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KARAIKUDI – 630 003

DIRECTORATE OF DISTANCE EDUCATION

III-SEMESTER

MASTER OF SOCIAL WORK

34934B

MEDICAL SOCIAL WORK

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UNIT – I MEDICAL SOCIAL WORK

Medical social work

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1.1 Introduction

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 healthcare services are delivered. They are known as medical and healthcare social workers. They may serve as case managers, patient navigators, and therapists in medical settings.

The largest percentage of healthcare social workers works in hospital settings. A growing number of healthcare social workers are working in outpatient healthcare settings or nursing/rehabilitation facilities

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. Social workers address questions such as: Who should we intervene and when should they intervene? Interventions may include connecting patients and families to necessary resources and supports in the community like preventative care; providing psychotherapy, supportive counselling, or grief counselling; 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.

Retrieved from (https://en.wikipedia.org/wiki/Medical_social_work) on 26/08/2019

1.2 Definition

A branch of social work provided by social workers with an advanced degree, in a hospital, skilled nursing facility or hospice, to patients and their families in need of psychosocial assistance.

Retrieved on 26/08/2019 from

(<https://medicaldictionary.thefreedictionary.com/medical+social+work>)

1.3 Concept

- Medical social work deals with the problems of the patient which are related to the physical and psychological environment

- It is oriented towards the assistance of those people, who during their treatment face social, physical, economic and psychological problems.

Retrieved from (www.pitt.edu/~super7/25011-26001/25321.ppt) on 27/08/2019

1.4 Objectives

- Helping people enlarge problem solving and coping abilities.

- Facilitating interaction between individuals and others in their environment.

- Helping people obtain resources.

- Making organizations responsive to people influencing interactions between organizations and institutions.

Retrieved

from(<https://educartcleresource.blogspot.co/2012/11/objectives-and-purposes-of-medical.html>)on 27/08/2019

1.5 Nature

Medical social work is based on the assumption of the individual's dignity

- Guided and inspired by basic values social work

According to medical social work--

- Health refers to that state or condition, in which an individual is capable to utilize all the capacities of his social living.

Medical social work considers human health with a broad perspective.

- The treatment is not the final solution for illness in medical social work.

- Disease and diseased person are different from each other.

- Medical science gives emphasis on the disease but ignores the importance of the diseased person.

But the medical social work studies the diseased person viz. the social aspect of the disease

Medical social work deals with

- The prevention of disease,

- After care of the patients and

- Social rehabilitation of patients,

-and not just limited to the treatment of disease.

1.6 Need and Scope

In a world filled with injustices and incredibly complex, pressing challenges, we need people who are committed to making a difference in the lives of people within their communities more than ever before, and that's precisely where social workers come in.

Medical social workers are responsible for offering the support and resources that patients need in order to fully recover from a medical illness or injury as well as the resulting emotional, physical, or psychological concerns.

Through their commitment to bring about positive social change, helping individuals of all ages thrive in their local environment and being an advocate for those who have lost their voice, social workers play a prominent role in improving the lives of those who need it most.

Though they work with vulnerable or disadvantaged populations, the benefits of a social worker's service are especially significant. Without the help of a passionate social worker, countless patients would have gone without the support and guidance they needed in order to lead the healthy, fulfilling life they deserve.

Retrieved from(<https://uiu.edu/college-search/importance-social-work.html>)on 27/08/2019

Scope of Social Work Practice:

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.

The scope of practice in hospital social work includes:

Assessment

- Comprehensive psychosocial assessments of patients, including families, carers and significant others
- Risk assessments, and comprehensive interventions, for child abuse and neglect, family violence, intimate partner violence, elder abuse, sexual abuse and exploitation
- Capacity, functioning and development assessment, including support and participation requirements, housing and accommodation.
- The utilization of evidence informed screening tools for a range of issues

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Counselling, mediation and therapeutic interventions

- Counselling and targeted therapeutic interventions aimed at helping patients/families/carers adjust to hospital admission
- Counselling and targeted therapeutic interventions in order to address adjustment to diagnosis, trauma, possible role changes, emotional/social responses to illness and treatment
- Grief, loss and bereavement support through counselling and therapeutic interventions
- Comprehensive interventions in relation to chronic health conditions (with a particular focus on self-management issues, impact on health outcomes and where co morbid psychosocial complexities exist)
- Mediation and conflict resolution
- Career support, in relation to self-care, health and wellbeing
- Group work and support programs including psycho-education
- Developing culturally appropriate therapeutic interventions

Crisis interventions

- Supporting vulnerable/people in crisis to navigate and communicate their needs/wishes within the hospital system
- Acute services provided to emergency departments due to traumas resulting in sudden traumatic injury or death and major crises (including natural disasters)

Advocacy

- Supporting individuals, families and carers to be self-advocates, or advocating on their behalf
- Advocating for change on an organizational and systemic level Case management, service coordination and multidisciplinary work
- Case management and the coordination of services both within and external to the healthcare service
- Referrals to other services
- Ensuring communication and understanding about post-hospital care among patient, family, carer and healthcare team members
- Educating hospital staff on patient psychosocial context and needs
- Promoting communication and collaboration among healthcare team members
- Coordinating patient discharge and continuity of care planning
- Undertaking a range of statutory functions relevant to local legislative requirements, this may include: child protection; mental health services; vulnerable adults; power of attorney and public trustee or guardianship and administration

Education, resourcing and practical assistance

- Resourcing and support in accessing appropriate information and financial assistance
- Providing patient/family/carers education on the levels of health care, roles of healthcare team members, assisting patients and families/carers in communicating with members of healthcare teams, understanding medical information and advance care planning

Policy, program design and research

- Guiding and supporting the implementation of 'patient centered' models of care at organizational level

- Developing policy, design and evaluation of programs
 - Engaging in research and publishing peer reviewed journals
- Social workers provide specialist clinical expertise** in addressing the psychosocial aspects of:
- Child abuse and neglect, domestic and family violence, intimate partner violence, sexual abuse, elder abuse, and exploitation
 - Bereavement, grief and loss support work in order to improve coping mechanisms and psychosocial outcomes, in relation to depression, disability, suicide, sudden and traumatic death
 - Socio-legal issues and ethical decision making, for example: advance care planning, enduring power of attorneys, end-of-life decision making and planning, cessation of medical interventions and organ donation
 - Chronic health conditions including: mental health, trauma, adjustment to diagnosis and disability
 - Family interventions and support in relation to complex psychosocial issues, which includes family therapy and family case conferencing
 - Developing culturally responsive and inclusive interventions, including the delivery of culturally sensitive, secure and safe practices in coordination with other professionals including interpreters, Indigenous liaison officers and Aboriginal health workers.
- Retrieved from(Hospital Social Work, April 2016 © Australian Association of Social Workers National Office – Melbourne) on 27/08/2019

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1.7 Roles and functions of a Medical Social Worker

Hospital social workers provide direct services to patients and their families/cares (including significant others) aiming to minimize the negative impacts of illness and hospitalization. A hospital social worker's role is to enhance social and emotional functioning through targeted interventions and the mobilization of services and supports. Social workers intervene in the context of a patient's social environments and relationships, recognizing the effects of the psychological, familial, social, economic and cultural determinants on health and wellbeing. In their commitment to human rights and social justice, social workers advocate for the rights of patients and their families/cares, against discrimination, exclusion and abuse they can sometimes experience. With their focus on patient-centred care and the ability to consider the complexity involved from a psychosocial perspective, social workers offer a unique contribution to the hospital system in providing services to meet the multidimensional needs of patients and their families/carers. Professional social workers are employed in a wide range of hospital settings including public and private, both acute and sub-acute, across metropolitan, regional and rural areas. They work with children, adults, families and communities across a wide range of units and specialty areas including, but not limited to:

- Emergency departments
- Intensive care, including neonatal

- Paediatrics
- Obstetrics
- Oncology
- Renal
- Neurology
- Trauma
- chronic health conditions
- Cardiac
- Burns
- Geriatric services
- Psychiatric and mental health
- Sexual assault and child abuse
- Rehabilitation
- Transplantation
- Drug and alcohol services
- Palliative care

Day-to-Day Activities of a Medical Social Worker

The daily challenges and responsibilities of being a medical social worker vary depending on the healthcare setting, which includes hospitals, nursing homes, assisted care facilities, and residential treatment centres. Generally speaking, medical social workers are part of an interdisciplinary team of care providers and allied health professionals who work in concert to serve patients with conditions spanning the entire healthcare continuum.

Some of the primary work activities of a medical social worker include:

Patient Intake Screening

Patients with a history of mental illness or who meet other high-risk criteria usually undergo an initial screening with a medical social worker. The social worker performs a comprehensive assessment of the patient's social, emotional, environmental, and financial needs. The results are shared with other members of the healthcare team, as they may affect the patient's treatment plan and prognosis.

Patient Counseling and Education

Medical social workers help patients and their families cope with the emotional and social responses to illness and treatment. They also educate patients and their families on entitlements, community resources, and health insurance coverage. They may also lead support group discussions or provide individual counselling.

Discharge Planning

Before a patient is discharged, the medical social worker handling the case will ensure that the services the patient requires are in place and that the patient will be properly cared for at home. This can mean arranging for resources to pay for medications and/or medical equipment, linking patients with social service providers, and coordinating home care services.

Patient Advocacy

A medical social worker is first and foremost a patient advocate. It's the responsibility of the social worker to ensure that a patient's wishes are followed. Social workers can directly advocate on behalf of the patient

by facilitating communication with healthcare providers or arranging health insurance coverage, but they may also advocate for patients' rights in general through policy making and thought leadership.

Retrieved from (Scope of Social Work Practice: Hospital Social Work, April 2016 © Australian Association of Social Workers National Office – Melbourne) on 27/08/2019

1.8 Historical development in India And Abroad

Notes

History of medical social work – three phases

- Ancient and medieval
- British period
- After independence 1947

Ancient and medieval

- Kautilya 'sarthastra' – mentioned about the mental disorders
- Mental disorders mentioned in ayurveda, unani and siddha
- Mental illness was considered as the demons and sins
- Mauryan period concentrated on community psychiatry (world famous caves at Ajanta, Ellora)
- King Ashoka concentrated on mental health
- Lord Venkateshwara temple- Chola period referred Sri Veeracholaeswara hospital
- MaulanaFazulur – Hakim & MahmoodKhiliji – started mental hospital at
- Kilpauk

In British period

- Warren Hastings- 1784 introduced the 'mental health treatment for soldiers
- Lord Cornwallis (1786-93) the first mental hospital at Bombay -30 patients
- Mental hospital in south India at madras - 1794 by surgeon VallentineConolly
- In 1920' Christian missionaries had came to India
- Tata institute of social sciences- 1936
- Around 1945, some Indian doctors who had been in abroad had observed the functioning of "almoners" in Britain and medical social workers in the USA, as part of the health team. They felt the need to have a similar pattern of team work in India as well

After independence

- As per Bhore committee recommendations for all India institute mental health was set up
- First medical social worker was appointed in J.J. Hospital, Bombay, in 1949.
- Madras school of social work (MSSW), Chennai was established in 1952
- Loyola College of social sciences – 1963
- Rajagiri college of social sciences, Kochi 1973
- Karve institute of social service, Pune- 1963
- Bachelor of social work (BSW) 1967 started, JamiaMilliaIslamia, New Delhi
- The medical council of India's report in 1973

- Six medical social workers in each of the preventive and social medicine departments
- National mental health program started in 1982

Historical developments of medical social work in abroad

Britain

Medical social workers in Britain and Ireland were originally known as hospital almoners or "lady almoners" until the profession was officially renamed medical social work in the 1960s. In 1895, Mary Stewart became the first lady almoner in Britain with her appointment to the Royal Free Hospital in London for a three-month trial period. Some sources credit Anne Cummins as the "mother of almoners" as she had the ability and the funding to first establish a comprehensive social work service at St Thomas's Hospital in London in 1909. The emergence of public health and social work were obtained during the 19th century by John Snow who helped bring an end to the cholera eruption in London of 1848. He gathered information about cholera by charting the area of the outbreak, detecting those with the disease and creating ways to deposit the waste sanitarily. In 1945, the Institute of Almoners in Britain was formed, which, in 1964, was renamed as the Institute of Medical Social Workers. The Institute was one of the founder organizations of the British Association of Social Workers, which was formed in 1970. In Britain, medical social workers were transferred from the National Health Service (NHS) into local authority Social Services Departments in 1974, and generally became known as hospital social workers.

