CONCLUSION

Everything that happens to the individual has well developed and equally manifest psychological bases, but medical tradition is so deeply rooted in anatomy, chemistry, and physiology that psychology is often viewed as irrelevant and unscientific and the writer believes that the psychiatrist is responsible for the meager acceptance of theories, observations, and clinical findings regarding emotional factors in the production of disease largely on account of their obscure language in their reports to the medical profession at large. In spite of this short coming psychiatrists, by and large, have seen their responsibilities increase far beyond those of a few years ago. Whereas formerly they were chiefly occupied with the ordeal of assigning patients to institutions "with high walls" around them for safe keeping, because they had developed full blown psychotic reactions, he is now fully engaged in the deliverance of maximum health to individuals of today. In this short exposition, it has been demonstrated that in the categories of psycho-somatic medicine, war reactions, acute grief reactions, and psycho-gynecology new vistas are opening for a fuller understanding and utilization of psychology in the very near future. Just as peace does not mean the absence of war, but the presence of justice—health does not mean the absence of organic disease but the presence of well being and it is here that the psychiatrist's responsibilities increase, not in the labeling of suffering people with a "fancy and jargon" stigma but in the crystallization out of the crucible of life a feeling of well being.

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Social Service Management of Glaucoma*

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YOU have heard three papers this morning on Pathology and Etiology—Symptoms and Diagnosis—Treatment and Management of Glaucoma. In order to do our most effective work in the prevention of blindness and the adjustment of patients to their visual disabilities, all the knowledge of etiology, symptomatology and treatment in the world, plus the finest equipment is not enough. We must deliver the patient with glaucoma to the doctor and keep him there, and we must treat his atitudes and manipulate his environment as well as treat his eyes to obtain the best results.

Patients with sufficient intelligence, initiative and funds to take themselves to the private office of an ophthalmologist at the first sign of difficulty are, we must admit, very much in the minority—the great majority are either in the free and part-pay clinics, under the care of optometrists, or under no care at all.

To reach the patients under improper care, or no care, is a job of education to be done by public and private health organizations, but that is another story. I shall confine my remarks to what can be done to prevent blindness through social service management in our eye clinics and hospitals.

Medical Social Service had its beginning about 1906 when the late Dr. Cabot of the Massachu-

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setts General Hospital in Boston, recognized the need for some service whereby his tuberculosis patients could be individualized according to their needs, and kept under treatment. Since that time Medical Social Service has been integrated into the Medical Care Programs of increasing numbers of hospitals and clinics, and public and private welfare agencies. Among the more recent additions has been medical social service in eye clinics and hospitals.

The National Society for the Prevention of Blindness in its far-reaching program, undertook in April, 1931 to participate in the establishment of an experimental training course for social workers to be carried out by the Social Service Department of the Massachusetts Eye and Ear Infirmary and the ophthalmologists there.

Scholarships were granted to medical social workers to take these courses, which were later extended to Washington University Hospitals in St. Louis. These workers, following training, returned to their respective hospitals to function as eye workers. It was felt that without an understanding of the eye and its functions as a part of the body, without an understanding of eye diseases and defects in their relation to cure and disability the medical social worker would be able to do only half a job.

This same organization in April 1928, entered into active cooperation with the Massachusetts Eye and Ear Infirmary by making available in the social service department a special worker for handling glaucoma cases only. Dr. George S. Derby, then chief of the Eye Department and a member of the National Society's Board, was particularly interested in glaucoma as a disease capable of control if brought under early medical treatment and continued supervision. Intensive work along this line was undertaken at the Infirmary to demonstrate what might be accomplished by a careful and complete method of following up glaucoma patients. It is interesting to turn to the first report of this study and then to the final reporting, made shortly before the Society's withdrawal from the demonstration in April 1932, when the entire salary of the worker was put on the payroll of the Infirmary to continue the work as a regular staff contribution.

