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REPORT OF MEDICAL SOCIAL CONSULTANT

WAR RELOCATION AUTHORITY

Helen K. Shipps

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HEALTH SECTION

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SUBMITTED BY

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December 15, 1945

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D E F I N I T I O N

Excerpt from Administrative Instruction on Medical Social Work, issued May 22, 1943.

"Medical social work shall constitute a part of the medical service available on Relocation Centers. It will give assistance (1) to patients, in helping them to meet the social problems associated with illness; (2) to the medical staff, in reporting social factors having a specific relation to diagnosis and treatment, and in planning with physicians the patient's care in the light of complicating social and psychological factors; and (3) to community agencies in rendering medical-social reports and interpretations."

On December 1, 1942, a Medical Social Consultant was added to the staff of the Health Section, which, in addition to clerical help, included a Chief Medical Officer, a Nurse Consultant, a Sanitary Engineer Consultant and an Administrative Assistant. The expression for the need of medical social consultative service was simultaneous in the Health and Welfare Sections and the person appointed was being considered as an assistant to the head of the Welfare Section in the national office when word was received that the Chief Medical Officer was recommending the establishment of the position in the Health Section. This seemed to the Welfare chief a more sound development and the position was accordingly set up in the Health Section. It was the beginning, however, of the closest possible co-ordination of the two services, both at the national level and in the centers. The statement of medical social functions which became part of the manual instructions to centers included a fairly lengthy and detailed statement on functions in relation to the welfare department (Appendix I). Although issued as part of the manual material on health services, it was prepared jointly at the national office and copies were, of course, available to welfare departments at the centers.

Although the Public Welfare Consultant on the national staff had a remarkably clear understanding of medical social functions, this was not true in the earlier stages of the work of some other members of the national staff whose previous experience had not included familiarity with medical programs in detail. Because of this,

it happened that the year following the institution of the program the Executive Officer recommended that the work be incorporated in the general welfare program, on the ground that the Bureau of the Budget would be less likely to approve the appropriation for medical social work and that positions for "counsellors", whose need had already been recognized, would not be questioned. Consideration was given to this suggestion but it was finally decided to keep the work as part of the Health Section. The wisdom of this decision was particularly evident when the WRA program was entering its final stages after the lifting of the exclusion order and patients were to be transferred to west coast hospitals and sanatoria. The Health Division, maintained in the San Francisco field office during the whole period to take care of problems in connection with the several hundred persons of Japanese ancestry who had remained in hospitals in the evacuated area, had naturally built up good will which paid immediate dividends in the readiness with which patients were accepted for transfer from relocation center hospitals. The medical and medical-social machinery functioned smoothly and effectively in this rather complicated piece of work. Perhaps the other chief gain which later justified the allocation of the position to the Health Section was the real support given the program by nearly all of the principal medical officers in the centers. While they might have appreciated service rendered by another department, active professional support was much more readily given when the physician himself was recognized as the leader from whom the service stemmed.

First weeks in the Washington office were occupied with working out functions, establishing positions for center staffs, and recruiting personnel. In addition to correlation of functions with the Welfare Sec-

tion, a statement of basic functions was worked out with the assistance of the American Association of Medical Social Workers, which organization showed a gratifying interest in the program from the beginning. Invaluable assistance was given by Miss Edith Baker, Chief of the Medical Social Unit in the Children's Bureau and an outstanding leader in the profession. In addition to a real knowledge of functions in relation to both private and public agencies, she had a wide acquaintance with qualified personnel which made her advice most helpful in our early selections.

Close relationships were maintained with the Civil Service Commission. Miss Elizabeth Cosgrove, at that time head of the Social Service Unit, and her assistant, Miss Charlotte Abbott, came to the WRA office for a conference with the Medical Social Consultant and a representative of the WRA Personnel Section on the question of functions, qualifications and grades for the center positions. In the beginning, the positions were set up at a P-2 level, except for the provision of a P-3 classification for the medical social work position at an especially large project or for a position involving supervision of the work at two projects. Later, as replacements had to be made, the positions were re-classified to P-3 at all centers (Appendix II). In making the classifications, two comparisons were taken into consideration. In view of the qualifications required, the classification was low as compared with the positions of the counsellors in the welfare sections. On the other hand, some thought had to be given to the fact that the position of Chief Nurse was at a lower salary level and that, on the hospital staff, there might be certain complications arising from a too great divergence in classification. The later reclassification was readily justified by the scarcity of qualified personnel

for replacement and made easier by the fact that meantime a Senior Chief Nurse position at P-3 level had been approved for three of the large centers.

The American Association of Medical Social Workers invited the medical social consultant to be a member of their War Time Services Committee and in other ways maintained interest in the program. A 1943 fall number of the AAMSW Bulletin carried a brief article regarding the work and the Association members who were already on the staff in various centers. A more detailed article has been requested for the Bulletin and is now in process of preparation. The active interest of the Association in the program was a decided asset in recruiting personnel. Utilization of this recruiting "tool" was later justified as several of the staff medical social workers rated their work at the various centers as one of the most worthwhile of their professional experiences.

Schools of social work, through their medical social departments, were most cooperative in personnel recruitment, notably the social work schools at the Universities of Chicago and California, and Washington University in St. Louis. As is inevitable in such situations, cooperation was closest where the consultant had previous personal or professional ties. Mid-Western, rather than Eastern, recruiting was found to be more fruitful.

Establishment of the medical social position on the national staff was not the first experience of medical social service for at least a portion of the evacuees. Service of this type was instituted at the Santa Anita Assembly Center by Miss Margerette Fugita, a qualified medical social worker who had been employed for several years as a member of the

staff of the Social Service Department at Los Angeles County Hospital. Later she gave almost two years of excellent service at the Topaz Hospital until her own relocation to a professional position in Cleveland, Ohio. Only one other evacuee, Miss Hideko Nakazawa, who was just completing her two year postgraduate course at the University of California at the time of the evacuation, was qualified in this field. She was placed on the Tule Lake Hospital staff and did a helpful piece of work during her year and a half at the center. The Chief Medical Officer, during the summer and fall of 1942, canvassed the Schools of Social Work and discovered that there was only one other qualified evacuee in the country, a young woman just completing her work at University of Chicago and planning to continue work in that city. The Chief Medical Officer's conception of the part to be played by medical social work in the total health program dated from his experience as a member of the staff of the U. S. Children's Bureau.

The consultant first entered on duty with the Health Section staff in the San Francisco office. Orientation and work started together with a series of seven Center visits during the next two months and a return to Washington about the time the headquarters of the Health Section were transferred here. The first visit was to Manzanar, December 5 to 8, and covered the period of the "incident" at the Center. Looking back, it is of interest that even during a relatively disturbed period, it was professionally successful and the routine started was more or less characteristic of all the early visits to centers, viz:

(1) Interpretation to the Principal Medical Officer, who had no previous experience in working with a medical social worker but showed

keen interest in a statement of functions and the way in which they might fit into the general health program. He later became one of the most enthusiastic supporters of the service.

(2) Interviews with the Chief Nurse and the Public Health Nurse, both of whom were favorable to the proposed program, though the latter was the only person on the hospital staff with any previous experience in working with medical social workers.

(3) Conference with the Head Counsellor who had already seen the need for such service and was contemplating the addition to her staff of an assistant with Medical social training. She was quick to see the advantages of having the position a part of the hospital staff; (a) that her own department might secure more complete medical-social reports from someone actually in the hospital, and (b) she would be able to fill the position with another person who, in turn, would work out cooperative plans with the medical social worker.

(4) During this visit, the consultant started a function which was never quite lost, a sort of "itinerant case work" program. The population included three three-fourths Alaskan Indian children whose father was at the Minidoka Relocation Center and whose mother was a tuberculous patient in a hospital near Seattle. The consultant was asked to secure a report of the father's attitude and a week or two later interviewed him together with the counselor at Minidoka. Much later the mother was interviewed at the sanatorium and a report of that interview added to the then voluminous folder, which the consultant last saw on the desk of the Relocation Adjustment Adviser in the Seattle Area Office. It was interesting at that point to be able to lighten a few of the facts in a complicated

case. In the course of the next three years, with consultations on problem cases in all the centers, one noted how often familiarity with individual cases was helpful. This was particularly true during the first half of 1945 when the movement of ill persons back to West Coast institutions was getting under way.

(5) The search was started for evacuee personnel and interviews held, always with a twofold purpose; first, in order to locate persons who might be available as assistants to the appointed medical social worker (see Appendix II, description for evacuee position of Medical Social Assistant); second, this kind of interview would lead inevitably to a discussion of the future plans of the evacuee, especially if there was evidence of any real interest in social work as a profession. During this first visit, the consultant met Miss Mari Okazaki, who later completed two years of training at the New York School of Social Work on a scholarship basis. At that time, she was fairly certain she wanted to do social work but was not decided as to whether her major interest was in group work, in which she had had some pre-evacuation experience, or in medical social work. Arrangements were made for her to assist in one of the hospital clinics so that she might have some basis for judging her own reaction to work in a medical setting.

