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MEDICAL SOCIAL WORK IN BOMBAY

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This article is a slightly modified version of a chapter in *Hospital Administration in Bombay—A Report.* The study was undertaken as part of the research programmes of the Department of Civics and Politics, University of Bombay.

The Survey was an inquiry into general aspects of administration in three hospitals run by the Bombay Municipal Corporation. It sought to inquire into the personnel relationships among different categories of nursing staff, of their relationship to the administration, their attitude to nursing in general; the nature and quality of service rendered to the patients, the attitudes of the Resident Medical Staff and the role of the Medical Social Worker.

We were interested in the role of the Medical Social Worker for medical social work was a new field in hospital administration, so far as India was concerned. We were therefore interested in their attitudes; and in the attitudes of other members of the hospital staff, towards them. We may here record our appreciation of the work done by the Medical Social Workers in these hospitals. They worked in an environment not altogether conducive to efficient work performance and, some of them at least, struck us as dedicated. Indeed, some of them helped us immensely in the drawing up of the questionnaires.

The general method of inquiry was that of administering questionnaires and conducting personal interviews, but in the case of the Medical Social Workers, we had the benefit of meeting them often, and talking to them informally about matters relating not only to their own work but also about hospital administration in general. In many cases, indeed, they were the most friendly persons in these hospitals.

Of the three hospitals (herein referred to as *X, Y* & *Z, X* had the largest number of workers. In fact this was the first hospital to appoint a Medical Social Worker in September 1954; and since then six more workers have been appointed. Hospital *Y* had two Medical Social Workers and Hospital *Z* had only one.

Since Medical social work is a comparatively a new concept in India, a brief discussion of its nature may provide a useful background to the actual findings of this Survey.

Medical social work may be defined briefly as 'the application of the methods of social service work in the sphere of health and more especially in the hospital setting'. It is, in other words, a form of social service. This ideal of service finds its fullest expression in a hospital; here the doctor, the nurses and the rest of the hospital staff are all engaged in social service because their work is essentially humanitarian, viz. the cure of disease and the alleviation of suffering. Today however, the term social worker is applied to the *trained* social worker for whom social work is both a vocation and profession.

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Social service in hospitals has been the result of the revolution in the attitude of doctor to patient. Traditionally, it had been the practice to treat a disease from the strictly medical point of view. But the inadequacies and anomalies of such an approach soon became apparent. The earlier approach had led to a negligence of and unconcern for the non-medical aspects of illness. For instance, doctors did not realise that a patient's inability or reluctance to undergo specified medical treatment might be due to financial, social or psychological reasons. The few who might have suspected the operation of non-medical factors were in no position to confirm their suspicions. Where a patient was discharged from hospital after treatment, there was no way of ensuring that the prescribed after-care would in fact be taken. Within the hospital, there was a startling lack of co-ordination—thus the same patient might be treated at different times by different departments for apparently unconnected illnesses but there was no method by which a doctor would automatically learn the patient's medical history. In most cases, the doctor would be too-pressed for time to go into such details himself. The family doctor who had an intimate knowledge of the patient and his relatives and possessed other background information about the patient's family, had a distinct advantage over his counterpart in the hospital, for his treatment was influenced, albeit unconsciously, by this additional knowledge. The hospital doctor might rely on his colleagues for professional information of various kinds but there was no one to whom he could turn for information about the patient's background and history. There had to be then some agency which would provide the doctor with data bearing on his patient's illness, whether this pertained to his earlier medical history or to certain non-medical factors connected with his illness. Hospital social service came into being to perform this function and to fill the gaps in medical treatment. It did not however, merely supplement medical treatment but proved to be its necessary complement. Until the social worker entered the hospital, the clinical picture had been an incomplete one. The trained social worker brought to medical treatment her special training and skill with human beings. In so doing, she helped to modify the hitherto impersonalised hospital treatment.[2]

The primary aim of the social worker is social service through case work. In the hospital, she functions as part of the medical staff. This implies an interest in and a general knowledge of medical treatment for effective functioning. Because she is part of the medical team bringing to it her own special knowledge of human behaviour, she is designated the medical social worker (MSW). Medical social work came into being because some doctors and nurses realised the need for making the patient well and keeping him well. It is in this sense an *extension* of medical treatment.

