service to an increased caseload is not to be restricted to the environmental level of treatment. At present, student workers are able to take whatever time they require with cases, under careful supervision which is of good standard. Staff workers, however, are under too much pressure to be able to take as much time as they would wish with their cases. It is unfortunate that plans for new clinics (such as the neurology and diabetes clinics), which include positions for caseworkers, must be postponed because of lack of personnel. This gap is keenly felt by the department, and will only be filled gradually. The department does not wish to assume expanded duties of this nature until it is in a position to render competent service.

"Social casework should be made available to all patients who need it regardless of their economic status or of the hospital facilities of which they avail themselves."[2] The social service is presently concentrated in Outpatients' Department partly because of tradition, and partly because other departments have not yet fully realized what social work

1. ibid., p. 4
2. ibid., p. 4

is or what it has to offer.[1] Many doctors and patients still cling to the idea that social service is only for the indigent patient. The department is aware of this attitude, but realizes that there is a large field for its service in the other sections of the hospital. In order to open the door for expanded service in this direction, the department has offered its service to all patients upon request. Some referrals have been received for service to private patients, but, to date, these have been predominently requests for placement, and not generally for professional consultation. There is room for much interpretation of the social worker's function and the department is gradually doing this, on an individual worker-patient-doctor basis whenever the opportunity arises. If staff increases should become a reality, it is hoped that workers will be assigned to private wards on a full-time basis. The department hopes that by day-to-day interpretation, social service will be recognized as a natural and necessary part of the hospital team, and the demand for service will result in increased budgetting for social service staff. A beginning has been made, and the social service department is carefully watching development and new opport-

1. The organization of the Outpatients' Department is an outgrowth of tradition, and is extremely confused. It has no single head, and, instead, operates on several levels of authority: medical, nursing and lay. It will soon be necessary for the hospital administration to plan for complete reorganization of the Outpatients' Department, probably with a structure similiar to that of the Health Centre for Children, another hospital service. In the Health Centre, one doctor is in complete charge, and all services (medical, nursing and lay) are his responsibility. Until this reorganization is undertaken, Outpatients' Department will remain a chaotic disorganization. It does provide good service to patients, but at the expense of their patience, dignity and comfort. Outpatients' Department also provides transportation for patients, which is a departure from most similar Outpatients' Departments' service. However, the car used for this service is the one which was purchased for use by social workers; with the result that the workers have no transportation for home visits, and this service is neglected.

unities.

(b) Referral: The method of referral as practised at Vancouver General Hospital is in accordance with the prescribed standards, for the doctor has "the responsibility to recognize the social and personal problems that may affect the patients' medical care, and to bring these problems to the attention of the social workers."[1] It is true that the entire medical staff is not yet aware of social service but those doctors who refer do so repeatedly. The clinic doctors naturally come into more direct contact with social workers, and are therefore familiar with this service. The psychiatrists and neurologists are more accustomed to social service than other physicians are, and they rely on the workers for social histories which are automatically prepared before their patients reach them for examination. Emotional components of illness and the role of the social worker in treatment are more acceptable in the newer field of psychiatry than in general medicine, which may account for this seemingly unbalanced situation. The head of the new neurology clinic has requested that a social history be prepared for every patient, and that a weekly interview be held with each patient; however, the department has regretfully not been able to assume this added function because of present staff limitations. It is encouraging that increased interest in the work of the department is being shown by other doctors, and increased referrals are to be expected from them.

"Other professional or non professional personnel within the institution may also refer patients to the social service department."[2] The department accepts such referrals which are usually brought to their attention by nurses, therapists or dietitians. These referrals are investigated and are accepted for service or are referred to the proper community

1. ibid., p. 4
2. ibid., p. 4

resource.

"Health and welfare agencies, courts, schools and churches ... may request consultation regarding persons with difficulties related to illness. The patient himself, his family or others ... may ask for help."[1] The department accepts such referrals in the same way as others. As yet, many outside agencies do not seem to be fully cognizant of the consultative service of the department, and, consequently, their referrals tend more to be requests for medical reports on patients in hospital or attending clinic. Referrals in the reverse direction, from the department to the agencies, are more common, possibly because the department needs to make use of community resources, while the agencies do not necessarily rely on the hospital service. There is room for broader interpretation of its service to the community, a task which the department may gradually be able to accomplish.

