

REHABILITATION OF PARAPLEGIC PATIENTS.

The origins and development of work at
the Western Rehabilitation Clinic and the
role of the Social Worker.

by

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ABSTRACT.

It is commonly said that rehabilitation is not the prerogative of any one group or person. This thesis surveys the method by which the achievements of the rehabilitation programme developed by the Department of Veterans' Affairs were made available to those civilians who suffer paraplegia or quadriplegia. It traces the changes in the existing programme as it altered from one which was solely medical in nature, to one which provides services for physical, social and vocational effects of the person's illness.

The recognition of the non-physical aspects of illness also helps to emphasize that a handicapped person is a human being and, as such, is a member of society. These non-physical aspects are not only his own reaction to his physical conditions, but also the reactions of the society in which he lives. The problem in developing this rehabilitation programme has been getting the support and close co-operation of interested people and agencies in the community

How the problem has been met so far is examined by a survey of the role of the agencies concerned in this particular programme. The changing procedures are illustrated by means of case records of patients who were clients of the Social Service Department of the Vancouver General Hospital. The records used are those which best illustrate the degree to which the programme was an integrated rehabilitative process.

The transition from a medical treatment programme to a total rehabilitation programme has not yet been completed; a medical, rather than a rehabilitative, diagnosis is still used to establish eligibility for training at the Rehabilitation Centre. Little use has been made of casework services, because the social worker-placement officer is doing work which should be done by the General Hospital and the National Employment Service.

The study concludes by suggesting that the next steps required are; to have vocational placement done solely by the Special Placement Section of the National Employment Service; to have the General Hospital Social Service Department provide casework service to the patients in the hospital; to interpret to the personnel involved, the role of each person and agency in the programme, and to further co-ordinate the activities of the various agencies using the facilities at the Rehabilitation Centre by discussing common problems of rehabilitation and the needs of patients with the members of their auxiliaries.

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REHABILITATION OF PARAPLEGIC PATIENTS.

Chapter 1

THE REQUIREMENTS OF A COMPLETE REHABILITATION PROGRAMME.

The Western Society for Rehabilitation was incorporated under the Societies Act of British Columbia in 1947. The Society's aims were to construct, equip, and operate a rehabilitation centre for severely disabled orthopaedic patients. The planning followed the recommendations of the Baruch Committee on Physical Medicine (New York), and the experiences which the four Department of Veterans' Affairs Rehabilitation Centres in Canada encountered. The Baruch Committee has stated that "the goal of rehabilitation is to achieve the maximum function of the individual and to prepare him physically, mentally, socially, and vocationally for the fullest possible life compatible with his abilities and disabilities." This definition has been accepted by the Western Society for Rehabilitation as the goal for its services.

This definition implies several things. First, it implies that rehabilitation is an integrated process. It is a process which deals with four of the major components of the patient as a person. It is concerned with his physical condition, his position as a member of society, his mental outlook on life, and his occupational placement. Secondly, it implies that a patient may react to his new position in such a way that his outlook on life may have to be altered before he can live the

"fullest possible life compatible with his abilities and disabilities". Thirdly, it implies that the patient's position in society, or in his family, may be altered as a result of his physical disability. It recognizes that it may be necessary for a patient to change his occupation, if he had one, or require special training to give him a degree of economic independence. Finally, it recognizes that the process of rehabilitation started in a treatment centre can continue after the patient is discharged. It is an attempt to prepare him, while he is there, in such a way that he may reach the ultimate goal of the rehabilitation process: a maximum level of functioning in his home, at his work, and in society. Originally, the name of the Society was The Western Society for Physical Rehabilitation. As their programme developed, and more of the non-physical aspects of rehabilitation were introduced, the word "physical" was dropped, because it implied that the Centre was a medical centre, when, in reality, it has become a centre for rehabilitation.

In this thesis, preparing a person mentally is taken to mean that, as a result of face-to-face relationships in his daily life, he may come to see himself as a member of society who is functioning at his maximum capacity. He will realize, also, that by so functioning, he is fulfilling his obligation to society. Preparing a person socially is taken to mean that his ultimate placement will not cause an unjust burden to be

placed on his family, and that society will accept him for what he has to offer. This definition implies that a person who was physically well enough would not be discharged to his home if his mental attitude was such that the other members of the family might be adversely affected. Conversely, if a person required nursing home care because of his physical condition, he would not necessarily be placed there if his family could not accept such a plan. "Abilities and disabilities" are taken as including the assets and liabilities in the patient's physical condition, his mental outlook, and his social and vocational position.

The Group to be Studied.

The present study is concerned with the rehabilitation of those patients who are classified as paraplegics and quadriplegics. Paraplegia is the complete or partial motor paralysis of the lower extremities, or of the lower part of the body¹. Quadriplegia involves all four extremities and the lower part of the body. There is a complete or partial loss of sensation in the case of traumatic paraplegia and quadriplegia, including light touch, pain, heat, cold and vibration. At the same time, the internal organs, such as the bladder and bowels, may become paralytic; and the skin, due to a lack of sensation and disturbed circulation, becomes liable to pressure sores. The causes of the paralysis are either spinal cord injuries, or damage to the central nervous

1. Gingras, G. "Rehabilitation of the Paraplegic Patient", Treatment Service Bulletin, Feb. 1947, Vol. 4, No. 2, p. 5.

system by virus attack. In this study, the patients who are paraplegic as a result of a disease have been stricken with poliomyelitis. They have been left with varying degrees of residual paralysis or weakness as a result. The fact that there are differences in the degree of the physical handicap will affect the ultimate placement of the patient. This thesis will not attempt to evaluate the success of the rehabilitation programme as it has developed. It will be concerned with the degree of help the patient receives in adjusting mentally, socially and vocationally.

Poliomyelitis.

"Poliomyelitis is an acute viral disease, which, in its most characteristic form, involves various parts of the central nervous system, particularly the motor neurons of the spinal cord, producing varying degrees of weakness and paralysis of the voluntary muscles".¹ In the majority of cases, "polio" is in a mild form, and does not show signs of central nervous system involvement in the upper respiratory or gastrointestinal system. It is world-wide in its distribution, and there is evidence that shows it existed over 5,000 years ago. It was first noted in a recognized medical record, that was written in Sweden, in 1784. Apparently, polio existed for thousands of years without being

1. Harrison, T.R.(ed.) The Principles of Internal Medicine, The Blakinstone Company, Toronto, 1950, p.1067.

recognized. There are three factors which account for the delay in recognizing this disease. First, there are the recent advances in medical science, which emphasizes observation and recording. Secondly, until seventy years ago, there were few epidemics of polio. Doctors only had to deal with isolated cases. The epidemics have been increasing in the last seventy years, and the improved means of communication resulted in news of the epidemics being brought to a great many people. News of those epidemics which terrified sections of the United States at the turn of the century was presented to the public by means of daily news reports. The third reason why polio was not recognized for such a long period of time, is because the epidemics are limited to the United States, Canada, Holland, Australia, New Zealand and the Scandinavian countries. There were, then, no records of epidemics in the writings of the ancient world.

In 1937, in the city of Toronto, a serious epidemic of polio occurred. Special clinics were established to spray the nasal passages of 5,000 children. It had been found by Dr. Edwin Schultz that, by spraying the nasal passages of monkeys with zinc sulphate¹, polio could be prevented. Although this stopped the virus in monkeys, it did not in human beings. The control group of 5,000, was compared to 6,300 children who had not received

1. Berg, R.H. Polio and Its Problems, J.B. Lippincott Co., Montreal, 1948, p.37.

treatment. The difference between the attack rates in the two groups did not exceed one per cent.¹

The doctors knew that nerve cells are damaged by the polio virus. This knowledge led them to dispute the claims of Sister Kenny that polio was primarily a skin infection, which did not affect the nerve cells.² Few doctors disputed the value of her treatment. Unfortunately, some doctors did dismiss her approach entirely because of this error. The press tended to emphasize the disagreement between these doctors and Sister Kenny.

In North America, the doctors followed the practice of English doctors, and immobilized the affected limbs. Instead of conserving the muscles, as was hoped for, it too often resulted in the muscles withering from disuse. These results tended to create the impression, in the public's mind, that polio always left the patient a cripple.

Possibly, the fight against the disabling aspects of polio which Franklin Delano Roosevelt waged has been the greatest source of inspiration to those people who have attempted to salvage the victims of polio. Here was a grown man, who was a victim of a disease commonly known as "infantile paralysis". Here,

1. Berg, R.H. Polio and Its Problems, J.B. Lippincott Co., Montreal, 1948, p.43.

2. Ibid, p.126.

also, was a man not pitied for his disability, but respected for his ability. President Roosevelt was severely crippled by poliomyelitis. He was not particularly handicapped by it.

R. H. Berg reports that, "Of all the victims of poliomyelitis, fully fifty per cent of those who succumb to acute attacks will recover completely. They will show no trace of muscle weakness or loss of power. Of the remaining fifty per cent, almost a half will recover, with, perhaps, just a trace of weakness or muscular paralysis. Of the remaining twenty-five per cent, from three to ten per cent will die. Thus, we have left about fifteen or twenty per cent of all the acute cases who will be left with severe and permanent¹ paralysis. It is assumed that the percentages in Canada will be about the same. The importance of this group is, not because of its size in numbers, but because of the cost of hospital care, equipment, and retraining. In the first case to be presented later in this thesis, the hospital bills from 1947 to 1951 have² amounted to over \$22,000. Case # 4 shows that, by investing \$3,500 in rehabilitation, the Welfare Department of British Columbia is expected to save \$17,500 during this man's lifetime. These figures are not cited to illustrate that a rehabilitation programme is responsible for a saving of money, in contrast to the

1. Berg, R.H. Polio, p. 122.

2. Kinsmen Brief to British Columbia Hospital Insurance Service, 1951, p.1.

cost of maintenance where an inadequate programme existed. They show merely that the medical costs of caring for a severely disabled post polio patient are great. So are the rehabilitation costs.

Traumatic Injury to the Central Nervous System.

