THE SOCIAL WORKER IN THE TREATMENT TEAM

An examination of representative cases in the Vancouver General Hospital Out Patient Department.

by

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ABSTRACT

The social worker in the treatment team is a phrase that is heard often today. In this age of scientific specialization, no one person can possibly utilize all the available knowledge required for health and welfare. Medicine, like all the other applied sciences, has developed so rapidly that theories change from day to day. Through all this exciting and revolutionary change, the person who is sick is often forgotten. The patient is often referred to as a peptic ulcer or a tumour.

At this present stage, there has been a rather interesting development. Medical scientists have suddenly realized that there is a definite relation between the mind and the body in sickness. There is, therefore, a need for a specialist who has skills in the treatment of social and emotional problems. It is in this area that the social worker lends her skills to the treatment team. Treatment no longer is complete with relief from pain and the physical discomfort; it must also be a relief from fear of financial insecurity, environmental problems, personality maladjustments and emotional frustration.

This study is an attempt to show where the social worker can be of value in the medical setting. Social work in the Vancouver General Hospital is still infantile in its development and it is hoped this study will be of some help in defining the function of the social worker. The lack of real casework services made the selection of cases very difficult. The cases used were, for the most part, done by students. The ten cases which were used were considered good examples of social work in the hospital setting.
DEDICATION

This thesis is dedicated to Miss Eleanor Bradley, casework supervisor in the Social Service Department of the Vancouver General Hospital. The inspiration and encouragement she gave is gratefully appreciated. I wish to express my gratitude also to Dr. Leonard C. Marsh for his assistance in criticizing and evaluating the research material.

(Miss) Mary Frew Bowkett.
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CHAPTER I

MEDICAL SOCIAL WORK
The primary function of a hospital is the care of the patients. The manner of their organization and the efforts of all their administrative, professional and service personnel are directed toward the provision of medical care to combat illness. The patient is the focal point about which all activities of the hospital revolve. (1).

Medicine today is an exceedingly complicated and costly service. Billions of dollars are spent each year in public health and medical care. The rapid growth of governmental medical services has brought about a need for accurate thinking in the basic elements of complete medical care programs and standards of adequate quality of care. Hospitals no longer provide custodial care for the sick; instead they are medical centers for the whole community; providing a constellation of highly specialized and scientific facilities for all people.

The modern practice of medicine is characterized by the exercise of teamwork, the doctor assumes the role of the leader and the other professional personnel associate with him. The medical social worker contributes to this teamwork process by the practice of social casework. Complete medical care cannot be effective if the patient does not have the desire or the ability to carry out the medical recommendations. The social worker's contribution lies in the understanding of the social and emotional factors which are preventing the effective use of medical services. Environmental problems, economic deprivation or medical misunderstanding may be contributing toward the patient's illness or the duration of a disability. Knowledge of emotional behaviour in illness, the understanding of medical science and practice, the acceptance of the patient as a whole organism and the knowledge of community resources are all basic to the role of the medical social worker in the treatment team.

(1) Commission on Hospital Care, Hospital Care in the United States, The Commonwealth Fund, New York, 1947, p. 66.
The professional social worker in the hospital team has been a development of the late 19th and early 20th centuries. Medical social work before this time was an unorganized lay service; stemming from the philosophy of responsibility toward one's fellow man. The tremendous advances in medical knowledge made a division of tasks necessary for complete medical care. This increasing specialization; the realization that illness was both emotional and organic was an influence in necessitating the need for a specialist in dealing with the social and personality problems in illness.

MEDICAL SOCIAL WORK BEFORE THE 20th CENTURY

Medical social work had its beginnings in the rise of the Christian Churches. The philosophy of the churches was based upon the obligation and responsibility of people to their fellow men. An example of this philosophy was evident in the 17th century in the work of St. Vincent de Paul. This famous man is considered to be one of the fathers of present day social work. St. Vincent de Paul was responsible for organizing a group of nurses within the church for the purpose of visiting the sick. This service may be presumed as a primitive beginning for both medical social work or public health nursing.

By the late 18th century, lady almoners had become a common part of the English hospital organization. The almoners sought to comfort the patients in the hospitals by caring in informal ways for their economic problems. The inception of lady almoners into hospitals was primarily for the purpose of establishing eligibility for free medical care. Hospital administrators of that time found the eligibility studies were tedious and time consuming; the need for personnel for this type of work therefore introduced the lady almoner to the hospital staff. Lady almoners attained a more responsible position in hospitals in 1890 through the influence of Charles S. Loch who was then Secretary of the London Charity
Organization Society. With this new position of influence, the lady almoner was assigned the responsibility of bringing the resources of the community to the patients in need in the hospitals. This stage of development was an important precursor of modern professional social work.

There was also a form of social work developing in the hospitals for the insane in England. This was an entirely voluntary organization known as the Society for After Care of Poor Persons Discharged Recovered from Insane Asylums. Their services were concerned with the placement of patients either in foster homes or convalescent institutions or guiding the adjustment of patients back into the community.

The development of the nursing profession has had an important influence upon origination of medical social work. The primary function of the nurse is of course the rendering of medical care. However, nurses have also given help to patients with their social and emotional problems. The nurse has played a significant part in the unorganized services to patients by being constantly at the bedside during periods of pain and anxiety or visiting the home while the patient was becoming rehabilitated.

The training of medical students has also been an instrumental in the formation of the profession of medical social work. The first example of instruction in medical social work for student doctors was instituted by the Medical School of Johns Hopkins University in Baltimore, Maryland. Dr. Charles P. Emerson, the Director of the hospital included training not only in the classroom, but in field work experience as well. The students worked through the Charity Organization Society of Baltimore. Each student was assigned a certain number of families and they were charged to "learn the intimate relationship between the ills of the physical body and the home environment. (2)."

From these early unorganized services, the modern profession of medical social work has evolved. The work of these early pioneers and the increasing awareness of hospital personnel of the social and emotional needs of the patient have been responsible for the introduction of social workers into the hospital. Today, medical social workers provide four main types of services; (1) direct service to patients through casework, (2) indirect service to patients through administration, supervision and consultation, (3) community organization through the organization and co-ordination of resources within communities and (4) teaching. Social workers provide these services in six general areas, (1) municipal, provincial and dominion public health programs, (2) public and private hospitals, (3) professional schools, (4) public and private clinics, (5) municipal, provincial and dominion voluntary health agencies and (6) public and private welfare programs.

INFLUENCE OF THE MAYO CLINIC

The division of tasks was begun by Dr. W.W. Mayo, Sr., and his two sons, William and Charles, when they graduated from medical school in 1890. They each specialized to some extent, the father in obstetrics and gynecology, Dr. William Mayo in abdominal surgery and Dr. Charles Mayo in eye surgery. They consulted on different cases and decided in conference on a plan of treatment for their patients. It was from this beginning that the clinic idea evolved.

Dr. Mayo, Sr., always held as a motto, "No man is big enough to be independent of others". (4) It was this motto that influenced the beginning of the Mayo Clinic. In the embryonic stage, the clinic was involved essentially in surgery. These consultations took place in the back room of a home belonging to Mrs. Carpenter, one of Dr. Mayo Sr.'s patients. Dr. Mayo would advertise a certain operation and all

(3) "A Statement of Standards to be met by Social Service Departments in Hospitals and Clinics", American Association of Medical Social Work, June 1949.
who were interested were invited to attend to discuss and criticize.

The clinic became established in the middle 1890's when St. Mary's Hospital in Rochester was built and staffed by the Sisters of St. Francis. The Mayo doctors were invited to become the attending physicians because of the interest and help they had given during the formation of the hospital. Other partners were added to the staff after this time. With each new member, more facilities were added and greater knowledge was accumulated.

The reorganization and building of the Mayo Clinic was begun in 1914. "It emerged as a distinct institution, a complete clinic, including laboratories, housed under one roof". (5)

Miss Clapsattle, author of the book, "The Doctors Mayo", suggests that teamwork among doctors is the most practical achievement in modern medicine. The Mayo Brothers have been called the fathers of the teamwork process although Dr. William Mayo, Jr. said if they were, they did not know it. He has been quoted as saying, "We merely tried to solve the problems of their overwhelming practice in the way that seemed at the moment most likely to improve their surgery." (6)

The Mayos, at all times, brought in surgeons who would enhance the standards of the clinic. They were never threatened by the fear of having their glory dimmed. They were interested in all phases of research and made special provision to participate in lectures and clinics in all other parts of the continent and Europe. The Mayo Brothers actually managed to retain, in co-operative form, the individualism Dr. William Mayo, Jr., said could no longer exist in medicine.

In actuality, the clinic did not remain a partnership but became a voluntary association that was both a group partnership and a corporation. All the members were on a fixed salary including the Mayo Brothers. The organization was not

essentially a department store type of clinic where there were separate sections for different needs. "Its sections were not independent units, clustered in one building for convenience; they were integral parts of a working whole". (7). There was an insistence on the personal responsibility of the clinician to the patient.

A patient entering the Mayo Clinic with a complaint would be examined by two diagnosticians separately. The diagnosticians would consult to determine the most suitable specialist for the patient. The patient would receive an explanation of the tentative diagnosis and be prepared for transfer. The diagnosticians in consultation with the specialist would make a plan for treatment for the patient. The physicians and patients in this way were assured of exact diagnosis and confidence in treatment. "With growth a measure of specialization developed among the men....the Mayo brothers kept them working in teams none the less, instead of splitting off each into a little pigeonhole of his own - and wisely, because a team can undertake problems of greater magnitude than any one individual alone would have either the time or the technical knowledge to tackle". (8)

In all cases, the doctors at Mayo's treat the patients as an individual and not as a research subject. The case is studied and consulted upon solely to help the patient himself. Dr. William Mayo, Jr. expressed this feeling when he said, "Group medicine is not a financial arrangement, except for minor details, but a scientific co-operation for the welfare of the sick". (9). Dr. Mayo said that three things are vitally important for the teamwork process. Firstly, there must be an


(9) Helen Clapesattle, "The Doctors Mayo", University of Minnesota Press, Minneapolis, 1941, p. 706.
active ideal of service instead of personal profit. Secondly, a sincere concern for the care of the individual patient. Thirdly, an unselfish interest in the progress of every other member of the professional group.

With these ideals, the Mayo Clinic laid the foundation for the momentous advance of medical teamwork in the 20th century. Many other professions have been added to the original organization including medical social work. The medical social worker has been an active part of the treatment team at Mayo Clinic for approximately fifteen years. Many important research studies have developed since 1945 in psychosomatic medicine in the Clinic in which the social worker has played a major role. Today at the Mayo Clinic a patient can receive the most complete care known to medical science.

**EFFECT OF THE CHILD GUIDANCE CLINIC**

The Child Guidance Clinics, because of their research and their effective use of the team, have had a most spectacular influence on the teamwork process. They were perhaps the first to recognize the value of the many professions, such as the psychologist, the social worker, the group worker, the doctor, and the psychiatrist.