China

Medical social work was started in 1921 by Ida Pruitt in Beijing. In-service training was given to social workers for carrying out casework, adoption services and recuperation services.

India

Dr. Clifford Manshardt an American missionary in 1936 started formal training in social work in India through Dorabji Tata Graduate School of Social Work. The first medical social worker was appointed in 1946 in J.J. Hospital, Bombay. In 1960s scope of medical social workers increased in India.

Ireland

In Ireland, the origins of medical social work go back to Paediatrician Ella Webb, the first physician in Ireland to appoint almoners to work in her dispensary for sick children that she established in the Adelaide Hospital in Dublin, and to Winifred Alcock, the first almoner appointed by Webb in 1918.

United States

The Massachusetts General Hospital was the first American hospital to have professional social workers on site, in the early 1900s. Garnet Pelton, Ida Cannon and Dr. Richard Clarke Cabot were the central figures of the hospital social work. Clarke credited his approach as similar to that of Anne Cummins in London. Cannon started specific training for medical social workers in 1912. The major duties carried out by medical social workers were case management, data collection, follow ups, care coordination, health education, financial assessment and discounting patient medical fees.

In the 19th century Dorothea Dix, activist, was seeking to influence state legislatures and the U.S. Congress in order to create America's first mental asylum. Jane Addams and Lillian Wald's work led to better health conditions for citizens which resulted from their activist strategies.

Retrieved from 1.1 (<https://www.slideshare.net/mdaaquib/historical-development-medical-social-work-in-india>) on 27/08/2019

Notes

1.9 Let us sum up

In this unit you have learnt about the definition, concept, objectives, its nature, need and scope; the roles and functions of a medical social worker: and the historical development in India and abroad. This knowledge would make you understand what medical social work is and its related aspects. Thus, the introduction unit of the medical social work would have brought you closer to know the concept of it. This content might play very important role in your service.

1.10 Unit end exercises

1. List out the importance of medical social work in current scenario
2. How the medical social worker been in olden days
3. Explain how medical social work emerged
4. Trace out the nature of medical social work
5. Explain why the role of medical social work in hospitals and write down the main functions of a medical social worker

1.11 Answer to check your progress

1. Medical social workers typically work in a hospital, outpatient clinic, community health agency, skilled nursing facility, long-term care facility or hospice.
2. The first medical social worker was appointed in 1946 in J.J. Hospital, Bombay.
3. 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.
4. Medical social workers assess the psychosocial functioning of patients and families and intervene as necessary.
5. Health refers to that state or condition, in which an individual is capable to utilize all the capacities of his social living.

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UNIT II – MEDICAL SOCIOLOGY AND ITS RELEVANCE TO MEDICAL SOCIAL WORK PRACTICE

*Medical Sociology and Its
Relevance To Medical Social
Work Practice*

Structure

2.1 Introduction

2.2 Medical sociology

2.2.1 Medical sociology

2.3.2 Its relevance to medical social work practice

2.3 Practice of social work methods in hospital settings

2.3.1 Practice of social work methods in hospital settings

2.3.2 Their need and importance in working with the patients and families

2.4 Scope and limitations of practice

2.5 Let us sum up

2.6 Unit end exercises

2.7 Answer to check your progress

2.8 Suggested readings

Notes

2.1 Introduction

Medical sociology is a new field within sociology. It attempts to analyze social action and social factors in illness and illness related situation. The ultimate for this is that we would be able to appreciate the meaning and implication of any illness episode for the symptomatic person, as well as significant others, the health professionals and all other stakeholders in the wider society.

Retrieved from on 29/9/2019 http://www.nou.edu.ng/sites/default/files/2017-03/NSS_409-MAIN.pdf

2.2.1 Medical sociology

The French philosopher Auguste Comte (1798–1857)—often called the “father of sociology”—first used the term “sociology” in 1838 to refer to the scientific study of society. He believed that all societies develop and progress through the following stages: religious, metaphysical, and scientific.

Samuel Bloom considers medical sociology to be an interdisciplinary field that studies the relationship between social factors and health and illness: one of "the greatest hopes" of the founders of medical sociology fifty years ago "was that it would create a place for sociologists in a new academic role in medical field.

Medical sociology is simply the study of the effects of social and cultural factors on health and medicine. Specializing as a medical sociologist helps individuals view the healthcare system as a function of the society and serve it by examining and improving all its facets. It is a stepping stone towards greater career opportunities in the medical field.

Medical sociology important is the critical role social factors play in determining or influencing the health of individuals, groups, and the larger society. At its inception, work in medical sociology was oriented toward finding solutions relevant for clinical medicine

The "sick role" is a theory in medical sociology that was developed by Talcott Parsons. His theory of the sick role was developed in association with psychoanalysis. The sick role is a concept that concerns the social aspects of becoming ill and the privileges and obligations that come with it.

This discipline also looks at health and illness in relation to social institutions such as the family, work, school, and religion as well as the causes of disease and illness, reasons for seeking particular types of care, and patient compliance and noncompliance.

Medical sociology is the sociological analysis of medical organizations and institutions; the production of knowledge and selection of methods, the actions and interactions of healthcare professionals, and the social or cultural (rather than clinical or bodily) effects of medical practice. The field commonly interacts with the sociology of knowledge, science and technology studies, and social epistemology. Medical sociologists are also interested in the qualitative experiences of patients, often working at the boundaries of public health, social work, demography and gerontology to explore phenomena at the intersection of the social and clinical sciences. Health disparities commonly relate to typical categories such as class and race.

Medical Sociology is concerned with the following perspectives:

- Looking at how diseases in the population are located among social groupings.
- Explaining how people respond to diseases with a view to defining them in predictable ways from the perspective of their culture and their social class within a particular culture.
- Describing how society prescribes means of treating diseases.
- Investigating how social institutions give their support to the medical organizations in their bid to treat the sick

Retrieved from https://en.wikipedia.org/wiki/Medical_sociology

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2.1.2 Its relevance to medical social work practice

The practice of advocating for individuals and communities is social work. Social work plays a major role in medical sociology in the form of medical social workers. Medical social workers deal with the emotional,

social and financial needs that frequently accompany with healthcare issues. They generally work in medical and surgical hospitals. They perform duties like new patient admissions, discharges and following up on aftercare plans. Medical Sociologists, Social Science Researchers, Social Workers, Sociologists are mainly involves in social work.

- Social workers and their relation with patients
- Solving healthcare issues
- Neglected tropical diseases

Medical sociology, sometimes referred to as health sociology, is the study of the social causes and consequences of health and illness. ... What makes medical sociology important is the critical role social factors play in determining or influencing the health of individuals, groups, and the larger society.

Retrieved from(<https://www.omicsonline.org/conferences-list/medical-sociology-and-social-work>)on 29/9/2019

2.3 Practice of social work methods in hospital settings

Medical Social Workers assist patients and their families with health-related problems and concerns. In the hospital setting, Medical Social Workers play an important role in coordinating patient discharge planning.

Hospital social workers provide direct services to patients and their families/carers (including significant others) aiming to minimise the negative impacts of illness and hospitalisation. A hospital social worker's role is to enhance social and emotional functioning through targeted interventions and the mobilisation of services and supports.

Social workers intervene in the context of a patient's social environments and relationships, recognising the effects of the psychological, familial, social, economic and cultural determinants on health and wellbeing. In their commitment to human rights and social justice, social workers advocate for the rights of patients and their families/carers, against discrimination, exclusion and abuse they can sometimes experience. With their focus on patient-centred care and the ability to consider the complexity involved from a psychosocial perspective, social workers offer a unique contribution to the hospital system in providing services to meet the multidimensional needs of patients and their families/carers.

Work, Social Group Work, Community Organisation is more effective in intervening with the patients.

Through Social Case Work Individualized treatment can be given to the clients/patient. By using Social Group Work groups of clients/patients with similar problems can be addressed through education and recreation and so on. Through Community Organisation Programme the medical social workers meet the community at large and create awareness and educate the people about the occurrence of disease and relapse of it.

Indirect Methods of Social Work like Social Welfare Administration, Social Work Research and Social Action can also be used. Through Social Welfare Administration an voluntary Organisation can be established to work in the community to educate the people on Health

and Hygiene, Community Health and so on. Through social work research the social workers can take up research on the cause and preventive aspects of the disease in the community. Through Social Action mass education can be given to the people on the curative, preventive and promotive aspects of the disease.

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https://www.google.co.in/search?biw=1043&bih=558&sxsrf=ACYBGN Su7n450oyM22PCF411ZCdsLpvz5w%3A1570081844642&ei=NIyVXa 7rJs6kwwgOikZioBw&q=Practice+of+social+work+methods+in+hospital +settings&oq=Practice+of+social+work+methods+in+hospital+settings &gs_l=psy-ab.3..0.470001.470846..471855...1.1..0.237.237.2- 1.....0....1j2..gws- wiz.....10..0i71j35i362i39.PSP557cQeNM&ved=0ahUKEwui1fjUsv_kA hV0knAKHAlIBnU4ChDh1QMICw&uact=5on 29/9/2019

2.3.1 Practice of social work methods in hospital settings

Hospital social workers help patients and their families understand a particular illness, work through the emotions of a diagnosis, and provide counselling about the decisions that need to be made. Social workers are also essential members of interdisciplinary hospital teams. Working in concert with doctors, nurses, and allied health professionals, social workers sensitize other health care providers to the social and emotional aspects of a patient's illness. Hospital social workers use case management skills to help patients and their families address and resolve the social, financial and psychological problems related to their health condition. Job functions that a social worker might perform within a hospital include:

- Initial screening and evaluation of patient and families
- Comprehensive psychosocial assessment of patients
- Helping patients and families understand the illness and treatment options, as well as consequences of various treatments or treatment refusal
- Helping patients/families adjust to hospital admission; possible role changes; exploring emotional/social responses to illness and treatment
- Educating patients on the roles of health care team members; assisting patients and families in communicating with one another and to members of health care team; interpreting information
- Educating patients on the levels of health care (i.e. acute, sub- acute, home care)
- Facilitating decision making on behalf of patients and families
- Employing crisis Intervention
- Diagnosing underlying mental illness; providing or making referrals for individual, family, and group psychotherapy
- Educating hospital staff on patient psychosocial issues
- Promoting communication and collaboration among health care team members
- Coordinating patient discharge and continuity of care planning
- Promoting patient navigation services

Retrieved from (NASW Center for Work force Studies & Social Work Practice Social Workers in Hospitals & Medical Centers) on 29/9/2019

2.3.2 Their need and importance in working with the patients and families

Social workers help families improve relationships and cope with difficult situations such as divorce, illness or death. They guide families through the counselling process, by helping them identify problems, set goals and find solutions to their troubles. In a crisis situation, such as neglect, substance abuse or violence, they may also recommend legal action, such as having children temporarily removed while the parents work through their difficulties.

Facilitating Communication

A social worker often begins by simply encouraging family members to communicate. Sometimes, families have barely spoken to each other for months by the time they enter counselling. The social worker acts as a neutral third party, helping family members share their fears, concerns or disappointments in a non-confrontational way. They often ask questions designed to help families to discover the underlying causes of their problems. For example, if a child is misbehaving, it may not be because he disrespects his parents, but rather because he's troubled by tension in his parents' marriage. A social worker would help him articulate these thoughts so the entire family could discuss and understand them.

Intervention

Social workers sometimes suggest immediate solutions, even if short-term, to help families work through problems or defuse potentially volatile situations. A social worker will often attempt to stabilize the family unit, including addressing individual members' issues, so that counselling will be more effective. For example, if one family member has a serious drug or alcohol problem, the social worker may recommend he enter a treatment facility before continuing with therapy. Or, if one family member has a mental illness such as depression or bipolar disorder, the social worker may advise him to visit a psychiatrist who can prescribe medications to help him manage his condition.

Conflict Resolution

Families often enter family counselling because they have an immediate problem that's creating stress and conflict within the family. A social worker's first objective is to help families understand and solve the issue. If trouble in the parents' marriage is causing discord throughout the family, the social worker will help the couple address their issues with each other so they can work as a team in caring for their children instead of constantly arguing. They will also counsel the children to help them understand their parents' problems have nothing to do with them. If children are acting out because they're upset about their parents' divorce, or about the death of a parent or other family member, the social worker will help them find ways to deal with their grief or fear.

