SOCIAL SERVICE IN AN OUT-PATIENT DEPARTMENT.

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Knowing that the American Hospital Association is organized for the "promotion of economy and efficiency in Hospital Management" I shall confine my talk on Social Service to its relation to those two administrative features. Of Social Service in relation to progressive Medicine and to the humanitarian side of medical care I shall not be able to speak, although to both it has a contribution to make. I wish also to emphasize the fact that in America, Social Service, in an organized form, is but eight years old. A beginning only has been made and each year does and should see changes in its program. Also as the needs of one hospital are quite different from those of another, so should the character of a Social Service vary in each institution and again in each city according to its local charitable and health problems. Social Service is a tool whose value depends on two factors—the training and experience of those doing the work and the use made of it by administrators and physicians.

It was in the Out-Patient Department that Social Service had its beginning. That its need was first felt there may have been due to a sense of ineffectiveness of which a physician is far more conscious in an out-patient department than in the wards of a hospital. In the latter he is given every facility for painstaking and thorough care of his patients; the opportunity for their control including the entire regulation of their daily routine; every tool for expert diagnosis and treatment is available. Above all, as a patient remains in the hospital in most cases as long as the physician feels it necessary, he may look forward to a reasonable period of time in which to test his diagnosis and observe his patient's reaction to treatment. How different from the situation in an out-patient department! There patients file by in rapid succession. There is often little time for thorough examination and the

equipment of an out-patient department has, in many instances, suffered in comparison with the needs of the wards. The assistance necessary for careful recording is too often lacking and, above all, many patients do not come back. Treatment is prescribed half-heartedly with the knowledge that much of it will not be, cannot be carried out. Dr. Cabot describes this situation so vividly in his first annual report when he says, "There occurs many times each year a scene not unlike that described in Alice in Wonderland:

"Have some wine," said the Hare.
"I dont' see any," said Alice.
"There isn't any," said the March Hare.

Without any sense of the humor and pathos of the situation we say (in substance to many patients): "Take a vacation, get a job, get a set of teeth, or get a truss. There is none in sight and no means of getting any."

Social Service is not a panacea for these problems, but Social Service can offer definite lines of assistance to the physician and administration, which may lessen certain discouraging aspects of an out-patient service. The most obvious one and, therefore, the one on which most emphasis has been placed, is that in connection with making treatment possible. The explanation of this may lie in the evolution of medical service and medical science. The first in the passing of the family physician and the second in the passing of pills and powders.

The passing of the family physician intimate with the whole background of his patients' lives leaves the doctor in an Out-Patient Department to suffer under disadvantages unknown to the old family practitioner. Lack of knowledge of a patient's inheritance, home condition, domestic problems and financial status are all handicaps to diagnosis and treatment and ones which the Social Worker can materially lessen by home visiting and by added interviews in the dispensary.

The passing of pills and powders and the substitution in many instances of fresh air, rest, wholesome food and recreation has left a gap not met by the apothecary. In the first year of one Social Service Department 1,000 patients were referred for more than fifty reasons. These reasons have been classified into what

might be called Social Prescriptions found necessary by the doctor as part of treatment. They include instruction in hygiene, temporary home during treatment, provision of glasses, orthopedic plates, false teeth, special diets, general health built up previous to operation, provision for unmarried mother. Bad habit to be broken, home and industrial adjustment for the cardiac, tuberculosis and many others.

In order the more effectually to give this personal service to the individual patient, Social Workers have been finding it necessary to develop their organization and methods of work in a somewhat different form than was anticipated. The first Social Workers were placed in an office which constituted in medical parlance a Social Clinic. To this clinic or department were sent those patients for whom the physician asked special help. Thus the choice of patients for Social Service was entirely dependent upon the interest, leisure and ability of the doctors to select them. In many Social Service departments it was not at all uncommon, nor is it today, to have referred from the same clinic with each change of service quite different types of problems. From a given clinic during one doctor's service only patients needing convalescence would be referred. During the next doctor's service unmarried, pregnant girls would be sent. During a third doctor's service the majority of patients referred would be those requiring an operation, and to plan for the family during the absence of the bread-winner or home-maker would be the demand. This irregularity of opportunity made Social Service seem a matter of accident and those doing the work could feel no assurance that the patients sent them were the ones which they were most likely to be able to help, for in Social Work no less than in medicine there are ills for which cure or relief is still unfound, as the chronic loafer, and others again for which there is almost as sure a specific as quinine for malaria. These unsatisfactory features of Social Service combined with others realized in the day's routine brought up the questions for which there seemed no available answer:

What are the problems of an Out-Patient Department? In which of them, and in what ways may Social Workers be of use?