"When the referral is made by someone other than the physician, the physician is consulted as to the advisability of including casework service as a part of his plan for the patient's medical care."[2] The department carefully observes this policy, and does not attempt to work with patients without the doctor's knowledge and permission. The doctors are kept advised about the worker's contacts by personal discussion, or by recording placed on the patient's medical chart by the worker.

(c) Recording: "The social record is indispensable in rendering effective service to the patient and in maintaining good casework practice. It is for use, not only in the patient's present care, but in enabling the social caseworker to give more effective service when the patient is referred again."[3] Careful records are maintained by the social service

1. ibid, p. 4
2. ibid, p. 4
3. ibid, p. 4

department, some of which are lengthy, and others brief enough to be contained on cards. These records are filed, for ready access for purposes of referral by the workers, for teaching or for administrative evaluation. The records are adapted to the requirements of individual cases and contain the available information about each patient referred. Each social history contains a face sheet with relevant statistical data, both social and medical, and also a documentary record of interviews. The records prepared by student workers are usually in detailed "process recording"; but, in general, other records are briefer. Each record is kept in separate envelope, and filed in metal filing cabinets. The confidentiality of the records is guarded, and they are not available to persons outside the department staff.

(d) Statistics: The department makes use of several statistical sheets in order to keep careful count of patients served and work done by individual workers. Each worker maintains her own daily work sheets, which she transcribes to her monthly work report at the end of each month. This report includes the record of the patients served, whether active or inactive during the month, cases closed, letters written, telephone calls, conferences, interviews, visits, referrals, and so on. Most of this information is of value, but record of incidental contacts, telephone calls and such items would seem to be superfluous and an unnecessary claim on the worker's time.

One item on this monthly report is the record of cases discharged to the Provincial Mental Hospital. There seems to be no particular reason for this except that for years a record has been kept of all committments, and special arrangements have to be made with city or municipal authorities for transportation costs. However, these are administrative functions, and should not be performed by the social service department.

Moreover, the reports devote a good deal of space to placements, which service occupies a major role in the department's work. Indigent patients are placed by mutual arrangement with the city or municipality responsible, and the social service department acts as liaison between the hospital and the patient's legal residence. Again, this is an administrative function which should not be delegated to the social service department.

A second monthly statistical sheet is prepared by each worker, which is intended to summarize the quantity of work and the numbers of patients served. One section of this report is devoted to "admitting services" to Outpatients' Department, and could be eliminated if this duty were removed from the social service department. Another item on this report refers to transportation of outpatients, which is not a legitimate function of the department, and is a result of tradition which is not yet outgrown.

Each worker's monthly reports are submitted through the casework supervisor to the director of the department. Cumulative totals are then prepared for submission with a narrative report to the assistant director of the hospital who is responsible for the social service department. In this way, the hospital administration is kept informed of the activity of the department. A comprehensive annual report is likewise prepared and submitted to the hospital administration for inclusion in the annual report of the hospital, and for presentation in summary form at the annual meeting. In this way the factual data provided are made available for evaluation of the service rendered, for programme planning and for any study projects which might arise. These records and statistics have been of particular value to the department itself in planning experimental redistribution of staff duties, and to students

concerned with medical social work papers and theses.

The department has recognized the value of carefully kept statistics, and has experimented with revised statistical sheets, which were introduced two years ago. At present, another revision is being considered, in the belief that more meaningful statistical reports will result. The department feels, with Harriett M. Bartlett, that "the effort to clarify function and improve the quality of work has its own value, ... since it is an essential part of professional growth."[1] Growth and development of the department are coming from within. The process is necessarily gradual, because of the need to break down tradition; but by starting within itself, the department should have a secure and stable base upon which to build in the future.

