THE CARE OF THE CHRONICALLY ILL

A Survey of the Existing Facilities and Needs of Vancouver.

by

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Abstract

This study surveys the resources, facilities for care and medical treatment provided for the chronically ill of Vancouver. The historical development of the problem has been briefly covered, also, the probable future situations which will arise. As the care of the chronically ill has become one of the major public welfare problems in the post-war period, the economic circumstances and implications of chronic illness have been emphasized.

Each of the institutions described was visited and over two hundred chronically ill patients personally interviewed. More than four hundred files and records were read in various social agencies; information was also secured from interviews with administrators, directors and owners of the various services described.

The survey reveals many problems and inadequacies. Hospital, clinical and custodial facilities for the most part are seriously inadequate and not always properly utilized. A confused administrative structure and an unsatisfactory division of responsibility are further obstacles to more effective co-ordination. Recommendations for the improvement of existing situations and the creation of new services are made. The importance of the social caseworker in the establishment of an effective treatment program for the chronically ill is stressed.
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THE CARE OF THE CHRONICALLY ILL

A Survey of Existing Facilities and Needs of Vancouver.
Chapter I

The Nature of Chronic Illness

The provision of facilities and funds for the care and treatment of thousands of chronically ill and incapacitated people has become the most pressing public welfare issue of the post-war period. Social assistance payments for the maintenance and care of the chronically ill have doubled and even trebled within the past ten years. In Canada, social assistance is available only to the unemployable, and, of the population included in this category, the chronically ill represent an unprecedented and exceptionally high proportion. For every person known to the public welfare authorities there are two others, either in private hospitals or in their homes, who are financially independent and able to carry on without requiring public assistance. Thousands of chronically ill persons are known only to the private physicians who give them periodic check-ups and prescribe their medicines. Considering the high cost of prolonged medical and hospital care it is remarkable that the proportion in receipt of public assistance is not greater.

Chronic illness knows no economic boundaries; the rich man in the comfortable mansion is just as likely to be a victim of a chronic cardiac condition as the old age pensioner in a cheap house-keeping room along the waterfront.

The man in the street invariably thinks of a chronic invalid as a person of advanced age suffering from an incurable disease. It amazes most people to learn that over half the patients in institutions
for the chronically ill are under the age of forty; also, that a person can be chronically ill for forty years and not miss a day's work.

Dr. Ernst. P. Boas, director of the famous Montefiore Hospital for Chronic Diseases in New York and an outstanding authority on chronic diseases, gives these startling figures:

"Eight per cent of persons with chronic illnesses are children under the age of fifteen; eight per cent, individuals between the ages of fifteen and twenty-five; one third are young adults from twenty-five to forty-four years of age; one third are in the age group between forty-five and sixty-four and sixteen per cent are sixty-five years of age or older. The problem is one of the productive years of life. Full seventy per cent of the cases occur in persons under fifty-five years of age."(1)

To most lay people the terms "chronic" and "incurable" have become synonymous. The word "chronic" usually conjures up a picture of a bed-ridden old man or woman who has not many more days to live. This stereotyped idea has unfortunately affected government thinking so that the procuring of any sizable appropriation from government funds for more adequate institutional care of the chronically ill is at present an impossibility. Mary C. Jarrett another outstanding American authority on chronic diseases, believes that the indifference and lack of understanding of the public is the greatest single obstacle in the way of implementing an adequate diagnostic and treatment program for chronic diseases. She says:

"The term 'chronic' has become so identified in common usage with extreme bodily infirmity that even those whose profession is the care of the sick are apt to forget that it is merely a way of expressing

the difference between an acute disease, which comes suddenly and in the course of a comparatively short time will result in death or complete recovery, and a prolonged disease process, which usually has a gradual beginning and leaves traces of permanent injury to the body even when a practical recovery has been made. Partly because in the diseases, classed as chronic, there is rarely a complete restoration of function in the body cells affected, and partly because because medicine has begun to gain knowledge of the nature and treatment of these forms of disease comparatively recently, they have been regarded as incurable; so that 'chronic' and 'incurable' have come to mean the same thing to most persons."(1)

Another common misconception is that chronic diseases affect only the poorer classes of society. True, the public welfare authorities know only the chronic cases in the lower income groups but there are thousands of people who live with their chronic diseases without becoming a charge on the public.

People who were indigents before they became chronically ill are in a definite minority. Admittedly the majority of the patients occupying beds in chronic institutions are people without any income or resources; but it is important to remember that in almost ninety per cent of these cases the cost of prolonged medical and nursing care, which can reach fantastic figures at times, has used up the savings and resources of these people until they have been forced as a last resort to become public charges. There is, on the other hand, considerable evidence that low income families are more likely to contract certain chronic diseases such as rheumatic fever and tuberculosis; but it can be said without hesitation that when chronic illness strikes a family, whether it be rich or poor, the impact is equally devastating whatever

the income level. The importance of environment upon chronic illness is still important. It has sometimes been said that "poverty breeds chronic disease". Poor housing, lack of proper sanitation, lack of proper food and warm clothing and often lack of medical care accentuate the problem of chronic illness amongst the lower income groups. Dr. Boas says that:

"There is hardly a family, one member of which is not stricken by some such illness as heart disease, rheumatism, cancer or diabetes. He who has had personal experience with an individual disabled by a chronic illness knows the cost that it entails in physical and mental suffering and knows further how the presence of a chronic invalid conditions the life of a whole family. The presence of an invalid whose physical and mental suffering, whose needs, desires, whims and fancies are always in the foreground, determines the work, the recreation and the development of the lives of the other members of the family. Even in a well-to-do home a chronic invalid is a burden on the whole household, among the poor these difficulties are accentuated and often lead to intolerable situations."(1)

It is safe to say that the major causative factor behind the dependency of thousands of otherwise self-supporting families upon public assistance is some form of chronic disease. A Massachusetts survey found that the incidence of chronic illness was fifty per cent higher among the poor than among those in the higher income groups. Among families receiving some form of public assistance, 62.3 per cent had members suffering from chronic disease. (2) In a survey of chronic disease in Cleveland, Mary C. Jarrett arrived at this conclusion:

"The frequency of chronic illness has been found in various surveys to increase with the


(2) Ibid., Page 30.
decrease of income. The incidence of chronic disability is much more serious amongst the low income groups."(1)

Richard Conant, another American authority on chronic disease, claimed that chronic illness was the greatest single cause of poverty in the United States, being responsible, by a conservative estimate, for twenty per cent of it. (2)

Particular Aspects of Chronic Diseases

The number of deaths from contagious and infectious diseases has decreased in recent decades but the deaths from chronic diseases have increased. Great strides have been made in the past century in lowering the rates of infant mortality and deaths from communicable disease. Deaths from tuberculosis have declined greatly and deaths from pneumonia have become comparatively rare. As a result of improved diagnostic and public health facilities, cancer and heart diseases have supplanted infectious diseases as the leading causes of death. In 1900 the five leading causes of death in the United States were listed as (1) tuberculosis, (2) pneumonia, (3) enteritis, typhoid fever and other intestinal diseases, (4) heart disease, (5) cerebral haemorrhage and thrombosis. By 1945, pneumonia, enteritis and typhoid fever were at the bottom of the mortality lists. Tuberculosis is no longer the major cause of death. Heart diseases are now far out in the lead in the number of deaths with cancer second on the list. Cerebral haemorrhage and thrombosis have moved up to third place with fatal accidents.

(1) Jarrett, Mary C., Care of the Chronically Ill of Cleveland and Cuyahoga County. Cleveland, The Benjamin Rose Institute 1944, Page 3.

occupying the fourth position (largely because of the great increase in automobile traffic). Nephritis now holds fifth place. In 1947 the five leading causes of death in Canada were (1) diseases of the heart, (2) cancer and other malignant tumors, (3) violent deaths, (4) nephritis, (5) diseases peculiar to the first year of life. Unfortunately mortality statistics do not give any indication of morbidity. A person with a cardiac disorder may live one day or he may live thirty years after the onset of his illness. Deaths from arthritis are recorded low in the mortality tables, but an exceptionally high number of beds in institutions caring for chronic invalids are filled with arthritics because of the long term, crippling nature of this particular disease.

Seventy years ago chronic diseases caused only one-fifteenth of the deaths in the United States; today they are responsible for as many as one-half. Chronic diseases have become not only a major cause of death but also a major cause of illness and invalidity. As has been pointed out before, years of sickness may precede death from a chronic illness but lay people looking at mortality tables fail to take this into consideration. Dr. Boas speaks very strongly about this point:

"Although the pestilences have been brought under control, the great volume of chronic diseases form a plague of as great proportion as any to which mankind has been subject. It is a hidden and insidious plague, lacking the dramatic and fearsome qualities of a major epidemic. It is this that makes it all the more deadly for its wide range is hardly recognized; society has not yet learned of the toll that chronic


disease takes in illness, death and cause of destitution and of family life ---- there is no realization that they are ever present and inescapable, that they occur at all ages, and that if we are spared them in our youth, they will almost inevitably overtake us in our older years!(1)

In 1935 it was estimated that one per cent of the population of the United States were chronic invalids.(2) Canada now has an estimated population of twelve million people. On the basis of this figure there are 120,000 people suffering from one of the chronic diseases in this country. This figure may seem to be exceptionally high but surveys carried out in various cities in the United States apparently confirm it. The Massachusetts Department of Health found, in a house-to-house survey covering most of the state, that one in every one hundred and nine persons was completely disabled by chronic illness, including tuberculosis and mental diseases. The Council of Social Agencies in Boston estimated that the chronically ill in that city, excluding tuberculosis and mental diseases, numbered one in every one hundred and five persons in the city. A Philadelphia survey estimated that in industrial cities, one out of every two hundred individuals were disabled by some form of chronic illness. The United States Public Health Survey, conducted on a nation-wide basis and involving millions of people in 1935, estimated that 23,000,000 persons in the United States had some chronic disease or permanent impairment; of these 23,000,000 persons, 1,500,000 were permanent invalids.(3)

Despite all the figures to the contrary about the number of

(2) Ibid., Page 7.
(3) Ibid., Pages 7 - 8.
chronically ill people in the lower age groups, the fact still remains that the majority of the patients in beds in chronic institutions in both Canada and the United States are over seventy years of age. In the Montreal survey of chronic diseases conducted under the auspices of the Metropolitan Life Insurance Company, it was found that almost half of the patients in chronic institutions were over the age of sixty. (1)

Another interesting fact discovered was that the age group of greatest concentration among the aged is ten years later for females than for males, which reflects the greater longevity of females. (2) The majority of these patients were suffering from degenerative diseases which were the direct result of the great strides made by the medical profession in prolonging the human life to twice what it used to be. Efforts in this direction are being pressed still further, and, as the number of the aged increase, so will the numbers of chronically ill older persons. In the United States it was estimated in 1940 that seven per cent of the population was over the age of sixty-five. By 1970 it is estimated that ten per cent of that country's population will be over the age of sixty-five. (3)

In 1900 the life expectation of a male American at birth was 48.23 years, that of a female being 51.08 years. By 1942 it had been extended to 63.65 years for males and 68.61 for females. Thus, male expectation of life has increased fifteen years since the beginning of the century,

(1) Special Committee of Montreal Social Workers (Mrs. M. A. Lanthier, Chairman), *The Case of the Chronically Ill in Montreal.* Metropolitan Life Insurance Company, Canadian Head Office Ottawa. 1941, Page 5.

(2) Ibid., Page 11.

and the average length of life has been increased by practically one third in forty years.\(^{(1)}\) The life expectation of a Canadian male in 1942 was 63.0 years at birth and for a female 66.3 years.\(^{(2)}\)

These figures give some indications why the problem of caring for the chronically ill is becoming more serious. Medical science, coupled with better public health measures, better social services and reduced maternal mortality, has succeeded in prolonging life, now its task must be an effort to succeed equally as well in caring for those whose life has been prolonged, only to spend their later years in helpless misery and suffering. Hospitals for the chronically ill are crowded with people whose bodies have simply worn out.

**What is Chronic Illness**

Up to this point only the more general aspects of chronic diseases have been discussed. It is necessary, however, to decide what infirmities are included under chronic illnesses and just how a chronic illness differs from an acute illness. Specialized definitions of chronic illness are as many and varied as the number of diseases known to medical science. Most of the definitions agree on two facts however. Chronic disease is usually the name given to a disease of long and indefinite duration which can be alleviated but only in rare instances, cured. In the Montreal survey a chronically ill person was defined as one whose

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disability was of three months duration or more, and who was therefore incapable of following the daily routine of an average normal individual and whose disability would continue for an indefinite period. (1) Doctor Boas does not attempt to define chronic disease, but instead sets out the boundaries within which he thinks a chronic disease falls. He maintains that "chronicity is a concept, so that no classification of disease as acute or chronic can be absolute". It is his opinion also that "whereas chronic diseases are insidious in their onset and slowly progressive, acute diseases have a self limited course from which a person either recovers completely or dies. The course of chronic diseases extend over months or years; there may be arrest of the morbid process, but there is never complete restoration to normal." (2)

In the National Health Survey of 1935 in the United States a chronic disease was defined as a disabling or non-disabling chronic pathological condition known to the informant, the symptoms of which had been recognized for at least three months. (3) Private physicians and hospitals are prone to regard a chronic disease as one that may be expected to require an extended period of medical supervision and/or hospital, institutional, nursing or supervisory care. (4)

(1) The Care of the Chronically Ill in Montreal, Metropolitan Life Insurance Co., 1941, Page 5.

(2) Boas, Ernst P., M.D., The Unseen Plague, Chronic Disease, J. J. Augustin Inc. 1940, Page 19.


Under one or other of these definitions, practically every complaint listed in the medical dictionary could be called a chronic illness. Long term orthopedic cases, such as an elderly person with a broken hip bone, are certainly in need of prolonged hospital or nursing home care and in many cases patients in this category never completely recover. Some hospital authorities, even in Vancouver, definitely regard long term orthopedic cases as chronically ill people. Mental diseases and mental deficiency are chronic diseases in every sense of the word, but they are such a specific section of the whole field that it is questionable whether mental illness and such diseases as diabetes and cardiac disorders should be discussed under the same general heading. Similar questions arise in regard to tuberculosis. Although the contagious aspects of tuberculosis are well known, there are many persons with a chronic tuberculosis condition that is quite as crippling and as incurable as the severest case of arthritis. Is cancer an acute condition or a chronic condition? It seems reasonable to assume that cancer is an acute condition until the tumor becomes malignant and inoperable, or, in other words, terminal. Many doctors and hospital authorities have widely differing viewpoints about the disease of cancer. Which should be assumed correct? Post-polio cases and paraplegics are certainly incurable although in many cases their condition may be improved. They are suffering from the after-effects of a disease or accident, but they have no disease symptoms which could be aggravated.

In practically every study of chronic disease mental diseases and tuberculosis have been omitted. They are classed as special categories for which they feel reasonably adequate diagnostic and treatment
facilities have already been provided. The general public also does not regard these two illnesses as chronic diseases.

Dr. Boas lists the five most prevalent chronic diseases as (1) rheumatism, (2) heart disease, (3) arterio-sclerosis and high blood pressure, (4) hay fever and asthma, (5) hernia; and as causes of disability (1) nervous and mental diseases, (2) rheumatism, (3) heart disease, (4) tuberculosis and (5) arterio-sclerosis and high blood pressure. The leading chronic diseases in their order as causes of death are: heart diseases, cancer, arterio-sclerosis (and high blood pressure), nephritis.

The duration of these diseases prior to death is difficult to estimate in that it depends on the nature of the disease, the treatment provided, the degree of accuracy with which the original diagnosis was made and the stage at which the disease was recognized. In a Massachusetts survey it was found that patients with untreated cancer lived on an average of two years, those with a heart disease from seven to nine years, those with chronic rheumatism fourteen years or more and person suffering from rheumatic fever lived an average of fifteen years after the onset of the illness.

A chronic disease may vary widely from place to place in terms of prevalence, disabling effects and mortality. Rheumatism, the most prevalent chronic disease, is second as a cause of disability and fourteenth as a cause of death. Tuberculosis, although only fifteenth in prevalence, is a major cause of disability and death. Heart diseases rank high in prevalence, disability and mortality. Rheumatism cripples

(1) Boas, Ernst P., M.D. The Unseen Plague, Chronic Disease, J. J. Augustin Inc. 1940, Pages 8-9.
far more than it kills. It is a much more serious cause of invalidity than cancer, which ranks high as a cause of death. Organic diseases of the nervous system cause disability and invalidism of very long duration. Patients with degenerative diseases of the nervous system form a large proportion of those in custodial homes for the chronic sick. (1)

The Chronically Ill in Vancouver

It was estimated in 1947 that thirty-four per cent of the total population of B. C. and 43.5 per cent of the population of B. C. residing in organized territory, lived in Vancouver. (2) The City of Vancouver now has an estimated population of 376,000. (3) Assuming that one per cent of the population is suffering from chronic disease, there are 3,760 people in this city who can be classed as chronically ill. This estimate is probably very low. Retired people from all over the Dominion and especially from the three prairie provinces are coming to British Columbia in ever increasing numbers. The moderate climate of Vancouver attracts hundreds of residents from outlying districts of the province who wish to escape the rigours of the interior winters. Many of these are sick people suffering from one or another of the chronic diseases. They come to Vancouver where there are better opportunities for medical attention and where cheaper living accommodation is available.

Proof of this is found in the number of old age pensioners in Vancouver compared with the number in the whole province. There are now

(1) Ibid., Pages 10-13
(3) Figure given by the Assessment Division at the Vancouver City Hall, March 1, 1949 for Vancouver proper.
approximately 9,000 old age pensioners in Vancouver. Well over four hundred field service reports were examined by the worker to find what proportion of these were in need of medical care. Almost every report read thus: "Pensioner has been having a great deal of trouble getting around because of his arthritis"; "Pensioner finds it difficult to manage in his upstairs room because of his heart condition"; "Pensioner has considerable difficulty in walking because of a circulatory disorder" and so on without end. Another striking indication that the numbers of chronically ill persons in this city are increasing rapidly can be found in the 1948 annual report of the Victorian Order of Nurses, Vancouver Branch. In 1947 the V.O.N. paid 15,060 visits to 364 chronically ill patients. In 1948 they paid 20,013 visits to 516 such patients. Not only did the number of cases increase but also the average number of visits per patient. A very high proportion of these patients were in need of much more than two or three visits a week by a visiting nurse. Most of them were people who should have been in nursing homes or boarding homes. A considerable number of these people were patients who would, under normal circumstances, be receiving active treatment in an acute hospital; but because of the chronic nature of their condition and because of the scarcity of hospital beds they found it impossible to gain admission.

Further indications of the increasing numbers of chronically ill people coming to Vancouver are the long list of Vancouver residents awaiting admission to the Infirmary, the great demand for private

(1) Annual Report for the Year 1948, Victorian Order of Nurses, Vancouver Branch.
nursing home accommodation despite their exorbitant rates and the ever-increasing numbers of chronically ill patients being referred to the Vancouver General Hospital Outpatients' Department by physicians too busy to care for them.

In 1946 there were only 3,802 institutional beds for the chronically ill in the whole of Canada, of which 1,643 were in ten institutions in Ontario. At that time British Columbia had 364 beds in the Marpole Infirmary and its subsidiaries. This number of available beds in these provincial institutions had been reduced to 330. In addition to these, there were 220 beds for Vancouver cases available in Glen, Grandview and Heather Street Annex Hospitals. Shaugnessy Hospital and its subsidiaries provided about 150 beds for the institutional care of the chronically ill veteran. Mount St. Joseph's Oriental Hospital has accommodation for thirty-five chronically ill orientals. Private nursing homes bring the total available beds up to a maximum of 800 beds. Less than two thirds of the beds being used are occupied by Vancouver residents. The vast majority of these beds provide custodial care only, and in most cases no attempt is made to provide even a minimum of treatment facilities or more than nursing care. There is nothing except the Marpole Infirmary that even remotely resembles a real chronic hospital. It has been previously estimated that there are about 3,760 chronically ill people in Vancouver with about one third (1,250) in need of accommodation in special institutions.


(2) Only about fifty of these beds are occupied by Vancouver residents.
Only about one person in fifty in Vancouver knows that Glen, Grandview and Heather Street Annex Hospitals even exist. The majority of the residents of Vancouver believe that the Marpole Infirmary is an old people's home and they are completely unaware of what is being done there for the chronically ill. Obviously the hospitals and the City Social Service Department cannot hope to improve standards in existing institutions or double their accommodation if the general public, who after all supply the funds, are completely unaware that there is a problem or that there are conditions that need improving. A good public information campaign is greatly needed.

It is highly important to realize that the new scheme of compulsory hospitalization just coming into effect in British Columbia makes absolutely no provision for the chronically ill; and yet the whole success of the scheme rests on the assumption that not a single patient will remain in hospital a day longer than is necessary. If a chronically ill patient is forced to occupy an acute bed for lack of other more suitable accommodation, the whole scheme is impeded.

Outside of the City Social Service Department the Metropolitan Health Department and interested officials in the Vancouver City Hall, few people in the city have any conception of the staggering cost of providing public assistance for chronically ill persons, boarding home and nursing home care for the indigent and medical and nursing care for thousands of chronically ill in Vancouver. Only the thousands of people in Vancouver suffering from chronic disease have any realization of just how limited are their facilities for diagnoses, treatment and bed care.
The whole situation in Vancouver could be summed up in one paragraph paraphrasing a statement of Dr. Boas:

"The existing facilities for the care of the chronic sick present a very confused picture - patients at home that should be in hospitals, patients in homes for the aged, that are not prepared to minister to their wants, patients in convalescent homes occupying beds needed for another purpose; a mad confusion of patients and institutions - the patients scrambling to find refuge where they may, the institutions admitting them grudgingly, and having admitted them, not providing the care that they need. It is a scene of great disorder. Public and private hospitals, homes for the aged, convalescent homes, visiting nurse services, after-care agencies, medical social work departments and family service agencies - every one of them accepts with reluctance the burden of the chronic sick, and tries to shift responsibility to another agency which is no better prepared for the task."(1)

The Purpose of This Study

The present study is an attempt to evaluate the effectiveness and extent of the facilities that already exist for the care of the chronically ill population of Vancouver, and to suggest how these facilities can be improved and strengthened. An attempt will be made to point out what basic pre-requisites for the proper care and treatment are lacking; and an examination of the administrative structure already set up to deal with the problem of the chronically ill will be carried out to assess its effectiveness and shortcomings. Well over two hundred chronically ill patients have been personally interviewed and twice that number of hospital and social service files read. Each of the institutions described was visited personally and several days spent in

(1) Boas, Ernst P., M.D. The Unseen Plague, Chronic Disease, J. J. Augustin Inc., 1940 Page 75.
each case in Glen and Grandview Hospitals, Heather Street Annex, the Outpatients' Department of the Vancouver General Hospital, and the Marpole Infirmary. Administrators or owners of the various institutions and organizations were interviewed at length and various aspects of the whole problem were discussed with social workers involved in the hospital clearance or local assistance programs.

This study is primarily a study of the chronically ill residents of Vancouver and the institutions for their care and treatment within the city boundaries. Unfortunately chronic illness does not always abide by city limits; it was found that frequently institutions outside of Vancouver and residents of other parts of the province had to be referred to because of the utilization of the facilities of Vancouver by the whole province and the utilization of provincial institutions for Vancouver residents. To clarify this point, a Vancouver resident or a Vancouver responsibility for the purposes of this study, is a person who has lived in Vancouver continuously for one year. For persons in receipt of social assistance the term "Vancouver responsibility" is used to describe a person who lived in Vancouver continuously for one year without being in receipt of any form of public assistance before applying for social assistance. Burnaby, North Vancouver, West Vancouver and Richmond are not included in this study even though they make full use of Vancouver's hospital and medical facilities whenever their own are inadequate. North Vancouver is the only adjacent municipality with a hospital of its own.

Since the terms "chronically ill" and chronic invalid are so wide in scope and application, it is found necessary to limit their
definition. For the purposes of this study a chronically ill person is defined as one whose disability has been of ninety days duration or more, who has been incapable of following the daily routine of an average normal individual and whose incapacity will probably continue for an indefinite period. Except in rare cases the patient is suffering from a condition that can be alleviated but not cured. Also for the purposes of this study, persons suffering from pulmonary tuberculosis, psychotic disorders and congenital defects including, the deaf, dumb and blind have not been included on the grounds that these are categories for whom special provision is needed and has been already made; they are in any case not ordinarily classified as chronic diseases. The term "chronic invalid" has been used to describe a person who is unemployable because of some chronic disease and is not able to care for himself. A "chronically ill" person may be a chronic invalid or he may be afflicted by a chronic disease which does not make him completely unemployable. This person, although physically impaired in some way, is able to provide for his physical needs, though in need of medical care. Certain minor definitions and abbreviations have also been standardized.

(1) The Vancouver General Hospital is referred to as the General Hospital. The shortened form, "City Social Service" has been used rather than the full name of "The City Social Service Department of the City of Vancouver". The shorter title "Marpole Infirmary" has been used in place of "The Provincial Infirmary at Marpole". A "staff" patient is one who is not able to pay for his own care. The terms "nursing home" and "private hospital" have been used interchangeably because of their identical function in Vancouver. An "Acute" hospital is one in which generalized services including maternity and surgery facilities are available.
Chronically ill patients and the institutions caring for them have been divided into four main groups. Group "A" patients are those requiring medical care for diagnosis and treatment which, with few exceptions, is obtainable only in the acute hospitals. Group "B" includes patients requiring little more than skilled nursing care such as provided in the nursing homes and in the Marpole Infirmary. Group "C" need only custodial care which is available in various types of boarding homes throughout the city. Group "D" refers to those more fortunate cases who, though suffering from some chronic disease, are still able to live in their own homes and to carry on with the aid of a private physician without nursing or custodial care.
Chapter II

The Chronically Ill and the General Hospitals

In Vancouver, the chronically ill patient requiring active diagnostic and treatment services can find them only in the Vancouver General Hospital, St. Paul's Hospital and St. Vincent's Hospital. Through no choice of their own, these hospitals are forced to provide the only Class "A" care that is available for the chronically ill in Vancouver. Each of the hospitals, particularly the Vancouver General Hospital, faces the problem of how to maintain a constant turnover of beds when an appreciable number of these beds are occupied by chronical invalids for whom no alternative accommodation can be found. The hospitals are forced to admit many chronically ill persons when their condition becomes so emergent that they cannot continue in their own homes or in a nursing home. The problem is intensified at the Vancouver General Hospital where so many of the patients are staff patients admitted through the Out-patient's Department.