(6) A very brief visit with the Project Director, who was much occupied with post-incident complications, completed the first Center visit and was the beginning of a relationship which varied necessarily from project to project but was more and more a stimulating professional experience.

Comments will be made on the Manzanar medical social program later in this report but it may be of interest to note here that the first incumbent, appointed in February, 1943, made an excellent demonstration. In addition to establishing the position firmly in the hospital and in relationship with other departments she helped, through participation in YWCA and other community activities, to bridge the social gap which always tended to exist between hospital and community and with special reason at Manzanar where the hospital location was about a mile from administration offices and living quarters.

As succeeding visits followed more or less the same pattern, only some of the outstanding features and the significant variations will be mentioned. At Tule Lake, and a week or two later at Topaz, the consultant met what amounted to almost a demand for a psychiatric social worker on the part of the Welfare Department, supported in each instance by the Project Director. It was explained that no such position had been established but that a medical social worker with psychiatric training might fill the need. By April the position was filled in this manner and for most of that year one medical social worker supervised the program at the two centers. This worked fairly well as long as qualified evacuee workers remained on the two hospital staffs. The appointed person was able to assist with establishment of procedures, in planning the whole program, doing some actual case work and giving real service on a consultative basis. As it worked out, she was particularly effective in consultative work at Topaz where the Welfare Department worked out a fairly elaborate plan for utilization of her services. At both Tule and Topaz, the need for medical social work was more obvious to the Welfare Department than to the hospital staff. At Tule, this was in part due to the fact that the Principal Medical Officer

was about to go into the Navy and that the Chief Nurse had no previous experience in working with medical social workers. Also, the services already being given by the evacuee staff member was sufficient to meet the needs which were obvious to other members of the hospital staff.

No actual opposition to the program was met at any of the centers. At Minidoka, perhaps, the least need was expressed. An evacuee with a minimum amount of training was functioning in the hospital and seemed to the Principal Medical Officer quite adequate, though he was willing to accept any further assistance offered by the national office. The position there was filled the following May and there was an interesting contrast in his attitude a year later when permission was asked to detail his Medical Social Worker to another project for thirty days. He consented to the detail but said "Please do not keep for any longer period the most helpful person on my staff". (At this center the Principal Medical Officer stayed for the whole period and the Medical Social Worker for 26 months.) The visit to this center had been combined with escort of two delayed evacuees, illegitimate mothers, from the coast. Most of one day at the center was spent tramping around in the mud with the Head Welfare Counselor, making a number of home visits, establishing rapport with Welfare Section by sharing his mud as well as his medical social problems.

At Gila River, also, no need for medical social service was recognized by the hospital staff. After two or three days of individual conferences, a meeting was held which included the Assistant Project Director, the Head Counselor and the Public Health Nurse. The Principal Medical Officer agreed to the program only because all the others definitely supported it. This physician, who has remained on WRA staff for the whole

period, has since been most appreciative of the part played by this service in his hospital program. In 1944, in requesting the establishment of an assistant's position, he said, "One medical social worker has been able only to scratch the surface of the needs in this area."

At each of the Arkansas centers, it happened that the Chief Nurse was a person with several years of previous experience with the Indian Service. This was probably a contributing factor in the understanding of the significance of social complications in medical situations evidenced in rather unusual degree by these two chiefs of nursing service. The same held true at Poston, but it happened that the medical social consultant did not visit there until a much later date. At Jerome a rather remarkable piece of work was being done by Miss Amy Murayama, an evacuee with no previous technical training but who had worked in the hospital at Santa Anita Assembly Center under supervision of a trainéd evacuee. There was at that time no Welfare Counselor at Jerome, but a small group of evacuees, none of whom had technical training, had organized a departmnt and assigned each of its half dozen members to the function for which he or she was best qualified by previous experience. Miss Murayama was a "natural" in case work and with a nice appreciation of medical situations; working in close cooperation with the appointed public health nurse, she was contributing a real service to the hospital and the community. As in other situations of this kind, the consultant naturally discussed future plans and training even though relocation was, in December, 1942, only a dim prospect. It may not be out of order to say at this point that Miss Murayama later relocated to Chicago and was granted a two year scholarship for completion of college and a year of postgraduate training in social work. Medical social

work by an appointed staff member was not instituted in the Arkansas centers until July, 1943, when an excellently qualified person was found to supervise the work in both centers, spending three days per week at each center. Because of the qualify of the appointee and the nearness of the centers, this continued to be a satisfactory arrangement until the closing of the Jerome Center in June, 1944, following which she was available for full time work at the other center.

Personnel recruitment, functioning normally through the Personnel Office of the WRA and the Civil Service Commission, had always to be supplemented by the utilization of professional connections with others in the field of medical social work. The total number of qualified personnel in this speciality was quite insufficient to meet the war time expansion of services. Then, too, the fact that only one appointment was contemplated at each center, and that functions in this area were in most instances not familiar to other members of the center staffs made it essential that care be exercised in selection. A total of twenty-one appointments were made, in addition to two transfers from Welfare to hospital staffs during the final stages of thework at the centers. Two appointees came on a basis of a year of leave of absence from other positions, and, in one instance, the leave was extended to a second year. Three of the appointees were married to men who were in the Armed Forces in the Pacific, and, in each of those instances, the husband was a tolerant person glad to have his wife working with the evacuated persons. In only one case was an appointment entirely unsuccessful and terminated after a short period. Practically all of the appointees were members of the American Association of Medical So-

cial Workers with experience far above the minimum requirements. Several had had experience in public welfare or some other form of social work in addition to post graduate training and experience in the medical social field and there was evidence that the varied background was valuable in orientation to the center programs. For the most part the personnel standards were kept very high and the effort along this line was repaid by a service which was recognized as a real contribution to the total program.

Project visits for supervision naturally consituted a major portion of the consultant's responsibility. With one exception some groundwork had been done by the Consultant before a medical social worker was appointed to the center staff, and an effort was made to visit within two or three months following each appointment. In addition to the newness of the program, the isolation was another factor tending to increase the need for such visits. The great distances to be covered and certain other duties of the Consultant made frequent visits out of the question. The need was met in other ways by the fortunate circumstance that both the Chief Medical Officer and the Nurse Consultant had a real understanding of medical social functions. Thus their center visits also could be used effectively in assisting with various adjustments, particularly in interpretation of functions to the medical and nursing personnel. The mutual understanding of functions on the part of the members of the Health Section staff compensated in great measure for some of the numerous handicaps inherent in such a program. Frequent exchange of reports and occasional meetings at various centers, in addition to the rather rare occasions when staff members were together in the national office, kept the program unified.

On the basis of the general statement of functions, and after a few months experience in any given center a more practical and detailed statement applicable to the particular setting was worked out during a visit by the Consultant. In some cases this was simply a guide for future development and, in others, was circulated to various departments over the signature of the Principal Medical Officer, serving an educational purpose and at the same time giving status to the service as part of the total health program.

Center visits always included conferences with members of the Welfare staff and often included participation in Welfare staff meetings. These conferences were of great value in clarification of functions, and often were the occasion for fruitful discussion of complicated cases. Due to the fact that many of the medical social workers had had previous experience in a more general field of social work, their appreciation of the functions of the Welfare Sections was usually adequate. On the other hand, few of the counsellors had worked closely with medical social program. The Consultant's visit furnished a logical opportunity for discussion of mutual problems. As the WRA program moved forward step by step and the relocation of evacuees to outside communities assumed greater proportions, co-operation with the relocation program followed much the same pattern already laid down with the Welfare Sections although it was not always such a close relationship.

Staff medical social workers were encouraged to make contacts with other professional people in the states in which they were located and, in some instances introductions were arranged through national channels. At one time the Director of the Medical Social Unit at the Children's Bureau and her West Coast Regional Assistant met the Consultant at a center. Three

years of close co-operation in the services offered for crippled children at the centers, and the circumstances surrounding return of some of those children to the previously evacuated area, made it worth while that the persons responsible for continuing service to these children should visit a center. It was an interesting and effective setting for discussion of follow up plans and the method of routing medical-social reports for patients returning to their former homes. The Principal Medical Officer at this partucular center was one of those who, two years previously, had seen no need for this kind of service. It was gratifying to note his close team work with the Medical Social Worker on his own staff, and his keen interest in discussion with the visitors.

Monthly reports on medical social work at the centers were made to the principal medical officer and copies routed to the consultant at the national office. Reports containing material which might be significant for other workers were copied occasionally and sent to all centers. Evaluation of reports was used as a supervisory tool. Fairly free correspondence was maintained with the workers on problem cases. These expedients compensated in part for the infrequency of center visits by the Consultant. A typical monthly report is attached in Appendix III. The following table gives the statistical portion of the medical social report for the same center for a period of one year, August 1, 1944 to July 31, 1945.