The MSW's function may be summarised briefly as 'relief, information and listening'.[3] Under the head of relief, her functions are fairly clear. If for any reason the patient is unable to maintain himself, it becomes the duty of the medical social worker to tap

[1]Examples of this are given by H. S. Richardson in *"Patients Have Families"*.

[2]"One of the chief differences between private practice and hospital practice is that the latter always tends to become impersonal". Francis Peabody in "The Care of the Patient" quoted by Leonara B. Lubinow in *"Hospital Trends and Developments—1940-46"* edited by Bachmeyer A.C. and Hartman G. (The Commonwealth Fund, New York, 1948).

[3]M. Antoniettee Cannon, "The Use of Medical Social Work" In Dors Goldstein (ed) *"Readings in the Theory and Practice of Medical Social Work"* p. 29. (University of Chicago, Second Impression 1958, published 1954).

available resources. At times, when the patient suffers from a prolonged illness, it may be necessary to provide relief for the family also. This is generally done by getting into touch with institutions or agencies devoted to such relief work and arranging for the family's needs. In case of accidents, the MSW may arrange to secure compensation and at times even employment.

Her duty does not end there. She is also responsible, to a significant extent, for ensuring that the best results will be got out of the treatment. In the past the effectiveness of medical treatment was often reduced by the patient's unwillingness or inability to follow the doctor's instructions. Where hospitalisation was not necessary, it was difficult to ensure the patient's co-operation. In cases where the patient was treated in hospital, the doctor's care was brought to nought by the patient's ignorance or neglect of necessary after-care. Today it is the MSW who ensures that the patient does in fact carry out the doctor's instructions by providing for what is known as follow-up. care. It is the MSW's duty to undertake this either by personally visiting the patient at his home or by arranging for the patient to visit the hospital periodically for medical check-up. Medical treatment, one might say, is extended beyond the hospital and reaches out to the patient in his home. Richardson points out that, "It is the adjustment of the medical treatment to the conditions of the home which I have always regarded as characteristic of medical social service".[4] This is a process which, according to him, requires the "individualization of cases".

The phrase "individualization of cases" is incidentally, the key to the method of her work, viz. 'case work'. For instance, if a doctor finds that a patient does not respond to treatment as he should or that he is reluctant to undergo the treatment prescribed for him, he turns to the MSW for help. The MSW by skilful interviewing and sympathetic approach tries to discover the reason(s) for the patient's reluctance or lack of response. She familiarises herself with his family background and the nature of his difficulties, financial or psychological. She seeks to understand the patient. For her the patient is more than a patient—he is a human being with his own problems; his hopes and fears. She adopts an approach that will enable the patient to confide in her and this task calls for an exceptional degree of skill. Her only concern is the need of the patient in relation to the ability of the institution to meet it. This task over, she passes on the information she has collected to the doctor so as to provide him with the necessary background for his treatment. It is equally her duty to win over the patient by explaining to him the necessity of his active co-operation with the doctor and by helping him to overcome such difficulties as might stand in his way. Where the patient suffers from an incurable disease or is faced with the permanent loss of a limb or organ, the MSW can help a patient to accept the situation. She can prevent him from becoming a burden by showing him how to make the most of what he has. In fine, she can put him on the path to rehabilitation—physical and emotional.