The acute general hospital as at present constituted is unsuited for the care of long-term patients. The average long term patient requires less costly care than that provided in the acute general hospital. To continue to care for the long-term patient in the acute hospital is wasteful; it provides care which is more expensive than he actually needs, and which is often unsuited to his requirements. (1)

(1) The work of a joint committee; Planning for the Chronically Ill, Public Welfare Vol. 5, No. 10, October 1947, Page 221.
If a chronically ill person is admitted to the hospital when his condition becomes acute, what is to be done with this patient after his acute condition subsides and his chronic complaint required active medical treatment for a long period afterwards?

The Centralization of the Problem in the Vancouver General Hospital

Almost since the Vancouver General Hospital's inception the chronically ill have constituted a major administrative and financial problem. After forty-six years of operation the question of what to do with the chronically ill is still being asked. With the implementation of the new compulsory hospital insurance scheme, the question of what to do with the chronically ill occupying acute beds becomes even more in need of solution. Every bed in the hospital occupied unnecessarily by a chronic patient reduces the number available for the accommodation of the acutely ill. Despite the efforts of the hospital administration and the hospital medical social workers, a significant number of beds, which should normally be at the disposal of acutely ill patients, are occupied for long periods of time by patients who are in need of nothing more than convalescent hospital or nursing home care. The acute symptoms of their illnesses have subsided and they require only a minimum of medical and nursing care.

Continuous efforts have been made by the hospital authorities to provide a maximum of medical care with a minimum utilization of the acute hospital facilities. Historically this has been accomplished by using annexes or leasing beds in private nursing homes to care of the chronically ill. In 1917, a building known as the Military Annex was constructed on the present site of the Semi-Private Pavilion to house
war casualties. Gradually as the number of wounded soldiers decreased, the beds were turned over to the care of chronic patients from the main hospital. By 1928 the building (then known as the 12th Avenue Annex) held 250 patients, both male and female, most of whom were chronic invalids. Both paying and non-paying patients were accommodated there. By 1930 the last of the veterans had been removed.

In February 1917, a bankrupt hotel in Marpole, now known as the Marpole Infirmary, was taken over by the Vancouver General Hospital to serve as an outlet for its chronically ill. The provincial government assumed control of the institution in July 1923.

Again in 1918, Heather Street Annex, a group of frame buildings opposite the hospital on Twelfth Avenue, was opened to accommodate victims of the "Spanish Influenza" epidemic. Gradually these beds also came to be used for chronic invalids. The same buildings, though recently moved one block away to make room for a new nurses' home, are still in use.

About 1931-32 the Vancouver General Hospital began placing patients requiring long-term nursing care and those that were considered to be chronically ill in the private nursing homes of Glen, Grandview and Bayview. About the same time, a small number of patients were placed in the Royal Derby Hospital and the Florence Nightingale Hospital. The numbers placed in these two institutions were small and placements in them were discontinued after a few years.

By 1937 the main hospital became so crowded with chronics and the hospital was in such desperate financial straits that something had to be done to release some of the beds being occupied by chronically ill patients no longer in need of acute hospital care. In that year the
provincial government induced the hospital to set up an independent Social Service Department (under the directorship of Miss Olive Cotsworth, R.N.) to work out a system of hospital clearance and to act as liaison office between the hospital and the City Social Service Department. Working in close collaboration with the hospital social service department, the Medical Section of the City Social Service Department made arrangements for nursing home care to be provided for chronic and convalescent cases in selected private hospitals. The scheme put into operation in 1937, continued until July 1942 at which time the City Social Service Department withdrew from any participation in the hospital clearance program. The City Social Service still continued to accept responsibility for patients in Heather Street Annex. Mount St. Mary had been opened the previous year and this, along with the Marpole Infirmary, was expected to provide sufficient accommodation for the chronically ill cared for by the Vancouver General Hospital.

At one time the Vancouver General Hospital considered closing down Heather Street Annex. However, in January 1943 the General Hospital agreed to keep open and to operate Heather Street Annex on the condition that the City Social Service Department would pay the full cost of operating the institution. Under this agreement all admissions to Heather Street Annex were to be made through the City Social Service Medical Section and not through the Hospital. Medical care for the patients was to be provided by the Vancouver General Hospital.

In January 1948, the City Social Service Department changed its policy again and agreed to accept financial responsibility for all patients in Glen and Grandview Hospitals. Medical, dietetic and social
service supervision in these institutions was provided by the General Hospital.

Problems of Admission and Discharge

Before making an examination of the current situation in the General Hospital it is necessary to discuss the question of admission and discharge to the hospital that existed prior to the beginning of the compulsory hospital insurance scheme. In the final analysis, the system in use regulates the admission of the chronically ill to the hospital and their ultimate dispersion to their homes or to continued care in nursing homes or boarding homes.

Each public ward in the hospital has a certain number of staff beds, admission and discharge to which are regulated by the resident interne of the ward. Approximately one third of the staff patients are admitted through the Outpatients' Department of the hospital, the other two thirds being referrals from private practitioners. Doctors in the Outpatients' Department must consult with the resident interne of the ward before admitting any patient. Both staff and paying patients are admitted directly if their case is one of extreme emergency; certain beds are kept continually available for this purpose. Paying cases admitted for medical and surgical treatment are admitted by nurses in the main hospital admitting office. Seriousness of the illness and priority in date of the doctor's application for a bed are determining factors in admission. When there are beds available for the less acute cases, the doctors and the nurses in the admitting office discuss the case and decide whether it is necessary to admit the patient. If the doctor can prove the necessity of hospitalization, the patient will be
admitted. Usually beds are booked about seven days in advance for non-emergency cases. Several wards have beds which are controlled by individual doctors, e.g., an orthopedic specialist may have four beds and a genito-urinary specialist two, which are reserved for their cases. The admissions and discharges to these beds are decided by the individual doctors. This means in effect, that a chronically ill person, whose illness causes him considerable discomfort but whose condition is not regarded as acute, has little chance of being admitted to hospital; later his condition may become so acute that nothing can be done for him.

The resident interne discharges patients from the staff beds under his control when he decides that the patient has recovered sufficiently. If the patient is an interesting or unusual case the chances are that he will be kept in hospital longer than, say, a sick old woman, suffering only from diabetes who has little interest for the learning interne. All other patients have their discharge date decided upon by their own doctor. Usually a paying patient does not stay a day longer than necessary because of the expense. When a person requires a longer than ordinary period of hospitalization it is the duty of the accounting department to judge whether the patient's future ability to pay his hospital bill is exceeded. When this situation occurs, the patient's doctor is notified that the patient will be transferred to the staff list. Some doctors discharge their patients rather than have this happen.

Many of the staff cases and a few of the private cases are kept in the hospital because the doctors refuse to discharge them to inadequate or unsuitable living accommodation. If they were discharged
they would only be re-admitted within a short time. The Social Service Department arranges for the accommodation of these people in nursing homes or boarding homes. Transfers to private boarding and nursing homes for paying patients as well as for staff patients are arranged by the social workers. (1)

Chronic Patients Occupying Acute Beds in the Hospital

The total ward capacity of the Vancouver General Hospital excluding maternity, infectious disease and the three annexes is 881 beds; of these 814 were occupied when a check was made (by the Social Service Department) on August 1, 1948. When the ward lists were again checked on August 12, 186 of the original 816 patients were still in hospital on that date. Checking again after thirty days, 109 of these patients were still found to be occupying "acute beds". In other words, eight per cent of the total number of beds in the hospital at that time were occupied by persons who had been in the hospital for at least thirty days. Of the original 816 patients in the hospital on August 1, 1948, twenty or 2.4 per cent had been admitted to either Glen or Grandview Hospitals (Heather Street Annex was closed during this period).

On November 1, 1948 a further check of ward lists was made by the Social Service staff, and it was then found that of the original 816 patients, fifty-one or 6.2 per cent were still occupying acute beds in the hospital.

(1) The above description of admissions and discharges to the Vancouver General Hospital has been changed considerably by the inauguration of the new hospital insurance scheme. There is now no such thing as a "staff" or a "paying" patient. The demand for beds has become much more urgent and the chances for a chronically ill person to be admitted are even more remote.

(2) Vancouver General Hospital considers that the average length of stay of its patients is eleven days.
hospital. Four more admissions to Glen or Grandview Hospitals brought the total number of admissions to these institutions to twenty-four or approximately three per cent of the original 816. Three of the remaining fifty one were eliminated because they were not considered to come within the scope of this study. (1) An examination of the medical condition of the remaining forty-eight patients showed that the majority of the patients were there because of the need of prolonged hospitalization rather than because they were chronic invalids.

Table A

Reasons for Being in Hospital

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraplegia and post-polio</td>
<td>11</td>
</tr>
<tr>
<td>Fractures</td>
<td>8</td>
</tr>
<tr>
<td>Heart &amp; Circulatory Disorders</td>
<td>5</td>
</tr>
<tr>
<td>T.B. of Spine or Hip Bone</td>
<td>3</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2</td>
</tr>
<tr>
<td>Burns</td>
<td>3</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>2</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
</tr>
<tr>
<td>Gastro-Intestinal Disorders</td>
<td>1</td>
</tr>
<tr>
<td>External Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Urinary Disorders</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

Excluding the fracture cases and the post-polio and paraplegic cases which must be treated as special categories, there were twenty-nine cases left from the original 816 who were suffering from disorders of a chronic nature.

(1) Of these three, one had T.B. of the chest, one had a congenital defect and the third was suffering from a psychotic disorder.
An examination of the length of stay of these twenty-nine patients in the hospital showed wide variations in the time spent in hospital.

Table B

Length of Hospitalization Period

<table>
<thead>
<tr>
<th>Time (days)</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 - 120</td>
<td>11</td>
</tr>
<tr>
<td>121 - 150</td>
<td>4</td>
</tr>
<tr>
<td>151 - 180</td>
<td>2</td>
</tr>
<tr>
<td>181 - 210</td>
<td>2</td>
</tr>
<tr>
<td>211 - 240</td>
<td>2</td>
</tr>
<tr>
<td>241 - 270</td>
<td>2</td>
</tr>
<tr>
<td>271 - 300</td>
<td>0</td>
</tr>
<tr>
<td>301 - 330</td>
<td>2</td>
</tr>
<tr>
<td>331 - 365</td>
<td>2</td>
</tr>
<tr>
<td>More than 365 days</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
</tr>
</tbody>
</table>

Approximately one half of the twenty-nine patients were over the age of sixty.

Table C

Age Distribution of Patients

<table>
<thead>
<tr>
<th>Ages</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 10</td>
<td>4</td>
</tr>
<tr>
<td>11 - 20</td>
<td>1</td>
</tr>
<tr>
<td>21 - 30</td>
<td>7</td>
</tr>
<tr>
<td>31 - 40</td>
<td>1</td>
</tr>
<tr>
<td>41 - 50</td>
<td>2</td>
</tr>
<tr>
<td>51 - 60</td>
<td>2</td>
</tr>
<tr>
<td>61 - 70</td>
<td>5</td>
</tr>
<tr>
<td>71 - 80</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
</tr>
</tbody>
</table>
Of these twenty-nine people, ten were paying for their care, five were paying as much as they or their families could afford, and fourteen were staff cases unable to contribute anything toward the cost of their hospitalization.

The eleven paraplegic and post-polio cases are considered as a separate category; nevertheless, for all practical purposes they are chronic invalids, unable to work or care for themselves. They have been brought together at the Vancouver General Hospital and have been kept there because of the training facilities and physio-therapy treatments available only in this hospital. Five of the eleven were from towns outside of Vancouver. Some of these paraplegics and post-polio do not need acute hospital care but until recently no alternative accommodation has been available for them. Almost all of the paraplegics and post-polio cases had been in the hospital for at least six months. One exceptional patient was admitted to the hospital on August 1, 1945 and had received treatment continuously since then.

It appears that only a convalescent hospital and a chronic hospital operated in conjunction with the Vancouver General Hospital is the only solution to the problem. The General Hospital will continue to have thirty or forty beds filled with chronic and convalescent patients unless alternative accommodation is made available. The three annexes cannot possibly hope to cope with the number of patients that the hospital would like to transfer to them.

The Outpatients' Department of the Vancouver General Hospital

The present Outpatients' Department can trace its origin back to the year 1906 when it was formed as an adjunct of the old City Dispensary.
It was not until 1915 that the medical services carried on by this department were completely taken over by the Vancouver General Hospital and a properly constituted Outpatients' Department was set up in some old frame buildings near the hospital. A wing of the Heather Street Annex was taken over by the Outpatients' Department in 1926.

The work of the department was carried on at first by a voluntary Medical Director and a staff of attending doctors, nurses, social service workers and clerical workers. In 1938 a full-time Assistant Medical Director was appointed. He was to take complete charge of the more routine medical services. In 1939 the clerical staff was re-organized and a Chief Clerk appointed. In September 1943 the Outpatients' Department was transferred to its present quarters in the Semi-Private Pavilion.

In 1915, 450 cases were treated by the Outpatients' Department; in 1947 the total number of patients was 5,749.

Eligibility for free treatment in the Outpatients' Department is based on income and residence. A single person earning less than seventy dollars a month is eligible for free treatment; for a married couple the maximum is ninety dollars. An exemption of twenty dollars for each dependent thereafter is allowed. At frequent intervals the scale of eligibility is reviewed and allowances made for changes in the cost of living. New eligibility rules for this year are being drawn up and the exemptions will be considerably liberalized. Family allowance is not counted as income and borderline cases having heavy medical expenses are given every consideration. The Clinic accepts all Vancouver

(1) The position of Assistant Medical Director is now vacant and there is a group of doctors that work on a rotation system with senior internes participating more actively in the work of the Outpatients' Department.
residents but a person from an outside municipality, e.g., Burnaby, Richmond, New Westminster and Surrey, is accepted for care providing he obtains a written order from that municipality. North Vancouver provides separate facilities for its own residents. The Medical Services Director of the Province of B.C. also refers patients to the clinic. A patient may be referred to the Outpatients' Department by any private physician or he may personally apply at the clinic. The public health nurses and City Social Service workers are responsible for a large number of the referrals to the Department.

When a new patient is admitted he is given a complete physical examination and has routine tests performed by an intern. A preliminary diagnosis of the patient's condition is made. The patient is then referred to one of the special clinics for treatment by a specialist. In some cases the patient is examined in several different clinics before a definite diagnosis of his condition is made. It is the policy of the Outpatients' Department to have every patient admitted or readmitted, interviewed by the social worker.

There is one group of sick people in the low income group that are not able to avail themselves of the services provided by the Outpatients' Department. These are the people living on pensions or superannuation payments who are too ill to come to the Outpatients' Department for treatment and diagnosis. Their income is not low enough for them to qualify for social assistance and its accompanying medical care. Their income is either a little more than the eligibility minimum or they are not old enough for Old Age Pension. The private medical practitioner, unless he has known the family over a period of years, is unwilling to
make frequent and non-paying visits, especially when he has a large practice. Many families of moderate or low income e.g., around one hundred dollars a month, do not receive medical treatment until their condition is too serious to be alleviated or their condition becomes so acute that they have to be admitted to the hospital. An adequate system of Health Insurance is the only method which would ensure that these people would receive proper medical care prior to the hospitalization stage.

In an effort to ascertain what treatment facilities for the chronically ill were provided by the Outpatients' Department of the Vancouver General Hospital, the files and medical charts for fifty long-term patients were read and summarized. Each of these patients had been active cases in 1938 and they were still active cases in 1948. The selection was purely at random, taking the first fifty of the approximately one hundred cases in the filing cabinet. The period 1938-1948 was chosen because it provided a chance to examine the effects of chronic illness upon these people during three entirely different periods when wages, living conditions and availability of medical care varied greatly. The post depression years and the first years of the war saw an increase in the numbers of chronically ill people coming to the Outpatients' Department for diagnosis and treatment. The private physician no longer needed the assured but low remuneration that he received during the depression for the medical care of indigents. Instead, as the numbers of his paying patients increased he began to refer more and more of his non-paying cases to the Outpatients' Department.

During the war, many of the special clinics and treatment facilities provided by the Outpatients' Department were curtailed or
discontinued due to a shortage of doctors. The war had another effect upon certain groups of chronically ill individuals. Due to an extreme shortage of labour, many persons previously considered unemployable were able to secure employment and earn good wages, which precluded them from receiving free medical treatment from the Outpatients' Department. There still remained a small but recognizable group of chronically ill people who received very low incomes and required continual medical care. Their numbers again increased after the war. At the same time, more people than ever before were able to pay their doctor's bills, and as the private physician's practice increased he became more reluctant to use his time to treat the chronic and often non-paying patient. In consequence referrals to the Outpatients' Department have increased considerably since the end of the war.

With a few exceptions, the fifty cases sifted out in the present study received continuous treatment during the whole ten year period. Only in the younger age group was the income level raised sufficiently to make them ineligible for treatment at the Outpatients' Department for part of the war years. The fifty cases examined were mostly in the older age group. As it happened, the fifty cases studied comprised thirty males and twenty females. Some of the cases had been known to the Outpatients' Department for several years prior to 1938 but others came to the Department in 1938 for the first time.
Table D

Time of First Application for Treatment at the O. P. D.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
<td>1</td>
</tr>
<tr>
<td>1931</td>
<td>1</td>
</tr>
<tr>
<td>1932</td>
<td>4</td>
</tr>
<tr>
<td>1933</td>
<td>3</td>
</tr>
<tr>
<td>1934</td>
<td>10</td>
</tr>
<tr>
<td>1935</td>
<td>0</td>
</tr>
<tr>
<td>1936</td>
<td>1</td>
</tr>
<tr>
<td>1937</td>
<td>1</td>
</tr>
<tr>
<td>1938</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
</tr>
</tbody>
</table>

Of the fifty patients, thirty were over the age of sixty-five. The one person under twenty years of age was a girl (aged 14) who had received continual medical care for a variety of childhood complaints since her birth.

Table E

Age Distribution of the 50 Patients

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21</td>
<td>1</td>
<td>61-65</td>
<td>5</td>
</tr>
<tr>
<td>31-35</td>
<td>1</td>
<td>66-70</td>
<td>11</td>
</tr>
<tr>
<td>36-40</td>
<td>1</td>
<td>71-75</td>
<td>9</td>
</tr>
<tr>
<td>41-45</td>
<td>5</td>
<td>76-80</td>
<td>6</td>
</tr>
<tr>
<td>46-50</td>
<td>2</td>
<td>81-85</td>
<td>3</td>
</tr>
<tr>
<td>51-55</td>
<td>4</td>
<td>86-90</td>
<td>1</td>
</tr>
<tr>
<td>56-60</td>
<td>1</td>
<td>Total</td>
<td>50</td>
</tr>
</tbody>
</table>

As a matter of interest it can be noted that of the fifty persons studied, twenty-six were born in the British Isles, fifteen in Canada, five in Scandinavia, two in Russia, one in Czechoslovakia and one in the U.S.A. All of the fifty persons had been resident in Canada for at least
ten years prior to 1938 and only fourteen had lived in British Columbia less than ten years. Only three of the fifty had lived in Vancouver less than three years. In other words, the group was a fairly representative B.C. group.

An analysis of the medical diagnosis of the fifty patients reveals that twenty-eight out of the fifty were suffering from heart disorders, arthritis or diabetes, and many had some combination of the three.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Disorders</td>
<td>12</td>
</tr>
<tr>
<td>Arthritis</td>
<td>9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>3</td>
</tr>
<tr>
<td>Thyroid Disorders</td>
<td>3</td>
</tr>
<tr>
<td>Genito-Urinary Disorders</td>
<td>2</td>
</tr>
<tr>
<td>Stomach Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Anaemia</td>
<td>2</td>
</tr>
<tr>
<td>Varicose Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Chronic Otitis Media</td>
<td>2</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>2</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>1</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of the fifty patients did not receive continuous medical care in the sense that they saw the doctor every time they came to the clinic. For instance, the person suffering from diabetes, although receiving periodic check-ups, came regularly for his insulin but did not see the doctor every time that he came to the clinic. Of the seven diabetics, five were suffering from other disorders such as arterio-sclerosis or cardiac conditions. The diabetes in itself did not make the person unemployable, but the patient's age and the other diseases in conjunction
with the diabetes, made chronic invalids out of them. Similarly, eight of the twelve persons suffering from cardiac disorders had additional afflictions such as arthritis, ulcers, etc. Seven of the arthritics had other complicating illnesses.

Of the fifty patients, the condition of twenty-eight had not improved at all during the ten year interval and the diagnosis of their illness in 1948 was exactly the same as it was in 1938. It must be noted however, that the majority of these patients would have died if they had not received the treatment and medicine that the Outpatients' Department provided for them.

Of the fifty patients, twenty had required at least one period of hospitalization for their illness; several had required four and five periods. Eight of the fifty had not required any hospitalization. The other twenty-two had had one or more periods of hospitalization for illness other than the one for which they were receiving constant treatment in the Outpatients' Department.

All of the cases examined were in receipt of some form of public assistance (1) or were from extremely low income homes.

Table G

Financial Circumstances of the Patients

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>In receipt of social assistance</td>
<td>15</td>
</tr>
<tr>
<td>In receipt of old age pension</td>
<td>14</td>
</tr>
<tr>
<td>Disability or other pension</td>
<td>9</td>
</tr>
<tr>
<td>Earning an income of $70 or less</td>
<td>8</td>
</tr>
<tr>
<td>Supported entirely by relatives</td>
<td>4</td>
</tr>
<tr>
<td>or other members of the family</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
</tr>
</tbody>
</table>

(1) Under the new scheme of medical care for assistance recipients, all social assistance, old age pension and mothers
According to this evidence, well over half of the chronic cases are in receipt of some form of assistance. In fact, of the 5,749 patients that attended the Outpatients' Department in 1947, 3,648 or sixty-three per cent were in receipt of some form of assistance.

St. Paul's Hospital and the Chronically Ill

St. Paul's Hospital opened its doors in 1894 to take in twenty-four patients. The hospital, now with a bed capacity of 650, is operated by the Sisters of Charity of Providence. Today it is the largest private general hospital in British Columbia. The hospital has its own staff of doctors and all patients are admitted to the hospital by their own doctor, whereas in the Vancouver General Hospital staff patients are admitted by the resident internes. The same doctors are responsible for the discharge of their own patients and the hospital administration constantly checks the doctors and patients to see that no patient is kept in hospital any longer than is necessary.

A much needed improvement was inaugurated by the opening of a social service department in September, 1948. Prior to this, the removal and placement of chronically ill patients in alternate accommodation was the responsibility of the floor supervisors. All arrangements for placement are now being made by the social worker but it seems hard to believe that case-work services for 650 patients can be provided by one lone social worker.

With the opening of this department, several chronic patients who have occupied acute beds for many years were placed in nursing homes allowance cases will be cared for by private physicians and will not go to the Outpatients' Department except for special reasons. This scheme came into effect March 1, 1949.
and boarding homes. In January 1949, the Sister Superior of the hospital stated that there were only about twelve beds in the hospital still occupied by chronic invalids. Prominent amongst the twelve patients were five very old women who have been in the hospital some time but whom the sisters feel it would be impossible to move because of their frailty.

St. Paul's Hospital has only twenty-five "staff teaching beds" compared to the several hundred of the Vancouver General Hospital so that the problem of what to do with large numbers of chronically ill indigent patients is not so pressing.

The chronically ill patients mentioned before are all on one floor to make it easier to provide nursing care for them. Since St. Paul's Hospital has no wards holding more than eight patients, the individual patient gets more attention than does the patient in the large public wards at the Vancouver General Hospital. The average ward is actually a four bed ward.

The nurses in the hospital have become quite attached to many of the long-time chronic patients and become very indignant when one is moved out of the hospital. These staff patients receive the same treatment and care as a paying patient.

If the demand for acute hospital accommodation continues it will become necessary for the hospital to make arrangements for the removal of even the small number of chronically ill patients occupying acute beds. Since the commencement of the hospital insurance scheme St. Paul's Hospital has had to increase the turnover of beds in the hospital. At present the chronic patients occupying acute beds are receiving unnecessarily expensive care and despite the hospital's moral responsibility to care for some of these people, these extra beds must be made available. The
hospital has an excellent social service department in operation and the interests of the patients are certainly being given first consideration in that they are not being too pressed to go to other accommodation.

St. Vincent's Hospital

St. Vincent's Hospital was opened at its present location (adjacent to Shaughnessy Hospital) in July 1939. Operated by the Sisters of Charity of the Immaculate Conception, it is the most recent addition to the acute hospitals of Vancouver. It has a capacity of 103 beds and 17 bassinets, and provides services under contract for most of the employees of the Canadian Pacific Railway. Because of the type of patients who come to this hospital, and its comparatively small bed capacity, the hospital has no chronic invalid problem of any magnitude. At the time of the worker's visit there were only two patients who could be classified as chronically ill. Both of these patients were still urgently in need of acute hospital care and only one was to be referred to the Inspector of Hospitals Office for placement; the Sister Superior stated that excellent co-operation is secured from the doctors in having their patients discharged as soon as they are no longer in need of acute hospital care. The hospital maintains excellent relations with Inspector of Hospitals Office and the Medical Section of the City Social Service Department, and as a result, the hospital has never had any difficulty in having its chronic patients removed to a nursing home or boarding home whenever that becomes necessary. All arrangements for placement are made by one of the sisters of the hospital.
Chapter III

Institutions for the Care of the
Chronically Ill in Vancouver

Chronically ill patients requiring skilled nursing care are cared for in the private hospitals and nursing-homes of Vancouver. Some are privately owned and operated while others are publicly owned or publicly subsidized. For a city the size of Vancouver there are surprisingly few private hospitals for the care of the chronically ill and convalescent patient.

Glen Hospital

Glen Hospital had its beginning at 1134 East 12th Avenue where in 1920 Miss Kate Smith, a graduate nurse, and her sister Mrs. Mary Westwood opened a private nursing-home. They started with four patients but were soon overwhelmed with applicants seeking care. Before long they moved to a larger house at 2734 Glen Drive whence the present name of Glen Hospital is derived. Soon this building too proved inadequate and the present building at the corner of Salisbury and Napier streets in the Grandview district, the former home of an Australian millionaire, was taken over in 1924. With this move the capacity of the nursing-home was expanded to thirty-eight. The demand for nursing-home care became so acute that the house next door was taken over as an annex. In 1937 a new modern concrete annex was added to the original building and forty-eight additional beds were made available, bringing the total capacity of
the institution up to eighty-six.

