A patient is not a mere specimen presenting a pathological lung condition but a human being with a personality, reacting to his environment. Holding this view, Dr. Banerjee, in the following article, develops the idea that a trained Social Worker in a T. B. Hospital can help in properly planning the treatment of a tuberculous patient, in the light of his social and economic conditions.

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The great progress of medical science in recent decades has forged new weapons for curing and preventing disease, particularly those of communicable nature. When bacteriology revealed that there are external, biological causes of diseases, physicians were often inclined to overlook the social, economic and individual factors which were as much responsible for diseases, with the result that there arose a tendency to study only the disease and how it affected the heart or lungs rather than the whole patient as a Person.

For a long time, the medical profession in India regarded tuberculosis as an isolated medical problem. It was only very recently that physicians started looking at it in its total social, economic and to some extent psychological background. Consequently, it is becoming obvious that the most expert care aided by new discoveries in medical science and technique of control may be of little avail if social, economic and emotional factors involved in the disease are ignored. Hence, there has been of late a slow move towards studying the patient, not as a specimen presenting a pathological lung condition but as a human being with a distinct personality, reacting in its social, emotional and somatic aspects.

As more hospitals and sanatoria are established today to give sound medical aid to the tuberculous, the medical profession has to deal with patients away from their relatives and home environment. This separation itself may accentuate the emotional problems of patients, and also prevent the physician from knowing his patient as a total person. Therefore, the doctor, who has a vast amount of work in the field of his specialisation, is obliged to delegate certain aspects of his patients' problems to some other individual who is specially trained to handle them. This means a division of responsibility between the doctor and the medical social worker, with their respective concentration upon the medical and psycho-social aspects of illness.

Functions of the Social Worker.—The functions of the social worker in a hospital or sanatorium are multifarious. Generally the value of the social worker is recognised for her ability to acquire financial aid for the patient, because she keeps in close touch with such community resources as trusts and charities of which neither the doctor nor the patient may be aware.

Apart from securing financial aid for the patient and his family when necessary, the social worker renders also other services to them. She helps the patient to accept his diagnosis and medical recommendations and sees to it that there are no obstacles in carrying them out. If there are domestic complications in the way of his treatment, the social worker deals with them. In this connection, it is essential to remember that
the needs of a tuberculous patient cannot be completely separated from those of his family; he cannot be expected to recover in a hospital or sanatorium if the needs of his dependants are not met adequately. So, apart from helping the patient to adjust himself to the requirements of the treatment of his illness, the social worker also helps the family to adapt itself to the new situation. By working with the patient and his family, the social worker lessens the patients' anxieties and enables him to complete his medical treatment without 'signing out' against medical advice.

Problem of After-Care.—Serious and difficult as are the problems of the person affected with tuberculosis, there is the later and still greater problem of 'after-care'. What is to be done with the patient who has reached a stage when his disease is arrested. So long as he was in the hospital or sanatorium, it was comparatively easy to follow the prescribed regimen. On his return home, he may find himself a man apart if he continues to live as he lived in an institution. He has to adapt himself to the family and the latter to him. The social worker has to follow up a discharge case very carefully. She has to see that the patient in his attempt to adjust himself to his world does not over-exert leading to reactivating of the disease. Though tuberculosis is a recurrent disease, every attempt needs to be made in the direction of allaying the anxiety of the discharged patient for whom the danger and the fear of a return of the disease hangs like the sword of Damocles and affects his personality. Besides, his ability to support himself and his family must be restored as physical restoration alone is not the end of medical treatment. Since illness gives the patient a special position in society, the cure is not complete before the patient has been re-adjusted socially and enabled either to resume his old position or become reconciled to the new one. Therefore, the social worker very often has to assist a dischargee in securing a job better suited to his physical condition and also helping to adjust himself to his new work.

In the attempt to help the tuberculous, the worker has to keep in mind that the disease is communicable and that, therefore, she has to deal with a public health problem. Several fundamental factors have to be kept in mind when attacking post-discharge problems. Many tuberculous people apparently well and certainly able to work are at times open cases, i.e., they are throwing off tubercle bacilli. The closed case today may be an open one tomorrow. Also some are 'chronic carriers' of the disease. Therefore, the field for employment is to some extent limited. Hence, the social worker attached to tuberculosis service has to look to the suitability of employment both from the point of view of the dischargee and of the community. She has not only to be in the know of suitable jobs in the community but has very often to take a lead in organising vocational instruction and workshops for the tuberculous.