They recognized that every profession has an individual viewpoint in diagnosis and treatment. This was the result of the great variety in background of professional education. They realized the value of the many opinions in being able to uncover diverse problems in individual children. They decided that for complete professional service many points of view were necessary and they utilized the skills of these professional people to the utmost. Accordingly, they used the method of staff conferences for free discussion. Each person contributed to the maximum of his professional knowledge to produce with the greatest certainty the pictures of the living child. Together these members would construct to the best of their abilities a tentative method of meeting needs.
The strength of the clinic "lies in the fact that it brings to the problem a breadth of view possible only from the interplay of diversity trained minds and in providing natural liaisons between the several professional groups which must be enlisted in any effective attack upon children's problems". (10).

MEDICAL SOCIAL WORK IN VANCOUVER GENERAL HOSPITAL

The social service department of the Vancouver General Hospital grew out of the services of the Women's Auxiliary. Many of the functions of this original group are retained by the social service department today. It was around 1913 that the Women's Auxiliary found that the services they were providing were too great for their voluntary organization. They, therefore, hired a full time person to provide their social work services to the hospital.

This social worker who was untrained began to increase the services of the Women's Auxiliary until the work could not be handled by one person alone. The Women's Auxiliary could not encumber itself financially with the hiring of more social workers. The Vancouver General Hospital, therefore, took over the social work service and made it a department within the hospital.

By 1926 the social service department was firmly established. It was very small, however, and was staffed by untrained personnel. The service given by the department was mainly environmental. The main objective was, however, to keep the patients' welfare in mind. All the services though, maintained the distinct flavour of the Women's Auxiliary which was, of course philanthropic.

In 1940 there was an attempt to clarify the function of the social service staff. The department was still influenced by the traditional ties of the Women's Auxiliary and the untrained personnel. The workers were performing a routine clerking function. There was no recognition of the skills of a medical social worker.

The services were concerned with the environmental problems for the non-pay patients. These problems consisted generally of needs for appliances, financial assistance and nursing home care. This constant pressure of routine prevented any valid interpretation to other hospital personnel.

In 1948 an important development took place within the department. The Health Centre for Children was opened with a trained social worker on its staff under the supervision of the case-work supervisor. This was the first time a department had opened with the recognition of the need for social work to integrate the social with the medical structure for treatment.

There are at the present time thirteen social workers in the department. The Director of the department, the casework supervisor and the worker in the Maternity Clinic have nursing degrees. There are three workers with certificates in social work. Five workers have B.S.W. degrees and two have M.S.W. degrees. The aim of the department at present is that no new workers will be hired unless they have the M.S.W. degree. This, of course, should have a dramatic influence in the growth of the department.

The department has been prevented from growing normally because of three main reasons. Firstly, the department was held by the ties of tradition set down by the Women's Auxiliary. Secondly, the time-consuming routine work has limited the opportunities for good interpretation. Thirdly, "the presence of untrained personnel did not permit good casework services and created misunderstanding of the actual function of medical social workers". (11)

In 1951 a work-survey was done and presented to the administration. This survey pointed out the ways in which the workers were prevented from performing as medical social workers because of the time-consuming clerical work which they

had to do. It was recommended that more clerical staff be hired in order to release workers for casework. If these recommendations are carried out, it is expected that the department will be able to fulfill the four standard services recommended by the American Association of Medical Social Workers.
CHAPTER II

THE SOCIAL WORKER AND THE DOCTOR.
11.

The organic approach in medicine still retains a strong effect on the practice of medicine. This system is one in which there is insistence on a "solid pathological foundation for medical understanding". (12). The psychosomatic approach, however, is not a new discipline; it has only been case aside because of the medical discoveries in bacteriology, pathology, biochemistry and biophysics. "Actually medical literature dropped the word 'man' and began to speak of the human organism which was being studied so precisely, and which could be manipulated so mechanically". (13).

The term "psychosomatic" infers that every disease has in its cause both psychological and physical factors which influence the course of the illness. English and Weiss in their book, "Psychosomatic Medicine", make four classifications of psychosomatic problems. (14). Group one includes the functional problems with no definite bodily disease to account for the illness. Group two includes those diseases which are partly dependent on emotional factors. Group three includes those diseases wholly within the realm of physical disease which have to do with the vegetative nervous system. Group four includes those diseases which have a relationship between psychological disturbances and structural alteration.

Not all doctors accept the psychosomatic approach to illness. This approach depends on the physician's sensitivity to and understanding of the patient as well as his knowledge of tissue pathology. He must know about the emotional factors in illness and human motivation. This approach is difficult in this era of specialization. The social worker who has received adequate training in the understanding of human behaviour as it is related to illness, frequently can fill the gap which


may exist between the needs of the patient and the service which the physician is prepared to give.

Today, a complete diagnosis of a patient must be threefold; that is, the patient must be viewed as a biological, psychological and social entity. The general practitioner in the small town many years ago, could himself make this complete diagnosis. Since the era of the "Family Doctor" has vanished and has been replaced by the "Specialist", there is evidence that a complete diagnosis can best be achieved by the hospital team. (15). The medical social worker, like the other members of this team has a specific function to perform. From her contact with the patient and his family during this period of stress, she is able to objectively discern those psychological and environmental factors which may be influencing his illness. From her numerous contacts, not only with the patient, but other members of the hospital staff, she can formulate an impression of the patient as a total social being. In this way, the medical social worker can facilitate the physician's desire to make a more complete diagnosis.

It is no longer important to know only the name of the disease that the patient has. It is, on the other hand, vitally important to know how, and even more particularly why, a patient became ill. It is the social worker who has the skill to get this information. She has been trained to evaluate the significant and causitive social factors in illness. The social worker's knowledge of the way personality, economic factors and environment affect a patient and the doctor's knowledge of physical conditions give an accurate basis for diagnosis and treatment of the patient's medical-social problems.

The value of a social worker's contribution to the treatment in the psychosomatic approach depends on the very fact that she has been trained in a different field.

(15) The term, "Family Doctor" was used through the late 19th and early 20th centuries to denote the family friend, counsellor, guardian and teacher.
SOCIAL FACTORS IN ILLNESS

Illness is said to be the major cause of a dependency in people. There are many major social problems in our society which are at the root of illness in many instances. Such things as poverty, malnutrition and poor housing spread infection and lessen people's resistance to disease. Illness is also common in people who are humiliated, depressed and despairing with the threat of low incomes and social assistance.

The person who is sick usually has a group of symptoms both physical and emotional. It is, therefore, important to know what kind of a person is suffering, what was happening to him when he became ill, how he is reacting to his illness, what has been the pattern of his whole life situation and finally, what is most important, what does illness mean to the individual.

The social worker is trained to understand and evaluate these social factors and their influence on people. She receives this information through her case work skills in interviewing. The social history which she prepares for the doctor is valuable for estimating the personality and the ability of the person to accept treatment and the reaction pattern of the person in life. The history also serves a therapeutic purpose. Through discussing his problems with the social worker, the person feels relieved from his anxieties and feels as though someone is interested in him as an individual. Finally, the history is indispensable in making a diagnosis and planning treatment.

METHOD OF REFERRAL

In the Vancouver General Hospital, a referral to a social worker is supposed to come directly from the doctor. Since the patient comes to the doctor because he has physical discomfort, the doctor, therefore, is the person responsible for his care. If the doctor recognizes that there are some personal or environmental difficulties which may be responsible for the illness or is interfering with his recovery,
then a referral to the Social Service Department is made.

The referral slip is put on the patient's chart stating the reason for the referral and the physical diagnosis. The social worker on the ward receives the referral slip and interviews the patient. In this first interview, the worker attempts to make a social diagnosis. She then contacts the doctor and together they plan the method of treatment.

Up to the present time, this method of treatment has not been in practice in the Out Patient Department. Two of the four workers in the Out Patient Department have been performing in a clerical capacity. That is, the morning hours are taken up in establishing eligibility for service in Out Patient Department, the afternoons spent in procuring appliances for the patients.

The referrals that have been given to the two ward workers in the past have been concerned mainly with the placement in nursing homes, procuring appliances and referring to the City Social Service Department for financial assistance.

From this picture, it can be seen that the social worker has not been functioning according to the standards set down by the American Association of Medical Social Workers. According to these Standards, the function of medical social workers should be in five general areas. Firstly, the social worker should practice social casework. Secondly, the social worker should participate in program planning and policy formulation within the medical institution. Thirdly, the social worker should participate in the development of social and health programs in the community. Fourthly, the social worker should participate in the educational program for professional personnel. Fifthly, the social worker should participate in social research.

Social casework in the past has only been made available to patients in Out Patient Department or staff patients. This may be due to the fact that no particular effort has been made to indicate to the doctors that casework treatment can be a
very worthwhile part of medical treatment. The time consuming clerical jobs of the social workers in Out Patient Department have prevented them from doing good casework. The cases used for this study have, therefore, been limited. The cases that have been chosen were those which showed referrals according to the Standards of the American Association of Medical Social Workers and have been carried out on the most part by students.

CASES SHOWING THE WORKER'S HELP IN PLANNING DISCHARGE

Mr. M was a 48 year old labourer with a physical diagnosis of rheumatoid arthritis. He was referred by the doctor for help in discharge planning because Mr. M did not have any money and this was making him feel anxious. The patient had spend 900 days in hospital over a period of four years. His handicap had progressed from a mild pain in his ankles to confinement in a wheel chair where he was considered to be absolutely helpless.

During the first interview with the patient, the worker found that he had suffered a series of emotional frustrations and economic deprivations which correlated with his admission into hospital. Each admission found the patient's condition considerably weakened.

The worker and doctor in conference decided to make a concrete plan of treatment for the patient. The worker gave case work help to the patient and his family. In this way, she was able to lessen the frustrations and build up the strength of the family and the patient. She acted as a liaison between the physiotherapist, occupational therapist, the City Social Service Department and the doctor. In this way, the patient felt that people were really interested in his welfare and he responded to the help.

In time Mr. M was able to buy a small store and sold the products made by himself and other handicapped patients. His handicap was lessened considerably although he never completely regained his former physical strength because the
damage of four years had changed his bodily structure. He lived in a small dwelling unit in the back of his store and the housekeeping duties were performed by the patient’s mother.

Through the case worker’s recognition of the social factors in illness and what illness meant to the patient, she was able to give a real service to the patient, the doctor, the patient’s family and the community in helping to restore the patient to independence and comfortable mental and physical health.

Mr. P was a sixty-four year old single labourer from out of town. He had been referred from an out of town doctor to Out Patient Department, because he could not find any organic reasons for his complaints. He was given a physical examination in Out Patient Department and they, in turn, could find no organic reason for his pains. The doctor referred the patient to the social worker to see if any social problems could be responsible for his illness.

The social worker interviewed the patient. She found that he was exceedingly depressed. He wept constantly during the interviews and seemed to be suffering from terrible pain. Mr. P had been unemployed for two years and his resources were nearing depletion. His pains had begun when he was dismissed from employment. He had been employed in heavy construction work all his life and he could not accept the fact that he was no longer an asset to an employer. Illness to Mr. P was, therefore, a socially acceptable mode of escape from an intolerable situation. His only wish was to be admitted to hospital so that he could die.

This information was given to the doctor who did nothing constructive from there. The patient came in to Out Patient Department a month later and another doctor saw him. He was interested by the social information and contacted the worker. Mr. P in the meantime had developed a physical diagnosis of muscular atrophy and diabetes mellitus. He was then admitted to hospital.