Teaching

A social worker's long-term goal is to teach families how to work together to solve and prevent problems. In addition to helping them resolve their immediate issues, they will also educate them about family dynamics and how they impact both individual members and the family as a whole. They will help them understand how they approach problems and why the way they respond to conflict may make the

situation worse. They will also help them to create a plan for more effectively handling conflict in the future. For example, Medical social Worker may recommend them to hold weekly family meetings where they can openly discuss their concerns.

Retrieved from(<https://work.chron.com/role-social-worker-family-counseling-13712.html>)on 29/9/2019

2.4 Scope and limitations of practice

The scope of practice in hospital social work includes:

Assessment

- Comprehensive psychosocial assessments of patients, including families, carers and significant others
- Risk assessments, and comprehensive interventions, for child abuse and neglect, family violence, intimate partner violence, elder abuse, sexual abuse and exploitation
- Capacity, functioning and development assessment, including support and participation requirements, housing and accommodation
- The utilisation of evidence informed screening tools for a range of issues

Counselling, mediation and therapeutic interventions

- Counselling and targeted therapeutic interventions aimed at helping patients/families/carers adjust to hospital admission
- Counselling and targeted therapeutic interventions in order to address adjustment to diagnosis, trauma, possible role changes, emotional/social responses to illness and treatment
- Grief, loss and bereavement support through counselling and therapeutic interventions
- Comprehensive interventions in relation to chronic health conditions (with a particular focus on self-management issues, impact on health outcomes and where comorbid psychosocial complexities exist)
- Mediation and conflict resolution
- Carer support, in relation to self-care, health and wellbeing
- Group work and support programs including psycho-education
- Developing culturally appropriate therapeutic interventions

Crisis interventions

- Supporting vulnerable/people in crisis to navigate and communicate their needs/wishes within the hospital system
- Acute services provided to emergency departments due to traumas resulting in sudden traumatic injury or death and major crises (including natural disasters)

Advocacy

- Supporting individuals, families and carers to be self-advocates, or advocating on their behalf
- Advocating for change on an organisational and systemic level

Case management, service coordination and multidisciplinary work

- Case management and the coordination of services both within and external to the healthcare service
- Referrals to other services

- Ensuring communication and understanding about post-hospital care among patient, family, carer and healthcare team members
- Educating hospital staff on patient psychosocial context and needs
- Promoting communication and collaboration among healthcare team members
- Coordinating patient discharge and continuity of care planning
- Undertaking a range of statutory functions relevant to local legislative requirements, this may include: child protection; mental health services; vulnerable adults; power of attorney and public trustee or guardianship and administration.

Education, resourcing and practical assistance

- Resourcing and support in accessing appropriate information and financial assistance
- Providing patient/family/carer education on the levels of health care, roles of healthcare team members, assisting patients and families/carers in communicating with members of healthcare teams, understanding medical information and advance care planning.

Policy, program design and research

- Guiding and supporting the implementation of 'patient centred' models of care at an organisational level
- Developing policy, design and evaluation of programs

There exists lots of limitation in the practice of medical social work in Hospital settings. In India medical social work as a profession is not accepted in the hospital administration. The Physicians have not really understood the role of social worker in the hospital settings. Social Workers are made to do some menial work like giving token and accompanying the patients. Appointing a social work is considered as a financial burden to the hospital. Very few hospitals in India have appointed medical social workers. Moreover the patients also do not spend time with the medical social workers for want of time.

Retrieved from <https://www.aasw.asn.au/document/item/8644> on 29/9/2019

2.5 Let us sum up

In this unit you have learnt about what medical sociology means. How it is relevant to medical social work practice. The practice of social work methods in hospital settings and their need and importance in working with patients and families. The scope and limitations of the practice were also learnt.

2.6 Unit end exercises

1. Is it necessary to have social workers in hospitals? If yes, state it
2. State the limitations of medical social workers in India.
3. What do you understand by the term medical sociology?
4. Explain about the scope in medical sociology
5. Point out the limitations of medical sociology

2.7 Answer to check your progress

1. Medical social workers deal with the emotional, social and financial needs that frequently accompany with healthcare issues.
2. Hospital social workers use case management skills to help patients and their families address and resolve the social, financial and psychological problems related to their health condition.
3. A social worker will often attempt to stabilize the family unit, including addressing individual members' issues, so that counselling will be more effective.
4. A social worker's first objective is to help families understand and solve the issue.
5. Medical social workers deal with the emotional, social and financial needs that frequently accompany with healthcare issues. They generally work in medical and surgical hospitals. They perform duties like new patient admissions, discharges and following up on aftercare plans.

2.8 Suggested readings

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UNIT III – PSYCHOLOGICAL, SOCIAL AND ECONOMIC IMPLICATIONS OF ILLNESS AND DISABILITY

*Psychological, social and
economic implications of illness
and disability*

Notes

Structure

3.1 Introduction

3.2 Psychological, social and economic implications of illness and disability: for the patient and his family

3.3 Let us sum up

3.4 Unit end exercises

3.5 Answer to check your progress

3.6 Suggested readings

3.1 Introduction

This unit gives an understanding about the implication of the illness and disability on the patients and their families. The patients develop lots of psychological problems, social problems and have economic problems too when the patient is hospitalised due to illness and become disabled.

3.2 Psychological, social and economic implications of illness and disability: for the patient and his family

There are several ways that chronic illness can influence family life. Family members may experience strong emotions, such as guilt, anger, sadness, fear, anxiety and depressed mood. These are normal reactions to stress.

There are several ways that chronic illness can influence family life:

- Daily routines may change because the limitations of the ill member and the demands of treatment may require that others be more available.
- Families may need to share care giving responsibilities; this helps all members feel they are contributing to a loved one's welfare and it also protects any single member from caregiver fatigue.
- Family members may experience strong emotions, such as guilt, anger, sadness, fear, anxiety and depressed mood. These are normal reactions to stress. It is useful to talk about these emotions within the family.
- The ill member may need to find ways to be as independent as possible, given the limitations that the illness causes.
- Despite the demands of the illness, families may need to work hard to maintain a sense of "normal" life. This can benefit the ill member, as well; it may help him or her integrate into family life more

and may reduce the ill member's sense of guilt regarding the demands the illness places on the family as a whole.

- In addition to disease specific symptoms, people commonly complain of invisible symptoms such as pain, fatigue, and mood disorders. Pain and fatigue may become a frequent part of your day. Physical changes from a disease may affect your appearance. These changes can turn a positive self-image into a poor one.

Key impact areas

Most chronic diseases have similar effects on family members including psychological and emotional functioning, disruption of leisure activities, effect on interpersonal relationships, and financial resources. However there may be some aspects which attain dominance in one particular disease as compared to other diseases.

Emotional impact

Family members suffer greatly from the emotional effects of living with, and caring for, a relative with a disease, with the impact of some diseases being felt by every member of the family. Emotional impact was the most common topic discussed in the literature. The psychological distress felt by family members often results from their feelings of helplessness and lack of control. Many different emotions are mentioned by family members; guilt, anger, worry, upset, frustration, embarrassment, despair, loss, relief. Each emotion affects family members in different ways and to different extents, often depending on the disease severity of the patient, and the period of time that has passed since the diagnosis. Female partners of cancer patients had higher psychological distress than male partners. However, no significant difference was seen between genders when measuring overall quality of life of relatives. There may be gender differences in responses to caregiving although there was no difference in the well-being of partners of rheumatoid arthritis patients, based on the gender of the patient. It is not just the parents and partners who are affected emotionally by a relative's disease. For example, siblings of children with pervasive developmental disorder suffered from "significant adjustment problems" compared to a control group.

Financial impact

One of the greatest burdens on family members of patients is the financial cost to the family. This can include treatment costs, transport to appointments, the cost of hiring a carer, and adapting their home environment. The financial strains felt by family members of patients often lead to stress and worry. Family members of dermatology patients increase their working hours in order to support their family financially, and many need state benefits to cover the extra costs which may lead to compromises for other family members. When caring for a child with cerebral palsy, providing even the basic necessities put financial pressure on the parents and accessing funding was also challenging, which again increased stress and emotional effects. The difficulties involved in accessing funding are greater in low income families, who often receive minimal support and face greater problems with social functioning and relationships.

Impact on family relationships

Family members of patients experience a negative effect on their family relationships, both between the relative and the patient, and between other members of the family as a result of the patient's illness. Poor family relationships do not bode well for chronic disease management regardless of the disease and often family members find relationships difficult as they do not know how to emotionally support each other. Family members of patients with multiple sclerosis reported negative effects on their relationships with each other, resulting in arguments, tension, and a lack of understanding of each other's feelings. In particular, relatives struggle to deal with patients whose beliefs, outlook, and behaviour have altered as a consequence of their disease. There was little time for relationships between other members of the family.

Partners of patients experience a negative effect on their sex lives as a result of the patient's disease, often as a result of the patient's symptoms or not having time to spend together as a couple due to another family member's illness. It can lead to friction between couples, and in some cases can lead to the breakdown of relationships, or partners seeking sexual encounters outside the relationship.

However, in some families relationships can grow stronger as the family members work together to help each other and become more closely knit. In families with a child with an intellectual disability, the majority were taking the initiative to maintain good family relations, and engaging in family activities to encourage this. An increase in family closeness was also found in families of cancer survivors; one husband of a survivor said "I look at life differently after that. I feel much closer to her."

Education and work

Living with, or caring for, a relative with a disease can have a large impact on the education and careers of family members. This could include disruption of school work in siblings or children of the patients or the employment of adults being affected and the burden of care placed upon them. Some families of children with disabilities felt that some of their family members would not be able to attend work or school in the near future. One family member is quoted: "The unpredictable natures of our children's health and lives do not often fit with a typical, progressive work profile". In eight of the 34 families studied, one or both parents had given up an education or career to care for their child with a disability. 40% of family members of dermatology patients felt that their employment was affected by their family member's skin condition. Reasons included needing to look after the patient, attending hospital appointments, and emotional effects affecting work. Looking after a patient with cancer can also have a huge impact on a family member's work on a day-to-day basis. Family member carers were reporting late for work, missing work, spending time at work talking on the telephone to their relative and some left work due to their carer responsibilities.

Leisure time

An important part of family Quality of life in family members being able to participate in the hobbies they enjoy. The barriers that prevent

families from taking advantage of leisure opportunities link into other domains of family quality of life, including lack of time due to the responsibilities of care, limited finance, and lack of support available. However, encouragingly, it has been shown that when family members do take the initiative to plan leisure activities, they usually work out positively, despite the restrictions due to the relative's illness, and families show high satisfaction with this achievement.

Family members also find difficulty in taking family holidays, often depending on the disease state of their relative. Problems with finding suitable accommodation can make holiday planning "awkward". Relatives of patients with skin diseases described limitations of holiday planning, for example not wanting to swim together at the beach or their relative having to wear certain types of clothes.

Social impact

The burden on family members caring for a person with a disease has a drastic effect on their social lives from their friends and felt that they could only contribute to depressing conversations, and therefore lost friends as a result. Other family members described friends "drifting away", as they do not understand the family situation.

A large number of individuals with a relative suffering from a skin disease complained of social disruption. Conditions which result in visible signs of disease (for example basal cell carcinoma on the face or chronic obstructive pulmonary disease requiring oxygen therapy) may have a greater effect on the social lives of patients and their relatives, for fear of strangers' reactions to their visible condition. Mothers of adolescent patients suffering from severe chronic pain reported more restrictions in their social life than mothers of children with less severe chronic pain and the authors suggest that this could be directly related to the illness.

There are several ways that chronic illness can influence family life. Family members may experience strong emotions, such as guilt, anger, sadness, fear, anxiety and depressed mood. These are normal reactions to stress.

There are several ways that chronic illness can influence family life:

- Daily routines may change because the limitations of the ill member and the demands of treatment may require that others be more available.
- Families may need to share care giving responsibilities; this helps all members feel they are contributing to a loved one's welfare and it also protects any single member from caregiver fatigue.
- Family members may experience strong emotions, such as guilt, anger, sadness, fear, anxiety and depressed mood. These are normal reactions to stress. It is useful to talk about these emotions within the family.
- The ill member may need to find ways to be as independent as possible, given the limitations that the illness causes.
- Despite the demands of the illness, families may need to work hard to maintain a sense of "normal" life. This can benefit the ill member, as well; it may help him or her integrates into family life more and may reduce the ill member's sense of guilt regarding the demands the illness places on the family as a whole.

