No. 1

SOCIAL SERVICE AND HOSPITAL EFFICIENCY

BY

HELEN R. Y. REID, B.A.,

Director Social Service Department of the Victorian Order of Nurses.

Issued by the Charity Organisation Society of Montreal.

MAY, 1913

SOCIAL SERVICE AND HOSPITAL EFFICIENCY

MARK TWAIN once said of the New England weather, that "everybody was talking about it, but nobody did anything." In regard to Social Service work some of us are trying to do something and we hope that many will talk about it.

It has been said that cities have no conscience, and this often seems true when we read of typhoid epidemics, the summer slaughter of young babies, the unrestricted prevalence of tuberculosis and the highest death-rate among civilized nations. Doctors and institutions already overtaxed are often left to grapple with hydra-headed evils which the unintelligent and sometimes unscrupulous guardians of civic health and virtue have allowed to grow up in our midst. In Montreal, as elsewhere, we are slowly feeling our way towards a higher standard of efficiency in matters affecting public health and morals. If the civic sense of the value of preventive work lags behind that of the intelligent public, it means more expense to the taxpaying community, a heavier burden on charitable organizations, a greater loss of life and manhood to the country, as well as untold suffering to the family unit and individual.

Such exhibits as the Tuberculosis Exhibit and that of Child Welfare held here not long ago, emphasize the note of **prevention** which is surely becoming as dominant in Canada as it has become across the border in all medical and charitable work. During the past ten years much has been accomplished in laying bare the needs of our communities along these lines. We are beginning now to realize that it is as great a charity to keep a man well and out of the hospital bed as to care for him after he is in it. Who is there who would not regard it as even a greater service? Is it not better, more decent, and in the end less expensive to keep our jails empty and our schools full, to regulate

our liquor traffic and lessen the number of criminals, to see to it that our homes and streets and lanes are sunny, sweet and clean, and that there is room to spare in our insane asylums, our homes for the feeble-minded and our sanitaria for tuberculosis? In this great field of preventive work a splendid harvest awaits the efficient and properly trained worker.

In the United States, where the demand for trained workers in all philanthropic activities is recognized as vital to the success and economy of institutional work, Schools of Philanthropy and Social Service have been formed in many of the larger centres. These aim to give professional and technical training to those who desire to enter upon any form of social work. More specifically, students are prepared for service as expert visitors for charitable institutions dealing with the care of families, as matrons or administrators, inspectors (tenement houses, factories, etc.), social service workers in hospitals, workers in clubs and settlements, in the Public Service branches dealing with health, charities and corrections, and investigators of social conditions and institutions. Complete courses of lectures are supplemented by practical work and observation in institutions. These courses vary in length—a full diploma course in New York and Boston requiring two years, while a medico-social course to fit workers for Hospital Social Service takes, at the Boston School, five months, and in Bellevue Hospital, New York, only three months—the last being a post-graduate course open to nurses only. A large number of nurses and college graduates follow these courses and fit themselves to fill well-paid posts that await them all over the country. Over two hundred students were enrolled last year in the New York School of Philanthropy.

The day has gone by when general service of an all-round kind is considered sufficient in any department of life, be it economic, industrial or professional. The man with the trade commands a better salary than the unskilled laborer, and he is, potentially, a better man because of his wider knowledge and usefulness. We pay more for our expert cooks and French dressmakers than for our "generals" and

"the woman in by the day," but we now expect the **efficiency** that commands the higher salary. We have our specialists in science, medicine and law, and to them we turn for the expert work that cannot be given by general training only. We hope for this high standard of efficiency, and as supporters in time, work, and money, we are entitled to expect it in the work of our hospitals and other public institutions.