The doctor and the worker held a conference concerning the patient. The
doctor felt that the prognosis for the patient was not favourable. He had not responded to treatment and was not interested in co-operating with the doctor. The doctor asked the worker to find out what was troubling Mr. P in order that he would respond to treatment.

The worker saw Mr. P over a period of one and one half months. The patient's main concern was that he had nothing to live for. The worker gave Mr. P considerable warmth and sympathy. She contacted the Social Welfare Branch in his area to help him financially. Mr. P was able to express his anxieties; gradually he began to feel secure and responded to treatment. Mr. P was fearful that his niece, with whom he had been living, would not be able to care for him. The worker interviewed the niece and helped her to understand the illness. The worker referred the niece for financial help and also secured the assistance of a public health nurse in the area to talk to the niece regarding the diabetic diet. Mr. P began to feel more and more secure and his response to treatment was rapid. The prognosis changed from exceedingly grave to exceedingly favourable.

The worker and the doctor talked with him about his limitations and his capacities. He accepted these well and made concrete plans for a small truck garden on his farm. He said it was always something he wanted to do; he was finally discharged after one and one half months of treatment.

If the first doctor in this case had been able to follow up the social diagnosis, the patient might have been spared his illnesses. Fortunately, the second doctor recognized what the social worker could do in this case and included her in treatment two days after the patient was admitted. As soon as the frustrations were removed, the patient responded and was discharged much earlier than had been expected.

The social worker played a definite part in treatment in this case. Her knowledge of community resources and her diagnostic skills prevented the man from
developing a chronic illness. The doctor in his turn was able to give a more effective physical treatment to the patient as his anxieties were lessened.

Mr. K was a 23 year old unemployed man. He had never been employed for longer than a month because he was deaf and dumb and was therefore dependent upon his family for financial support. He had been hospitalized for a period of eight days because of a nasal obstruction. The doctor referred the patient because he felt this minor operation would restore the patient's hearing to some degree and he would therefore need some help in rehabilitation. The doctor felt that the patient had considerable intelligence and the worker could help through her knowledge of community resources.

The social worker in interviewing the patient and his family found that there was considerable enmity between the patient and his father. This had been brought about because the patient resented his dependent position and the father had done nothing to help him regain his hearing.

The worker was able to enlist the help of a speech therapist and a school teacher for the patient. While he was receiving this education, financial support was given to him so that he could be independent of his family. The worker also helped the family to recognize and accept the patient's needs to emancipate and be independent from the family.

The patient learned to read and speak well enough to take permanent employment and was no longer frustrated because of his feelings of dependence and inadequacy.

The social worker was able to help the doctor because of her skill in diagnosing the environmental situation and her knowledge of community resources. She acted as a liaison between the speech therapist, the school teacher and the doctor in helping them to understand the patient's personality and what his handicap meant to him.
Miss L was a seventeen year old girl from out of town with a diagnosis of hysterical paralysis. The doctor made a referral to the social worker because he wanted casework treatment for the patient and foster home placement or discharge. The cause of the paralysis stemmed from the patient's father's desire to send her to a Pentecostal Bible School which the patient did not like. She could not defy her father verbally, and as a result, she developed a complete paralysis.

The doctor knew about this conflict, but he recognized that he lacked the skill to deal with the problem and asked that the social worker give the treatment. The social worker and doctor met in a conference every two weeks and planned their treatment with the patient, so that they could give the patient the security of a united front.

The worker acted as a liaison between the doctor, physiotherapist, occupational therapist and the nurses. She helped these members in the team to understand the patient, and in this way each person knew the patient and what their role in treatment was to be. The patient received considerable security in this and responded to treatment through resolving her conflict. In a period of seven months, the patient understood her conflict and changed her pattern of behaviour.

The social worker found the foster home for the patient and prepared the foster parents for the transfer. The social worker saw the patient constantly and it was with her that the patient developed the strongest relationship. The worker acted as the hub in the wheel of treatment for this patient. The doctor recognized her skill in dealing with this problem which was essentially an emotional one.

CASES SHOWING THE WORKER'S HELP WITH PSYCHIATRIC PROBLEMS

Mr. T was a thirty-eight year old unemployed labourer with a diagnosis of inadequate psychopath. He had been known to the psychiatric ward at Vancouver General Hospital five years previously under a different name. He had been admitted
for shock treatment at that time.

He was referred by the Family Welfare Bureau because he requested psychiatric help. He was given an appointment with a psychiatrist and the doctor asked the worker to prepare a social history. In interviewing the patient, the worker was able to find that the patient had had a grossly inadequate environmental background. The patient had no inner strength to change his pattern nor could he establish a relationship long enough to benefit from case work help.

When the patient was seen by the psychiatrist, he wished to sign a voluntary committal for Essondale. The doctor and the worker in conference, decided that the patient's personality was so badly damaged that he would not receive any benefits from his committal. They recognized too the patient's right to self determination and the committal was signed.

The patient returned from Essondale two weeks later and said that he had received no help. The doctor and the worker decided at this time that no psychiatric help could be given to the patient at this time. They felt, therefore, that the worker would be the person to give the patient enough support through a warm relationship to release his anxieties at the moment and help him to secure employment.

The worker was able to help the patient to carry out this plan. Mr. T's personality would have been threatened in a long term casework relationship. His anxieties at that time were relieved enough for him to take employment. The worker realized that when the frustrations became too much for Mr. T, he would again seek some support.

In this case, the worker's social history was instrumental in helping the psychiatrist to make a diagnosis. The psychiatrist recognized the worker's ability to help the patient and requested her social skills in this area.

Miss M was a thirty-six year old unemployed stenographer. She had no physical problem but was requesting psychiatric help. The doctor referred the
21.

patient to the social worker for a social history. In the process of securing this, the social worker felt that the patient would not benefit from psychiatric treatment.

Miss M and her mother lived together and Miss M was extremely dependent upon the mother. She did not agree with the mother's wishes but she was so dependent that she could not emancipate herself. She was unable to retain employment for any length of time because she could not make decisions or take any responsibility without the mother.

The psychiatrist and the social worker decided in conference that psychiatric help would be of no benefit. They decided that the social worker could give the patient help in her area of conflict by giving her a warm relationship. It was felt that this relationship would give the patient enough support to emancipate herself from her mother and also give her a feeling of strength in her capabilities.

The worker developed a strong relationship with the patient over a period of time. The worker helped her to emancipate enough to take employment. The worker worked closely with the employing agency so that the patient would have an opportunity to take very gradual responsibility. In this way, the patient was able to feel secure and an asset to the community. The strength she gained in her area of employment had considerable effect on her emancipation from her mother.

The period of treatment continued for approximately seven months. At the end of this time, the patient left her mother and was successful in procuring employment in another city. The patient gained so much strength in herself that she was finally able to get married.

In this case, the psychiatrist was able to see, through the social diagnosis made by the social worker, that psychiatric treatment was not what the patient needed. He was able to understand the abilities of the social worker to deal with an environmental problem and give supportive treatment. The patient's real problem
lay in her earliest development. If the psychiatrist had offered help in that area, the patient would have become so threatened that a psychosis might have been the result. The psychiatrist and the social worker realized this problem. They were able to recognize, therefore, the patient would receive enough strength to meet her life problems without too much discomfort and frustration.

CASES SHOWING THE WORKER'S HELP IN RELIEVING ENVIRONMENTAL PROBLEMS PRECEEDING PHYSICAL CARE

Mrs. F was a sixty-one year old widow employed as a domestic. Her physical diagnosis was a single glaucoma. She had been attending Out Patient Department for a period of 5 years with a series of physical problems. She was a person who had a need to be extremely independent and she could not accept her physical diagnosis. She was exceedingly hostile in the clinic and caused a great disturbance on her visits. The doctor referred her to the social worker because he was desirous that the worker help her accept her limitations so that she would become less troublesome to herself and the clinic.

Mrs. F had been independent all her early life. She married in later life and was exposed to a great deal of economic instability. In spite of her deprivations, she was happy with her husband. Mr. F died in 1944 and it was then that the patient began to develop her illnesses. She did not respond to treatment because she did not want to get well. She had an outward need to be independent and illness was a socially acceptable form of satisfying her inner needs to be dependent.

The worker received this foregoing information while in the first interviews with the patient. In conference, the worker and the doctor decided that not a great deal could be done to actually help this patient in accepting her illness. They decided, therefore, that the worker should establish a warm relationship with the patient and to help her release the hostility she felt toward the clinic. They also planned to help Mrs. F retain her need for independence but perhaps join in the entertainment at Canadian National Institute for the Blind. They felt that this
might help her to accept her illness to some degree and also give her a pleasant social release with her limiting handicap.

The social worker served as a source for the patient's hostility for many weeks. As the patient felt acceptance and reassurance from the worker during the periods of hostility, her behaviour changed. She no longer had a need to be hostile in the clinic and she therefore accepted treatment. She was able to retain her independence because the worker secured assistance for her through the City Social Service Department until she felt well enough to take employment. Finally, the patient joined into some of the entertainment at the Canadian National Institute for the Blind.

The worker, through her skill in diagnosis, was able to show the doctor how the patient became ill, what illness meant to her and the kind of personality she had. The worker helped the doctor again in her recognition that the patient could never really accept her illness and its reasons. They could only hope to help her live more comfortably with her limitations. The worker's knowledge of community resources was of considerable benefit in this case.

If the doctor had not realized that the worker could be of some help, the patient would very probably have left the clinic. That is, her hostility over her own inadequacies may have forced her to refuse the service. If that had been the case, the patient may have done some permanent damage to her sight and to her personality.

Mrs. S was a thirty-two year old housewife with two children. Her husband was a labourer. She had a physical diagnosis of myasthenia gravis, Reynauds Disease, migraine and anxiety state.

The psychiatrist made a referral to a social worker because he realized it would only be a matter of about a year before the patient would feel the limitations of the myasthenia gravis. He wanted the worker to secure homemaker service for
the patient while she was in hospital in order to reduce her anxiety state. Later, when the patient was discharged, he wished the worker to help Mrs. S accept her illness and help her to make permanent plans for the family.

The worker, in conference with the doctor, decided that they would carry this problem together. The worker was to prepare the home for the homemaker and relieve Mrs. S's anxieties in that area. The doctor in the meantime continued to see the patient in the hospital and treated her on a more intensive level. The patient's anxieties diminished considerably when she attained a feeling of security with the doctor and social worker working together to help her.

The patient was discharged a month later. Her anxieties around the environmental level were diminished and she experienced no feelings of fear or frustration in returning home. The patient continued to see the doctor in Out Patient Department once in every six weeks. The worker on the other hand saw the patient every week. The psychiatrist lessened his visits with the patient because he felt his services would not longer be of any value. Mrs. S's illness had originated very early in her developmental history. She was now the victim of an incurable disease because her body had become sensitized to this constant frustration.

The psychiatrist realized that he could do nothing to help the patient. Her greatest need at this point was help in accepting her illness and in planning for her family for her eventual invalidism and their acceptance of that.

The patient had experienced many emotional trauma in her lifetime. Her mother had suffered through a mental disorder and eventually became an alcoholic. She later committed suicide (by hanging), and for this, the patient felt responsible. The patient then married Mr. S who was exceedingly dependent. He had a desire to be independent and went into business for himself. As a result, the family suffered through economic instability. The husband's personality was so weak that he could not offer his wife any support. Their marital relationship was exceedingly strained.
because both were dependent people. The children were also affected through this disharmony and were developing physical complaints.