STATISTICAL MEDICAL-SOCIAL REPORT

		For One Year
I.	INTERVIEWS WITH PATIENTS:	
	On Wards	291
	Office or OPD	524
	Home Visit	330
II.	MEDICAL CONSULTATIONS:	
	With Doctors	1115
	With Nurses	258
III.	COLLATERIAL INTERVIEWS REGARDING PATIENT:	
	With Social Welfare	135
	With Other Sections	183
	Relatives or friends of patient	765
IV.	LETTERS AND REPORTS WRITTEN:	
	To Social Welfare	950
	To Other Sections	138
	Other projects or WRA Hdq.	225
	Other Agencies or Individuals	1457
V.	PARTICIPATION IN ARRANGEMENTS FOR OUTSIDE MEDICAL CARE:	
	To Billings	No. of patients
	To Cody	No. of patients
VI.	COMMITTEE MEETINGS, CONFERENCES, ETC. OTHER THAN INTERVIEWS AS INDIVIDUAL CASES:	353

In addition to supervisory visits, the Consultant was sometimes detailed to a center staff for a period of thirty days or more during an interval when the center position was vacant or to meet some other emergency. In June, 1944, when one of the Arkansas centers was being closed and the half-time staff worker was needed full time, the Consultant substituted at the other center. This type of detail was of value, not only to meet the emergency situation, but in furnishing the Consultant with experience which was most helpful in her conferences and in practical interpretation of national policies. The longest detail was the final one to the Emergency Refugee Center for the group of European refugees. Because of the comparative smallness of this group, a position for a medical social worker had not been established. Effort had been made during the early days at the Shelter to establish procedures between the Health and Welfare Sections which would give the necessary service, but the complications in the Shelter situation, including the prevalence of psychomatic factors among the medical cases, had made this plan quite ineffective. A thirty day detail to the Shelter lengthened to a ten-week one as the Consultant evaluated the situation, demonstrated the need for a permanent position, and carried on with a routine medical social program until a suitable appointment could be made. 1/

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1/ For a fuller discussion of the medical social work program at Fort Ontario the interested reader is referred to the final reports on the Refugee Shelter.

Variations in the development of the medical social program in the centers will appear in the individual center reports. Some mention of the outstanding problems, of the procedures developed to meet them, and of the emphasis on certain aspects of the program growing out of the peculiarities of certain situations or of differences in the backgrounds and the interests of individual medical social workers, belongs in this report.

Medical social reports and interpretations to Welfare Sections were an important part of the work at each center and the first forms developed, and later standardized, were for use in this connection. These reports became increasingly important as the relocation program grew. With final plans for closing the centers, different systems were worked out for medical and medical social reports to Welfare Sections and Relocation Divisions. In one or two centers the worker reviewed all the medical records in the hospital, and in other centers various methods were utilized for the selection of certain groups of records reviewed first by the principal medical officer before reports were prepared for his signature. Care was used in each center to keep the final responsibility for such reports a purely medical one even though most of the details were handled through the office of the medical social worker. Another medical report question which was always a problem was that of reports on physical ability to work, on which depended welfare grants and compensation. Pressures were brought upon evacuee physicians to make such certifications

favorable to the applicant. To relieve such pressures, and to enable the medical staff to devote their time to more essential medical service a variety of procedures developed, some quite simple and others rather elaborate plans. In each instance, it was one of the administrative duties which medical social service seemed justified in accepting. Reports to outside agencies, particularly on cases of crippled children and on mental cases, early became medical social functions but in these cases the need for social interpretation was obvious and was accepted as a normal function, not an administrative "chore".

Service to crippled children represented one of the most complete pieces of medical co-operative service in the whole program and naturally became in part a medical social function as the latter service was established. Reports of cases under supervision of the State Crippled Children's Service in the three West Coast states were sent to the Medical Social Consultant in the State Health Departments in the states in which centers were located and these departments were asked by the U. S. Children's Bureau to participate in follow-up service, with an offer for assistance with Federal funds if necessary. The WRA Medical Social Consultant encouraged the center workers to contact the appropriate state representative, and services were carried on with no serious break for old cases as well as for new ones discovered on the centers. One center, in which a particularly effective piece of team work developed between Medical Social Worker and Public Health Nurse, had a special clinic which included all children with bowlegs

and flat feet discovered in a survey of nursery schools and kindergartens. At center closing, or when individual families relocated, reports on all cases needing continued follow-up by Crippled Children's Services were sent to the proper state health departments, attention of the medical social consultant. Knowledge that this would be done was reassuring to families, especially to those relocating in new areas. A unique piece of work at the Manzanar center deserves mention. A very well qualified teacher for handicapped children was employed by the Education Section and assigned to work at the hospital where a large room in the children's ward was made into an attractive school room. In addition to the in-patients, some heart cases needing supervision were brought in as day students and had their lunches and afternoon naps at the hospital as well as therapeutic exercises which, during the summer months, included work in a victory garden between the wards. Instead of sending the children for examinations or surgery to outside hospitals and clinics, the California State Crippled Children's Service sent an orthopedic surgeon from Los Angeles at regular intervals to hold clinics at the center hospital. Some strabismus cases were taken care of in the same manner. The Medical Social Worker played a key part in this program, working closely with the medical staff, the special teacher, and the families. The ward was the pride of the Education Section and of the whole hospital staff, from the principal medical officer to the orderlies. The excellence of the teacher and her close liaison with medical social service were major factors in the smooth

working out of the program.1/

Before the medical social program got under way, arrangements had been made in most of the states involved for commitments of mental cases to appropriate institutions, and normal procedures for interstate transfer to institutions at the point of legal settlement were made applicable at a somewhat later date through negotiations by the Chief Medical Officer with the appropriate departments in the three West Coast states concerned. Early commitment cases at the centers were in most instances handled by Internal Security with, of course, proper medical certification. Centers welcomed the assumption of some responsibility in these cases by the medical social worker and, in general, her services included contacts with patient and family and preparation of medical-social reports for the institution to which commitment was being made, follow-up with relatives and, where distances were not too great, arrangements for occasional visits of relatives to the patient. The Consultant discussed with the medical historian at one state hospital an outline report which was not too elaborate but which included provision for the factual information which might be needed in verification of legal settlement in another state, and for such information on social and emotional factors as might be available.

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1/The Education Department at Manzanar prepared a report which is available in the WRA Library and is entitled "Classes for the Physically Handicapped."

A sample report on a case handled by the Consultant during one of her early center details was distributed to the center workers. Since transcripts accompanying patients in cases of interstate transfer did not always include the medical-social reports, extra copies of these were provided and a method worked out to insure their delivery to the proper institution in the event of a transfer.

Commitments were probably a little more frequent than in normal communities of the same size, but without much more careful study than has been possible no general statement could be made connecting the traumatic experiences of evacuation and the abnormality of center life with the incidence of mental disease. Occasionally there would be a mental break in which the social history revealed a fairly obvious contributory cause in the patient's reaction to some evacuation or center experience. One such case was that of a young man of artistic temperament but with no history of real instability in his own life or that of his family as far as could be ascertained. His reaction to evacuation, and to the loyalty questions involved in the registration and segregation programs, had evidenced a maximum of strain and it was not too surprising that he walked out the gates of the center one day, unable to heed the calls of the military police because he thought he was being pulled out by a helicopter. This lad was hospitalized and given electric shock treatment as well as psycho-therapy. He responded rapidly to treatment and was paroled back to the center within three or four months, apparently well. Relocation and medical social

service worked closely together on this case to speed up a plan for the family to be reestablished in an eastern city so that further exposure to the environment in which the break had occurred was avoided.

Medical-social history on another mental case, also a young man, is included in Appendix III. The significance of this particular case at this point is that the patient had a history of a previous break and a second one might have been expected with any undue stress. An elder sister, who gave the social information in this case, evidenced such great strain that both the physician and the worker were convinced that she, also, might be on the verge of a break down. Supportive treatment was given her for some time and she was encouraged to work as a nurse aide and later in one of the offices. The worker visited "George" shortly after his commitment and was able to bring back a good report to the family as his improvement in response to shock treatment was immediately evident even though he required a period of approximately a year of hospitalization. Arrangements were made later for the two sisters to visit him, and other contacts with the elder sister in particular carried on for a period of several months. She seemed able to talk out her tensions in a few long interviews, and thereafter responded nicely just to continued friendly contacts as she entered into a more normal life, with some of her interests centered outside the home.

Pre-psychotic and other medical cases in which psychosomatic factors were obvious, though perhaps less frequent than had been anticipated by some members of the staff, were nevertheless sufficient to

gain the attention of any interested worker. With only one medical social worker on each hospital staff, intensive case work was possible on a very limited number of cases. With older patients, too, the language handicap was a barrier not easily overcome, though it was surprising how much could be accomplished even without the language. The Consultant was interested, during one center visit, to note a patient who was evidently on quite intimate terms with the local worker and who came into the office and chattered rapidly in Japanese, evidently quite satisfied with the sympathetic and understanding nods of the worker. The worker, familiar with the family situation and with the patient's worries, apparently had no trouble in guessing what she was saying. The rapport was excellent and some real therapy was being carried out even though only a few actual words were understood on either side. There is no way of estimating the amount of this kind of work which was carried on, and no diagnostic statistics are available to indicate prevalence of stomach ulcer or other such cases in which emotional factors are known to be a frequent contributing factor. The Consultant once heard two of the staff physicians commenting on the comparatively large number of stomach ulcer cases which they had observed in the clinics; the younger physician was particularly interested in the fact the patient usually dated his symptoms back to evacuation, registration or some other definite traumatic experience within the center.