The social worker is already to be found among church visitors and deaconesses, in the settlements and charity organizations, and wherever visiting is done among the poor. It is in this field that a need is being felt for greater efficiency and for workers whose one specialty—say for nursing or domestic science—has been filled out, and whose mental attitude has been enlarged, by the study under expert direction of the many problems affecting public health. If we have not these workers in our midst, can we not develop them by affording opportunities for study and practical field work through educational agencies already existing here or elsewhere? If we cannot develop them, then let us import them from places where the same need has been felt and answered in the form of Social Service schools and Schools of Philanthropy. The trained worker we must have as well as the efficient volunteer if we hope to do the best preventive work for our cities.

With the fine record of good works and benevolence to our credit, no one can say that Montreal's institutions have not made good use of the material which they have at hand in the way of workers, paid and voluntary. But we cannot stand still. We must either improve our methods or lose ground. It costs money both ways, but the money that is spent for efficient service is a legitimate expense, while there is little or no justification for the ignorance which results in waste and loss of time and money. It is a matter, therefore, of the greatest satisfaction to learn that a step in a direction which will make this possible is already being contemplated by one of our best known educational institutions. It is probable in the near future that a University Extension Course in Practical Hygiene and one in Social Econo-

mies will be opened to women desirous of fitting themselves for positions of Health Inspectors and visitors in the city's service, or of improving themselves as volunteers in any sphere of social work. Pratical field work in the study of local institutions, lectures, district visiting and case conferences may possibly be offered by the Charity Organization, and would serve as an additional attraction to the opening up of this new field for women workers. In close connection with this we contemplate with gladness the prospective organization on a more intelligent and comprehensive basis of the Board of Health of our city. The active influence towards this end of such bodies as the City Housing and Planning Association, the City Improvement League, the Local Council of Women—to mention but a few—insures for us in the not distant future an up-to-date Board of Health with a staff of trained Inspectors and visitors working with augmented interest and intelligence for the public good.

The **medical-social work** that has been done in Montreal is easily resumed. Apart from individual efforts, the first organized medico-social service we find in connection with the Victorian Order of Nurses. During the typhoid epidemic in 1910, this Order established a social service department of from 60 to 70 volunteer workers, who, during that serious time, worked towards the relief and rehabilitation of 160 families, and faced the general problems of poverty and sickness with amazing results considering the emergent and volunteer nature of the organization. Besides serving all the needy cases on the district, this committee covered every case in the Emergency Hospital and worked in the homes which had often been left desolate by the removal to the hospital of one, two, or three of the members of the household. On the district even more intimately than in the hospital we see how sickness brings poverty, and poverty is, perhaps, the chief cause of sickness; how civic neglect tolerates bad housing, and bad housing carries with it vice and tuberculosis; how contagion spreads through crowded tenements; how lack of knowledge kills babies more than lack of care; and how great is the need of combating that gravest of diseases, ignor-

ance, by the power of education carried into the home and made vital by the inspiring influence of a friendly hand. Be it remembered, too, that no report will ever show the extent or benfit of this most important part of social service work—the work of education and instruction. During the epidemic, the services of the Victorian Order Committee were placed at the disposal of the Royal Victoria and General Hospitals for their typhoids needing after care, and five cases were handled from these sources. Had there been trained workers in the wards who had the time and experience to find the needy ones and thus relieve the nurses and superintendent, doubtless many more cases would have been handed on and helped.

Out of this, however, came great good; for among the volunteers working for the Victorian Order was an earnest band of workers from Melville Presbyterian Church, and they became definitely interested in Hospital Social Service. Permission was obtained to place a partially trained worker in the General Hospital wards to follow up Prostestant cases needing care after dismissal. After one year's work, the Hospital became sufficiently alive to the good accomplished—the saving to the institution and the help to the patients, to undertake the payment of the worker's salary, the church still providing the funds necessary for relief emergencies.