World War I produced the first large number of paraplegics and quadriplegics who were paralyzed as a result of injury. Few of them lived long enough to reach a base hospital, because of the transportation difficulties. Of those who did, most died within a few years. Medical complications arose because of the long bed rest required. Pressure sores meant a loss of body fluid; inability to properly empty the bladder led to genito-urinary infections, and the long periods of lying still led to the formation of calculi causing kidney infection. Added to these dangers was the lessening of resistance due to persistent and severe pain.¹

During World War II, the introduction of the antibiotic drugs and the rapid evacuation to base hospitals meant that a far higher percentage of these men returned to Canada. The efforts to rehabilitate these men has led to rapid advance in similar programmes during the last few years. Those who were injured as a result of war service are being cared for by the Department of Veterans' Affairs. The group studied are those who have been injured in industrial

1. Gingras, G. "Rehabilitation of the Paraplegic Patient", Treatment Service Bulletin, February 1947, Vol.II, No.2, p.2.

accidents, at home, and at play.

In the fight against poliomyelitis, effort on a national scale has been concentrated on trying to control the disease. The rehabilitative aspects have been left largely to local groups. For traumatic paralysis, due to war injury, single governmental departments have been responsible for establishing a rehabilitative programme in North America. In the first instance, there was widespread public awareness of what the disease did. In the second, there was little public knowledge, because the numbers were not large, but a single agency was faced with the problem of rehabilitating these men.

What Rehabilitation Means.

In studying the development of a rehabilitation programme in Vancouver, emphasis must be placed on the degree to which those programmes are truly rehabilitative. Rehabilitation is not a method of doing something¹, that is, "a system of procedure or conscious regularity", as "method" is defined in the Oxford dictionary. It is a "phenomenon which shows a continuous change in time, whether slow or rapid". It is not what is done for a person, but what is offered to a person for his own use. Because each patient reacts as an individual to his disability, rehabilitation is an individualized process. The degree of his reaction to his disability, plus society's reaction and his family's reaction to that

1. Hamilton, K. Counseling the Handicapped in the Rehabilitation Process, The Ronald Press Company, New York, 1947, p.63.

disability, determines the extent to which he is handicapped.

A man who can no longer support his family may feel completely worthless if providing for his family was his way of showing his love for them. For such a person, illness could have great social implications. Deafness might well mean the end of a career for a musician, yet it could be a blessing to a riveter in a boiler factory. Disabilities, then, could force a person to seek new employment, or could permit him to carry on as before. Paraplegia might be a slight handicap to an accountant, who could resume his former job without suffering any loss of "status" or income. Paraplegia could cause great anxiety to a logger, who lacked the education for a sedentary job; a job which could well mean a lower standard of living for his family.

The Patient.

Permanent disability invariably produces dependency, whether temporary or permanent. For a paraplegic or a quadriplegic patient, "recovery" is a matter of adjustment to the disability.¹ There is no "cure". The patient is dependent, at first, on the doctor to save his life. Later, he depends on the doctor to restore his physical ability to the highest possible level. Seldom can he pay the hospital bills, and often his family must seek financial help. For a long time, he is completely dependent on those around him. He is bathed,

1. Hamilton, K. Rehabilitation, p.49.

shaved, fed, turned in bed, and requires help in order to eliminate body waste. He cannot plan for the future without help. He depends largely on the knowledge others have of the community in order to start making those plans. Yet, somehow, he must not lose his desire to be an independent person. Confidence in his own ability must be maintained. This can seldom be achieved unless those around him, those who are helping him, see him as an individual. Knowledge of the patient comes from the nurses' observations of him from day to day; information gathered by the Social Service Department of his previous life and his place in his family; information gathered by his vocational counsellor, and from the findings of psychometric tests if they are needed.

In a hospital setting, about the only thing which is not done for him is his thinking. It is influenced by both his past and the present. The way in which he reacts may not seem at all intelligent. He may be rude and extremely critical of those who are trying to help him. He may blame his illness for this, whereas, in reality, it is his fear of being discharged into a friendless world as a cripple. This fear may make him reject all efforts towards independency.

The Frame of Reference for Rehabilitation.

No matter how a paraplegic or quadriplegic patient reacts to his disability, he could never join the army as a soldier, because of his physical diagnosis. No matter how slight his physical disability, he could never

be independent unless he wanted to; nor could he be employed on a competitive basis if he did not have sufficient training to do the job; nor could he be employed regardless of his physical disability, his reaction to it, or his vocational training, if there was no job in the community for him. His disability will invariably create certain handicaps for him. Hamilton has defined a handicap as "the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level"¹. The goal of rehabilitation is, therefore, focused on the patient and his handicap, and not on his disability.² Armed with the knowledge he has about the patient as a person, each member of the rehabilitation team uses his own particular skills to help the patient help himself. In a phrase, it is applied casework.³

Because his handicap is in a single unit, the patient, the rehabilitation process must be co-ordinated. It is not possible for one specialist to work with his disability, and when that is done, for another to work with his family, at which time yet another steps in to remove inhibiting reactions from his thoughts, and he, in turn, signals the start of the vocational retraining. It is his body that is crippled, his family that suffers, his

1. Hamilton. Rehabilitation, p.17.

2. Ibid, p.19.

3. Ibid, p.8.

place in society and industry that has changed. Co-ordination between the various disciplines is necessary, because one diagnosis alone seldom constitutes the rehabilitation diagnosis. The rehabilitation diagnosis is compiled from the physical, social, mental and vocational diagnoses.¹

The rehabilitation process should start as soon as possible. This is apparent when we realize that the physical or medical diagnosis is part of the total process. There is no set time for the other aspects of the process to be introduced, because rehabilitation is so individualized. Hamilton states that it should begin at the time of recognition of any permanent disability that will constitute a handicap. This definition does not limit "disability" to "physical disability" alone. Dr. G. Gingras, Director of Physical Medicine at Queen Mary's Veterans' Hospital, Montreal, has stated that the paraplegic rehabilitation programme, which took two years under the "salvage" or "case finding" method, can now be achieved in four months where the facilities for preventing the "deterioration" of the patient as a person are brought into play at once.²

How have the various aspects of rehabilitation, as outlined above, been met in the

1. Hamilton, Rehabilitation, p.8.
2. Letourneau, C.U. Rehabilitating the Handicapped, The Rehabilitation Society for Cripples, Montreal, 1951, p.14.

development of the rehabilitation programme for paraplegic and quadriplegic patients in Vancouver? In order to examine this programme, it will be divided into two major headings. The first includes the resources, and the second, the process. The resources, public and private, will be studied in order to determine why they originated and what services they offered. Added to this survey of resources will be illustrative cases, which will try to show why changes in the concept of rehabilitation as each new resource was created, or an existing one altered its policy. There is little written material concerning the origin and function of the agencies. The information has been largely gathered through a series of interviews with personnel of each agency discussed. The "cases" used are taken from the files of the Social Service Department of the Vancouver General Hospital. The information obtained from there is supplemented through interviews with various personnel, such as occupational therapists, the physiotherapists, placement officers from different agencies, and rehabilitation officers.

Chapter 2.

THE DEVELOPMENT AND THE PROGRAMME PRIOR TO JANUARY, 1949.

The Vancouver General Hospital was founded in 1902, as a voluntary, non-profit institution. It operates as an "open" hospital; this means, in part, that it accepts all people who are in need of acute medical care. It undertakes the treatment of infectious diseases, and its services are available regardless of a person's race, colour, creed, or ability to pay. The cost of this free service was met, until 1949, by grants from the City of Vancouver and the Provincial Government, though these grants have been discontinued since the inauguration of the British Columbia Hospital Insurance Scheme, except for the work of the Out-Patients' Department. Free service of this nature is not for indigent people only. It is also available if there is evidence that the responsibility for meeting the hospital bills will prove to be too great a burden for the patient or his family. An example of this policy was seen in the record of Alan, discussed in a later chapter. Alan's father was earning approximately \$250.00 per month. He owned his own home, and was buying a car. There was only one other child in the family. Alan had contracted poliomyelitis ten years earlier, and was left with some paralysis of one leg. It was apparent that the many small medical bills this family had been faced with during the last ten years had

made it impossible for them to save any money. Because of this, and their apparent willingness to pay what they could towards his retraining at the Western Society for Rehabilitation, he was taken on as a staff-non-pay patient. This meant that he would get free hospital and doctors' care for the remainder of his stay, and the hospital would absorb his bill, which was over \$2,000.

Vancouver Occupational Industries.

The so-called Vancouver Occupational Industries was started in 1930 as an auxiliary service for the hospital patients. The purpose it was to serve was two-fold; to provide the long-term patients with a means of occupying their enforced idleness usefully, and to give them some occupational training. As its programme developed, a plan for paying wages to the trainees was instituted, and a committee was formed later to help the trainees secure employment. One of the qualifying criteria for retraining was that the patient had to be indigent.

By 1939, its policy had altered, and it was then functioning as a convalescent workshop. Its aims were to retrain those patients who were forced, because of illness, to change their occupation, and to build up "work tolerance", so that the patients would be better prepared for work elsewhere.

This agency was not able to operate effectively, because the applicants were not screened carefully enough before they were accepted for training at the workshop. It tended to become a place of permanent

employment for people who could never work in a competitive market. Added to the problem of having too low a rate of turn-over, was the inability to obtain well-trained instructors during the war-time prosperity who would work for \$100 per month. In 1945, twenty-seven disabled people, who showed no signs of ever being able to work in a competitive market, were laid off because the agency could not afford to pay them their maintenance of \$28 per month. Later in the same year, the agency ceased to exist, because it was losing money.

The faults of its programme were; improper screening, no periodical examination of its programme, and the belief that it could be self-supporting when it was only open to disabled indigents.

From the time that the Vancouver Occupational Industries closed, until the 1st of September, 1947, there were no occupational therapy or handicrafts taught to the patients. For most of the patients, this was of little consequence, for they were not in the hospital long. For the paraplegic and quadriplegic patients, this was important, for they spent months, and often years, in the hospital. In 1947, the paraplegic and quadriplegic patients were on Ward West 3 of the SemiPrivate Pavilion. While there, they had the services of a well-organized, industrious Women's Auxiliary. The Auxiliary provided such services as letter writing, reading to people who could not hold books, running the library, making purchases for the

patients, and many other small but important jobs. On the 1st of September, 1947, Miss E. Galt, a graduate in Arts and Crafts from St. Anne de Bellevue Military Hospital, was added to the hospital staff. She was to work primarily with the paraplegics and quadriplegics. Her duties were to be directed to "getting the patients in a receptive mind so they would accept further rehabilitation". In teaching leatherwork, weaving, moulding, etc., no emphasis was placed on output. The work was to stimulate their interests and to provide a diversion from the dull daily routine of the hospital ward".

