ACTA SCIENTIFIC MEDICAL SCIENCES

Volume 2 Issue 6 September 2018

Review Article

The Study of Medical Social Worker how was this Evolved in India and how Medical Social Service Officer in AIIMS can Changed the Problem Faced by Patients

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Received: June 15, 2018; **Published:** August 14, 2018

Abstract

Medical social work is a sub-discipline of social work, also known as hospital social work. Medical social workers typically work in a hospital, outpatient clinic, community health agency, skilled nursing facility, long-term care facility or hospice. They work with patients and their families in need of psychosocial help. Medical social workers assess the psychosocial functioning of patients and families and intervene as necessary. Interventions may include connecting patients and families to necessary resources and supports in the community like preventative care; providing psychotherapy, supportive counseling, or grief counseling; or helping a patient to expand and strengthen their network of social supports. Role of a medical social worker is to "restore balance in an individual's personal, family and social life, in order to help that person maintain or recover his/her health and strengthen his/her ability to adapt and reintegrate into society". Professionals in this field typically work with other disciplines such as medicine, nursing, physical, occupational, speech and recreational therapy. Introduction of Hospital Social Work in India was influenced by the work of lady almoners of Britain and medical social workers in America. The physicians of India who visited Britain and America for study got the opportunity to observe the activities of almoners and medical social workers. After returning in India some of the physicians were very interested to start similar activities in there hospitals or clinics. The opening of social and preventive medicine departments in medical colleges, psychiatric clinic in some of the general hospitals and training programs in medical social work in some of the school of social work in Bombay and Delhi placed student for practical training in hospital and clinic give further impetus to the development of medical social work in India. The first medical social worker in India was appointed in 1946 in the J. J. Hospital in Bombay. Gradually, medical social worker began to be appointed in other hospitals and clinics of India. At present, medical social workers are working in almost all the States of India. In a study conducted at AIIMS we found out that the patients coming for registration at AIIMS new Delhi were given a form those who wanted the help The forms were analyzed and the results were found out age, education qualification, gender, marital status.

On basis of that we did the study and the data was analyzed. The result showed in the study was alarming.

Keywords: Medical Social Worker; India; AIIMS

Health problems of a community are seen as outcomes of interaction between certain causative agents and individuals, which are mediated by the environmental conditions. In other words, the malfunctioning of social system in terms of population explosion, unemployment, poverty, ignorance, old age, unhygienic living conditions, bad housing, poor nutrition, incompatible dietary habits, poor quality of sanitary facilities, lack of safe drinking water, etc. are the causes of ill health. Thus, it is assumed that ill health is only a symptom of social disequilibrium. In medical science, curing illness or good health has been postulated as a result of application of medicine. Many social scientists are of the opinion that health is misunderstood with treatment, which is not a precondition for good health. Prof. Imrana Qadeer feels that the consciousness of the people, culture and power of the dominant classes influence the concept of health and approaches to control health problems. Thus, it is clear that social forces or factors are very vital for the health of the masses. In the field of social work, how social factors in health were recognized has a specific history. The first

initiative was registered in England around 1880, when a group of volunteers working for an asylum started making home visits for the discharged patients. In 1895 in England, Sir Charles Loch's recommendation regarding lady almoners' visits to the patient's home in order to prevent the abuse of drugs given by the charitable hospital paved the way again for the introduction of medical social work. In the USA, during 1900, home visits for discharged patients (from hospital) was introduced to provide home level care by the nurses. It divulged the value of social factors in health. In 1902, Dr. Charles Emerson appreciated the significance of social aspects in illness. He was of the opinion that medical students should work as volunteers under the charity or agencies and need to study the socio-economic as well as emotional conditions of patients. In fact, in 1905, when Dr. Richard C Cabot established the Department of Medical Social Work at the Massachusetts General Hospital in Boston, the real importance of social factors in health was formally accepted in social work profession. Thereafter, trained social workers were appointed in different hospitals of USA to improve the quality of health care, to understand the social factors related to illness as well as treatment and to utilize community resources in comprehensive patient care. In India, the first social worker in health care was introduced in 1946 in J.J. Hospital, Mumbai and then in 1950 in Lady Irwin Hospital, Delhi. The present chapter will make an effort to understand various issues needed to carry out social work in health care sector. Health in our society, most of the times, 'Health' is neglected and the same is not fully understood, unless it is partially damaged. Traditionally, it has been perceived as "absence of disease" in narrow sense. Meanings of 'Health' expressed in various dictionaries are 50 Social Work Intervention with Individuals and Groups comparatively better than the traditional concept.