The worker recognized that Mrs. S had the greater strength in this relationship. She was, therefore, able to give enough support and counselling to Mrs. S to understand the strains and help her to modify them. This supporting relationship helped to stabilize the family economically and emotionally. Mr. S was able to continue his business without undue hardship which increased his feelings of independence. The children, were in turn, relieved from the emotional strain and the physical complaints were lessened. Finally, Mrs. S was released from these environmental pressures and was able to accept her illness and plan concretely for her family.

This case clearly illustrates the role of the medical social worker in treatment. As the patient's anxieties were relieved in the hospital setting by the psychiatrist and the social worker, the patient was able to be discharged. The doctor realized that the main source of frustration was in the social area. It was there that the social worker was able to bring her skills into treatment. This team process, therefore, enabled the patient to accept her illness and prevented the family from physical, emotional and economic deprivation.

Mrs. G was a forty-eight year old housewife with seven children with ages ranging from four to twenty years. Her physical diagnosis was gynecological complaints. The doctor referred the patient because she was so upset in her environmental problems that she could not accept treatment. The doctor recognized that the environmental situation needed the skills of a social worker. He prepared the patient for her interviews by explaining that until her social problems were relieved, he could not beneficially give her physical treatment.

Through the process of interviewing the worker found that the main source of frustration in the family was a thirteen year old spastic child. This child
had been severely rejected by all the family. The father, who was an inadequate psychopath accused the mother of being responsible for the defective child. The father completely dominated Mrs. G and she, therefore, had so many mixed feelings that illness seemed like the only escape for her.

The worker and the doctor, in conference, decided that the personalities of Mr. and Mrs. G could not be changed. The best plan, therefore, would be to remove one of the sources of frustration, namely, the spastic child. The doctor realized that the social worker knew the community resources and had special skills in dealing with this environmental problem.

The social worker continued to see Mr. & Mrs. G and helped them to accept the removal of the child to a mental institution for children. Psychological and physical examinations were given to the child and her mental status warranted the move. This little spastic child would definitely benefit from the institution emotionally because of her severe disturbance in that area. The mother and father were able to talk about this with the worker. The patient received considerable benefit because she released her guilt and anxious feelings about the child. The social worker knew that the mother did not have the inner strength to understand her own feelings about the child. It was felt, therefore, by the doctor and the worker that with the removal of the child, the main source of friction in the family relationships would be eliminated.

Mrs. G was finally able to accept treatment for her own illness when the child was removed. Her frustrations and anxieties around the child had been decreased and she was willing to focus on and receive benefit from treatment.

In this case, if the doctor had not recognized that Mrs. G had been upset, all attempts to treat her would have failed. The result would have been very costly in time and in terms of the patient's health. Such a delay might have resulted in her refusal to come back. The patient's husband's personality and her own physical
weakness may have promoted a severe illness either mentally or physically. The doctor's recognition of the environmental problem, therefore, resulted in reducing the family strains, enabled successful treatment of a minor illness and, finally, gave the thirteen year old spastic girl an opportunity to grow in comfortable and accepting surroundings.

Mr. C was a sixty-four year old married farmer. He had a physical diagnosis of muscular dystrophy and idiopathic epilepsy. Mrs. C, the patient's wife was exceedingly handicapped in that she was completely paralyzed on the whole left side of her body.

Mr. C was referred to the social worker for placement. He was a problem for the doctor because he could not accept his condition as chronic and would not accept the doctor's plan of treatment. The plan was to put Mr. C in a nursing home run by the City Social Service Department which is on hospital grounds. The doctor felt that then the dystrophy would be controlled and some attempt could also be made through over-feeding to give Mr. C greater strength.

Mr. C was exceedingly hostile to the worker in the first interviews. Mr. C had always been proud of his independence and because of his strong inner needs to be dependent, he felt that if he got into hospital he would never come out again. The worker was able to help Mr. C understand his chronic condition and the benefits he would receive from hospitalization. Mr. C decided that he would see a private doctor once more before he consented, just to see if the opinions regarding his diagnosis were the same. The doctor and the social worker agreed to this because they understood Mr. C's personality and his right to self determination. Mr. C came back later and decided to accept the first plan of treatment.

In this case, the social worker through her skill in diagnosis, understood the patient's personality and respected his right to decide for himself. She was able to help the doctor understand this also and he did not become impatient. The
The doctor could see that the patient had a need to satisfy himself in all other directions before committing himself to a plan other people had made for him.

**SUMMARY**

Since the unwell person usually presents symptoms indicative of emotional as well as physical disturbance, it is important to have some awareness of the kind of person who is presenting the symptoms. The pattern of his whole life situation, significant incidents which occurred prior to the onset of his illness, his reaction to his illness and finally the meaning which illness has for him, are the integral part of his illness. The social worker, because of her casework skills in interviewing, is able to obtain this information. The gathering of this information is not an end in itself but rather a means to an end. The social worker is equipped to understand and evaluate social factors and their influence upon people; prepares a history which enables the physician to come to some conclusions regarding the patient's personality and his ability to accept and respond to treatment.

Miss De La Fontaine in her article of "Psychosomatic Medicine and Case Work", has an interesting comment as to how the two disciplines of medical social work and the doctor can function. (16). She suggests that it is the social worker who treats the "illness" and the doctor who treats the "disease". She clarifies this statement by defining the two areas. "Illness is a deviation from health or from that state in which all natural functions and activities are performed freely, efficiently, without pain or discomfort. Illness is a state in which the process of living produces symptoms that prevent some of the natural activities of the body from being performed freely and efficiently."

In her second definition, she states that, "Disease may be defined in a restricted sense, as an abnormal state of the body resulting from the harmful effects..." (16) De La Fontaine, Miss E., "Some Implications of Psychosomatic Medicine for Case Work", Journal of Social Case Work, June 1946, p. 128.
of processes, inpirous substances, or accidents. Disease is recognized by object-
ive examination either as a structural change or as an abnormal condition revealed 
by chemical, physical or biological methods; as such, it is called organic disease".

Miss De La Fontaine goes on to say, "These definitions are not meant to 
differentiate between different degrees of involvement of mind, body and environment, 
but rather they are attempts to clarify the area appropriate to the layman and 
physician; that is, illness to the patient, social worker and doctor and the area 
appropriate to the physician only (that is, disease)."

Patients develop illness and diseases as a response to the stresses and 
strains of external and internal stimuli. It is not known why certain people have 
organic vulnerability in one area and not in another. People react differently, 
even though they may have the same organic defect. Medical doctors have begun to 
realize that certain somatic functions are correlated closely with certain emotional 
conflicts. The main area of conflict seems to be in the consideration of which 
comes first, the emotional disturbance or the organic difficulty. There are some 
diseases, however, in which there is some vague knowledge as to which comes first.

It can be seen, therefore, that it is vitally important to know the patient 
as a whole person in treatment. It must be known why the person chose this part-
icular organic disturbance to express his discomfort and trouble. The history must 
also contain the environmental factors which may show the constitutional predis-
position to the organic defect. This social information, accompanied by the 
doctor's physical information, should give an accurate basis for treatment.

The psychosomatic approach to illness is as old as Hippocrates, the "Father 
of Medicine". The tremendous advances in medical science have reached such propor-
tions that it is now impossible for one person to know the whole field. The emphasis, 
therefore, has been placed in specialization in small areas of the body. In the 
process, the patient as a whole living person has been lost. Medical doctors are
now aware that man does not function in small sections; his body and mind are so closely interrelated that they cannot be separated. It is in this area, therefore, that the medical social worker becomes an indispensable part of the treatment team. It is the social worker who can assist in pointing out the interrelationship of the patient's family and environmental constellations. It is with her knowledge and skill, therefore, that she brings to the doctor the patient as a living man, a human being with individual worth and not an organ by itself.
CHAPTER III
THE SOCIAL WORKER AND THE COMMUNITY
In a medical setting, the social worker has a different role to play from workers who are in family or children's agencies. The patient comes to the clinic or hospital because he has physical discomforts. The objective of the patient therefore, is to seek relief from his pain. The doctor, if he recognizes the psychic problems around the disease, will refer the patient to the social worker. The social worker's status therefore, is very much different from the situation in other social agencies where a client seeks direct help with a social or emotional problem from the social worker. The medical worker on the other hand has only her social skills in diagnosis and treatment to the patient. There are no resources such as financial assistance, foster homes or homemaker services within the setting. The worker in the medical setting, therefore, has to have a great knowledge of the resources in the community so that she can co-ordinate them skilfully in the total care of the patient. The social workers in the medical setting are too apt to feel that when the patient is relieved of this illness, he has been treated. According to the National Council on Rehabilitation, "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable". (17).

Mr. K. Hamilton in his article, "A Sound Rehabilitation Program", says that, "Rehabilitation is creative. It aims to define, develop and utilize the assets of the individual and his community. Its purpose is to restore competitive capacity, independence and personal satisfaction". (18). In order to carry out a program of rehabilitation there must be a utilization of all existing community resources, an intelligent realization of those that are lacking, and finally, some social action to overcome the lacks in the community.

It is therefore a responsibility of the professional social worker to be

(17) National Council on Rehabilitation, August 1943.

well informed regarding the available resources. The social worker with her knowledge of social diagnosis and her skills in social treatment is in an ideal position for integrating, utilizing and promoting community services. The social worker can fulfill this responsibility in many ways. Firstly, she must have an extensive knowledge of illness and its social implications. Secondly, she must be aware of people's attitudes toward illness and the social implications involved for them individually. Thirdly, she must be aware of the meaning and experiences of patients as individuals and as members of family groups toward illness. Fourthly, she must share this knowledge with the members of the hospital team and other agency personnel. Fifthly, she should promote group conferences with patients and with their families and friends. Sixthly, she should be a representative in the planning and initiating of group resources both curative and preventive. Seventhly, she should reach out and present her knowledge to appropriate citizens and volunteer groups in the community.

GROUP DISCUSSIONS

The use of group discussions in Vancouver General Hospital is exceedingly limited. The discussions are usually confined to two people in various combinations, for example, the doctor and the social worker, the doctor and the nurse, the social worker and the occupational therapist. The decisions regarding treatment therefore, are never group decisions. It has not been general practice for all the various people helping the patient to sit down at one set time to confer.

However, a new system was set up in the Neurology Clinic in the Out Patient Department for epileptic patients, employing the group discussion method exclusively. The group consists of a psychiatrist, a neurologist, an occupational therapist and a social worker. Other professional persons serve in a consulting capacity when the need arises. These other persons may be a neuro surgeon, an employment counsellor of Y.M.C.A. representative. This group was formed because there had been no real treatment for the epileptic or his family. The disease itself bears a social stigma
and it has always been shrouded in mystery. The group felt that these people could become independent and useful citizens if they were to receive help in the physical, mental, social and vocational area.

The clinic at the present time is for young adults and it is organized under the Neurology Clinic. This clinic is held once every week. The social worker receives a referral on each patient automatically from the attending doctor. She is used for her social skills and for her knowledge of resources. The worker interviews each patient and formulates a social diagnosis from the social history. The worker also tries to contact and interview the patients' parents.