A further experiment is now being made in both the Montreal General and Royal Victoria Hospitals. Through the initiative of the Charity Organization Society and the co-operation of the Victorian Order of Nurses, a district nurse has been placed at the disposal of the general out-patient department of each hospital, and a college graduate with special training in domestic science and city health visiting has entered one clinic—the last-mentioned giving practically all her time for a purely nominal fee. Unfortunately, all these workers are not under any supervision or direction, and they are using experimental methods. It remains to be seen whether their work proves sufficiently, not only the benefit of Social Service—this can hardly be a matter for question in the

mind of any up-to-date doctor—but also that the time is now ripe to establish Social Service departments as integral parts of their institutions. If our Hospitals and Nursing Associations would take advantge of such post-graduate courses of lectures and practical field work as may be offered by University, Charity Organization Society and District Nursing Association, it would afford those of their nurses who have the spirit for Social Service an opportunity for fitting themselves for any public or institutional work they care to follow. It would soon provide the Hospitals with a staff of social workers already acquainted with the routine and administration of the Hospital. The advantage to the nurses in thus opening up to them new lines of work is evident.

With a 1912 record of 72,000 out-patient admissions, and 4,582 in the wards, the Montreal General Hospital offers a special opportunity for follow-up care. Situated as it is in the working heart of the city, its clientèle includes hundreds of people who are affected with the awful diseases of ignorance and poverty which the trained social worker is better fitted to cope with than the busy doctor. Can we not lend a hand to this most worthy cause of social service in the hospital and by supplying volunteer committees and funds under hospital direction help on the great work of cure and prevention which this institution has pledged itself to pursue?

Hospital Social Service, not then called by that name, started as long ago as 1791, in the London Hospital in Whitechapel Road. A nurse with three assistants has had charge of the work there for the last twelve or fourteen years. It was taken up in the Massachusetts General in 1905, with one worker at a desk in a corner of a corridor. There are now 22 workers, 24 volunteers, and 15 student volunteers in the wards and three clinics, and the sum of $15,500 was last year expended on salaries, supplies and special purposes. Since then great interest in the subject has been created, and forty or fifty hospitals have established the service. Bellevue Hospital, New York, has now a staff of 35 workers in the wards, two clinics and offices, besides special

volunteer committees in eight departments. The Boston Dispensary inaugurated social service in 1909, and the staff now consists of 9 regular workers, 8 student workers, and 4 volunteers, $6,000 being the item of expense for this department taken from the General Dispensary account.

A point has been raised as to the advisability of outside philanthropic agencies providing Social Service for hospitals. Dr. Cabot and Mr. Michael Davis endorse in their reports the following views on this subject of Miss Wadley, head worker in Bellevue Hospital, N.N.:—

"In asking financial support, and even in admitting their patients, do not hospitals tacitly guarantee to do everything possible to effect a cure? If, then, the medico-social clinic and social workers are positively needed to that end, is it not the hospital's plain duty to establish and maintain that department just as much as it now maintains its drugstore and its ward nurses, or its X-ray room?

"And this duty is not accomplished when a hospital accepts such a service from some philanthropic organization—the closest co-operation there must be with all such—but to accomplish the best work the impulse and direction must come from within the hospital itself, from its medical staff, if possible, or from its superintendent.

"It is a **therapeutic** undertaking and needs medical understanding for its direction and execution, and as such should be dignified by being made a department of the institution—otherwise such a service must fail of its highest achievement."

Mr. Davis says: "The intimate relation between the clinical physician and the social worker cannot be developed unless the social service were supervised by the management as an integral part of the administrative system of the institution."

For the following suggestions *re* **Hospital Efficiency** and frequent verbal treatment my acknowledgements are due to Mr. Michael M. Davis, Ph.D., Director of the Boston Dispensary (42,000 out-patients in 1912); to Dr. Richard C. Cabot, chairman of the Social Service Department of the Massachusetts General Hospital

(40,000 patients in out clinics in 1912); to Dr. C. Morton Smith, of the Boston Dispensary; to Dr. Menass Gregory and Miss Mary Wadley, of the Bellevue and Allied Hospitals of New York.