It is particularly in this last respect that the MSW's role as a "listener" emerges. For, the severest blow to a patient—and the consequent necessary readjustment—is often emotional. Increasing realisation of this fact has led to a shift in emphasis and attention from the environmental to the emotional factors in a patient's illness. This has naturally affected the nature of medical social

[4]H. B. Richardson, *"Patients Have Families",* p. 210.

work[5] and greater stress is laid today on the emotional problems of the patient. By her concern with individual cases she provides the patient with an outlet for emotional release and this release of tension helps him to adjust to changed circumstances. The MSW is peculiarly fitted to play the role of a sympathetic listener, both by training and because of her position in the institution. She is part of the hospital staff and partakes of its authority and prestige. The patient therefore, is ready to go to her even if he is not aware of the social or emotional factors in his illness. At the same time it is possible for the MSW to establish a personal relationship with the patient. The MSW does not issue orders. She can appreciate his difficulties and the patient can talk to her without the embarrassment and loss of status that a visit to any outside social agency may imply. By talking to the MSW the patient is able to clarify his own attitudes; she, on the other hand, gets an opportunity to study his case individually and report to the doctor.

Within the hospital, the MSW has an important place as the link between the doctor and the patients. While bringing her peculiar talents and knowledge to bear upon medical treatment she nevertheless functions as part of the medical team. The medical worker functions in an area in which the doctor expects co-operation from those who assist him—the ward-sister, the nurses and the rest of the staff, including the menial staff who help in ward work. Yet her contribution is not easy to evaluate. She has no doubt certain 'concrete' duties, but her primary role as a case worker does not lend itself to evaluation. The main thing is of course for the doctor to realise that there is more to medical treatment than diagnosis and prescription. Even when this becomes obvious, it is not always easy to understand what the MSW is trying to accomplish or to gauge the results of her efforts. When there is no clear grasp of her role, there is a constant temptation to allot to her administrative duties and more so in view of the fact that she possesses skill in interviewing and ability to co-ordinate administrative matters. Thus the admission and discharge of patients, routine follow-up care and clerical work may be entrusted to her. But to involve the MSW in time-consuming activities of this nature is to undermine her true function in the hospital.

The MSW is the link that connects the hospital to the various social agencies of the community. Her responsibility for relief, rehabilitation, compensation, institutional placement, transport, etc. means that she tries to be in contact with the different agencies catering to these needs and to tap their resources when necessary. The community on the other hand must be prepared to co-operate and act in an organised manner to try and meet the demands of the hospital. This implies that the community should have a sympathetic awareness of the needs of the sick and disabled and that it should be prepared to meet those needs as far as possible by the provision of adequate resources. To the community agencies, the MSW appears as the representative of the hospital authorities. Changes in hospital policy or even in the methods of hospital care have repercussions on the community and the MSW in its eyes may become wrongly identified with such a policy. It is necessary to remember that the MSW is not finally responsible for the policy a hospital may follow. Of course, the nature of her knowledge and her capacity for social research make her co-operation in policy-making indispensable and it would be desirable to associate her with its formation. But care must be exercised to see that

[5] *Ibid.*, p. 218.

her true role is not misunderstood. The fact that the hospital is generally unable to meet the needs of the community gives occasion for blame and the MSW may find herself the target of criticism which will render her task difficult. The opposite may happen. A policy followed by a voluntary social agency may be such as to make co-ordination between it and the hospital difficult. This lays the agency open to the charge of lack of sympathy and non-cooperation while it frustrates the objectives of medical social work. An awareness of the inter-relatedness of hospital and community needs is therefore essential if the MSW is to function efficiently and effectively.

In India, in addition to her normal tasks, the MSW has one additional responsibility. This is to make known the values and necessity of medical social work. Whereas in the West, its importance is today an acknowledged and accepted fact, in our country it is still a new concept. Its full and universal acceptance will take time and patience and it is up to the MSWs who are already in the field—thanks to a few enlightened institutions—to prove the value of their work. This will not be easy. For the MSW does not work in the limelight. An effort has to be made if medical social work is to achieve its due recognition and this is the responsibility of the MSWs themselves.

We might recapitulate what we have said so far by a definition of the MSW suggested by Theodore Sould:[6] "The interpretation of physical disability, the exploitation of community resources for treatment, and the relieving of anxieties and fears concerning ill-health are essentially the functions of the medical social workers."