At the end of the week the members of the group have a conference concerning all the patients interviewed by the social worker. The social worker presents to the group the social and emotional diagnosis of the patient and his family. The other group members present the diagnosis of their contact with the patient and then together the group will assess the patient. At the present time only those patients who will benefit from the group help in a very short period of time are chosen. The object of the clinic is not medication alone but the treatment of medical, social, emotional and vocational problems.

One evening every week is set aside for a group discussion with the parents, relatives and friends of the epileptic. These meetings are useful in three main ways. Firstly, they are arranged so that the parents may have an understanding of the illness itself and its emotional and social implications for the patient and his family. Secondly, it is an opportunity for the professional group to understand the problems and the conflicts of the parents. Thirdly, it is a form of therapy for the parents in that they realize other parents are having similar problems.

The clinic at present is still in its infancy and no report was available at the time of this study. The group intends to expand its services to all categories of people, not just those in the Out Patient Department. Their intention is to
include the middle income groups, particularly those who are eligible for the
Out Patient Department and yet cannot afford specialized care. The group also
plans a definite program of social information through addresses to lay groups and
pamphlet and newspaper publicity.

The epileptic clinic is an interesting development at Vancouver General
Hospital. The group realized an immediate need for a person with a knowledge of
community resources. The social worker was considered to be the logical person for
this work; she was hired therefore, to function in that capacity. It was later
shown that the social worker was also of definite help in the treatment process
because of her knowledge of the social and emotional factors in illness. It is
interesting in this instance that the other professional people in the group should
first see the worker as a resource person. The worker made use of this opportunity
and served in that capacity until she had the opportunity to use her other skills.
If the epileptic clinic is to be used as a measuring stick for the understanding of
social work by other professions, the workers must have a more than average know­
ledge of the community resources. If the worker is accepted by the group for this
skill and is able to proceed in this capacity with competence, she may then be able
to initiate the use of her other skills.

INTER AGENCY CONFERENCES

The professional contacts between agencies are a great area of weakness in
Vancouver General Hospital. There is little actual sharing of cases, and the
referrals are poor. The department considers that the best referrals are received
from the City Social Service Department where there is recognition that casework
is a function of the department. The other agencies do not seem to understand the
function of the medical social worker. This situation is the result of poor social
work in the hospital in the past; a lack of recognition on the part of social workers
both in and out of the hospital regarding the actual function of the medical social
worker.
The medical social worker should have contacts with all agencies because not all patient problems are essentially medical. If the social worker were to receive a child with asthma as a referral from the doctor, with the problem stemming essentially from a parental marital conflict, the worker would make a referral to another agency. This case may be handled by the family agency helping the mother and father, and the medical social worker helping the child. The same principle of the social worker and doctor helping the patient applies to inter agency co-operation. The patient has a right to feel the security of all professional people working with unity and co-operation for his benefit. If the patient were to feel discrepancy and disharmony, he would immediately feel guilty or insecure and no one agency would be able to give him complete help.

The medical social service department is completely dependent on other agency help for problems other than medical. It is therefore extremely important that there should be co-operation and understanding of roles within the various agencies. The situation as it is at present could be rectified through inter agency conferences and visits, and by reports and discussions. Good services to patients can only be given when the community relationships are strong and well co-ordinated.

**INTER AGENCY METHODS OF REFERRAL**

The most common referrals from the Vancouver General Hospital social service Department are for financial assistance and for nursing home care to the City Social Service Department. The percentage of referrals to other agencies is much smaller than those sent to the City Social Service Department. There is a much smaller percentage of referrals to the social service department in the hospital than there is from the hospitals out to the agencies. Nearly all of the referrals are from the City Social Service Department. The reason for this is that the workers in the City Social Service Department do not have time for casework services and they depend on the medical workers to provide this service for the patients which they refer.
Since this study was started there has been an increase in the referrals from other agencies, especially the Family Welfare Bureau.

There are perhaps three main ways of making good referrals. Firstly, if an agency has a client whose problem seems to be in the area of physical illness, there should be a referral to the medical social worker. The agency worker, the doctor and the medical worker should sit down in conference and decide who would be the person best suited to serve the client's needs. Secondly, if the medical worker has a patient whose problem seems to be a family one, the worker would refer the case to the family agency. The medical worker would arrange to have a conference with the doctor if necessary, the appropriate agency worker and herself. Again, this method of group conference is the answer for the client receiving the best kind of service for his problem. Thirdly, the medical worker and an agency worker may share a family problem. A fictitious case was suggested previously regarding the asthmatic child and the parents with a marital problem. This sharing of work requires a high degree of co-operation and teamwork. The client is the first one to feel conflicting ideas among those who try to serve him. It is, therefore, a responsibility to the profession and the standards of agencies to co-ordinate the services so that there is neither overlapping nor gaps in the services to clients.

OTHER COMMUNITY CONTACTS

The group discussions in the epileptic clinic and the inter agency contacts are the main sources of community activity conducted by the workers in the social service department. The workers in the hospital have made only very meagre contacts with the community in the past. Now that there is some definite idea as to the real function of the worker in the hospital, more community activities and understanding can be expected.

Within the hospital itself, there is some inter departmental contact. The Director of the social service department and the case work supervisor do give
some lectures on the function of medical social work to groups such as student nurses, student dieticians and student administrators. Lectures are also given to the volunteers who assist in the Out Patient Department clinics. These volunteers are from the Women's Auxiliary; they assist by giving soup to patients during the morning, providing a transportation service for non-ambulatory patients coming to clinic and serving as part-time stenographers. The lectures given to these groups of people have been very inadequate because they are too brief. It would be more beneficial if they were carried out over a period of months instead of days. The reason for this brevity lies generally with the lack of understanding of the role of the medical social worker by the social workers themselves and of course by the rest of the hospital staff. The lectures are concerned for the most part with routine matters as to how the social workers function in securing glasses, appliances and nursing home care for patients. If the workers are going to integrate the services within the community, they must first begin in the institution where there are 1200 employees.

The workers could gain recognition within the walls of the institution by giving lectures to various groups, being represented on committees, giving written interpretations through reports and employees' bulletins and finally by showing good casework practice to employees in the day-to-day contacts. As yet, the workers have not been asked to discuss their role to the doctors in such things as ward rounds and symposiums. It is to be hoped that the workers will make an attempt to do this in the near future.

The workers could gain some recognition in the community outside the institution by various means. Firstly, by inter agency discussions and visits. Secondly by discussion groups with families and friends of people suffering from illnesses like arthritis, cancer, glaucoma and many others. Thirdly, by being represented not only in professional organizations but groups like Church Young
People's Groups, Canadian Clubs, Rotary and many others. Fourthly, by writing articles for magazines, newspapers, bulletins and reports. Fifthly, and finally, by practising good casework, because it is patients who will carry the results of good treatment into the community.

CASES SHOWING REFERRALS FOR FINANCIAL ASSISTANCE OR OUTSIDE PROFESSIONAL CONTACT

Mr. P was a sixty-four year old single labourer with a diagnosis of diabetes mellitus and muscular atrophy. Mr. P's illness was an escape for him from the frustrations of financial deprivation. Mr. P was most anxious to be admitted to hospital. He had been an independent labourer and now he was too old to be an asset to the labour market. He had been unemployed for a period of two years and his savings were depleting rapidly.

The worker recognized that Mr. P's financial frustration was aggravating his physical condition. Mr. P was eligible for Provincial social assistance and the worker notified the appropriate agency. The worker discovered that Mr. P's niece with whom he lived was also without funds. She was also eligible for assistance and the worker made the appropriate referral. Mr. P experiences considerable relief from frustration on receiving financial assistance. He was assured of security for life. His niece could not stay with him because she too would receive assistance. Mr. P began to discuss plans for discharge. He wanted to get well and his response to treatment was amazing. The doctors felt he would be in hospital for many months but he recovered so rapidly that he left in less than two months after admission.

The worker contacted Mr. P's niece to make plans for discharge. The worker discovered that she was very apprehensive about the discharge because she did not understand the illness or its implications. The worker was able to help the niece through her interpretations. The worker secured the assistance of the public health nurse in the area and the niece felt more secure in having Mr. P discharged.
The public health nurse was going to call twice weekly for a time in order to help the niece understand the illness and the nursing problem involved. Later, when the niece felt more secure, the visits would be on a weekly basis.

In this case there would have been very little response to treatment if the worker had not recognized Mr. P's main source of anxiety. Her knowledge of resources in the community helped Mr. P to recover very rapidly and prevented a chronic illness. In understanding the family problems related to illness, the worker prevented Mr. P's niece from undue frustration and anxiety. The preparation of the home for the patient's discharge assured Mr. P a comfortable and relaxed home atmosphere which came through the niece's understanding of the illness and its implications. The worker's knowledge and use of the community resources in this case prevented a chronic invalidism and certainly made rehabilitation a reality for Mr. P and his niece.

Mr. M was a forty-three year old labourer with rheumatoid arthritis. He had been incapacitated for a period of four years. He would spend a period each year in hospitals or the city nursing home. As soon as he felt better he would be discharged and given social assistance. Mr. M was referred to the worker by the doctor for a social history. The worker was able to help Mr M receive release from the tensions and frustrations he was feeling regarding his problems. As the tensions were reduced, Mr. M was able to relax and use his rigid limbs. He was eventually able to work and with the worker's help face the future realistically.

He was able to own a store which retailed the products made by handicapped veterans. In this way he became a productive and independent citizen, no longer dependent on the public for support. Mr. M was able to give to the community instead of being supported by it.

The worker in this case enlisted the support of the City Social Service Department. They worked closely in trying to understand why Mr. M became ill.
The medical worker showed the agency that Mr. M had so many frustrations and tensions in his history that he became increasingly rigid. When his tensions were reduced and he was given some direction, he wanted to become self-supporting. The City Social Service Department was able to understand this and co-operated with the medical worker in giving financial assistance until Mr. M could become independent.

Mr. K was a twenty-three year old unemployed deaf and dumb patient. He was referred for discharge plans but was eventually helped to emancipate himself from his parents on whom he depended, by learning to speak and write.

The worker received the co-operation of the City Social Service Department for financial help. She showed the patient's need to be independent and the agency co-operated by giving the patient financial assistance while he was taking lessons from the speech and language therapists.

The speech therapist who is employed by the Health Centre for Children, co-operated with the worker in helping Mr. K. He was actually not eligible for the therapist's assistance, but the worker's presentation of Mr. K's case made the therapist feel that the extra work with Mr. K would be beneficial to him.

The worker went to the Normal School to obtain a language therapist for Mr. K. The principal of the Normal School became interested in Mr. K's case and offered the services of one of his students.

The worker co-ordinated all these community services for Mr. K's total rehabilitation. The worker realized that Mr. K's problem was not essentially a medical one and her knowledge of the community resources helped Mr. K to become independent. The worker acted as the hub in the machine of rehabilitation. It was the worker who interviewed Mr. K and diagnosed his social needs. Through her skill in diagnosis and her knowledge of resources, she made these facilities available to Mr. K. She prepared the patient for the new people in the rehabilitation team and also prepared the team members for Mr. K. The worker initiated the
new resources as the patient needed them. She gave Mr. K continual support by seeing him every week and encouraging him. She helped Mr. K's family to understand the treatment and why it was being given. Thus the worker was able to use the community resources to their greatest extent to help this patient gain complete independence.