In 1948, it was decided to move the paraplegic and quadriplegic patients from the Semi-Private Pavilion to the third floor of the Infectious Diseases Hospital (IDH3), and Miss Galt moved with them. The Women's Auxiliary, however, did not. They did not know that Ward IDH3 was a non-infectious ward, and evidently no-one bothered to tell them; consequently, there was no-one to look after the library, run the canteen wagon, write letters, look after the bank accounts of quadriplegics, read to them, or do their personal shopping. Miss Galt undertook these duties, along with her other ones. In addition to these jobs, she has also developed others; she arranges for the annual outing to the Hobby Show at the Pacific National Exhibition, arranges for a "movie" to be shown on the ward every two weeks, and helps the physiotherapists make devices so that patients can feed themselves. In addition to this, she arranges dinner

parties in her room. In this work, she has the close co-operation of the Dietetic Department, who also recognize that these parties help the patients to overcome their self-consciousness resulting from their awkward eating habits, and also provide a type of social contact which is over and above the ward contact. (Many of the patients are in private rooms).

Still another social affair she arranges is the monthly birthday party. This is sponsored by the Mount Pleasant Branch of the Canadian Legion (117), and is held once a month. Fruit and cigarettes are provided to all the patients, and also a birthday cake, which is inscribed with the names of all the patients having birthdays in that month. The patients whose birthdays are in that month gather around the table in the occupational therapy room, and hold a joint birthday party. Later, a piece of cake is given to each patient on the ward.

The work done by Miss Galt certainly relieves much of the monotony for the patients, and illustrates the great number of services required, apart from the nursing and medical care, to get the patients in a receptive mind to accept further rehabilitation.

On the ward, she has the close co-operation of the nurses, aides and orderlies, but, because their duties take up so much of their time, they cannot help to the extent they would like to. Many of the patients need to be lifted, turned, bathed and fed by the staff. Because of this, the staff's work is harder than on most of the other

hospital wards. This leads to a fairly high turnover in staff, particularly in the case of orderlies. Many of them do not stay on the ward long enough to become a part of Miss Galt's programme. There is, however, one group of patients for which very little is done. This is the group of infants who are recovering from poliomyelitis. These children do not fall within the scope of this thesis, but it is obvious that the nurses, orderlies and nurses' aides cannot spend time playing with these children. Unless the Women's Auxiliary is asked to provide some sort of nursery play-time for them, these children will continue to sit in their cribs day after day.

Hospital Social Service Department.

The role of the Social Service Department in the Vancouver General Hospital is now quite different from what it was ten years ago. Originally, its function was that of a placement agency. The chief task was to arrange for nursing home or boarding home placements for those patients who no longer required acute medical care. Another job it performed was that of arranging for the purchase of appliances for patients who could not pay for them. The social workers would find out the legal residence of the patients, as defined in the Residence and Responsibilities Act. They would then write to the Welfare Department in the responsible community and ask them to assume their share of the cost. This procedure did not take as long as might be imagined, for, under the Hospitals Act, such letters must be replied to within fourteen days. Unfortunately, the role of

the Social Service Department on Ward IDH3 was largely restricted to such duties. As the staff of the Social Service Department increased, some casework was done on an intensive basis, but the major portion of the work is the routine type described above. The other major area in which the Department works is that of trying to interest various agencies in the community to obtain, or provide, better facilities for the patients after their discharge. This has been done by interpreting to the agencies, or friends and relatives of patients, the needs of patients after discharge, or through specific requests on behalf of an individual patient. The Department has attempted to interpret hospital routines to interested people, and indicate to them how they can be of help to the patients during and after their period of hospitalization.

Provincial Welfare Services.

Under the terms of the "Social Assistance Act", assistance may be given in money or in "kind". Section 'C' lists institutional, nursing, boarding or foster home care as "kind". Sections 'E' and 'F' list counselling services and Health Services. Section 'G' of this interpretation of the Act is of particular interest to the present study, for it lists, "occupational training, retraining, or therapy for indigent persons and mentally or physically handicapped persons". Physically handicapped persons were not given occupational training or retraining under this Act.

What was given was the payment of Social Allowance to unemployable persons and their dependents, and the provision of nursing-home and boarding-home care. The cost for this care was met jointly by the Provincial Government (80%) and the responsible municipality (20%). The Residence and Responsibility Act sets out the conditions under which a municipality is responsible for the care of its residents. The cost of this care, as it comes within the Social Allowance Act, is not the same as the per diem rate which is charged against a municipality under the Hospitals Act. The Provincial Government was not attempting to restore working capacities; it was providing assistance to people who appeared to be chronically incapacitated.

Workmen's Compensation Board.

The first Workmen's Compensation Act was passed in 1902. The Act, which came into effect at that time, gave a workman, who was injured "in any accident arising out of and in the course of his employment", the right to sue his employer for damages if his injury was caused by the personal negligence or wilful act of the employer. In 1916, this unsatisfactory Act was repealed, and replaced by a new Compensation Act, which created the Workmen's Compensation Board. This Board was charged with assessing the cost of the burden of accidents on the industries, and at the same time it was to inspect and regulate accident-prevention equipment. The function of the Workmen's Compensation Act was two-fold; to provide insurance, and to prevent accidents. In the Sloan Report of 1942, a further idea was incorporated; that of

rehabilitation. The argument used for broadening the programme from one of a mere system of insurance, to include rehabilitation, was that accident prevention was not strictly a part of an insurance programme, and it formed a large part of the Board's work. The report states that "everyone probably would agree that prevention is better than cure, and cure is better than compensation. Therefore, when prevention fails to prevent, we must give attention to cure". The Workmen's Compensation Act protects the worker against having to work with unsafe machinery. It provides him with a pension in the event that he is permanently disabled. Through its policy of paying a worker for his disability and not for the resulting handicap, even following rehabilitation, the Act offers security. The rehabilitation services offered to him give him an incentive towards bettering his financial position. They are not given as an uncertain alternative to the security of a fixed income.

A rehabilitation section on these lines was added to the Workmen's Compensation Board in March, 1943. This section must work within a yearly budget of \$75,000, and its services are open only to those who suffer permanent partial impairment, which prevents them from returning to their former occupations. They are eligible for retraining, providing their injuries resulted from accidents occurring on or subsequent to March 18th, 1943. It is expected that the Sloan Report, now before the legislature, will substantially increase their budget.

There are six rehabilitation officers employed by the Workmen's Compensation Board. Their function is to see that the injured workmen get the services they require in order to be rehabilitated. Their work is chiefly that of co-ordination and counselling. Close co-operation between the rehabilitation section and the various agencies in the community is essential. Use is made of such agencies as the Social Service Department of the Vancouver General Hospital; the Rotary Counselling Service; the facilities at the Western Society for Rehabilitation, the Vancouver Vocational Institute, and correspondence courses from the Department of Education in Victoria. To facilitate this close co-ordination, they work closely with each of the larger hospitals. One is stationed in Victoria to serve all Vancouver Island claimants, and another is stationed at the "Board's" physiotherapy department on Second Avenue.

The Board does not provide casework help, but relies on various agencies in the community to offer this service if it is thought to be needed. This help cannot always be provided to the degree required, because the efforts of the rehabilitation officer and the social workers cannot always be effectively integrated. In the present programme of rehabilitation offered by the Compensation Board, one aspect of rehabilitation is, consequently, largely neglected. That aspect is the social implications the illness has for the patient.

In 1945, two more organizations were added to the programme. These were the Kinsmen's Charities and the Canadian Paraplegic Association. Both are interested in obtaining the best possible care for paraplegic patients. One worked to unify the services in the various communities and the other to extend the specialized services of the Department of Veterans' Affairs.

Kinsmen Clubs.

During World War II, the number of Kinsmen Clubs in Canada had increased in number by 75%. During this time, they were all engaged in a united effort; the Milk for Britain Fund. In 1945, following the end of the war, this work stopped, and the Kinsmen's Club of Vancouver decided that they would survey the welfare programmes existing in the Province, to see what services they could best provide. They found that, with polio patients, the incidence is low, approximately 1/10th of 1% of the population. (In British Columbia, this amounts to fifty cases per year, although about every ten years the number runs up to about two hundred cases). It did not appear that the costs would be too great, for they would be augmenting the services which were available. Their survey showed that nothing was being done in the Province to rehabilitate people with residual paralysis resulting from polio, except to provide medical and hospital treatment. It demonstrated a shortage of funds, a lack of equipment, and a lack of trained staff.

Physical retraining was being done at the Physical Medicine Department of the Vancouver General Hospital only. This survey, which was financed by the Kinsmen, and made by Dr. Alan Brown of Toronto, recommended that a programme of assistance to residual paralysis polio patients be considered. In planning such a programme, Dr. G. F. Strong asked the Kinsmen to join in the establishment of a centre to provide such services, and this was considered by the Club.

From 1945 to 1948, the Kinsmen's Club of Vancouver raised \$69,000. All of this was spent on equipment, such as wheel chairs and braces for the patients, as requested by doctors; for vocational training, as requested by the Social Service Department of the Vancouver General Hospital; and on the training of three physiotherapists. These physiotherapists were to work at the Vancouver General Hospital for three years in return for their training. Through one of their members, who is a doctor, the Kinsmen gained the co-operation of the Vancouver General Hospital. A Polio Board of doctors was created, and each polio suspect was cared for by a member of this Board. This arrangement tends to greatly reduce the size of doctors' bills for the patients.

It is interesting to note that the Kinsmen do not use the appeal of a crippled child in their money-raising drives. Their scrap-book of newspaper publicity

for the last two years shows only four articles and pictures about children. It is not a fund to combat "infantile paralysis", as it is in the United States. It is an appeal to raise money for a cause which they consider will be supported because of its inherent merit, and does not need to depend on an emotional basis for success. Their principal means of raising money is through a mail subscription campaign. Separate from this campaign are the many local campaigns which attempt to raise ten cents per wage earner in the community. This is done by tag days, dances, Sunday shows, bottle drives, small raffles, display windows with collection cans, whist drives, and various other schemes. In all of these efforts, the advertisements concentrate on the aspect of rehabilitation; rehabilitation which is for society's benefit, not just an act of pity.

Canadian Paraplegic Association.