Of the three hospitals studied in this Survey Hospital, *X* was the first to engage the services of a MSW. In September 1954, 2 trained MSWs were appointed under the supervision of the Senior AMO. By 1959, the number of MSWs had been increased to 7. The objectives of the Social Service wing as defined in the Annual Report of the Hospital suggest that the functions of an MSW were clearly understood.

The Report states :—

> This Department is an integral part of medical-care arrangement at this Hospital. It helps in finding out the social, economic and environmental factors associated with the onset of diseases, whether these factors are interfering with the satisfactory progress in the treatment and thereafter the final rehabilitation of the patient is done to reasonable physical and mental efficiency. From this point of view social and emotional aspects of the patient's illness were carefully investigated and the treatment was so adapted as to obtain maximum benefit from the treatment. Home visits, whenever necessary, were also paid in cases where family as a unit had to be studied. Case-work service was rendered particularly in psycho-somatic illness in consideration of each patient's personality and social environment. Patient's intelligent cooperation is brought about by giving him an insight into the nature and problem of the disease and every possible help is extended towards the completion of treatment. Many outside community resources were tapped in order to assist the needy patients. After the completion of treatment, follow-up of patients was carried regularly to find out the degree of improvement maintained by them and to assist them if necessary by the way of medical and social help.

Medical social work was introduced in Hospital *Y* with one MSW in 1955; later on another MSW was engaged: Hospital *Z* followed in 1956 with one MSW and there has been no addition since.

[6] *Ibid.,* p. 218.

Thus, during the period when the Survey was carried out, the total number of MSWs in the three hospitals was 10. Their ages varied from 23 to 29 years. Their educational qualifications were good: 6 were graduates (one in Science), and 4 had taken their Master's degree (of these, 1 had a degree in law also). 6 of the MSWs graduated from the University of Bombay and the remaining 4 were from Lucknow, Poona, Nagpur and Banaras. Of the 10 MSWs, 9 had a diploma in Social Service Administration, 1 had a degree in medical social work. It is interesting to note that 7 of these had taken their diploma from the Tata Institute of Social Sciences (one had in addition a diploma from Poona); 1 was from Nirmala Niketan, 1 had studied at the London School of Economics and 1 had a degree from Baroda University.

Only 2 MSWs had been abroad and of these 1 had received her training in the London School at her own expense. Both of them, agreed that their experience in foreign countries had been valuable. Three MSWs were scholarship holders and of these 1 was an assisted student.

The nature of the MSW's work brings her into contact with people from all walks of life speaking different languages. A knowledge of languages spoken in the region therefore becomes indispensable. It is therefore gratifying to learn that most of the MSWs can speak 3 languages or more—English and Hindi are spoken by all. Eight MSWs know Marathi and 5 know Gujarati (these are not necessarily their mother-tongues), 3 speak Konkani. Other known languages are Kannada, Sindhi, Tulu, Bengali and German—each spoken by 1 MSW.

An interesting fact that emerges is that most of these MSWs have taken up this profession by choice, fully aware of the nature of the work they would be called upon to do. They did not just get caught up in this work by accident as is the fate of graduates in other fields. A desire to do some sort of social service was the chief motive for most of the MSWs interviewed. The hospital was chosen as one of the best means of fulfilling the desire to help the needy. Two MSWs had participated in social activities in college and were therefore attracted to this profession. One MSW came from a family whose members were working in related fields and was inspired by their example For another MSW, the decision grew out of a personal experience. An illness in the family revealed to her the necessity of help in such cases and she decided to make this profession her career. Only two MSWs refer to the salary attached to this job as an attraction. One MSW declined to answer One might conclude that for most the work itself was the chief attraction—they were willing and indeed eager to utilize their talents in a cause which appeared to them to be noble.

Since medical social work has been only recently introduced in the hospitals, few. have experience of any considerable length. The majority—7—have less that 2 years' experience, and 3 of these have been working for periods between a fortnight and two months. Only 3 MSWs have experience ranging between 3 and 5 years.