Miss M was a thirty-six year old unemployed stenographer. She requested psychiatric help but the psychiatrist and social worker felt that here the worker would be the best person to help Miss M with her environmental and employment problems. The patient was overly dependent on her mother. She resented her dependency but was not strong enough to emancipate herself.

The worker contacted the employment bureau of a company where Miss M finally sought employment. The worker was able to enlist the support of the woman in charge of the bureau through her explanation of Miss M's case. Together they were able to help Miss M adjust to the employment situation and receive satisfaction from small successes. With this adjustment and the worker's continued support in the environmental area, Miss M was able to emancipate herself from her mother and obtained satisfaction and security from employment. The worker was able to recognize and utilize the community resource in the person of a personnel officer in a large company. The patient's rehabilitation lay in the employment area and the environmental area. Rehabilitation in both of these problems was necessary before she could receive the help she requested.

CASES SHOWING INTER AGENCY CO-OPERATION

Mr. C was a sixty-four year old married farmer with a diagnosis of epilepsy and muscular dystrophy. The referral was made to the worker for planning nursing home care for the patient.

The patient was exceedingly hostile about plans for entering a nursing home. He had always been very independent and he resented giving way to dependency
and would not accept his illness. Eventually the worker was able to help him accept and plan for nursing home care.

A referral was made to the City Social Service Department through whom applications must be sent for nursing homes. The worker in the City Social Service Department did not realize Mr. C's need to be considered independent and her method of approach when filling out the application made Mr. C exceedingly hostile. As a result of this interview, Mr. C refused to enter a nursing home.

The medical worker recognized this problem and talked with the City Social Service Department worker concerning it. The medical worker again helped Mr. C accept the plan for admission and again called in the worker from the City Social Service Department. This time the relationship was good and Mr. C accepted the application form. Both the worker from the City Social Service Department and Mr. C had been prepared by the medical worker for this interview. Mr. C had been helped to understand why certain questions were put on the application forms particularly concerning financial eligibility.

This case points out the benefits from close co-operation between financial and case work agencies. If the medical worker had not recognized Mr. C's need to be considered independent, he might never have been able to accept the nursing home plan. The worker from the City Social Service Department was also helped through her understanding of this need. She may have felt that Mr. C really did not wish care and thus would have dismissed his application.

Mr. C's rights to self determination were respected in this case. He resented feeling dependent and through recognition of this he was able to plan for himself which would probably make him more responsive to treatment and be a retention of his personal pride and self respect.

The worker's knowledge of the community resources and the ways of using them helped Mr. C accept a plan which was not essentially his but that of the
The worker was able to carry out his plan by using the resource as though it was Mr. C's plan and his decision. Thus she protected Mr. C from dependency and also carried through with the doctor's orders.

Mrs. F was a sixty-one year old widow whose occupation had been char woman. She had a diagnosis of glaucoma which she could not accept and it made her exceedingly troublesome in the clinic. The referral was made for the worker to help Mrs. F accept her illness and thus become less troublesome.

Through case work help, the worker let Mrs. F use her as a sounding board on which she could give vent to her hostility about her illness. This relationship with the worker helped Mrs. F to adjust herself to the clinic routine and receive some benefit from the medical treatment.

As Mrs. F began to feel better physically, she became more accepting of her disease. The worker was able to suggest the Canadian National Institute for the Blind recreation clubs to Mrs. F which she previously would have refused. The worker contacted the Canadian National Institute for the Blind to tell them about Mrs. F and which clubs she would be most likely to enjoy. Mrs. F finally joined one of the clubs and seemed to feel satisfied with the activities. Mrs. F now had something to live for, she could enjoy recreation even though her capacity was limited by partial blindness. She felt comfortable with other people whose illnesses were similar and she was no longer hostile and unhappy.

This case shows that the doctor and the worker did a great deal to help Mrs. F accept her illness and the treatment but Mrs. F needed something more. The worker recognized this need for recreation and used the community resource best suited for Mrs. F's rehabilitation.

Mrs. S was a thirty-two year old married woman with a diagnosis of myasthenia gravis, Reyauds Disease and an anxiety state. The referral was for
the worker to assist the psychiatrist in helping the patient understand her illness and for homemaker service.

The worker through her knowledge of community resources sought the assistance of the Family Welfare Bureau. She explained Mrs. S's problem to this agency and they decided through the conference method that the Family Welfare Bureau would provide the homemaker but the medical worker would supervise the home because the problem was essentially a medical one.

Through the services of the homemaker, the patient was able to relax and rest enough to accept the treatment of the psychiatrist. As she received strength in treatment she could accept her illness and plan for the future. Thus this community resource made possible a complete treatment plan by the worker and the psychiatrist.

Miss L is a seventeen year old single clerk with a diagnosis of hysterical paralysis. The doctor referred this girl to the social service department because he wanted some help in treatment and also because he wanted the worker to find a foster home. The worker worker closely with the homefinder at Children's Aid Society. She explained the case to the homefinder and what she would expect the foster parents to be like. From this description, the homefinder found what she felt was a suitable home.

It was decided in conference with the Children's Aid Society that the medical worker should select and supervise the foster home because the problem was a medical one. The worker investigated and chose the home and continued to see Miss L when she finally was moved there. This case of inter agency co-operation saved this patient from the trauma of a change in agencies and workers. It shows that in certain instances the client's welfare stands above the agencies' policies. It is only through professional co-operation therefore, that this kind of plan can be handled efficiently for the patient's complete rehabilitation.
Mr. T was a thirty-eight year old unemployed single man with a diagnosis of inadequate psychopath. This case is an example of an excellent referral from another agency. The patient went to the Family Welfare Bureau seeking psychiatric help. The worker in this agency recognized Mr. T's need for a proper diagnosis both psychiatric and medical. She explained the services of the Family Welfare Bureau and why she was making a referral to the Vancouver General Hospital social service department. She explained the function of the medical service department and how they would help him. She finally phoned the department for Mr. T and made an appointment.

Thus, when Mr. T arrived for his appointment he understood the services of the department and the role of the worker. This process saved a great deal of time for the medical worker. She was able to work into the social history data for the psychiatrist immediately. The client too received the service he was seeking with the greatest possible speed.

Mrs. G was a forty-eight year old married lady with seven children. Her diagnosis was psychogenic gynecological complaints. The referral was made because the doctor felt there were personal problems which were preventing Mrs. G from accepting treatment. The worker found that the home situation was very poor and that the main source of frustration was the presence of a thirteen year old spastic daughter.

The worker felt that the daughter was neglected and the mother felt exceedingly guilty about this. The worker felt that nothing could be done to help the girl in the home. She therefore discussed the possibility of placement of this child in a school for mentally disturbed children. Mrs. G seemed to feel considerably relieved with this suggestion because it reduced her feelings of guilt.

The worker contacted the school and preparations were made for the child's admission. Mrs. G was helped to feel as though she was doing the right thing for
the child. The child in turn was prepared and the move to the school was made.

The worker's knowledge of this community resource and how it was used helped to restore the G family to unity and gave Mrs. G an opportunity to accept medical treatment for herself. The worker realized that the school would help the severely disturbed child and it would also help Mrs. G whose guilt feelings were partly responsible for her illness.

**SUMMARY**

In this chapter it can be seen how vitally important it is for the medical social worker to have an extensive knowledge of community resources. Rehabilitation is not just the restoration of physical strength but instead the restoration of all the areas which make up daily living. A person cannot be a healthy and wholesome individual unless he can function physically, mentally, socially and vocationally to his own and society's satisfaction.

The worker in the medical setting has only the facilities for helping a person regarding the problems in the area of illness. She therefore has to depend on the resources in the community for giving the patients a professional standard of casework help. The medical worker more than any other type of social worker is dependent on the community for assistance. It is therefore a responsibility of the worker not only to know the existing resources but to be instrumental in developing new ones.

The medical worker too has a responsibility for social action in the community not only for the promotion of new resources but for the prevention of illness. This should be carried out through lectures to patients, families and friends, to community groups and through written publicity. The worker is interested in the prevention of sickness and in the social maladjustments which result from such sicknesses: she is in a position to know the causes and the results from these sicknesses and it is therefore her responsibility to speak with authority in the community.
CHAPTER IV

THE SOCIAL WORKER AND THE ADMINISTRATION
The Vancouver General Hospital is a public institution or functions under the authority of the British Columbia Hospital Act; and under this assumes responsibility for any person who requires medical attention. Staffed by 1200 employees, both professional and non-professional, it gives a 24 hour per day service every day in the year. The American Hospital Association which is recognized as the authority for setting the standards for medical care, has given the Vancouver General Hospital a grade A standing. One of the standards which is emphasized by the Association is a social service department which upholds the recommendations of the American Association of Medical Social Workers.

The hospital is controlled by a group of lay citizens known as the Board of Governors. The membership to this Board is open to any interested person requiring only a $10.00 fee for an annual membership and a $100.00 fee for a life membership. The function of the Board is similar to that of the stock holders in a corporation. The principle responsibility of the Board is the election of seven of the members of the corporate body to the Board of Directors.

The Board of Directors is composed of seven members elected by the corporate body, three appointed by the province of British Columbia and three appointed by the municipality of Vancouver. The Medical Director and the lay Director of the hospital serve as advisors to this Board but they do not possess any voting power. The main function of this Board is the formulation of the over-all policy of the hospital, the provision of personnel and facilities for the care of patients and the selection of the medical staff.

The Medical Board is made up of all the chiefs of the different medical services. The chief is the oldest senior doctor under sixty years of age in a particular service. This Board does not have any direct authority on the hospital administration. They serve in an advisory capacity in the formulation of policy, in relieving medical staff problems and in suggestions for new kinds of treatment.
service for patients.

There are three lay assistant directors under the supervision of the lay Director. They are responsible for the supervision, planning and organizing of the fifty various departments. These assistant directors have a great deal of power in that they can usually finalize matters of policy and finance within the various departments. An appeal can be made to the Director but his decision is usually in accord with that of the assistant directors.

It can be seen therefore that the line of authority in the Vancouver General Hospital is very clear and concise. The Social Service Department is one of the smallest of the fifty departments. This department is not represented on the Board of Management which consists of all the Directors of the important departments which are concerned with treatment. This is because the value of the department has not yet been recognized within the administration. It is felt that with advertisement to the administration in the form of good casework practice and good reports, a real acceptance and recognition would be the result.

WAYS OF HELPING THE ADMINISTRATION

In an institution where there are 1200 employees and 50 various medical departments there is an excellent opportunity for the patient to become lost in the sea of specializations. The patient may see many different kinds of specialists with no one person taking the time or the interest to make the patient feel that he is a person. The social worker has the training and skill to fulfil this function if she is given the time and the opportunity to assist.

If a patient were to be allowed to receive treatment from various departments with no one person to help him understand the treatment, he could very likely become a chronic clinic case. For example, a man with feelings of tension brought about by a marital problem may demonstrate symptoms of arthritis. His anxieties become so great that his limbs become rigid and sore. If he were referred to such
clinics as physiotherapy, X-ray therapy, physical medicine, general medicine, internal medicine and many others with little relief from his real problem, his physical condition would probably become increasingly rigid and immovable. The treatment would not help the patient because the source of tension is in the marital problem. As the physical condition becomes worse the marital problem too is aggravated. This might be through loss of earning power or through the physical deformity that usually accompanies the disease.