According to the Webester dictionary, "Health is the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain". As per the Oxford English Dictionary, "Health is the soundness of body or mind; that condition in which its functions are duly and efficiently discharged". With the advancement of science, the concept of health has been evolved over a period of time from an individual concern to a world-wide social goal. These changing concepts are bio-medical concept, ecological concept, psycho-social concept, holistic concept, etc. In biomedical concept, if one is free from disease, (s)he is considered as healthy. Under it, human body is viewed as a machine and disease is an outcome of helplessness of the machine. Doctor repairs this machine and his ultimate suggestion is medication. Ecologists have defined health as a dynamic equilibrium between human beings and their environment and illness is maladjustment between these two factors. In the psycho-social concept, health is influenced by social, economic, political, cultural and psychological factors of the people concerned. The holistic concept is the conglomeration of all the above-mentioned three concepts. It indicates that all sectors of the society, such as industry, agriculture, animal husbandry, housing, education, public works, communication and others, have effect on health. The definition of 'Health' given by the World Health Organisation (WHO) is widely accepted and is broad in its perspective. According to WHO (1948), "Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity". Here, physical component pertains to the body, mental to the mind and social to the entire socio-cultural Social Work in Health Care Sector 51 environment. Therefore, it is evident that factors from all these spheres have a direct significant role in shaping and defining the health of an individual. Though the definition of WHO is positive in implication, it has been criticized by many academicians or researchers. For instance, Prof. Imrana Qadeer (Social Action, July September, 1985) [1] argues that this definition tends to focus on the ideal rather than the actual, since it assumes the notion of an absolute, i.e. the 'complete well-being' of an individual, rather than examine the relationship of the individual with his social environment. It also ignores the fact that health or well-being has a range and cannot be an absolute quantity (or quality). Many people feel that the definition of WHO is irrelevant, since nobody in this world is completely physically, psychologically and socially perfect. If we accept this definition, we are all sick. Despite of the aforesaid limitations, the concept of health shaped by WHO is standard, positive and tries to represent the aspirations of the common people. Prof. Qadeer says, a comprehensive concept of health, apart from specifying the physical and mental status of individuals, should have an inbuilt social dimension, reflecting the exploitation of one class by the other, struggle of the exploited against this exploitation, and their conscious, collective effort to rebuild society. Health Care WHO has acclaimed that health is a fundamental human right. In order to achieve it, health care is essential. 'Health' is a broader concept, but 'Health Care' is the subset of health. 'Health' is influenced by a number of factors, such as basic sanitation facility, safe drinking water, housing condition, adequate food, healthy lifestyles, environmental hazards, communicable diseases, provision of medical care, etc. But, the term 'Health Care' refers to services provided by any institution (may be government organisation or private institution or NGO) to alleviate pain and suffering caused by a variety of diseases. Health care is not medical care, which indicates to those personal services that are provided directly by physicians or rendered as a result of physician's instructions. Thus, we can summarize that medical care is a part of health care and health care is a subset of health. There are three levels of health care, i.e. primary, secondary and tertiary. In the primary level care, individuals come in contact with the national health care system. Sub-Centres (SCs) and Primary Health Centres (PHCs) play the role of service providers with the help of

multi-purpose workers, village health guides and trained dais. In the secondary level, more complex problems are dealt with. Community Health Centres (CHCs) and district hospitals serve this purpose. Tertiary level care refers to highly specialized services, which are provided through regional or apex institutions like Medical College Hospitals, All India Institutes, etc. In the wake of independence, efforts were made very sincerely to improve the health care facility. Hence, there was a gradual evolution in the approaches of providing health care. At first, Comprehensive Health Care was introduced, which emerged from the Bhore Committee's (1946) recommendations. "It suggested integrated preventive, curative and promotional health services from 'womb to tomb' to every individual residing in a defined geographical area". As a result of it, SCs and PHCs came into existence. The second approach in health care originated in 1965 as 'Basic Health Services'. "It was understood as a network of coordinated, peripheral and intermediate health units capable of performing functions essential to the health of an area. The third approach was propagated as 'Primary Health Care', which was declared in Alma-Ata Conference, USSR, in 1978 in order to attain the goal of 'Health for All by 2000 AD'. "Primary Health Care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford". Dr. Gouri Pada Dutta is of the opinion that the year 2000 has come and gone, but the Declaration has not been materialized. In fact, it seems to be progressing in the reverse direction. The attitudinal change in developed countries is ominous; by converting health into a commodity, multinational corporations are trying to make developing countries into easy prey at the market place. However, there is a silver lining in this desperately gloomy situation. The National Health Assembly held in Kolkata 2000 and People's Health Assembly held in Bangladesh in 2001 clearly contradicted the ominous attempt of the World Bank and its allies. As many as 94 countries agreed to make the Alma Ata Declaration a success by raising the slogan 'Health for All Now'. Concept of Patient as a Person As per the Oxford English Dictionary, the term 'Patient' refers to a person who receives medical treatment under a doctor (either in the clinic/hospital or in the home/community). The word 'Person' is viewed as human being who is an individual with distinct characteristics. Thus, the term 'Patient as a Person' indicates to consider a patient, in spite of having sick role, a normal person who is supposed to perform many familial as well as social functions. These functions may include participating in decision making related to family affairs, carrying out responsibility pertinent to family economy and child care, listening to psycho-social problems of 54 Social Work Intervention with Individuals and Groups other family members and expressing sympathy for the same, giving/receiving respect to/from others, showing solidarity for community welfare, etc. In the field of medical and psychiatric social work, this term is important for four types of people, such as doctor, family members, community people and social worker. When a patient is admitted in the hospital, many things, which are usual in the lives of the hospital staff, often create emotional crisis in the life of the patient. Patient cannot get adjusted to the hospital environment as a result of smell of medicines, inappropriate response from the staff, lack of doctor's visit, unhygienic condition of the ward, sub-standard food, fear created from the sufferings of many other patients and death, etc. Hence, doctor should handle the patient as a person by giving less importance to the sick role. On the contrary, patients have some expectations from many people. They want that, especially family members and neighbours, should understand their psycho-social problems, extend emotional support and should not keep them isolated considering as patient. The term 'Patient as a Person' is also important to social worker. By practicing it, social worker tries to reduce the burden of a disease on the patient. In this regard, the social worker, without giving much importance to the patient's sick role, engages him/her in different activities, gives respect, knows his/ her many other problems (apart from the disease) and suggests referral services towards their solution. Social and psychological factors involved in diseases and their treatment there are many instances where medical professionals feel that giving so much importance to sociopsychological factors is idiosyncrasy. But social scientists do not agree. They rationalize that these factors affect personal health, community well-being. Hence, a few social and psychological factors are discussed below to understand their influence on disease and treatment. Social Factors a) Poverty: It results in low income, sub optimal diet, chronic hunger and so on. These lead to malnutrition, which lowers the resistance to all diseases. Poverty also brings overcrowding of population. In an urban slum or rural area, in a family, many people live in a single room. When one member of the family suffers from one communicable disease (e.g. tuberculosis), he is in close contact with others and, thus, can easily transmit the disease to them. We also confess that poverty is the root cause of unhygienic environmental sanitation and poor housing, which in turn, induce respiratory infection, skin infection, rat infestation, arthropods, accidents, high rate of morbidity and mortality, etc. b) Migration: It is both a cause and a consequence of various social, cultural and economic constraints experienced by the people in society. Rural elites migrate to the city for advanced education and, subsequently, take up urban jobs, adding to the family's wealth. On the other hand, poor peasants and tenants, landless labourers, marginal groups and poor artisans migrate to the big villages, towns and cities in order to avoid unemployment. As far as health is concerned, migration severely affects