For many years only private patients with their own doctors attending them were admitted. In 1933 Glen Hospital contracted to take several staff patients from the Vancouver General Hospital. The numbers of these were steadily increased until on January 1, 1948 the General Hospital contracted for every bed in the nursing-home. The agreement specified that all private patients in the hospital at that time should remain, but no further private patients should be admitted after this date. At present only five of the eighty-six beds are still occupied by these private patients. The hospital is now owned by the two sons of Mrs. Mary Westwood, one of whom is the present manager. Glen Hospital, now the largest privately owned hospital in B.C. is licensed to care for "old-age, semi-medical and infirmity" cases.

The Vancouver General Hospital paid Glen Hospital $45 per month for each staff case placed there in 1933. Gradually this amount was increased to $60, to $72, to $80, then to $90. Since December 1, 1948 the General Hospital has paid $105 per month per patient. The owners of the hospital have found it feasible to take these patients at lower rates than are asked by other private nursing-homes, because they are assured of keeping every bed filled. They can realize a steady income without having to face the problem, all too familiar in this field, of the patient who enters as a paying patient, but after using up his resources, continues to occupy a bed without payment until the owner can have him removed or make arrangements with the municipal authorities to assume the responsibility for his care.

A doctor from the Vancouver General Hospital sees each patient twice a week. An orthopedic specialist also visits once a week. The
dietitian from the Vancouver General Hospital visits once a week and the medical social worker twice a week.

The hospital has a staff of thirty-five, including six graduate nurses and eighteen nurses' aides. Glen Hospital was one of the first hospitals in B.C. to use nurses' aides, and the present system of training and employment of nurses' aides throughout the province is largely based on the Glen Hospital system.

Glen Hospital considers itself more of a convalescent hospital than a chronic hospital. Statistics for the year 1947 seem to support this claim. If possible the General Hospital tries to place its younger patients there and most of the long-term orthopedic cases are placed there, rather than in Grandview Hospital.

<table>
<thead>
<tr>
<th>Patients under care 1947</th>
<th>341</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients admitted</td>
<td>251</td>
</tr>
<tr>
<td>Carried over from 1946</td>
<td>86</td>
</tr>
<tr>
<td>Discharged</td>
<td>150</td>
</tr>
<tr>
<td>Deaths</td>
<td>106</td>
</tr>
<tr>
<td>Total Number of Hospital Days</td>
<td>31,027</td>
</tr>
<tr>
<td>Patients in hospital December 31, 1947</td>
<td>85</td>
</tr>
</tbody>
</table>

Figures for 1948 are not yet available except that the number of deaths for the year was sixty-two, about the average over a number of years.

The hospital itself is a large, gaunt three-storey house with a concrete addition tacked on the side; the administrative departments and the kitchens occupy the basement. The old original part of the building was never intended as a hospital and the service facilities in this part are very inadequate. The wards, of various sizes accommodating from two to twelve patients, are kept quite clean and the linen is changed frequently. The food is good but lacks variety; several of the
patients complained of not getting enough.

In the course of his work with the City Social Service Department, the worker spent considerable time in Glen and Grandview Hospitals and had an excellent opportunity to observe the operation of the hospitals and to become familiar with the patients. Except in a few cases, every patient was interviewed at frequent intervals during the four month period.

The chief complaint that can be made against Glen Hospital is that it suffers from a serious shortage of staff. All of the patients complained of lack of attention but all felt that what they did receive was good. The greatest need in Glen Hospital is male orderlies. The nurses are not strong enough to manipulate the male patients without help and even many of the female patients are too heavy to be moved. This lack of male orderlies prevents many of the patients from getting out of bed as often as they might, and crippled patients find it practically impossible to get a helping hand when they would like to manage on their own.

A visitor to the wards is struck by the lack of little extras that one is accustomed to seeing in other institutions caring for the sick. Very few of the patients have their own radios and there appears to be practically nothing with which patients can occupy themselves. No occupational, recreational or physiotherapy facilities are provided. Some of the patients would be too sick to take advantage of such facilities but most of them would be greatly benefited. It has sometimes been said that the most unhappy people are those with nothing to do. This is certainly true in this hospital. It is most depressing to go from bed to bed hearing each patients' complaints; they have nothing to do except talk to the patient in the adjoining bed — if that person is able to talk.
Many of the patients feel that this place is the end of the road and bitterly resent being left in such a place to die. They feel that it is humiliating and degrading to have to accept social assistance and to have to answer the numerous questions of the social worker. No attempt is made to consider the individual needs, desires or interests of the patient other than a certain amount of routine nursing service. The hospital, as a private enterprise, is run as economically as possible so that the maximum profit is realized. Extras cost money and decrease profits.

On the whole the city gets what it pays for at Glen Hospital; Class "B" care for the chronically ill is provided. Standards of cleanliness and of nursing care are fairly good but might easily be improved. The pressing need is a greater emphasis on treatment rather than merely the providing of a bed for the limited purpose of clearing these patients out of the General Hospital. The lack of recreation, occupational therapy and sufficient social service facilities precludes any form of treatment program and makes this a custodial centre rather than a properly organized chronic or even convalescent hospital.

Grandview Hospital

Less than a block away from Glen Hospital is Grandview Hospital situated on the corner of Napier Street and Victoria Drive. It also is a large three-storey frame house converted into a nursing-home. At this point the similarity between the two institutions ends.

Grandview Hospital, now the oldest private hospital in Vancouver, was opened in 1912 by a group of doctors for the care of medical, surgical and maternity cases. In 1914 the present owner and his wife, a graduate nurse, took over the sixteen bed hospital. Until the admission of
maternity cases was discontinued in 1934, various types of patients were admitted. The present owner is very proud of the fact that 1,555 babies were born in the hospital during this period. Several times the hospital was on the verge of bankruptcy. Finally in 1935, lack of patients and lack of money necessitated a change of policy in the hospital and four chronic staff cases were taken from the Vancouver General Hospital.

Each year a little has been added to the building, bringing the capacity up to the present number of sixty beds. The staff has been expanded from five to twenty-six. Because of poor working conditions there has been a great turnover in nurses and the hospital is now understaffed to a dangerous degree.

The building occupied by the hospital is very old and somewhat dilapidated. The lower floor is used for male patients and most of the second floor for female patients. Both male and female patients use the same bathroom. The old saying that "first impressions are always the worst" holds true here. The first impression on entering this building and which remains, is the stench of urine and excreta. The bed linen on the beds of the male patients is dirty and changed infrequently; and this condition is aggravated by the extreme shortage of staff.

The patients receive a minimum of nursing care and if they are

(1) A very interesting description of Grandview Hospital by Dr. A. K. Haywood and his associates is found in the Report of the Vancouver Hospital Survey Commission Upon the Hospital Situation of Greater Vancouver (1930). "Grandview hospital is in a poor locality of the city and those using it are of moderate means.

At the time this building was visited it was dirty, odorous and very poorly equipped for the class of work attempted. It has accommodation for fifteen patients. There are no facilities for sterilization; the whole place seemed to be in very poor condition and the impression was gained that very questionable work might be done there without interference."
able to manage on their own, they become forgotten men. The food is poor, and every patient interviewed complained about it. The lack of male orderlies to care for the male patients makes it practically impossible for the nurses to do anything for many of the patients even if they had time.

The wards for women upstairs are considerably better than the male wards downstairs. There are more and better nurses there and the difference between the two floors is striking.

Sanitary and lavatory facilities for the men downstairs are gravely inadequate. The stench of what facilities there are and the nauseating odour of the unemptied urine bottles standing for long periods on the tables beside the patients' beds is enough to give anyone a bad impression of the place. In one room in particular downstairs, where there were several Oriental patients and a Hindu patient, conditions were indescribably filthy.

Part of the blame for these conditions can be laid to the shortage of staff, but a large part of it was due to the fact that until recently the matron in charge was not temperamentally suited to caring for this type of patient and the result was a continuous conflict between the matron, the patients and their families. Recently a new matron has been appointed and there has been considerable improvement in every respect. Unfortunately facilities for the staff are almost as bad as for the patients and for this reason it is very difficult to keep a complete staff.

The patients are all dissatisfied and complain continually. The reputation of the hospital has spread throughout the city with the result that social workers find it a hopeless task to persuade patients in the General Hospital to go to Grandview Hospital. Patients are afraid that
they will not receive the proper treatment there and their friends and relatives will be unwilling to visit them in such a place.

The total bed capacity of sixty is under contract to the General Hospital. No private patients are accepted. Medical, dietetic and social services are provided by the General Hospital. The doctor and social worker visit the hospital twice a week and the dietician once a week.

Grandview Hospital receives the same per capita payment of $105 a month as Glen Hospital.

Absolutely no extras or comforts, recreational or occupational therapy facilities are provided for the patients. As in Glen Hospital many of the patients could not use these facilities if they were provided but there are very few patients who could not get some enjoyment out of a radio in the ward.

Grandview Hospital is a striking example of why an institution caring for the chronically ill should not be run as a profit-making private enterprise. The Vancouver General Hospital and the City Social Service Medical Section have no alternative to the placing of their patients in this hospital. Insufficient beds are available for the chronically ill and they have to take what they can get. The needs of the patient are of secondary importance. The authorities responsible for the supervision of standards in institutions such as these must take the blame for allowing such conditions to exist.

Heather Street Annex

Heather Street Annex was built in 1918 to care for the victims of the Spanish Influenza epidemic of that year. The one-storey frame building, still in use, was built and opened for the reception of patients
within two weeks from the commencement of construction. For several years the building was used as a military annex. Gradually the forty-five beds in the building were turned over to staff chronic cases. For many years at least twelve of the beds were used for V.D. patients. Until 1943 the Vancouver General Hospital Outpatients' Department was housed in one wing of the building. When this Department moved to its new quarters in the Semi-Private Pavilion in 1943, another forty-six beds became available. The General Hospital planned to tear down the Annex at this time. The City Social Service Department persuaded the hospital to continue operating the Annex on the condition that the City Social Service Department pay the full cost of the patients' care. All admissions to the institution were to be through the Medical Section of the City Social Service Department. This arrangement has been continued to the present day. In 1948 Heather Street Annex was licensed as a private hospital.

Heather Street Annex (now known as Heather Annex) was closed from June to November 1948, so that the buildings could be moved from their old location on the corner of Twelfth Avenue and Heather Street to make way for a new nurses home. The present location is at Thirteenth Avenue and Willow Street. Fifty-six of the patients were housed in the Infectious Diseases Hospital until the Annex was re-opened. The remainder were placed in various city boarding homes. When the building was re-opened, the twenty-four patients placed in the boarding homes were left there because there was more urgent need for the beds for more seriously ill patients. (1) As before, the Vancouver General Hospital

(1) At the time of writing nearly all of these patients left in the boarding homes have been re-admitted to the Vancouver General Hospital as they were in reality too difficult to care for in boarding homes.
retained its twelve-bed genito-urinary pre-operative and post-operative ward as part of the acute hospital facilities, administered quite separately from the eighty bed chronic hospital.

Except for a short period during the war, Heather Street Annex has always used male orderlies instead of nurses. The hospital has always felt that male orderlies are much more capable of caring for the needs of chronically ill old men than nurses. The staff appears to be well trained and quite capable, and most important of all the patients seem to be getting the individual care and attention that they want and need. More orderlies are needed but the present staff of sixteen, assisted by kitchen staff and cleaners, apparently manage fairly satisfactorily considering the handicaps under which they work.

Being situated just across the road from the General Hospital, the patients in the Annex receive considerably more medical care than the patients in Glen and Grandview Hospitals. The doctor in charge visits the patients at least once a day and sometimes oftener. Internes and specialists from the General Hospital are readily available and are called in when needed.

The City Social Service Department pays the General Hospital $105 per month for each patient that is a Vancouver responsibility, just as it does for those patients that are Vancouver responsibilities in Glen and Grandview Hospitals.

There are many things wrong with Heather Street Annex nevertheless, chief amongst them being the size of the wards. There are four large public wards with twenty-five, twenty-two, twenty-one and thirteen beds. The wards are extremely plain and utilitarian and rather depressing
in appearance. The beds are placed quite close to each other and the only privacy that a patient can have is when the curtains are drawn around the bed. There are few patients under the age of sixty-five in the whole institution and the number of men who are quite senile is rather high. It is most depressing to hear an old man at one end of the ward moaning loudly with pain while the whole ward must listen to him. The patients have nothing to occupy their time and do nothing more than lie around. The whole atmosphere of the place seems to be one of hopelessness. These are old men who are about to die so nothing more is done for them than is absolutely necessary.

The food is good; it is brought over to the Annex in steam trolleys from the main hospital.

Heather Street Annex provides better physical facilities than the other two institutions, but, even though it is not operated for profit, there is not enough difference to show the advantages of a publicly operated non-profit institution over a privately-owned profit-making institution. Any superiority that the Annex has over the other two institutions is purely the result of its proximity to the resources of the General Hospital.

Mount St. Joseph's Oriental Hospital (Chronic Section)

In October, 1946 the Sisters of the Immaculate Conception opened their new 100 bed hospital at 3080 Prince Edward Avenue. The old St. Joseph's Oriental Hospital, operated on Campbell Avenue for over twenty years, was made into a tuberculosis hospital for Orientals. The top floor of the hospital with thirty-five beds is devoted to the care of the chronically ill men. The remaining sixty-five beds are used as
an acute hospital for maternity and surgical cases.

The chronic patients are cared for in large airy three and four bed wards with one seven bed ward running the full width of the hospital. Ambulatory patients have specially built low beds to make it easier for them. There seemed to be a noticeable lack of attendants and nurses when the institution was visited. The Sister Superior stated because of staff shortages, the patients received only the minimum amount of nursing and supervisory care. Despite this, however, the wards are spotless and the linen immaculate.

The hospital, like all institutions of this size, has no facilities for the care of patients that are suffering from mental disorders. When a patient becomes senile the hospital has difficulty caring for him until he can be admitted to the mental hospital. An unusually large number of the patients were hemiplegias but the arthritics were also numerous.

The sisters have cared for some of these patients for an extraordinary long period of time. One of the patients had spent fifteen years in both the old and the new hospitals and looked well enough to live for quite a few more. Ten of the thirty-five patients had been chronic invalids and incapable of caring for themselves for more than ten years. All of the patients are staff patients except four who are being paid for by a benevolent society. The other thirty-one patients are considered to be Vancouver responsibilities but the City Social Service Department accepts only twenty of them as eligible for payments from that department. The City Social Service Department pays five dollars less than the current standard boarding home rate for those whom
they accept as Vancouver responsibilities; at present the hospital is paid fifty dollars per month per patient. This lower rate is paid because of an agreement whereby the hospital receives a substantial tax exemption as a hospital and charitable institution.

Because the hospital and the City Social Department are not in agreement and also because the hospital finds it easy to fill its beds with its own acute patients who develop into chronic invalids, few Orientals are accepted in the hospital from other outside agencies.

All of the chronically ill Orientals in this hospital are advanced in years, most of them being over seventy years of age. The majority of the patients have wives and families in China and many of them have no friends or relatives here in Vancouver to visit them.

At one time attempts were made to provide occupational therapy facilities for the patients. Few of them were able to make use of these services and they were discontinued, so that now no recreational, occupational therapy or physiotherapy facilities are provided. The patients are kept clean and comfortable and provided with any medicines that they need; and, as far as the hospital authorities are concerned, they need nothing more. These patients are receiving Class "B" or nursing-home care of a minimal nature.

The Holy Family Hospital

This small institution, although at present caring for only fifteen chronically ill patients, will if its plans materialize, play an extremely important part in the care of the chronically ill in the future.
In April, 1946, four Sisters of Providence purchased a large private residence at 7801 Argyle Street in South Vancouver. The poor location of the hospital is a definite limitation upon the use that could be made of its services. The hospital is about ten blocks from the nearest bus stop. It is so far away from the city centre that the patients' private physicians come to visit only when they become acutely ill. The new Fraserview housing project is now being built up around the hospital so that its location will no longer hinder its effectiveness as a hospital.

There are four Sisters and two nurses' aides caring for the fifteen female patients. The patients, although crowded, appear to receive good nursing care and the food they receive is excellent and attractively served.

Since the original building was bought, the roof has been raised and an extension built on to one side to provide more room for patients. No further expansion is contemplated until the projected two hundred-bed hospital, for which the land has been already purchased, can be built. This order of nuns operates several large chronic hospitals in other parts of Canada and the United States. A short time ago the Sisters opened a new two hundred-bed chronic hospital in Edmonton, operated in conjunction with the University of Alberta Medical School. It is regarded as one of the most up-to-date hospitals of its kind in North America.

The Sisters have already run into financial difficulties with three of their fifteen patients. Like typical chronics they were able to pay their bills for a while but they and their relatives soon ran out of money. The Sisters are now faced with the problem of what to do with the patients who are still in need of continual nursing care for
which they cannot pay, and for whom the City Social Service Department
will not as yet accept responsibility. The sisters have come to Vancouver
at the request of their religious superiors to set up a chronic hospital
without sufficient information regarding the existing situation in
Vancouver. If the projected two hundred-bed chronic hospital is construct-
ed, it seems highly improbable that this number of paying patients can be
found. For the non-paying patient the City Social Service Department will
have to enter into the picture, and it would be well for this institution
to work out all of these problems of liaison and referral while the
institution is still small. This institution provides good "B" class
care although it is not licensed as a nursing-home.

The Private Nursing-Homes and the Small Private Hospitals.

In Vancouver, as in all other large centres, numerous small
privately owned and operated hospitals, or as they are more popularly
known, "nursing-homes" have sprung up. These small institutions play
an important role in the treatment of the chronically ill in that their
clientele includes many of the more affluent people afflicted with chronic
illness, who are unknown to the acute hospitals or to the publicly
subsidized institutions. At present the demand for beds in these private
institutions is so great that they are able to charge unreasonably high
rates and are in a position to decide which patients they will accept
and which they will refuse. A seriously ill patient with a small bank
account, unless placed through the City Social Service Department, has
little chance of being admitted. The City Social Service Department is
so hard pressed for accommodation for the patients referred to them that
they sometimes have to pay the rates demanded, no matter how high they are.
The lowest rate in the nursing-homes is $4.50 per day for a semi-private room, with $8.00 a day the average rate for a private room. These rates do not include the services of a physician or any extras. One nursing-home charges the patients extra for laundry service.

One day in January, 1949, the nurse of the City Social Service Department made a telephone survey to find how many beds were available and vacant. She found only two vacancies, both of which were $8.00 -a-day beds. The proprietors of Glen and Grandview Hospitals continually emphasize that they could turn out every city case they have, increase their rates by $50 a month, and fill their beds in a couple of days, without advertising. While the city is paying $105 a month for their patients in Glen and Grandview Hospitals they must pay from $120 to $180 for a considerable number of patients in these private nursing-homes. It is understandable why the city authorities have not been pressing Glen and Grandview Hospitals too hard to have their standards improved; if they did so they would probably lose what few beds they already have. It must be said, however that a few of the nursing-homes such as Oakhurst (37 beds) and the Bayview (23) cooperate by taking many city cases at a special rate of $120 per month. The assured income makes these arrangements profitable to them.

Every nursing-home has the patient who came into the institution with a few thousand dollars in the bank but who, after a year or so of heavy medical and nursing-home bills, ran out of money. At one time the practice was to refer these patients to the City Social Service Department if they were Vancouver responsibilities, and have them transferred to other nursing-homes where the rates were not so high and where the city
was willing to pay the bill. At the present time, the shortage of beds has become so acute that the city has no place to which to transfer these patients, and they are forced to leave them where they are and pay the rates demanded by the institution. The City Social Service Department has almost one hundred patients waiting in their homes or in rooming houses for admission to nursing homes as well as the considerable number of patients in boarding homes that should be in nursing homes. The General Hospital also has about twenty patients that could and should be cared for in nursing homes.

The situation has become so desperate that the city is seriously considering erecting some Quonset huts to provide temporary accommodation. With conditions as they are today, the private nursing homes can ask what they please and get it.

In Vancouver there are nine main private hospitals other than those already described. Eight of these are licensed to care for "medical, chronic and convalescent cases" and one for surgical and maternity cases as well.

Table H

Private Hospitals (Feb. 1949)

<table>
<thead>
<tr>
<th>Name</th>
<th>Capacity</th>
<th>Lowest Rate (per day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakhurst</td>
<td>37</td>
<td>$4.50</td>
</tr>
<tr>
<td>Bayview</td>
<td>23</td>
<td>$4.50</td>
</tr>
<tr>
<td>Athlone</td>
<td>18</td>
<td>$4.50</td>
</tr>
<tr>
<td>Houghton</td>
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<td>$4.50</td>
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<tr>
<td>Packenham</td>
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<td>Kitsilano</td>
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<tr>
<td>Margaret</td>
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</tr>
<tr>
<td>Kerrisdale</td>
<td>24</td>
<td>$6.00</td>
</tr>
<tr>
<td>Chatham House</td>
<td>21</td>
<td>$6.00</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td></td>
</tr>
</tbody>
</table>

(1) With these there must be included four other nursing homes (cont'd)
Under the regulations covering the licensing of these institutions, a graduate nurse must be in attendance at all times. The nursing-homes find it advantageous and extremely economical to employ only three or four graduate nurses with most of the work being done by nurses' aides and attendants at half the cost. Private physicians seem to lose interest in their patients when they are admitted to nursing-homes. In a group of patients interviewed in a private nursing-home, it was found that the patient's doctors paid them a visit on an average of once every two weeks. Several of the patients had not seen their doctor for over a month.

The furnishings of these nursing homes range from a plain hospital bed with a bare table beside it to elaborate and luxurious rooms with everything that a patient could possibly want.

The real tragedies behind these places lie in the fact that dozens of sons and daughters, feeling a moral obligation to provide a sick parent with the best care possible, use up all of their savings, mortgage everything they have, to pay their hospital and medical bills rather than accept charity. Finally, when the burden becomes intolerable, they ask the City Social Service Department to help them pay part of the cost. Gradually they shift more and more of the burden to the City Social Service Department until eventually the total cost is being paid by the city.

in adjoining municipalities and accepting some Vancouver cases. These are:

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingsway Nursing Home (Burnaby)</td>
<td>45</td>
</tr>
<tr>
<td>McKay Nursing Home (New Westminster)</td>
<td>25</td>
</tr>
<tr>
<td>Melrose Park Nursing Home (New &quot; )</td>
<td>37</td>
</tr>
<tr>
<td>Seaview Nursing Home (West Vancouver)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>119</strong></td>
</tr>
</tbody>
</table>

(2) Mostly surgical and maternity but a few chronics.
Under the present regulations of the Hospital Insurance Scheme, patients who pay their fifteen dollar premium receive free hospitalization as long as they are acutely ill. As soon as they are diagnosed as being chronically ill, however, they are no longer eligible for care in an acute hospital. They are then discharged to a nursing-home or to their own homes. If they are admitted to a nursing-home they must pay a minimum of $4.50 a day for much less care, when they are just as sick (in their opinion) as they were in the acute hospital. Naturally this does not seem right to the patient.

As in the other institutions described previously, these nursing-homes are almost completely lacking any recreational, occupational-therapy and physiotherapy facilities. Many of the patients need them but this is a secondary consideration to making a profit.

The Marpole Infirmary and Its Subsidiaries

The accommodation for the chronically ill so far reviewed is that in privately owned and operated institutions, and in those institutions which the city controls either directly or indirectly. The provincial government also accepts responsibility for a certain number of chronically ill people in its institutions at Marpole, Mount St. Mary and Alco. The provincial government does a very good job in caring for the chronically ill in its institutions. With more extensive financial resources available, the provincial government has taken the first steps toward the implementation of treatment program for the chronically ill.

Marpole Infirmary and its subsidiaries are designed to provide institutional care for the chronically ill whenever the municipalities
are unable to do so. In exchange for this provision of accommodation by the provincial government, the municipalities are expected to share the costs. The system of hospital clearance, operated by the provincial government, channeled through the Inspector of Hospitals Office and used to remove patients who are not acutely ill from acute hospital beds, is based on the premise that if there is no other place for the chronically ill patient then theoretically he or she can be placed in the Infirmary.

The Marpole Infirmary and its subsidiary, Mount St. Mary at Victoria, have become the only real chronic hospitals in B.C. When the institutions were originally set up they were designed to provide custodial care with some nursing care. Unintentionally the provincial institutions have become the only treatment centre in the province for the treatment and rehabilitation of the chronic invalid. A remarkable number of patients admitted to Marpole Infirmary as hopelessly incurable, have walked out of the institution, able to live normal active lives.

In February, 1917, a bankrupt hotel at the intersection of Hudson and Marine Drive in Marpole was taken over by the Vancouver General Hospital to provide a place for its chronically ill. The provincial government took over the institution in July, 1923 and has operated it continuously ever since. Between 1923 and 1937 the standards of care and treatment were very low and it was not until the institution was completely re-organized in 1937 that the institution began to achieve its present status. In that year also, the name was changed from the Marpole Home for Incurables to the Marpole Infirmary. The requirements for admission set up in 1937 are still applicable:

"The Infirmary was established for the care of any person, who being a chronic patient affected with some body disease, does not require or is not
likely to benefit from care or treatment in a general hospital or other special hospital, but nevertheless requires institutional care. Six types of patients are barred from admission; habitual drunkards, drug addicts, epileptics, patients suffering from infectious or contagious disease or needing isolation for any reason, and patients suffering from senile dementia or unsound mind. (1)

In July, 1941 the provincial government contracted for 100 beds in the Mount St. Mary Hospital in Victoria, operated by the Sisters of St. Anne. That contract has now been extended to cover 105 beds. In August, 1943 Alleo was taken over to care for infirmary type patients but it was not until 1944 that this institution came under the Marpole Infirmary for administration.

In 1947, because of the danger of fire in the building, the capacity of the Marpole institution was reduced from 144 to 124, leaving only one large ward of male ambulatory patients on the third floor. In 1948 the use of Alleo has been restricted to 100 beds, due to the unsuitability of the buildings and facilities for the care of the bed-ridden chronic patient.

Mount St. Mary and Alleo are operated as subsidiaries of the Marpole Infirmary with all admissions and discharges made through Marpole. The Superintendent of Infirmaries has her office at Marpole. The sex, physical condition of the patient (whether he is ambulatory or not), the location of a patient's home and relatives, and whether he is a provincial or a municipal responsibility determine the institution in which the patient will be placed, e.g., a bed-ridden chronically ill person from Vancouver Island is almost invariably placed in Mount St. Mary.