Illness impacts not only the physical condition, but also the psychological and social health of patients and their families. Understanding the unique aspects of the illness and anticipating reactions to tests and diagnoses can help guide a course of action to minimize distress and maximize benefit for both the patient and family. Referrals to specialists or support services can also help address the psychological health of the patient and family.

The personal and permanent nature of disease can raise a range of emotions including guilt, fear, and helplessness. Specialists such as counsellors, social workers, and psychologists, as well as members of support groups, can be extremely helpful to patients and families as they deal with these difficult issues.

A Lifetime of Affected Relationships

Illness and condition of disability have powerful effects on families. Like many chronic conditions, they may require continuous attention and lack cures. They have implications for the health of relatives. So a genetic diagnosis for one family member may mean other biological relatives are at risk, even if they currently show no symptoms. In addition to the medical implications, genetic disorders present emotional challenges and special reproductive implications. Families may be concerned about difficult treatment options, the chance that additional offspring will inherit the condition, and prenatal and new-born testing decisions.

Impact of a Diagnosis

The psychosocial impact of a disorder varies by the nature of the condition, the relationship of a person to the affected individual, and individual personalities. Every family is different, and it is difficult to predict how people will react to a diagnosis. It is helpful to think in advance about some of the possible reactions so you can be prepared and minimize distress.

Patients

A diagnosis can provide a great benefit to patients. When the condition is rare and patients and families spend years without knowing its name or cause, a diagnosis can help make sense of the situation. Diagnoses can lead to improved treatment options and access to support services. They can also help other family members make decisions about their own lives.

A diagnosis may lead to negative reactions, too. A common response is that the science of genetics is confusing and frustrating. Patients identified with a illness and disorder may consider themselves at fault or “broken” or interpret their diagnosis as leading to something they cannot handle. A diagnosis can lead to concerns about stigmatization.

The reaction to a diagnosis varies from individual to individual and is affected by many factors including age, gender, education, religion, and culture. Providers should be aware of these differences and understand the patient’s background in order to communicate effectively.

Parents

Understandably, diagnosis of a condition may put stress on a relationship. Couples with an affected child often face difficult family-planning decisions because future children may have a chance of

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inheriting the condition. Depending on the condition, parents may also be faced with hard choices regarding prenatal testing and termination of a pregnancy. The magnitude of these decisions and their outcomes impacts both individuals and relationships. Parents may experience guilt due to the hereditary nature of genetic conditions.

Family

Unaffected family members should not be forgotten in the case of an illness and disorder. When one family member is diagnosed with a disease, family members who do not have the disease often feel guilt that loved ones are affected when they are not. For adult-onset diseases, unaffected spouses may view their partners differently. The diagnosis can lead to a breakdown in communication. Siblings of children with special needs sometimes feel neglected because parents may focus more time and effort on the siblings affected by a genetic condition. Including unaffected family members in the care of individuals with special needs can help them examine their own emotional issues. Adults who are diagnosed with a genetic condition and are considering having a child may need to consider the chance of having an affected child, as well as their ability to care for the child.

In cases where a genetic test is predictive, other family members may misinterpret the results as a diagnosis rather than an indicator of risk for a condition. It is important to keep in mind that genetic test results are often complex and may be difficult for patients and their families to understand. In some cases, a genetic test may reveal the risk status of other family members who may not wish to know this information, potentially encroaching upon their autonomy or privacy.

The financial burden of a chronic genetic condition can also lead to stress among family members. A family already struggling financially may be intimidated by the costs associated with caring for a child with special needs. Referrals to appropriate support services are crucial to help ease the stress caused by a genetic diagnosis. Advocacy groups, state health departments, and The Patient Advocate Foundation are all organizations that may provide a starting point for support services.

In general, support or advocacy groups and community resources can provide ongoing support to patients and their families with genetic conditions. Support groups provide a forum for sharing experiences about caring for a family member affected with a genetic condition, coping with a new diagnosis, obtaining healthcare or other services, and healing. Members of support groups know first-hand what it means to be faced with a diagnosis and need accurate, up-to-date information? Staying connected with their community helps individuals fight the feelings of isolation that often surround families living with an illness or disability.

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3.3 Let us sum up

The psychological, social and economic implications of illness and disability for the patient and their families were discussed in this unit.

Psychological, social and economic implications of illness and disability

3.4 Unit end exercises

Notes

1. How the family members of the patients with disability are psychologically affected?

3.5 Answer to check your progress

1. Diagnoses can lead to improved treatment options and access to support services.
2. Families may be concerned about difficult treatment options, the chance that additional offspring will inherit the condition, and prenatal and newborn testing decisions.

3.6 Suggested readings

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Psychological, social and economic implications of illness and disability

Notes

UNIT IV - CONCEPTS OF PATIENT AS A PERSON

Structure

- 4.1 Introduction
- 4.2 Concepts of patient as a person
- 4.3 Patient as a whole
- 4.4 The psychosomatic approach
- 4.5 Multidisciplinary team work
- 4.6 Need, importance, and principle;
- 4.7 Role of social worker as a member of the team
- 4.8 Let us sum up
- 4.9 Unit end exercises
- 4.10 Answer to check your progress
- 4.11 Suggested readings

4.1 Introduction

This unit gives the reader an understanding about the concept of Patient as a Person. Patient is a person with all emotions. Whoever it may be they have to be treated with much care and concern in the hospital. It should not be differentiated as rich or poor, young or old, men or women, people with high profile or unpopular people.

4.2 Concepts of patient as a person

The concept of “persons” and its implications for how people should be treated have featured in debates in moral and political philosophy for centuries. We provide just a brief overview.

The term “person” is often equated with the term “human,” but can be used in a more technical way to refer to beings (human or otherwise) that (a) have particular (valued) characteristics and/or (b) belong to a group whose members have particular ethical privileges. The characteristics associated with the concept of persons include abilities to reason and communicate, emotionality, abilities to act intentionally, self-awareness, self-regulation, potential to suffer in particular ways, and interests in preserving and developing self and identity. Different authors have emphasized different characteristics and generated different implications from these, including in terms of which humans or other beings they think should count as persons, and (less often) what is due to them and what can be expected of them as such (Chappell 2011). On all accounts, however, persons have a different ethical standing than nonpersons.

There are important concerns, however, about use of the concept of persons when thinking about how human beings should be treated. If the characteristics associated with the concept are understood as criteria for judging which individuals should count as persons, those humans who do not clearly and consistently demonstrate them might apparently be excluded from the protection of requirements that they be treated as persons (Chappell 2011). In this article we are committed to developing an understanding of what it means to treat patients as persons that will not have negative implications for anyone who needs health care. We seek an understanding of person-centred care that applies, for example, to babies and young children, people with intellectual or developmental impairments, people who are anaesthetized, and people with dementia. In health care, person-centred care is where the patients actively participate in their own medical treatment in close cooperation with the health professionals. Sometimes relatives are also included in creating the health plan. The person-centred model of health care is used both for in and out patients, emergency care, palliative care as well as in rehabilitation.

Defining Patient-Centred Care

Patient-centred care is the practice of caring for patients (and their families) in ways that are meaningful and valuable to the individual patient. It includes listening to, informing and involving patients in their care. The IOM (Institute of Medicine) defines patient-centred care as: “Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”

Overview of Picker’s Eight Principles of Patient Centred Care

Using a wide range of focus groups — recently discharged patients, family members, physicians and non-physician hospital staff— combined with a review of pertinent literature, researchers from Harvard Medical School, on behalf of Picker Institute and The Commonwealth Fund, defined seven primary dimensions of patient-centred care. These principles were later expanded to include an eighth – access to care. The researchers found that there are certain practices conducive to a positive patient experience and their findings form Picker’s Eight Principles of Patient-Centred Care.

1. Respect for patients’ values, preferences and expressed needs

Involve patients in decision-making, recognizing they are individuals with their own unique values and preferences. Treat patients with dignity, respect and sensitivity to his/her cultural values and autonomy.

2. Coordination and integration of care

During focus groups, patients expressed feeling vulnerable and powerless in the face of illness. Proper coordination of care can alleviate those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination of clinical care
- Coordination of ancillary and support services
- Coordination of front-line patient care

3. Information and education

In interviews, patients expressed their worries that they were not being completely informed about their condition or prognosis. To counter this fear, hospitals can focus on three kinds of communication:

- Information on clinical status, progress and prognosis
- Information on processes of care
- Information to facilitate autonomy, self-care and health promotion

4. Physical comfort

The level of physical comfort patients report has a significant impact on their experience. Three areas were reported as particularly important to patients:

- Pain management
- Assistance with activities and daily living needs
- Hospital surroundings and environment

5. Emotional support and alleviation of fear and anxiety

Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over physical status, treatment and prognosis
- Anxiety over the impact of the illness on themselves and family
- Anxiety over the financial impact of illness

6. Involvement of family and friends

This principle addresses the role of family and friends in the patient experience. Family dimensions of patient-centered care were identified as follows:

- Providing accommodations for family and friends
- Involving family and close friends in decision making
- Supporting family members as caregivers
- Recognizing the needs of family and friends

7. Continuity and transition

Patients expressed concern about their ability to care for themselves after discharge. Meeting patient needs in this area requires the following:

- Understandable, detailed information regarding medications, physical limitations, dietary needs, etc.
- Coordinate and plan ongoing treatment and services after discharge
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis.

8. Access to care

Patients need to know they can access care when it is needed. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices
- Availability of transportation
- Ease of scheduling appointments
- Availability of appointments when needed
- Accessibility to specialists or specialty services when a referral is made
- Clear instructions provided on when and how to get referrals.

At a global level, there is a seismic shift in thinking about empowering patients to take an active role in their care plan. At One view we see

first-hand how technology can help transform healthcare facilities and help them realize their ambitions to engage patients and significantly improve outcomes. The One view Healthcare Solution including our core platform, coupled with our feature pack modules – patient experience, communications, workflow and patient portal – provides healthcare facilities with the technological advantage to deliver real Patient-Centric Care.

Health care leaders and patients' advocates internationally have struggled for decades to improve patients' experiences of the way health care is delivered. There are various reasons for this. Some reasons relate to practical obstacles, but in this article we focus on ways of thinking about "person-centered care" and associated concepts. Ways of thinking about these concepts can have important implications for how health care staff understands the value and ethical significance of their interactions with patients.

Person-centered care and near synonyms such as patient-, client-, family-, and relationship-centered care refer to forms of care that are intended to correct tendencies for health care to be either (1) too disease-centered (taking an unduly limiting biomedical approach, focusing narrowly on pathologies, and applying disease-standardized and often unnecessarily high-tech "solutions" that give insufficient regard to the subjective illness experiences, particular interests and autonomy of patients), or (2) too system- or staff-centered (being inappropriately oriented to serve the interests of the organisation and/or professional provide services, and using one-size-fits-all approaches that again give insufficient regard to the particular interests and autonomy of the people who use services) (Epstein et al. 2010; Gerteis et al. 2002; Hobbs 2009; IAPO 2007; Mead and Bower 2000; Mezzich et al. 2009; Stewart 2001; World Health Organization 2007).

Retrieved on 24/09/2019 from (https://en.wikipedia.org/wiki/Person-centered_care)

(<https://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/>)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3746461/>

4.3 Patient as a whole

Treating the whole person involves giving each person tailored and personalized therapies specific to their genetics, nutrition status, lifestyle, and capacity for implementing suggestions, not just a set of instructions to follow.

It is important to care for the whole person and to see them as just that; a whole person, not just a patient or diagnosis. Holistic nursing care involves healing the mind, body, and soul of our patients. ... Holistic care is a philosophy; it's a method to ensure care for all parts of a patient.