it. Rural-rural or rural-urban single male (poorer class) migration leads to contracting and transmitting of STDs, HIV and AIDS as a result of risky sexual behaviour. Women migrants, who work for brick-kiln, construction, crop cutting, tile making, cane bamboo craft and so on,. These health problems of migrant women include body aches, skin irritation, sun burn due to working in heat, respiratory problems and allergies arising out of bad working conditions, lacerations, heavy menstrual flow, etc. Migrants also carry diseases like malaria, tuberculosis, jaundice, unhealthy habits and the like with them. c) Personal habits: The personal habits of each of us have a bearing effect on the disease. For example, the eating habits of some persons. There are a few people who even when they can afford, do not take milk, milk products or vitamin A. This vitamin is vital for maintaining bodily resistance to infection. Sometimes, drastic starvation for the purpose of slimming, indulged by boys and girls, is also a dangerous procedure and detrimental to healthy living. The habit of taking food late or excessive drinking, though not the direct cause of any infection, indirectly paves the ground for many diseases by lowering the resistance to infection. d) Low intelligence, low education and personal ignorance: As a result of it, many people do not know the nature or causes of a few killer diseases and, consequently, do not take any precautionary measures. For example, sometimes people mix up freely with the TB patients and are not aware that they are inhaling germs when a patient coughs on their face. Likewise, many respiratory infections, intestinal infections, arthropod-borne infections, zoonosis and surface infections (trachoma, tetanus, leprosy, STD, etc.) may also be caused as a result of low education and personal ignorance. e) Working condition: Those who are called upon to work in the dark, low light and improperly ventilated area are easy victims of blindness. Not only this, the nature of work sometimes is a direct cause of blindness. For instance, carpentry, black smithy, stone-crushing, chiseling, hammering, chopping wood, etc. Apart from blindness, bad working conditions can also lead to many diseases like heat exhaustion, heat cramps, frost bite, caisson disease, occupational deafness, leukaemia, pancytopenia, injuries or accidents and so on. f) Social stigma: Many diseases, such as tuberculosis, leprosy, filaria and so on, bring shameful feeling or reputation to the patients. The chief cause of it may be the sense of rejection that prevails upon the minds of people living in the family as well as in the community. People assume that they may be infected if they mix up with the patients. A male adult suffers more due to his non-acceptance in the work place. A big anxiety about going back to work is caused by the fear of rejection by colleagues and authorities. Many questions come in his mind. Will he be looked down upon because of his disease? How will he be able to carry on in such an unfriendly atmosphere? However, a woman is also not so sure of acceptance by her husband and relatives. Though it is a fact that only a few women are actually deserted by their husbands on account of the disease, the fear of rejection or desertion is uppermost in the minds of a large number of women patients. We also come across the fact that, sometimes, the relatives of the patients become isolated as a result of social stigma. g) Cultural factor: With the slow departure of caste system and impact of Western culture, outside eating and drinking habits have been developed amongst people. In cities and towns, very casually, refreshments by going to hotels or restaurants. They are neither hesitant to take food or drinks prepared by the persons belonging to other castes, nor mind to eat foods from plates and cups used by others. Many patients visit these restaurants and the crockery used by them is used by others too. In the hotels or restaurants crockery is seldom sterilized. Sometimes, it is mere dipping of tumblers and cups in a bucket full of water; that is all that goes under the name of cleaning. Unless we sterilize these materials, they remain a rich source of infection and can spread many diseases. h) Other factors: Along with the above mentioned aspects, many other social factors, such as urbanization and industrialization, availability and accessibility of health services, superstitions and traditional beliefs, drug addiction and alcoholism, etc. also influence a number of diseases or their treatment. Psychological Factors: a) Emotional problem: Every individual in the world wants to live and takes precautions for survival. But there are some patients in whom this 'will to live' is not strong. Death is more welcome to them due to intensive suffering and emotion. Thus, a mind, which is concerned with death, helps to prepare the body for the disease, and illness, in turn, intensifies the mind's activity along those lines. b) Anxieties and tensions: Everybody suffers from it in day to day life. Though each one develops from the childhood onwards, there are various mechanisms or techniques for relieving or controlling anxieties. Many persons go on involving themselves into too many activities in order to regulate them. The people make these activities or techniques permanent habits in their adulthood, against which they cannot revolt. Thus, there are varied personal factors that play significant role in people's life, sometimes become very embarrassing in the real life situation and expose many psychological disorders. c) Fatalistic attitude: People depend on the fate and feel that all the illnesses will be controlled by the god. This attitude brings lethargy and inertia among them. On the part of the individual as well as community it is a stumbling block and broadens the scope of diseases. Role of Social Worker in the Health Care Team the term teamwork has become a commonplace in health care organisations in the 21st century. Teams are viewed as important functioning units and the potential benefits of teamwork are duly recognized as well as applauded. Depending on the level of integration, teamwork is distinguished by such terms as multidisciplinary interdisciplinary and transdisciplinary. In multidisciplinary teamwork, experts from different disciplines are associated with the client, but each one is accountable for his or her disciplinary activities. The interdisciplinary teamwork presupposes interaction among various disciplines. The resource persons perform diversified activities, but also are liable for the group ef-