Occupational Therapy.—It is true that in a well planned tuberculosis hospital or sanatorium, occupational therapy department takes up the responsibility of training patients in arts and crafts. The aim of such a therapy is to assist and hasten recovery from disease through any activity, mental or physical, definitely prescribed and guided for the purpose. The teaching of arts and crafts to the tuberculous, while it does occupy their time,' usually offers little hope of using the acquired skill as a remunerative vocation after discharge. What they are usually getting is merely diversional and avocational and not vocational instruction. Occupational therapy has, therefore, to take a new direction. Definite educational courses have to be formulated, based on a knowledge of the needs of the individual, determined by a careful study of his social, economic, educa-
tional and occupational background, his physical and intellectual capacities and limitations, his aptitudes and ambitions. As the social worker is in touch not only with the patient but also his home background, she can assist the occupational therapy department in this venture. Besides, after the patient has learnt the vocation, the social worker has to follow up the case and see that he is settled in life, well adjusted to his new environment and properly established in the habit of having his 'check up' done at regular intervals.

Though the medical social worker attached to a hospital, clinic or sanatorium may work with tuberculosis patients directly, her functions are slightly different. For instance, a patient may be diagnosed as tuberculous for the first time in a clinic. He may refuse to accept the diagnosis and want to go to some other doctor. In such a case, the first and foremost duty of the social worker is to help him to accept the diagnosis and undergo the treatment. If he decides to do so as an out-patient, the worker has to arrange for it. An O. P. D. patient often becomes irregular due to various social and psychological reasons. When a patient is hospitalised, he may have partly accepted the diagnosis. Here the problem centres more round accepting the new environment and getting used to being away from home and following the routine prescribed by the staff. In the sanatorium, the problem is very much the same. However, as a sanatorium is usually situated in a locality away from the town proper, it is possible that the patient may not have any visitor from home during the visiting hours. In all the three situations, the problem of after-care and rehabilitation is not lost sight of.

Organization of Entertainments.—The medical social worker attached to a tuberculosis hospital or sanatorium has, however, to hold entertainments from time to time to create a spirit of cheerfulness in the patients and help them overcome their home-sickness as well as the boredom of long treatment. She may have to organise a recreation club with the help of the members of the staff and the patients. She has also to encourage patients to develop hobbies and arrange to provide facilities for them. Such activities contribute much to the patients' recovery.

When the social worker is attached to a domicilliary service unit, usually known as Home Treatment Centre for Tuberculosis Patients, she has to be in close touch with the patient and see that the medical instructions are carried out adequately; that is, she has to see that the patient does not as far as possible infect others and that contacts are screened regularly. Here, though the social worker does not have to handle social and emotional problems arising out of the separation of the patient from home environment, she has to look into his domestic affairs to see that the patient gets enough nutritive diet while under treatment. She does not have to deal with this problem so long as the patient is in the institution and has facilities to carry on the doctor's suggestions.

Health Departments need Social Workers.—Even public health departments should have medical social workers attached to them, as they can render an important service in combating tuberculosis if the disease is notifiable. In that case, all cases of tuberculosis can be referred, immediately following diagnosis, to the medical social service section. The medical social worker will study the emotional, social and economic factors which reveal the patient's feelings about his diagnosis and his readiness and ability to carry out recommendations for treatment and also assist him and his family in taking the necessary medical treatment. In the case of those patients who take treatment under private physicians, the social worker can
follow them through their doctors. When a health visitor is attached to such a depart-
ment, she follows each case of tuberculosis in a routine manner. Only when behaviour
problems arise or the social and economic conditions seem to be a hindrance in the
treatment, it is necessary to refer the case to the medical social worker for intensive social
study and possible social care.

Joint Planning of Treatment.—Referrals
to the medical social worker can be made
at any time. When she enters the case at
the point when diagnosis and recommenda-
tions have been made, mutual agreement
between the physician, the health visitor and
the medical social worker as to the part each
will play in the plan of treatment can be
outlined jointly. When the case is referred
for social study and social and emotional
treatment after the medical plan has already
been agreed upon, there is an inevitable risk
of overlapping in the functions of the health
visitor and the medical social worker. This
is readily understandable if one considers that
both are working with the same patient and
the same medical social problem. This can
be avoided to a large extent, however, if the
reason for referring the case to the medical
social worker is understood and accepted by
the other two. The reasons for referring a
case to the medical social worker need to be
consciously and clearly stated. Once the
study of the patient's problem has been
completed, the team should determine the
division of responsibility for following the
case through. Invariably the physician is
responsible for the total plan of medical care.
So far as the division of responsibility
between the health visitor and the medical
social worker is concerned, the plan may
follow one of the three patterns: (1) when
the health problem is paramount, the health
visitor should carry the major responsibility
and the medical social worker should serve
only as a consultant in the social aspects of
the service; (2) when the case is one calling
for the special skills of both the health visitor
and the medical social worker, it should be
carried co-operatively; (3) when the social
situation assumes major proportions, respon-
sibility for social study and treatment should
be assigned to the medical social worker.