We have mentioned earlier that the MSWs in Hospital *X* were placed under the supervision of the Senior AMO. There is no full-fledged Department of Social Service as such and so is the case with the other two hospitals. The organisation in this matter appears to be flexible. There is no hierarchy in Hospital *X* and at least 4 of the 7 MSWs there are happy with the present arrangement. The other 3 were, however, in favour of a more rigid and formal structure. In Hospital *Y* the position appears to be slightly ambiguous. One MSW maintained that there was some

sort of hierarchical arrangement but the other MSW claimed that this was unnecessary (with only 2 MSWs in this hospital, it is easy to appreciate her position). In Hospital *Z* with only 1 MSW, the question did not arise at all.

If there is one thing on which all the MSWs are agreed, it is that the nature of medical-social work is not clearly understood by the members of the staff. Medical-social work was often thought to be merely the provision of financial or medical aid to the patients. The MSW then comes to be regarded as part of the administrative machine and her contribution to the *treatment* of the patient is but dimly understood. According to the MSWs, the rest of the staff were not sufficiently aware of the social aspects of medical treatment except perhaps in those cases where physical rehabilitation was found to be necessary. It was left to the MSWs themselves to try and get the staff interested in their work and also to explain their role. This they have to some extent attempted to do. However, the degree of awareness as well as the response to the MSWs' efforts varies with the different categories of hospital personnel.

In Hospital *Y*, for instance, both the MSWs found the Head of the institution ready to co-operate; but as far as the departmental heads were concerned, 1 MSW expressed the opinion that they were very co-operative, the other felt that they displayed only a passing interest. Both agree that the RMOs do take some interest in their work while the medical students are indifferent to it. According to 1 MSW, this indifference is shared by the nurses but the other feels that the nurses do take some interest. In Hospital *Z*, the MSW found the head of the institution and the departmental heads to be co-operative as well as interested. About the RMOs it is difficult to state categorically—some show interest, others are indifferent. The nurses take some interest, some of them actively co-operate. The MSW does not comment on the attitude of the medical students. Probably she does not come into contact with them. This, if correct, would mean either that their instructors do not point out the importance of medical-social work and therefore students are ignorant of its nature or that the students are themselves indifferent to it. (The findings on the whole would favour the former presumption). In Hospital *X*, MSWs are unanimous in saying that the institutional head has shown interest; as well as extended co-operation. Where the departmental heads are concerned, the majority claim that they too are co-operative, but 1 MSW with considerable experience opined that the attitude varies from person to person so that while some of them take an interest, the rest remain largely indifferent. The attitude of the RMOs is said to vary from one of co-operation to indifference while 1 MSW claims that some of the RMOs are positively antagonistic to medical-social work. Two other MSWs add that RMOs are in general indifferent and show no appreciation of medical-social work. Almost half of the MSWs hold that nurses are indifferent and uninterested; according to the rest attitudes range from cooperativeness to indifference though there is no antagonism.

There is a significant similarity in the reasons given by the MSWs for staff attitudes towards medical-social work. All the MSWs feel that there is a lack of understanding about the nature of their work. This they ascribe to the fact that the social aspects of medical treatment are not included in medical studies. Further, there is a half-yearly turn over of the resident medical staff which is not inclined to take any active interest in the functions of the MSW. The RMOs are concerned only with getting some experience and training. They are generally over-worked and so the necessity of referring