fort. Transdisciplinary teamwork has these characteristics to a greater extent. Representatives of various disciplines work together, but only one or two team members actually provide the services. In health care setting, social workers work in the interdisciplinary. Medical professional or psychiatrist, medical or psychiatric social worker, clinical psychologist, occupational therapist, trained nurse, etc. are the members of health care team. The important functions of social worker associated with this team are as follows: a) He notes down the social history pertaining to the patient's childhood and school performance, home condition, inter personal relationships in the family, job performance, psycho-sexual history, attitudes, hobbies, interests, etc. in order to understand or analyse patient's perennial problems in the context of present difficulties. This background information collected by the social worker and the medical professional's or psychiatrist's report as well as the findings of the psychologist help to diagnose and plan treatment. b) Social worker expounds the nature of disease or illness to the patients and their family members. He also explains how frequently the same disease can occur, what would be its impact at the individual level or at the group level, and the treatment procedures recommended by the doctors. c) A social worker, as a member of health care team, can help the patient and family to find out the way towards better social adjustment. In this regard, he may provide emotional support and bring environmental modification by working with the employer or educational institution or family member or neighbourhood. d) Many a time, lack of resource makes it difficult for a patient to receive appropriate medical or psychiatric care. Hence, social worker pools community resources in order to provide money or Social Work in Health Care Sector 61 medicines or clothes or prosthesis to the poor patients, so that they can continue treatment as per the advice of the doctor. Apart from this, social workers also keep in touch with other social agencies available in the community, who refer the cases regularly to the clinic. This helps in proper co-ordination of services. e) Activities related to group work with the patients and their family members are undertaken by the social workers in order to provide recreational facilities, necessary awareness and therapeutic inputs. Group work is supposed to be used as a primary activity in the psychiatric institutions where long-term cases exist, but tentatively, only 24.1 per cent social workers consider it as primary function [2]. The fact is that most psychiatric departments provide services mainly through OPD (Out Patient Department). Though CGCs (Child Guidance Clinics) accentuate on the group work/therapy while working with children, very few CGCs organise group activities involving the parents for the purpose of therapy, counselling and education. Apart from psychiatric setting, group work method is generally neglected by the social workers, especially in institutional heath care services. f) Social worker helps the client in rehabilitation. In health care setting, rehabilitation is a process of helping a patient to return to normal life or attain the best possible lifestyle following a serious illness or injury. It may be social rehabilitation (restoration of family and social relationships) or psychological rehabilitation (restoration of personal dignity and confidence) or vocational rehabilitation (restoration of the capacity to earn a livelihood. g) Facilitating in referral services is one of the important functions of social worker. Referral service means linking a client or patient with an agency or programme or professional person that can and will provide the service needed by the client.

In medical setting, a patient may be referred to a clinic or polyclinic or nursing home or hospital. In psychiatric set up, a patient can be referred to CGC (if child is having behaviour problem) or de-addiction centre (if alcoholic or drug addicted) or psychiatric department (for more opportunities pertaining to the therapeutic inputs) or mental hospital (to deal with the chronic and acute mental patients requiring physical treatment). The extent to which cases are referred to medical social workers or psychiatric social workers by other members of the health care team is an important indicator of the recognition of social work services. h) Social worker gets involved with the follow up of the patient and his family, so as to stabilize the gains made during treatment. In medical or psychiatric institutions, in order to carry out follow-up activities, patients or their families who visit OPD are interviewed to assess the progress made by the patients after discharge. In CGCs, follow-up includes a greater degree of self-investment on the part of social workers in conducting interviews with the children, their parents and relatives, visiting homes and schools, etc. in order to ascertain the outcome of the intervention. i) Social worker is also associated with the teaching, supervision and staff development activities. In order to provide social work knowledge, he teaches undergraduate and post-graduate level medical students, social work students, physio-therapy as well as occupational therapy students, nursing students, etc. and supervises interns, student social worker (for field work), para-professionals, volunteers and the like. With a view to upgrade the performance of the staff, social worker also organises seminars, conferences and workshops inside or outside the hospital. j) Records that are maintained regularly and have clarity and objectivity are important for the continuation of treatment of the client, organisational development and social research. Social workers take the responsibility of maintaining these case records, registers, files and correspondence for future guidance and research purposes. It is found [2] among the social workers that tentatively, 87 per cent and 97 per cent regularly maintain registers and case sheets. Very few social workers, i.e. almost 12 per cent and 19 per cent up-to-date their process records and summary records, respectively. k) Research