Hospital cures cannot be effective if patients are turned out of ward beds too soon in order to make room for worse cases than their own, or if they require subsequent treatment which they are not in a position to follow. After-care is needed to prevent John X. from progressing from one hospital ward, where his diagnosis was pneumonia to another ward or hospital with a diagnosis of tuberculosis, all for the want of an overcoat, perhaps, when he left the ward in the very early stage of convalescence. If the social worker is not at hand to help James S., surgical case, discharged as improved but needing dressings, what is to become of him, living alone, unable to work, with room rent overdue? Even if he were able to work, what employment would permit of his taking practically three half days a week to wait sometimes two hours for his turn in a crowded clinic? Here we have a vagrant in the making unless he has the proper nourishment to build him up and means are found to house him and let him take his treatment. Half measures are sheer waste and a case should be seen through to a practical conclusion. Each disease and each individual require different social as well as medical treatment, and kindly common sense must supplement the doctor's orders. Cases of tuberculosis, perhaps, need to be placed in institutions or under class treatment. They may require home nursing or mountain air, and the patient or family may need to be supported during the time of treatment. Precautions must often be taken against contagion—new cases are frequently found during visits to the home and investigation of conditions there. Help may be needed in finding or changing work for cases of discharged tuberculosis, typhoid, alcoholism, heart disease, industrial diseases, chronic joints, etc.; and the general work of instruction in hygiene of the person and home has always to be pressed by a social worker in order to supplement the work of the doctor in the ward or clinic. Here we have poor William M., ill for two years with abscess and sub-

sequent amputation of the leg. He needs strengthening food and, later, a $100 wooden leg to enable him to fill the position that is waiting for him. Little Jane F. needs glasses or a brace—the family are too poor or ignorant to realize the importance of this. The social worker is successful in educating them to the right point of view, perhaps has to assist them, and Jane becomes a valuable working member of society instead of a half-blind discouraged woman or cripple.

Similar service may be rendered to cases in the outdoor clinics of hospitals or dispensaries. In the three cities of Boston, New York, and Chicago, the out-patient departments and reputable dispensaries are providing for fully 2,500,000 people (45% of the population of Chicago and in Boston and New York 1-3%) and are expending annually at least $1,500,000. In the country as a whole, millions of dollars are thus spent. Practically nothing has been done, however, to estimate achievements in relation to expense—to compare results with the cost. An out-patient clinic diminishes its efficiency and wastes a large part of its time and money in examining patients who never come back for treatment. Thousands of dispensaries now treating disease are still content to assume that if the patient does not come back after the first visit he is probably cured.

As Dr. Cabot, of the Mass. General Hospital says: "This is like supposing that a school boy who never comes back after the opening day of school is staying away because he is cured of all ignorance and possessed of all knowledge." The frequency and regularity of patients' return are undoubtedly affected by the length of time they have to wait; the pleasantness or curtness with which they are treated by the employees of the institution; the clinical routine, the amount of privacy during examination, the number of personal questions asked, and the tact and skill with which such information is sought. Even objects of charity are human beings. Mr. Michael M. Davis, Director of the Boston Dispensary, says in this connection: "If we would realize our ideal of treating not only diseases but men, women, and children, one of

the practical things to do would be to see that the rules and general routine of out-patient clinics are adapted to patients as well as to administrative convenience. The particular blindness of a medical institution is to see diseases instead of persons—a series of more or less abnormal, and therefore interesting limbs, eyes, livers, and hearts incidentally connected with human beings. We need to have the eye that sees people as well as disease. The patient must be lookd upon as a human being, a member of society, and results are to be judged by the improvement produced in his health, his working and living efficiency as a member of a family." In a study of clinical efficiency last year in the children's clinic of the Massachusetts General, Dr. Cabot found "that out of 779 patients 57% of miscellaneous cases had only one visit, 50% of children with bronchitis never came back, 45% with chorea made only one visit, and so on through a list of 7 other diseases. Many of these children were doubtless cured, but only a second visit can enable us to be sure of this. They may have died, they or their parents may be too indifferent too busy, or too ignorant to carry out the treatment, or they may have gone to other hospitals or private doctors. Without a home visit or a second visit to the clinic it is impossible to be sure that the bronchitis has not turned out to be tuberculosis, that the choreic child has been kept sufficiently quiet without making it neurasthenic."