In the summer of 1928, 365 patients were registered in the follow-up files, which contained a fairly complete accounting of all glaucoma patients treated at the Infirmary. Efforts to trace the 365, resulted in finding that seventeen had died; nine had applied elsewhere for treatment; two had left the country; six were bedridden, and the whereabouts of thirty-four could not be ascertained. The remaining 297 were kept on the books for supervision and treatment. At the end of 1931, 823 patients were on the follow-up list (now 3,000), an indication not only of a much more thorough control of the disease incidence, but also a more general recognition and acceptance by the public of the care offered.*

This demonstration showed that assignment of a worker to this group made possible the routine follow-up of all glaucoma patients and that a systematic plan of clinic procedure enabling each patient to have individual and sympathetic consideration could be put through. Facts which might have significance in the study of cause, and evaluation of treatment were made available through acquaintance with living conditions and a checking up on the use of medicine prescribed, and the following of medical recommendations. The social worker's value as interpreter is particularly great with glaucoma sufferers, who become easily discouraged under long-time treatment. Her skill as a case worker may be of greatest assistance to these patients for whom relief from anxiety and of home complications is vital.* A similar demonstration was made at the Illinois Eye and Ear Infirmary in Chicago, inspired by the Illinois Society for the Prevention of Blindness a few years ago.

After examining the records of glaucoma patients for a four year period, Dr. Harry S. Gradle, noted occulist and chief of staff of the Infirmary and vice-president of the Board of the Illinois Society for the Prevention of Blindness, discovered that only 4 per cent of them remained under observation; the others having drifted away. He obtained a $5,000 grant from the Sprague Foundation to establish a supplemental glaucoma service about three years ago, and started to combat the inertia and hopelessness of

* From social service with eye patients by Eleanor P. Brown. Presented at the Regional Conference of the American Association of Hospital Social Workers, New Orleans, La., February 12, 1933.

patients who failed to keep up treatment. With the aid of a medical social worker and with two additional physicians giving treatment, Dr. Gradle was able to completely change the glaucoma picture at the Infirmary. Now all but 4 per cent of the sufferers are kept under observation and treatment; 96 per cent are being treated and the disease arrested, and almost all will keep what vision they have.*

The following is a condensation of the Infirmary's report for June 30, 1942 made by the social worker: "Glaucoma cases average between 500 and 600 clinic visits per month. Total enrollment now 1,300, about 60 per cent of the cases were active and 35 per cent were inactive for such reasons as: (1) unable to profit from further medical care; (2) left state; (3) transferred to another clinic or private physician; (4) died, etc. The remaining 5 per cent of cases should be under medical care but have refused to return." A statistical report such as that gives the doctors an evaluation of the clinic attendance and some idea of how their services are being utilized.

I gave the examples of the demonstration at these two large eye clinics to show what can be done with organization and social service, and to show the interest and program of such private organizations as the National and Illinois Societies for the Prevention of Blindness. These organizations also do much in the way of education of the laity in the prevention of blindness and in stimulating the passing of legislation in the interest of sight saving.

What interested me most during my three months as a student at the Massachusetts Eye and Ear Infirmary was the dispatch with which the glaucoma cases were handled in the clinic, and the fact that each glaucoma patient was known personally to the social worker and her volunteer worker.

As soon as a diagnosis of glaucoma was made a large gold star was placed on the patient's chart, this star demanded the respect and attention of every doctor, nurse, social worker, and clerk in the clinic. The case immediately came to the attention of the glaucoma worker in order for her to get acquainted with the patient, to see that he obtained an understanding of what was expected of him, and to evaluate his social situation to determine if there were any social factors that stood in the way of treatment.

Each morning as the eye patients "poured" into the clinic by the scores, the charts with the gold stars were put in a special rack so that the indicated work on them, such as tensions, fields, and return vision, could be done immediately by residents, and the glaucoma patients could be lined up in the dark-room ready for examination and recommendations when the physician in charge for the day arrived. This enabled the doctor to proceed rapidly and reduced the anxiety and strain on the glaucoma patient, caused by undue waiting in the clinic. The social worker circulated among the patients, establishing rapport, gathering additional data, standing by for any consultation the patient might feel the need of, and interviewing new patients. The patients know that they may return at any time to the social worker to secure a prescription for miotics even though it is not time for their clinic visit. They are impressed with the importance of never being without drops when they have been recommended.