The Canadian Paraplegic Association was founded in 1945. Originally, it was comprised solely of veterans, but, as soon as it was founded, the members voted to undertake to extend the achievements of the Department of Veterans' programme to civilians. Through soliciting membership from interested people, it undertook to finance civilian paraplegics in the Department of Veterans' Affairs Hospitals, on a repayment basis. As the veterans were rehabilitated, and moved out into the community, more non-veterans were brought in, until eventually they out-numbered the veterans. Lindhurst Lodge, in Toronto, which had originally been given to the Department of Veterans'

Affairs, to be used as a rehabilitation centre, was made over as a gift, for a nominal \$1, to the Canadian Paraplegic Association.

The Western Division of the Association was being formed at the same time as the Western Society. As it was expected to be easier to raise funds for a local society than for a national association, the Western Division of the Paraplegic Association did not continue its organizational drive. It agreed to aid in the formation of the Western Society and has continued to give active support to the Society.

The "Walking School".

In 1946, another step towards the establishment of a rehabilitation centre was taken when a walking school of the orthopaedically disabled was formed. This School was run by Martin Berry, a specialist who ran a similar school in California. He used the facilities of the Department of Physical Medicine at the Vancouver General Hospital. It functioned as a physical retraining centre only. Most of the paraplegics who attended these lessons were financed by the Workmen's Compensation Board. This is in keeping with their policy of utilizing all existing resources in the community to rehabilitate a worker. Those polio patients who could not pay for their own training or equipment were financed by the Kinsmen Club. As well as the private patients, those financed by the Kinsmen Club, and those financed by the Workmen's Compensation Board, there

were a small number of non-pay patients instructed.

The programme at this time needed to be revised. First, the facilities were overcrowded. Secondly, the programme lacked unity. The Walking School was using the facilities of the General Hospital, but it did not come under the Hospital's jurisdiction. Use was being made of the Hospital's Social Service Department for a few of the patients. Patients were being financed by the Kinsmen's Club and the Workmen's Compensation Board. There is no evidence available which would indicate that there was any co-ordination of effort. The school appeared to be accepted by the agencies as a part of the hospital. However, because a great number of the referrals came from outside sources, it was important that there be close co-ordination between the agencies. Apparently, this was never achieved.¹

The Rehabilitation Process.

What the rehabilitation programme offered to patients prior to January, 1949, can be illustrated by looking at the Social Service Department records of two patients.

The first record used is that of Betty. She was an attractive, twenty-year-old girl, who was stricken with polio in 1930. At that time, there was little medical knowledge on how to repair the damage caused by the disease, or on how to utilize effectively what muscle power she had left. Her record shows what could happen to any person who was severely disabled by polio twenty years ago.

1. The Head of the Hospital Social Service Department summed up its programme with the comment that, "It illustrated the need for the Western Society for Physical Rehabilitation".

It also illustrates how various agencies were used, at first, in an unintegrated way, and later, in a co-ordinated effort, to rehabilitate this girl.

She was admitted to hospital in 1930 and remained in hospital until January, 1938. While in hospital, she painted miniatures, copied from larger paintings, which she sold through the Vancouver Occupational Industries. She was removed to a nursing home, through arrangements with the City Social Service Department, in 1938. In 1940, she was moved home, where she was cared for by a younger sister. She is described in the record as being extremely demanding of this sister. She stayed at home for five years. In 1945, her sister was being married, and her husband refused to consider having this patient in their home. Apparently, her original discharge to the nursing home was arranged by her doctor, for the record shows no referral at that time. Her move home, and later to a City nursing home, was arranged for by the City Social Service Department, apparently.

She was brought over to Mr. Berry's Walking Class to see if she could benefit from it. At the time, she was unable to dress herself, due to partial quadriplegia; she could not go to the toilet by herself, or get from her bed to a wheel-chair. It was judged that she would be able to learn to care for herself if she attended the School, and so she was enrolled. The cost of transportation was paid for by the Hospital. A wheel-chair, a brace, and a drop-foot

splint, were provided by the Kinsmen, on request of the doctors and the Social Service Department. The Women's Auxiliary of the Hospital also provided a leg brace. On May 27th, 1947, she was re-admitted to the Hospital, on the grounds that the competitive attitude on the ward would be better than life in the nursing home. The Kinsmen financed an Art Course for her, at the request of her "board" doctor. The Social Service Department acted on behalf of the Kinsmen in arranging for accommodation for this course to be taught. Her Art instructor found that the girl was extremely good at painting miniatures, but felt that her long stay in hospital had completely killed any creative ability she might have had. Her progress towards physical recovery was slow, but she continued to show fairly steady improvement. She stayed in hospital until January, 1952. The later years of her stay are discussed in the next chapter.

Case # 2. This is the record of "Sadie". She was a thirty-year-old girl, who had been stricken with polio in 1938, whilst living on the prairies. She was living in Vancouver with her married brother at the time of her referral in September, 1947. This record illustrates the confusion which arose between agencies during the time the Walking School was in use. It was arranged to have her brought to the Walking School by taxi, but no-one had considered whether or not she could get into a taxi. She could not, and so it was necessary to admit her to hospital in October, 1947, in order that she might attend the School. The girl was referred to

the hospital by the Kinsmen's Club, and was referred to the Walking School by the City Social Service Department. She applied to the Kinsmen for \$1,300, for treatment and three months' hospitalization. This was granted. However, she was admitted by the hospital as a staff-non-pay patient, and it was only when the head nurse objected to her staying out overnight that the confusion as to who was paying for her treatment was eliminated.

From 1938 to 1947, she had been living with her married brother. She helped with the serving, and similar jobs, whilst sitting in her wheel-chair. She would get out of her wheel-chair onto her hands and knees, and scrub and wax the floors, although she was paralyzed from the waist down.

Her progress at the Walking School was very good, and in February, 1948, she was discharged to her brother's home. The City Social Service Department continued to pay for her transportation to the Walking School for the next few months. By this time, she was walking well with crutches and leg braces, and appeared to have reached her maximum physical recovery. She was granted Social Allowance by the City, but that ended in October, 1948, when the patient married.

These two cases illustrate the typical procedure followed prior to 1949. In discussing these records with various staff members, the lack of co-ordination was very apparent. Questions on finances, discharge plans,

etc., were answered with, "I do not know who paid for it", or, "We were not consulted; I imagine it was the City".

The records on "Betty" indicate that, for seven years, she was hospitalized, during which time she was "pampered by the staff" and was known as "the sweetheart of the ward". This over-indulgence apparently led to her demanding attitude at home. The five years she spent at home well illustrates the difference between placements; that is, moving a patient out of the hospital, and the type of planning which must be done in a sound rehabilitation programme. Good rehabilitation demands that the family also be considered. Family solidarity must not be jeopardized because of the assumption that patients would be happier at home.

There is no record in either file of conferences, which would indicate a rehabilitation diagnosis was formed. Procedure was not integrated. The programme could only be described as a medical treatment plan. It was not a rehabilitation programme, in the fullest acceptable sense.

The Founding of the Western Society for Rehabilitation.

In 1947, Dr. F. G. Strong, who had arranged for Martin Berry to come from California, called a meeting of fifteen interested people in the community, to see if it was possible to obtain community support for the establishment of a rehabilitation centre. The plan was for a centre which would serve all severely orthopaedically disabled people.

Two of the people at this meeting were from the Kinsmen's Club. Dr. Strong explained what he wanted, and illustrated what the possibilities of retraining were, by showing motion pictures taken at Shaughnessy Hospital. Dr. Strong said that he could raise the money for the initial buildings, but that a building alone was not enough. Mr. Percy White, of the Kinsmen's Club, said that it was not wise to ask the subscribers for money without showing them what such a centre had to offer. He suggested that, if the land was purchased, and information was collected on what would be necessary, the subscribers would give their money more willingly. This plan was accepted, and the land was purchased by the Kinsmen's Club.

The purpose of the programme was to be to extend the achievements of the Department of Veterans' Affairs programme for paraplegics to civilians. Various committees were established to investigate the need for such a centre, to plan the construction, to raise the money, and to study different programmes. The main sources of information were the Baruch Committee of Physical Medicine (New York) and the Department of Veterans' Affairs. Building and programme plans were obtained, and these were altered to fit local needs. Mr. E. Desjardin, who is a paraplegic himself, supplied information about the Centres in Winnipeg and Toronto. Some of the staff of the centre were engaged before the centre was completed, and they also contributed their ideas.

In the summer of 1948, construction of unit one of the centre was started, and on January 2nd, 1949,

the centre was officially opened. It provided accommodation for thirteen resident trainees and four resident staff members. The full-time staff totalled six. It was being supported by the Federal and Provincial governments, the Kinsmen's Club, its own Women's Auxiliary, and the Western Branch of the Canadian Paraplegic Association, as well as private contributors.

Chapter 3.

THE DEVELOPMENT AND THE PROGRAMME SINCE JANUARY, 1949.

The year 1949 saw two important additions to the rehabilitation programme. One was the Western Society for Rehabilitation; the other was the introduction of Hospital Insurance. The changes that occurred in the programme with the introduction of Hospital Insurance were not many, but they had important economic and social implications. Hospital Insurance applies generally only to those people who are classified as acute medical cases. Under the original ruling, a polio patient was said to be acutely ill for only two weeks. If his doctors reported that he required further hospital care, the benefits were usually extended; if his benefits were extended, the patient was no longer permitted to go home for the weekend. To do so, he would have to be discharged from the hospital. If a patient was well enough to go home for the weekend, then it was argued that he was not "acutely" ill, and hospital payments were stopped. On September 6th, 1951, the B.C. Polio Fund submitted a brief to the British Columbia Hospital Insurance Inquiry Commission. The brief was incorporated into the Commission's report in its entirety, and, as a result, polio patients are now entitled to benefits for a minimum period of three months. This period can be extended, as it was under the previous arrangement.