Marpole Infirmary itself, located at one of the busiest intersections in Vancouver, is totally unsuitable and inadequate as far as the actual building is concerned. The building is a fire-trap and for this reason non-ambulatory patients are kept on the two lower floors. The wards are large (allowing the patients no privacy at all). One ward has thirty patients in it. The service facilities are hopelessly inadequate, and accommodation for the staff and administrative offices are very limited. The occupational therapy department is in the basement along with the dining hall for ambulatory patients. A large well-equipped and well-staffed kitchen on the main floor serves the whole institution. Food for the patients is taken around the wards on steam trolleys. The food is excellent, attractively served and varied in menus.

Graduate nurses are in constant attendance, with numerous nurses' aides and orderlies to assist them. The staff is of an exceptionally high calibre and take an unusual interest in the patients under their care. The staff caters to the individual needs of the patients, and patient after patient when interviewed was high in his praises for the care and attention that he received. The patients are kept clean and the linen spotless. The place is filled with a variety of frames and gadgets which the patients use to get around with. If a special type of backrest is needed so that a patient can sit up in bed, then that contrivance is provided without question.

(1) The Marpole Infirmary has an exceptionally active Women's Auxiliary which provides many extras for the patients. The Auxiliary sponsored the first physiotherapist in the institution to convince the government of the necessity of such a service. The Marpole Infirmary Auxiliary is an outstanding example of how a provincial institution can employ volunteer groups to the best advantage.
Medical care is provided by a young general practitioner who visits the institution three times a week and is on constant call, day and night. The very latest medicines are used and in the provision of medical or treatment services there seems to be no limit to what will be tried. Patients needing X-ray services are taken to the Vancouver General Hospital by ambulance. Patients are also taken to the Vancouver General Hospital to see specialists in the Outpatients' Department. An eye specialist and a dentist visit the hospital regularly. Several patients are receiving treatment at the Cancer Clinic and all patients receive an annual chest X-ray as a check on tuberculosis. Occupational therapy and physiotherapy are used extensively and have become an integral part of the treatment program.

A detailed analysis of the patients in the Infirmary was made even though all of the patients were not Vancouver responsibilities. The institution provided an excellent opportunity to study the age distribution, the length of stay in hospital, and the medical diagnosis of a large group of chronic patients. The Infirmary provides an illustration of the types of patients that would normally be cared for in a chronic hospital. The majority of the patients in the institution have spent some time in nursing-homes and boarding-homes before being admitted to the Infirmary.

The ages of the patients vary widely from twenty to several over ninety with an average age of 67.2 years. The vast majority of the patients were in the sixty to ninety group.

(1) Thirty-five of the 126 patients in the institution on February 1, 1949 were Vancouver responsibilities.
Table I

Age Distribution of Patients in the Marpole Infirmary

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>Age</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21</td>
<td>1</td>
<td>60 - 69</td>
<td>28</td>
</tr>
<tr>
<td>21 - 29</td>
<td>1</td>
<td>70 - 79</td>
<td>28</td>
</tr>
<tr>
<td>30 - 39</td>
<td>4</td>
<td>80 - 89</td>
<td>28</td>
</tr>
<tr>
<td>40 - 49</td>
<td>18</td>
<td>Over 90</td>
<td>6</td>
</tr>
<tr>
<td>50 - 59</td>
<td>12</td>
<td>Total</td>
<td>126</td>
</tr>
</tbody>
</table>

The length of stay of the patients in the institution has varied from twenty-five years to one month, well over half of the patients having been admitted within the past five years. (See Appendix B, Page 168)

In terms of medical diagnosis, the arthritics predominate, and patients suffering from degenerative diseases are a close second because of the advanced age of some of the patients. (See Appendix B, Page 169)

Interviews with the patients and discussion of their problems and experiences brought forth almost unbelievable hardships – the situations these people had to face and work out on their own – great insecurity, fear of becoming completely helpless, dislike of being so dependent and sensitivity about their illnesses. The patients like the location of the Infirmary and enjoy a part of the busy community where they are located rather than being isolated in some suburban district, completely isolated from the world. All of the patients were loud in their praises of the staff and of the Superintendant in particular. None of the patients had any complaints about the food or the physical facilities of the infirmary. All felt that they were receiving the best medical care that they had ever received and that everything that could
possibly be done for them was being done. The occupational therapy
facilities of the institutions were particularly praised as a service that
helped them to keep their minds occupied. An arthritic patient, completely
rigid with a Marie-Strumpel spine making doll furniture with the aid of
mirrors, a young man of forty with advanced Parkinson's Disease doing
beautiful oil paintings and a man paralyzed for twenty years as the
result of an accident who was taking a high school correspondence course,
were all eloquent testimonies to the effective and enlightened treatment
program carried on in the Infirmary.

Mount St. Mary

This institution in Victoria, with a possible capacity of 105
patients, had sixty male and forty-two female bed patients on February 1,
1949. Most of the patients in the institution are from Vancouver Island
or from the interior of the province. Five out of the 102 patients were
Vancouver responsibilities.

Mount St. Mary was built to be a chronic hospital. There are
small wards, even a few private ones, and the whole place is spotlessly
clean and very efficiently run. Infirmary cases are mixed in with other
private patients. The Sisters, assisted by nurses' aides and orderlies,
give the patients excellent nursing care. A private physician, on
continuous call, visits daily.

Physically the institution is incomparably better than the
Marpole Infirmary. The building was built for chronic patients and
contains special innovations for this particular type of patient. The
occupational therapist from Marpole gives part of her time at Mount St.
Mary but the use of these services are a much smaller part of the
treatment program than at Marpole. Mount St. Mary prefers to take bed patients and consequently gets more of the type of patient that is completely helpless. The provincial government pays a per capita per diem rate for the patients placed there with provisions for a yearly revision of the rate paid.

Excellent supervised nursing care of the "Class B" type is provided here.

Allco

Allco started as a logging camp; during the depression it was used to accommodate physically incapacitated relief recipients and now it has been converted into a subsidiary of the Marpole Infirmary to house ambulatory male patients who are chronically ill but need "Class C" or custodial care. Theoretically, only ambulatory cases are kept here, but ambulatory chronically ill patients have a propensity for becoming complete bed patients, especially in a place such as Allco. With a nominal capacity of 120 and an accepted capacity of 100 there were eighty-three patients in the institution on February 1, 1949.

Allco is totally unsuited for its purpose. It is seven miles from the nearest town of Haney and too far from the city for friends and relatives to visit. The patients live in small cottages or huts that were once loggers' shacks. Only about half of the cabins have inside bath or toilet facilities.

The patients are supervised by male orderlies and are visited at least once a week by a doctor from Haney; he is on call twenty-four hours a day however. A "sick-bay" is provided for the more acutely ill patients who are too sick to stay in their own cabins. Needless to say
this "sick-bay" is always filled.

It is felt by the Infirmary administrative staff that many of the patients occupying nursing-home and boarding-home beds in Vancouver could be placed at Allco if the institution was properly interpreted to the patients. The medical social workers in the hospitals consider that it is not reasonable to ask a patient to go to a place like this; but in any case patients who have heard about Allco or have friends and relatives in Vancouver cannot be swayed by persuasion to go to Allco. Theoretically men who have been loggers, miners and fishermen are supposed to want to stay in the outdoors until they die. But in practice, men of this type who become chronically ill and unable to manage for themselves, want to stay in town close to civilization just as much as a Vancouver man.

On February 1, 1949, eight out of the eighty-three patients in the institution were Vancouver responsibilities. These patients had an average age of seventy-six. Four out of the eight had been admitted from Heather Street Annex.

An occupational therapy hut has been built and a full-time occupational therapist is employed. Some beautiful pieces of cabinet work have been made by the patients despite their disabilities. A recreation hut has been built so that the patients do not have to stay in their living quarters when it rains.

Allco does provide "Class-C" custodial care. From a humanitarian point of view the place should be closed and a proper institution built in Vancouver. The provincial government has provided excellent services at the Marpole Infirmary and at Mount St. Mary but its thinking as far as Allco is concerned is far back in the depression period.
Allco has been used, despite its proven inadequacy, to care for chronically ill old men. Like many others, buildings taken over as "a temporary measure" remain in operation continually and it seems that patients will be housed at Allco indefinitely.
Chapter IV

Social Assistance and the Chronically Ill

Under the provisions of the Vancouver Incorporation Act the city is held responsible for the supplying of facilities and care for its sick and infirm, its poor and its destitute. The administrative body set up by the city to determine need and to provide financial aid to those persons who are unable to care for themselves is known as the City Social Service Department of the City of Vancouver. The incapacitated and chronically ill persons who are classified as unemployable are provided with monthly cash payments for rent, food and fuel. If they are physically incapable of caring for themselves the city assumes the responsibility of providing custodial or nursing care for them.

In Vancouver, as in every town or city in Canada, social allowance payments now constitute one of the major items of city expenditures. In Vancouver alone last year, social assistance payments to Vancouver residents totalled $1,475,416 with an additional $3,675,000 in old age pensions and $145,000 for mother's allowances. (1)

Applicants for social assistance can be divided into two main groups. The largest group consists of men and women between the ages of sixty and seventy who are too old to find employment but are not old enough to qualify for old age pension. In 1948, almost half of the 2860 cases (representing 3780 persons) in receipt of social assistance in Vancouver were in this group. A second and very large group are the (1) Annual Report, City Social Service Department, 1948, Page 2.
persons who are unemployable for medical reasons. The vast majority of these people are chronically ill persons in every sense of the term. A person in this group receiving social assistance over a period of years for medical reasons (except for cases of orthopedic impairment), is a chronic invalid whose illness has reached such a stage that he has to become completely dependent upon the community for care.

In August and September of 1948, a worker of the City Social Service Department made an analysis of the approximately 1400 cases who were in receipt of social assistance at that time for reasons other than old age. Of these 1400 cases, 247 were receiving social allowances because of tuberculosis, 108 for mental conditions (mental deficiencies and psychotic disorders) and twenty-six for incapacity from cancer. The others were receiving social assistance for a wide variety of other ailments with a majority of them suffering from seven major complaints. Circulatory disorders headed the list with arthritis and rheumatism a close second. The seven major groups into which forty per cent of the total cases fell were as follows:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory and cardiac disorders</td>
<td>222</td>
</tr>
<tr>
<td>Arthritis and rheumatism</td>
<td>189</td>
</tr>
<tr>
<td>Partial or complete paralysis</td>
<td>58</td>
</tr>
<tr>
<td>Chronic asthma</td>
<td>56</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>31</td>
</tr>
<tr>
<td>Diabetes</td>
<td>30</td>
</tr>
<tr>
<td>Anaemia</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>609</strong></td>
</tr>
</tbody>
</table>

The remainder included small numbers of persons in different categories, i.e., three persons receiving assistance because of kidney disorders, two for hyperthyroidism, ten for skin diseases, four for lumbago, and five

(1) There is actually a third group which includes deserted wives and children, unmarried mothers, and wives whose husbands are imprisoned in Oakalla Prison. This group is small and seldom numbers more than 150 cases in the whole city.
What is the cost of this burden of illness? Assuming for the sake of simplicity that all of the 609 persons in the seven main categories were without dependents and were in receipt of the maximum allowance of thirty-five dollars for a single person with no dependents, the City Social Service would provide them with $21,315 a month or $255,780 in actual assistance payments in one year. The cost of the medical services to these people and the maintenance of their dependents if they had any, would increase this figure considerably. From these figures alone it can be seen that the maintenance of the chronically ill is a heavy financial burden in Vancouver. It is true that the city actually only pays twenty per cent of these social assistance costs and the provincial government eighty per cent, but it is still the tax payer of Vancouver who foots a large part of the bill no matter which level of government arranges the disbursements.

The City Social Service Department and City Boarding Homes

It was not until 1937 that the City Social Service Department became involved in the placement of chronically ill people in boarding and nursing homes to any great extent.

In that year a scheme of hospital clearance involving the City Social Service Department, the Vancouver General Hospital and the Provincial Tuberculosis Unit in Vancouver was set up, under the supervision of a physician, for the purpose of moving long-term patients occupying acute beds in the two institutions to nursing homes and boarding homes. The system set up in 1937 is in operation today with only a few modifications. Prior to this date the only outlet that the General
Hospital had for the disposal of its chronically ill was in whatever beds it could get in Glen, Grandview and Bayview Hospitals, these being used as annexes of the main hospital. Because of the excessively long occupancy of acute beds by non-paying patients in the Vancouver General Hospital, many of whom did not need hospital care, there was an extreme shortage of beds and the hospital fell deeply in debt. The hospitals were in danger of becoming boarding homes or convalescent homes for unfit indigents, particularly old people.

Marpole Infirmary was supposed to provide for the chronically ill incurable but this institution was hopelessly overcrowded and had a long waiting list. The annexes - Glen, Grandview, and Bayview Hospitals - were also filled to capacity.

As part of the program of hospital clearance, the city social service took over Bayview Hospital and along with it two other nursing homes, Oakhurst and Houghton. These three institutions had a total capacity of 100 patients. The owners were paid thirty dollars per patient per month. Patients who were occupying acute hospital beds and were no longer in need of this type of care were moved to these institutions.

In July 1941, Mount St. Mary was opened as an institution for the care of the chronically ill and operated as a subsidiary of the Marpole Infirmary. Patients from the three city-operated nursing homes were transferred to Mount St. Mary and the city withdrew from any further

(1) A Vancouver Hospital Clearance Plan: a report by Dr. J. Moscovitch, after one year's operation of the plan, issued through the Social Service Department, City of Vancouver (mimeographed) Pages 9 - 10.
nursing-home responsibility; at the same time it continued to provide boarding-home care when called upon to do so.

Within a year, the City Social Service Department was again faced with the problem of what to do with the large numbers of chronically ill people occupying acute beds. To care for some of these patients, Heather Street Annex was taken over and devoted entirely to the care of chronically ill male patients who were no longer in need of acute hospital care. In 1943 the Vancouver General Hospital entered into an agreement with the City Social Service Department whereby the hospital agreed to operate Heather Street Annex and the City Social Service agreed to pay the costs, on the condition that all admissions to the institution would be made through the Medical Section of the City Social Service Department. This scheme is still in operation.

In the meantime, the City Social Service Department developed its numbers and standards of care in boarding homes. For some time a full-time social worker was employed by the Department to search out boarding-home accommodation for those persons who needed custodial care but not necessarily nursing-home care. Rates of payments were raised and some attempt was made to place individuals in boarding homes most likely to suit their needs. A number of the boarding homes that were opened during this period are still in operation.

Since July, 1941, the provincial government has paid up to eighty per cent of boarding-home costs up to a specified maximum (at present $50 per month). Any costs above this maximum were to be a full charge upon the city of Vancouver. For patients in nursing homes, however, the provincial government contributed nothing. This created an unusually
confused administrative situation, and accentuated the hospital problem by making it cheaper for the city to maintain a person in an acute hospital bed than in a nursing-home bed. The Goldenberg Report recommended that the provincial government contribute toward nursing-home care on the same eighty-twenty basis as it did for boarding-home care. 

As a result of these recommendations, the provincial government agreed to pay eighty per cent of the cost of boarding-home care up to a maximum of ninety dollars. The City Social Service Department entered the nursing-home field again. Effective January 1, 1948, the City Social Service Department paid the Vancouver General Hospital ninety dollars per month for every patient in Glen and Grandview Hospitals that was found to be eligible for social assistance. The hospital in turn paid the nursing-home owners. The City Social Service agreed to pay for these patients on the understanding that a full investigation into the financial circumstances of each patient would be made, and residence, income and assets checked as in any ordinary social assistance application. The same arrangement for Heather Street Annex was made and the hospital was paid ninety dollars per patient per month for these patients as well. Since December 1, 1948 the cost of care in these three institutions has been set at $105 per month. The provincial government still pays only eighty per cent of the ninety dollars, the payments in excess of this

being a hundred per cent Vancouver charge. For the month of November 1948, the City Social Service Department paid the Vancouver General Hospital $11,770.32 for the patients in Glen, Grandview and Heather Street Annex.

Patients placed in private nursing homes for lack of other places to put them, cost the City anything from $120 to $160 per month, with all charges over ninety dollars being borne entirely by the City. On January 1, 1949 there were approximately sixty patients in these private nursing homes that were paid for by the City Social Service Department. Using the minimum rate of $120 per month, these patients' care is costing $7200 a month, with a more likely figure being $10,000. The province's share of the minimum would only be $4,320. As a contrast in costs, patients placed in Glen and Grandview Hospitals in 1937 were cared for by these institutions for forty-five dollars a month.

**Custodial Care in the Boarding Homes**

Acting as "half-way houses" to the nursing homes are the city boarding homes that supplement the nursing homes and provide custodial care for those people who are unable to manage on their own but do not need supervised nursing care. These boarding homes provide the physical necessities of life, namely, food, warmth and shelter but little more.

In the City of Vancouver there are about 490 boarding-home beds licensed under the Welfare Institutions Licensing Act. All institutions or homes caring for the aged and handicapped adult in receipt

(1) Effective April 1, 1949, the provincial government has agreed to pay eighty per cent of costs up to $105 per month per patient for nursing-home care. In cases where the private hospitals can show that they are operating at a loss the provincial government will pay up to eighty per cent of $120 per month per patient after an inspection of their(cont.)
of some form of social assistance must be licensed under this act. A boarding home is defined as a home where an individual receives custodial care, but is quite capable of being up and about and able to clean and dress himself.

Not all of the licensed boarding homes will take "city cases". Some take only patients placed by the Medical Section of the City Social Service Department; some take only a few city cases and have private cases as well; some take city cases only when they can not get private cases. However, even if they have only two "city cases", they must conform to the regulations laid down by the Welfare Institutions Licensing Act. Some boarding homes take only special types of cases. One proprietor takes only arrested tuberculosis cases; another takes only old age pensioners by private arrangement, asking only their old age pension and not the regular boarding home rate that could be demanded from the city; some take only certain ethnic or religious groups; some take only men, some only women and some both.

Some of the boarding homes are well furnished and comfortable and provide many extras for the patients. Others are very poor, providing only the absolute minimum of facilities, a bed, a chair and a corner in which to put the patient's belongings. In some, the food is excellent and is attractively served; in others the patients slowly die of malnutrition. There are good boarding homes and very poor boarding homes; some are operated by the owners to make as much money as possible.

books has been made by the Hospital Insurance authorities.

(2) Boarding homes that do not take people in receipt of some form of assistance are not covered by the Welfare Institutions Licensing Act. These homes must however conform to city licensing regulations.
with the least possible expense; others are operated by conscientious proprietors who provide their patients with as many extras as possible, leaving themselves only a modest return.

The boarding homes care for three to forty patients, the average being about twelve. Most of the boarding home operators started out with two or three patients. Very quickly they learned that it did not cost five times as much to care for five times as many patients and that they could make more profit with ten patients than with two.

The majority of the homes have found it profitable to take city cases despite the fact that they could get higher rates from private cases. From city cases they have an assured, dependable income. The City Social Service has recently raised boarding-home rates from fifty dollars to fifty-five dollars per patient per month. Boarding homes caring for T.B. cases receive sixty dollars per month.

The Medical Section of the City Social Service Department, working in close co-operation with the Assistant Inspector of Welfare Institutions, has been striving desperately to increase the number of beds that are available but with little success. Until the housing situation becomes less acute there is not much hope of any substantial increase in the number of beds. The demand for beds has become so acute that the City Social Service Department has had to pay social assistance up to fifty dollars per month for a chronically ill person in an ordinary rooming or boarding house. By doing so the landlady can be persuaded to provide extra facilities and a certain amount of care for this person. In this way the chronically ill assistance recipient can carry on a little longer and not need to be admitted to a nursing home or boarding home.
The few available boarding-home beds can then be used for more urgent cases. Recently the City Social Service Department has been paying a trained medical orderly to visit numbers of these people in their boarding houses and hotel rooms, preparing a meal for them, helping them clean up, doing such things as changing dressings etc. This is another attempt to keep these old, and in most cases chronically ill, people where they are for as long as possible because there are no boarding-home beds available to put them in.

In short, the nursing homes are filled with people who would normally be cared for in a chronic or convalescent hospital; the boarding homes are filled with people who need more than custodial care and should really be in nursing homes. In the cheap rooming houses in every part of the city; in the rooms of the "skid-road" hotels, and in the back room of relatives' homes there are hundreds of men and women who are getting along the best they can until some proper provision can be made for their care.

In 1947, the Provincial Supervisor of the T.B. Social Service, working in close co-operation with the City Social Service Department and the Inspector of Welfare Institutions, made a survey of boarding homes in Vancouver for the provincial Director of Welfare. This survey threw some interesting sidelights on the boarding-home situation. At the time the survey was conducted it was found that 78.4 per cent of the residents of the boarding homes were over the age of sixty, and 27.4 per cent of the patients had reached such an advanced stage of mental deterioration that they could be classified as senile. The survey estimated that 40.8 per cent of all the occupants of the boarding homes were potential
cases for the Marpole Infirmary, the Home for the Aged (Essondale) or the Provincial Mental Hospital. Only 7.5 per cent of the occupants were considered suitable for rehabilitation. The survey also found that most of the vacancies in the boarding homes were caused by deaths, rather than the recovery or an improvement in the patients' conditions.

A considerable number of these boarding homes have been visited personally by the writer. It would be fair to say that the main disease most of the occupants are suffering from is old age. Too many of the occupants seemed to do nothing more than lie around on their beds all day. Few of the women were knitting or sewing and for the men there were not even cribbage boards or playing cards. These people were constantly complaining about their food, the facilities provided by the boarding home and the mistreatment they had received from the staff. This continual complaining could be traced back to the fact that the patients had nothing to occupy their minds. Many of the boarding homes did not have even a radio for the patients to listen to. Unless a patient is able to visit the doctor on his own, he seldom sees one. Several of the patients interviewed had not seen a doctor for six months or more. Many of the patients feel that they have been left there to die and resent it bitterly. Very little active treatment for the patients' illnesses is available because the boarding-house operators, except in rare instances, are not nurses.

Referrals to the Medical Section of the City Social Service Department for boarding home placement are made by the workers in the four different units of the City Social Service Department, the hospitals, doctors, public health nurses and in a few cases by the Provincial Medical
Services Division. Four nurses are kept busy arranging placements in boarding homes and nursing homes and doing the routine work of arranging for glasses, dentures and appliances for assistance recipients. The demand for beds is so acute that the selection of the best type of boarding home for an individual is not possible. When a bed becomes vacant, the person who is in the worst condition gets it, without regard to the suitability of that accommodation for that particular case. At present, the only sure method of gaining entry to a boarding home is to become so ill that admission to an acute hospital becomes necessary. After a stay in the hospital, removal of the patient to a boarding home or nursing home is arranged.

Should the City Take Over Glen and Grandview Hospitals As It has with Heather Street Annex?

The situation mentioned above is one of the main arguments used by the City Social Service Department for the assumption of control over Glen and Grandview hospitals by that Department. The Vancouver General Hospital is unwilling to relinquish its control over the two subsidiary hospitals because it would lose the only outlet it has for its chronic patients. The hospital wants to continue using Glen Hospital as a convalescent hospital as it has in the past. The City Social Service Department contends that most of the patients moved from the hospital are ones that have been known to that Department for a long time, and, the only reason that they have had to be admitted to the hospital was because their condition became acute while waiting for admission to a boarding home or nursing home. The City Social Service Department would like to regulate admissions to the nursing homes as they do for the
boarding homes so that a patient could get into a nursing home and receive sufficient care without becoming acutely ill. In actual practice the City Social Service Department controls the discharges from the two hospitals. If a patient in Glen or Grandview Hospitals recovers sufficiently to be moved to a boarding home it is necessary that application be made to the City Social Service Department for a bed. By controlling the boarding-home beds the control of discharges becomes an accomplished fact. The City Social Service would like to control admissions to Glen and Grandview Hospitals so that it could freely move patients from boarding homes to nursing homes. If there was a patient in a nursing home who could manage in a boarding home, then that patient could be exchanged very readily with a patient in a boarding home who needed nursing-home care. By this arrangement, placements could be co-ordinated and developed into a treatment program. The General Hospital believes that if they keep control over the institutions they can provide higher standards of care than the City Social Service Department. City Social Service control over Heather Street Annex appears to have been more beneficial than detrimental.

If the City Social Service Department took over control of admission to Glen and Grandview a duplication of accounting services would be eliminated. In the same way a duplication of services provided by the two social service departments could be prevented. At present each patient is asked the same questions by two different workers. It is the duty of the medical social worker in the Vancouver General Hospital to determine each patients' eligibility for assistance before referring the case to the City Social Service Department. This Department has found the hospitals standards of eligibility are far more lenient than 
those acceptable to the City Social Service Department. The hospital often allows a $250 exemption for a patient's funeral expenses, but the City Social Service Department allows a maximum of only $150. More difficulty is experienced with old age pensions. Under the old age pension regulations, the pensioner can have well over one thousand dollars in the bank and still receive free medical service. But, as soon as he is admitted to the nursing home, he must surrender his pension cheque and forfeit his savings until he has only $150 left in the bank. If he was in the General Hospital for a short period of time he did not have to surrender his cheque. He received infinitely better care in the hospital than he did in the boarding home. Why does he have to surrender his pension cheques and his savings when he is receiving less expensive and poorer care than before? So far no-one has provided any answer except that nursing-home care is not covered by the new system of compulsory hospital insurance.

It often happens that the General Hospital refers a case to the City Social Service Department for payment. The City Social Service worker finds out that this patient has some assets or income that makes the patient ineligible for a full allowance. In some cases it is felt that a husband, son or daughter could make some contribution toward the patient's care. The case is referred back to the hospital for the collection of that portion of the cost for which the City Social Service Department is not responsible. The hospital is not able to collect these contributions from the patients' families and the two accounting sections refer the case back and forth. It would obviously be simpler to have one accounting section to deal with the accounts for Glen and Grandview Hospitals as well as for Heather Street Annex. It is no small advantage
that it would permit the one social worker seeing the patient to do a little social work instead of being nothing more than an investigator into the financial circumstances of the patient.

These are but a few of the administrative problems involved, but every one of them prevents the working out of an efficient and smooth-running program for the most effective care and treatment of the chronically ill.
Up to this point the chronically ill have been discussed only as a group. The main features in caring for the chronically ill have been pointed out, along with some of the implications of chronic diseases. They had to be supplemented by case illustrations to show the individuality of chronic disease. These cases show also that chronically ill people are normal human beings with the concerns of ordinary people added to those which result from the chronic illness. Their stories reveal vividly the heavy economic cost of chronic illness; this falls on the families and individuals involved, but is also borne in part by the community at large.