2. Participation in Programme Planning and Policy Formulation within the Medical Institution.

At Vancouver General Hospital the social service department has been an integral service for many years, and has not been inactive in programme planning and policy making. Through the annual reports, the director has consistently attempted to bring the needs for social service, in the hospital and without, to the attention of the administration and to the community, and has suggested improvements in social services. How far-reaching these suggestions were, or what influence they might have had is uncertain, but they indicate that the department felt genuine concern and attempted, in some way, to remedy conditions generally. The department's stature is growing, and it is interesting to note that plans now under consideration for new hospital buildings include offices for social workers on each floor. The department is participating in the planning of the hospital, and is being included in the planning by the senior authorities to a greater extent than before.

1. Bartlett, Harriett M., Some Aspects of Casework in a Medical Setting George Banta Publishing Co., A.A.M.S.W. 1940 p. 8

3. Participation in the Development of Social and Health Programmes in the Community.

A social service department in a medical setting is necessarily dependent upon community resources, and must therefore be familiar with these resources as well as the lack within the community. "It is the responsibility of the .... department to use this knowledge in community planning to contribute to the understanding of social problems which illness creates and aggravates; and to point out community services needed to facilitate rehabilitation and prevention of illness and disability."[1] The department has taken an active part in joint planning for patients, particularly through conferences with other agencies and organizations. The conferences at the behaviour clinic, for example, serve not only to work out a plan of treatment, but also to interpret some of the function of the department itself to the community as represented by the teachers and nurses. Representatives from the department have participated in educational programmes such as for increased public understanding of arthritis, with the intention of interpreting the role of social work in disease. Much broader interpretation of this nature could be made to the general public, but the department has concentrated at present on interpretation to professional medical and social staffs. Broader programmes of interpretation will follow more easily when this base is firmly established.

The social service department is able to keep the administration of the hospital informed of developments in the community and its own activity by day-to-day contacts as well as through the more formal reports.

4. Participation in the Educational Programme for Professional Personnel

"The social service department should engage in teaching in

1. A.A.M.S.W., op cit., p.5

line with the responsibilities .... (the hospital has) .... toward training of professional personnel."[1] Vancouver General Hospital conducts a large scale teaching programme. There is a large nursing school which carries out complete training of registered nurses. (At one time, during 1948, 384 student nurses were enrolled). Doctors, dietitions, administrators, technicians and radiologists are trained at interne level. Student social workers also receive field training at the hospital, in collaboration with the University of British Columbia. The opportunity to acquaint other professions with social work has not been fully utilized. Recently, however, an important start was made by scheduling three lectures from the social service department in the junior nurses' course. If this proves of value, the department feels that the lectures may continue in the two senior years, which should do much towards establishing a mutual understanding between the two professions. To date, little has been done to include such formal instruction about social work in the other training programmes, and interpretation has been solely on a day-to-day individual basis. There may be wider opportunity for participation in the medical training programme when the new medical school is operating at the University of British Columbia. There is also some indication that cases to be studied on ward rounds will be in conference form. Social workers, nurses, technicians and doctors together will be able to study the cases presented, and each may then participate in the diagnosis and planning for treatment. Such an interchange of thought and contributions from each professional group would broaden and coordinate the service of all, as well as increase their understanding and appreciation of each other.

An important and valuable method of teaching which cannot be ig-

1. ibid., p.6

nored, is in the day-to-day individual contact outside the formal teaching programme. The department and its workers are aware of their responsibility, and hope to demonstrate their service in actual practise. This is often a slow, harrowing process, but progress is being made in the desired direction. The department is faced with the dilemma of desiring to stimulate a greater recognition of the need for social service, and, at the same time, of not wishing to create too great a demand before it will be possible to supply service at least in part.

In a similar vein, it might be possible for the department to promote a more comprehensive programme of interpretation to the volunteer group within the hospital. This would include the members of the Women's Auxiliary and also the members of the Board of Trustees. It is not improbable that the majority of the volunteers still think of social service as it was in the earlier days, a philanthropic organization. Interpretation to this group would automatically broaden community understanding of medical social service through the wider associations of these individuals.