There are four economic implications arising out of the administration of the Hospital Insurance scheme. Prior to its introduction, the Kinsmen had paid some of the hospital bills for the polio patients. The record of "Sadie" shows that these costs can be great. In theory, every patient would be entitled to Hospital Insurance benefits, for it is a universal compulsory scheme, but, according to the Treasurer's Report of the 49th Annual Report of the Vancouver General Hospital, for 1950, "of the more than 32,600 patients admitted to the hospital in 1950, some 17.2% of those admitted did not have hospital insurance coverage. This placed a serious burden on the hospital's finances, for the hospital does not refuse admission to anyone in need of acute medical care." This free work done by the hospital cannot be included in the daily rates charged. To aggravate this situation further, the financial grants obtained from the Province and the City of Vancouver were discontinued when Hospital Insurance came into effect, except for out-patients' services. The economic position of the hospital is worse than it was before hospital insurance was introduced, because of the services it extends to staff-non-pay patients.

The British Columbia Polio Fund, which consists of forty-four Kinsmen's Committees and four other committees, found that about thirty per cent of the polio patients were not covered under the hospital insurance scheme. They undertook to pay the insurance premiums for

those polio patients who are not entitled to insurance benefits. Their concern was largely for the children whose parents had not provided insurance for them. They believed that the argument put forward by the Board of Polio doctors, i.e., that it was a person's moral obligation to pay his premiums, was not sufficient to meet the case. They would not accept the implication that a child might be denied necessary treatment because its father had not met his obligations.

There is yet another economic effect of the hospital insurance administration. When a patient is ruled to be no longer eligible for hospital insurance, he or his family is notified to that effect. Unfortunately, several months may elapse between the time that a patient is no longer covered by the insurance plan, and the time he is notified. His first inkling of the situation may well be a social worker's visit to discuss finances. The anger which is aroused by the ruling is often intensified by the delay in notification. The knowledge that he has been ruled to be no longer acutely ill is not as disturbing to the patient as the fact that he owes the hospital several hundred dollars. Nor is it as disturbing as the implication that his condition has been classified as chronic by a person who has never seen him.

The Western Society for Rehabilitation.

The opening of the Rehabilitation Centre eliminated the need for the Walking School. To avoid a duplication of effort and services, the Western Division of

the Canadian Paraplegic Association became inactive. Their advice and help are still available, as they still function in an advisory capacity, and hold their meetings in the Rehabilitation Centre. This arrangement has the effect of keeping their association membership functioning. By so doing, it tends to maintain the interest of the people who were originally attracted to it. Because the policy of the society has been directed towards giving service to all orthopaedically disabled persons, other organizations similar to the Paraplegic Association have been asked to establish their offices at the Centre. The Cerebral Palsy Association of British Columbia have their offices and treatment rooms at the Rehabilitation Centre. The British Columbia Division of the Canadian Arthritic and Rheumatism Society also have their medical branch there, and use the pools, tanks and residential accommodation. Apart from avoiding a duplication of services, this arrangement offers an excellent opportunity to increase the number of community contacts. People who are interested in the Arthritic Society, those who are interested in the Cerebral Palsy Association, and those interested in the Paraplegic Association, could be told of the broader needs of any rehabilitation programme. Their tasks might then alter from fund-raising for their particular organization, to taking an active part in an overall rehabilitation programme. Their role in that programme would be one which would consolidate community activity. At the time of writing, three of these groups are co-ordinated in some areas. There

is a medical advisory board, comprised of doctors from each group. There is also the close co-ordination between the staff, for both the Arthritic Society and the Cerebral Palsy Association pay for the use of the equipment.

Co-ordination amongst the staff is achieved through their working together and, more formally, through weekly case conferences. These conferences, which are chaired by the Medical Director, are attended by the physiotherapists, the physical training instructor, the brace-maker, and the social worker-placement officer. The patients' progress is discussed, and each team member presents his point of view about needed changes.

Unit One of the Rehabilitation Centre has accommodation for thirteen resident trainees. All resident trainees must be capable of self-care, which means they must be able to dress, get in and out of bed, feed themselves, and go to the bathroom themselves. These requirements are not as difficult to meet as they might appear, because the building is designed for people in wheel-chairs. The wash-basins are low, as are the coat-hangers and light switches. The rooms are all designed so that the trainees can navigate around easily in the wheel-chairs. The beds, the toilets and the showers are equipped with bars, which enable the trainees to pull themselves out of their wheel-chairs.

The other group of trainees are the non-residents. They usually come to the Rehabilitation Centre for a part of each day. Usually, they are brought to and

from the Centre in the car which has been provided by the British Columbia government, and is maintained by the Women's Auxiliary. Each trainee is brought to the Centre on a three-months trial basis, and at the end of that time, his progress is evaluated, and he is either discharged, or his training period is extended. A person will be discharged as a result of not having shown any physical improvement, for it is judged that he will not benefit from further treatment, and is no longer a suitable candidate for the Centre. The limited space and staff makes it imperative to enrol only those people who can be assisted. Even with careful screening, it became obvious that the facilities were not adequate. In the Spring of 1950, Unit Two was added. This included, a laundry room for the trainees, a remedial pool, two hubbard tanks, a library, a dispensary, a physical medicine department, a playroom, speech therapy and physical medicine department for the Cerebral Palsied children, as well as administration offices and more bedrooms for residential trainees. This unit, which was planned with Unit One, was opened in November, 1950. So well had the plans for Unit One been worked out, that only a few very minor changes in construction were necessary.

Expansion in staff members also took place when Unit Two was opened. Originally, the Rehabilitation Centre had planned to have its own brace shop. They were unable to secure the services of a skilled bracemaker, and were uncertain of just what work there would be for him to

do. Arrangements were made to secure braces from the Prosthetic Services Department of Shaughnessy Hospital (D.V.A.) They soon learned what types of prosthesis they would require, and so it was decided to hire a full-time bracemaker. However, there were none available, and so it was necessary to train one. This was done at Shaughnessy Hospital (D.V.A.) and, later, Sunnybrook Hospital in Toronto (D.V.A.). His training was financed by means of a National Health Grant.

The Third Annual Report of the Society tells of their activity in securing as much first-hand knowledge as possible. In this respect, the Medical Director and other key personnel travelled to similar centres in Eastern Canada and the United States. The report also includes the recognition of the necessity of securing the services of a social worker-placement officer. His function would be to act as liaison between the various agencies, to do job and home placement, and to work with the patients and their families on a casework basis. He also was to have an intake interview with each trainee, to acquaint them with the building and programme. Casework would be carried on as a part of the treatment, only if the patients came to him with specific problems, or if they are referred by the Medical Director for specific problems.

Government Participation.

Both the Provincial and the Federal Governments have contributed grants to the Rehabilitation

Centre. The Provincial and Municipal Governments have paid allowances to the patients and their families, and have provided nursing home or boarding home care. Section 'G' of the "Social Assistance Act", which lists "occupational training, retraining, or therapy for indigent persons or mentally or physically handicapped persons", was not made a part of the Provincial Welfare Services policy until September 19th, 1951. The delay was largely due to the reluctance of Municipalities to pay their share of the cost - twenty per cent.

The Provincial Welfare Department did finance three "test" or "pilot" cases, which were all ruled to be provincial responsibilities in accordance with the Residence and Responsibilities Act. Later, the City of Victoria and the City of Vancouver each accepted a "case" as their responsibility. The method by which aid was requested from the two Municipalities was quite different. The Vancouver girl had just completed her education at the University of British Columbia. Her father was opposed to accepting any help from the Welfare Department. It was through the efforts of the hospital Social Service Department that he would agree to accept such aid, and that the City of Vancouver would grant it. When the "City" had agreed to pay their twenty per cent of the cost, they notified the hospital Social Service Department. The Victoria resident was a forty-two-year-old man, who had been gradually worsening, physically, as a result of polio, since

January, 1949. He was admitted to the hospital in December of that year. In November, 1950, as a resident patient in the hospital, he started to take out-patient's training at the Rehabilitation Centre. This was at his own expense. It consisted of going up to the Centre each afternoon in their car for remedial exercises. The Medical Director of the Rehabilitation Centre approached the Assistant Provincial Health Officer for financial help on the patient's behalf. He, in turn, referred the request to the Deputy Minister of Health, who passed it on to the Deputy Minister of Welfare. He made contact with the City of Victoria, who agreed to assist for one year, as soon as the patient's assets were down to \$500. This was achieved by the summer, and he was accepted as a City of Victoria responsibility as of the 1st of July, 1951.

There was another scheme for government participation about the same time. This was a plan which would have had the City of Vancouver and the Provincial Government each paying the cost of financing four beds. In April of 1951, two patients were transferred from the hospital under the arrangement. However, the plan was dropped, and the cost of their training was met from other sources. Because the negotiations between the City of Vancouver and the Provincial Government started in July, the "City" did accept the cost of retraining these people as of July 1st, 1951.

There was very little change in the programme as far as the patients were concerned, during this

period. Life in the hospital was much the same as before. There was the added physical training at the Rehabilitation Centre. The patients who went up for the afternoon were very enthusiastic in their praise for the Centre. The fact that the physiotherapists from the Centre came to the hospital to treat a large number of the hospital patients seems to have prevented any feeling that one of the groups was privileged. The training, apart from muscle exercises, also included learning how to get in and out of bed and how to dress. There are very difficult tasks for paraplegic and quadriplegic patients. The patients who were not going to the Centre could see the struggle and effort that was necessary in order to learn self-care. Before they could go to the Centre, they, too, had to struggle to get out of bed; a struggle which often ended in failure and exhaustion. It was their determination, aided by the patience, reassurance and understanding of the physiotherapists, which was to start them on their way to physical recovery.

In July, 1951, a social worker was added to the staff in the Rehabilitation Centre. As part of his work, he accompanies the Medical Director of the Centre during ward rounds at the Hospital. The Medical Director introduces him to the patients who are considered to be likely candidates for the Rehabilitation Centre.

Apparently, this decision is reached on the basis of a physical diagnosis. Under this arrangement, the Centre

worker is not likely to see those patients who are unlikely to be candidates for the Centre. In some instances, such people may be referred by the Medical Director to his worker, who will, in turn, refer them to the hospital Social Service Department. There is close co-operation with the Social Service Department in working with these patients. There is one difficulty here which needs to be overcome. The Polio Foundation collects money to help polio victims, yet all polio patients do not know of the fund's existence, as not all of them are seen by the social workers. The hospital maintains that it is up to the patient to decide whether or not he wants to talk to a representative of the Polio Foundation. A means of overcoming this difficulty would be to have the Polio Foundation print a small two- or three-paged booklet, explaining their role. This could be extended, to outline all the resources at the patient's disposal. This would ensure that each polio patient knows that the fund is available, and their enquiries would be a means of contact for the Social Service Department.