work includes activities of varying complexion from the formulation of research problem, development of hypotheses, selection of methodology, data collection, data analysis, to report writing. Off and on, it is found that the social worker is involved in each phase of these research activities, which forms a part of their functions. But it is also pragmatic that none of the social workers carries out independent research work. They regard it as an auxiliary function. l) In order to carry forward 'Mental Hygiene Movement' and propagation towards 'Health For All - Now', social workers keep in touch with the community by dint of write ups in periodicals, audio-visual, radio, TV, etc. m) A social worker associated with a health care team also acts as a promoter of community residential care provider. People who have no families or whose families can no longer care for them at home and who do not belong to a hospital or nursing home require community residential care. n) Apart from all the aforesaid functions, social worker attends emergencies as and when required. There are two types of emergencies, i.e. medical emergencies and social emergencies. Burns, cardiac problems, poisonings, traumas, etc. are the true medical emergencies. Social emergencies include cases of child abuse, spousal abuse, elder abuse, rape and so on. All these have some common characteristics, i.e. they are unexpected, happen suddenly, endanger the patient's life, and the patients or families are not prepared for the same. As a result, patients or families face uncertainty, numerous questions, a flood of emotions and a need to plan response to the situation. Social worker, in this context, provides support in reducing the degree of uncertainty and in understanding as well as gaining control over the situation. Conclusion Social work has been a part of health care scene for more than a century. It has made significant contribution in various health care fields, such as hospitals, clinics, rehabilitation centres, nursing homes, health departments, health agencies, etc. The terms like health, health care, patient as a person, psychosocial aspects of health and so on, have been redefined in social science and social work under the social development paradigm and the same refined knowledges have reinforced the capacity of social workers in health care in the 21st century. Now, social workers understand that illnesses have different meanings to the individual, family and the community. Hence, being a member of health care team, the social worker tries to give equal importance to the patients, their families, hospital environment as well as administration and community affairs.

In short, practice of hospital social work emerged in U.K and USA. Some major steps can be identified in the way of development of Hospital Social Work. The first step was recognition of after care of patients of mental hospitals and appointment of visitors to avoid recurrence of ill near. The second step of development of medical social work was appointment of lady almoners in English Hospitals. The step was practice of visiting home of patients by visiting nurses. The fifth one was training of medical students in social agencies. The sixth step was establishment of medical social work department in Massachusetts Hospital in Boston in 1905. The seventh step was establishment of American Association of Medical Social Workers (AAMSW) in 1918. The last and most important step was establishment of National Association of Social Workers (NASW) in 1955. Since its inception, its medical social work unit is working to date for the development of Hospital Social Work globally. Existing Hospital Service Departments of India.

In India hospital social work is not considered as a profession and known as hospital social service program. Those who work as hospital social workers are known as hospital social service officers.

Medical conditions affect far more than the body. They can result in an onslaught of emotional, financial, and social needs. Social workers are adept at helping people meet these sorts of needs - and so we find social workers in many locations where health services are delivered. They are known as medical and health care social workers. They may serve as case managers, patient navigators, and therapists The largest percentage of healthcare social workers work in hospital settings. Some are in outpatient health centers.

In hospital settings, social workers may handle discharge and also review new admissions for issues that need addressing. They may help patients locate various resources within their communities. In these settings, they may work any hour of the day or night.

A hospital social worker may have a caseload of patients with widely varying needs. Some will need to weigh the risks and benefits of different healthcare options. Some will need help writing advanced directives or making end of life planning.

Social workers in clinic settings coordinate care for patients who are expected to need a continuum of services. When children have complex health needs, the medical and health social worker may work with the whole family.

In addition to handling the regular routines, a medical social worker needs to handle crises as they arrive. This may involve offering counseling or therapy. Social workers in medical settings sometimes treat or even diagnose psychological condition. Social work is a vital and continuously changing profession. I'm proud to continue supporting citizens to the best of my ability. At a time of austerity and great challenge, my colleagues and I help the most vulnerable people in society and achieve positive outcomes for as many of them as we can. We rock.

The main activities of the Hospital Social Services are as follows:

1. To work as a team member in the multidisciplinary team consisting doctors, nursing and paramedical staff. To coordinate and help the patients, family and other team members. Maintain liaison with the hospital team.

2. To make the patient and his family understand the medical problem or disability he is suffering from, in a language the patient and his family can understand. To help the patient cope with the disability/illness and make him adjust to it emotionally.

3. To assess the social condition of the patients and provide appropriate counseling.

4. To help the patient find ways and means to financially manage with the illness/disability. Making the patient manage and tap resources for carrying out his treatment and support the family.

5. To help arrange financial support, for carrying out patients' treatment where needed from Governmental and Non-governmental organizations. In addition suggest ways to the patient and his family to reduce economic burden on the family.

6. To advice the patients/persons with disability on available disability benefits from the government and help them to get those benefits.

7. To help the patient/persons with disability and his family sort out inter-personal problems as a result of illness/disability. To help restore the role of such a person, such as a father, son, mother, daughter, husband or wife etc. in the family.

8. To help the person with disability/illness to adjust to his environment, including issues of removal of architectural barriers and encouraging independence in patients.

9. To assist with the doctor in the discharge planning, making protocols, and to involve patient and family members in the social work.

10. To help the patient in smooth transition from hospital to the community and maintain the link with the patient, the community and the health services. To do follow up with family so as to stabilize the gains made during treatment. This may involve Case Work, one to one counseling method, Group Work and Community Organization'.

11. To reach out to the people in their homes to convince them about the preventive measures and explain nature of illness and treatment involved.

12. To create awareness among the people to stimulate people's participation in health care programme.

13. To educate/interact with the community to help the community adjust with patients having disability or illness. To make the community adaptive for the disabled to help them integrate the disabled with them.