In this connection, it may be mentioned
that just because ill-health is a major pro-
blem in the family, it does not follow that
the total programme of service to the patient
and his family must be under the physician's
direction. Professionally competent medical
social workers will not work out social plans
for the patient independently of the physician-in-charge, but will always seek his guidance.
However, they have an area of service to
render, involving special knowledge and
skills with which the medical profession is
not necessarily familiar; at times, social
planning can be done best in co-operation
with the physician and health visitor (on
the case), but not necessarily subject to the
physician's approval.

If the public health department has a
case finding programme or B. C. G. vaccina-
tion scheme, the social worker of the team
will be of much help when resistance from
individuals has to be overcome. Most
people are afraid of screening. They are
afraid of the unknown, i.e., what may be
discovered and they wish to avoid it.
There is also resistance to B. C. G. vaccina-
tion. Some are afraid that some disease
germ will be let inside and to some others,
it means pollution. A doctor or a health
visitor will be able to give medical inter-
pretation to people about the significance
of screening and B. C. G. vaccination, but
when the problem centres round emotional
resistance, it is the social worker's job to
handle the situation.

Community Planning and Health Educa-
tion.—In addition to the above services, the
medical social worker co-operates with
various public and private agencies in deve-
loping new resources in the community and participates in community planning for health and welfare. An important field where her help is very essential is health education. The purpose of health education is to inculcate the principles of healthful living in order to secure the full-cooperation of the individual in the maintenance of his own health. Sometimes people feel that a nurse, or a health visitor can impart health education because they know about health. As the handicap of illiteracy restricts the methods of appeal to the spoken word or to visual demonstration, if the nurse or the health visitor knows how to speak in vernacular fluently, she can do a good job of it. The medical social worker knows enough about health matters to impart it soundly to the lay group. Not only the content but the technique of imparting too is very important. It is one thing to give a few lectures or visual demonstration on health to the masses but it is quite different to help the community or group to assimilate the knowledge and put it into practice. To achieve this end, the educator should have a sound knowledge of the techniques of group work and community organisation—techniques to be studied in a professional school of social work.

Training Case Aides and Health Workers.—
As there is a dearth of professionally trained medical social workers in our country, it has become imperative to train up a few case aides and health workers to do a part of the job. A qualified medical social worker can impart training to them. However, it should be remembered that a medical social worker herself cannot train other social workers just as one doctor cannot train other doctors. As there is need for a medical college staffed with various specialists to impart training to students to become doctors, similarly, a medical social worker needs to have his or her training in an accredited school of social work manned by various specialists. The case aides and health workers can supplement the work of medical social workers, but can never substitute them. In a hospital, for instance, there are cases that need very intensive social study and social care. Such cases must be taken care of by medical social workers. But, there are simpler cases which case aides with educational qualifications upto Matric can handle, provided they are given some orientation in understanding human behaviour and are guided by trained medical social workers. As our hospitals today cannot afford to have more than one or two medical social workers due to financial stringency, it is economic to have a few case aides attached to them. Similarly, health workers with similar educational qualifications can be trained by medical social workers. They can be oriented in current health practices and problems and taught something about community, group and individual approach. They can carry on health education for better living in communities under the guidance of a trained medical social worker and the doctor.

Social Orientation of Hospital Staff.—
Besides the above, a medical social worker has various other functions. She is responsible for the social orientation of the staff of the medical setting to which she belongs. Since the medical social worker brings to the medical setting (e.g., hospital, clinic or sanatorium) knowledge and skill different from those of any other group there, it is appropriate for the worker to create in the staff an awareness of the social and emotional factors that are related to the medical and health needs of the patient. This can be achieved by participation in ward rounds and staff meetings, and also by a programme of in-service training.

Besides, a medical social worker should participate in the education and training of student nurses, medical students, dietitians,
students specialising in hospital social work, occupational therapy, etc. She should also participate in the determination and formulation of hospital, clinic or sanatorium policies, with a view to socialising the set-up.

The medical social worker can be of immense assistance in the field of research. Since she helps the patient to accept medical recommendations and works for the continuity of treatment, she can enable physicians to observe the results of any particular treatment in which they may be interested. Or, when a patient does not respond to a certain type of medical treatment, the social worker can find out for the physicians whether or not the deterrent is a social factor which first needs handling before he is expected to respond. Such information would be of help in the verification of his reactions to a particular treatment. So much for medical research. The medical social worker can help in the promotion of social research too. She observes the social and emotional components of the disease, studies the lack of community resources, the need for new sources and can throw much light on these problems. Properly kept case records by a medical social worker can provide research material to other social workers in the community.