The Case of "Betty" (continued).

The record of Betty shows that a complete rehabilitation process was not automatically created with the opening of the Rehabilitation Centre, yet her final placement was achieved as a result of the improved services which developed during the period of her treatment there. Soon after the Centre opened, Betty became

an out-patient there. In January, 1949, the hospital Social Service Department requested the City of Vancouver to pay for her training at the Centre. This was refused. In March, a similar request was made to the Director of Welfare, but this, too, was refused. Betty continued to go to the Centre, five afternoons a week. This situation existed until shortly after the publication of the brief to the Hospital Insurance Inquiry Commission. In that brief, the Kinsmen noted that the cost of hospital care for Betty, from January, 1947, to September, 1951, amounted to approximately \$22,400. This cost was being absorbed by the hospital. It was the realization of what the hospital had spent that finally led to her placement in a boarding home. The timing of her placement was not a pre-arranged step in an integrated rehabilitation process, but her ultimate placement was a result of close co-operation between three agencies; the Rehabilitation Centre, the hospital Social Service Department, and the City Social Service Department.

In November, 1951, a report was sent to the City Social Service Department, giving a summary of her history, and outlining her present abilities. A request for a boarding home placement was made at this time. In answer to this request, a letter was received by the hospital Social Service Department, stating in part "we have no home which would be suitable". Through the

efforts of the Rehabilitation Centre social worker, a suitable home was found for her, and the City agreed to pay the cost of it, as it would not be more than the alternative of a nursing home placement. She was taken to see this home by the hospital worker, in January. During the next five days, she was given a great deal of reassurance, and together, the plans were worked out in great detail. At the time of writing, two further visits have been made by the hospital worker, and it appears that Betty is settling down well. In the very near future, her treatment at the Centre will stop, as it is felt that she has reached the point of maximum recovery. Before her treatment is discontinued, the two social workers plan to co-ordinate their services in an effort to help her accept this decision.

Because the City of Vancouver is paying for her boarding home, they, too, are included in the planning for this girl, for it will be their social workers who will see her once she completes her training at the Centre.

The Record of "Tommy".

This is the record of a young man, named "Tommy", who was admitted to the hospital on August 5th, 1947, as a polio suspect. He was left with a residual weakness in both upper and lower extremities, and in the back and neck. Eight months after his admittance, he was referred to the Social Service Department of the

hospital for aid in rehabilitation plans. Later, he attended the Walking School for a short time. However, he did not have a wheel-chair of his own, and expressed a great deal of resentment about having to borrow one. The Kinsmen, who were financing his treatment at the Walking School, were prepared to purchase a chair for him, but this was actually finally done through the Golden Gloves Association, of which he was a member. It is interesting to note that this patient came from a broken home, and was brought up by his grand-parents, and later by an aunt and uncle. He said that, as a child, he was discriminated against. He felt that he was excluded from the gang, because he had "buck teeth and cross eyes". It was to overcome being "picked on" that he had taken up boxing. The social worker's report states that, "in his illness, with its resulting disability, he experienced the same feeling of insecurity as in childhood; helpless, over-sensitive, distrustful, and with some ideas of persecution". The record shows that he was often "irritable", "down in spirits" and "pessimistic".

A benefit fight was put on by the Golden Gloves Association, which he attended, along with some other patients. However, when the chair arrived, it was faulty, and the patient became very critical of the delay in replacing it. It was only after he was allowed to make the necessary inquiries that he showed signs of overcoming his feelings of insecurity. He received one

month's training at the Centre, which was financed by the Kinsmen. Later, he was accepted by the Provincial Government as a Provincial responsibility, and they financed further treatment at the Centre. He enrolled in a Board of Education correspondence course, to obtain his Senior Matriculation, and later, with the help of the Kinsmen's Club, he took an accountancy course. He is now employed as an accountant. Government participation meant that the services of the Centre were available to him as a citizen. It was a recognition of the responsibility of Public Welfare to restore the capacities of an individual. Assistance in money, or in "kind", is given to restore or maintain a person's capacities. This record shows how relief can be an aid in helping a person become independent. Such use of public assistance should do a great deal to remind the public that the primary purpose of relief is rehabilitation. If independence cannot be restored, then humane care must be provided.

The Record of Mr. "Jones".

Mr. "Jones", a married man, whose normal occupation had been logging, was admitted to the hospital on March 9th, 1948. Like "Tommy", he, too, was confined to a wheel-chair, although he did not suffer any involvement in his arms. Unfortunately, his record was not available, so it was impossible to learn how he was aided by the rehabilitation programme. It is known that he was financed at the Centre by the Provincial

Government, and, as part of his rehabilitation programme, he attended the Vancouver Vocational Institute. There, he learned shoe repairing. He is now working at that trade, and is supporting his wife and family. The brief to the Hospital Insurance Inquiry Commission reports that, by investing \$3,500 in rehabilitation, the Social Welfare Department of British Columbia is expected to save \$17,500 during this man's life-time. This record shows the introduction of the Vocational Institute into the rehabilitation programme. Patients who use the Institute do so to learn a trade. Their progress is marked according to the degree to which they have mastered their trade. Their qualification upon graduation is based on their skill as a tradesman, and not on the fact that they are confined to a wheel-chair. The emphasis is on what the patient can do, not on what he cannot do. Because of this, there is an excellent opportunity to emphasize to an employer that the patient is a tradesman, who is qualified to do the work he is hired for. He has his ability to offer his employer in return for wages. He is not a cripple who needs a job.

The Record of "Mary".

"Mary" was admitted to the hospital on December 26th, 1949. She was suffering from a fractured spine, following a leap from her bedroom window. She stated that she had been attempting to escape from the "devil". She is about forty years old, and is the mother

of two children. In the hospital, her spine was set, and three weeks later she was transferred to the Provincial Mental Hospital. Whilst there, she was treated for paranoid schizophrenia. In September, she was re-admitted to the Vancouver General Hospital. Although a detailed report was received from the Mental Hospital, apparently no casework treatment was undertaken with this patient. The hospital Social Service Department was asked to compile a social summary in accordance with the policy laid down between the municipalities and the Provincial Government. This was done, and an outline of her residence, along with information on her family and financial status, was submitted. This summary also included a brief history of her psychiatric disorder, plus a description of her attitude towards rehabilitation. This social summary, plus a medical summary signed by the Medical Director of the Centre, was sent to the City Social Service Department. They contacted the responsible municipality, who accepted their cost of the treatment. The Committee which reviewed this, and all cases, consisted of a representative of the Municipality of the City of Vancouver, a representative from the Provincial Welfare Department, and one from Provincial Welfare Medical Services. The application was approved, and the hospital Social Service Department was notified, so that they could arrange for her transfer to the Rehabilitation Centre. In October, 1951, she was transferred to the

Rehabilitation Centre. It is interesting to note that the request for treatment at the Centre was, apparently, made on a medical diagnosis only, in spite of the fact that she had experienced three previous emotional breakdowns. This disregard of the emotional factor has influenced the prospects of rehabilitation. Once steps for her transfer from the Centre were started, this patient showed many signs of her previous disturbance. Her present prospects of rehabilitation are rated as "poor".

The Record of "George".

This record illustrates the programme carried on by the Workmen's Compensation Board before and after the establishment of their rehabilitation section.

"George" was injured on his first day at work. Because his injury occurred before March 18th, 1943, he was not eligible for rehabilitation. He was returned to his home from the hospital, where, he states, he "sat on the porch and watched the cars go by for nine years". During this time, he received his pension of \$67 per month, plus needed medical equipment. In addition, his family received \$1.50 per day, as a nursing home fee.

In June, 1951, he was re-admitted to the hospital for a physical check-up. Whilst he was a patient in the hospital, he was referred to the Social Service Department for aid in rehabilitation plans. The patient evidently told the Compensation Board

Rehabilitation Officer that a social worker was seeing him. This Rehabilitation Officer sees all the "compensation" patients in the hospital every Friday. The outcome of this arrangement was a meeting between the hospital Social Service Department and the Compensation Board Rehabilitation Section. This meeting accomplished several things. It gave each group an opportunity of learning how the other functioned. It set up a procedure whereby there was closer co-operation between the two services, and it was responsible for the Compensation Board using the services of the hospital social workers to deal with family problems which were affecting the patients' progress.

In keeping with the Compensation Board's policy of using all available resources in the community, plans were made for George's transfer to the Rehabilitation Centre. As he was not eligible for rehabilitation, the goal of "self-care" has been set as the objective. In the process of his physical rehabilitation, community resources will be explained to him, and an effort to interest him in vocational retraining will be tried.

The Record of Mr. "T".

Mr. "T" is a sixty-year-old logger, who emigrated to Canada from Eastern Europe thirty years ago. He has not heard from his family since he left his home, and he has no friends here. In September, 1950, he was

injured in a logging accident, which has resulted in flaccid quadriplegia. He apparently will never gain any use of his arms or legs. He is in receipt of a pension from the Workmen's Compensation Board; however, the pension is not large enough to pay for private nursing home care.

After he had been in hospital for a year, he was referred to the Social Service Department for "help in plans for rehabilitation". Rehabilitation, for him, will be nursing home care, preferably in pleasant surroundings. In the Spring of 1952, Mr. T still had not been told that he would get no useful functioning from his arms and legs. The Medical Director of the Rehabilitation Centre tried to find a suitable nursing home for him, that would still leave him some of his pension money. This could not be done. The Director was reluctant to use the services of the Marpole Infirmary, because the patient would have to sign over all of his income to the Provincial Government. In the meantime, Mr. T is occupying a bed in an acute hospital. He is not receiving daily hydrotherapy, as the staff can only find time to do this for him in the morning, and he objects to going to the tank in the morning.

The Record of Mr. "A".

Mr. "A" is, in his own words, a "lone wolf". He, too, is a quadriplegic patient. His injury resulted from a fall from a hotel window. Unlike Mr. "T", this patient's paralysis is spastic. As a result, he is

bothered a great deal by spasms, or involuntary muscle function of both legs. He was in the hospital for seven months before being referred to the Social Service Department. The degree to which he will recover is, apparently, not known. At the time of referral, it was expected that he would go to the Marpole Infirmary. This plan was later changed to the Rehabilitation Centre. The present plan is to transfer him to the Infirmary. There is another factor present, besides his physical condition. It is one of money. He, too, would have to sign over all of his money (if he has any) before going to the Infirmary. The patient himself expressed a great deal of anxiety about the thought of such a move, and even refused to discuss the word "chronic", as it is defined by the Hospital Insurance Services.