now and then to the MSW naturally appears to them an additional burden which could well be avoided. Among some of them the feeling persists that medical-social work is unnecessary. As 1 MSW pointed out, so much of the MSW's work lies in the field of 'invisible' or 'intangible' social relationships, that the results of their efforts are not always apparent (as in the case of ancillary services like Physical Therapy or Occupational Therapy) ; consequently there is no realisation of the true nature or necessity of medico-social work. The MSW is regarded as a rather well-paid superfluity whose services could easily be dispensed with. One MSW observed that where the departmental heads themselves showed lukewarm interest, the rest of the staff could hardly be blamed for not being cooperative. For instance, the RMO who is mainly interested in getting experience cannot be expected to bother about an individual patient's case. One might say that there is an inherent defect in the training given to medical students. This conclusion is borne out by the almost unanimous opinion of the MSWs that medical students are totally indifferent to medical-social work. The fact that the rest of the staff is overworked and has its own problems only adds to a basic attitudinal short-coming. Narrow attitudes and hazy conceptions about the function of the MSW also serve to restrict interest to the obvious field of her operation. There seems to be an inability on the part of the staff as a whole to realise that the MSW is an indispensable part of the team. As 1 MSW puts it, there is a lack of both cooperation and coordination. One MSW interpreted the desire to avoid referrals to the MSW as an attempt to escape responsibility by finishing off with the case as quickly as possible. Only 1 MSW admitted that perhaps they—the MSW—had not done their best to awaken in the staff an interest in medical-social work or a recognition of its importance.

What were the kind of cases referred to the MSW? The answers given seem to comprehend a fairly wide range—financial aid, medical aid, institutional placement, rehabilitation, supply of drugs and appliances, transfer and discharges of patients, follow-up care, the investigation of psychological and social difficulties that cause the patient to resist treatment, social histories and economic information concerning the patient and his family, and finally, the causes of marital discord and attempted suicides.

One MSW from Hospital *X* said that on an. average 400 cases were handled by a single MSW in one year and of these about 60 or 15% directly involved case work, relating to psychological, emotional and social problems. The nature of work done may be seen from the figures given below for Hospital *X for* the year 1960:—

Medical, Surgical, Paediatric and Gynaecology cases:

Social data for diagnostic purposes	3,352
Medical Aid, appliances	1,415
Case work, follow-up	898
Arrangements for discharge, institutionalisation and convalescence	153
Rehabilitation	80
Families of patients suffering from T.B., Meningitis referred to Organised Home Treatment Clinic for family X-Ray and B.C.G. Vaccine	93

In addition to such work, the MSWs in Hospital A' now give lectures to internees. This has brought about an increase in the number of cases referred to MSWs. One MSW believed that these lectures helped to arouse interest in medical-social work: "They now know about medical social work", she emphasised.

In spite of this, in none of the hospitals is there a full-fledged department of medical-

social work.[7] In Hospital *X,* the MSWs are attached to the Department of Social and Preventive Medicine. They do not have facilities for their work. Hospital X has allotted three rooms for the use of the MSWs, but even here there is no guarantee of privacy. For patients who approached the MSW with personal problems like family planning,[8] this can be very embarrassing. The MSW also finds it difficult when she has to interrogate patients regarding details of their family history or of financial problems. In such cases, the MSW asks her colleagues to *move out* of the room for a short while during the interview this arrangement is obviously unsatisfactory.

We are also pained to note that the MSWs are not provided with any clerical assistance. Requests for such help have been made according to 1 MSW but apparently without success.. This means that case histories have to be written out by hand by each MSW. Such a procedure besides being time-consuming and tiring, makes the maintenance of records rather unsystematic, and discourages research. No copies are taken as there is no provision for duplication so that each report has to be maintained carefully in the original and in the varied hand-writings of the MSWs. It might be argued that since the MSWs are not normally called upon to do any work outside their sphere, they should not mind doing the routine work connected with their job. After all, nurses too maintain records though their work is more taxing than that of the MSW. This (possible) argument does not impress us. We feel that the valuable time and energy lost in the clerical work and maintenance of records might more fruitfully be devoted to research and study. We would like to stress particularly the undesuitabilily of allotting to MSWs duties not directly connected with medical social work. Four out of the 10 MSWs claim that they are called upon to perform such duties.