The social worker's afternoons are given over to follow-up of broken clinic appointments, helping patients to arrange hospitalization which frequently includes communications with patient's family or other social agencies and workers in the community, and various other efforts to manipulate the patient's environment in order to expedite treatment. To give a concrete example of what we mean by manipulaing the environment, the following case is given:

Mrs. Davis, age 45, has been diagnosed as having simple chronic glaucoma. Her central vision is 20/20 but she has begun to lose vision in the fields—miotics have failed to control the tension; therefore, a trephine operation has been recommended. Mrs. D. is bewildered. She tells the doctor that in the first place she does not feel the need of an operation because she can still see well and she has no pain—and in the second place it would be impossible for her to leave her home and children to enter the hospital. The doctor succeeded in explaining the nature of simple chronic glaucoma to her and in convincing her of the expediency of accepting the operation but Mrs. D. still maintained that it was impossible for her to leave her home. It was at this point that she was

* Reported in the Chicago Tribune, August 3, 1941.

sent to talk with the social worker.

Mrs. Davis' story was as follows: There were six children ranging in age from 5 to 14 years. The husband, a laborer, made barely enough to feed and house the family adequately. The oldest child, a boy of 14, was crippled due to an orthopedic condition, and required extra care. The second child was a girl of 12 whom the mother was afraid to leave at home without proper supervision. All of the children had to be fed, kept clean and sent to school—most of them were undernourished—so to this mother hospitalization was out of the question. The financial worries and worry about her crippled son caused undue stress and strain on this woman, thereby adversely affecting her eyes. It would be a tragedy to allow this woman to become blind when her family and society need her so much. With Mrs. D.'s permission, the case was referred to the Family Welfare agency. With the proper interpretation they agreed to accept the family for supplementary relief and case work.

The family welfare agency placed a trained housekeeper in the home, so that Mrs. D. could enter the hospital and not worry about her home and children, they supplemented the budget so that the children could have milk, fruit and vegetables in their diet. The oldest son was placed in a school for crippled children where he could receive specialized care, and finally the father was replaced in another job where he was able to make enough money to adequately care for his family. The mother received her operation, and later another one through the same sort of management. The tension has held fairly well, and there is hope of preserving useful vision for Mrs. D. The worker's duty was to interpret the medical data to the Family Welfare agency. In addition to the other information given to the Welfare Agency by the eye worker in a letter was this paragraph:

"Glaucoma is a condition of the eyes due to increased intra-ocular pressure. The normal eye is continuously manufacuring and draining off its fluids. In glaucoma there is continued manufacture of the fluid, but some mechanical failure to drain it. The confined fluid exerts pressure on the retina (the seeing part of the eye) and the optic nerve and slowly causes blindness, treatment will not restore vision already lost, but with diligent treatment, it is possible to retain the remaining vision. Glaucoma patents need to remain under treatment throughout life. Part of this treatment in Mrs. D.'s case is operation as soon as possible; undue stress and strain also tends to aggravate glaucoma. Therefore, your assistance to this family so that Mrs. D. can enter the hospital, and be relieved of worry would be considered a direct contribution to the prevention of blindness of Mrs. Davis."