The last two records were cited because they both concern the Marpole Infirmary, and the apparent reluctance of the Medical Director of the Centre to use its facilities. His reluctance to use the Infirmary appears to be because of the government policy, which states that each inmate must sign over all his assets before he will be admitted. The facilities are regarded by the Director as being the best available in this area. The facilities are made so good because of the activities of an excellent Women's Auxiliary. This Auxiliary is also the Auxiliary to the Rehabilitation Centre. They were asked to undertake the job at the Centre because of the excellent work they had done in improving the social

life of the people in the Infirmary. To offset the danger of the Auxiliary becoming less active as the present members leave it, it might be well to have a closer contact between the Auxiliary members and the staff at the Centre. New members to the Auxiliary would certainly gain knowledge and inspiration from talking to the staff members and seeing how sympathetically they work with the patients. In such a manner, the Auxiliary could make the Infirmary an extension, in spirit, of the Rehabilitation Centre. It could not offer the same hope to the patients, but it could offer them a setting, and programme, which would permit these patients to function to their maximum capacity, physically, mentally, socially and vocationally, for the fullest possible life compatible with their abilities and disabilities.

The Record of "Alan."

The life history of "Alan", a teen-aged boy, who has been left with residual paralysis in all four extremities, illustrates well what post polio paralysis can mean to the patient, his family and the community.

When Alan was three years old, he contracted polio, and was left with weakness in one leg. He is described by his mother as being a very independent child. He would always try to minimize any illness or hurt he had. When he was six years old, he became enuretic and would sometimes soil himself. His mother "followed medical advice" and was "hard with him". After almost a year of strictness, she "could not stand it any more" and treated him more kindly. He had also developed a fear of being confined, and

would almost become hysterical if his arms were held.

At school, he was picked on by other boys, and one day, whilst trying to escape from them, was struck down in the road by a wood truck. His mother described in detail the many serious falls he had during the ten years he "dragged himself around". During this period, he had joined the Boy Scouts, and was quite active in them, although he did not get along too well with some of the boys.

On one of the first days of January, 1949, he came in after playing all day in a snow-house. He "did not feel well", and in the morning his condition worsened. The family doctor was called, and diagnosed the condition as polio, but, when he was told that Alan had polio ten years ago, he decided that it could not be polio, and left some aspirin for him. By the end of the week, Alan's condition was so bad that he could only move his head. His parents "reluctantly" phoned for another doctor, who admitted him to hospital as a polio suspect.

He stayed in the hospital until December, 1950. There were several instances of disagreement during this time, between the hospital staff and Alan's mother. In December, he was discharged home as an out-patient of the Rehabilitation Centre. Some of the staff members described his behaviour as "cocky", while another felt he was a "sissy". On December 20th, he disregarded the physio-therapist's advice; tried to get off a treatment table

unaided; fell and broke his leg. He was re-admitted to the hospital at that date. His parents had agreed to pay for his care at the Centre, but they received no bill for the two weeks he was there.

In the hospital, he was soon able to get around again in a wheel-chair which had been bought for the ward by the Kinsmen. His schooling, which was being carried on by means of a correspondence course, and a visiting teacher from the Department of Education, was continued. On August 3rd, 1951, he was referred to the Social Service Department for aid in plans for rehabilitation. The worker knew nothing of his history, nor how this illness had affected his family. From talking to various staff members, it was learned that Alan was considered to be "a little beast" or "a boy with too much spirit". He had pulled the hair out of the chest of a quadriplegic patient, struck another, and so annoyed other patients, that he was denied access to their room. His mother was described as being "very interfering". She, supposedly, had told him that he need not do the exercises, and on one occasion had put a dollar on the floor and told him he could have it if he could crawl to it.

It was decided that his parents should be interviewed to find out more of the details of the boy's early life experiences. This was done only once. Before further interviews could be held, notice was received from Victoria that the requested extension on his hospital insurance benefits had been denied. It was back-dated several months, which meant that his parents owed the hospital over

\$2,000. When Alan's mother learned this, she became extremely angry. The worker's second visit was then one in which he encouraged her to express her resentment to the hospitals, doctors, and social workers. She told how a hospital staff member said that Alan could walk if he wanted to, and that he wet his bed just to cause them extra work. This information, and much of Alan's early history, was passed on to the Medical Director and the social worker at the Centre.

Alan's case was being considered by the Hospital Board for the "staff-non-pay" category. The worker discussed the costs, and the family's ability to pay, with Alan's mother. Although his father held a steady well-paid job, it was felt that the burden of meeting this bill might lead to a breakdown of the family, because of economic or other reasons. Their willingness to contribute towards the cost of his care at the Rehabilitation Centre was a reminder that they would continue to have medical expenses, which would again leave them unable to save. The worker also surveyed the physical facilities in the home, as the Medical Director was anxious to have him discharged home so he could commence out-patient treatment at the Centre. It was found that the home could be easily altered. This was reported to the Medical Director and his worker. A report was also submitted to the staff-non-pay Board, who decided not to ask the family to meet this bill.

Further telephone contacts were made with the worker at the Centre, because of two major problems. One

was to continue casework services with Alan's mother, as it was felt that she was a very dependent person, who would need all the details of any plan worked out for her son. The hospital worker agreed to continue seeing her until it was felt that she could accept a transfer to a new worker. The other problem was what to do about Alan's schooling. He could not take all the courses necessary by correspondence, because of his weak arms; it was not possible to obtain a visiting teacher; and Alan was confined to a wheel-chair, which meant that he would not be admitted to school, because the school board could not accept responsibility for him on this basis. Nevertheless, through the combined efforts of the two workers, and with the co-operation of the Vancouver School Board, Alan became the first student to attend school in a wheel-chair.

In September, it was decided, in a conference with the Medical Director, that Alan should be discharged from hospital. Plans were made to have him taken to the Centre from home each morning, to school at noon, and home at four in the afternoon. Two of his courses were to be by correspondence, and the others were to be taken at school. The school timetable is what is known as a revolving timetable; That means that the same subject is not taught at the same time each day. It was necessary, then, for the school principal to make special arrangements for him.

On the day that Alan was to be discharged, the worker went to the ward and found Alan and his mother

there. They were both upset. The charge nurse knew nothing of discharge arrangements, for the doctor's orders were that he be discharged when the necessary arrangements were made. This was immediately cleared up, and Alan left for home.

As well as the services indicated, Alan also made use of the many services provided by Miss Galt, and he was also introduced to the leader of the handicapped Boy Scouts, who explained their function to him.

On the first day that Alan attended the Centre, the careful plans were upset. It had been arranged that Alan would eat at the Centre. The meal would be paid for by the Women's Auxiliary. When a physiotherapist, who did not know of the arrangement, told him he could buy milk to eat with his lunch, Alan thought he was expected to pay for his lunch. The result was that he did not eat. This matter, and one or two minor points concerned with his schooling, showed that it was not practical for a worker at the Centre to see Alan, while the hospital worker saw his mother. It was, therefore, decided to transfer Alan's mother to the worker at the Centre. An interview was held with her, and she was found to be agreeable to the idea. She expressed some doubt as to what Alan would be able to do after he finished his schooling. She was told of the use made by the Centre of the Rotary Counselling Service. It was explained that the tests they gave were not just intelligence tests, but were

directed towards finding out what the person could best do, and what he would be happiest at. The transfer to the new worker was made, and he carried through this suggestion, as Alan was also agreeable to it. As a result of the test, Alan has become quite interested in radio repairs, an occupation which would be suitable to his physical mental and vocational abilities.

The manner in which staff members at the Centre were to deal with Alan were discussed with them, and it was felt that he would resent anything which would suggest that other trainees were being favoured by the staff. His attempt to get off the table, at which time he broke his leg, was shown to be typical of his early behaviour. His independence was also explained as being a possible means of gaining approval from his mother.

Later, an instructor at the Centre mentioned that Alan appeared to be terrified of falling, and consequently he would not try to walk. This was also discussed between the social worker and the instructor, who agreed that, in view of his early history and his recent broken leg, he had good reason to be fearful of falling. A second suggestion was also made; that Alan was using his physical condition as an attention-getting device. Various staff members ^{were} then/asked if they felt he was too demanding and, because they had not seen any indication of this, the suggestion of his fear of falling was accepted as the reason.

The record of Alan illustrates to what extent a patient's family can be affected by illness. It shows the necessity of agencies such as the Kinsmen's Clubs, the hospital, with its free services, and the Rehabilitation Centre.

To secure his education, a visiting teacher's services, as well as correspondence courses, and co-operation of the Vancouver School Board, were necessary. The choice of vocational training was largely influenced by his psychological testing, because the poor workmanship of his handiwork in the hospital had given no indication of his mechanical ability. His record also indicates the co-ordination necessary between the various treatment personnel and the various agencies involved in his rehabilitation. The integration was both on the formal case conference level and on the informal, but important, interchange of information during the daily treatment periods.

Co-ordination.

Co-ordination requires the sharing of the information one staff member possesses, with other treatment personnel, if it will influence their relationship with, or understanding of, the patient. This implies that each treatment person knows the particular role of the rest of the staff in order to know what information can be considered to be pertinent. One boy on the ward was considered to be a "mean,

spoilt brat", by one of his nurses. It was only after the social worker told her that his objectionable behaviour started when his mother had not visited him, as planned, but had gone to another province, and had to be traced by the police, that the nurse could accept his behaviour as natural.

Co-ordination is also required between the various agencies in the community. As in the case of personnel, the agencies, too, must possess knowledge of the various resources, and how they function within their individual agencies. The need for this inter-agency integration is illustrated by the following record. "June" was admitted to the hospital as a polio suspect. Because of the difficulty in diagnosing polio, most polio patients are given this type of diagnosis on admittance. Her condition was found to be one of hysterical paralysis. She was referred to the Social Service Department for casework and rehabilitation help. The Social Service Department was faced with the problem of securing money to finance this girl's vocational training. They recognized that, if she was self-supporting, she was not likely to be re-admitted to hospital. It was not possible to obtain the necessary funds, except through the Kinsmen. This was done, by stating that the girl was admitted as a polio suspect, which was true. However, the Kinsmen subsequently learned that she did not have polio, and withdrew their support

after the girl had completed part of her training.