In preparing material for this report, the following memo written by the Consultant in March, 1943, came to light:

"The raison d'etre for our existence was expressed by the anlayst in his report on the effects of mass registration on individuals, and by the chief nurse at one of the centers (an experienced nurse with several years in Indian Service) who said, "I shiver to think of the people who will die because they do not want to get well, and of those who are ill ..... and I mean really ill ..... because they are worried."

"If our hospitals are not to be filled with cases of anxiety neurosis, and of stomach ulcers, hypertension, hyperthyroidism, and other diseases closely associated with emotional disturbance, we must have people trained to work with the medical staff in the treatment of these conditions in their early stages, assisting in diagnosis (furnishing material which may be an aid to diagnosis) and treatment as well as in the manipulative services associated with convalescence, chronic care, etc."

"A medical social worker on each hospital staff would, in the course of a year, render to hundreds of patients the kind of service which would help in the prevention of break-downs. And each anxiety situation is a potential cause of trouble for a family or for a larger group."

People did not die in any large numbers. The morbidity rates were better than in average communities of the same size. We cannot know the number who worried themselves into illness, or who were helped through crises by skillful and friendly social services. Such cases were less

obviously and less frequently present in the relocation centers than in the Emergency Refugee Shelter for the small group of European refugees under WRA supervision. The experiences of these two groups are scarcely comparable yet it seems obvious that the cultural backgound of the Japanese, which encourages emotional control, must have been a beneficent factor in many instances.

During the fall of 1942, the U. S. Public Health Service, the agency responsible for medical care under the Western Defense Command, transferred to the WRA the financial and custodial responsibility for 634 patients hospitalized in West Coast institutions during the evacuation and assembly center period. Custodial responsibility was accepted from the Army for an additional 405 patients whose hospitalization antedated evacuation. Most of the second group were mental patients, though a number of tuberculous persons were included. On the other hand, the bulk of the USPHS hospitalizations were for tuberculosis. Nearly half the number were in Los Angeles County, a fairly large number in the Bay Area, and the balance were scattered throughout other California counties and in the states of Washington and Oregon. Practically all of the patients had relatives in the relocation centers, and the Chief Medical Officer made an early survey of the tuberculous cases by mail in which the patients were aksed to give some information about their families and to express their own plans or desires in the event of recovery sufficient to enable them to be discharged from sanatoria. In Los Angeles County, all contacts with patients were made through the Social Service Department of the Los Angeles County Hospital. Patients in other hospitals were contacted through hospital superintendents or social service departments. By May, 1944, there were 320 tuberculous patients remaining in sanatoria within this area which meant

that nearly 300 had been discharged, in most cases to join relatives in relocation centers. A small number of mental cases and other chronics had been discharged and, of course, there had been a few deaths. A large amount of correspondence was involved as, in addition to careful medical review, effort was always made to comply with the wishes of patient and family as far as possible. Most of this was handled by an administrative assistant in the San Francisco WRA office, working under close supervision of the Chief Medical Officer. The Consultant kept in touch with the program, and correspondence with the centers was directed to the attention of the medical social worker as soon as such workers were appointed. A considerable amount of such correspondence originated at the centers as worried relatives wanted patients to be permitted to join them or asked for reports as to their condition. Some of the situations were extremely complicated as, for instance, that of a family in which the mother, a seventeen-year-old son and an infant were hospitalized in three different sanatoria and the balance of the family evacuated to one of the centers. After a period of several months, the baby was ready for discharge and it was important to know the wishes of the mother (who spoke only Japanese) as well as the family situation at the center. The seventeen-year-old, by this time, was an ambulatory patient and permission was given him to visit his mother in order to act as interpreter and also to reassure her by the opportunity to discuss the problem with another member of her own family and by the knowledge that her wishes would be adequately interpreted. Another situation involved a romance which had developed between two patients at one of the sanatoria. The man in the case was discharged to relatives in a midwestern state, after arrangements had been made for him to continue

his pneumothorax treatments, and the girl was persuaded to remain an additional six months until she had completed her period of supervised exercise. During the period up to the lifting of the exclusion order in January of 1945, the Chief Medical Officer and the Consultant had made visits to a few of these hospitals but the bulk of the work was done by correspondence. Even with this major handicap in case work, it was gratifying that most of these cases could be handled with a considerable degree of understanding.

Following the lifting of the exclusion order, the Consultant spent six months on the West Coast with headquarters in the San Francisco office. A survey was made of tuberculous and other chronic patients in center hospitals, tuberculosis again constituting the largest single problem as there were found to be some 200 patients who would need continued sanatorium care after closing of the centers. By this time there remained approximately 140 tuberculous patients still hospitalized in the previously evacuated area. These patients were immediately concerned about their own futures as well as about their families. The Consultant, with some help from the Administrative Assistant and the Medical Social Worker from Manzanar, visited the sanatoria and interviewed all patients, reassuring them as to the immediate future and discussing their plans in relation to their families. Reports of these interviews were sent to the medical social workers, with additional copies to the Welfare Sections in the centers in which relatives were living in an effort to co-ordinate plans for patients and families. The fact that the Consultant was by this time familiar with all the centers, and in a few instances knew the relatives, was a great help in these interviews, which were obviously a great boon to persons who had felt isolated for so long a period. The various medical staffs were most co-op-

erative and it was interesting to note that in some instances the Nisei patients who were ambulatory were active participants in various social activities as, for instance, one who was associate editor of the sanatorium magazine, "Pep." These visits were designed to pave the way for discontinuance of financial responsibility by WRA on June 30, and for admission of new patients from the center hospitals. For the most part, neither was a surprise to the hospital authorities and the discussions were most cordial. Actual applications for admissions were begun in the early spring and, of course, on an individual basis after instructions had been given the centers as to the type of medical and social report desired. At first these were all handled through the San Francisco office and later through the three area offices in San Francisco, Seattle and Los Angeles. In May, a medical social worker was transferred from one of the centers to the Los Angeles office to take care of hospital admissions in that area. In the San Francisco area, the Administrative Assistant, who by this time was familiar with all the health policies of the organization and with many of the hospitals in the area, was made responsible for the hospital phase of the relocation program. Washington and Oregon had a comparatively small number of hospitalizations to anticipate in the movement back to the Coast. The Consultant had visited the sanatoria concerned and discussed plans with other appropriate authorities but, after the first few tuberculous patients were transferred, the program was left to be completed by the Relocation Adjustment Adviser. At the relocation centers, all cases in which hospitalization was anticipated were prepared by the medical social workers; other dependency cases were the responsibility of the Welfare Sections, with medical reports routed to them by the medical social workers.

A P P E N D I X I

Functions of Medical Social Work in Relocation Centers. Issued May 22, 1943 as an Administrative Instruction and later, December 7, 1943, incorporated in Manual material on Health Services.

WAR RELOCATION AUTHORITY

Washington

May 22, 1943

ADMINISTRATIVE INSTRUCTION NO. 54

SUPPLEMENT 1

Subject: Health Service in Relocation Centers
Medical Social Work

Administrative Instruction No. 54, approved October 9, 1942, is hereby amended to add the following Section XI.

XI. Medical Social Work

Medical social work shall constitute a part of the medical service available on Relocation Centers. It will give assistance (1) to patients, in helping them to meet the social problems associated with illness; (2) to the medical staff, in reporting social factors having a specific relation to diagnosis and treatment, and in planning with physicians the patient's care in the light of complicating social and psychological factors; and (3) to community agencies in rendering medical-social reports and interpretations.

A. Organization

The Medical Social Worker shall function under the administrative direction of the Project Medical Officer, and receive technical supervision from the Medical Social Consultant in the Washington Office.

B. Functions

1. To be responsible for in-service training and supervision of other medical social personnel.
2. To cooperate with the Community Welfare Section in basic training of social work personnel, taking part in a planned lecture and case conference training program.
3. To cooperate with the social, recreational, educational and other services available in the Relocation Center for meeting the needs of patients.
4. To bring to the attention of the medical officer or other appropriate personnel recurring social factors which impede adequate medical care for any group of patients.

5. To provide information to the attending physicians regarding social situations of patients which may influence medical treatment or hospital discharge plans.
6. To assist patients to carry out medical recommendations through an adjustment of social problems interfering with medical care.
7. To help patients and families meet the social problems involved in convalescent, chronic or terminal care.

C. Records and Reports

A separate record of each case shall be kept in a confidential file. A monthly statistical and narrative report shall be made to the Project Medical Officer.