Who directs patients to the MSW? The majority of patients who approach the MSW do so on the advice of the doctor or nurses. Sometimes the ancillary services get into touch with the MSWs and on occasion, the MSWs directly approach the patients. Of the MSWs interviewed 8 mentioned the ancillary services as a source of referrals and 7 claimed that they got into contact with the patients on their own initiative. All of them mention the doctors as referring cases but only 4 MSWs said that the nurses directed the patients to them.

How do patients learn of the activities of the MSW? According to 5 MSWs, the patients were directly aware of their work; 8 said that their source of information was the doctor and 6 mentioned the nurses and the ancillary services as the agency guiding and directing the patients. Two MSWs claimed that patients were indebted to "other patients" for their knowledge of medical-social work.

The MSW first learns of a patient's problem through the referring agency—doctor, nurse, etc—except in these cases where patients directly approach or are approached by the MSW. However, all the MSWs emphasised that a real understanding of the patient's problem could be had only by interviewing the patient himself. At times indeed, relatives and/or employers may be interrogated and this may be followed by visits

[7]This was also remarked upon by one of our investigators in her report. She observed that a MSW is attached to one department or the other. There is no separate department or departmental head who can take an interest in their work and guide them. "When the hospital staff is indifferent towards them it becomes very difficult for them to work. Perhaps this is their main grievance."

[8]It should be noted that cases for family planning are *not* referred to the MSW and this work is done by her largely on her own initiative.

to the patient's home to learn at first hand the patient's circumstances, but by and large, the interview remains the chief source of information.

All the hospitals maintain a fund—the Poor Box Fund —from which patients who are in need are supplied with medical and financial aid in the shape of drugs, ampules, surgical appliances, travelling allowance, etc. If the patient is not poor, he may be asked to pay at least half the cost of the medicine, or alternatively, to contribute to the Fund. Social welfare agencies and, charities are tapped for aid and the physician's samples received by the Dean and the doctors are donated by them to the Fund. A feeling of inadequacy of supplies of drugs etc. voiced by 1 MSW is borne out by interviews with the other categories of staff.[9] There is a fair consensus of opinion as to the lack of essential drugs which makes it difficult for doctors to prescribe such medicines and this is attributed largely to paucity of funds. We therefore consulted the annual reports wherein details regarding the Poor Box Fund are given. We found that out of the total receipts of the Fund, only a limited portion (about 20%) is spent on immediate patient care i.e. on supply of costly medicines and injections, appliances, blood transfusion charges, travelling expenses etc. A considerable portion of the receipts are invested in public securities or held in cash form with the banks. We have been assured that there is no municipal regulation governing the amount and nature of these investments and our inquiry reveals that the allocation of these funds is left to the discretion of the hospital authorities. We approached the hospital authorities to find out as to why so little was being spent on immediate patient care and were informed that "the surplus cash balances in the fund after meeting all expenditure are invested in public securities and Bank deposits with a view to earning interest as an additional source of income to the Fund"—an explanation which we are constrained to remark is not very enlightening. For what we would really like to know is *why* there is such a large surplus.[10] Can it be seriously suggested that the patients who go to municipal hospital are for the major part well able to provide for themselves? Moreover, our Survey reveals that patients are largely ignorant of the existence of the Poor Box Fund, and seek its assistance when directed by doctors or nurses. They are too busy to inquire into the financial condition of the patients so that the latter are deprived of assistance to which they are entitled. The MSW cannot be expected to do this on her own except when she directly approaches a patient.

Nor it this her job. Her task is to render material aid where necessary—normally on the suggestion of a doctor or nurse—but chiefly to extend 'social treatment'. She must help the patient to understand his problems and persuade him to undergo the necessary medical treatment if he appears to be reluctant to do so. In those cases where an operation is indicated, she must prepare the patient for possible after-effects. At times, she may

[9]This is also borne out by the remarks of one of our investigators: "The Medical Social Service Department worked with various handicaps, the main being limited financial resources. The majority of the patients referred to them were those needing financial help or drugs, and with the little they had at their disposal, they had to derive the maximum advantage,—with the result that not many could be helped. Only the very deserving could be helped. This has an indirect effect on the number of cases referred. If RMO's feel that there is not much the MSW can do; he will naturally be reluctant to send patients to her. Our investigation pointed out that "as the results were not very significant, many RMO's were reluctant to refer their cases." She adds that the majority of cases referred were TB cases, i.e. that (anti-TB) drugs were in demand. If these are not readily forthcoming the RMO's tend to lose interest in the MSW's work.