The following is an example of a case that did not receive prompt attention: A case of glaucoma came to the attenion of a social service department of a clinic that does not have the services of a social worker exclusively for the eye clinic, in the following way:

The relief worker telephoned to say that in an interview with Mrs. C. she had noticed that the patient appeared to be losing her sight. On questioning the patient, worker was informed that Mrs. C. had been under care in the eye clinic but had not been in attendance for six months because an operation had been recommended, and she could not face it. A review of the medical record revealed that an operation had not been recommended at all, but at the time of the last visit six months before the doctor had asked that Mrs. C. return the next day for fields and tension. It was reported to the relief worker that no operation had been recommended but patient should never have discontinued treatment. The relief worker was asked to send the patient to the hospital social service department for an interview. The interview revealed that Mrs. C. thought that the *fields* and *tension test* was an *operation* and in sheer fear had stayed away. As a result she received no treatment for six months and lost much useful vision in the interim. By that time she *really* needed an operation. This should never have been allowed to happen. At the time that the diagnosis was made, the case should have automatically been brought to the attention of some one who would assume the responsibility of, interpreting the nature of glaucoma to the patient, of letting the patient know what was expected of her in the way of cooperation, of individualizing the patient that some one was interested in her as a person, and of securing the assistance of her family and other social agencies in helping patient continue treatment. Because the doctor said, "return in two days for fields" was not enough. The doctor may have assumed that because the patient

registered in the eye clinic for care in the first place that she was prepared to carry out any recommendations, but the doctor did not know what prompted Mrs. C. to come to the eye clinic. Actually she had felt that a little medicine and a pair of glasses would solve her problem immediately and was not prepared for anything so traumatic as a recommendation for an operation on her eyes, and escaped at the earliest possible moment.

We grant that it is generally conceded that the doctor should interpret his findings and recommendations to his patients himself, and this he does in his private practice, but in a busy clinic it is more often than not impossible for the doctor to take the time, when perhaps 10 or 15 patients are still awaiting his services and the morning hours are swiftly passing, and the time drawing near for the doctor to go to his office.

In addition to the actual mechanics of keeping the patient under care there are the all important emotional factors. One could go on forever about them as they are so far-reaching. What does loss of vision mean to the individual patient, and what are the emotional factors that stand in the way of treatment, and to he patient's adjustment to diminished vision or blindness? There are many such factors.

The following excerpt from a social case record, presented by Miss Ruth Emerson of the University of Chicago Clinics in a course of lectures sponsored by the Illinois Society for the Prevention of Blindness this Spring, gives evidence of emotional response in a young man whose vision has been failing over a period of years. He has been aware of the doctor's doubt that blindness could be prevented and was operated in the hope that possibly, but not probably, an increase in vision might be obtained or further loss of vision prevented. Up to the time of the operation he had managed to continue his employment as an office worker.

> "The patient said that although his father and brothers were out of the house day times, they left things for him so that he would be comfortable and time passed for him. His family looked out for him well but there were certain strains in the situation anyway. His father remained apprehensive about his eye condition, asking constantly how much he could see and trying to get him to admit progress. His father was so anxious about it all. Then, too, his brother, Jack, who did so much for him, occasionally "threw up" to him how much care he had to receive. Patient said it was "tough being so dependent" on his family. They all had their own interests and it was no fun having to look out for him. Although up to the time of his operation he had continued to go to dances and to go out with his friends, patient did not feel he would want to try to go out at all until his sight returned. If he were to go out, he would have to be led, everyone would ask what was wrong with him, and he would constantly be subjected to people's sympathy. Up until his operation, although his sight had been failing rapidly, he had managed to put on a good front. With the aid of his closest friends who looked out for him, he had managed to cover the fact of his poor vision. In a crowd, his friends had helped him so skillfully that even girls whom he dated did not realize he had defective vision. At dances his pals would deliver him to the girl with whom he had booked a dance and would manage to be around at the end of the dance to steer him to the next girl or back to the "gang of fellows." They made change for him, helped him across the street inconspicuously and made it entirely possible for him to cover things up. He, himself, had learned certain ways of concealing his handicap, too. His friends kidded him often, saying that what he lacked in sight he made up in "blarney." But there was too much to cover up now and patient had decided to absent himself from all except his best friends until he could see again. Worker thought that perhaps it would be hard to "come back" if he waited too long —that when we shut ourselves away from people, we sometimes become used to seclusion and can't find our way back. What made patient feel that he couldn't face his old group? He said that it was their constant inquiry about his health. While some of his friends were really concerned, others were just curious, and some very definitely would use this "against him." There was no other way but to rest at home, do all he could to help his eyes heal, and wait until his vision returned, then begin going about again."