D. Cooperation with the Welfare Section

1. When the basic problem is a medical one in which the social situation, or the patient's reaction to it, may have a direct bearing on the illness or on medical care, case work responsibility will be carried by the Medical Social Worker and reports given to the Welfare Section if the family is known to them.
2. When the basic problem is social, case work responsibility rests with the Welfare Section. The Medical Social Worker will receive social reports from Welfare Section, give pertinent social data to the examining physician, and report medical recommendations to the Welfare Section. She will assist the patient in her clinic or hospital adjustment and give medical social interpretation as needed.
3. When a basic medical and a basic social problem of equal importance occur in a given case, the point of origin and of the first intensive case work relationship may be the determining factor in deciding case work responsibility. Good team-work will reveal situations in which transfer of responsibility will effect best results.
4. It may happen that in a family known to the Welfare Section one member has a medical condition in which medical social work can be helpful. In such a situation, a consultation is indicated with a decision as to the responsibility to be carried by each.
5. Frequent, regular case conferences at which cases of mutual interest are discussed will furnish the best opportunity for constructive planning in individual cases and for allocation of responsibility in carrying out part or all of the plan.

D. D. Myer

Director

APPENDIX II

P-2 and P-3 standard position descriptions for medical social workers at Relocation centers, allocated May 13, 1943.

P-3 standard position description March 21, 1944, changing grade of the former P-2 position.

P-2 standard position description November 16, 1944, creating second position for larger centers.

Standard position description for evacuee medical social assistant, approved November 1, 1943.

STANDARD POSITION DESCRIPTION

Office for Emergency Management
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Position code: -2bA3.-
Date Allocated: May 13, 1943
C.S.C. Standard: _____
Date Promulgated: _____

Organization Title: MEDICAL SOCIAL WORKER P-3
Class Title: Associate Medical Social Worker

Minimum Qualifications:
(Cont'd.)

2. Completion of a two year course in an approved school of social work and four years' experience in the practice of medical social work, at least one year of which has been supervised experience in social service department meeting acceptable standards in a hospital or clinic, and one year of which shall have included supervisory responsibility, or

3. One year of social work training in an approved school of social work and five years' experience in the practice of medical social work, at least one year of which shall have been supervised experience in a social service department meeting acceptable standards in a hospital or clinic, and one year of which shall have included supervisory responsibility.

STANDARD POSITION DESCRIPTION

Office for Emergency Management
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Position code: -2bA3.-
Date Allocated: 8-3-43
C.S.C Standard: _____
Date Promulgated: _____

Organization Title: MEDICAL SOCIAL WORKER P-3
Class Title: Associate Medical Social Worker

Description:

Under the administrative direction of the Principal Medical Officer, receiving consultative service from the Medical Social Consultant on the national staff, supervises work on two centers or on one center with an especially large hospital capacity or develops a teaching center for preliminary training in medical social work.

Is responsible for in-service training and supervision of other medical social personnel. Cooperates with the Welfare Section on basic training of social work personnel, taking part in a planned lecture and case conference training program. Brings to the attention of the medical officer or appropriate personnel recurring social factors which impede adequate medical care of any group of patients. Cooperates with the social, educational, recreational and other services available in the relocation center for meeting the needs of patients. Provides information to the attending physicians regarding social situations of patients which may influence medical treatment or hospital discharge plans. Assists patients to carry out medical recommendations through an adjustment of social problems interfering with medical care. Helps patients and families meet the social problems involved in convalescent, chronic and terminal care.

Minimum Qualifications:

Education: Bachelor's degree from a college or university of recognized standing, and

1. Completion of an accredited course in medical social work in an approved school of social work and three years experience in the practice of medical social work, at least one of which has been supervised experience in a social service department meeting acceptable standards in a hospital or clinic, and one year of which shall have been in supervisory responsibility, or

STANDARD POSITION DESCRIPTION

Office for Emergency Management
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Position code: -2cA2-
Date Allocated: May 15, 1943
C.S.C. Standard: _____
Date Promulgated: _____

Organization Title: MEDICAL SOCIAL WORKER
Class Title: Assistant Medical Social Worker P-2

Description:

Under the administrative direction of the Principal Medical Officer, receiving technical assistance from the Medical Social Consultant on the national staff, organizes and carries out a program of medical social work in the health service of the relocation center, and assumes other related duties as assigned.

Is responsible for the supervision of medical social assistants in the relocation center, bringing to the attention of the medical officer or appropriate personnel recurring social factors which impede adequate medical care of any group of patients. Cooperates with the social, educational, recreational and other services available in the relocation center for meeting the needs of the patients. Provides information to the attending physicians regarding social situations of patients which may influence medical treatment or hospital discharge plans. Assists patients to carry out medical recommendations through an adjustment of social problems interfering with medical care and also assists patients and families to meet the social problems involved in convalescent, chronic and terminal care.

Minimum Qualifications:

Education: 1. Bachelor's degree from a college or university of recognized standing, and completion of an accredited course in medical social work in an approved school of social work, plus one year of supervised experience in the practice of medical social work in a social service department meeting acceptable standards in a hospital or clinic, or

2. Completion of a two year course in an approved school of social work and two years of experience in the practice of medical social work, at least one year of which has been supervised experience in a social service department meeting acceptable standard in a hospital or clinic, or

3. One year of social work training in an approved school of social work and three years experience in the practice of medical social work, at least one year of which has been supervised experience in a social service department meeting acceptable standards in a hospital or clinic.

STANDARD POSITION DESCRIPTION

Department of the Interior
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Date Approved: MAR 21 1944
C.S.C. ~~Number~~ Standard: R-Pending

Organization Title: MEDICAL SOCIAL WORKER * P-3
Class Title: Medical Social Worker

Description:

Under the administrative direction of the Principal Medical Officer, receiving consultative service from the Medical Social Consultant on the national staff, directs the medical social work program on a center.

Is responsible for in-service training and supervision of other medical social personnel. Cooperates with the Welfare Section on basic training of social work personnel. Brings to the attention of the medical officer or appropriate personnel recurring social factors which impede adequate medical care or any group of patients. Cooperates with the social, educational, recreational and other services available in the relocation center for meeting the needs of patients. Provides information to the attending physicians regarding social situations of patients which may influence medical treatment or hospital discharge plans. Assists patients to carry out medical recommendations through an adjustment of social problems interfering with medical care. Helps patients and families meet the social problems involved in convalescent, chronic and terminal care.

Desirable Qualifications:

Education: Bachelor's degree from a college or university of recognized standing, and

1. Completion of an accredited course in medical social work in an approved school of social work and two years experience in the practice of medical social work, at least one of which has been supervised experience in a social service department meeting acceptable standards in a hospital or clinic, and one year of which shall have been in supervisory responsibility, or

(OVER)

STANDARD POSITION DESCRIPTION

Department of the Interior
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Date Approved:_____
C.S.C. Standard:_____

Organization Title: MEDICAL SOCIAL WORKER * P-3
Class Title: Medical Social Worker

Desirable Qualifications: (continued)

2. Completion of an accredited course in an approved school of social work and three years' experience in the practice of medical social work, at least one year of which has been supervised experience in social service department meeting acceptable standards in a hospital or clinic, and one year of which shall included supervisory responsibility.

* Supersedes
Medical Social Worker (Medical Social Worker) P-3 5-13-43
Medical Social Worker (Medical Social Worker) P-2 5-13-43

OM-953

(end)

STANDARD POSITION DESCRIPTION

Department of the Interior
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Date Allocated: 11-16-44

Title: ASSISTANT MEDICAL SOCIAL WORKER P-2

Description:

Serves as assistant to the Medical Social Worker, P-3, in carrying out the medical social work program in a center with more than one camp or in a center of 18,000 to 20,000 persons.

Assists supervisor in all phases of the program by working with members of the Community Management Division to secure social, educational, recreational and other services to meet the needs of the patients. Consults with attending physician on various cases concerning the social situation of individual patients and assists patients to adjust social problems in carrying out medical recommendations.

Is responsible for counseling in relation to social situations of patients which may affect medical treatment or hospital discharge plans. Makes recommendations, subject to approval of the Medical Social Worker, of recurring social factors which impede adequate medical care for any group or patients. Counsels patients and families and assists in meeting social and relocation problems involved in convalescent, chronic and terminal cases.

Maintains case records and makes preliminary medical social reports for utilization in the center or for assistance to patients and their families in developing relocation plans.

Directs the medical social work program in the absence of supervisor and assists in the supervision and training of evacuee personnel working in the program.

(continued)

Desirable qualifications:

Education: Bachelor's degree from a college or university of recognized standing, and

1. Completion of an accredited course in medical social work in an approved school of social work and one year's experience in the practice of medical social work, or

2. Completion of an accredited course in an approved school of social work and two years' experience in the practice of medical s ocial work.

STANDARD POSITION DESCRIPTION

(Evacuee Only)

Office for Emergency Management
War Relocation Authority
Relocation Center
Community Management Division
Health Section

Position Code: 2-b-549
Date Approved: 10-1-43
Salary: $16

Title: MEDICAL SOCIAL ASSISTANT

Description:

Assists the Medical Social Worker by securing information regarding social situations of patients which may influence medical treatment or hospital discharge plans and, under supervision of the Medical Social Worker, helps patients and their families to carry out medical recommendations and to meet the social problems involved. Performs related duties as assigned.

APPENDIX III

STANDARDIZED FORMS FOR MEDICAL SOCIAL WORK AT ALL CENTERS

1. WRA 375 - Monthly Report

2. WRA 268 - Medical Social Service, used for reports filed with medical records and sometimes for medical-social reports sent to outside hospitals.