In choosing the group of cases, an attempt has been made to show the experiences of a representative aggregation of chronically ill people; there is a variety of ages; there is a variety of medical diagnosis and diseases; there is a wide variation in family and economic backgrounds, and in the amount of medical care and hospitalization experienced. None of the cases summarized are presented in a true case study form. An attempt has been made to bring out some of the important emotional implications of chronic illness for both the individual and his family.

(1) The majority of the cases presented are secured from personal interviews with these people and gaps in information filled in from agency records.
Keeping the Home Together:

The case of Mrs. G. is representative of thousands of low-income families in the city who have received medical care from the Vancouver General Hospital Outpatients' Department over a period of many years.

Mrs. G., now aged forty-seven, was born in Scandinavia. At the age of seven she had an attack of rheumatic fever with no apparent after-effects. Mrs. G. was married in 1920 and came to Canada in 1926. It was not until Mrs. G. applied for entry to the United States the following year that she discovered that she had a serious heart condition. In the next few years she found that she had to restrict her activities more and more as her condition became progressively worse. In 1933, Mrs. G. became pregnant and came to the Outpatients' Department for examination. The specialist who examined Mrs. G. advised her to allow her pregnancy to be terminated and to be sterilized to prevent any further pregnancies. Due to the condition of Mrs. G's heart, her life was in danger if the child should prove difficult to deliver. Mr. G. would not consent to this, and, contrary to all expectations, Mrs. G. safely delivered a baby boy a few months later.

At this time the family were in desperate financial straits. Mr. G. could find no employment and was suffering from an acute eye infection, but, because he had no money, he refused to go to a doctor. Finally he was brought to the hospital by the V.O.N. nurse, by which time the infection had developed to such an extent that Mr. G's eye had to be removed. Much against the will of Mr. and Mrs. G., the family was forced to go on relief. After about one month, Mr. G. found a job peddling fish. He earned only three or four dollars a week but somehow or other
the family made valiant efforts to live on this amount. The family, in order to keep their home, sold most of their personal belongings, including their clothes, to pay the taxes. For several years the family eked out a bare subsistence from the fish business but were never far from starvation level. Mrs. G. continued to attend the Outpatients' cardiac clinic regularly and received medicines and periodic check-ups from the doctors there. Mrs. G. was continually warned by the doctor against doing so much heavy work around the home and at various times she was actually ordered to stop all work and spend most of her time in bed.

The family had opened a little fish store and were living in rooms behind it. As Mr. G. was sick most of the time himself, Mrs. G. operated the store as well as doing all of the housework.

In 1939 Mrs. G. had a severe heart attack and was confined to the hospital for three weeks. In order to get bed rest, Mrs. G. was moved to Glen Hospital where she stayed for three and a half months. She returned to her home and the following year the doctor at the Outpatients' Department again had to order Mrs. G. to stop doing so much work about the home. To supplement the family income, Mrs. G. had been caring for two foster children. In 1941, at the request of the doctor looking after Mrs. G. in the Outpatients' cardiac clinic, the hospital social service department arranged with the Family Welfare Bureau for a visiting homemaker to spend three days a week in the home. When this service was terminated however, Mrs. G. went back to doing as much work as before, if not more. By this time Mr. G. had secured employment in a downtown hotel but as his salary was still only $60 a month, Mrs. G. continued to operate the fish store. After about a year of this arrangement, Mr. G.
received a slight increase in salary and they were able to close the store. Mrs. G. continued to do her own housework and visited the Outpatients' Department regularly for her medicines and periodic examinations. Mrs. G. had another heart attack in 1947 but was not admitted to the hospital. Since then her condition has gradually deteriorated and she is only able to do light duties about the home. The husband now gets approximately $100 a month wages and with the assistance of the son they are able to carry on.

Mrs. G. will undoubtedly continue on in the home until her condition reaches such an acute stage that hospitalization or nursing-home care will be essential. Mrs. G. has kept going as long as she has because of her devotion to her family and the strength that this family gave to her. This is an interesting case because it seems evident that institutional care would have made a helpless invalid out of the patient rather than improve her condition. On the other hand, an adequate visiting nurse and visiting physician service could have done much to retard the development of her illness; probably also a more prolonged visiting homemaker services would have aided in the alleviation of this patient's condition.

The low income of the family wage-earner has contributed considerably to the intensification of the patient's difficulties in accepting the limitations placed upon her by her chronic cardiac condition.

Old Age Brings Additional Difficulties

Mrs. H. represents the hundreds of chronically ill older people who are cared for and maintained by a son or daughter for many years.
Eventually, an impending break-up of the son or daughter's own family, resulting from the insatiable demands of the chronic invalid, necessitates the removal of the chronically ill parent to a boarding home or nursing home.

Mrs. H., now aged seventy-three, has been a diabetic for twenty-two years. Her three daughters (one of whom is also a diabetic) are all married with families. After divorcing her husband in 1936, Mrs. H. went to live with her youngest daughter. Within a short time, this daughter separated from her husband who refused to have Mrs. H. in the house any longer. The daughter insisted on keeping her mother with her. Originally Mrs. H. had been fairly financially secure but gradually all of her resources were used up and she and her daughter were forced to sell many of their personal belongings to pay the rent and to buy food. They moved from an apartment to cheap housekeeping rooms. The other two daughters of Mrs. H. refused to help the younger sister in caring for the mother. The youngest daughter soon could not carry on any longer. Her mother tormented her continually and made life miserable for her by her unreasonableness and unending demands upon her. When the daughter injured her knee and incurred heavy doctor's bills she refused to care for her mother any longer. In November, 1943, Mrs. H. was placed in Glen Hospital, where the daughter paid for one month's care. But, since the daughter was only earning $80 a month and paying $70 a month for her mother's nursing-home care, the General Hospital agreed to assume the responsibility for Mrs. H's care. After two months in Glen Hospital Mrs. H. was transferred to the Vancouver General Hospital to have a gangrenous toe amputated. Mrs. H. refused to allow the doctors to perform the operation. Mrs. H.
spent two months in the hospital before been transferred to a boarding home. Six days later she was readmitted to the hospital in a diabetic coma. Mrs. H. and the boarding home owner had clashed continually during that six days because Mrs. H. claimed that she did not get the attention that she needed. The boarding home owner stated that Mrs. H. would not follow her diet and disturbed the other residents of the boarding home to such an extent that the place was in a continual uproar. After eight days in the hospital, Mrs. H. was again transferred to Glen Hospital. Application for her admission to the Marpole Infirmary was made in October, 1945. Twelve months later, the doctor said that Mrs. H. was no longer in need of nursing-home care and was capable of managing in a boarding home. Mrs. H. did not want to go to a boarding home but she went anyway. She stayed in the boarding home for five weeks and no boarding home was ever so glad to see a patient leave. During her stay in the boarding home, Mrs. H. refused to take her insulin, fought continually with the other patients and kept the place in a perpetual uproar. She was admitted to the General Hospital in a diabetic coma. After spending another seven months in the Vancouver General Hospital, she was again transferred to Glen Hospital where she still remains.

Mrs. H. now has her hands and feet terribly crippled and deformed by arthritis and she also has Parkinson's disease at an advanced stage. Actually this white haired old woman, sitting on the edge of her bed all day, presents a pitiful spectacle, but what she lacks in physical ability to get around she makes up for with her tongue. She is very unpopular in the hospital because she takes a sadistic pleasure in tormenting the other patients in the ward until they are reduced to tears.
Mrs. H. considers the medical and nursing care that she is receiving totally inadequate to her needs and she is very hostile toward the medical social worker because she has not been admitted to the Infirmary.

Mrs. H. is rather an unusual case in that she is suffering from three major chronic diseases all at once, i.e., diabetes, arthritis and Parkinson's disease. Mrs. H., being over seventy years of age, is typical of the effects of chronic illness on the older person with no income or financial resources. When a son or daughter is no longer financially able to support the parent, application for social assistance must be made.

Mrs. H's main trouble is that she has nothing to occupy her time or her mind. She could certainly benefit from the facilities that are available at the Marpole Infirmary. Much of her behaviour is a symptom of her Parkinson's disease.

Medical Care Is Not Always What is Needed

The case of Mr. J. is a glowing example of the need of a definite and co-ordinated treatment program. The constant shuttling of a chronically ill patient from hospital to nursing home and then to the hospital again can be nothing other than detrimental to the patient.

Mr. J., aged forty-nine and single, is a former logger. He would spend a few months in one logging camp and then move on to another. He usually spent his winters in a Dunlevy Street Hotel. Mr. J. was admitted to the Vancouver General Hospital in January 1944 with osteomyelitis of the right hip. After two weeks in the General Hospital he was transferred to Glen Hospital for a two week period of convalescence. This period of convalescence was extended to two months.
By the end of March, 1944, the doctor considered that Mr. J's condition had improved sufficiently for him to be moved to a boarding home. Mr. J. refused to go and later walked out of the hospital. He paid $124 out of his last $160 toward his account. For the next two years Mr. J. made a living by doing odd jobs. He lived in a cheap waterfront hotel.

In October, 1946, Mr. J. was again admitted to the Vancouver General Hospital, this time with a diagnosis of T.B. of the hip. After five months in the Vancouver General Hospital, Mr. J. was again moved to Glen Hospital. Within a short space of time he became the most unpopular patient in the institution. He refused to co-operate with the nurses and did not get along with the other patients. Glen Hospital put up with him for two months and then had him transferred back to the Vancouver General Hospital. One month later he was transferred back to Glen Hospital again where he remained for another five months. Once more his diseased hip required acute hospital medical treatment; he returned to the Vancouver General Hospital for another two month's stay and again he was transferred back to Glen Hospital. Here he stayed until March, 1948, at which time the doctor decided that Mr. J. was no longer in need of nursing-home care and could be moved to a boarding home. Mr. J. emphatically refused to go. He asked the social worker to get him a room in the hotel in which he had been living prior to his admission to hospital. The hotel refused to have him back because of the trouble they had had in providing extra services for him while he was living there. Mr. J. left the hospital on his own and managed to find a room by himself. In May, 1948, he was re-admitted to the Vancouver General
Hospital with a diagnosis of osteo-myelitis of the right hip. Three months later, after a great deal of interpretation by the social worker, Mr. J. was persuaded to go to a boarding home. Mr. J. was just getting used to the place and beginning to get adjusted to boarding-home life, when the City Social Service Department decided that he was to be moved to Mrs. S's boarding home where the rates were not so high. Three weeks later Mr. J. was re-admitted to the Vancouver General Hospital. One month later Mr. J. was declared ready for transfer to Glen Hospital by the attending doctor. Mr. J. refused to go to Glen Hospital but he was willing to return to Mrs. S's boarding home. As there were no vacancies in Mrs. S's boarding home at that time, Mr. J. asked the social worker to find a hotel room for him. This the worker was unable to do, so accommodation in a church hostel was arranged. Mr. J. did not like the place and stayed there only two nights. Finding himself a cheap room in one of the poorest districts of the city, Mr. J. continued to receive medical treatment at the Outpatients' Department from where he was admitted to the hospital again in October, 1948. One month later it was again suggested that he be transferred to Glen Hospital. Mr. J. again refused to go, giving as his reason that he did not get enough to eat there. He asked to go to Mrs. S's boarding home but there were no empty beds available there. Mr. J. stayed in the Vancouver General Hospital until the first of December at which time the doctor asked that Mr. J. be transferred to Heather Street Annex where he could receive more active medical treatment than he could at Glen Hospital. This was arranged and there Mr. J. remains, for how long, nobody knows.
Mr. J. is only one of hundreds of single, unattached men living in cheap hotels and rooming houses, who should be in a properly constituted chronic hospital. Because Mr. J. comes from the "skid-road", and is destitute the attitude has been: "just put him any old place, what does it matter?" Any hospital or nursing home or boarding home is supposedly superior to anything that he has been used to. Little consideration is given to the actual needs and desires of the individual.

Any trace of planned treatment for this patient is hard to find. After four years of shuttling back and forth between nursing home, boarding home and hospital, no-one has taken the time to find out why Mr. J. refuses to go to a nursing home or boarding home.

An attempt was made to determine the total cost of Mr. J's care in the hospital, nursing home and boarding home but since staff patient's accounts are not computed separately, it was impossible to do so. However, the cost must have amounted to many thousands of dollars. It would be much cheaper to have a chronic hospital to care for patients such as Mr. J. What will become of Mr. J.? Mr. J. appears to have another five or ten years of hospital and nursing-home care to look forward to. Will he spend the rest of his life being shuttled from one institution to another and finally end up in the Marpole Infirmary?

In the meantime, Mr. J. remains an embittered, unhappy and unco-operative man who is fighting the world that does not make any attempt to understand him. Somewhere along the line, the casework services that should have been made available to this man were not provided.
Some Never Give Up Hope

Nothing is more devastating to a family than to have the main wage-earner struck down with a chronic illness. The whole family is forced into a state of destitution and eventually, as a last resort, they are forced to apply for social assistance.

Mr. S. aged 35 and a former longshoreman, has been bed-ridden because of an arthritic condition since 1940. During the early stages of his illness Mr. S. invested his savings in a small confectionary store, which he was able to operate until he became too badly crippled. He then sold his business and his wife went to work in a factory. He and his wife lived with his parents. In 1941, Mr. S. was hospitalized for nine and one half months, during which time his condition became progressively worse, despite the use of every known method of treatment for arthritis. Mr. S. returned home and received further treatments by his family physician with no noticeable improvement in his condition.

Mr. S. was confined to the Vancouver General Hospital for five days in 1942 and two weeks in 1943 when his arthritic condition flared up again. Mr. S. was admitted to the Vancouver General Hospital again in 1944, where he received extensive fever therapy treatments without any improvement in his condition. By the summer of 1945, Mr. S's body had become completely rigid and he was only able to move his head. His wife found that she could not work and provide her husband with the care that he needed so she quit her job. About a year previously, they had purchased a small, three-roomed cottage with the last of their savings. Finally they reached the stage where Mrs. S. had to apply for social assistance so that they would not starve to death. A short time later, the doctor who
had been caring for Mr. S. told him that his case was hopeless and that there was little more that could be done for him. Mr. S. became very depressed and morose. For two months during the summer of 1946 Mrs. S. was able to secure sufficient part-time work to allow them to go off social assistance. Although Mr. S's condition was steadily getting worse, he refused to have any outsider come in to stay with him while his wife was working. He brooded a great deal while she was absent and became most unreasonable in his demands upon her. In September, 1946, Mr. S. was admitted to the Vancouver General Hospital with internal haemorrhages. He returned home after three weeks hospitalization.

By 1947 Mrs. S. had decided that it was her duty in life to stay at home and care for her husband and to make the remaining years of his life as comfortable as possible. Mrs. S. scarcely leaves her husband's side now. She reads to him by the hour and tries to satisfy every demand.

Throughout the City Social Service Department's four years contact with this family, the different workers who have come in contact with Mr. S. have taken an unusual interest in his case. The Medical Section of the City Social Service Department has provided Mr. S. with extra medicines, clothing and various articles that he has requested; no other assistance recipient has ever received the extras that have been provided for Mr. S. However, Mr. S. remains extremely unhappy; he does not think that the medical treatment that he is receiving is satisfactory and he is continually requesting new treatments for arthritis that he reads about in papers and magazines. He will not consider going to the Infirmary as he believes that it is a place for old men. Mr. S. spends
his days lying in a bed by a window, watching the people going by on the street and envying them because they are not helpless and dependent as he is. His wife, now aged 28, hovers at his side refusing to leave the house for fear that he should want something.

This young couple are forced to spend the rest of their lives on social assistance because of the husband's incapacitating chronic illness. This is a case where institutionalization is opposed by the patient. He might benefit greatly from such care as there is available at the Marpole Infirmary. Institutionalization of Mr. S. would free his young wife from the responsibilities she has assumed, and she would be able to live a more normal life. Surely if social casework services are of any value at all then something could and should be done to work out a better arrangement than this for the young couple.

It Takes Time to Be Admitted to the Infirmary

The length of time that a patient has to wait to get into an institution for the chronically ill is extremely demoralizing. By the time admission can be arranged, the patient's condition has deteriorated so much that there is no possibility of rehabilitation.

Mr. H., aged forty-six and single, was originally a farmer in the Edmonton district. In 1934 he had a stroke which hospitalized him for several weeks. He recovered sufficiently to go back to work on his farm. He moved out to Vancouver to live with his sister in 1937. In 1938 he had another stroke which left him helpless and bed-ridden. The doctors told him that there was nothing more that they could do for him. Mr. H., still a young man, refused to concede that his condition was incurable. He tried everything to effect a cure; he went to
chiropractors; he went to a Japanese electrical therapy centre for numerous treatments; he went from doctor to doctor; nobody could do anything for him. In the meantime he had used up all of his money and had to go on relief. Five years ago Mr. H. contracted a severe case of influenza which left him even more helpless than before. He was admitted to the Vancouver General Hospital and remained there for ten days before being transferred to Grandview Hospital. Mr. H's condition improved slightly there and by the time he left, nine months later, he was able to walk several blocks. The doctor decided that he no longer needed nursing-home care and he was transferred to Mrs. B's boarding home where he remained for over a year.

Mr. H. was placed in the first boarding home that had a vacant bed without any consideration of his needs. This particular boarding home was in a rather isolated part of the city and was set a long way back from the street. Mr. H. laughed when he was asked what medical treatment he had received while he was in the boarding home. He said that the only medical treatment he had received was a few laxative pills. Mr. H. described in some detail how lonely and isolated he had felt in this place. His one desire was to see the cars that he heard passing by on the distant street.

Mr. H's condition deteriorated gradually and eventually he became completely bed-ridden again. He was transferred to Heather Street Annex in 1945. Three years and two months after his application for admission to the Infirmary was approved, he was admitted to that institution.

Although Mr. H. has only been in the Infirmary since the first
of January, his condition has started to improve already. He is able to get around quite well in a wheel-chair now and he has become less incontinent. Mr. H. now realizes that there is little that can be done medically for his condition but he is determined to use the Infirmary's occupational therapy and physiotherapy facilities to the utmost extent.

Any patient who must wait three or four years for admission to the Marpole Infirmary after his first application is made, loses any interest in the transfer and becomes so resigned to living in other institutions that actual admission to the Infirmary comes as an anti-climax. His physical condition retrogresses so much that he may not be able to take advantage of the facilities offered by the Infirmary when he does get there. Great harm may have been done to this man by denying him the occupational therapy and physiotherapy treatments that he should have had. Mr. H. is a quiet likeable patient who got along well wherever he was placed and for this reason his transfer to the Infirmary was not pushed.

_Continued Institutionalization Can Be Harmful_

The case of Miss D. illustrates how many chronically ill people become so institutionalized that they become completely dependent and unable to manage on their own even though they should be able to do so. This is a case also where existing nursing homes and boarding homes could not provide sufficient medical care to allow the patient to be transferred from an acute hospital.

Miss D., aged twenty-three, lived with her mother, seventeen year old sister and thirteen year old brother in a small two-roomed suite in the West End prior to her admission to the Vancouver General Hospital
in September, 1946. Because of poor health, Miss D. had not been able to go to work after leaving school at the age of sixteen. She had a small income of $30 a month from a D.V.A. pension which she received after the death of her father. Miss D. was admitted to the hospital with a diagnosis of empyema and broncheastisis, which condition necessitated the surgical removal of part of a decomposed lung. After twenty-four days in the hospital she was discharged to her home. Her condition became steadily worse. Because the mother worked during the day, and the brother and sister were at school, there was no-one at home during the day to care for Miss D. Her relations with her family were not too cordial. Miss D. was re-admitted to the Vancouver General Hospital again in January 1947. After a month in hospital, Miss D. was again discharged to her home. Again she did not receive the proper food, rest and care that she needed and her lung began to haemorrhage again. Three months after discharge to her home Miss D. was re-admitted to the hospital again in June, 1947. In October, 1947 the doctor referred Miss D. to the social worker for placement in a boarding home. As no boarding-home beds were available it was suggested that Miss D. be placed in a nursing home until a boarding-home bed was vacant. Miss D. refused to go to a nursing home and made arrangements to live with a married sister. One month later she was back in hospital with a haemorrhaging lung. Her condition was critical and she was not expected to live. In January, 1948 the doctor again considered her ready for discharge to a nursing home or boarding home. As Miss D. was still haemorrhaging slightly and she had to have a supply of oxygen available at all times, the hospital did not press for her discharge. In the
meantime, Miss D's mother was showing little interest in having her daughter return to the home and refused to accept any responsibility in planning for her future care. Miss D. enjoyed her stay in the hospital tremendously. She was known all over the hospital for the beautiful paintings that she did. In December, 1948, the doctors decided that they could do nothing more for Miss D. and the social worker was asked to arrange for Miss D. to go to a boarding home. After much procrastination, Miss D. finally agreed to go to a boarding home. Miss D. went to a boarding home where there were several other young people like herself.

The social worker arranging the placement did not expect Miss D. to stay in the boarding home very long. She was very unsettled there and complained that she did not get sufficient attention or care. Miss D. lacks self confidence and is still very apprehensive about her health.

Miss D. obviously needed medical care that was not available in a nursing home or boarding home but she was becoming so institutionalized that all of her initiative and independence was being destroyed. Should she be confined to an institution at the age of twenty-three when she could lead a more normal life, under proper care, outside of the hospital?

A chronic hospital with occupational therapy facilities would be the ideal place for Miss D. to spend the rest of her life but is institutionalization of every chronic invalid to be the objective of a program for the care of the chronically ill?

(1) Miss D. has recently died very suddenly while at the Vancouver General Hospital receiving treatment.
Poverty Accentuates the Problem

The case of Mr. O. is one in which maladministration in the past has made a chronic invalid out of a person who might well have become a useful, self-supporting man if he had been given a better chance. This is an example of how chronic illness can be incurred as a direct result of a family's continued poverty over a period of years.

Mr. O., aged thirty-five, has spent almost the whole of his life on social assistance. Mr. O's father died in 1914, leaving his mother with three dependent children and no money. From 1916 to 1918 the family were on relief; from 1919 to 1921 the mother received mother's assistance. For a few years after this the family was supported by the oldest son. Eventually this son could support his mother, brother and sister no longer. The younger sister was picked up on a sexual immorality charge by the police and committed to the Girl's Industrial School. The mother and Mr. O. continued to live under appalling conditions, never far above the starvation level. They lived in any cheap room they could get and at one time the mother and her sixteen year old son were forced to sleep together on a single cot.

At the age of fifteen, Mr. O. had contracted rheumatic fever and spent three months in the hospital with the permanent heart impairment that resulted from the disease. In 1930, Mr. O., then aged 16 was declared to be unemployable for the rest of his life by the doctor. Neither Mr. O. nor the City Relief Department accepted this verdict. Mr. O. would find a job and earn a few dollars and immediately the Relief Department would cut off relief payments for the mother. Being
single, Mr. O. was considered to be responsible for his mother's maintenance. The mother was sick most of the time and was confined to bed almost continually. The whole depression period was a constant war between the Relief Department and Mr. O. He and his mother continued to live under deplorable conditions, still sharing a single room and never knowing from one day to the next whether they would have their relief allowance of groceries or not. Because of Mr. O's gradually worsening heart condition, he was only able to hold jobs for a few days before being laid off.

In 1936, to complicate things still further, the relief authorities decided that Mrs. O's ninety-four year old father should move in with the mother and son. He was destitute and no place else to go. Naturally Mr. O. objected to having to accept this additional responsibility.

In 1937, much against his mother's wishes Mr. O. got married. Four months later a child was born and three years later another. Mr. O. left his mother and he and his wife went to live in a couple of small rooms. The mother would have nothing to do with the new wife. Mr. O. continued to receive social assistance until June, 1940. For the next four years, Mr. O. managed to find sufficient employment to keep him off of assistance. For two years he worked in the shipyards. Throughout this four years, however, Mr. O. spent many weeks in bed because of his heart condition.

In 1944, Mr. O. suffered two severe heart attacks and was ordered to bed by the doctor for an indefinite period. For the next two years the family lived on social assistance with Mr. O's condition
continuing to be unchanged.

In 1946, Mr. O. secured some part-time casual work and for another nine months he was off of social assistance. When Mr. O. was again forced to apply for assistance, his condition had become extremely bad. In March, 1947, Mr. O. was declared to be permanently unemployable by the doctor, and the family were put on mother's allowance. Mr. O. and his family are still on mother's allowance and as Mr. O. is still confined to his bed for most of the day, it looks as if this thirty-five-year-old man, along with his wife and two children are going to be public charges for the rest of their lives.

Any casework services that have been given this family has been purely accidental. What might have been done for this family with a more enlightened relief department during the early days is only problematical. This case illustrates the long-term nature of chronic illness and the need for a treatment program. Low income and loss of earning power are inseparably linked to chronic illness. The lack of foresight of the relief authorities in the 1930's has been one of the direct causes of this man's present dependency upon public assistance.

Chronic Illness Breaks up a Family

The case of Mr. M. is one of many where the family splits up and goes different ways after the main wage-earner is removed from the home by chronic disease. Older children are forced to leave school to support the family. This is one of the few examples that could be found of a person who was admitted directly to the Marpole Infirmary from the home. Almost every present-day admission to the Infirmary is directly from a hospital or a nursing home.
Mr. M., aged sixty-seven, is married with three children, aged twenty-nine, twenty-six, and twenty-two years. The family formerly lived on a farm in Alberta and came to B.C. in 1939. Mr. M. had a severe attack of lumbago and arthritis in 1932. These were symptoms of a post-infectious disease condition. The family bought a farm on the outskirts of Vancouver. Mrs. M. and the son did most of the work. In October, 1939 Mr. M. became acutely ill again and he was confined to the Vancouver General Hospital for ten days.

Mr. M. felt very keenly about his inability to support his family. He did not like to see his wife do all of the work that it was necessary for her to do. Mr. M. became very irritable and practically unbearable about the home. He became very sullen and refused to speak to his family for weeks at a time. Finally the family was forced to ask for the admission of Mr. M. to the Infirmary. He had lost the use of his lower limbs and was too difficult to care for in the home. When Mr. M. was admitted to the Infirmary in November, 1939, the son aged 17 quit school and went to work to support the family. This boy had been an exceptionally clever student and he had planned to continue his education on into University. He supported his mother and sister for several years before going out on his own. He is now a logger on Vancouver Island with no hope of continuing his education. The mother and two daughters have moved to California and the oldest daughter has managed to work her way through University and expects to receive her degree this spring. Mr. M. is left here alone. Mr. M. feels very guilty about being the cause of the break-up of the family.