This circle of visits to clinics with no benefit from treatment is exceedingly costly to the administration. If, however, there had been a social worker there to help when it was found the patient was not responding to treatment, this situation would have been different. The worker with her skills in interviewing would have noticed that the patient was suffering from tensions in the environmental situation. The worker would have allowed the patient to discuss his problem which would in turn have released the tensions. In this case the worker might have referred the case to the Family Welfare Bureau where the patient could receive the best sort of help for his problem. The illness itself could probably have been treated in shorter time, thus reducing the cost to the administration, and perhaps preventing the development of a chronic condition.

Another problem of considerable importance with which the administration must deal are those patients who either have not paid the B.C. Hospital Insurance Service premiums and are thus made staff patients or those who are in hospital over 30 days and are not acute cases. The B.C. Hospital Insurance Service scheme does not cover patients who are not in the category of acute care after 30 days. These patients too become staff patients if they are still confined after 30 days. In the 1950 annual report of the Vancouver General Hospital, it stated that 17% of the work done in the hospital was free work for staff patients. (19). This was (19)"Annual Report of the Vancouver General Hospital" 1950.
illustrated as a very serious problem and because of it the hospital was having a difficult time avoiding a deficit in the budget.

This year a ninety-day experiment was tried in the Semi-Private Pavilion to try to remove some of these "long-stay" patients. A social worker was used in the experiment because of her knowledge of the community resources for such things as nursing homes and financial assistance. The department felt that this would be an excellent opportunity to show the administration the value of medical social workers.

The doctors would refer their "long-stay" patients to the social worker and then she would make an initial interview. In other cases, the administration knew those persons who were "long-stay" and the worker would interview them, then consult with the doctor. No report was available at the time of this study but it is known that a great deal of successful work was done through the skill of the social worker. The experiment is now to be considered a permanent part of the hospital treatment and may be extended to other wards in the hospital.

The team used in this removal process included as well as the social worker, the head nurse on the ward, the assistant director in charge of the ward and the doctor of each patient involved. The worker through referral either by the doctor or the administration would interview the patient for a social diagnosis. The social diagnosis would be presented in conference to the other team members. Each team member would present his opinion and together a decision would be reached regarding the patient.

This process has been found very useful to the administration. Many "long-stay" patients have been discharged thus reducing the costs for the administration and in turn making more beds available for acute patients. The patients have received benefits from this experiment. Through the casework help given by social workers they have either been able to make concrete plans for discharge or they have been
helped to reach the point where they wish to get well and leave hospital.

The administration has been helped to realize that the "long-stay" patients cling to the hospital for security. They realize that if these patients were discharged without the help of a social worker they would probably develop another illness in order to remain in the hospital. They can now see the value in having the social worker help the patients. The worker uses her techniques to understand the patient and his problems. Her skills enable her to decide whether the patient's problem is in the environmental, economic or personality areas. When she has decided upon the area of conflict she brings it before the team members. It may be that with a short casework contact with the worker the patient will be ready for discharge. In other cases the casework treatment may take longer; the social worker therefore must convince the administration that the patient should remain in hospital until casework treatment can be given. The members of successful discharges and the social worker's abilities in discussing human motivations and the functions of social workers to the team members has convinced the administration that the social worker can be of inestimable value to the hospital.

The social worker could also help the administration if they were to be represented on the Board of Managers. The worker's understanding of the patient and his problems would help in the co-ordination and promotion of treatment services and administrative policies within the hospital. The worker sees the patient as a whole person, not as an organic part in a broken machine. She knows and understands his needs and would be helpful in presenting them to the administration.

The professional worker has been trained to understand the role of other professional people in the hospital and of the administrative practices. As she sees the patient as a whole person, so does she see the hospital as a whole unit. Her skill in understanding the institution, the people served and the professional persons who serve, should be helpful to the administration where they do not
actually have contact with the people they serve nor are they represented on the treatment team.

The administration should make referrals to the social service department in cases involving "long-stay" patients or chronic hospital cases if the doctors do not refer them. The workers in receiving these referrals would expect to work with the administrator involved as she would with the doctor or outside agency. The patient must feel secure through the unity of policy and ideas by all professional employees in the hospital.

CASES SHOWING THE SOCIAL WORKER'S ASSISTANCE IN THE DISCHARGE PLANS

Mr. M had rheumatoid arthritis and had received over 900 days of care in the hospital over a period of 4 years. Every time he was admitted, he became a staff patient. The worker, through casework help in the treatment team was able to help this man to restore his independence and his physical health so that he no longer required hospital care.

If this man had been referred to the social worker at an earlier point in treatment, it would have saved the administration a great deal of money and time. What is even more important of course, it would have prevented Mr. M from becoming damaged physically.

If Mr. M had been referred to the department when he first entered the clinic at which time he suffered with only vague pains in his ankle, it would have saved a tremendous amount of time and money. At the present time, the administration feels it costs $13.00 per day to treat a patient in hospital. Mr. M's treatment for 900 days in hospital has therefore cost $11,700.00 at present day rates. If this patient had been seen as a whole person with environmental problems, he never would have been admitted to hospital because his frustrations around the environmental situation would have been relieved immediately through the social worker's skill in social diagnosing and treatment. As it was, the patient was
saved from chronic invalidism and lifetime care by the administration of either
the hospital or some nursing home.

Miss L was the seventeen year old patient with hysterical paralysis. She
was an interesting example of the type of patient who changed from an acute to a
chronic case. Her condition was considered acute by the administration for a period
of six months and she received benefits from the B.C. Hospital Insurance Service.
She became a staff patient after this period and was classed as a chronic case.

Miss L had a serious neurosis, the conflicts she felt regarding her father
and religion could not be expressed in words because she feared punishment. The
only socially acceptable way she could defy her father's wishes was to develop a
paralysis, making it impossible for her to carry out his demands.

In order to help this type of patient, the worker must develop a trusting
relationship. The patient must be helped to tell the story of her life and when
she feels trust in the worker she will talk about her fears and her conflicts.
The worker must then help the patient understand why she developed this illness
as a defence against her conflicts. This type of treatment can be given only over
a long period of time. If it is hurried, the patient will feel guilty and develop
more defences. The worker through her skills in understanding the patient, will
know when the patient is ready to accept treatment and when to stop.

The administration was helped to realize what the plan of treatment was
and why the patient needed to remain in hospital for a long period of time. The
patient remained a staff patient for one and one-half months and then was dis­
charged.

If the doctor had not realized that the patient had an emotional illness,
the patient would probably have remained in hospital over a period of years. This
patient recovered very rapidly because the doctor and the worker recognized where
the area of conflict lay and together they planned the method of treatment. All
the people on the team of treatment understood the patient because the social worker had discussed the patient with them. The administration understood the patient's illness and in this way everyone knew the goal of treatment and they all worked toward it. The patient felt secure and her response was exceedingly rapid. The worker therefore helped to prevent the administration from years of free work for this patient.

Mrs. S was the thirty-two year old married lady with the physical diagnosis of Reynaud's Disease, myasthenia gravis and anxiety state. The worker's help in securing home maker service for the patient's family and her casework treatment in the environmental level was of tremendous benefit to the administration.

Mrs. S was in hospital at the time of referral. Her discharge was hastened by the relief of having a homemaker in the home. The anxiety she felt regarding her home situation was aggravating her physical condition. When Mrs. S realized that her home was operating efficiently, she was able to accept and benefit from treatment.

When Mrs. S was discharged, the casework treatment she received from the worker helped to relieve the problems Mrs. S was having with her children, relieved a rather precarious marital situation and finally helped to stabilize the economic situation.

Through this help the patient was able to accept her illness and plan concretely for her eventual chronic condition. If this patient had not had the social work treatment with the environmental problem, the anxiety state which was aggravating her condition would probably have advanced the time of her chronic condition. As it was, she was relieved of the anxiety state and discharged. Her environmental problems were dimished, her physical condition was not aggravated and she would probably be able to enjoy two to three years of normal healthy living in her home.

The financial state of Mrs. S and her family would force her to become a
staff patient. Thus, if she had not received social work help, the administration would have been responsible for the case of Mrs. S for possibly fifteen years. With the aid of the social worker, however, the time of hospitalization was reduced and through relieving the marital situation the economic status of the family increased.

Mr. P was the sixty-four year old single labourer with a diagnosis of diabetes mellitus and muscular atrophy. Through casework help the patient was relieved of the financial burden which was aggravating his condition and the fear of no longer having his niece to care for him.

As the problems were brought out by the patient and relieved, he no longer wished to remain in hospital. The doctors were prepared for the fact that Mr. P was a chronic case and after several months in hospital would need nursing home care. However, after casework help over a period of one and one-half months, the patient recovered his physical strength very rapidly and was discharged to his home.

This case is a startling example of the value of the social worker to the administration. In terms of money, thousands of dollars were saved by the administration in this case.

CASES SHOWING THE SOCIAL WORKER'S ASSISTANCE IN PLANNING FOR CHRONIC PRE-PSYCHOTIC PATIENTS

Mr. T was diagnosed as an inadequate psychopath who was requesting psychiatric help. The personality of the patient was so damaged that he could not have benefited from psychiatric help. The doctor recognized through the social worker's social history that some help could be given to the patient in the area of social support. He therefore made the referral to the worker for her skills in this supportive treatment.

The worker did help the patient to secure employment and relieved the mental frustration he was experiencing at that time. This treatment by the worker
prevented Mr. T from becoming a chronic mental patient. The social worker recognized that Mr. T will always need support when his frustrations become too much for him. His personality was so damaged in his early years that no real treatment can be given now. He can manage adequately if he is given help when life becomes too much for him at certain times.

This type of help can be given over a period of about two months in clinic interviews. If he was not able to see a social worker at these times, Mr. T would probably develop a psychosis which would then confine him to an institution for a long period of time.

This case illustrates how the worker can save the administration from the cost of chronic care. This type of patient needs supportive treatment probably once every two or three years for a period of two months. If he did not receive this help, however, his mental health would become seriously impaired and lead to an eventual confinement. Thus, with social work help the patient remains an independent productive citizen and the hospital is prevented from the cost of long term care.

Miss M was a thirty-six year old stenographer who was requesting psychiatric help. Her conflicts lay in the areas of her environmental and employment situations. The worker gave the patient the treatment she needed and helped her to emancipate herself from her mother and receive satisfaction from employment.

The interviews were held in the Out Patient Department clinic over a period of seven months. If this patient had not received the help of a social worker she probably would have developed a severe neurosis. She did not have the strength to deal with reality alone. The psychiatrist did not have the time nor the skill to deal with this problem. The patient could only be helped around her reality problems. If an attempt had been made to help the patient on a psychiatric level she would probably have developed a severe neurosis. The worker had the skill to diagnosis where the area of treatment would be most beneficial to the patient.
The treatment the patient needed was given by the social worker and prevented tremendous costs to the administration. If this help had not been available, the patient would have been a chronic mental case through either not receiving any help from the Out Patient Department or through incorrect treatment by the psychiatrist because of his lack of time and skill in social treatment.