From all that has been said above, it must be evident that for social work in connection with tuberculosis, we need the services of well qualified social workers with specialisation in medico-social field. Anybody just interested in this work will not do. Social work methods have a scientific basis. Methodical skill is essential for scientific social work. It is not just intuition and commonsense. The profession of social work today presupposes a scientific body of knowledge which should be acquired in an accredited school of social work before any individual is entitled to practice it.

Recruitment and Training of Medical Social Workers.—Very often it is thought that concentration on educational requirements would make one overlook necessary personal attributes of the workers. Our schools of social work do pay attention to personality factors in the selection of students, and have been fairly successful in recruiting university graduates, men and women, who possess those qualities of warmth, sympathy, and sensitive understanding that are regarded as necessary for the successful practice of the profession of social work. No person should be allowed to take up a medical social worker's post unless he or she has had the necessary specialised education in the field, possesses maturity of judgment and a definite interest in working with patients. Academic preparation for this type of social work is extremely valuable and essential. A good combination would be (I) an adequate background of general education, (II) interest in the sick, (III) ability to overcome fear and aversion of the sight of blood, dread of disease and death and, (IV) special training in a school of social work in such subjects as, sociology, social pathology, Indian social problems, social legislation, case work, group work, community organisation, information on psychiatry, psychology, symptoms, causes and treatment of diseases, psychosomatic medicine, social and emotional components of illness and their care, and administration of medical social departments in various settings and so on. Students should be familiar with research methods also. Medical social work course per se is not enough. Every medical social worker should have general education of at least the B. A. standard; and medical social work training should be on a post-graduate level with supervised field work placements.

In training medical social workers for the tuberculous, in other words, in training the tuberculosis social workers, it is not necessary
to limit their training programme to tuberculosis field only. Some think that a tuberculosis social worker under training should have field work experience only with T. B. patients. They, however, fail to see that such a procedure will make the worker’s vision narrow. There is the danger of her viewing the patient as a tuberculous lung only rather than as a person. Besides, a tuberculosis patient may also have diabetes, asthma, venereal disease, mental disorders, etc. It is important that the social worker should know how a normal person behaves as well as how a person behaves under stress and strain; she should know what are the social and emotional components of long and short term diseases, infectious diseases, psychoses, neuroses, behaviour, habit and personality disorders, etc. If a tuberculosis social worker is not familiar with the normal behaviour of human beings and the social and emotional problems arising out of various organic and mental diseases, she may take any particular reaction in the tuberculosis patient as due to tuberculosis only while it may be just his normal behaviour or may be due to some other reason, physical, social or emotional. The field work programme should give the tuberculosis social worker enough grounding in working with healthy people as well as people suffering from various organic and mental diseases, and also familiarise her with various community resources and how to use them. Therefore, her field work placements should be in adult and child psychiatry departments, hospitals, clinics, sanatoria, community centres doing health propaganda, and also family welfare agencies, where she can see and understand, away from the hospital setting, the personal and family problems arising out of the individual’s illness.

Today many in our country object to the post-graduate training of social workers. They feel that it will sharply cut down the number of trained social workers, and at a time when the need for them is greater than ever before. However, every profession at one point or another in its development has to choose between emphasis upon quantity and emphasis upon quality, and our country should be sorry to choose the former. For erecting a house or bridge of brick and mortar, we need the services of well qualified and trained engineers with good educational background in the field. Then what about the training of those who deal with human material, the social engineers who are engaged in promoting the social well-being of individuals, families and groups and in restoring to useful life persons who have been victims of diseases and disasters! How can we be satisfied with three or four months' training for medical social workers given by various organisations? What sort of training can they impart within such a brief period in skilful handling of social and psychological problems arising out of diseases? We may be able to turn out many 'so-called medical social workers' who can be employed on small pay. But are they really qualified for the work? It is as absurd as giving medical degree to a person after a short course of training for about a year after I. Sc. and allowing him to practise as a doctor, because in our country there is shortage of doctors. The quantity would increase, but then the quality would suffer and in its turn affect the well-being of the people.

For dealing with the social and emotional problems arising out of tuberculosis, we need in our country the services of well-qualified male and female medical social workers; their salary should be in accordance with the training required for the position and the responsibility to be shouldered by them. Adequate salary coupled with high academic requirements should produce workers of integrity imbued with the spirit of service and the self-imposed responsibility for continuously educating themselves in new developments in this special field.