Medical:

At the core of every patient is his or her **medical condition or need:** heart disease, pregnancy, stage 3 breast cancers, or maybe weight loss. What's important to note here is that if an individual has a number of

health issues, he or she perceives their medical needs as a whole and interconnected? The individual is not focused on singular diseases, as perhaps a specialized clinician might be. From minor to major, the medical or health-related need is what defines the care request and clinical interaction. One of the individuals we spoke to as part of this work had suffered a debilitating fall, which left her with multiple medical and neurological issues. She felt that none of the physicians would take the time to sit down with her and come up with a holistic strategy. Her health issues were looked at “as one-offs, not as a whole person,” which led to disjointed and disconnected care.

Psychosocial:

Layered atop the medical is the **psychosocial state**: the mental and emotional state, social system, and functional capabilities of a patient. Does this person suffer from anxiety? Is he or she depressed? Does this person’s social support network and environment foster a positive psychosocial state?

One’s psychosocial state ties closely to what many refer to as the social determinants of one’s health. This layer is crucial to understand because it can either inhibit or enable a person’s ability to actively take part in caring for him or herself. For example, many people find themselves in a deep depression following a diagnosis, after realizing that their once-normal state is no longer. This was very true of another individual we spoke to as part of this work, who was suffering from Crohn’s disease and decided to see a psychiatrist who “helped me see and treat certain aspects of my condition that are not addressed medically.”

Attitudes and Beliefs:

Another component of a whole patient is one’s attitudes and beliefs, which break into two parts. First are the beliefs or perceptions one has formed over time regarding one’s health and care. These beliefs are often based on the individual’s own experiences or those of family and friends. People will often share about an overly positive or negative experience receiving care. For example, someone might recount waiting five hours at a certain emergency department (ED), or how his mother died after a failed regiment of a certain type of cancer treatment. Frequently, these negative experiences transform into vows to never return to a particular facility, or to never have a certain treatment, despite the fact that the facility may be widely regarded in a positive light or the treatment may be the best option for the patient.

The second part is the attitudinal category one falls into, which depends largely on how much involvement the individual has in his or her own health and care. A minimalist might be someone who denies a health condition or does the bare minimum recommended by a health care provider. A maximalist, on the other hand, might be someone who proactively seeks health information and is engaged in her own care planning. The attitudinal category one falls into is linked to an individual’s personal experiences or those of family and friends. This category will inevitably change over time, as one is exposed to new such experiences.

One proactive individual had strong beliefs and perspectives against the use of blood transfusions. After giving birth to her premature baby, who was in critical condition, a number of physicians recommended a blood

transfusion for her daughter. “I felt backed up against a wall,” she explained. “The doctors wouldn’t listen to me.” She eventually found a doctor that she felt would listen to her and she was able to discuss and land on a treatment option that didn’t require a transfusion. Her takeaway: “I learned that when I feel strongly about something, [doctors] have to explore it enough until you prove me otherwise. I like doctors that are willing to work with me [and] will work with me through my ignorance.”

Information and Communication Preferences:

The last component that makes up a whole patient is information and communication preferences: how someone learns, when someone is open to learning, how someone seeks out information, and how someone prefers to exchange information with a care team. For example, we have found a growing preference among people to email or message their doctor when they encounter a health question rather than initially scheduling an appointment, as it provides a quick and convenient response to their discrete need. Some will go as far as seeking out care teams that offer email or messaging services, or other communication methods that they value and use.

As these layers are added, a clearer, more complete picture of a patient’s unique values will start to emerge. The differences in the makeup of the layers highlights that—while the medical prognosis may be the same across two patients—the delivery of care, proposed care plan, and manner in which the care plan is communicated could be vastly different to best align with who those two individuals are.

One healthcare organization that has started to peel away at the layers of a patient to truly recognize and understand who they are is Iora Health, a Cambridge, Massachusetts-based primary care provider organization. Iora has built a unique care model that has recently gained traction with many other health systems. They start by working from a care team model that employs a doctor, nurse, behavioral health specialists (as needed), and a Health Coach. Health Coaches are hired both for their interpersonal skills as well as for their awareness of the communities the patients are from, helping inform the whole person understanding. As Iora’s website explains, “we know people by name, but more importantly by their dreams, fears, and challenges.”

Without a whole patient understanding comes misalignment. Otherwise manageable chronic conditions will continue to spiral out of control when a patient’s denial attitude towards their health isn’t identified and supported through coaching. Otherwise straightforward heart procedures will result in continued hospital readmissions when a poor home life is not identified, or an unsupportive spouse who encourages frequent fast food meals is not educated alongside the patient, throughout the full course of a procedure. The model of healthcare will continue to be reactive, rather than proactive, if health systems aren’t set up to holistically understand and support patients.

Truly understanding patients is complex work, but focusing on them as multi-faceted individuals will enable the design and delivery of people-centered care and service offerings. Gone should be the days of patients feeling unheard or seen as a number, because it is possible to meet individual people where they are holistically: emotionally as well as

medically. Models such as this one can be used as a tool to start. The process begins by recognizing the four layers to a patient and using them as a template, first to guide information-gathering from patients, and then to design the right solutions and appropriate care paths custom to the individual patient.

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(<https://www.continuuminnovation.com/en/how-we-think/blog/understanding-the-whole-patient/>)

4.4 The psychosomatic approach

Hospital-based “multidisciplinary teams” often involve all levels of “staff” on the treatment pyramid including aides, nurses, physician assistants, physical therapists, social workers, anaesthesiologists, and attending physicians. These “teams” are consistently more effective than randomly assigning staff to the emergency room (ER), the floors, the Intensive Care Unit (ICU), the operating room (OR), or other locals. These “teams,” acting as “well-oiled machines,” counteract the “silo or halo effect” (e.g. characterized by the “I am too important because I am...”), break down communication barriers between specialists, and provide better cooperation among all specialists. Utilizing such cohesive teams limits adverse events (AE) (e.g. including morbidity/mortality), improves patient outcomes, decreases patient length of stay (LOS), and increases patient satisfaction. Additional benefits for the “staff” include improved job performance, reduced AE/complications, reduced costs, and increased job satisfaction, while the “staff” and hospitals benefit from greater retention of experienced personnel. We must continue to work with our hospital administrators to ensure that these “multidisciplinary teams” stay together for the “greater good” of the patient, “staff,” and the institution.

Some physical diseases are believed to have a mental component derived from the stresses and strains of everyday living. This has been suggested, for example, of lower back pain and high blood pressure, which some researchers have suggested may be related to stresses in everyday life. The psychosomatic framework additionally sees mental and emotional states as capable of significantly influencing the course of any physical illness. Psychiatry traditionally distinguishes between psychosomatic disorders, disorders in which mental factors play a significant role in the development, expression, or resolution of a physical illness, and somatoform disorders, disorders in which mental factors are the sole cause of a physical illness.

The psychosomatic approach requires of the practitioner broad knowledge and skills relevant to the psychosocial, metabolic and physical responses of patients. The approach, being holistic, becomes appropriate in many different clinical situations (and should not be restricted to a few so-called psychosomatic diseases). Wise physicians and perceptive laymen have recognized the validity of a psychosomatic approach for over 4000 years. Although the prevalence and incidence of psychosomatic disturbances are difficult to estimate (and probably underestimated in many surveys), data support the statement that family physicians should employ a psychosomatic approach in at least 15 per

cent of cases. The general internist will probably encounter primarily psychosomatic disturbances in about 30 per cent of his patients; for example, many common presenting symptoms such as fatigue and chest pain arise in a setting of psychological stress. Apart from a sound knowledge of the genesis and manifestations of metabolic and structural changes, the physician must be familiar with the causes and symptoms of psychological disorders. Skilful interviewing and history-taking provide the data necessary to analyse and unravel psychosomatic interplay. Psychotherapeutic interviews often enable both the patient and the physician to understand the clinical problem: this understanding appears to aid recovery.

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(<https://www.ncbi.nlm.nih.gov/pubmed/1225838>)

4.5 Multidisciplinary team work

A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient. ... This co-ordinates their services and gets the team working together towards a specific set of goals.

an (MDT) should consist of psychiatrists, clinical nurse specialists/community mental health nurses, psychologists, social workers, occupational therapists, medical secretaries, and sometimes other disciplines such as counsellors, drama therapists, art therapists, advocacy workers, care workers.

Each individual on a multidisciplinary team brings to their work the skills associated with their particular profession or discipline. These are the skills that are in evidence in their work on the team and with individual service users.

Health care, by definition, is a multidisciplinary profession in which doctors, nurses, health professionals from different specialties must work together, communicate often, and share resources. Health teams are often made up of a variety of professionals – called cadres in health care – each with specialized knowledge and responsible for different tasks. These multidisciplinary teams are made up to solve health problems. Successful health teams strive to understand the patient's situation, ask probing questions about the problem, make an initial assessment and, after discussion, provide a recommendation. Teams can also work together to develop health promotion for diverse communities and instill disease prevention behaviours amongst patients

Teamwork became an important health intervention for a number of reasons. First, clinical care is becoming more complex and specialized, forcing medical staffs to attempt complicated health services and quickly learn new methods. As Aging populations, the increase of chronic diseases like diabetes, cancer, and heart disease have forced medical staffs to take a multidisciplinary approach to health care.

Secondly, researchers have found that working together reduces the number of medical errors and increases patient safety. Teamwork also reduces issues that lead to burnout. No longer is one person responsible

for the patient's health; today, an entire team of health workers comes together to coordinate a patient's well-being. Health teams help break down hierarchy and centralized power of health organizations, giving more leverage to health workers.

Third, because teamwork is centered on solid communication, patients and their families sometimes feel more at ease and report they accept treatments and feel more satisfied with their health care. Health workers are also found to be more satisfied with their work. A study found nurses who go through successful team building efforts are more satisfied with their work.

Multidisciplinary care - when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organizational umbrella or by professionals from a range of organizations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.

A multidisciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care

- general practitioners;
- practice nurses;
- community health nurses;
- allied health professionals (may be a mix of government and non-government community health professionals) such as physiotherapists, occupational therapists, dieticians, psychologists, social workers, podiatrists and Aboriginal Health Workers;
- Health educators - such as diabetes educators - providing promotion and prevention clinics and other activities.

Multidisciplinary teams convey many benefits to both the patients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team members.

To ensure optimum functioning of the team and effective patient outcomes, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined.

This requires:

- respect and trust between team members;
- the best use of the skill mix within the team;
- agreed clinical governance structures;
- agreed systems and protocols for communication and interaction between team members.

These issues are complex and achievement of them can involve significant change to work practices and organisational arrangements, as well as multifaceted implementation strategies.

Examples of multidisciplinary teams

Community Mental Health Teams

The community mental health team (CMHT) is widely regarded as the model for all multi-disciplinary teams. Social workers and community

psychiatric nurses are the mainstay of CMHTs. Other professionals include occupational therapists, psychiatrists and psychologists.

Youth Offending Teams

These were set up after the Crime and Disorder Act 1998 and consist of social workers, probation officers, housing, employment and educational professionals. They are monitored by the Youth Justice Board.

Child and adolescent mental health services (CAMHS)

CAMHS are multidisciplinary teams working in a community mental health clinic or child psychiatry outpatient service. These provide a specialized service for children and young people with mental health disorders. Team members are likely to include child psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, and art, music and drama therapists.

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https://www.hrhresourcecenter.org/HRH_Info_Teamwork.html

Notes

4.6 Need, Importance and Principle

Multidisciplinary teams convey many benefits to both the patients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team members.

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. Multidisciplinary Teams may specialize in certain conditions, such as Cancer.

Multidisciplinary teams (MDTs) are promoted as a means to enable practitioners and other professionals in health and social care to collaborate successfully. Sufficient diversity of professions and disciplines, suitable leadership and team dynamics, and supportive organizations are important enablers.

These provide a specialized service for children and young people with mental health disorders. Team members are likely to include child psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, and art, music and drama therapists

Multidisciplinary care is an integrated team approach to healthcare. The evaluation of treatment options and treatment planning are collaborative processes involving medical and allied healthcare professionals in concentration with the patient and the patient's family.

Multidisciplinary teams convey many benefits to both the patients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team members.

The 'Principles of multidisciplinary care' provides a flexible definition of MDC, allowing for variation in implementation according to cancer type and the location of service provision. The principles are designed to be relevant for all cancers, across a range of health-care settings. A summary of the 'Principles of multidisciplinary care' include:

- A team approach, involving core disciplines integral to the provision of good care, including general practice, with input from other specialties as required
- Communication among team members regarding treatment planning
- Access to the full therapeutic range for all patients, regardless of geographical remoteness or size of institution
- Provision of care in accordance with nationally agreed standards
- Involvement of patients in decisions about their care.
-

4.7 Role of social worker as a member of the team

In an interdisciplinary team, specialist's work closely together sharing specialist knowledge across disciplines. Each professional takes responsibility for co-ordinating their information and intervention with that of other members of the team. These interdisciplinary solutions are felt to enhance and improve care.