Recent Changes in Process.

During the last months of 1951, two major changes have occurred in the process since Alan was discharged home. The first is that the worker from the Centre accompanies the Medical Director on his ward rounds in the hospital. In this way, he comes in contact with all the patients, who will be later transferred to the Centre, at an early date. This means the time-lag between admission to hospital and the interview with the social worker, has been greatly diminished. This is important, for someone must evaluate the patient's reaction to his illness. His reaction may slow down the rehabilitation process, or severely limit the degree to which he can be rehabilitated. The person who makes that evaluation should be one who has the training for such a job. The often-used argument that not all patients need casework is quite true. But it implies that someone has judged the patient's ability to meet the frustrations of an entirely altered world; a world that has altered almost overnight. The decision as to whether a patient needs casework help or not should be made by the social workers.

There is a second aspect to having the evaluation done by a social worker. That is one of preventative social work. The idea that a patient was

referred to the social worker because he had a problem, is apparently still widespread. Because social work treats through the relationship established between the patient or client and the worker, the evaluation itself includes an element of treatment. That treatment, no matter how slight, may enable the patient to adjust to his new situation. If it does not, it still affords the basis for building the necessary relationship between the worker and the patient.

The second change has been in the administration of the Hospital Insurance Scheme. Now, the hospital is notified that a patient will be cut off from benefits at a specified future date, in accordance with their policies. Also, the time it takes to rule on whether an extension will be granted has been greatly reduced. The hospital administration now holds it to be the doctor's responsibility to tell his patients about any Hospital Insurance ruling. Patients are no longer suddenly confronted with large hospital bills, as they were in Klan's case. This means that resources to pay for their hospitalization can be introduced to the patients as a part of their rehabilitation process. Aid from the government or from the Kinsmen's Clubs does not appear to be charity, granted because they are in debt. The financial help becomes one of the many aids which are extended to rehabilitate these patients.

Chapter 4. EVALUATION.

The development of the rehabilitation programme shows two closely related elements. These are, first, the development of resources in the community, and secondly, the development of the rehabilitative process.

The rehabilitative process has often been referred to as teamwork. This concept has the medical officer as captain of the treatment team. Unfortunately, there can be authoritative captains who cannot delegate authority, as well as those who can fit well into a more passive leadership role. The word "team" can imply many things. It may connote the skilful, co-operative playing of a soccer team, or it may suggest a team of horses who work together because they have to. To avoid the range of impressions the words "captain" and "team" might suggest, the words "rehabilitative process" will be used to evaluate what is commonly called "teamwork".

The rehabilitative process is the bringing to the client the variety of skills available in the community. It is by definition an integrated programme. The degree of integration depends on two things. First, there is the time element between the utilization of various skills. Secondly, there is the exchange of information. Each staff person should be aware of information which might affect her attitude towards the patient, or the nature of her treatment.

The physiotherapists take their instructions from the doctor, but they report any new condition to him. In such a way, they help to change the future exercises which will be ordered for him. Their observations can, therefore, alter the prescribed treatment.

The interpretation of skills can take place in two settings. There is the formal case conference, and the brief informal meetings which occur in the daily contacts. Each Friday, at the Rehabilitation Centre, there are formal case conferences held. All members of the treatment staff, as well as personnel from outside agencies, attend. Three or four cases are reviewed each week in this manner. The patient's medical history is reviewed, and the staff members evaluate his progress or attitude, as based on their observations of his attitude towards his setting and his ability to perform the prescribed exercises. The patient is then brought in and is examined by the Medical Director. He supplements his diagnosis by the reports of the day-to-day progress of the patient. The patient is asked to express any difficulties he thinks could be overcome. After the patient leaves the room, a discussion is held by the staff members, and a revised treatment schedule is compiled. The candidates for these conferences are selected by the personnel. The conferences function to combine the skills and knowledge of the staff. The programme adopted is based on their recommendations. It must be approved by the

Medical Director, because of his responsibility for the patient's physical well-being.

The factors of time, and the pressure of work, do not permit the formal conference to be used for all patients at all times. Problems occur which must be met as soon as possible. This is done largely through the daily contacts of the staff members. Few, if any, of these brief meetings, are recorded. Because rehabilitation is a process, the daily interpretation of services is more important than the formal review type of case conference.

A new element is introduced in the integration of services, because of the fact that the treatment personnel work in various settings. There is the extension of the Rehabilitation Centre into the hospital, through the Medical Director, who sees most of the patients on the ward, through the physiotherapists, who give patients their exercises on the ward and in the Centre, through the remedial physical training instructor, who gives mat classes at the hospital and who helps the bracemaker by getting measurements for the various types of splints the patients need, and through the social worker, who accompanies the Medical Director on ward rounds. The weekly visits of the rehabilitation officer from the Workmen's Compensation Board are an extension of that agency into the hospital. Integration is not merely, then, an integration of the skills and knowledge of a group of individuals. It also involves an integration of resources.

Each department functions as a part of its own agency. It also functions as a part of a rehabilitation programme, which is beyond its agency's jurisdiction. What may be regarded as functioning well in its own setting may be detrimental to the overall programme, as the record of "June" illustrates. This inter-agency integration has not been as close as it should have been. The biggest factor, apparently, is the newness of the programme. Staff members are still critical of the people in various agencies, because they do not understand each other's role. Those people, on examination, are found to be performing their job well, as it relates to their particular agency. Prior to adequate staffing of his department by social workers, the Medical Director was responsible for all aspects of treatment, including the social aspects, of the patients with their illness. This even included securing a passport for a patient who was returning to Norway.

This arrangement was a means of getting things done; however, it also slowed up the process of integration. The Medical Director is familiar with the complexity of the programme, and realized that it would take a great deal of integrating to acquaint the hospital Social Service Department with the programme. At the same time, he was faced with the necessity of keeping the programme functioning as well as possible. He had to choose between limiting his services to his patients, in order to

have time to interpret the programme to the hospital Social Service Department, and trusting that the Social Service Department would gradually learn what the programme involved. He chose to help his patients, and took what steps he could to improve the programme. To ensure that the patients were seen in the hospital by a social worker, he elected to have the social worker at the Centre accompany him on ward rounds. Because this social worker is responsible for offering casework help and for "placements" at the Centre, he, too, is unable to devote much time to interpretation to staff people. By having to do things for himself, the Director has tended to slow down the excellent process of community organization which is characteristic of the Society. By using his own social worker in the hospital setting, he is getting around a lack in the resources rather than having the hospital extended its services.

Integration between the agencies involves more than just an understanding of role of the personnel. It includes the interests of those people in the community who are interested in each of the agencies. Their support of the agency provides the money which permits the agency to participate effectively in the rehabilitative programme. Community organization is not just the integration of existing social agencies. It includes the people who are interested in those agencies, and the people who are interested in the Rehabilitation Centre. The development

of the programme illustrated first the use of available agencies. These included the Department of Veterans' Affairs, the Kinsmen, the Canadian Paraplegic Association, and the Vancouver General Hospital. After the establishment of the Centre, other agencies came in to use the services of the Centre, and through contacts established there, used the original agencies to better advantage. The inclusion of other services, such as the Canadian Arthritic and Rheumatism Society and the Cerebral Palsy Association, has brought more interested groups into the group. The Rehabilitation Centre has become a centre of community interest. The "community" is largely that group of people who are actively interested in aiding some particular group.

The future of the Rehabilitation Centre will depend a great deal on its relationship with the larger community. To obtain wider support, it must be selective in choosing the people it serves. It cannot hope to serve all handicapped patients directly. It can help them indirectly by offering advice, or acquainting them with other resources in the community.

The second influencing factor will be a regular evaluation of its programme, to see if it meets the implication of its goal. An original confusion as to what helping a patient to achieve his maximum was, has been partially cleared up. Apparently, it was thought that the services of a psychologist was the means of

preparing a patient mentally for rehabilitation. It was planned to hire a psychologist after it was learned what his contribution would be. It is still hoped to add a psychologist, but it has now been demonstrated that, to prepare a patient mentally, it is necessary to relieve him of his emotional stresses, so that he may use his mental capacities to the fullest extent. Use is at present being made of the Rotary Counselling Service to discover latent abilities, and so serve as a guide to vocational rehabilitation; and to aid in evaluating the patient's personality. These tests will serve as a guide for case-worker-placement officer. So much of his time is presently devoted to placement, that the Counselling Service is used chiefly to aid in job placement or vocational rehabilitation. This situation exists because there is not a suitable agency in the community to provide job placement for these people. The Special Placements Section of the National Employment Service was used originally. It was not found to be effective. The opinions expressed by various rehabilitation officers is that the Employment Service lacks community contacts. This lack appears to be due to two factors. The first is a lack of endeavour to make the contacts. The second, and more important, is that the Employment Service is a government office. It was established to aid people secure employment. As a government agency, it cannot refuse to try to place a person, and the result is that their work is hampered by

trying to help people who cannot work. Alternatively, they place him in a job and hope he can manage it. Unfortunately, this latter choice too often means that the employer loses confidence in the Service, and so another contact is lost.

Because so much time is spent by the social worker at the Centre on placement, little use is being made of intensive casework. Casework is limited to "environmental" and occasionally "supportive" casework. It is hoped that a placement officer will be added to the staff in the future, to relieve the social worker of this work. He will then be able to devote more time to the patients in the hospital; work more intensively with the trainees in the Centre, and offer better service to the patients' families. The history of "Alan" and the record of "Betty" indicate how important it can be to extend casework services to the patient's family.

The fact that the worker does so much of the vocational placing is a second indication of an attempt to get around a lack in the resources. Here, too, the staff of the Centre are attempting to do the job themselves, rather than trying to have the agency in question further develop its own programme.

The solution to this problem appears to lie in an unpublicized effort at rehabilitation which is in an experimental stage only. It is a co-operative effort of various rehabilitative agencies and the Department of

Education. It is held under the auspices of the Council for the Guidance of the Handicapped. If it becomes an educative programme for the personnel involved, each person will realize the limitations of the various agencies. Joint efforts can then be made to correct any faults that exist in all phases of the rehabilitation programme. Until this effort is made, there will be duplication of effort in the rehabilitation of all the patients who come under the various rehabilitation schemes.

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