Mr. M., with a diagnosis of tabes dorsalis is able to get
around the Infirmary on crutches. His condition has improved since his admission there but it will never improve sufficiently for him to leave the institution. Mr. M. has become one of the Infirmary's most active participants in all of its many activities.

Institutionalization in this case has been beneficial to both the patient and his family in that the family have not been forced to support and care for him for the rest of their lives.

Permanently Unemployable at the Age of Twenty-Two

Mr. A. and his wife, a young self-supporting couple with no savings, are typical of the families that are forced to apply for social assistance as soon as the husband becomes chronically ill.

Mr. A., aged twenty-two was married three years ago to his attractive nineteen year old wife. They have one child two years old and a baby two months old.

Mr. A. was apprenticed as an aeroplane motor mechanic at the age of fourteen. At the age of sixteen he went to work as a mechanic in one of the largest garages in the city and worked there at a salary of approximately $210 a month until the onset of his illness. The family rent a small four-room bungalow in a good district.

In 1942, Mr. A. was in a motor accident where he fractured a couple of ribs. Since he felt no pain, the doctor taped up his ribs without having an X-ray done to see if there were any internal injuries. In the spring of 1947 Mr. A. began to have pains shooting up his back and to have severe attacks of nausea. His doctor could not find the exact cause of his illness. Finally after numerous X-rays, blood tests and examinations, the doctor decided that he had T.B. of the kidneys. Once
this diagnosis was made, his Blue Cross insurance payments were discontined. The doctor ordered Mr. A. to stay in bed until noon every day and not to do work of any kind. The A's were financially destitute and had no alternative to applying for assistance. All Mr. A's earnings had been used to buy household furnishings. To complicate the situation, Mrs. A. was expecting her second child in about three months time. It was arranged for Mr. A. to receive about $700 worth of streptomycin through the Outpatients' Department of the Vancouver General Hospital.

His doctor hoped to arrest the infection in his kidney sufficiently so that it could be removed. Unfortunately Mr. A. built up an immunity to streptomycin and the T.B. infection spread to his other kidney. As Mr. A. did not feel ill, he did not spend the mornings in bed as the doctor had ordered. He was working about the home continually. Mr. A. had considerable difficulty living on the $60 a month social assistance after the comparatively high standard of living he had been used to. Neither he nor his wife were able to budget their small income. Finally Mr. A. refused to try and live on social assistance any longer and went back to work. He felt that it was better to go to work than to have to try and live on social assistance. He worked for one month and his condition immediately became much worse. He was forced to apply for social assistance once more. Mr. A. is supposed to have extra food but anything extra in the family is given to the baby or the two year old girl. Mr. A's condition is getting steadily worse and the infection in his kidneys is spreading to other parts of his body. Within a short time he will be completely incapacitated. The doctor does not give him more than another two years to live. The doctor does not feel that hospitalization will serve any useful purpose.
With a proper treatment program for the care of chronic illness, coupled with social assistance payments according to need, this man's condition might have been so improved that he could lead a normal life for many more years. What this family needs most of all is sufficient social assistance to buy enough food, clothing and fuel to carry on until Mr. A's death. In the meantime the young nineteen year old wife and two children must get along the best they can with no future to look forward to. Institutionalization would remove the husband from the home but would it serve any useful purpose at this stage of the man's illness? Existing social work agencies could perform a valuable service in assisting this man in planning for the future of his family and for his own care when his condition becomes more acute.

Disabilities Can Be Overcome

Mr. T. is a case where a chronic invalid has been able to adjust his life to his illness and to direct his activities accordingly. This is a striking example of the value of occupational therapy facilities to a chronically ill person.

Mr. T., aged fifty-three, was a former railwayman. He was born in the United States but moved to Canada when still a boy. He lived in various towns in B.C. before moving to Vancouver in 1931. He is single with no close relatives in this province.

The first symptoms of Mr. T's arthritis appeared about 1925. Gradually his joints began to stiffen and become inflamed and, within a short time, every movement gave him great pain. Eventually he was forced to quit his job. The railway brotherhood to which he belonged helped him financially for some time but finally he was forced to go on relief.
Before applying for relief, he sold all of his personal belongings, even some of his clothing to be independent as long as possible. As his arthritis became more crippling he found it almost impossible to manage on his own in the cheap rooming houses he was forced to live in.

A specialist in arthritis had become interested in Mr. T's case and he tried out every drug and treatment for arthritis known to medical science at the time on Mr. T. In May, 1934, Mr. T. was admitted to the Vancouver General Hospital. During his two and one half year stay there he received fourteen series of Gold treatments. In January, 1937 after 956 days in the acute hospital, Mr. T. was transferred to the B. Nursing Home. He spent almost a year there before he was transferred to the H. Nursing Home where he remained until he was admitted to the Marpole Infirmary in July 1941. While in the B. Nursing Home he received two more series of Gold treatments. Since admission to the Marpole Infirmary, the inflammation and pain in his joints has abated and he has now completely rigid with a "Marie Strumpel" spine, being able to move only his head and hands.

Mr. T. has been the special exhibit at the Infirmary for many years. Every visitor to the place has been taken to see the wonderful miniature doll furniture that Mr. T. is able to make with the aid of mirrors and with specially made tools and equipment. Any skilled craftsman would be proud to say that he made these exquisitely carved and fashioned articles. The patient is kept so busy with his work that he has little time to worry about his illness. He also finds that he is physically tired by night and is able to sleep and eat better. Mr. T. won a special award at the Pacific National Exhibition for his work last year.
Because of the physiotherapy treatments that Mr. T. receives, he is able to make the maximum use of his hands. This man, although terribly crippled and bed-ridden enjoys life to the full because he realizes that everything that could be done for him medically is being done, and he is kept so busy that he has not time to let his condition get him down. Mr. T. is looking forward to at least another ten years of life in his busy corner in the Infirmary.

Mr. T. has experienced all of the difficulties that chronic illness brings with it. The only thing that he has missed is a boarding home placement. If a proper chronic hospital had been available it is possible that Mr. T. would not be as badly crippled as he is now.

These studies point out the total inadequacy of present facilities in Vancouver for the care of the chronically ill and the urgency for a complete revision of our social casework concepts as regards the chronically ill. The insufficiency of present social assistance payments are evident. Until there is a change of policy in this respect, no treatment program for the care of the chronically ill in the home can ever be implemented. The pressing need for a chronic hospital for active treatment of chronic diseases is brought out very clearly in these studies.
Chapter VI

The Essentials of a Community Program

"The chief aim of the treatment of chronic disabilities in which complete restoration to normal can no longer be expected is to arrest the progress of the disease and to enable the patient to maintain or resume his accustomed place in society and in his family. The patient must be taught to regard his illness, not as the focus of his life, but as a handicap to overcome." If this principle, laid down by Dr. Boas in his valuable study, was followed even in part this would be a much happier world for the chronically ill.

The Effect of Divided Responsibility Upon Existing Facilities

Judging from the picture which has been described for Vancouver, there are two fundamental problems involved in the provision of the necessary diagnostic, treatment, and institutional care of the chronically ill. Is the provision of these facilities primarily the responsibility of the hospital or is it strictly a public welfare problem - one of social assistance cases who also need medical services? This is important since it has been made abundantly clear that the majority of people suffering from chronic illness eventually are forced to rely upon public assistance for their care. If it is a public welfare responsibility, who is responsible for the financial cost? Should it be the provincial government, or the municipality; or, if both, how should the costs be divided.

(1) Boas, Ernst P., M.D., The Unseen Plague, Chronic Disease, J. J. Augustin Inc. 1940, Page 22.
Unfortunately the City of Vancouver, with its limited taxation resources and an increasing public demand for roads, sewers and other public utilities, has had to decide on a strictly dollars-and-cents basis when it came to the matter of providing any facilities for the sick and indigent of Vancouver. Instead of asking what is needed and what can be done for these people, the City and its administrative bodies have had to ask: how much will it cost; is it reasonable to ask the provincial government to share; and, not infrequently - is it an expense that can be postponed for a few years?

It has been difficult for the hospital administrators and provincial welfare authorities to convince the city of its responsibility for the provision of nursing-home and boarding-home care for the chronically ill. For many years the city felt that its responsibility ended with the provision of social assistance for them in their homes.

After its experiences during the depression with mass unemployment and relief, with all of its attendant evils, the City Social Service Department was reluctant to participate in any large scale program for the care of the chronically ill. In 1937 however, the City Social Service Department was one of the instigators of the plan for the removal of long-term hospital patients to nursing homes and boarding homes, and eventually became an integral part of the total program. At first the city had to assume the full cost of the whole project. It was not until 1939 that the provincial government accepted responsibility for eighty per cent of social assistance costs. This did not include boarding-home or nursing-home care. Had the war not intervened there might well have been developed a co-ordinated program for the care of the chronically
ill. But, the enlistment of large numbers of the medical profession, the shortage of housing accommodation and the cessation of any new building prevented any action being taken for six years. However, in 1942 the provincial government assumed eighty per cent of the cost of boarding-home care and provided an additional one hundred beds for the chronically ill at Mount St. Mary. As a result of the recommendations of the Goldenberg Report in 1947, the provincial government agreed to assume eighty per cent of the cost of nursing home care. The situation as it exists today is that the city and the provincial government are each delaying action hoping that the other will assume the responsibility for providing the necessary facilities and accommodation for the care of these unfortunate chronic cases.

Within the city itself three distinctly separate agencies have provided most of the facilities at present available for the chronically ill. This has been one of the main reasons for the lack of a sound treatment program for the chronically ill of Vancouver; and the separation of facilities between the City Social Service Department, the Vancouver General Hospital and the Provincial Infirmaries has probably helped to postpone the construction of a central, properly equipped hospital in this city.

This division of responsibility has worked out somewhat in this way; The Vancouver General Hospital provides medical care, treatment and accommodation for the largest number of the city's chronically ill; the City Social Service Department assumes the financial responsibility for the care and maintenance of dependent persons whether in the home, boarding home or nursing home; the government admits to the Provincial
Infirmary those chronically ill persons who are no longer able to care for themselves and for whom there is no suitable accommodation in city institutions. Admissions to the Infirmary from Vancouver within recent years have been so few that the City Social Service Department and the Vancouver General Hospital hesitate to take the time to write up such cases for Infirmary admission. Any admissions that are made are regarded as inconsequential in relation to the over-all problem.

To add to the confusion different arrangements have been made by the provincial and city governments for the care of the acutely ill in the general hospitals. Until the inception of the new hospital insurance scheme the annual deficit of the Vancouver General Hospital was made up by a straight grant from the City of Vancouver. Most of this deficit was incurred by the hospital through its provision of outpatient services, acute hospital care for the city's indigent and the cost of nursing-home care in its satellite hospitals of Glen, Grandview and Heather Street Annex. At one time it was estimated that it was costing the hospital $35 a month more than it was receiving from the City Social Service Department for the care of each patient in the annexes. These small deficiencies soon added up to one large deficiency. For a short time the provincial government made a special per-diem payment for every recipient of social assistance cared for by the General Hospital as an acute case. This grant was made without reference to the City Social Service Department.

Then, too, cases that were the responsibility of the federal government were being cared for by the Vancouver General Hospital without financial aid. The war veteran in receipt of War Veterans' Allowance received medical and hospital care at the Vancouver General Hospital and not at Shaughnessy Hospital until about a year ago. The pensioner is now entitled to care at the military hospital but his wife (cont)
To add to the administrative tangle there is the provincial Inspector of Hospitals Office whose duty is to act as a clearing-house for chronically ill patients occupying acute hospital beds in every part of the province. If a patient is a "Vancouver responsibility" then the Medical Section of the City Social Service Department is asked to find alternative accommodation. But the removal of non-residents of Vancouver from beds in Vancouver hospitals is a different problem altogether. These patients still need nursing-home or boarding-home care and services that are available only in Vancouver; but because of the shortage of custodial beds in Vancouver, the City Social Service Department is unwilling to provide accommodation for non-residents.

The problem of what to do with the out-of-town residents that are flocking to Vancouver for such specialized services as are provided by the B.C. Cancer Society, the Canadian Arthritis and Rheumatism Society and the Rehabilitation Centre for the Physically Handicapped is apparently only beginning. At present the City of Vancouver is paying a large percentage of the cost of several services, which to become effective, must become provincial responsibilities.

In addition there are voluntary services that play an important role in caring for the chronically ill in the city. Outstanding among and dependents must still come to the Vancouver General Hospital. There are hundreds of War Veterans' Allowance recipients attending the Vancouver General Hospital Outpatients' Department, partly because they have been going there for so long that they do not wish to change, and also because they think they get better care and attention at the Vancouver General Hospital. Temporarily at least, the city has been relieved of the responsibility of providing institutional care for these people by the opening up of special chronic wards at Shaughnessy Hospital and the provision of custodial care at Hycroft and the George Derby Health and Occupational Centre in Burnaby.
these are the Victorian Order of Nurses who are supported by the Community Chest, by grants from the provincial government and by an annual grant by the city. This is a self-contained organization and functions independently of the hospitals, the City Social Service Department and the provincial institutions. A closer integration of service seems to be necessary. Somewhat similar considerations apply to such services as the visiting homemaker services provided by the Family Welfare Bureau for families with, for example, a chronically ill mother or father.

The original plan in setting up the Children's Hospital was that it would be able to care for a considerable number of chronically ill children of Vancouver as well as to provide a generalized hospital service for children. The demands made upon it has forced the hospital to curtail the services they offer chronically ill children, The Preventorium has taken an occasional chronically ill child as has the Queen Alexandra Solarium on Vancouver Island, but other than these there is no place for the long-term treatment of the chronically ill child. What services these institutions do provide are not correlated into any treatment program nor integrated in any way with other services provided for the chronically ill.

The private hospitals and nursing homes in Vancouver, the boarding homes, whether city or provincially licensed, each go their own way. Among them there is a wide variation in services provided and no one body determines exactly the institution in which a patient should or could be placed. These private institutions play an extremely valuable role in caring for the chronically ill and they should be utilized to their full extent. But some central body is needed to weld these various institutions into an effective and planned treatment service for the
chronically ill.

The wide diversion in services offered, sources of financial support, ownership, operation and administrative practice will preclude any solution of the problem of the chronically ill until they have been merged into a harmonious group working toward a common objective. The present system leads to a constant overlapping of services, and in the important area of bed care, a competition among the various groups for what beds are available, that only inflates costs and increases the likelihood of emergency additions.

The Required Facilities for Effective Care

These are some of the hindrances that already stand in the way of the implementation of a long-term treatment program for the chronically ill. There are also, however, some facilities that are lacking altogether, though they are essential to any program in Vancouver. These deficiencies have been the main causes for the division of responsibility within the city; they have forced the authorities to resort to improvisation, and have encouraged the use of temporary measures to cope with the urgency of the problem.

The major needs are threefold. First and undoubtedly foremost, Vancouver needs a chronic hospital. Secondly it needs a social assistance program that pays social allowances on the basis of need rather than only up to a maximum that allows bare subsistence. Thirdly, a single administrative body is needed for the organization of facilities and accommodation for the chronically ill of the whole city, a body with an advisory council composed of representatives of all interested groups in the city. Operated in conjunction with the chronic hospital as auxiliary
units there must be such resources as a visiting nurse and visiting physician service, an outpatients' department and a homemaker service.

The Need for a Chronic Hospital

In the 1930 survey, conducted by Dr. Haywood, of the hospital situation in Vancouver, it was estimated that 500 convalescent and chronic beds were urgently needed at that time.\(^\text{(1)}\) If 500 beds were needed at that time it is probable that double that number are an urgent necessity now. It is generally considered that one chronic hospital bed is needed for every 1000 population in any area.\(^\text{(2)}\)

On this basis a minimum of 500 chronic hospital beds are urgently needed in Vancouver. With the inception of the medical school at the University of British Columbia for which a teaching hospital for chronic diseases will be needed and the development of special services for persons suffering from cancer, arthritis and the after-effects of poliomyelitis, it seems reasonable to expect that even more than 500 beds will be needed. In Vancouver at present the only institution, other than the acute hospitals, which provides active treatment for chronic diseases, is the Marpole Infirmary. The Infirmary, however, was designed to provide custodial care only and was not intended to become a treatment centre.

The Vancouver General Hospital has already become too large and too difficult to administer without further additions but any chronic hospital

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\(^\text{(2)}\) See for example, Care of the Chronically Ill and Aged: Proposed Recommendations of the Inter-departmental Co-ordinating Committee, Province of Saskatchewan, September 1948. Recommendation IV, section 3.
that is built in Vancouver should be built close to the Vancouver General Hospital. The Montreal survey of chronic diseases made this recommendation:

"From an administrative standpoint a hospital for chronic illness should be maintained in close relationship with the other types of hospitals which now exist in the city. This would allow for free and easy transfer of patients from the chronic hospital to the general hospitals, and also to the custodial homes now available. Patients would have to be transferred from time to time to one or another institution depending on changes in their clinical condition."(1)

Most experts on chronic diseases are unanimous in approving this plan. If a chronic hospital is set off somewhere by itself it soon becomes inflexible in its relationship with other community services and gradually becomes static in regard to the treatment of the chronically ill. Many hospitals compromise and operate one wing as chronic hospital with a considerable degree of success. There is, however, universal acceptance of the fact that "most patients with chronic illness requiring hospitalization are best cared for in a unit of a general hospital especially designed to meet their needs. This arrangement encourages patients to seek and use care since it is near their homes, families and friends, makes available existing facilities of general hospitals, provides opportunity to internes, nurses and staff for experience and teaching in chronic disease; avoids expensive duplication of existing general hospital facilities, and affords the most ready means of transfer to and from the acute and chronic disease sections of the hospital when needed." (2)

(1) The Care of the Chronically Ill in Montreal, 1941, Page 24.

The Saskatchewan Inter-Departmental Co-ordinating Committee emphatically declared that hospitals for the chronically ill should be developed within the framework of the existing general hospital. If a separate building is constructed, it should be on the same grounds as a general hospital, in order to insure joint administration and the common use of facilities.\(^1\)

The present plan drawn up by the Vancouver General Hospital is to build a 300-bed convalescent hospital in 1949 in a location adjacent to the present hospital. Within the next five years a new 800-bed acute wing is planned. After these two buildings have been built it is proposed that the present main building, built in 1906, be converted into a chronic hospital. This plan is sound and progressive in scope but hundreds of chronically ill people need institutional care right now; they cannot wait for five years or even one year.

If a chronic hospital is constructed, a portion or wing of it should be devoted to the care of chronically ill children. In Vancouver there is no accommodation for the chronically ill child under the age of eighteen except in the Children's Hospital, though actually this institution takes only children under sixteen. The Marpole Infirmary cannot take them until the age of eighteen. The Preventorium, although intended primarily for the care of children exposed to T.B. has taken a few chronically ill children, usually those recuperating from rheumatic fever. But this is the exception rather than the rule. When a chronically ill child is admitted to a hospital at present, he either remains there indefinitely

\(^1\) Care of the Chronically Ill and Aged: Proposed Recommendations; Inter-Departmental Co-ordinating Committee, Government of the Province of Saskatchewan, September 1948. Recommendation IV.
or returns to his home no matter how desperate his need for special institutional care. One nine-year-old boy with chronic nephritis spent almost six months in the Vancouver General Hospital because there was no other place he could go; finally he had to return to a very inadequate home in which there were absolutely no facilities for his proper care. In Glen Hospital at present there is a sixteen-year-old paraplegic boy who has had to be placed there for lack of accommodation elsewhere. This boy is in the same ward as about twelve old men, some of whom are quite senile. There are numerous children suffering from rheumatic fever who are discharged to poor environmental surroundings and inadequate care with the full knowledge that their condition will worsen because there is no hospital or institution to accommodate them.

In addition to accommodation for chronically ill children there will have to be some provision for the institutional care of the epileptic who cannot be adequately controlled from a medical point of view in the home. Vancouver (and British Columbia) has been very backward in recognizing the needs of epileptics for care and treatment in special institutions. It is estimated that there are at the present time fifty epileptics in Vancouver alone in desperate need of institutional care. Undoubtedly there are twice that number who would benefit from care and treatment in a chronic hospital.

A chronic hospital should not degenerate into a purely custodial institution for the chronically ill. It should be used primarily for the diagnosis, treatment and alleviation of chronic disease. When only custodial care is necessary, the patient should be transferred to an institution such as the Marpole Infirmary.
When the building of a chronic hospital is suggested the first question raised is who should finance hospital construction? Undoubtedly the provincial government will have to provide most of the construction costs but there are distinct possibilities of aid by federal subsidies.

The provincial government is the only level of government in the province able to finance a large construction program such as this and to maintain the institution properly. Since the provincial government already assumes complete responsibility for two large groups of chronically ill people, namely the tubercular patient and the mentally ill, it does not present any insurmountable difficulty for them to take over this closely related group. Only by having a provincially-operated program for the diagnosis, treatment and institutional care of the chronically ill can an effective and co-ordinated program be developed. The provincial T. B. Hospital operated on the grounds of the Vancouver General Hospital has the facilities of the Vancouver General Hospital at its disposal but still remains a treatment and institutional care centre for the tubercular patient from many parts of the province. The effect of the greater sources of revenue of the provincial government is clearly seen at the Marpole Infirmary, where every facility that can be used is made available to the patient with little consideration as to the cost. In a provincially-operated chronic institution its facilities will be available to every resident of the province and not only to those who live within the city limits. Because certain medical programs are available only in Vancouver, (1) It is expected that the federal government will contribute up to $1000 per bed toward the cost of construction of chronic hospital facilities. Such a course of action was proposed at the 1945 Dominion Provincial Conference.
the city has borne more than its share of the financial burden in caring for the chronically ill. This situation, bitterly criticized by the Vancouver city council, will continue to exist until the chronic hospital is operated as a provincial institution.

The provincial government could construct a chronic hospital similar to the new Clinic of Psychological Medicine at Essondale which itself could be used as a chronic hospital without a single alteration. Among its many advanced features are the public wards divided by waist-high partitions into semi-private accommodation providing a patient with some degree of privacy without completely isolating him from the other patients. The provincial government has already erected two institutions for the care of the senile aged which are perfectly designed chronic custodial units with all of the most modern ideas for the care of one particular type of chronic illness. These units have been mentioned only to show that the provincial government can and does provide the best type of institution for certain kinds of chronic illness. It should do the same for other chronic diseases.

Without doubt it will be found that the vast majority of chronically ill people seeking admission to a chronic hospital are either indigent or of the lower income groups. If a proper approach to the problem of chronic disease and its accompanying economic evils is not established from the very first, the chronic hospital may soon become, in the mind of the public, a charitable institution designed primarily for the care of the indigent sick. In the cities that operate chronic hospitals, it has been found that many people are forced to be institutionalized for no other reason than that they are poor and there is no other
place where they can get adequate care. Chronic disease strikes all classes and the lack of proper care and treatment is as serious for those who are able to pay as for those who cannot. A chronic hospital should be a community institution serving all sections of the population, rich and poor. In this way the hospital may achieve a greater degree of financial stability because of the additional income from those able to pay, resulting, of course, in a still higher quality of service to all.

The Marpole Infirmary is operated very successfully on this principle. The paying and the non-paying patients receive exactly the same care and treatment, with only the office knowing all the facts. The joint committee, before mentioned, made further recommendations regarding the financial ability of the chronically ill to pay for their care:

"Under no circumstances should chronic disease hospitals or units be limited to the indigent. The lack of facilities is felt by all sections of the population. High standard will be maintained most effectively if the facilities are geared to meet the requirements of the entire community. Also the admission of patients who are able to pay will reduce the need for tax funds. It must be recognized however that prolonged illness exhausts the financial resources of many patients, necessitating payment from tax funds for their care."(2)

It is reasonable to envisage what would be the effect of the opening of a 500-bed chronic hospital in Vancouver. In all probability every bed in the institution would be filled within a matter of weeks. In the first place, a considerable number of acute beds occupied by chronically ill people would immediately become available for the accommodation of acutely ill people that have not been able to gain admission to the


(2) Ibid., Page 222.
hospital because of lack of beds. Secondly, the pressure upon and the demand for private nursing-home care would abate somewhat, and some attempt could be made to select the nursing home that best meets the patient's needs. Pressure upon the boarding homes would also be lessened and there could be a more concerted attempt to be selective in the accommodation used. Boarding homes could then be used more for the care of people suffering from nothing more than old age who need only custodial care. What would be most important would be the effect of decreased demand for nursing-home and boarding-home care. One official in the City Social Service Department made the statement that there was nothing wrong about the nursing homes and boarding homes in Vancouver that a little competition could not cure. Places that provided inferior services would either have to improve their standards or go out of business. Nevertheless, no matter how large a chronic hospital was built, there would still be a need for nursing-home and boarding-home care to provide custodial accommodation for those patients who can no longer benefit from the treatment services of a chronic hospital. The infirmary type of institution would continue to play a vital part in the over-all program in that there would be several hundred patients for whom only custodial care was necessary.

Care For Those Not In Need of Chronic Hospital Care

A chronic hospital may greatly benefit those in need of this particular type of care but what of those chronically ill people who do not need institutional care? Chronic hospital care is not always the type of care that best suits the patient's needs. Dr. Boas has this to say about this particular aspect of chronic illness:
"Manifestly a chronically ill patient should receive the type of care that he actually requires. His needs will vary from time to time. Often after a period of medical care improvement occurs so that custodial care becomes sufficient. On the other hand a patient who has been adequately served by custodial care may experience a sudden progress of his disease that demands medical care. Some of the chronic sick receive unnecessarily expensive care; they are in a hospital when a custodial home would be sufficient; they are served by a visiting nurse rather than by an attendant. In the case of others the picture is reversed and the care they receive is insufficient. Care ill-suited to the needs of the patient results in economic loss to the community and often unfairness to the sick."(1)

The essence of a good system is one in which there is no difficulty experienced in achieving the maximum mobility for every patient. It must never be forgotten, however, that medical needs do not always decide what type of care a chronically ill person should have. Poverty compels many chronically ill people to seek institutional care.

There are hundreds of chronically ill persons in this city who do not need any type of institutional care and are quite capable of carrying on normal activities in their own homes with only the aid of a visiting nurse service and with regular visits from the family doctor.