CASES SHOWING THE SOCIAL WORKER'S ASSISTANCE IN PLANNING FOR CHRONIC CLINIC PATIENTS

Mrs. F was the sixty-one year old widow with a diagnosis of glaucoma. The worker helped Mrs. F to become less troublesome in clinic, helped her to accept her illness and finally through this, to enjoy some recreation. Mrs. F could not accept her physical diagnosis and made many unnecessary visits to the Out Patient Department with many types of physical complaints. This was of course exceedingly costly in both time and money for the clinic. Through casework help the patient was able to accept her illness and take pleasure in outside activities. In this way she no longer needed to have vague physical complaints and the clinic visits were reduced. Thus, the administration was saved from the costs of needless visits which might have resulted in a chronic hospital case.

Mrs. G was the forty-eight year old woman with seven children who had a diagnosis of psychological gynecological complaints. The doctor realized that environmental problems were preventing Mrs. G from accepting treatment. The worker was able to diagnose the problem and succeeded in removing the source of the frustration which was the presence in the home of a thirteen year old spastic child.

When this removal took place, Mrs. G was extremely relieved and ready to accept treatment for her physical complaints. If this patient had continued to receive physical treatment with no exploration into the source of the anxiety, it would have been a costly experience for the administration. The patient might have received years of clinic treatment from the Out Patient Department without feeling
any relief from her anxiety. The anxiety would have aggravated her physical condition until permanent physical damage might have been the result. As it was, the source of the frustration was removed in a period of one month. Her illness stemmed from the guilt she felt in rejecting her spastic child. The relief from this frustration would probably result in the patient's physical complaints being almost nebulous, for she would no longer have any need to be ill.

**SUMMARY**

The social worker can help the administration in the hospital, not only by saving cost and time in the Out Patient Department and on the ward but in other ways such as representation on the Board of Managers and assisting the co-ordination of treatment services.

The administration of a large institution such as the Vancouver General Hospital has a tremendous responsibility in the maintaining of adequate facilities and in spending public money. These administrative problems are often so time-consuming that the administrator is completely removed from the people he is serving. It is the social worker therefore, who can help the administrator in understanding the patient and his needs and the administrator who makes the satisfaction of these needs available. This service by the worker could be available to the administrator through reports and conferences. It would be a saving both in time and money and what is more important, assure patients of adequate treatment.

The worker can also be of help to the administration in her skill in handling of staff relationships. When many services are available in treatment, there is usually a division between departments. The worker could be of great assistance in helping to co-ordinate the services and in defining the roles. The medical worker has been trained to use many resources in the rehabilitation of the patient and this experience would help in her assisting in bringing the resources together and in inter-departmental understanding.
Finally, the worker can help the administration in resolving one of the largest problems of any general hospital, the removal of the chronic "long-stay" patient. The "ninety-day" experiment described in this chapter pointed out how the worker has had a great number of successes because it is now to be considered a permanent function of the social service department.

The social service department is growing rapidly and is becoming more and more an integral part of the administration. In the future it can be expected that the service to the administration will be as much a function of the department as it is to the doctors. The hospital is growing so rapidly and there is such a tremendous influx of new treatment service that the administrators are even more removed from the people they serve. It is to be expected therefore that the social worker's work will be increasingly in the area of bringing the patient as a social personality to the administration in the co-ordinating of treatment services for his benefit.
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS.
From various angles this study has illustrated the role which the social worker can play in the treatment team in the medical setting. Team work is accepted in some areas, but not as yet in others. The tremendous advances in medical science in the late 19th and early 20th centuries brought about an era of intense specialization. There was a great amount to be learned about each small area of the living body and it was found impossible for one man to know it all. The doctors, therefore, became specialists in sections of the human organism. Later, it was found that in this increasing need to specialize, the patient as an integrated social and emotional being, was lost. It was then, therefore, that medical social work became a valuable asset in the treatment team with the doctor, the community and the administration.

Of course the social worker in the hospital works under the leadership of the physician. The patient comes to the hospital because he is seeking relief from physical pain. The doctor decides in which way the social worker can help him and he will refer the patient to the social worker, stating the problem on the referral slip. Workers in the past have received referrals for routine environmental problems for the most part, with little recognition of the potentialities in the medical social worker. This lack of recognition has been particularly noticeable in the doctors who serve in general medicine. The best referrals seem to come from the neurologists and psychiatrists. This situation is obvious because the emotional factors in neurological and psychological illnesses are much more easily seen than they are in the field of general medicine.

In the Vancouver General Hospital Out Patient Department the doctors do not receive any monetary reward for their services. These doctors serve in the clinic for a three month period and in a consulting capacity for the remainder of the nine months in the calendar year. These staff doctors, as they are called, are appointed by the Medical Board; they are all specialists and it is considered an honour to
become a staff doctor. Their duties consist of serving in the Out Patient Department, consulting for staff patients on the ward, and teaching and supervising of internes. In return for this service, each doctor has a certain number of beds assigned to him for the patients in his private practice.

From this outline, it can be seen that service in the Out Patient Department is considered an arduous, non-profit duty by some doctors. They arrive late to the clinic although appointments begin at nine A.M. Their services are rushed and often inefficient. Patients have to wait for hours for appointments and in many cases receive only five to ten minutes of attention. The patient, therefore, is often hostile about waiting and, feeling physical discomfort, he does not give a true picture of himself. This disgraceful handling of patients is not true in all cases but it does happen often enough to include it in this study. There are, on the other hand, many doctors who give a great deal of time and interest to these non-pay patients. These doctors are usually the ones who give excellent referrals to the social service department and some worthwhile treatment has been the result.

The value of the social worker in medical treatment is that the patient's physical recovery is usually dependent on his emotional and social state of health. The worker, through her skills in social diagnosis and treatment, can be of tremendous service to the doctor. It is an accepted fact that the doctor is more competent in the area of physical treatment. Physical and social treatment cannot be separated like the "mind" and the "body". The worker and the doctor, must, therefore, work closely together if there is going to be a successful rehabilitation of the patient.

In the preceding chapters, there was also an attempt to point out that the workers in the medical setting had a greater need for community resources than any other type of social agency. It was pointed out that the inter-agency referrals were not good at the present time. This present situation is not the fault of the medical social workers alone but of the other agencies as well. There seems to be
a general lack of understanding of the functions of the separate agencies. This is the result of poor administrative policies within the agencies and a lack of skilled personnel. The increase of trained personnel should change this situation to some degree.

The workers in the hospital are totally dependent on outside resources for the rehabilitation of the patient. It seems that the worker in the hospital is being accepted by her knowledge of community resources. It is, therefore, vitally important that the inter-agency functions improve. The workers in the hospital are responsible for the integration and promotion of community resources. If they are to receive recognition, they must accept their position as resource persons and perform successfully in this role. When they achieve success, it will be much easier to present their potentialities in treatment skills.

It has been pointed out that the Vancouver General Hospital is expanding rapidly. New buildings are being constructed and new buildings are being added. This tremendous increase in specialties has of course increased the financial budget. The administrators are more than ever occupied with administrative duties and are becoming more and more removed from the people they serve. The social worker can be of inestimable service in bringing the patient as a person to the administrators. It is she who knows the patient and his needs and it is she who can present them to the administrator who makes the fulfillment of these needs possible.

The main source of frustration to the administrators at the present time is the chronic non-pay patient. The ninety-day experiment described previously, pointed out the usefulness of the worker in helping to remove these patients. The worker had an opportunity to work directly with the administrator and it has helped tremendously in showing the real function of the social worker in the medical setting. It was so successful that this work with the administration will
be a permanent function of the social work department. The experiment was started in the Semi Private Pavilion which does not include patients from the Out Patient Department. This has, therefore, increased the status of the social worker. Their service is not available for indigent patients alone but for all patients.

RECOMMENDATIONS

The first recommendation of this study has already been carried out. It was that a job analysis be done so that the routine clerical functions of the workers be eliminated. It is felt that well trained and supervised volunteers or a well selected clerical staff would do this work successfully. The supervision of this staff could be conducted by the Social Service Department. The eligibility, routine application forms which must be filled out are exceedingly time consuming for the workers. If this intake job was taken over by clerical staff, it would release the workers for good casework.

The second recommendation would be that the Women's Auxiliary put the fund they have available for appliances in a central place. As it is, when a patient is in need of an appliance, the workers must call the Women's Auxiliary for approval, phone the supply depot for the cost of the appliance and again phone the Women's Auxiliary for the approval of cost before the requisition can be put through. This type of work is time consuming also and prevents the workers from doing casework. It is therefore, recommended that the Women's Auxiliary permit the workers to make requisitions up to the cost of $50.00. Anything above that amount should, of course, have the approval of the Women's Auxiliary.

A third recommendation would be that workers should be able to order taxis for their own patients without first having the approval of the Director. This again is time consuming and pointless. The workers in the medical setting actually have a great deal of personal responsibility. They receive their cases directly
from the doctor, the casework supervisor acts only as a consultant. It is felt, therefore, that with this tremendous responsibility toward the patients, the workers could also take responsibility for ordering taxis.

The fourth recommendation is that with the release of the workers from eligibility studies and routine functions, there would be enough workers released for clinic duties. It is recommended that there be one worker in each clinic to handle those cases exclusively. The worker should sit in the clinic with the doctor and discuss each case for its possibilities. In this way, patients with social problems could be detected immediately. Their social problems could be dealt with so that they could benefit from physical treatment and therefore reduce the cost to the administration.

Some clinics may need more than one worker. It is recommended that there should be a study done in each clinic to try to detect the percentage of the cases that could benefit from casework treatment. The problems of the patients in the Out Patient Department are greater because of the financial problems and the infrequent personal contacts with the doctors. If the worker can present an adequate history and an adequate plan for follow-up, the doctor will be able to handle more patients with less time and with more efficiency.

The fifth recommendation is that there should be a worker for every one hundred staff beds. These staff patients, like the patients in the Out Patient Department, have greater social problems in financial stress and brief contacts with doctors. The workers, therefore, have a greater pressure in preparing histories and in making discharge plans.

The sixth and final recommendation is that there be a greater effort on the part of the Department to define its function and the role of the individual workers. There should be an attempt to present the function of the workers through interdepartmental discussions and lectures and through the employees' bulletin. There
should be a vigorous attempt to co-ordinate and integrate the resources of the community. It is recommended that there be more inter-agency contacts through reports, visits and conferences so as to eliminate this present lethargy and jealousy between agencies.

If these recommendations were put in practice, it would be expected that there would be a change in attitude toward the social service department. The workers would have time for good casework service and through this practice the change would become evident. The younger doctors who are coming into the hospitals at the present time have been taught how to use the social service department. If the workers are to participate in the treatment process, they must be released from routine clerical work.

There have been great changes in the department this last year. More and better referrals have been coming from the doctors, the agencies and the administration. The workers cannot do both casework and clerical duties efficiently. If they are to be truly professional, they must be strong enough to release themselves from the routine and practice what is truly social work. The medical worker is responsible firstly, to the people he serves. If the worker is fully convinced that it is her responsibility to help people to develop and use their capacities to deal adequately with their social environment, then they will take the necessary steps to secure the highest in professional service.
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