"Social work, like other professions, is continually changing and increasing its body of knowledge. It is essential that members of the .... department have the incentive and the opportunity to improve the quality of their practice."[1] The social service department has depended chiefly upon supervision for staff development, and the caseworkers each have specified supervision periods. The casework supervisor's time is fully occupied, and, should additional staff be employed, more supervisory staff will be necessary as well. This will need to come from the field outside the hospital, unless present staff is trained to assume

1. ibid., p. 6

supervisory duties. A programme of inservice training would be valuable to the staff members by helping them to develop their potentialities for higher standards of casework. As is commonly the case in agencies, staff members have become so engrossed in the work at hand that further training has been postponed indefinitely. The tendency is for work to become routine, and a programme of staff development would be welcomed by the workers. The inclusion of study conferences with other professional staff might be an interesting and stimulating possibility.

Professional reading material is limited, but the department's library is accessible to the staff. Many of the books are of value particularly to medical social workers (such as Harriett M. Bartlett's Some Aspects of Social Casework in a Medical Setting, and Psychosomatic Medicine by Weiss and English); others are not necessarily confined to the medical setting. Pamphlets and publications such as Social Case Work are also available. The library is not complete, but is valuable for reference purposes, and new additions are gradually being made.

5. Social Research

The department has been actively engaged in studying problems peculiar to its own practise, and to the community as well. Proposals have been made for changes in the staff and for the distribution of work, and already experiments have been set in operation, as a guide for future planning. Likewise, from time to time, the department has released members from other duties in order to undertake specific research projects. One worker is at present engaged in conducting a survey on social aspects of poliomyelitis; another is specifically assigned to work with diabetes. In order to undertake these and similar duties, a certain flexibility of staff duties is required, as well as an interest in the work, and a wish to contribute to the field of knowledge. The department has cooperated fully within the limits of its available personnel, and its interest in

any such project is genuine.

The social service department of the Vancouver General Hospital has not yet reached the desired goal of providing a professional casework service to all patients who need it. Its standards of ethics and its respect for the individual rights of the patient are high. Its service is good as far as it goes, but only limited casework is provided. Due to the hampering effects of tradition, insufficient qualified personnel, and resistance from the medical and other professional personnel to recognizing the function of social casework, the department's status is not what it might be. However, the social service department is aware of the situation and is able to see the direction it must take for progress. By gradually increasing its staff, by acquiring better trained personnel, by improving its service and demonstrating its proper function; and by constant self-analysis, the department may build its service upon a solid foundation. When this is accomplished, it will be possible to give service which will merit the "A rating" the Vancouver General Hospital has earned for its service in general.[1]

1. Vancouver General Hospital is rated as an A class hospital by the American College of Surgeons (annually reviewed).

Chapter VI

Future Extensions of Service

Medical Social Work is a new profession, a new service for the sick person. It "emerged during the first decade of this century as a new specialty that proved useful to the old profession (medicine) and also extended the area of helping in the newer field of social work."[1] With the increasing specialization in medicine, the doctors know less about their individual patients and more about diseases. It is the social worker who can fill this growing gap; for while the doctor may treat the disease, not the patient, to the social worker the patient is a person who is sick and whose illness has meaning to him.

As the profession of medical social work grew, many jobs were assigned to workers, because it was difficult for lay persons to understand the place of social work in a hospital, and because social workers themselves could not clearly define their role. Moreover, they were adjusting with difficulty to the unfamiliar restrictions imposed by a hospital setting. Social service in a hospital must be a service within a service, for the hospital's primary function is to provide medical care to its patients. Experience has shown the desirability of social workers serving in a consultative capacity rather than assuming direct administrative responsibilities. The social worker has to be part of the hospital, and yet apart from it, identifying completely with neither the doctor nor the patient, although still endeavoring to assist both with the problem. The working relationship is always at least three-sided, and frequently multilateral.

1. Fink, Arthur E., The Field of Social Work, New York, Henry Holt & Co., 1942, p. 266.

Today, a medical social service department has a primary function: "to assist patients in meeting personal problems associated with their illness so that, in constructive ways, they may develop their capacities to cope with life as adequately as possible, and thereby ensure the greatest benefit from medical treatment. Casework services ... (have) added significance in the light of ... growing interest in understanding patients as individuals and in evaluating the social and environmental factors which are related to the illness."[1] In order to perform this function, social workers require prolonged training and specialized skills, and only fully qualified workers can be expected to maintain the professional standards required by modern hospitals.