[10]The position is similar in all the three hospitals studied.

have to approach other outside agencies for help. The services offered by the MSW to out-patients and in-patients are practically the same. These services are, as mentioned earlier, rehabilitation and institutionalization, placement and employment, transport and arranging for compensation, and follow-up care where indicated. Case-work is however, the most important means of helping patients.

In addition to her professional work, the MSW undertakes to give lectures so as to help spread the knowledge of medical-social work. In Hospital *Y,* the MSWs lecture on medical social work to the ancillary professions (though not to students). In Hospital *Z* the MSW delivers lectures to both students and the ancillary professions. In Hospital *X,* 2 out of 7 MSWs give talks on the nature of their work to the ancillary services and to medical students. These lectures, it is felt have succeeded in drawing attention to the social aspects of medical treatment. All MSWs agree that medical students should have a course in medical-social training as part of their studies since, in their opinion, students are generally ignorant of and indifferent to medical-social work.

The MSWs have maintained contacts with various trusts, charity organisations and welfare agencies in the city. Nine of the 10 MSWs are satisfied with the response of these agencies to their needs, which they feel is ready and good. Two MSWs mention occasional indifference on the part of these organisations and 1 MSW felt that though help was forthcoming it was at times unduly delayed. Of late it would appear that there has been an improvement in the willingness of welfare agencies to cooperate though no reason has been suggested for this. Where there is lack of cooperation, it is probably due to lack of funds (5 MSWs), lack of personnel (1 MSW), lack of organisation (1 MSW), time involved in investigation of the genuineness of the appeal (1 MSW), inadequate facilities and proportionately too great a demand (1 MSW), and sheer avoidable delay (1 MSW).

The hospitals do not subscribe to any journal which is directly connected with medical-social work, though they do subscribe to medical journals and journals on public health. Nine of the MSWs do not read any journals and only 1 reads journals on Public Health. One MSW refers to the library of the Tata Institute of Social Sciences. Three MSWs contribute articles and 1 is planning to do so.

CONCLUSION: —

Since medical social work has been introduced only recently in Bombay's municipal hospitals, we were particularly anxious to know how the MSWs had been received by the hospital staff and how far they had been accepted as a necessary component of the medical team. The main conclusion that can be drawn from the Survey is that authorities at the highest level are found to be cooperative but cooperation at the level of doctors and nurses is not readily forthcoming. True, there is no antagonism but there is indifference especially among the medical students. Partly this is due to defects in medical education which ignores the social aspects of the cure of disease. It is also to some extent a result of the paucity of funds which limits the usefulness of the MSW in those areas where doctors are most likely to ask for help, viz. the supply of drugs and medicines. For where doctors have approached the MSW for information about the social or non-medical background of their patients, the MSW has generally been found to be helpful. However, such referrals do not appear, on the evidence of the RMOs, to be very frequent.

The RMOs have by and large agreed that the MSW is a necessary part of the hospital staff but there seems to be little realisation

of her true function. To some extent this conclusion is borne out by the fact that there is as yet no separate Department of Medical Social Work. This means that the MSW has to be attached to some other Department—usually the Department of Preventive and Social Medicine—and share its facilities. She has no private room to see her 'clients' (this is not true of Hospital *Z)* and no clerical assistance to relieve her of routine task.

Finally, though the MSWs claim that they have tried to orient the hospital staff towards a realisation of the importance of their work, it is surprising that none of them appears eager to keep in touch with her subject by relevant literature or conducting research of any kind.