14. Participate in training programme of students in Medical Social Work (BSW/MSW), other para-medical students, Nursing students and NSS volunteers and other interested groups.

15. To participate in medico-social research.

16. To work in community based rehabilitation programme.

17. Any other duty assigned by the Head of the department. Providing psychological support to the patients and their family suffering from serious diseases or who need operation.

Providing transport facility for transporting the dead body of unanimous and poor patient. Helping poor and helpless patients to bear expense of pathology and treatment. Providing economic support or transportation fare to the poor and helpless patient for reintegrating in the family.

Giving priority to the poor and helpless, old or disable in getting treatment and providing them opportunities to get admission in the institutions run by Department of Social Services.

In a study conducted at AIIMS we found out that the patients coming for registration at AIIMS New Delhi were given a form those who wanted the help.

The forms were analyzed and the results were found out age, education qualification, gender, marital status. On basis of that we did the study and the data was analyzed.

Analysis of Data Collected from Service Recipients (Patients)

Age of the Service Recipients

Table 1 contains data about age of the service recipients. The data reveal that majority of the service recipients i.e. 25.7% belong to the age group of 41 - 50 years and smallest portion i.e. 5.7% belong to the age group of 61 - 70

About 20% of the service recipients belong to the age group of 21 - 30 years, 14.3% belong to the age group of 1-10 years and 14.3% belong to the age group of 31 - 40 years. Moreover, 11.4% and 8.6% belong to the age group of 11 - 20 years and 51 - 60 years. The data also indicates that 60% of the service recipients belong to the age group of 1 - 40 years.

Age	Frequency	Percentage
1 - 10 Years	5	14.3
11 - 20 Years	4	11.4
21 - 30 Years	7	20.0
31 - 40 Years	5	14.3
41 - 50 Years	9	25.7
51 - 60 Years	3	8.6
61 - 70 Years	2	5.7
Total	35	100
Mean Age	38.33	

Table 1: Distribution of the service recipients on the basis of age.

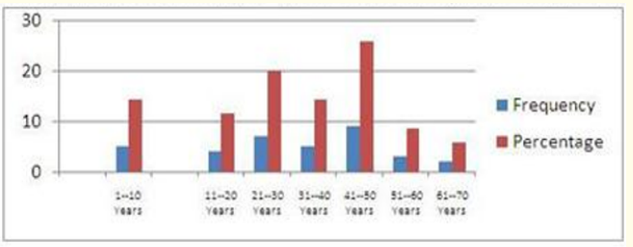

Figure 1: Presentation of data relating to the age of service recipients using pie chart.

Sex of the Service Recipients

Data furnished in table 2 reflect the sex of the service recipient. The data in the table indicate that the number of male service recipients is greater than the female service recipients.

Sex	Frequency	Percentage
Male	18	51.4
Female	17	48.7
Total	30	100

Table 2: Distribution of the service recipients on the basis of gender.

Marital Status of the Service Recipients

Data furnished in table 3 reflect the marital status of the respondents. Majority of the respondents (57.1%) are married, 31.4% are unmarried and only 11.4% are widow or widower.

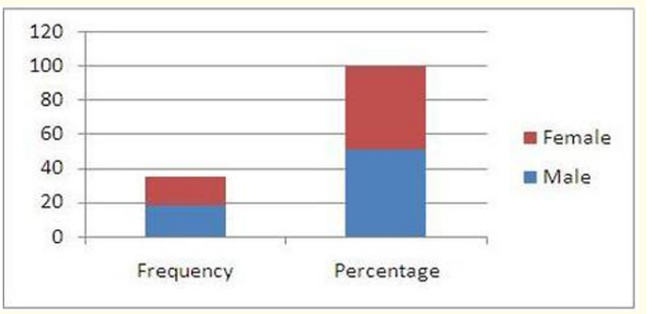

Figure 2: Presentation of data relating to the sex of service recipients using sub-divided bar diagram.

Marital Status	Frequency	Percentage
Married	20	57.1
Unmarried	11	31.4
Widow/Widower	4	11.4
Total	35	100

Table 3: Distribution of service recipients on the basis of marital status.

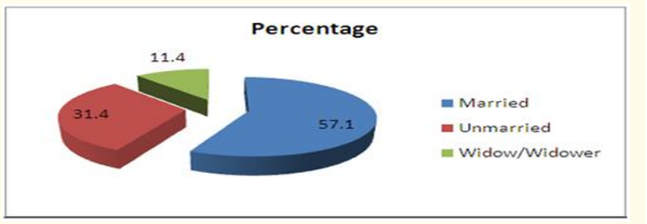

Figure 3: Presentation of marital status of service recipients using pie diagram.

Educational Status of the Service Recipients

Data contained in table 4 reflect educational status of the patients who receive services from hospital social service department. Majority of the service recipient (25.7%) have completed primary education while only 5.7% have SSC/HSC.

Distribution of service recipients on the basis of Education Status completed SSC/HSC. About 22.9% of the service recipients are illiterate and 8.6% are of under school going age. Moreover, one fifth of the service recipients can only read and write and 17.1% have completed lower secondary (class six to eight). Form the table it becomes clear that only 48.5% of the service recipients have institutional education.

Education Status	Frequency	%
Illiterate	8	22.9
Can only read and write	7	20.0
Primary (class 1 - 5)	9	25.7
Lower Secondary (class 6 - 8)	6	17.1
SSC/ HSC	2	5.7
Under school going age	3	8.6
Total	35	100

Table 4: Distribution of service recipients on the basis of education status.