The patient needs someone to study his reactions to his condition, and to evaluate the psychological factors which cause him to fail to cooperate in treatment and to consider how to help him to overcome his reactions. Since vision is one of our most important senses, if not *the* most importtant, it is easy to understand how much fear and anxiety may be associated with loss of it. The patient's entire pattern of life may be threatened by fear of losing employment and becoming a burden on relatives, friends and society in general, by fear of losing status, fear of boredom and unhappiness, fear of financial dependence, fear of physical dependency and loss of freedom to move about at will, to dress and care for himself.

The housewife besides having the frustration

of having someone else perform her accustomed tasks for her family is worried about money to pay some one else to perform these services.

The visually handicapped person, particularly if he feels blindness approaching, may envision himself as carelessly or slovenly dressed, unattractive and even repulsive. He may envision himself as isolated and deprived of doing and enjoying things which have been meaningful and which he has taken for granted.

Although these feeling are normal reactions unless recognized and guided they may warp personality.*

The visually handicapped person may feel ambivalent about the assistance he needs—on the one hand he may recognize the need for sympathy and want it, and on the other hand he may be hostile because he has to accept it, and fear that at best the sympathy will be tinged with pity.

Often patients become hostile toward clinic, doctor and everyone connected with it because an operation has been recommended. The worker needs to grant the patient the reality of his feelings, allow him to verbalize them, accept them, and sympathize with them before she can alter the patients' attitude. In fact she *must* do so before she can *hope* to alter his attitude and thereby help the patient to accept the recommendations.

On the other hand, we are likely to assume that all people want independence—this is not always the case—there are certain individuals who unconsciously *want* to be dependent, and failing vision is the ideal excuse; therefore, they will not cooperate in a plan to improve their vision. There are others who gain independence through their very dependence, for example, the patient who is seeking a pension for the blind and does not want his vision improved beyond the point where he would be eligible for a pension. In this way he secures "independence" through his dependence on a pension. This only proves that we have to individualize our patients and know that loss of sight does not mean the same to all. What loss of vision means depends upon the patient's personality and his life experiences.

What are the highest standards for a Medical Social Eye worker? First you must have a social worker with medical social training—that is a social worker that has been trained in the social implications of illness and how to apply them to the individual patient's needs. This worker needs to know something of eye diseases—she needs to be especially aware of their social implications—she needs to be conversant with the nomenclature of the ophthalmologist in order to have understanding and easy communication between the doctor and herself. It is taken for granted when we start with a good social worker that she has a sympathetic understanding of the various groups of people that are likely to find their way into the average eye clinic and some knowledge of human behavior. With this combination of training, a social worker in an eye clinic can do much to prevent blindness from glaucoma and other diseases.

It may be very easy to sit back and say that every eye hospital and clinic should have its social worker as an adjunct to the medical staff. Indeed that is an ideal, but we believe in it. However, we realize that this is not always possible. The practicality of having one depends on many things, among them are the volume of the eye service; size of budget; medical viewpoint; methods of administration; local understanding and affiliations and teaching opportunities. We cannot, however, overlook the very real opportunity, through such a worker to save sight, to stimulate medical understanding, to take part more thoroughly in community development, to progress haltingly towards the ideal of perfect service,* and to prevent more and more blindness from that insidious interloper, Glaucoma.

* Emerson, Ruth—"Psychological attitudes of the Visually Handicapped Toward Treatment." Paper given in a course of lectures in the interest of preventing blindness sponsored by the Illinois Society for the Prevention of Blindness March 9, 1942.

* Eleanor Brown From Social Service with Eye Patients—Presented at the Regional Conference of the American Assn. of Hospital social workers, New Orleans, La. February 12, 1943.