Besides curing acute illness, training nurses, advancing scientific research and teaching medical students, hospital efficiency must now include the meeting of the problems of after care, remedying home conditions which cause disease, instructing patients in hygiene and educating the public to co-operation with physicians. This huge wheel of hospital efficiency is kept moving onward by the stream of public benevolence which supports the hospitals, and if any of the spokes or paddles are missing, the energy of the stream is wasted.

The social worker's task in ward and clinic is to fill up the holes in medical work and to make that work tell permanently. She has to meet the problems of patients' lives which, running

alongside their physical condition, affect powerfully the continuity and practicability of adequate medical treatment. The follow up care given by the social worker is the most important step in assisting in carrying out treatment and in seeing that patients return to get treatment. The physician has, as a rule, neither the training nor the time to grapple with the conditions of poverty, industry and personality which lie behind a large proportion of the diseases of patients. Unless they are dealt with, however, neither patient nor physician can expect to get satisfactory results, and there is a good reason why the patient does not come back. The pressing medical work of diagnosis, teaching, and treatment, demands the whole time of the doctor, and yet, perhaps, because of ignorance, or home conditions inimical to the health of the patient, the cure will be only temporary, and the expense to the hospital, the work of the doctor and the burden on the charitable community will increase with each recurrence of illness, while the suffering of the patient is prolonged and the country loses a healthy and profitable citizen. And so, while recognizing the fact that the cure of disease is a public necessity, it has been borne in upon hospital authorities and doctors that the prevention of disease is not only a public economy and benefaction, but an economy which closely concerns their own institution— and that the responsibility of a modern hospital includes social service as well as medical— the after care of patients in their homes to prevent relapse as well as cures in the wards or clinics.

Dr. Cabot says of the Mass. Gen. Social Service "not until this year (1912) have workers been put in the clinics. That means that the workers had to take what cases were sent them, the medical men had to make the social diagnosis among the 40,000 sick people who visit the clinics annually as well as teach the students, diagnose cases, and advise treatment. Now the social worker is in three clinics where she can see all the patients and can select those most in need of what she can give. Furthermore, she can limit her intake according to her powers and put her strength and knowledge where it will

do most good." He adds, "Some of the hospitals which followed our lead in establishing social work **improved on us, for they put social workers in the clinics from the start.** Bellevue Hospital, in New York, did this in 1906, and the Boston Dispensary in 1909. We have learned from them and are now following their lead in method as they first followed ours in conception." Mr. Davis, of the Boston Dispensary, says: "Social workers must be placed in the clinics and in the hospital wards so that they can come into first-hand contact with the doctor and patient together. Nurses and social workers must pull together, and, when not combined in the same individual, the problem of adjusting their functions in the clinic is, and will be for some time, a delicate one."

This brings us again to the question of the worker herself. Dr. Menass Gregory, of the Pyschopathic division of Bellevue Hospital (12,000 ward admissions and 4,200 out-patients in this one division in 1912), speaks of the worker in these words: "A Hospital social worker, in addition to enthusiasm, broad sympathy, optimism, energy, tact and resourcefulness—qualities of prime importance for the work—should possess some training in physiology, hygiene and therapeutics, some insight into normal and abnormal psychology as well as some knowledge in social and domestic science. A social worker should not be selected merely because she has had the training of a nurse, but if she have the essential qualities and native ability needful for the social worker her training as a nurse will greatly enhance her usefulness."

For those who say they have no use for social service and do not like it, I will simply quote, in closing, an anecdote told of Charles Lamb. A friend said, "Come here, I want to introduce you to Mr. A." Lamb replied with his characteristic stammer and drawl, "No, thank you." "Why not?" "I don't like him." "Don't like him? You don't **know** him!" "That's the **reason** I don't like him."

THE WITNESS PRESS