MEDICAL-SOCIAL SERVICE AND FOLLOW-UP WORK IN THE EYE HOSPITAL.

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It will be admitted by all that no hospital at the present day which serves the people can give really efficient service unless it makes provision for social service work and establishes some sort of follow-up system. The importance of this subject, and the infrequency with which it is discussed at our meetings, form the justification for this paper. Probably a large part or all of what I am about to say is familiar to most of you here, but in spite of that I wish to outline briefly the status of medical-social service and follow-up work at the Massachusetts Charitable Eye and Ear Infirmary, and to invite your criticism and suggestions.

I need not go into the history of this department, except to say that it was started in 1907 with one worker and was financed by charitable persons outside the hospital, until in 1909 it was taken over by the hospital. A certain amount of follow-up work was being done by the Social Service, but no organized effort had been made along this line until 1916, and this was interrupted by the war. In 1919 a follow-up worker was installed at the Infirmary as a separate line of effort, and a year later she was placed under the Social Service Department in order to avoid the overlapping which inevitably occurred. I may say also that, as yet, our Social Service Department has not recovered from the contraction due to the war and to the loss by the hospital of an annual state appropriation of $45,000.

I will pass over the routine social service work which is

done in every hospital, such as the investigation, help, and placing of cases which come into the hospital from day to day, and its action as a means of contact between the hospital and the many charitable and other agencies which exist in every community. This work takes much of the time and is the daily routine of social service, and we accept it now as a matter of course.

As the work developed it became evident that we could not burden the social service or follow-up with every case which was admitted, and more and more we came to divide the material into certain groups.

From the standpoint of follow-up work, I think the most important group is formed by the acute cases, in which sight may be lost speedily unless provision is made for effective and continuous treatment. I refer especially to the severe corneal ulcerations, the acute cases of iritis, and to the injuries of the eye. All these cases should be admitted to the hospital, but there may be no bed or there may be an unwillingness on the part of the patient. Even if a patient refuses to enter, I do not think it is right for us to wash our hands of him and trust to luck that he will return to continue his treatment or will go elsewhere. We do not have this trouble often with the injury cases; but with the others, and when they refuse to enter, we register them on our follow-up list and take measures to induce them to return. Such measures are usually successful. At least, we can get them into other medical hands. It is certainly contrary to sound economic policy to abandon them.

From the standpoint of saving sight, one of the most important, if not the most important, group of cases we have to deal with is formed by the non-congestive glaucomas. The congestive glaucoma case will ordinarily return of his own volition. I regret to say that I have seen a not inconsiderable number of hospital cases that have gone practically blind because they have either been ignorant or were dis-

couraged with the apparent lack of benefit from treatment. It comes down to the fact that unless you have the means of reaching patients and getting them back, practically no glaucoma cases should be trusted on miotic treatment, and this works a very considerable hardship on those cases where miotics are indicated. Under our present arrangement, glaucoma patients are calendared for certain dates and are brought back with certainty. If on miotic treatment, they are seen frequently and until the doctor in charge is satisfied that they understand the technic of using the drops and are sufficiently impressed with its importance. They are then put on the regular schedule of visits every three months. We find that once the hospital patient realizes that a personal interest is being taken in his case it is comparatively easy to get him back.

The next group is the tubercular one, and in this I should like to include phlyctenular disease. The class for ocular tuberculosis which was carried on at our hospital for nine years has been described elsewhere and needs no comment, except to say that in my humble opinion it still forms the best method of handling this very resistent and stubborn disease. Unfortunately, our class was interrupted by the war and has not yet been reëstablished, but it will be when funds allow. These patients form a relatively small group and require intensive work, especially in the homes. The phlyctenular group presents a somewhat similar, but less acute, problem. It is not improbable that these cases also might best be treated in classes. This is the material that best illustrates the value of social work. At present all our phlyctenular cases are automatically referred to the Social Service Department. It is the duty of that Department to follow these cases through. They are given examinations of the nose and throat, teeth, and a general physical as a routine, and the home is investigated. In view of all the information obtained the future method of handling each

case is decided upon. As has been pointed out before, the phlyctenular child often means a case of open tuberculosis in the home, and as such is of importance to the community.