It is necessary for the administrative and medical staffs to recognize this function of a social service department, and yet, their understanding, acceptance and cooperation are directly dependent upon the department's ability to demonstrate and interpret its service. In a setting where traditions must be outgrown, the onus is clearly upon the department itself to clarify its position and elevate its status. This may be encouraged by instructions in the training courses for doctors and nurses, by staff meetings and conferences, and by day-to-day demonstration on the job.

Ideally, an adequately staffed, fully trained social service department, under an administration which has understanding and insight into professional casework, can function with few difficulties, and can be an effective part of the hospital team of combined professions. Its service is accepted and recognized, and its course is clearly defined. As the foregoing chapters have illustrated, the social service department of the Vancouver General Hospital has not yet attained the ideal

1. Commission on Hospital Care, Hospital Care in the United States, New York, the Commonwealth Fund, 1947, p. 93.

position, and some of the reasons for the discrepancies are indicated. It is necessary to remember that this social service department was emerging at the same time as the profession itself. It was not, of course, a professional service at the start, but, in common with the emerging profession, it was performing miscellaneous functions, endeavoring to find its place, and, at the same time, building a foundation upon which a professional service was to grow. It is encouraging to find that the trend is in the right direction. Many of the desired improvements are already being undertaken by the department; others have been postponed, although the department is aware of the need for them.

Several levels of service may be distinguished in the work of the social service department, and changes might be suggested in all of these. It would seem that the department has been hampered by many traditions of yester years, and has been aware of this, but uncertain how to free itself.

Suggested Reforms concerning Service to Patients

(a) Cooperative contacts with other professional persons.

As the most important function of the department is to provide consultation and assistance for patients, it would seem that the most obvious need at present is for more qualified workers. If the standard of service is to be raised and the availability of professional service is to be increased, at least double the present staff will be required. The department has consistently pressed for more workers, but has encountered a two-fold obstacle which is not yet removed. In the first place, although some demands for social service for certain new clinics cannot be met because of the lack of qualified graduate workers, many of the

doctors are not yet aware of professional social service, nor are they in the habit of making referrals. At the same time, the administration, intent on careful budgetting, can hardly be expected to provide for increased staff until the demand is more urgent. Therefore, the need for increased demonstration and interpretation of the nature of professional social service to the medical and administrative staffs becomes apparent.

The department is, at present, trying to make its work known on an individual worker-doctor basis, seizing opportunities when they arise. However, it would seem that the onus is upon the department to undertake a more active programme of interpreting its service, without necessarily becoming aggressive. There are many professional persons in the hospital who are completely unaware that social service is no longer a philanthropic service for indigent patients; but there is no reason to believe that these individuals would be resistant to interpretation of the professional service, or unwilling to cooperate when given some understanding of what it actually is. The department is at some disadvantage, compared to similar services in other hospitals, such as in Department of Veterans Affairs Hospitals, where social service is recognized by the senior levels of administration, and established as a professional service simply by adding these positions to the hospital organizations. However, tradition can be outgrown, and the department itself should initiate the necessary action.

It is encouraging to note that the department has been given increased recognition in the plans for the new building, where office space has been allotted with the hospital administration and on the wards. However, a less passive role assumed by the department at present might provide sufficient impetus so that its staff may be enlarged in advance to meet the future demands for service.

A more efficient distribution of existing staff might be worthy of consideration. For instance, the assistant director should be relieved of her administrative duties in the subsidiary hospitals, a function which was assumed in a time of emergency, and has persisted. The medical social worker's function "should supplement but not supplant the function of administration."[1] Similarly, the two workers assigned to admitting patients to the Outpatients' Department could be more effectively used as caseworkers than in this administrative capacity. This is another traditional duty which developed with the growing Outpatients' service. The present structure of the Outpatients' Department is so haphazard and confused, that it might be necessary to await its complete reorganization before social service can find its proper position there. With this reorganization, however, the social service department should be reassigned over the entire hospital on a more equitable basis.