3. WRA 376 - Medical Social Referral Sheet, which served a double purpose by being used as a request from the Welfare Section for a medical report, and providing space for the reply.

4. WRA 377 - Medical Social Face Sheet, used for medical social services.

5. WRA 378 - Daily Work Sheet.

WRA-375

DEPARTMENT OF THE INTERIOR

WAR RELOCATION AUTHORITY

Monthly Report

Budget Bureau No. 13-R049
Approval Expires: 1/20/46

MEDICAL SOCIAL SERVICE

For Month Ending March 30, 1945

Center Heart Mountain Relocation

I. INTERVIEWS WITH PATIENTS:

On Wards	19
Office or OPD	60
Home Visit	7

II. MEDICAL CONSULTATIONS:

With Doctors	132
With Nurses	21

III. COLLATERAL INTERVIEWS REGARDING PATIENT:

With Social Welfare	12
With Other Sections	16
Relatives or friends of patient	58

IV. LETTERS AND REPORTS WRITTEN:

To Social Welfare	122
To Other Sections	2
Other projects or WRA Hdq.	13
Other Agencies or Individuals	180

V. PARTICIPATION IN ARRANGEMENTS FOR OUTSIDE MEDICAL CARE:

To Cody . . . . Number of patients	2
To Billings . . Number of patients	13

VI. COMMITTEE MEETINGS, CONFERENCES, ETC. OTHER THAN INTERVIEWS AS INDIVIDUAL CASES: 10

(over)

VII. NARRATIVE...ANY SIGNIFICANT DEVELOPMENTS, E.G. (1) NEW PROCEDURES, (2) RELATIONSHIPS WITH OTHER AGENCIES (3) MENTAL OR OTHER PROBLEM CASES:

Reports, especially to Social Welfare, are taking an ever increasing amount of time. We are trying, as fast as possible, to get together the necessary information about the people with dependency problems. In every case, Social Welfare clears with Health Section, through the medical social worker, for any medical information available. If there is no recent report, the patient is asked to come for examination. We find one of the most difficult things is to get the staff doctors to make a definite statement regarding the physical limitations of a patient's illness. Through constant interpretation to the doctor of the reasons for requesting this information, we hope to secure more whole-hearted cooperation.

This month we have been concentrating on the unemployed old bachelors, likely candidates for an old folks' home. Most of one day was spent at the Hostel examining and interviewing all the inmates with a view to determining what future care they will need.

Several cases have been referred from the wards with the request that they be discharged home if possible or else transferred to hospitals outside. These include the post cerebral hemorrhage patients, also some of those with active tuberculosis. Many have been in the hospital for months, some even for a couple of years. As the nurses and nurses' aides leave, it is becoming more difficult to give proper care to these bed patients, so we are anxious to make other plans for them as soon as possible.

Patients taken out this month for special examination or treatment number 15. This includes eight with eye or nose conditions, three cases of malignancy, one ten year old boy for plastic surgery, one old man for hearing aid, one thyroid patient for basal metabolism test, one child for court hearing and commitment to the state training school for feebleminded. We are pleased at the promptness with which the case committed in January was handled. Already word has come that he may be sent to California for institutionalization; we are now awaiting transportation arrangements by the San Francisco office.

We have very fine cooperation from all the outside agencies we use in securing services for our patients. Particularly fine is the eye doctor in Billings. He seems genuinely interested in the patients we sent to him and frequently asks about individual ones. Recently at his request the medical social worker made a follow-up study of three cases receiving treatment during the past year. Another agency is the New Jersey Crippled Children services. In January we referred the case of a four year old boy who had been treated for congenital dislocated hip and whose family had relocated to Seabrook Farms. We have since received several excellent reports indicating close follow-up of this case.

Signed K. M. S.
Medical Social Worker

WRA-268

WAR RELOCATION AUTHORITY

MEDICAL SOCIAL SERVICE

NOTE: Identifying information, including that regarding previous residence, has been left out of this copy.

Date 1/8/45

Name George

Ward X
or
Clinic

Referred by: Doctor

Reason for reference: Social history. Possible commitment. Patient completely disoriented.

1. Reason for hospitalization: Admitted Rivers Hospital 12/29/43. Gasoline burns on arm and body. Apparently clear mentally at that time.

2. Informants: Two elder sisters: A and S.
Father: Y.
Employment Records.

Social report (date)

3. Parents and siblings:

Y., 65, father, farmer, apparently well. Speaks little English. Came to this country at age about 18. Born in Japan.

T., 55, mother. Born Japan. Came here before marriage. Described by daughter as "not well educated." Does not even go to Mess Hall alone, though we were not told why.

T., 27, brother. Relocated in Chicago, mechanic.

A., 24, sister. Graduated high school. housemaid '37-42. Very nervous and introspective. Assumes great responsibility for family. Says she had a breakdown for a couple of days at New Year's. "Just could not take it any longer" ----but "all is clear again now." Has worked at Mess Hall here until last of year as waitress. Intelligent, loyal, probably high standards, insight into other people's character.

S., 22, sister. High school graduate. housemaid ($40 mo.) until evacuation. Waitress to October 1942. Now office work. Apparently normal.

J., patient

B., 17, brother. Now junior in high school and working part time on farm. Has worked as gardener since "38, during vacations and sometimes after school.

T., 11, brother. School.

Another sister is married, the eldest in the family. She is the only one who did not go to high school. "Had been sick." At sixteen she ran away to be married. Has five children. Lives in an Arkansas Center. Two other siblings died. One, between T. and the eldest sister, died very young after being ill a day or two with a "cold." Another died in infancy, next to the youngest.

4. Childhood: Quite normal, according to sister. He had mumps, scarlet fever and measles. Otherwise very well. Was "not too smart" and repeated the first grade. Did not secure any history of infancy as mother was not seen.

5. School: Repeated no grades except the first. Would have graduated from high school in June, 1942, (age 18½) had evacuation not interferred. Graduated after

(Use other side if necessary)

(Surname of patient) (Given name) (Identification No.)

C-0306

7. coming to the Relocation Center.

6. Occupational: As per attached sheet. Farm helper, tractor driver, gardener (vacations and after school). Has been working as a tractor driver in the Center since finishing school.

7. Medical: Negative except childhood diseases.

8. Psycho-sexual: Pt. not in condition to be questioned. Sister says she thinks he has not been much interested in girls. Has been rather "shy." Has shown some attention to one girl here, usually in company with others.

9. Personality traits: Rather reticent. He "holds in--holds in," says the sister. He has been interested in sports and especially in music. Plays a trumpet, as do two of his brothers. He and a brother played in an orchestra in the assembly center. All the family like to sing, especially the youngest who is "always singing." In evenings, he would be out talking with other boys, or just at home reading or sleeping.

10. Trumatic experiences: The home has been a very severe one. Father, hard-working since he was young, had expected all the children to work hard. Patient says, "Father gave his right arm for us.....now I must give my right arm for him"....this, after he had burned his right hand recently. The eldest sister "ran away to get out of it." There has been conflict, too, because of customs. The children have not learned good Japanese, nor the parents much English. The children are embarrassed, and probably scolded, because they do not understand Japanese customs. This has been difficult here, especially at New Year's. The family, previously on a farm, had not been in a close Japanese community where New Year's customs were important. He has not given evidence of undue worry over evacuation nor of conflict over registration. There is no record of any member of the family requesting repatriation or expatriation, nor any question of their loyalty, so there are no apparent family conflicts on these questions. They are Christian, though not regular church attendants.

Previous break: "About" four years ago, patient had an attack similar to the present one. Sister wanted him taken to a psychiatrist but it was not done. Apparently it was not so severe as the present. It began by his asking for a car which the family got for him. Then he began driving very fast. The chief characteristic was hyper-activity. When, a few days after his admission to the hospital for burn treatment, he began acting strangely, the father was worried....afraid he "would go back to what he was before." He had no treatment, and seems to have recovered after about a month.

On October 27 of this year, the older brother left on relocation to Chicago. Patient did not express worry over this but probably "felt it very deeply as we are a closely knit family emotionally."

Since hospital admission, he may have had "too much attention and too much sympathy from visitors," says his sister. The gasoline burn would have not have occurred, she thinks if he had not been nervous and "disgusted." She did not account for this except in the story of the family's New Year preparation which seems to have precipitated some quarreling.

Sister, several times, said, "He is all right if people are patient with him."

WRA-376

DEPARTMENT OF THE INTERIOR
War Relocation Authority

MEDICAL SOCIAL REFERRAL

Date _____

FROM: Community Welfare Section

TO: Medical Social Service _____ Name of Worker

Name: _____ Address: _____

HOUSEHOLD

Name	Age	Kin	Remarks

Reason for referral, Summary of pertinent social factors & specific questions

Signed _____
Supervisor

Medical Social report and Recommendations: (Date)

_____
Medical Social Worker

Approved: _____
Chief Medical Officer

(Use reverse side if needed)

C-1805

WRA-377

DEPARTMENT OF THE INTERIOR
War Relocation Authority

MEDICAL SOCIAL FACE SHEET

Name: (Last) (First) Age Id. No.