The interstitial keratitis group pays the social worker a large dividend. A full-time worker is wholly occupied by these cases in our hospital. They are also referred to the Social Service by virtue of the diagnosis and are examined in much the same way as is the phlyctenular group. Once the diagnosis is made, however, their general treatment is carried out in the Syphilis Clinic of the Massachusetts General Hospital, and finally, when their eyes no longer need attention, they are turned over to this clinic for continued treatment. This group again is of public health importance, and great pains are taken to bring in and to investigate the condition of the parents and other children. A study of some of these cases was presented at the American Medical Association meeting in 1917. At present we have about seventy active cases under treatment.

Another important group is represented by the cases of ophthalmia neonatorum. Without the social worker we should be at a loss in handling them. Many of these babies require breast milk if they are to live. This may often be obtained from the mother or elsewhere, so that it is important to establish contact with the home at once. Perhaps the case shows neglect—it is for the social worker to find where the fault lies, that it may be presented to the proper authorities. In the gonorrheal cases the disease is present in the mother and often in the father, and they must be brought to the hospital and treated. For the benefit of future babies, they must be told plainly the nature of the disease they suffer from and what its consequences are, and a great deal of valuable work can be done along the line of preparing the home for the return of the baby. All this work should be done by other agencies than ours, but as yet the public health authorities have been unwilling to undertake it.

The last group I propose to touch is the myopic one. Prevention is better than cure. We see a not inconsiderable number of cases each year that have become industrially unfit through increasing myopia. We have started to check up our myopes each year, and expect to institute measures of control in those cases where progress is alarmingly rapid.

As a matter of survey, the Department has undertaken to tabulate for a year the industrial accidents which pass through the clinic or are entered directly to the wards from the scene of injury. During the past seven and one-half months 154 such cases have been admitted. The findings of the entire year may show something worth while, and the Department hopes to be able to work out the problem in conjunction with the Massachusetts Industrial Accident Board.

More and more, as time goes on, does the work take on a public health phase, and on this account it has been thought best to attach to the Department at least one worker who has an intimate knowledge of the entire workings of health departments and public and private health agencies in the state. The work is wholly an educational one, which cannot be carried out by the Department alone but, in its far-reaching aspect, is a coöperative one and can be done only by the close interrelation of outside and inside agencies.

One phase of follow-up has not been touched, which is the routine return of selected cases each year so that the final results of operation and treatment may be learned. This seems to me to be of the greatest importance for every hospital.

This, in brief, covers the principal lines along which we are working at present, and it should be emphasized again that this paper has not touched routine social service work, which must form a very large part of the activity in every hospital.

DISCUSSION.

DR. WM. F. HARDY, St. Louis, Mo.: There is one feature of Dr. Derby's paper I desire to discuss, that referring to phlyctenular conjunctivitis and keratitis. Though it may appear irrelevant to introduce into the discussion the question of etiology, it cannot be escaped if it be admitted that tuberculosis is connected in any form or in any manner with this ocular disease. All ophthalmologists may not be, but pediatricians quite generally are, convinced that phlyctenular ophthalmia is closely associated in some way with tuberculosis. Hospital care and follow-up observations by social service workers in conjunction with pediatric clinics have thrown light on this important and often troublesome condition.