Office accommodation is not satisfactory, and private rooms for undisturbed interviewing are particularly needed. Main social service offices and the office used in the Maternity Building offer no privacy; the large office formerly assigned to social service in the Health Centre for Children has been taken over for speech therapy; nor are there offices for social service on the wards. The need for increased clerical staff is likewise apparent. These inadequacies are frustrating impediments to the workers in their efforts to provide good service to the patients.

(b) Relationship with the Women's Auxiliary

The department is also still involved with the Women's Auxiliary in an unsatisfactory manner, with reference to transportation and procurement of appliances. The hospital administration has made no provision for transportation for the social workers. The Outpatients' Department,

contrary to usual procedure, provides transportation for many patients, a service financed by the Women's Auxiliary or by special arrangement with the City Social Service Department. However, the car which is used for this service was originally intended for the use of the social service department. Consequently, workers are without any means of transportation, and must appeal to the Women's Auxiliary fund for street car fare, or, alternatively, pay their own expenses. As a result, home visiting service is neglected, and the department tends to avoid giving service beyond the hospital. Some more satisfactory arrangement should be made whereby transportation costs for workers are included in the hospital budget. Likewise, the requests for transportation for patients should not be included among the social worker's duties.

It is not the hospital's function to provide appliances or dentures for patients, and the Women's Auxiliary performs a valuable service in this area. However, according to present policy, the applications must be presented to the Women's Auxiliary by the director of the social service department and her workers. This seems to be merely a matter of routine, and the application is usually accepted. It would therefore seem to be an unnecessary duplication of service for both the social service department and the Women's Auxiliary to be involved, and the applications could be presented directly to the Women's Auxiliary upon the doctor's prescription, without detracting from the service to the patients.

The Women's Auxiliary has consistently played an important role in the service to the hospital, and its willing participation should not be overlooked. Although its function should be separate from the social service department, the two services have many interests in common, par-

ticularly concerning the welfare of the patients. Future policy should be to cooperate carefully with this volunteer group, and, wherever possible, for the department to avail itself of the services of the Auxiliary and to accept its assistance within the social service department. There is a place for volunteers in every agency, and their service is worthy of consideration and respect.

(c) Concerning internal operation

The following suggestions for improvements in the social service department are of relatively less importance, although worthy of mention at this point. They do not directly affect the service to patients, but are concerned rather with the internal operation of the department.

In the first place, the job manual used by the hospital personnel department should be revised with reference to the social work positions described therein. This manual includes a complete and carefully prepared evaluation and rating of all positions within the hospital below the level of department heads. However, little understanding of the professional function of social casework is indicated in the job description, and a revision in which the social service department participates should be made. This would provide an opportunity to interpret the function of professional social casework, and would ultimately result in improved standards of service.

A related point to that just mentioned concerns the statistical records prepared by the social service department and submitted to the senior levels of administration. As described in a previous chapter, these reports have little meaning to the administration, and are not understood by the administrators. These statistical sheets were prepared independently by the social service department and have not been explained to the directors in charge. It would seem that the department

should try to interpret these statistics to the hospital administration, or collaborate with the executive in the preparation of forms which would be mutually valuable.

The filing system for social service records is not consistent, and, therefore, not completely efficient. It would appear that several attempts have been made in the past to reorganize the files, but a complete job was not done on these occasions. Consequently, it is often necessary to search in several places for a desired file. It is planned to house the social service records with all other hospital records when the reorganization of the records department is completed, which might be the opportune occasion to re-file the social service records. Although this would not be a duty for the social workers to assume, they should be able to give valuable consultation when reorganization is being done.

It may be seen that the development of the social service department is not yet complete, and a great deal of work remains to be done before its proper position is attained. The department will have much to offer by way of specialized service in a consultative capacity, and the hospital is just beginning to recognize this fact. If the department could share its own awareness of its potentialities and its shortcomings with the other professional personnel of the hospital, its position would be more appreciated, and its development would be supported and encouraged.

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