Understanding the Role of a Social Worker.

Being a social worker is often a challenging, yet rewarding career. Social workers are responsible for helping individuals, families, and groups of people to cope with problems they're facing to improve their patients' lives.

Many social workers find that direct counselling of patients, families, and groups is only one aspect of their broader set of responsibilities. Social workers will often serve as liaisons between different institutions to assist patients and collaborate with other health professionals to ensure patient wellness. They will become familiar with, and refer clients to, community resources. Social workers address legal issues, such as assisting with hearings and providing testimony relating to their patients. They also engage in research, policy development and advocacy for services. And of course, social workers must maintain case history records and prepare reports. Social work can be the kind of job that requires a great deal of overtime, and separating the emotional aspects of the job from the duties required can be a difficult undertaking. But there are plenty of resources, including websites, books and social media users that can offer great advice.

4.8 Let us sum up

In the unit we learnt about the concepts of patient as a person, the concept of patient as a whole. Psychosomatic approaches related to patients were discussed. The need, importance, and principles of multidisciplinary team work and role of a social worker as a member of the team were learnt.

Notes

4.9 Unit end exercises

1. List out the main things to note for the psychosomatic approach
2. Why multidisciplinary team work is needed?
3. What is person centred model of health?
4. Describe the concept of patient as a whole
5. List out the role of social worker in multidisciplinary team

4.10 Answer to check your progress

1. The person-centered model of health care is used both for in and out patients, emergency care, palliative care as well as in rehabilitation.
2. Patients expressed concern about their ability to care for themselves after discharge.
3. Multidisciplinary teams have evolved at varying speeds in different parts over the past 30 years or so in response to imperatives of central government.

4.11 Suggested readings

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UNIT V - THE HOSPITAL AS A FORMAL ORGANIZATION

Structure

5.1 Introduction

5.2 Hospital as a formal organization

5.2.2 Its goals

5.2.3 Technology

5.2.4 Structure

5.2.5 Functions

5.2.6 Departments

5.2.7 Administrative procedures

5.3 Implications of hospitalization for the patient and his family

5.4 Let us sum up

5.5 Unit end exercises

5.6 Answer to check your progress

5.7 Suggested readings

5.1 Introduction

This unit gives the reader a complete understanding about the hospital as a formal organisation. It is said as a formal organisation because it has its objectives, structure and functions.

5.2.1 Hospital as a formal organization

Hospitals are usually funded by the public sector, health organisations (for profit or non-profit), health insurance companies, or charities, including direct charitable donations.

The main function of a hospital is to provide medical care to patients in need.

An acceptable health care delivery system should have two primary objectives:

(1) It must enable all citizens to obtain needed health care services

(2) The services must be cost effective and meet certain established standards of quality

Other objectives

- Increase the range of services wherever there are opportunities to meet an area of customer need and demand, on financially viable basis

- Provide a safe and therapeutic environment for all patient, staff and visitors

- Increase overall satisfaction rates of patients, employees and visiting medical officers

- Achieve financial and human resource key performance indicators
- Maintain clinical indicators below aggregate rate for peer hospitals

Hospitals have to function very precisely, executing high-quality services every hour of every day. Organizations that have this sort of requirement usually take on a vertical organizational structure – having many layers of management, with most of the organization's staff working in very specific, narrow, low-authority roles. The numerous layers of management are designed to make sure that no one person can throw the system off too much. This structure also ensures that tasks are being done exactly and correctly.

Boards of Directors

Hospitals are corporations and are therefore overseen by boards of directors. Non-profit hospitals have boards that often consist of influential members of health care and local communities. Many hospitals were founded by a religious group and maintain religious affiliation. These hospitals often include clergy and congregation leadership in their boards.

Educationally affiliated hospitals are often overseen by universities. Therefore, university boards of trustees or regents may double as the board of directors for a hospital. Multi-hospital systems, particularly for-profit ones, usually have one board of directors overseeing numerous facilities

Executives Oversee Day-to-Day Operations

Boards of directors leave it to their executives to see that their decisions are carried out and that the day-to-day operations of the hospital are performed successfully. The chief executive officer is the top boss responsible for everything that goes on in a hospital. However, hospitals usually have chief nursing officers, chief medical officers, chief information officers, chief financial officers and sometimes chief operating officers, who also carry a lot of weight. This group of top executives forms the central core management.

Hospital Department Administrators

The top managers of each hospital department report to the core management. These people are responsible for one type of medical or operational service. Most departments are areas of patient care such as orthopaedics, labour and delivery or the emergency department. There also are non-patient-care departments such as food services and billing. Clinical departments usually have large staffs, significant supply and purchasing needs and numerous regulations they must comply with. Therefore, administrators often have assistant administrators who help them oversee their multifaceted operations.

Patient Care Managers

Within a department, there are the people who directly oversee patient care. Nurse managers, directors of rehabilitation services and supervising physicians have people under them who give hands-on patient care. This level of management ensures that the staff members are acting appropriately, giving the best care, addressing all of their duties, complying with hospital and legal requirements and, for nurses and allied health care workers, following physician orders.

When something goes wrong with a patient or a clinician, these people handle the problem. They also usually oversee schedules and basic human resource functions for their employees.

Patient Service Providers

Most of a hospital is composed of service-providing staff. From nurses and physical therapists to line cooks and laundry workers, it takes a lot of hands-on staff to make everything happen. These people have very specific job descriptions and duties, which hospitals need them to perform very well to ensure the safety and health of patients.

Retrieved on 14/09/2019 from <https://www.southernhighlandsprivate.com.au/About-Us/Mission-Vision-and-Objectives>
(<https://smallbusiness.chron.com/organizational-structure-hospitals-3811.html>)

5.2.2 Its goals

- Practicing holistic medicine from the standpoint of the patients.
- Fostering the development of excellent medical human resources in order to constantly improve the future of medicine.
- Promoting advanced medical treatments that can then be disseminated worldwide.
- Contributing to the advancement of local health care and medicine.

Retrieved on 14/09/2019 from (<http://www.hosp.yamaguchi-u.ac.jp/en/introduction/missions.html>)

5.2.2 Technology

In order to meet the rising standards of competition and modernity — as well as governmental standards for some — here are 10 types of health technologies for hospitals and health systems to stay competitive in 2012 and beyond.

1. A certified, efficient EHR system. The one piece of health technology that has received more attention than any other over the past several years is the EHR. It's understandable, since the federal government is providing stimulus payments to hospitals and the ambulatory settings for providers implementing a certified EHR as quickly as possible. Eligible professionals that show meaningful use of an EHR by this year may receive the first of three reimbursement payments totalling \$44,000 total through 2014, but those incentive payments will turn into penalty payments as of 2015.

EHRs keep hospitals competitive for many reasons, especially as the healthcare industry places a bigger emphasis on preventive care and population health, says Linda Efferen, MD, chief medical officer at South Nassau Communities Hospital in Oceanside, N.Y. In fact, she thinks EHRs and the related information technologies are the "glue" for the future of healthcare. "[EHRs are] a platform for communication," Dr. Efferen adds. "As a patient moves from one location in the healthcare continuum to another, we have another way to track patient

information across the continuum of care."

Bob Hitchcock, MD, emergency department physician at Manatee Memorial Hospital and Lakewood Ranch Medical Center in Bradenton, Fla., adds that hospitals with certified, efficient EHRs are also doing themselves a favor in the recruitment of physicians. From his experience as an ED physician, hospitals that have simple, easy-to-use EHR systems are much more successful in their physician recruitment efforts. "We've seen, in recruitment efforts [of ED physicians], a dramatic increase of enlisting and promoting an EHR system at hospitals," Dr. Hitchcock says. "But it has to be the right EHR. Physicians are becoming very savvy. They will interact with that technology every day with every patient, and technology can be as big of a deterrent as it is an attraction."

2. Surgical and service line technologies. When it comes to surgical technologies within a hospital, the administration needs to work in conjunction with its physicians and nurses to determine the best strategy. It may be instinctive to purchase the latest and greatest technologies that hit the market, but surgical equipment has high upfront costs, so it must be properly utilized and have a productive reputation.

Dr. Efferen says surgery, overall, has nearly made the mass-scale shift to minimally invasive procedures, and the technological poster child for those types of surgeries has been the robotic surgical system, such as the da Vinci Surgical System. "Certainly, having the tools to provide top-level care to their patients is what attracts physicians to a given hospital," Dr. Efferen says. "The da Vinci Surgical System is one example. I think it has gained a place where it's essential for hospitals to have. As new graduates come out, they're being trained on it. If that level of sophistication in technology isn't there, they're not in the right positions to provide that standard of care."

Neurosurgery departments have also been at the forefront of new surgical technology as their volumes of cases trend upward. Mitesh Shah, MD, a neurosurgeon with Goodman Campbell Brain and Spine at Indiana University Health Methodist Hospital in Indianapolis, points to the intraoperative MRI scanner as an example.

The intraoperative MRI is unique because it is used during surgery to remove brain tumors. Specifically, the most common types of cases that use this technology are craniotomies for brain tumors, transsphenoidal surgeries of pituitary tumors and placement of deep brain stimulators for Parkinson's disease. "It gives surgeons a lot of confidence and supports their intuition," Dr. Shah says. "It's the sense that, 'I'm able to be more precise.'"

Dr. Shah says IU Health has averaged six specialty cases per month with the technology, but they get the most value out of it by also using it as a regular diagnostic apparatus. "The unit should be utilized as a diagnostic tool so during downtime, it's not just sitting empty," Dr. Shah says. "You must use it continuously so your return-on-investment is reasonable."

Dr. Efferen adds that other service line technologies — such as imaging devices for invasive cardiology procedures and non-invasive oncology platforms — could be considered to give physicians and patients more options for treatment. "It's about allowing physicians to provide choices

to their patients in terms of different ways to get the care they need," she says.

3. Smart phones, tablets and applications. Over the past several years, the omnipresence of smartphones, tablets and their applications has been one of the biggest cultural shifts in the hospital setting, as well as society at large. They provide a wealth of information for physicians and other clinicians — and all within a fingertip's reach.

"More importantly, we're seeing a variety of applications for these smartphones that will allow physicians more interaction in the patient care experience," Dr. Hitchcock says. There are several popular smartphone and tablet apps for physicians. The iPad, which has almost become a default tablet, has countless popular apps for physicians and executives, ranging from medical calculators and medical Spanish to clinical presentations and actual EHRs.

While some hospitals may not directly provide smartphones and tablets to their physicians and clinical staff, hospitals still have to be aware of them, especially in an age where patient privacy is of utmost importance. Hospitals should make sure that all staff smartphones and tablets have the proper security features; otherwise, they stand as another outlet for data breaches, which could do significant harm to patients and the hospital's reputation.

4. Hybrid operating rooms. While hybrid ORs may seem like a newer technology, the concept has actually been around for more than 20 years. In the early 1990s, Juan Parodi, MD, an internationally renowned vascular surgeon in both the United States and Argentina, pioneered the first endovascular abdominal aortic aneurysm procedure, which led to the eventual creation of hybrid ORs. Greg McIff, global director of strategic cardiovascular marketing for GE Healthcare, says hybrid ORs today now allow the best utilization of space and time for hospitals and their surgeons. "The hybrid OR is an environment that enables a surgeon or an interventional specialist to perform catheter-based minimally invasive interventions as well as open surgery," Mr. McIff says. "Initially, hybrid ORs utilized high-end mobile C-arms with vascular imaging capabilities to perform AAA and other complex endovascular procedures. Today, many university and research hospitals have upgraded existing hybrid ORs by replacing the mobile C-arm and installing a fixed C-arm, as procedure growth warranted."