Dr. T. C. Hempelmann, of St. Louis, has just completed a study based on 196 cases, looking at phlyctenulosis from the viewpoint of the pediatrician. Speaking of the association of tuberculosis and phlyctenular disease, he states that the question is of more than academic interest, for if it can be proved that phlyctenular ophthalmia is a manifestation of tuberculosis or bears an intimate relation to this disease, then every child so afflicted has a right to demand the benefits of an anti-tuberculous regimen. Phlyctenulosis, when present, would then afford an easy means of recognizing clinical tuberculosis and prompt the initiation of such measures as would in many instances insure a reasonable chance of recovery in a disease of notoriously uncertain outcome. It was noticed that the longer the children were observed, the greater the percentage of tuberculous lesions which developed. Thus, although 51 per cent. of the children in the entire series of 196 cases showed tuberculous involvement of one or more organs, of 35 children who were followed for periods of from one to nine years—and this is the important point in relation to the paper of Dr. Derby—*83 per cent. developed tuberculosis of one sort or another.* This latter fact, I take it, is of the utmost significance, and imposes upon us the obligation to follow up phlyctenular cases, with the aid of the pediatrician, over a prolonged period of time, in order to anticipate, prevent, or mitigate the development of active tuberculosis.

DR. G. E. DE SCHWEINITZ, Philadelphia: Because until quite recently I have been for a number of years President of the Social Service Department of the University Hospital, which was founded largely under the inspiration of Dr. Cabot, I am greatly interested in Dr. Derby's excellent paper. The prevention of blindness, as well as the prevention of many kinds of degraded vision, has been greatly helped by a follow-up system and by education through the agencies of Hospital Social Service; in this respect ophthalmia neonatorum and phlyctenular keratitis are conspicuous examples.

Glaucoma patients are important in this regard. I venture to quote from an address on this subject delivered some years ago. The social worker who makes, to use Mr. Greene's expression, a calendar of glaucoma patients in any hospital, and properly follows them up, will do much, for it is through this channel that the education most readily passes to the races among which this disease is most prevalent. Furthermore, an important function of social service is concerned with the recognition of symptoms in those who have never presented themselves for examination and yet sadly need attention, not only in the house visited, but also in the neighbor's house, and quickly the knowledge of the symptoms of a disease which demands prompt treatment filters through the crowded street. Such a disease is glaucoma. While examining a poor woman who had never had any proper ocular attention and who was practically blind from glaucoma, one of the children remarked: "We used to wonder why mother, when she took us to the movies, always saw colored rings around the lights." If "mother" had only known what they signified, there would be one less blind woman in the city from which I come; there are many others.

The value of the follow-up system in the management of interstitial keratitis from the social service standpoint need not be emphasized; it is only too evident. But the social service worker can render the needed attention not only to the child with the keratitis, but usually can bring the parents to proper examination. One of our social service records summarized reads thus: A child with interstitial keratitis came to the dispensary; the social service worker found an older sister in the early stage of the same disease; persuaded the parents to undergo examination—both were syphilitic;

parents and children were placed under prolonged effectual treatment; since then the mother has given birth to a healthy child. Dr. Derby has rendered good service in emphasizing the importance of social service work in its relation to our special department of medicine and surgery.

DR. ARTHUR E. EWING, St. Louis, Mo.: I wish also to say a word with regard to the social service and its value in the matter of blennorrheal ophthalmia. In former days I had charge of a great deal of the clinical work in St. Louis in connection with Washington University, and we had then any quantity of blennorrheal ophthalmia in the clinic. I have noticed since the organization of the Social Service Department and since we have so many good trained nurses that this has greatly decreased, and I attribute it to the cleanliness that has been taught the people through the Social Service Department.

DR. W. E. LAMBERT, New York: I would like to ask if Dr. Derby considers it necessary to have all the social service workers graduate nurses, or may some of them be simply trained attendants? I think it best to have them all graduate nurses. One of the difficulties in the social service work is to make the Board of Directors and the superintendent appreciate the importance of this.

DR. GEORGE S. DERBY, Boston: Most of our social workers are graduate nurses, and I feel it is an advantage to have training as nurses. There is only one who is not a nurse, with the exception of the few volunteers, which we use for various purposes. I think it is a great advantage for them to have nurse's training.