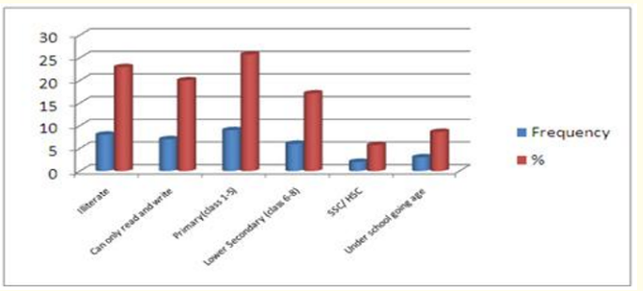

Figure 4: Presentation of data relating to the education of service recipients using bar diagram.

Analysis of data collected from hospital social service officers

Sex of hospital social service officers

Data furnished table 5 represents sex of hospital social service officers. The data indicate that female officers constitute 70% of the sampled population while males constitute only 30% of the sampled population.

Gender	Frequency	Percentage
Male	9	30.0
Female	21	70.0
Total	30	100

Table 5: Distribution of hospital social service officers on the basis of sex and age.

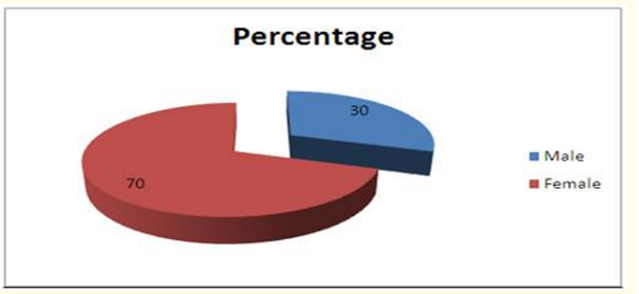

Figure 5: Presentation of data relating to the age of hospital social service officers using pie chart.

Limitations of Hospital Social Service Programs in India

From the analysis of findings of the study following limitations of hospital social service department has been indentified.

Limited sanction of fund is the major problem of hospital social service program of India. Due to limited fund the hospital social service officers can help all the poor patients. They can only help extremely poor but cannot bear the full cost of treatment. They only provide the patient with some medicines or other necessary things.

Hospital social service officers claimed that there exists lack of manpower. As a result, the cannot visit the patient regularly.

Sometimes, other professionals e.g. doctor, nurses and therapists even hospital authority do not want to cooperate with hospital social service officer. In India, doctors refer the patient to the hospital social service officer in most cases. Hospital social service officer do not select the patient directly for providing service.

Hospital social service officers in India involved in Psychosocial study, diagnosis, treatment plan, discharge planning of the patient. Only in the mental health sector.

The Hospital social service officer mainly provide the patient material servicer e.g. medicine, money and soon.

Jobs in hospital social service department of India do require specialized knowledge or educational background on social work/ social welfare. As a result almost all the social service officer have educational degree on social work. They lack in professionalism in performing their duties.

For these above mentioned limitations hospital social service program in India cannot provide proper services to the patients to ensure comprehensive welfare.

One of the objections of a research work is to develop insight, create new knowledge and expand the field of research. Before this study no comprehensive study on Hospital Social Services in India. The findings of the study the following recommendations have been presented for the improvement of hospital social service in India. Government should take necessary steps to increase fund for hospital social service programs.

Skilled manpower should be employed to ensure better care and servicer. Students of social work discipline should be given priority during appointing hospital social service officers.

Seminar, Symposium need to be arrange to make people know about hospital social service programmer and its necessary.

Hospital social service officer should build liaison with various welfare agencies for making effective referral. Government should take necessary steps for strengthening hospital social service department.

Hospital authority should ensure. Proper co-ordination for the improvement of hospital social service program and should ensure the participation of hospital social service officers in Psychosocial assessment, diagnosis, treatment and discharge planning of patients

The study has been conducted to explore present situation of hospital social service in India; existing programs, problems and solution to remove these problems. Findings of the study indicate that mainly people of lower income group receive services from hospital social service department. They mainly receive force medicines under the social service program. Other servicer e.g. psychological support, rehabilitative support etc. are given in a negligible quantity services provided from the department of hospital social service are not adequate for patients welfare.

Finding of the study also reveal that hospital social service officers confront various problems e.g. lack of fund manpower and coordination etc. during performing professional responsibilities. Due to these problems they cannot do justice with the patient care.

Research is a method of combining theoretical knowledge with practical experience. The present study has been conducted in order to compare practice of hospital social service programs in India with the theoretical aspect of hospital social work. In this study I have tried to find out the limitations of hospital social work.