Eventually the point will be reached where a definite plan of treatment for every chronically ill person will be laid out by the community diagnostic and treatment centres from the onset of the illness to death. For the indigent and low income groups an unlimited outpatient diagnostic service should be made available. The implementation of a treatment program for each individual required that early and skilful diagnostic service must be available to all without any reference to cost

or ability to pay. In practice this amounts to a system of pre-paid health insurance. The patient must be encouraged to consult his doctor at the time the first symptoms of chronic illness occur and not when seeing the doctor can be postponed no longer. Ready access to diagnostic and specialist service is essential to adequate care for every form of chronic disease. Many of the chronic diseases exhibit complex and varying symptoms that make them difficult to diagnose and treat.

A chronic hospital, the services of a physician available at all times, or the organization of an outpatient service for the early diagnosis and treatment are helpful to certain categories of the chronically ill. To others: the services of a visiting nurse in the home satisfies their wants and needs. At present there are only eighteen V.O.N. nurses in Vancouver to care for every person needing bedside nursing in the home. Besides the chronically ill they have large numbers of maternity cases and convalescent people to care for. There should be three times this number for a city this size.

Montefiore Hospital for Chronic Diseases in New York operates a home nursing service by visiting nurses who follow up patients after their discharge from hospital and provide regular nursing service in the home for those who do not need institutionalization. In England under the new National Health Insurance program, an extremely elaborate system of visiting nurses and special treatment clinics has been set up with the purpose of keeping the chronically ill on their feet as long as possible.

Many of the chronically ill do not even require the services of a graduate nurse; a practical nurse or a nurses' aid is quite capable of giving an insulin injection, giving a bath or changing a dressing.
Nurses' aides and practical nurses supervised by graduate nurses spread the visiting nurse services over a greater part of the population. The City Social Service Department has employed a trained medical orderly to visit many of the chronically ill old men living in cheap rooming houses and hotel rooms. In many cases his services are entirely adequate to the patient's need.

Under the present set-up in Vancouver, it seems best that the V.O.N. continue as an autonomous body without being affiliated with the hospital or City Social Service Department, but there should be a closer co-ordination of services with a representative of the nursing service sitting upon the inter-departmental committee discussed later on in this chapter. The system of purchasing nursing services has more advantages than disadvantages. It is much cheaper to purchase service such as that provided by the V.O.N. than to set up a similar service under municipal control. Most important of all, the provision of service would not take on a charity or social assistance tinge but would continue to care for all classes of patients, those without funds, those able to pay something for services rendered, and those able to pay in full.

If a treatment program for the chronically ill were set up in Vancouver, the visiting nurse service would have to be augmented by a similar visiting physician service. There are many chronically ill people who will not call a doctor until their condition reaches an emergent state because they have not the money to pay for his services. Besides this, unfortunately, there are some doctors who will not pay routine visits to chronic invalids in their homes because they feel that they are wasting their time visiting these people for whom they can
do little or nothing. Then there are the few doctors who lose interest when they find that chronically ill people are usually less able to pay their bills than others. A properly organized treatment program provides for the setting up of a panel of doctors who are constantly on call for the care of the chronically ill in their homes or in the institutions serving them. A rotation system is frequently used to distribute the burden and thus keep up the doctors' interest. The new system of Health Insurance in England provides for quite an extensive system of visiting physician services for the chronically ill. The Montreal survey of chronic diseases strongly recommended the implementation of such a service for the care of the chronically ill of Montreal who had to remain in their own homes and who were unable to pay for medical care.\(^1\) Such a system in Vancouver would be a tremendous aid to the chronically ill. The system could and should be operated as an integral part of the chronic hospital and its outpatients' department.

To round out a complete program for the care of the chronically ill in the home, a highly specialized and centrally controlled visiting housekeeper or homemaker service is necessary. At one time the City Social Service Department employed a considerable number of visiting housekeepers to care for family groups, finding that it was cheaper to pay a housekeeper's salary and keep the family together than it was to have the home split up and provide maintenance for each individual. Gradually the city has withdrawn from this field and the majority of such housekeepers (now known as homemakers) are provided by the Family Welfare Bureau of

\(^1\) *The Care of the Chronically Ill in Montreal*, 1941, Page 24.
Vancouver. This type of service is provided only when there are children in the family. The work of the Family Welfare Bureau has certainly been highly satisfactory except that there are not nearly enough of the homemakers available for the number of people who need their services. There are hundreds of older chronically ill people who need nothing more than someone to keep the home clean and cook a meal; with just this little extra help they are able to carry on without seeking institutionalization. Mary J. Jarrett made a very detailed study of the visiting housekeeper services in operation in New York for the care of the chronically ill, She said:

"How a chronic patient is to be cared for depends not only upon the type of medical and nursing service he requires but also upon the degree of his capacity and upon the resources of his home. Patients who are capable of attending a clinic with assistance may have to go to a hospital because there is no-one at home to look after him. Those who might be treated by visiting physicians may be in hospitals because the family is not able to give the necessary care. Sometimes lack of financial support forces a patient into an institution — — — —. There can be no doubt that home care is an essential part of a humane and economical system of provision for the chronically ill for both adults and children."(1)

A large proportion, probably a majority, of the chronic patients who must have some kind of personal attention to their physical needs do not require skilled nursing. In a great many cases, the family can give the necessary care. Some patients need the type of care that is given by a trained attendant. Others need only to be waited upon or to be assisted with household tasks, that is, such help as a housekeeper can give. (2)


(2) Ibid., Page 6.
Chronic Illness and Compulsory Hospital Insurance

Eventually some provision for the care of the chronically ill will have to be made under the new system of compulsory hospital insurance in British Columbia. It is a basic prerequisite to the success of the whole scheme that accommodation for the chronically ill be found so that every acute bed may have the greatest possible turnover in patients. It has been estimated that from twenty to forty per cent of all hospital beds are constantly being used for patients suffering from chronic diseases. If separate accommodation for the long-term convalescent and chronically ill person is not found, the whole system will founder. In Great Britain the first step taken by the National Health Insurance authorities, before inaugurating their scheme of free hospitalization, was to make special provision for the removal and accommodation of the chronically ill elsewhere, so that the maximum use of the available acute hospital accommodation could be made.

The present system of hospital insurance in B.C. provides payment for only that period in the hospital during which illness is at an acute stage; and as soon as the patient is no longer acutely ill he must either pay the full hospital rates or leave the hospital and perhaps try to gain admittance to a nursing home. The patient may feel little better although the doctor and the hospital administration have decided that he has improved sufficiently to leave. A new policy will have to be developed next year when the new convalescent hospital is opened at the Vancouver General Hospital. Will hospital insurance cover stay in a convalescent hospital? How much difference is there between a chronic invalid and a patient needing six months or more convalescence. All
groups need hospitalization equally as bad and it does not seem right that one group should be discriminated against because their period of sickness is of a long-term nature while others recover in a week or ten days. It is really the long-term or chronic patient who should have his hospital payments cared for.

In view of the above situation it seems essential that the provincial government appoint a man or a woman, not necessarily a doctor, to act in an advisory capacity to the administrator of the hospital insurance scheme with a view to the establishment of a provincial chronic hospital for the diagnosis, treatment and care of the chronically ill of B.C. This person should be familiar with medical social work technique and with the public welfare organizations in the province. This person should act as a liaison officer between the Social Welfare Branch of the Department of Health and Welfare of B.C. and the newly created Hospital Insurance Branch. With this as a beginning, a program for the proper care of the chronically ill can be developed in B.C.

A Scale of Social Allowances Based On Need

The present scale of social assistance payments provided for the chronically ill in the home is hopelessly inadequate. Instead of helping the chronically ill person to stay out of an institution the meagre grant forces him to seek hospital, nursing-home care or boarding-home care. The City Social Service Department has very definitely recognized this situation by the present policy of supplementing social allowances for a few chronically ill people so that they may have a little extra attention and consequently remain at home for a little while longer. At present a single man is expected to provide food, clothing
and shelter for himself out of his $35 allowance. Even the cheapest room now costs at least $12 a month and more likely $15. Twenty dollars for food alone spread over thirty days allows only about sixty cents a day for food with nothing for fuel, clothing, light, etc. A married couple receives only $50 a month instead of the $70 that one might expect they should get. For each additional dependent the parent receives a small additional allowance. The additional amount received will hardly buy milk for a child nowadays. The social assistance recipient and his family get unlimited free medical care but it does not help very much if the environmental difficulties under which he lives make it impossible for him to benefit from these medical services.

The chronically ill person will go to any lengths to postpone the day that he has to apply for assistance. The usual pattern is for the chronically ill person to sell everything he owns to obtain extra money to carry on for a little while longer. Patients are unwilling to go to Glen and Grandview Hospitals, until they are forced to because they do not want to become assistance recipients. The present inadequate rates of social allowances make it a degrading experience for an individual to apply for assistance. There are hundreds of chronically ill people barely existing on small pensions or annuities who are not eligible for social assistance. These persons are ineligible for the free medical care provided for the assistance recipient. A person has to be absolutely destitute, besides being unemployable, before any assistance can be provided.

Since the City Social Service Department controls a large number of the nursing and boarding home beds available for the care of the
chronically ill, the standards and policies of this agency determine what standards shall exist in these institutions. As long as the care of the chronically ill remains a charity or social assistance domain, large numbers of chronically ill people will be ineligible or unwilling to apply for the care that is available, no matter how good it is. There are many people who would try to exist on a few dollars a week rather than apply for assistance.

At present there is no attempt to provide social assistance according to need. In some cases, where the rent paid is higher than the allowable maximum, a small rental average is granted. A few fortunate chronically ill people, needing boarding-home beds that are not available, get a supplementary allowance to recompense the landlady for extra services. At no time is an attempt made to find out exactly how much a family needs to live on and that amount of allowance granted.

No treatment program for the chronically ill can hope to be effective without a radical alteration in the present scales of social assistance. All of the visiting nurse services, visiting physician services and other treatment services for the chronically ill will be useless until some attempt is made to provide social assistance according to need so that the chronically ill living at home are not forced to live in absolute poverty.

An Improved Administrative Structure

Despite the terrible shortage of facilities for the care of the chronically ill in Vancouver, there is much that can be done to straighten out the administrative tangle that prevents what resources there are available from being used to their full extent.
A great deal could be accomplished by the organization of an inter-departmental committee to co-ordinate the whole program for the care of the chronically ill. Up until the present time the main trouble has been that each individual agency has been running its own independent program. How much better it would be to have them working toward one common objective -- to provide the best possible care for each individual chronically ill person by the most efficient mobilization of all available resources. It might be surprising to discover how much could be accomplished by having the present departmental heads, both provincial and municipal, sit down around a conference table at least once every two weeks and thresh out their differences and air their problems. This group should include the following: The Inspector of Hospitals, the Inspector of Welfare Institutions, the Superintendent of Infirmaries, the Administrator of the City Social Service Department, the nurse in charge of the Medical Section of the City Social Service Department, the Social workers in charge of placements at the Vancouver General Hospital and St. Paul's Hospital, and a representative of the V.O.N. nursing service. It would be an achievement in itself to get these people together. Such a policy-making committee could accomplish much. First, a much more effective system of referrals from one agency to another could be effected. There could be a common sharing of information among the various agencies and much unnecessary file and record duplication would be eliminated. Chronically ill individuals needing social assistance would have their eligibility for social assistance determined only once. The medical social workers

(1) Such a body did function for a short time but was disbanded during the war.
in the hospital would cease to be mere placement officers and would not have so much of their time taken up with determining financial eligibility for different types of care. Some method could be devised whereby there would be one statistician to do the vast amount of statistical work necessary. A much closer relationship between the Provincial Infirmaries and the other agencies would develop and in time these agencies would come to realize why the Infirmary has to give preference to provincial rather than municipal cases. Some understanding of each others problems and limitations would be bound to have a salutory effect. Most important of all, the chronically ill would take on the identities of individuals and cease to be just cases with names and numbers. An inter-departmental committee such as this could work out some form of treatment program with even the present limited resources at their disposal. Mary C. Jarrett found that the same situation existed in Cleveland. She made this recommendation in her study of chronic diseases in that city:

"A community plan for the control and care of chronic illness will be a program of many unrelated parts. It will include many different services for prevention, recovery, rehabilitation and care. It must be planned for children, youth, the middle-aged and the aged. It must be organized on a broad scale, for the total problem of chronic illness is not a series of problems that can be met by one but a complex of interrelated problems that require simultaneous solution."(1)

In addition to the inter-departmental committee described above, a central planning and advisory body is essential as an advisory group to develop and plan a program for the chronically ill as visualized by the

(1) Jarrett, Mary C., Care of the Chronically Ill of Cleveland and Cuyahoga County, Cleveland, The Benjamin Rose Institute, 1944, Page 36.
community as a whole. It should include representatives of the provincial and municipal governments in a consultative capacity, the main body of the group to be made up of representatives from the medical and nursing professions, representatives from the Community Chest and Council, and such organizations as the Family Welfare Bureau, the Victorian Order of Nurses and the Children's Hospital. Most important of all it should have representatives of the non-professional groups such as trade unions, parent-teacher associations, service clubs and other public bodies interested in the problems of the chronically ill. In other words, a good cross section of the community should be represented. This large planning or advisory body could set up sub-committees to study the multiplicity of problems involved, to educate the public, to suggest improvements in standards and scope of existing facilities, and to assist in securing new and improved facilities. An advisory body such as this would justify its existence entirely if it did only one thing -- to delineate just where the responsibilities of the public welfare authorities began and where they ended.

This committee could act as an advisory body to an administrative group set up by either the municipal or preferably, the provincial government to operate the whole program of caring for the chronically ill of Vancouver. A compact organization of four persons, aided by a clerical staff, could go a long way toward by-passing many of the administrative conflicts that at present strangle anything that approaches a workable program. Since chronic illness is primarily a medical field, this administrative group should be headed by a doctor whose duty would be to determine what type of treatment the individual chronically ill person
requires. The second member of the group should be a medical social worker, familiar with the emotional problems of chronic illness, whose function would be to make available the casework services that the chronically ill person often so urgently needs, and to mobilize every available community resource for the effective treatment and care of the individual patient. The medical social worker would also be in a position to protect the interests of the hospital when necessary. The social worker from the City Social Service Department should be the third member of the group and he should be responsible for determining the financial circumstances of every patient in need of financial aid, and should also be the representative of the public welfare services of the province in general. The fourth member of this administrative body should be a public health nurse, responsible for visiting nurse services, visiting homemaker services as well as for the supervision and allocation of all available nursing-home and boarding-home facilities. To this administrative group should be referred every chronically ill person admitted to an acute hospital, every chronically ill person in need of some form of institutional care and every person known to be suffering from a chronic disease, irrespective of his financial circumstances. A system of referrals from private physician, public health nurses and every social agency in the city would have to be developed.

Obviously the setting up of such an administrative group will not work unless the agencies already involved in the problem can be persuaded to give up some of their jealously guarded prerogatives and privileges. But it is only by working together and by integrating and co-ordinating every resource of the community that the care of the chronically ill will cease to be a major problem.
Chapter VII

The Social Worker and the Chronically Ill

In the implementation of a program for the care of the chronically ill, the trained and skilled social worker plays an important part. Adequate medical service, proper institutional care and an administrative structure designed to meet the needs of the chronically ill person will be inoperable unless some attempt is made to interpret these resources so that the individual in need of them can appreciate their purpose. This is the point at which the social worker plays an important role. The inclusion of the social worker in the team of doctor, nurse and hospital administrators makes it possible to treat the person with a chronic ailment as an individual, so that his needs can be considered, his cooperation in treatment won and his morale bolstered. The Saskatchewan Inter-Departmental Co-ordinating Committee in its recommendations for the care of the chronically ill and aged of that province, regarded the establishment of adequate medical social services as a basic pre-requisite to the development of any program designed to meet the needs of the chronically ill. (1)

As a result of studies made in various cities in the United States, Mary C. Jarrett came to the conclusion that the medical social worker was the key to any community program for the care of the chronically ill.

(1) Care of the Chronically Ill and Aged, Proposed Recommendations; Inter-departmental Co-ordinating Committee, Government of the Province of Saskatchewan, September, 1948. Page 1.
ill. Her observations can be paraphrased in this way:

"In view of the fact that chronic diseases all involve medical, social and economic factors, the care of the chronic sick must include adequate social casework services as well as suitable medical and nursing service. The special treatment facilities required for patients are often determined as much by their social as by their medical needs, and the proper allocation of patients to one or the other of the available institutional or agency services depends upon the judgement of the trained social caseworker as well as upon that of the physician. The services of the trained social caseworker are valuable in assisting the patient in the early stages of a chronic condition to carry out the medical plan and care which will contribute to his recovery if he remains at home, or in arranging for his return to the community, if he requires institutional care for a limited period only." (1)

Unfortunately there is still too great a tendency to lump the aged, incurables, and the chronically ill into a special category, about whom not much is known and for whom social casework services are considered inapplicable. Social workers themselves have not always realized that the social adjustment problems of the chronically ill are great and in need of constant attention and understanding. A large part of the public welfare worker's caseload is made up of chronically ill people, but few public welfare workers have analyzed these cases carefully to find out exactly why most of these chronically ill people continue to be problem cases year after year and why their medical treatment does not alleviate the client's condition. The emotional components of chronic disease are far-reaching.

By the same token, the provision of case work services for the chronically ill is particularly challenging. The chronically ill person

demands much more intensive casework than the average family or acute hospital case. The contacts with the case may be for long periods stretching over many years, and work with the family of the chronically ill person will be as essential as the work with the chronically ill individual himself. The social and economic problems that arise as a result of chronic disease require skill and resources to be by-passed or overcome.

In a family or child welfare case, the caseworker gets satisfaction and keeps up interest in the case from some visible signs that progress is being made. Working with the chronically ill, the caseworker must be prepared to wait for long periods of time before any response to the caseworker's ministrations becomes evident; indeed, no visible improvement, despite the most diligent utilization of case work skills, may be expected. Plan after plan may be rejected, the client may show indifference and even violent hostility, and the worker may have continual feelings of frustration because of the absence of community resources for the adequate care of the chronically ill. Nevertheless the caseworker can gain great satisfaction from the immediate response and appreciation which some of the chronically ill show toward anyone who is genuinely interested in their welfare and the solution of their problems. The families and dependents of the chronically ill readily respond to and accept any services which are offered to them.

Only recently have studies been made into the emotional implications of chronic disease and the effect of a proper mental attitude upon the treatment and care of the disease itself. The emotional component is now regarded as a definite syndrome of the disease's nature. It has been definitely proven that a flare-up or recurrence of a
chronically ill patient's acute symptoms can be linked in every case to an environmental or family relationship difficulty. Dr. Boas emphasized this point very strongly in all of his writings and he says:

"Chronic illness has so profound an effect upon the patient's external life, upon his career, on his occupation, his economic status, his amusements, his hobbies, on his family relationships, on his habits of eating, drinking, sleeping and social intercourse, that he is often overwhelmed by the necessary readjustment of his mode of living." (1)

Casework Services Available

In the main, any caseworker services that have been directed toward the solution of some of the problems encountered by the chronically ill have been provided by the limited number of medical social workers in the Vancouver General Hospital and to a much lesser extent by the social worker-investigators of the City Social Service Department. In both cases any services provided are a by-product of the worker's individual interest in particular cases rather than the setting up of special organizations or agencies to serve the chronically ill. For several years there has been a medical social worker on the staff of the Children's Hospital but few of her efforts are specially directed toward the provision of casework services for the chronically ill child and his parents. It must be clearly recognized, however, that the extremely limited number of social workers is the biggest handicap to improved service in this field in practically every hospital.

The Vancouver General Hospital has appointed one social worker to be responsible for Glen and Grandview hospitals, and to provide some of the casework services required by the patients in these institutions,

but her time is so taken up with arranging accommodation for patients in the nursing homes, and with doing routine statistical work, that she spends very little time actually with the patients and knows many of their families only by the sound of their voices over the telephone. The other social workers in the hospital divide their time between the Outpatients' Department and the acute wards of the hospital. Part of their time is spent determining applicants' eligibility for treatment at the Outpatients' Department.

In the same way the largest proportion of the City Social Service worker's time is spent doing semi-clerical work - filling out forms and making routine investigations into the financial eligibility for some form of financial assistance, leaving very little time for the provision of casework services. The City Social Service worker, because of his extremely heavy caseload, picks out about a dozen special cases which he considers he can help. He gives them special attention and attempts to provide extra services for them. Almost invariably these are cases with children, with special problems (such as epileptics) or with young people having a personal appeal to the worker. The older, chronically ill person or the old age pensioner sees the social worker only when a routine visit is made to determine continuing eligibility at regular six-month or yearly intervals. It is inconceivable that very many emotional problems will come to the worker's attention in a half hour interview every six months or so. A worker may not even be aware of the fact that most of his social assistance cases are chronically ill people. When a social worker finds a client is too sick to carry on in the home any longer, he reports the fact to the Medical Section of the Department or
he may recommend that the client see a doctor immediately or apply for treatment at the Outpatients' Department. From this point on the worker ceases to be responsible for following up the case to see what treatment was provided.

For the patients in the boarding homes and nursing homes, other than Glen or Grandview Hospitals, the nurses in the Medical Section of the City Social Service Department or the district worker who pays a monthly visit to deliver comfort-allowance cheques are the only contacts that they have with social service facilities.

The Marpole Infirmary and its subsidiaries have no provision for a social caseworker to provide services for the chronically ill of these institutions. Actually the Superintendent functions as a social worker in that she maintains an unusual personal interest in every patient and is constantly available for consultation with the patients and their families when needed.

Within the past year a one-person social service department has been set up at St. Paul's Hospital to assist in placing the chronically ill in boarding homes and nursing homes and to provide casework services wherever the doctor considers it to be necessary.

Some of the clients of the Family Welfare Bureau are chronically ill people. Casework services as well as a visiting homemaker service for families with children are made available to a limited number of chronically ill in the home by this agency. Each of the Children's Aid Societies carry several cases in which children have been placed in a foster home because of the chronic illness of a parent or of the children themselves.
On the whole, the casework services that are available to the chronically ill are very dispersed, terribly inadequate, and limited in scope and application. Any casework services that have been made available for the chronically ill person have come from a variety of unco-ordinated sources with no defined course of action or planned purpose. Actually the chronically ill have never been identified as individuals and marked out for special attention. The need of the chronically ill for special services and special appreciation of their problems has yet to be acknowledged.

The Vancouver General Hospital Social Service Department

In 1937 the Social Service Department of the Vancouver General Hospital was set up as a separate department of the hospital with a budget of its own. Since that time the numbers of qualified social workers, have been steadily increased until the staff now consists of a director, a casework supervisor and six graduate workers. Five of the workers, including the casework supervisor, have their offices in the Outpatients' Department and the remainder have their offices in the main building of the hospital. The duties of these workers are many and varied so that only those that bring the worker in contact with the chronically ill person will be discussed.

Four of the social workers divide their time between the clinics of the Outpatients' Department and the two or more wards in the main hospital for which they are responsible. Until recently the practice has been for every new admission to the Outpatients' Department to be interviewed and, if possible, every staff patient on the wards to be seen by the social worker. Non-staff patients are interviewed only on the
request of the patient himself through the head nurse of the ward. Unfortunately, many of the doctors at the hospital regard the social workers as little more than placement officers to whom they turn only when they cannot make their own arrangements for the discharge of a patient to a nursing home or to the patient's own home. Referrals by doctors of non-staff patients to social workers for casework services are fewer than they should be. Constant interpretation of available services to the doctors is the only way in which this can be overcome. Some of the social workers are not too happy about having to see staff patients on the assumption that because they are staff patients they automatically have problems that people in the Private Ward Pavilion or the Semi-Private Pavilion never have. There are remarkably few requests from doctors for chronically ill patients in the Private Ward Pavilion to be seen by the social workers. This seems to indicate that the doctors do not know what services, other than arranging alternative accommodation for their patients, can be provided by the social workers.

Again, there seems to be a greater devotion of such time as the social workers have to give casework services, to the younger and in a sense more appealing patient. The old chronically ill person from the "skid road" or the "East End" for whom nobody thinks anything can be done comes off second best. It must be emphasized, however, that the social worker's period of contact with the patient is very brief -- sometimes only a few days, and the social worker naturally likes to concentrate on those cases for which the most can be done in a short space of time and to help those who most readily respond to her interest and services. The older chronically ill person has probably had some
unpleasant memories about another kind of social worker that he met during the depression in the relief line-ups. He takes a lot longer to accept the services offered by the social worker and does so with suspicion.

These same workers must spend at least half of their time in the Outpatients' Department interviewing patients there and determining the eligibility of new applicants. The social workers must spend a considerable time approving applications for glasses and surgical appliances. The worker has to determine the resources of the family and to decide whether they could pay for their own or not. It appears that some of this work could be done by a trained clerk. One worker stated that she had been so busy in the Outpatients' Department that she had only been able to get up to her wards and visit her patients once in the previous week. All of this points to one thing; that the social worker has little time to do real casework. When she does, she naturally concentrates on those patients that will most readily accept her services and stand to gain most from her plans and arrangements. A great deal of interpretation is still needed to convince the doctors that the social worker has a function, especially with chronically ill patients, other than to provide alternative accommodation. (1)

Another fault of the present arrangement at the Vancouver General Hospital is that because of lack of sufficient time, and too few

(1) What casework services are provided are of an exceptionally high quality but the social worker's services are so divided and the demands upon her limited time so great, that what she does do is negated by what she can not do.
workers, very few cases are followed up outside of the hospital or Outpatients' Department.

The caseworker is handicapped when she sees only the patient and not the family; she is equally handicapped when she sees the patient only in the hospital setting and not in his natural environment. Most of the visiting of patients in the home is done by student trainees. An adequate social casework service for the chronically ill should take in the home and family of the chronically ill person and not be limited to the confines of the institutional setting. If the patient is referred to the City Social Service Department or to a private agency, such as the Family Welfare Bureau, there is no follow up unless the patient is reporting back to the Outpatients' Department. As the Social Work Department of the Vancouver General Hospital is now operating, the chronically ill person in one of the acute wards or attending the Outpatients' Department is not getting casework services adequate to his or her needs due to the unnecessary demands upon the caseworker's time and services in other administrative fields where casework skills are not a necessity.