Present address: Ward Clinic

Pre-evacuation address: Religion

Problem:

Referred by:

Family Group	Kin	Age	Birth place	Occupation	Remarks

Interested Individuals:

Diagnosis:

Prognosis:

Service Rendered:

Date opened Date closed Worker

0-1806

WRA-378

DEPARTMENT OF THE INTERIOR
War Relocation Authority

MEDICAL SOCIAL WORK SHEET

DATE

NAME	PATIENT INTERVIEW			MEDICAL CONSULTANT		REPORT LETTER				INTERVIEW COLLATERAL			REMARKS
	WARD	HOME	OFFICE OR O.P.D.	DOCTOR	NURSE	SOC. WEL.	OTHER SECTION	OTHER PROJ. OR WRA HDQ.	OTHER AGENCIES	SOC. WEL.	OTHER SECTION	REL. OR FRIEND	

A P P E N D I X IV

REPRINT OF ARTICLE APPEARING IN "THE FAMILY,"
MAY, 1944

The author, Miss Gottfried, supervised the medical social work at two centers during most of 1943.

Reprinted from THE FAMILY *May 1944*
122 East 22d Street, New York City

Medical Social Work in the War Relocation Program

LEANORE V. GOTTFRIED

IN A MASS movement of families involving thousands of individuals of all ages, there are necessarily many social problems related to health. When the War Relocation Authority organized its segregation program in order to separate evacuees of Japanese ancestry according to their political affiliations, a significant part of the plan for the movement dealt with health factors. As a part of the medical service program, medical social work was assigned a definite function in planning and carrying through the movement.

After Pearl Harbor, when the people of Japanese ancestry were evacuated from the West Coast and established in relocation centers, it was learned that the great majority wished to follow the American way of life and were loyal to the United States. Some, however, indicated that they were neither loyal to this country nor sympathetic to its war aims. In order to fulfil its obligation to each of these groups and its obligation to safeguard and further the national interest, the War Relocation Authority decided upon a program of segregation of persons whose interests were alien to those of the United States from those who wished to be American. By setting aside one center as a segregation center, the remaining relocation centers would become more homogeneous as to population, and both their administrative and relocation programs would be facilitated. The movement was scheduled to take place in September and early October, 1943, and Tule Lake Center in northern California was selected as the segregation center. Inasmuch as segregees were to be sent in from nine other centers, it was necessary to plan the removal of the evacuees who were American in their loyalties and sympathies concurrently with the arrival of those declaring their lack of allegiance to this country. Those leaving Tule Lake were moved to other centers or were granted permission to relocate to communities outside the Western Defense Command.

To the residents of Tule Lake Center, the use of the center for the segregation program came as another upheaval in their already uprooted lives. Many probably had experienced emotional trauma in varying degrees when evacuation caused them to leave homes, farms, and places of business where they had invested so much of their life effort. Despite heavy financial losses and hostile attitudes in some of their former communities, many cherished the hope that at some future time they might be able to return to their earlier homes. This new plan meant leaving a community where they had gained a degree of security, organized a remarkable amount of community life, and established a place for themselves. Again they found that they must break up homes they had maintained for over a year, separate from friends and relatives, and travel to unknown parts of the country.

In order to help the evacuees meet the many social and emotional problems involved in relocation, a broad social case work program was carried out. Each family scheduled to leave was interviewed by a worker from the family case work section of the organization and an effort was made to base a plan on the needs of the individual family. Where health problems were recognized by the family interviewers, the individuals were referred to the medical social worker. Referrals also came from the medical and nursing staff, from other co-operating agencies, and directly from patients. During a seven-week period, 724 medical social interviews were held with persons having health problems that affected

their segregation plans, and 1,578 medical social reports were sent to co-operating agencies in the center.

Many of the situations fell into routine categories. For example, in many cases medical recommendations were necessary in order that special sleeping accommodations might be arranged in traveling. In others, plans had to be worked out for entire families to remain in the segregation center until ill members were sufficiently recovered to travel. Even in these routine cases, however, there were frequently symptoms of anxiety and fear and it was necessary to give interpretation and reassurance. In a large number of situations, continued case work service was required.

A great deal of the resistance to moving was due to a feeling in the community that Tule Lake Center was superior to the other centers in respect to climate, altitude, and general living conditions. Another reason for the reluctance to leave California was that these residents thought they would have more opportunity to return to their former homes if they remained. Many feared that after going to a relocation center, they might be forced to relocate in other communities even though they were not in a position to do so. A number of unfounded rumors also arose regarding conditions in the other centers, and there was a great demand to go to two specific centers that were particularly popular. Many evacuees tended to solve these problems by projecting their needs, real or imaginary, upon a health basis.

It was observed that patients with asthma and hypertension in particular requested that they be permitted to remain because they had undergone such marked improvement since coming to this center. It is possible that the emotional and psychosocial component of these illnesses was directly affected by the protected environment of the center. Here in the past year they had found financial security and release from the tension and anxieties of pre-evacuation days. Because of the nature of center life, individuals who had not been self-maintaining in the past experienced a transfer of economic dependence from parents and relatives to a paternalistic type of authority representing the government. Ulcer patients, however, complained of recurrences and aggravation of symptoms following their traumatic experiences in evacuation and the difficult adjustment of the succeeding months. In most instances, careful consideration of the complaints, interpretation of the reality factors of the segregation program, and reassurance as to the facilities both in traveling and in the various relocation centers were sufficient to work through the resistances.

Leaving Tule Lake Center was most difficult for aged people and particularly those with chronic illness. Many of them had exhausted their resources and had no relatives on whom to depend. Others had close ties to persons remaining in the center and knew no one elsewhere. They knew they would be unable to relocate and reestablish themselves in new communities because of their age, and they feared travel and the adjustment to the strange environment of another relocation center.

Mr. Sakutaro A, 62, had a history of a crippling arthritic condition for a number of years. He was unable to walk or use his hands or feet to any great extent. His family consisted only of himself and his wife who was much younger and in excellent health. When interviewed, he told the worker that he wished to remain in the present center because his condition was such that he would never be able to relocate. He also thought that he was not well enough to experience a long train trip. He had never been known to the Base Hospital but had been told by his physician prior to evacuation that there was no treatment for his condition. His wife, who had assumed full responsibility for his care, was obviously confused over the decision to stay. She said, however, that she wished to follow the plan that would be best for her husband's health and that she would remain if he wished to do so. At the same time she showed some apprehension at the prospect of remaining in a segregation center. The worker discussed with Mr. A his wife's feelings and also the political and social implications of remaining in a segregation center. It was obvious that he had not yet thought his decision through in the light of these factors.

He was assured that going to another center would not place upon him any pressure to relocate and also that, if he were able to travel, he would do so in the most comfortable manner possible. For example, he would be transported from his home to the train by ambulance, a lower berth would be arranged, and there would be medical attendance en route. Mr. A agreed that he would attend the clinic for an examination and if the

physician declared him able to travel, he would accept the plan. Accordingly he was examined and, apart from his arthritis, he was found to be in remarkably good condition for a man of his age. After the examination, he and his wife were satisfied to make plans for their departure.

In some cases, there was sufficient reason from a medical social viewpoint for individuals to remain in the center even though they were eligible to leave as far as their physical status was concerned.

Mr. Otakichi Y, was a 65-year-old man who was to be repatriated. His immediate family was in Japan. He was, therefore, scheduled to remain at Tule Lake Center. During his stay at the center, he had had surgery for carcinoma of the larynx and following the operation was unable to talk. He had been living with his brother, a 58-year-old bachelor, and had been cared for by him. Mr. Y had no other relatives in this country. Because of his indication of loyalty, the brother was scheduled to leave. However, he stated that he was willing to remain and care for Mr. Y provided that he could leave the segregation center in the event of the patient's return to Japan or of death. On the basis of the medical social recommendation, this plan was followed.

Mr. and Mrs. Mangoro T, 80 and 70 respectively, were also scheduled for removal. They both had had treatment in the clinic from time to time and, while neither had any serious ailment, both were quite feeble. They had three married daughters, and they requested permission to stay with the one who was a repatriate and was remaining at Tule Lake Center. Another daughter was still in Japan and the old couple hoped that after the war they could rejoin her and spend their remaining years in their homeland. The third daughter and her family were leaving the center and planning to relocate. Her relationship to her parents had never been a close one and neither she nor her husband wished to assume any responsibility for them. Besides, the parents had always lived with the daughter who was to be repatriated, and she told the worker that she had always expected to care for them as long as they lived. The medical social worker clarified with Mr. and Mrs. T the status they would have as segregees and, when it was apparent that they were satisfied, permission was granted for them to remain.