Several hospitals have started to install hybrid ORs over the past couple months — Lourdes Hospital in Paducah, Ky., St. Dominic Hospital in Jackson, Miss., and St. Vincent's Medical Center in Bridgeport, Conn., to name a few — but there are several things a hospital must consider. Firstly, hybrid ORs can potentially cost several million dollars. Not all small community hospitals may be able to invest in a hybrid OR right away. Secondly, a hospital must make sure that before installing a hybrid OR, it will be utilized frequently and will not tie up OR time and space for only one specialty. Lastly, for community hospital just venturing into the hybrid OR space, a mobile hybrid OR solution can be a viable economic option until procedure volumes justify a fixed hybrid OR. "Most hospitals are going to need flexibility and need to be able to manage the space and environment appropriately for what they're doing," Mr. McIff says.

5. Telehealth tools. There are several necessary components for a viable telehealth infrastructure. Certainly, there needs to be the right connectivity and support from the government — especially in rural areas — but hospitals have to be willing to take on collaborative telehealth tools of their own, says Steve Nitenson, RN, PhD, senior solutions architect for Perficient and an adjunct professor at Golden Gate University in San Francisco

Bidirectional video feed, cameras, TVs and wireless infrastructure are some of the elements hospitals are adopting to remain competitive in the telehealth realm. The biggest advantage hospitals will gain from telehealth technologies are the ability to help patients immediately while trimming down the costs of an acute-care admission. "Physicians needing to discuss referrals or consultations in real-time want to bring up a Skype-way of communication," Dr. Nitenson says. "Being able to treat patients at home means being able to have collaborative tools in a real-time environment or near real-time."

Healthcare reform is also emphasizing taking care of patients outside of the more costly inpatient environment. Dr. Efferen says these patient-centered medical homes and the associated telehealth strategies should be short- and long-term goals for hospitals. "The goal, increasingly, is to be able to reach into the patient's home in the community and do home visits and some care that we've normally provided in the acute-care hospital setting," Dr. Efferen says.

6. Ultrasound imaging devices. Physicians, especially those within the ED, have become more adept at using ultrasound imaging devices over the past 10 years, Dr. Hitchcock says. "We're starting to see hospitals are concerned with what equipment they're using in the ED, like ultrasound," Dr. Hitchcock says. "When I was going through training, we were using what radiology was throwing away. Now, hospitals are realizing they can attract and retain the latest and greatest, and that's important from a physician satisfaction perspective."

7. Infection detecting technologies. A high-quality hospital infection control program keeps a hospital competitive on several fronts. First, it keeps the hospital compliant with all regulatory patient safety issues. Second, low rates of infection are able to be publicized to patients to tell them, "You will be safely treated at this hospital." Effective infection control hospital programs also have the right technology to detect if and when there is a problem.

An example of an infection detection technology is the procalcitonin, or PCT, test for a hospital's sepsis program. Assistant Professor of Clinical Medicine in the Department of Emergency Medicine at the University of California, San Diego Medical Center Sean-Xavier Neath, MD, says the PCT test has only been available in the United States within the past three to four years. Essentially, the test is a tool that detects sepsis earlier, therefore avoiding the overutilization of antibiotics.

While there are upfront costs for the PCT test, Dr. Neath says it is cost-effective over the long term because it will allow hospitals to diagnose and manage infections more successfully and reduce the hospital's need to pay for pricey antibiotics. "There are a number of elements to justify implementation of this test in hospital infection control programs," Dr. Neath says. "This [technology] looks at improving patient care with a

readily available blood test. More assertive hospitals, forward-thinking hospitals, have been rapid adopters of this."

8. Healthcare staffing management technology. Staffing and labor costs can consume more than 50 percent of expenses at most hospitals. In order to keep those costs in check, hospitals can implement staffing management technology to keep scheduling at an optimal state without sacrificing patient care.

AnuradeSilva, PhD, CEO of Care Systems, says staffing management systems need to be fused together with an initial assessment of patient staffing so hospitals are not over or understaffed. "Seamlessness between these two broad types of functionalities creates an environment to respond to patient care needs by adjusting staffing without resorting to expensive outside staff or excessive overtime," Dr. DeSilva says.

9. Social media. Social media technologies such as Facebook, Twitter, CaringBridge, podcasting, wikis, blogs and others are not new (Facebook has already been around for eight years), and the services are all extremely accessible. However, not all hospitals utilize the technology — or at least utilize it in a well-structured manner.

If hospitals want to communicate and reach the broadest patient population possible, they should instill a social media plan. The basics of any social media plan include assessing the hospital's readiness, experimenting with the different types of social media technologies and services, establishing a direction, creating dialogue and monitoring analytics to see how a hospital's presence is being received.

10. Patient-friendly technologies. At the end of the day, hospital reputation is a major factor with regard to patient volumes. Health IT, surgical technology and the like help to shape the reputation, but how a hospital accommodates its patients directly with technology is just as critical. "Competition for patients in many markets is fierce, so the smart hospital is the one that leverages IT that directly impacts the patient," says Vince Ciotti, a principal at health IT consulting firm H.I.S. Professionals.

Mr. Ciotti says there are eight patient-friendly technologies that could make a positive difference in a hospital's reputation, position and patient satisfaction scores:

- **Central scheduling:** Having a single number for patients to call in order to schedule appointments and tests simplifies an otherwise roundabout task. "Most hospitals fail to implement central scheduling because the various departments insist on keeping their own schedules that they control for various reasons," Mr. Ciotti says. "Make it easy for [patients], and they will come."
- **Speech-assisted automated attendant systems:** Hospitals can stay competitive and also save money with a voice recognition phone system. The systems could reduce staff overtime and helps to avoid dropped calls or unpleasant patient interactions.
- **Master Patient Index:** MPI is a database that keeps a unique identifier for each patient. Patients can approach a registration window, show ID and skip the wave of forms because their information is in a HIPAA-compliant index.
- **Self-register kiosks:** Similar to self check-in stations at an airport,

self-register kiosks can be positioned in admitting, ER and outpatient registration areas that are secured, and patients can verify their identities or update their information.

- **Wireless connectivity:** Physicians, clinicians and other staff members are not the only people in a hospital who live on their mobile devices and smartphones. Similar to restaurant chains, hospitals should offer a friendly WiFi connection to make it easy for patients and visitors to access the wireless network.
- **Bedside computer terminals:** Bedside computer terminals allow patients to see the processes happening around them while still enabling physicians and nurses to update patient records efficiently.
- **Bedside medication verification:** A BMV system adds another layer of patient safety to a hospital's technology strategy. A nurse can scan a patient's badge with BMV, which confirms the patient is receiving his or her correct medication, and the patient sees it every day.
- **Online bill pay:** Patients are able to pay their phone, cable, utility and other service bills online. Hospitals that offer the same ability can stay competitive, and Mr. Ciotti says it could even improve the hospital's accounts receivable.

Retrieved on 14/09/2019 from (<https://www.beckershospitalreview.com/healthcare-information-technology/10-technologies-to-keep-hospitals-competitive.html>)

5.2.3 Structure

Organizational Structure

Organizational Structure refers to levels of management within a hospital. Levels allow efficient management of hospital departments. The structure helps one understand the hospital's chain of command. Organizational structure varies from hospital to hospital. Large hospitals have complex organizational structures. Smaller hospitals tend to have much simpler organizational structures.

Grouping of Hospital Departments

Hospital departments are grouped in order to promote efficiency of facility. Grouping is generally done according to similarity of duties.

Common Categorical Grouping:

Administrative Services Informational Services Therapeutic Services Diagnostic Services Support Services

Administrative Services

Hospital Administrators CEO, Vice President(s), Executive Assistants, Department Heads. Business people who "run the hospital". Oversee budgeting and finance. Establish hospital policies and procedures. Often perform public relation duties.

Informational Services

Document and process information, includes: Admissions Billing & Collection Medical Records Computer Information Systems Health Education Human Resources

Therapeutic Services Provides treatment to patients; includes following departments: Physical Therapy - treatment to improve large muscle mobility. Occupational Therapy - treatment goal is to help patient regain fine motor skills. Speech/Language Pathology - identify, evaluate, treat

speech/language disorders. Respiratory Therapy - treat patients with heart & lung disease. Medical Psychology - concerned with mental well-being of patients.

Therapeutic Services Social Services - connect patients with community resources (financial aid, etc.). Pharmacy - dispense medications. Dietary - maintain nutritionally sound diets for patients. Sports Medicine - provide rehabilitative services to athletes. Nursing - provide care for patients.

Diagnostic Services Determines the cause(s) of illness or injury, includes: Medical Laboratory - studies body tissues. Medical Imaging - radiology, MRI, CT, Ultra Sound. Emergency Medicine - provides emergency diagnoses & treatment.

Support Services Provides support for entire hospital, includes:

Central Supply - orders, receives, stocks & distributes equipment & supplies. Biomedical Technology - design, build repair, medical equipment. Housekeeping & Maintenance - maintain safe, clean environment.

Traditional Organizational Chart

Board Administration Information Services Therapeutic Services Diagnostic Services Support Services Admissions Billing, etc. Med. Records Computer Info. Health Ed. Human Resources. PT, OT Speech/Lang. Resp. Therapy Pharmacy Nursing Dietary Med. Lab Radiology Nuclear Med ER Cardiology Neurology Central Supply Biomedical Housekeeping Maintenance Dietary Transportation

Pyramid organizational structure

Board Administration Services, Information Services, Therapeutic Services, Diagnostic Services Support Services,

Board

All hospitals include some form of governing body opens in new window responsible for making high-level decisions about the organization. A hospital's board of directors is often drawn from the healthcare community and is made up of experts in their respective fields. Religiously affiliated hospitals often include clergy on their boards of directors. Teaching hospitals often include university faculty from the medical school with which they're affiliated.

Executives

Hospital executives are responsible for managing the organization, making financial decisions and overseeing business strategy. Medical and health services managers may oversee entire practices or clinical areas open in new window. A hospital typically has a chief financial officer who tends to the financial health of the business opens in new window and a chief operating officer or chief executive officer responsible for high-level business strategy and decision-making opens in new window.

Department Administrators

Department administrators report to the hospital executives and manage the day-to-day operations of specific departments within a hospital. The chief of surgery, for example, is responsible for overseeing daily activities within the surgical department as well as performing surgery. A chief of surgery might engage in public relations activities, fundraising and recruitment. A non-medical department within a

hospital opens in new window, such as food services or switchboard personnel, also have department administrators.

Patient Care Managers

Nurse Managers and supervising physicians are both patient care managers. These individuals manage small groups of professionals who provide direct patient care. They ensure that orders are carried out, that hospital employees are fulfilling their duties appropriately and that employees are complying with legal requirements.

Service Providers

The vast majority of hospital workers are service providers: doctors, nurses, orderlies, physical therapists, laundry workers and the many other people required in order for a hospital to function. They provide patient care, maintain records and ensure that the hospital is able to deliver care to patients in an effective manner.

Retrieved on 14/09/2019 from (<https://online.rivier.edu/program-resources/hospital-organizational-structure/>)

5.2.5 Functions

Hospital administration functions can be classified into three broad categories:

1. Medical - which involves the treatment and management of patients through the staff of physicians?
2. Patient Support - which relates directly to patient care and includes nursing, dietary diagnostic, therapy, pharmacy and laboratory services?
3. Administrative - which concerns the execution of policies and directions of the hospital governing discharge of support services in the area of finance, personnel, materials and property, housekeeping, laundry, security, transport, engineering and board and the maintenance.

Major functions of the administrative service

1. Provide service related to accounting, billing, budget, cashiering, housekeeping, laundry, personnel, property and supply, security, transport, engineering, and maintenance; and
2. Render support services to hospital care providers, clients, other government, and private agencies, and professional groups.

Responsibilities

1. To plan, direct and coordinate financial operations of the hospital;
2. To prepare work and financial plan and provide fund estimates for programs and projects;
3. To manage the receipt and disbursement of cash/ collections;
4. To administer personnel development programs, policies and standards;
5. To give advice on matters affecting policies, enforcement and administration of laws, rules and regulations;
6. To procure, store, manage and issue the inventory and disposal of unserviceable hospital equipment and materials; and
7. To provide general services such as repairs and maintenance, housekeeping, laundry, transport and security.

Functions of different departments under the administrative service

Administrative office – Directs and supervises the activities and functions of administrative units to effectively deliver quality support services.

1. Personnel section - Development and administration of a comprehensive manpower development program which includes recruitment and

selection, promotion, training, employee welfare and benefits, manpower planning and research.