There is one full-time medical social worker from the Vancouver General Hospital responsible for the 140 patients in Glen and Grandview Hospitals. All arrangements for transfers and admissions are arranged by this one worker. When the doctor decides that a patient in one of these institutions can manage in a boarding home or in the patient's own home, it is the responsibility of the worker to arrange this placement. The social worker has had to spend most of her time arranging placements rather than doing social casework.
The worker's services to the patients in the two institutions are seriously curtailed by a single geographic fact -- that the hospital and the two nursing homes are about three miles apart. Because of this, the worker is only able to visit each institution two afternoons a week. Everything that must be done, every interview that she must have with the individual patients, and every discussion that she has with the doctors and nursing staff about the patients must be accomplished in the two afternoons. The social worker accompanies the doctor on ward rounds and with the time that she has left, she must try to squeeze in her interviews with the individual patients. She is very fortunate if she can see ten patients for any length of time during one afternoon. There are so many patients and so little time that the caseworker has very little time to devote to the individual problems of most of the patients. Most of her work has to deal with "problem cases", patients who will not cooperate with the staff, patients who are not satisfied with the treatment that they receive, patients whose relatives demand special care or attention for them; patients who have become senile and difficult to handle in the institution, and patients who do not need nursing-home care any longer but refuse to go to a boarding home; the docile co-operative patient who may have many problems but does not let anyone know about them gets a minimum of attention from the caseworker.

This separation of the two institutions has another bad effect. The social worker finds it very difficult to see the relatives and friends of the patients because they are seldom at the institutions at the same time. If the social worker wants to see a patient's relatives or family, she must arrange for them to visit on one of the afternoons
that she is in the institutions or have them come to the hospital to see her. At the same time that the medical social worker is working with a patient, another social worker from the City Social Service Department may be seeing the same patient and seeing the same relatives to determine the patient's eligibility for social assistance. Most of the patients' relatives and families are known to the medical social worker only over the telephone. The remainder of the social worker's time is spent in the main office of the hospital social service department doing the large amount of routine clerical and statistical work for which she is responsible. Every patient that is considered eligible for admission to the Marpole Infirmary must have a detailed social history written up by this worker. The financial circumstances of every patient transferred to Glen or Grandview Hospitals or to Heather Street Annex from the hospital must be fully investigated and checked. If the case is eligible for social assistance, it must be referred to the City Social Service Department and a summary of the hospital's contact written up for them.

The hospital is fortunate in having an extremely competent and conscientious worker doing this job. She takes a great interest in the patients and is keenly aware of the inadequacies of the two institutions which she visits. She does a great deal of extra work on behalf of the patients and tries to do the most that she can for the patients despite the sheer physical limits. Experienced and knowledgeable as this worker is in the economic problems of the chronic invalid and the emotional aspects of chronic illness, the situation makes it impossible for her to give the best services where they are professionally needed, or where they would be of the best advantage to the hospital.
The social worker providing casework services to the chronically ill persons in the two subsidiary hospitals is doing an excellent job but the physical location of the hospitals prevents the chronically ill from receiving the services that they need.

The medical social worker visiting these institutions is not in the best position to arrange for a definite treatment program for the chronically ill person. She is under constant pressure by the hospital authorities to discharge patients from the two institutions as fast as possible so as to allow for more transfers of chronic patients from acute beds in the Vancouver General Hospital. Almost as soon as any patient in one of the two subsidiary hospitals shows any sign of improvement, he or she is discharged to make way for another case in more urgent need of the bed. This has an unfortunate repercussion since the patients in the two institutions, as well as the doctors in the hospital, come to consider that the social worker's only purpose is as a placement officer (1).

The problem of providing adequate social casework services for the chronically ill in the Vancouver General Hospital is not confined to that institution alone. The same situation exists in every general hospital in Canada and the United States. Dr. Boas made a statement about the situation in New York that is all too readily applicable to Vancouver:

"Social workers in hospitals are engaged in admitting patients, in determining how much they should pay for their hospital care, acting as clinic clerks or as administrators. They give relief to families, one of whose members is in hospital; they shuttle patients from hospital to convalescent home, or to a custodial institution for the chronic sick, but

(1) The writer has known several patients to break into tears when he approached them to speak to them because they were afraid that they would be moved. "Social worker" merely means the "placement officer" to them. With this unfortunate concept in the patient's mind the handicaps for casework are obvious.
rarely do they work out in cooperation with the physician a well thought out plan for the rehabilitation of the patient, with their employment of their knowledge of the social, economic and emotional factors that condition sickness."(1)

This situation will not change unless hospital administrators and doctors realize that the social worker has a great deal to offer and can make a great number of resources available in the drawing up of a plan of treatment for the individual chronically ill person. At present, due to the extreme shortage of beds, a hospital is much too commonly a huge machine into which the patients enter, lose their identities for a while, receive treatment almost on a mass production basis, and, after they are discharged (providing they have paid their bill) cease to be any concern of the hospital. In such institutions the social worker is regarded as just another part of the machinery to hasten the discharge of the patient. An interpretation program is needed if doctors themselves are not to act, unwillingly or otherwise, as if they are the only professional persons who can solve the patients' problems, and to prescribe treatment on the basis that chronic disease is solely a medical problem.

In an ideal system the social worker would be called in on a consultative basis on every case that was diagnosed as a chronic ailment and the physician would call upon a social worker, without hesitation or need of interpretation, for environmental and family circumstance information which might have some bearing on the patient's condition. From the time that that patient was diagnosed as having a chronic complaint, the social worker and doctor could and should work together toward the formulation of a plan of treatment and care that would serve the best

interests of the patient rather than be the most convenient disposition of the case for the doctor, social worker and institution concerned. The needs of the patient must always come first despite the apparent limitation of community services available for the care of that patient. The social worker should be employed as the skilled technician that she is, not as a clerk or a receptionist. To make such a program possible there must be at least one medical social worker to every ten doctors, not one to every fifty as there is now. Several prominent specialists in hospital administration, after concluding a comprehensive survey of hospitals in the United States, recommended the employment of medical social workers for these purposes:

A constant educational program must be carried on to make every doctor aware of the fact that social casework services can help him in his treatment of that patient's illness. It is the primary function of the medical social worker to provide the physician with adequate information concerning the patient's socio-economic status and environment and to interpret to the patient such terms of the physician's advice and instructions as may be required and helpful to the alleviation of his condition.\(^1\)

**A Newly Instituted Social Work Service**

The Social Service Department of St. Paul's Hospital has only been in operation for a few months and it is of course intended to apply to others besides the chronically ill patients occupying acute beds in this hospital. But there is already evidence that this new social service department has been able to profit from the Vancouver General Hospital's experience. There has been no attempt to do a sudden and spectacular

\(^1\) The Commission on Hospital Care, *Hospital Care in the United States*, The Commonwealth Fund, New York, 1947, Page 108. Recommendation No. 94.
job or convert doctors overnight to the view that a social service
department can solve all of their problems. A very definite policy of
never contacting a patient without the consent of the doctor or unless
at the request of the patient or the patients' relatives has been worked
out with excellent success.

Because St. Paul's Hospital is a private hospital which has
only twenty-five staff beds, it does not have the same problems as the
Vancouver General Hospital in finding alternative accommodation for large
numbers of indigent chronically ill persons. The number of cases that
have needed the services of the social worker has been small; and some
excellent, intensive work has been done. There is not so much pressure
upon the worker to have the patients moved out as quickly as possible.
The worker and the doctor have time to work out with the patient a plan
of treatment and care that best suits the needs of the patient.

Because of the small scale of this department's operations and
responsibilities, its efforts will not influence the total program for
Vancouver to any great extent but it might well become a model of what
the function of a hospital social service department should be or could be.

The Need For a Trained Social Worker in the Provincial Infirmaries

The patients in the Marpole Infirmary or one of its subsidiaries
have no casework services available to them at the present time except
the services that are provided by the Superintendent, who is a nurse not
a social worker. It has been assumed that a patient ceases to need the
services of a social worker upon entry into one of the institutions. By
some magic process, admission to the Infirmary is supposed to solve all
of his problems and to cure all of his troubles. In talking to many of the
patients this was found to be a fallacy.

The Superintendent and her staff are very busy people, and much as they would like to, it is impossible for them to become aware of difficulties encountered by individual patients in adjusting to institutional life and disturbed family relationships and incidents, both inside and outside of the Infirmary, that are emotionally upsetting to the patient.

The social histories that accompany the patients to the institution are very meager and uninformative. It is only by having a social worker at the Infirmary to do an interpretation job to the workers in the different municipalities that the Infirmary staff and the Infirmary doctor can fully understand the background of the patients physical condition. A social worker is needed to interpret the patient's background to the doctor but most important of all the social worker is needed to interpret the services and facilities of the institutions to the workers who are trying to get their clients admitted to the Infirmary. It is quite amazing some of the queer ideas that social workers in the various social agencies throughout the province have about the Infirmary. (1)

The Provincial Government has been slow in recognizing the need for a social caseworker in the Infirmaries and it is to be hoped that it will soon see its way clear to provide such services for the more than 230 patients in the three institutions. An excellent treatment program for the chronically ill has been developed at the Infirmaries but social casework services are needed to round out the program.

(1) Harvey, Isobel; Study of Chronic Diseases in British Columbia, A Report Prepared For the Minister of Health and Welfare, Province of British Columbia, March 27, 1946(typescript)
Casework Services For Patients In A Chronic Hospital

In the not-too-distant future it is hoped that Vancouver will have a chronic hospital with a capacity of at least five hundred beds. If such an institution does come into existence, it is essential that medical social workers should participate in the planning and organization of such an institution. In a chronic hospital it is to be desired that the social service department will not be relegated to the position of an auxiliary service but it will be accepted by the doctors and hospital administrative staff as a separate treatment organ of the hospital, helping the other hospital services to function at maximum efficiency. A ratio of one social worker for every five hundred admissions to the chronic disease hospital is considered to be the extreme minimum social work staff that should be available in a chronic hospital.

The duties of a social worker in a chronic hospital can be briefly summarized in this way: (1) to interview every patient when admitted or shortly afterward, and, with the aid of the patient, his relatives, and other agencies to prepare a complete social history for the doctor, (2) to use this information to interpret the patient's environmental and family background to the doctor, (3) to make the doctor aware of any emotional factors that have, or are likely to have, some influence on the patient's condition, (4) to keep in close touch with the patient's family and friends, (5) to arrange for nursing-home or boarding-home accommodation when the patient no longer needs to remain in the chronic hospital for treatment, (6) to provide casework services.

for the patient and the patient's family after his discharge from hospital, and (7) to mobilize and use outside community resources for the provision of the best possible care for each individual chronically ill patient.

Inter-Agency Referrals And Co-operation

In no other sphere can the social worker prove his worth more than in the utilization of the resources and services of other social agencies in the community. A good medical social service department could not and should not attempt to meet every need of the chronically ill but it should know where it could refer the patient for these services. A medical social service department should not attempt to be a Children's Aid, a Family Welfare Bureau and a Public Welfare Agency, and a Hospital Social Service Department all rolled into one. It should provide complementary services which are available when others are lacking. Social services for the chronically ill should not be the exclusive preserve of the medical social workers serving a chronic institution but should represent the combined efforts of every social agency in the community.

The impression should never be gained that it is only the lower income groups, that form such a large part of many agencies' clientele, that are eligible for casework services. Social casework services of the community should be available to every chronically ill person as a right that accompanies that same person's right to the best medical and treatment services that are available. It will take a great deal of interpretation and education to make the chronically ill aware of and desirous of the services of the caseworker and to encourage that same patient to seek help and guidance from a social worker as readily as he
or she would go to a doctor. Unfortunately the defeatist attitude - what could a social worker do for me? - is all too prevalent and most people never come near a social agency if they can avoid it.

It is only by the most judicious referral and follow-up of every case that a continuous casework relationship can be provided for the chronically ill. It does not do the person who has been chronically ill for twenty years much good to only see the social caseworker when he is admitted to hospital, when he has to apply for social assistance or when he needs to be admitted to a custodial institution. Social casework to these individuals should be a continuing service, not just something that he is provided with at infrequent intervals. The chronically ill person needs to be made aware that the social caseworker is always available and is interested in his progress and circumstances even when he does not need medical or institutional care.

It is not enough to refer a case to another agency and then, assuming that that agency is handling it, forget the case until it appears again back at the original referring agency. Case after case that was examined showed this lack of continuation of service. One social worker might work out a plan or course of action to better the circumstances of the patient and then something intervened - the patient was admitted to hospital, the patient moved to another district or the caseworker was transferred. Probably the next worker did not take the same interest in the case and either the patient stopped coming to the agency for help or the case was closed or dismissed by the worker as one for which there was nothing that could be done. Coupled with a complete lack of realization of just what the implications of this piecemeal casework service were to
the chronically ill person was the conveying of the idea to the client that this was just one more person who considered his condition hopeless, incurable and impossible to alleviate.

The medical social workers in the hospitals cannot visit every chronically ill person that is discharged from the hospital or to refer every case that they consider needs continuing casework services to another agency. At the same time, the agencies to whom the cases are referred should not be made to feel that every case that they receive from the hospital social service department is one for which the hospital thinks it can do nothing or a case which the hospital social workers have not the time to work with. A clear-cut policy has to be worked out to facilitate proper inter-agency referrals which are to the best advantage of the patient, rather than to the best advantage of the agencies concerned. In other words, a chronically ill person in need of casework services should not be referred to a social agency merely because the social worker is unable or incapable of doing anything more for that patient, but because that agency is best able and qualified to meet that patient's needs.

One social worker in one social agency can do little to help solve the problem of what can be done for the chronically ill, but that one social worker, working in collaboration with every other social worker and agency in the city, can do a great deal toward making the life of the individual chronic invalid more livable.

The Mobilization of Community Resources

The social worker can be invaluable in the organization and implementation of a community wide program for the diagnosis, treatment
treatment and proper care of the chronically ill. Only the social worker is able to make community resources and community services available to the doctor and institution as part of the patient's treatment process.

In Vancouver the plight of the chronically ill would not be nearly so hopeless as it is now, if the social workers coming in contact with these people knew what resources there are available in the community that are never utilized or, if they are utilized, in the wrong manner. The average citizen is completely unaware of the immensity of the problem of caring for the chronically ill. The same people are unaware of the total inadequacy of the accommodation and services that are available for the chronically ill.

A good education campaign needs to be carried out to point out to the tax payer how much he is already spending for the care of the chronically ill and how far short of the minimum requirements existing services fall.

There are thousands of citizens who are interested in providing both money and services toward the alleviation of suffering of other people. A few examples can be cited for illustration. The B.C. Cancer Society finds little difficulty in getting the public to contribute toward the extension of their services. The B.C. Tuberculosis Society receives contributions from nearly every home in the province. The recent organization of public support for the new Canadian Arthritis and Rheumatism Society is an outstanding example of community organization to benefit one group of the chronically ill. Again, the Women's Auxiliary of the Marpole Infirmary has done a wonderful piece of work in the provision of extra services and facilities in that institution,
without in any way interfering with the provincial government's responsibilities. At present, several women's organizations are becoming interested in the plight of the patients in Glen and Grandview Hospitals. There has even been an offer to form a women's club which will have as its main objective the provision of extras and comforts for the patients in these institutions. All of these examples show that the public is not indifferent to the needs of the chronically ill. Where the social worker and the Community Chest and Council come into the picture is to direct these efforts in the right direction and to utilize them to their full extent.

It is difficult to believe that the public as a whole are aware of the fact that there is absolutely no accommodation for the chronically ill child in existing institutions in Vancouver. The public has been very generous in its support of the Children's Hospital and if it was made aware of the need of a similar chronic or custodial institution there is every possibility that one would be built within a short time. If every social worker and every social agency, along with the Community Chest and Council, were to publicise the need of such an institution, and to compile statistics and case studies proving that need, then it would not be long before something was done.

A great deal of work remains to be done in other directions also. The Social Assistance Act of B.C. lays down no maximum limit to the amount of social assistance that shall be paid to a person in need. Local regulations decree that a single man shall receive a maximum of $35 a month social assistance if he is living in his home. There is a great job of community organization to be done to convince the tax payer that
it is in his best interest and cheaper in the end to provide social assistance to those that need it on the basis of need, not just up to the lowest minimum under which that individual can exist. Until social workers themselves are aware of the deficiencies and stronger in numbers, they may be too enmeshed in day-to-day administration to take the lead in seeking changes and revisions. The interest of the public and social agencies is there, but it needs to be awakened and mobilized. Financial support for any project only follows the expression of this public interest.
Appendix A

Shaughnessy Military Hospital

This military hospital was not included in the main study but this brief description of facilities available there is necessary for the sake of completeness and as a reminder that there are a number of ex-service men in the chronic illness category, even though their disabilities are not directly war-inflicted.

Shaughnessy Military Hospital is maintained entirely by federal funds and cares for veterans from all parts of the province.

Since the opening of the military hospital over twenty years ago, it has been found necessary for the federal government to make some provision for the care of the chronically ill veteran who is suffering from incapacitating disabilities other than those that were war-inflicted. A form of social assistance, known as the War Veteran's Allowance has been made available for the older chronically ill war veteran who is no longer able to work or find employment. This group of veterans is entitled to free medical and hospital care, but their wives and dependents are not.

At the Department of Veteran's Affairs offices in Vancouver, a regular outpatients' department is operated for those patients that need only medicines and general practitioner care. For those requiring active hospital care there are approximately 140 beds for their care in Shaughnessy Military Hospital. Most of the chronically ill patients are concentrated in four main wards. Patients occupying these wards were
suffering from chronic illnesses such as arthritis, arterio-sclerosis, Parkinson's disease and other true chronic diseases and not because of war-inflicted injuries.

When one of these chronic patients ceases to require active medical treatment he is transferred to either Hycroft or the George Derby Health and Occupational Centre. The equivalent of nursing-home care is provided in these institutions. Hycroft has approximately 110 beds available for chronically ill patients. The Derby Convalescent Centre has approximately the same number of beds available for both convalescents and chronically ill veterans.

A visit was made to the four wards which housed 106 of the 139 patients in the chronic categories. Medical care is provided by a city general practitioner who specializes in geriatrics. All of the patients seen appeared to be over the age of sixty-five. As in all veterans' hospitals, the patients were in receipt of every medical necessity that they could use; indeed, some of the equipment that was available for the care of the chronically ill is more expensive and extensive than that available in many acute hospitals. Extensive use is made of occupational therapy and physiotherapy and most interesting of all, the services of the hospital psychiatrist are used extensively. It was quite remarkable to see nearly every patient engaged some craft or hobby and many of the patients earn considerable money in this way.

The wards are operated on a very informal basis and from the conversation of the doctors it was gathered that some of the patients do little more than sleep there. Only about half of the patients were on the wards when the doctor made his ward rounds.
The majority of the patients were completely destitute and the only income that they had, other than their small comforts allowance, was from the sale of the articles that they made.

Shaughnessy Military Hospital is an excellent example of what can be done for the chronically ill when there is no limit to the money that can be spent on them and no limit to the facilities that are made available to them.

**Expanding Demands Upon the City Social Service Department**

The three organizations described in this section are provincial in scope and do not limit their services to the city of Vancouver. They have not been included in the main study because of the special nature of the services they provided.

Within the past few years Vancouver has become the main diagnostic and treatment centre in several fields of medicine for the whole Province of British Columbia. The expansion of facilities at the B.C. Cancer Institute, the recent opening of the Rehabilitation Centre for the Physically Handicapped, and the opening of the new office of the Canadian Arthritis and Rheumatism Society (B.C. Division) have brought hundreds of patients suffering from these diseases to the city for treatment and diagnosis. The city's overtaxed and insufficient boarding-home and nursing-home facilities have been put under still more pressure to provide accommodation for these people.

The B.C. Cancer Institutes' clinic, adjacent to the Vancouver General Hospital, is the only place in the province where the treatment
and diagnosis of cancer is carried out to any great extent. The Rehabilitation Centre for the Physically Handicapped is the only centre of its kind in British Columbia and in Western Canada. Post-polio cases and paraplegics are trained here to become self-sufficient and useful citizens. The B.C. Arthritis and Rheumatism society has recently received a large grant from the provincial government to provide special treatment services for the arthritic. Already several physiotherapists are sent out to visit the chronically ill arthritic in the home. Several acute hospital beds have been made available for the treatment of arthritis. A complete research and treatment centre is planned for the future.

The Cancer Society Social Service Section has worked out an agreement with the City Social Service Department under which that Department has agreed to administer any out-of-town cases, but will assume no financial responsibility or obligation to provide placement for these persons in boarding homes or nursing homes. If the Cancer Society can find boarding-home or nursing-home beds on their own without using any of the beds used by the City Social Service Department, the city has no objection to these out-of-town patients coming into Vancouver. In January, 1949, ten boarding-home placements and six nursing-home placements were made in Vancouver by the social worker at the Cancer Clinic. Patients that are "Vancouver responsibilities" are referred directly to the Medical Section of the City Social Service Department for placement through the normal channels.

At the present time no agreement between the provincial and municipal authorities has been drawn up to determine who shall pay for the treatment of patients at the Rehabilitation Centre. Their present
rates are $180 a month for accommodation with an additional charge of $60 a month for exercises. The City Social Service Department is very reluctant to agree to pay for these patients' care as they do not wish to establish a precedent. If they should agree to pay for the small number of Vancouver cases receiving care there, it would presumably be open to the people suffering from heart disease or arthritis to ask the same consideration. Efforts are now being made to interest the provincial government in paying the full cost of these patients' care with the City Social Service administering the cases.

If a research and treatment centre is built in Vancouver by the Canadian Arthritis and Rheumatism Society, additional boarding-home and nursing-home facilities will again have to be provided. The case studies made by the Society show that hundreds of arthritic persons are living in homes, rooming houses and hotels where they receive very little care or attention. Many of these cases are in urgent need of institutional care. It is impossible to estimate how many thousands of arthritics could have been prevented from becoming terribly deformed and crippled by treatment in a chronic hospital.

Soon there will be special centres for treating heart disease, as there is in the United States. As Vancouver expands, so will the number of treatment and diagnostic centres. The opening of the medical school at the University will give impetus to this program.
Appendix B
Table J

Period of Hospitalization of Chronic Patients
Marpole Infirmary, Vancouver, February 1, 1949.

<table>
<thead>
<tr>
<th>Period</th>
<th>No.</th>
<th>Period</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within present year</td>
<td>4</td>
<td>5 - 10 years</td>
<td>35</td>
</tr>
<tr>
<td>One year</td>
<td>19</td>
<td>10 - 15 years</td>
<td>24</td>
</tr>
<tr>
<td>Two years</td>
<td>13</td>
<td>Over 20 years</td>
<td>6</td>
</tr>
<tr>
<td>Three years</td>
<td>15</td>
<td>Total /</td>
<td>126</td>
</tr>
<tr>
<td>Four years</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

/ Computed from year of admission on record cards.
Table K

Types of Patients in Marpole Infirmary

Vancouver: February 1, 1949.

<table>
<thead>
<tr>
<th>Classification</th>
<th>No.</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases including the results of encephalitis, V.D., etc.</td>
<td>14</td>
<td>11.1</td>
</tr>
<tr>
<td>Diseases of metabolism and deficiency</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Tumors—benign and malignant</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>1</td>
<td>.8</td>
</tr>
<tr>
<td>Injuries – fractures etc.</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>13</td>
<td>10.2</td>
</tr>
<tr>
<td>Diseases of the blood</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Diseases of the nervous system Parkinsonism paraplegia, hemiplegia, etc.</td>
<td>40</td>
<td>31.6</td>
</tr>
<tr>
<td>Diseases of the bones, joints, muscles, etc. arthritis, osteomyelitis, etc.</td>
<td>28</td>
<td>14.1</td>
</tr>
<tr>
<td>Diseases and injuries of the eye, ear, nose, and throat</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Diseases of the genito-urinary system</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Degenerative changes associated with old age.</td>
<td>11</td>
<td>8.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>126</td>
<td>100.00</td>
</tr>
</tbody>
</table>
### Table L

**Age Distribution of Patients in Glen, Grandview and Heather Street Annex Hospitals**

<table>
<thead>
<tr>
<th>Age</th>
<th>Glen</th>
<th>Grandview</th>
<th>H.S.A.</th>
<th>No.</th>
<th>Total</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>40 - 49</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>50 - 59</td>
<td>8</td>
<td>9</td>
<td>2</td>
<td>19</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>60 - 69</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>31</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>70 - 79</td>
<td>24</td>
<td>20</td>
<td>21</td>
<td>65</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>80 - 89</td>
<td>17</td>
<td>18</td>
<td>14</td>
<td>49</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>90 and over</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>195</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>60</td>
<td>56</td>
<td>195</td>
<td>195</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table M

Types of Patients in Glen, Grandview and Heather Street Annex Hospitals

<table>
<thead>
<tr>
<th>Classification</th>
<th>Glen</th>
<th>Grandview</th>
<th>H.S.A.</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious &amp; parasitic disease results including V.D., encephalitis, etc.</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>9</td>
<td>4.6</td>
</tr>
<tr>
<td>Diseases of metabolism &amp; deficiency</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>3.6</td>
</tr>
<tr>
<td>Injuries, fractures etc.</td>
<td>16</td>
<td>7</td>
<td>2</td>
<td>25</td>
<td>12.9</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>13</td>
<td>18</td>
<td>10</td>
<td>41</td>
<td>21.0</td>
</tr>
<tr>
<td>Tumors - benign &amp; malignant</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>17</td>
<td>8.9</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>33</td>
<td>16.9</td>
</tr>
<tr>
<td>Diseases of the bones, joints, muscles</td>
<td>13</td>
<td>4</td>
<td>3</td>
<td>20</td>
<td>10.2</td>
</tr>
<tr>
<td>Diseases of the gastro-intestinal tract</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Diseases of the genito-urinary system</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>3.1</td>
</tr>
<tr>
<td>Degenerative diseases associated with old age (senility)</td>
<td>1</td>
<td>9</td>
<td>14</td>
<td>24</td>
<td>12.3</td>
</tr>
<tr>
<td>Diseases of the skin</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Undefined and unclassified</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>60</td>
<td>56</td>
<td>195</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Appendix C

Books and Surveys


12. Institutional Care for the Chronically Ill of Class "C" in New York, Welfare Council of New York, November, 1939, The Report of the Joint Committee on Institutional Care of the Chronically Ill of Committee on Chronic Illness and Section on the Care of the aged.


22. Province of British Columbia, *Statistics and Administration of the Welfare Institutions Licensing Act* for the year ending December 31, 1947, Department of the Provincial Secretary, Victoria, B.C., King's Printer.


24. Resources Manual, Section II, Social Assistance Branch, Department of the Provincial Secretary, December, 1945.

26. Special Committee of Montreal Social Workers (Mrs. M.A. Lanthier, chairman) *The Care of the Chronically Ill in Montreal*, Metropolitan Life Insurance Company, Canadian Head Office, Ottawa, 1941.

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