There were many requests for permission to go to a specific center because of health reasons. Some of these reasons were valid but others were quite unrealistic. For instance, there were many misconceptions regarding altitude and climate. During the course of a single morning, one elderly evacuee requested a certain center because he had hypertension and he thought the altitude was low, whereas another man asked to be removed from the list for this center as he had hypertension and he considered the altitude too high. In reality, the center was slightly higher than any of the other nine but not enough so that altitude would be considered a significant factor in planning. Exploration revealed that both men had valid reasons for going to the centers of their choice but that these were not based on health factors. A great many people thought that because of their health needs the travel distance should be a factor in the assignment to another center. Here again, fear and misconception were dispelled by giving factual information and by respecting the feelings of the individual through acceptance of his participation in the plan developed. Frequently adjustments could be made where it was desirable for residents to join relatives at another center who could assist in the care of an ill member of the family. Other patients were assigned to a particular center where they would have the required medical facilities.

The family of Mr. Hiroshi N had long been known to community agencies. Mrs. N had died some months earlier of a cardiac condition a short time after giving birth to a child. In addition to the new baby, there were four other children ranging in age from 15 months to 14 years. Mr. N cheerfully assumed the care of the four older children but, as there were no women relatives who could assist, baby Fumi was left in the hospital as a boarder for the first ten months of her life. The hospital staff recognized that the child's affectional needs were not being met and that she was not finding her proper place in the family constellation. Mr. N was reluctant to take her home even with the services of a part-time housekeeper, nor would he consider placement in either a foster home or child-care institution.

As segregation time approached, however, a series of interviews was held with him, and he brought out his genuine attachment to his children and his enjoyment in caring for them. He made the suggestion himself that he take Fumi home in sufficient time before the segregation program so that he could better learn to care for her and help her to adjust to the family group. The other children also were eager and excited at the prospect of having their little sister at home. Shortly after the child's placement in the home, word was re-

ceived from another center that, if the family could be transferred there, Mr. N's sister who lived there with her family would assist in the care of the children and then it would also be possible for Mr. N to secure employment. This was a happy solution and, accordingly, transfer to this center was arranged. Several times prior to departure, Mr. N brought Fumi to the hospital and it was obvious that the child was thriving physically and emotionally.

In the case of Mrs. Eiko M, 53, opportunity to go to the center of her choice appears to have been an important factor in her recovery. She had no history of illness prior to evacuation, but after coming to camp she complained that her hearing was not acute and that she had frequent headaches, tingling of the ears, colds, and draining in the back of her throat. She had been born in Japan and had come to this country as a young woman. She had worked as a midwife until a few years ago, and about that time her husband had died following a cerebrovascular accident. Her two sons were grown and one relocated just before segregation. She planned to make her home with the other son who was married and had a child. In May, 1943, she entered the hospital for observation and it was the physician's impression that she had an active pulmonary tuberculosis. Diagnostic studies, however, revealed only pleural adhesions and accordingly tuberculosis was ruled out. She showed limited improvement, however, and remained in the hospital until the time of segregation in September.

Because there had been a question of tuberculosis, it was planned that her family be assigned to the center where this group of patients was to receive care. When the worker discussed this with her, she was highly disturbed, and it was learned that all the people from her former locality had been sent to another center at the time of evacuation. She had no friends at Tule Lake or at the other center being considered. She wept bitterly when she found she could not go to the center of her choice, her temperature rose, and her physical condition became worse. The worker arranged for the medical department to review her case again, and when it was determined that there was no question of tuberculosis, a plan for change in assignment of centers was effected. She went from hospital to train by ambulance but upon her arrival at her destination she went with her family directly to her new home. After a few days' rest, she began renewing old friendships, resuming some of her former activities, and participating in the life of the community. She is now almost symptom free and considers herself quite recovered.

In many situations, various members of a family differed in political loyalty and interviews were held both on an individual basis and with the family group. Feelings sometimes ran high and it was often necessary to handle acute situations, particularly in families where there had been a long history of incompatibility. A large number of these situations were dealt with by the family case work section and in some cases certain members of a family elected to leave the center while others remained. The problem was a particularly serious one for adolescents who were not yet able to depart from the parental control and yet who could not reconcile themselves to voluntary segregation contrary to their feelings of loyalty. Sometimes a plan could be worked out whereby a guardian would assume responsibility or whereby placement at a school was possible. A few cases had health problems and were either handled directly by the medical social service department or on a consultative basis.

Mr. O had always been brutal and tyrannical toward his family. His marriage had been an arranged one—as is the case with practically all first generation Japanese—and in this particular case the social and cultural backgrounds of husband and wife had been very different. The children who were capable of doing so had left the home as early as possible and, since coming to the center, all but two had relocated. One remaining was a 27-year-old son who was mentally ill and extremely fearful of his father, and the other was our patient, Maeko, 24, who was tuberculous. Maeko was an attractive, intelligent, composed young woman who had always been helpful and co-operative as a patient and who accepted the prospect of transfer to another center cheerfully. One afternoon the worker was asked to see her on the ward and she was found to be in a highly disturbed, tearful state. She discussed her family situation freely for the first time and said that she was sure her father's treatment was the cause of her brother's mental condition.

At that time, the father was insistent on remaining in Tule Lake Center and he had threatened to kill the rest of the family if they attempted to depart. The mother was afraid to start packing and she was worried lest she could not send her freight off on time. The son's anxiety was so great that his condition was markedly worse. Maeko said that in the past the mother had never considered leaving her husband because she wanted to hold the family together, but now she was anxious to separate from him permanently. Despite their difficulties, however, the mother and children did not want Mr. O to be arrested and thus lose

his employment, inasmuch as he was doing a good job as the foreman of a work crew.

A conference was held with the head of the Internal Security Department and, as a result, not only was Mr. O warned about interfering with the movements of the family but a police warden was assigned to observe his behavior. The mother and children were greatly relieved and Maeko was able to prepare for the transfer without further emotional strain. Although she had worried over the possible results of reporting her father, she did not indicate any guilt in respect to her feelings of aggression toward him, probably because she had not caused him to be punished.

In addition to differences in political opinion, other factors frequently influenced members of a family to disagree on whether or not to leave the center. This was particularly true in cases where one person was mentally ill and either refused to leave or presented serious difficulties in moving. In a number of families, one member was still institutionalized for either physical or mental care in a public hospital in the state of original residence. Many people were under the impression that if they left California it would not be possible for their relatives to join them later at another place. Interviews in which policies of the agency were interpreted and up-to-date medical reports supplied were helpful in leading to the proper decision. Fear of permanent separation went very deep with this group of evacuees who were basically insecure and felt strongly rejected by society. In consequence, they requested repeated assurances that the patients would be restored to them as soon as they were medically ready for discharge.

Mr. Tomio H had a cerebrovascular accident immediately before the family was removed to the Tule Lake Center, and he was left with a complete paralysis on his left side. He was placed in a general county hospital and after a year and a half showed no improvement. His wife and children had great anxiety about the care he was receiving and were eager to have him at home. They thought that it would be unwise to leave Tule Lake Center unless he was permitted to join them before their departure. A medical report was secured which indicated that he was completely helpless, that he could not possibly be cared for at home, and that it was inadvisable to move him. Hospital facilities at the center were such that it was not feasible to transfer him there. This material was interpreted to the family, and they were encouraged to write to friends still living in their old community for a report on Mr. H's care. They did so and learned that although the hospital was overcrowded and short of staff due to the war situation, Mr. H was receiving satisfactory care and nourishment. The worker was able to supplement this report with information on the handicaps under which civilian hospitals are operating at the present time, and thus help the family to face the situation more realistically. They therefore made their decision to leave on the basis of loyalty and were secure in the knowledge that if it were possible at any time, the agency would take the necessary steps to restore the father to them.

While the majority of loyal evacuees leaving Tule Lake transferred to relocation centers, a number relocated directly to new areas. Here, too, health problems required consideration both in relation to travel and to readjustment in the new community. With the relocation officer of the War Relocation Authority serving in a liaison capacity, it was possible to help evacuees seek out and utilize medical facilities in the unfamiliar environment.

The U family consisted of the widowed mother and three adolescent girls, all still in school. The youngest girl, 12-year-old Kazuko, had had an accident some years earlier and had lost one leg. Prior to evacuation she had been under the care of the California Crippled Children Service and had secured a prosthesis through this agency. While in Tule Lake Center, she continued to receive service from the California agency. Mrs. U had supported herself and the children in the past and when the segregation program was announced, she decided to try to relocate. The Employment Section found her employment as matron in a children's institution in the Midwest, and the position included room and board for the entire family. Her only concern in leaving was in regard to continuing medical care for Kazuko. When she was given an interpretation of the function of the Children's Bureau throughout the country and the Crippled Children Service in the state to which she was going, she was greatly relieved. Arrangements were made for Kazuko to attend the Crippled Children's clinic in a nearby city.

By participating in the segregation program, medical social work was able to make a contribution to many individuals and families at a crucial point in their lives. Many families were helped in making adjustments to a very difficult situation and in making decisions that would greatly influence the whole course of their future lives. This paper attempts to illustrate one aspect of

the War Relocation Authority's policy trend toward individualization. As yet we can make only conjectures as to whether the postwar period will bring with it mass movements of people from one area to another. If such movements are necessary, surely the traumatic aspects will be lessened and the experience can be made more positive and constructive if situations are individualized and treated on a case work basis.