Such questions are in reality for the adminstration of an Out-Patient Department to answer. To answer them two steps are necessary: First a chance to study the facts, and second, a chance to experiment under favorable conditions. In both steps Social Workers have been enlisted.

To illustrate: In studying a general medical clinic it was found that of the total number of patients coming for treatment 63% of them made but one visit. The same per cent. has been found true with slight variation in a genito-urinary department and mental clinic. In the mental clinic just noted the experiment was tried of placing a Social Worker in the clinic and a result of personal visits and letters in three months the average visit per patient was raised from one to five. In a children's clinic by a postal card system of communicating with patients who did not return, the number of visits per patient was raised from two to four; while in a skin clinic in which a Social Worker sees every patient, as many as 57 patients have returned for treatment in answer to 58 letters.

In a three months' study of a mental clinic the number of cases with deferred diagnosis reached 46% of the total number, while during a similar statistical period in which there was a Social Worker in the clinic this number fell to 6%. At first sight any connection between Social Service and diagnosis may seem far-fetched, but the explanation is a simple one. The Social Worker's relation to diagnosis is largely one of following up the patients and getting them back sufficiently often to make it possible for the physician to make a diagnosis.

During a three months' service in a general medical clinic in which 30 patients were advised by the physicians to have operations only five are known to have done so—in this clinic there was no Social Worker —while in a gynaecological clinic every one of the 20 patients referred to Social Service had the operative treatment advised, and came back to the doctor so that he could see the results. The part which the Social Worker played with these patients was one of added persuasion to that of the doctors; seeing relatives and friends in regard to it; arranging for the families' care during the patients' residence in the hospital; seeing

that those patients requiring convalescent care secured it and that work was adjusted to the post-operative condition either temporarily or permanently.

In a study of 21 children with vaginitis it was found that they belonged to families consisting of 63 members. Through the efforts of Social Workers 46 of these were examined, the doctors finding in these 46, eleven other cases of infection. All 32 cases remained under treatment until discharged and those of school age were excluded from school with the understanding of the school and health authorities. When one reads in the recent studies on vaginitis the recognition that much of the so-called stubbornness to treatment and many recurrent cases are probably due to reinfection from some uncontrolled source and not as previously believed to the idiosyncracy of the disease, these figures take on a new significance. They also raise the question: Can the average clinical physician treating vaginitis, have, without some follow-up system, the knowledge and control of his patients necessary to the cure and prevention of their disease?

Just what proportion of all treatment prescribed is secured the records of an Out-Patient Department do not tell. However, in relation to equipment ordered, as for example, orthopedic apparatus or glasses, for which the Out-Patient Department retains the measurements, very definite figures are obtainable. Previous to the follow-up work of a Social Worker in an eye clinic, as high as 60% and never lower than 30% of the patients for whom glasses were ordered failed to return for them. With the help of a Social Worker this number has fallen to 4%. Thus the addition of a Social Worker to a clinic is an economy, when one considers the time of experts it takes to test eyes, the results to the eyes and to the relative efficiency of patients needing glasses who do not receive them.

To sum up: The finding of these studies and experiments seem to show three things to be true. First, that Social Service is one means of preventing certain uneconomic features of out-patient treatment. To wit, those involving the irregularity of attendance, the uncontrolled channels for the spread of infection, and the failure to carry out treatment prescribed. Second, if the social problems of an Out-Patient Department

are to be known with anything like completeness, and met with the least waste of effort, Social Workers should be placed in the clinic where they are easily accessible to both physician and patient. Third, such study is a means of knowing in just what degree the efficiency of an Out-Patient Department is increased by the addition of Social Service. Only by such cold analysis in terms of large numbers can fallacious arguments be prevented. Social Workers have much to learn from the scientific spirit of medicine. A physician does not argue a form of treatment to be good or bad from its reaction on one case, but from its proportionate results in a hundred cases. So Social Workers are striving to make for themselves a place in out-patient service not by recounting successful individual cases, but by demonstrating in relation to the whole work of an Out-Patient Department that they can and do contribute to its economy and efficiency.