Medical Social Services I Service Definition Introduction Patients and their families may need assistance to cope with or solve personal and social problems which arise as a result of illness or disability. Medical social workers of SWD are stationed in public hospitals and specialist out-patient clinics so that timely psychosocial intervention can be rendered to those in need. Purpose and objectives The objectives of Medical Social Services are: (a) to assist patients and their families with social and emotional problems arising from illness, trauma or disabilities; (b) to enable patients to make the best use of medical/rehabilitative services in medical institutions and in community; (c) to contribute to the total rehabilitation of individuals, and their reintegration into the society; and (d) to strive for the promotion of health for patients, their families and the community. Nature of service Patients as unique individuals require a variety of services tailored to meet their needs. Types of major services provided by Medical Social Workers include: (a) counselling services, either through casework or group work approach, for patients and families on their emotional or social problems arising from illness, trauma or disabilities; (b) psychosocial assessment, formulation of welfare plan and referrals for rehabilitation and community resources for patients and families; (c) provision of statutory duties, report and supervision on cases under Ordinances, such as Mental Health Ordinance (Protection of Children and Juveniles Ordinance etc.; (d) financial assistance/material assistance, e.g. waiving of medical charges, application for charitable/trust funds, referral for social security benefits, etc.; (e) collaboration with other medical and allied health professionals in the community teams to outreach persons in the community who are in need of treatment or rehabilitation; (f) talks and training to medical students, student nurses, social work students and para-medical staff on the social and psychological implications of illness and disabilities; (g) educational talks and programmes to patients, their families and the public on health and welfare related issues. Target group The major target group is the patients and their families, in public hospitals/clinics served by Medical Social Workers, who need assistance to cope with or solve their emotional and social problems which arise as a result of illness, trauma or disabilities. Medical Social Workers also serve the patients who require psychiatric emergency outreaching services or are outreached by some medical teams in the community. Medical Social Workers also provide training, talks and programmes for the medical and allied health professional as well as the public. II Performance Standards the service operator will meet the following performance standards: Outputs Output Standard Output Indicator Agreed Level** (General) (Psychiatric) Inpatient Outpatient Inpatient Outpatient 1 Average no. of cases served per worker per month in a year 65, 50, 55, 75, 2.

Average no. of manhours spent on psychosocial assessment/intervention per worker per month in a year 70, 80, 55, 65, 3. Average no. of manhours spent on collaboration work with Medical and Allied Health Professionals per worker per month in a year 15, 10, 15, 10. As different specialties and settings have their special nature and mode of practice, different agreed level of performance indicators are set for the respective services of General In-patient, General Out-patient, Psychiatric In-patient and Psychiatric Out-patient. Essential service requirements Medical Social Services should be provided by registered social worker. Quality Service operators will meet the requirements of the 16 Service Quality Standards (SQSs). Notes and Definition Output Indicators: Psychosocial assessment and intervention Psychosocial assessment and intervention refer to professional inputs rendered by MSWs in providing direct services to patients and their relatives. It includes social investigation, formulation of welfare plan, counselling services (casework/groupwork) and referrals for suitable social services.

Activities Definition

1. Interview Face to face contact with patient/patient's relatives for social investigation or counselling.
2. Home visit Counted by no. of hours spent on visits made to patient's/patient's relatives' home for the purpose of supervision/counselling and social investigation (excluding travelling hours).
3. Collateral Contact Other contacts with patient/patient's relatives and/or other concerned parties other than the medical and allied health professionals (e.g. schools, NGOs, other government departments, other units of SWD, etc.) on patients' problem, welfare and rehabilitation.
4. Group Work Service Group work services provided to patients/patients' relatives, including preparation work.
5. Social Report Counted by no. of hours spent on written social enquiry reports on patients submitted to court, medical officer, or to concerned parties in preparation for case conference, etc.
6. Referral Counted by no. of hours spent on making referrals by MSWs to other units of the Department, other government departments or non-government organizations/agencies for patients or their relatives (e.g. SSA, CSSA, CRSDA, CRSPS, DS, home help services, school placement, etc).

Collaboration work with medical and allied health professionals Collaboration work with medical and allied health professionals includes all interfacing activities with Medical Officers, Nurses, Occupational Therapists, Physiotherapists,

Clinical Psychologists, Pharmacist, Dietitian, etc. to achieve holistic care to patients and their relatives.

Activities Definition

1. Case Conference Meeting with medical and allied health professionals for case discussion on treatment/welfare plan for the patient.
2. Non-casework meeting All kinds of non-casework meetings with medical and allied health professionals excluding case conference.
3. Ward Round Ward rounds that involves case discussions with medical and allied health professionals.
4. Collateral Contact Other contacts with medical and allied health professionals on patients' problem, welfare and rehabilitation plan including consultation on unknown cases and general enquiries.
5. Talk and Training Activity Talks and training given to medical and allied health professionals, excluding talks to patients/relatives.
6. Joint Programme Counted by no. of hours spent on activities jointly organized with medical and allied health professionals including preparation work.

Now, social workers understand that illnesses have different meanings to the individual, family and the community. Hence, being a member of health care team, the social worker tries to give equal importance to the patients, their families, hospital environment as well as administration and community affairs. social workers maintain a dual focus in both assisting with and improving human wellbeing; and addressing any external issues that may be negatively affecting it, such as inequality, injustice and discrimination. Social workers draw on a broad range of skills, knowledge and research to ensure comprehensive assessment, interventions and a holistic analysis of the patient's situation. Social work assessments range from targeted and brief specific-needs analyses, through to comprehensive psychosocial and risk assessments of the full range of social and psychological needs, strengths and stressors. These assessments underpin needs-based and evidence-informed interventions that address the social and emotional issues that are impacting on the patient and their family/career's health, wellbeing, adjustment and recovery. Social workers are essential members of multidisciplinary hospital teams. Working with doctors, nurses, and other allied health professionals, social workers can educate healthcare teams to the social and emotional aspects and impacts

of a patient's condition. This information can significantly influence the patient's care plan to be more reflective of their needs [3-10].

Conclusion

Social workers offer a unique and valuable contribution in providing appropriate and targeted services to meet the complex psychosocial needs of patients, their family and careers in hospitals. Hospital social workers provide direct services aiming to minimize the impacts of illness and hospitalisation when a person's health is impacted by complex social, psychological, family and institutional dynamics. Accordingly, the profession of social work has a clear role in the continuum of hospital services.

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Volume 2 Issue 6 September 2018