2. Property and supply section - Procurement, storage, inventory, distribution and disposition of hospital supplies, materials, and equipment.

Retrieved on 14/09/2019 from <https://www.scribd.com/doc/50492666/FUNCTIONS-OF-THE-HOSPITAL>

5.2.6 Departments

These include mechanical maintenance, medical equipment maintenance, housekeeping, food service, building and grounds maintenance, laundry, and administrative staff.

Hospitals vary widely in the services they offer and therefore, in the departments they have. Hospitals may have acute services such as an emergency department or specialist trauma center, burn unit, surgery, or urgent care. These may then be backed up by more specialist units such as cardiology or coronary care unit, intensive care unit, neurology, cancer center, and obstetrics and gynecology.

Some hospitals will also have outpatient departments and whilst others may have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services (Rehab), and physical therapy.

Common hospital support units include a dispensary or pharmacy, pathology, and radiology, and on the non-medical side, there often are medical records departments and/or a release of information department. Nursing services are considered one of the most important aspects in the process of distinguished medical care.

Accident and emergency: Also called Casualty Department, where you are likely to be taken if you have arrived in an ambulance or emergency situation.

Admissions: At the Admitting Department, the patient will be required to provide personal information and sign consent forms before being taken to the hospital unit or ward. If the individual is critically ill, then, this information is usually obtained from a family member.

Anaesthetics: Doctors in this department give anaesthetic for operations and procedures. An anaesthetic is a drug or agent that produces a complete or partial loss of feeling. There are three kinds of anaesthetic: general, regional and local.

Breast Screening: Screens women for breast cancer and is usually linked to the X-ray or radiology department.

Burn Center (Burn Unit or Burns Unit): A hospital specializing in the treatment of burns.

Burn centers are often used for the treatment and recovery of patients with more severe burns.

Cardiology: Provides medical care to patients who have problems with their heart or circulation.

Central Sterile Services Department (CSSD): (Sterile Processing Department (SPD) - Sterile

Processing - Central Supply Department (CSD) - Central Supply) - A place in hospitals and other health care facilities that performs

sterilization and other actions on medical equipment, devices, and consumables.

Chaplaincy: Chaplains promote the spiritual and pastoral wellbeing of patients, relative's and staff.

Coronary Care Unit (CCU): (Cardiac intensive care unit (CICU) - A hospital ward specialized in the care of patients with heart attacks, unstable angina, cardiac dysrhythmia and other cardiac conditions that require continuous monitoring and treatment.

Critical Care: Also called intensive care, this department is for seriously ill patients.

Diagnostic Imaging: Also known as X-Ray Department and/or Radiology Department.

Discharge Lounge: Patients who don't need to stay in a ward are transferred to the lounge on the day of discharge. Many hospitals now have discharge lounges with facilities such as TV, radio, puzzles, magazines, books and newspapers.

Elderly services: Covers and assists with a wide range of issues associated with seniors.

Finance Department: Performs all works related to budget and ideal use of the items of such budget. Also, it prepares payrolls and monthly wages, and concludes contracts of operation and maintenance and purchases. In addition, it makes available all amounts of money required for procurement of all materials and equipment.

Gastroenterology: This department investigates and treats digestive and upper and lower Gastrointestinal diseases.

General Services: Support Services include services provided by Departments such as Porterage, Catering, Housekeeping, Security, Health & Safety, Switch, Laundry and the management of facilities such as parking, baby tagging, access control, CCTV etc.

General Surgery: Covers a wide range of types of surgery and procedures on patients.

Gynecology: Investigates and treats problems relating to the female urinary tract and reproductive organs, such as Endometriosis, infertility and incontinence.

Haematology: These hospital services work with the laboratory. In addition doctors' treat blood diseases and malignancies related to the blood.

Health & Safety: The role of the occupational health and safety department is to promote and maintain the highest possible degree of health and safety for all employees, physicians, volunteers, students and contractors, and actively participates in quality, safety and risk initiatives. Numerous health and safety issues associated with healthcare facilities include blood-borne pathogens and biological hazards, potential chemical and drug exposures, waste anaesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, hazards associated with laboratories, and radioactive material and x-ray hazards. In addition to the medical staff, large healthcare facilities employ a wide variety of trades that have health and safety hazards associated with them. These include mechanical maintenance, medical equipment maintenance, and

housekeeping, food service, building and grounds maintenance, laundry, and administrative staff.

Intensive Care Unit (ICU): (Intensive Therapy Unit, Intensive Treatment Unit (ITU), Critical

Care Unit (CCU) - A special department of a hospital or health care facility that provides intensive treatment medicine and caters to patients with severe and life-threatening illnesses and injuries, which require constant, close monitoring and support from specialist equipment and medications.

Human Resources: Role is to provide a professional, efficient and customer focused service to managers and staff and in turn facilitates the delivery of a professional, efficient and customer focused service to patients.

Infection Control: Primarily responsible for conducting surveillance of hospital-acquired infections and investigating and controlling outbreaks or infection clusters among patients and health care personnel. The department calculates rates of hospital-acquired infections, collates antibiotic susceptibility data, performs analysis of aggregated infection data and provides comparative data to national benchmarks over time.

Information Management: Meaningful information can be used in quality management, continuous quality improvement and peer review. By improving the quality of information, core data can be provided for randomized clinical trials, outcomes research and many studies.

Maternity: Maternity wards provide antenatal care, delivery of babies and care during childbirth, and postnatal support.

Medical Records: Includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc.

Microbiology: The microbiology department provides an extensive clinical service, including mycology, parasitology, mycobacteriology, a high security pathology unit, and a health care associated infection investigation unit, as well as routine bacteriology and an expanding molecular diagnostic repertoire.

Neonatal: Closely linked with the hospital maternity department, provides care and support for babies and their families.

Nephrology: Monitors and assesses patients with various kidney (renal) problems and conditions.

Neurology: A medical specialty dealing with disorders of the nervous system. Specifically, it deals with the diagnosis and treatment of all categories of disease involving the central, peripheral, and autonomic nervous systems, including their coverings, blood vessels, and effector tissue, such as muscle. Includes the brain, spinal cord, and spinal cord injuries (SCI).

Nutrition and Dietetics: Dietitians and nutritionists provide specialist advice on diet for hospital wards and outpatient clinics.

Obstetrics/Gynecology: Specialist nurses, midwives and imaging technicians providematernity services such as: antenatal and postnatal care, maternal and foetal surveillance, andprenatal diagnosis.

Occupational Therapy: Helps physically or mentally impaired people, including temporarydisability, practices in the fields of both healthcare as well as social care. Occupational Therapy promotes health by enabling people to perform meaningfuland purposeful occupations. These include (but are not limited to) work, leisure, self-care,domestic and community activities. Occupational therapists work with individuals, families,groups and communities to facilitate health and well-being through engagement or re-engagement in occupation.

Oncology: A branch of medicine that deals with cancer and tumours. A medical professionalwho practices oncology is an oncologist. The Oncology department provides treatments,including radiotherapy and chemotherapy, for cancerous tumours and blood disorders.Ophthalmology: Ophthalmology is a branch of medicine which deals with the diseases andsurgery of the visual pathways, including the eye, hairs, and areas surrounding the eye, suchas the lacrimal system and eyelids. The term ophthalmologist is an eye specialist for medicaland surgical problems. The Ophthalmology department provides a range of ophthalmic eyerelated services for both in and outpatients.

Orthopaedics: Treats conditions related to the musculoskeletal system, including joints,ligaments, bones, muscles, tendons and nerves.

Otolaryngology (Ear, Nose, and Throat): The ENT Department provide comprehensive andspecialized care covering both Medical and Surgical conditions related not just specifically tothe Ear, Nose and Throat, but also other areas within the Head and Neck region. It is oftendivided into sub-specialties dealing with only one part of the traditional specialty (ontology,rhinology and laryngology).

Pain Management: Helps treat patients with severe long-term pain. Alternative pain relief treatments such as acupuncture, nerve blocks and drug treatment, are also catered for.

Patient Accounts: The Patient Accounts Department answers all billing questions andconcerns, requests for itemized bills, and account balance inquiries. The patient accountsdepartment also assists patients in their insurance benefits for services rendered.

Patient Services: The Patient Services Manager is a source of information and can channelpatient queries in relation to hospital services to the appropriate departments.

Pharmacy: Responsible for drugs in a hospital, including purchasing, supply and distribution.

Physiotherapy: Physiotherapists work through physical therapies such as exercise, massage, and manipulation of bones, joints and muscle tissues.

Purchasing & Supplies: Purchasing & Supplies Department is responsible for theprocurement function of the hospital.

Radiology: The branch or specialty of medicine that deals with the study and application ofimaging technology like x-ray and radiation to diagnosing and treating disease. TheDepartment of Radiology is a highly specialized, full-service department which strives tomeet all

patient and clinician needs in diagnostic imaging and image-guided therapies.

Radiotherapy: Also called radiation therapy, is the treatment of cancer and other diseases with ionizing radiation.

Renal: Provides facilities for peritoneal dialysis and helps facilitate home Haemodialysis.

Rheumatology: Rheumatologists care for and treat patients for musculoskeletal disorders such as: bones, joints, ligaments, tendons, muscles and nerves.

Sexual Health: Also known as genitourinary medicine - Provides advice, testing and treatment for sexually transmitted infections, family planning care, pregnancy testing and advice, care and support for sexual and genital problems.

Social Work: Clinical social workers help patients and their families deal with the broad range of psychosocial issues and stresses related to coping with illness and maintaining health. Social workers, resource specialists and advocates form a network that addresses the challenges families face, increases accessibility to health care and other human services, and serves as a bridge between the hospital setting and a patient's family life, home and community.

Urology: The urology department is run by consultant urology surgeons and investigates areas linked to kidney and bladder conditions.

Retrieved on 14/09/2019 from <https://www.disabledworld.com/definitions/hospital-departments.php>

5.2.7 Administrative procedures

Errors have a tendency to compound themselves, so it is worth taking the time to ensure that essential tasks are carried out carefully. Many complaints arise from simple mistakes that could have been easily avoided. The most common administrative failures are:

- Failure to pass on important information
- Failure to arrange appointments, investigations or referrals with the appropriate degree of urgency
- Failure to review the results of investigations
- Failure to arrange follow-up and monitoring
- Mislabelling, misfiling and failure to check labels

Follow appropriate systems

Every hospital should have policies and procedures in place for checking medications, identifying the site of an operation, counting swabs and instruments, and so on. Even so, there are numerous incidents, complaints and negligence claims to show that these checks are far from fool proof; if you place too much trust in them, you may easily become complacent and assume that they have been carried out competently.

- Before carrying out a procedure, always check the patient's identity and look at the case notes and relevant images to establish the nature and site of the procedure, even if someone else has already prepared or marked the site.
- Familiarize yourself with your hospital's policy on ordering and administering blood products.

- Make sure that any specimens and accompanying forms or reports are accurately and fully labelled.
- See that all hazardous substances and waste are labelled with appropriate warnings.
- Be aware of health and safety legislation as it applies to your day-to-day work, eg, disposal of sharps, etc.
- No-one is perfect, so clinicians will occasionally overlook, forget, or not be aware of crucial information that has an important bearing on a patient's wellbeing. Patients therefore have an important role to play in the information system. If they are kept well informed and are encouraged to voice their concerns, they can act as a vital failsafe in the information system.
- Patients usually know what they're in hospital for; they know their medical history, they're usually familiar with their medication, they have their own welfare high on their agendas, and they rarely mistake themselves for another patient. It therefore makes good sense to stop and listen to them if they express concern about an intended procedure or treatment.

Adverse incident reporting system

What do you do if something goes wrong, or you have a close call? Do you think about reporting the incident? If not, you should do. All healthcare facilities covered by the Clinical Indemnity Scheme (CIS) are required to report all adverse incidents to the State Claims Agency. You should, therefore, notify the hospital's Quality and Risk Department or its equivalent as soon as possible after an adverse event.

The CIS defines a reportable incident as "any patient safety incident directly related to service user treatment or care which did or could have resulted in an adverse outcome".

The CIS uses the information for two purposes:

1. To improve patient safety by identifying high risk areas of practice;
2. To prepare for any claims that may arise from the incident.

Retrieved on 14/09/2019 from (<https://www.medicalprotection.org/ireland/booklets/avoiding-problems-managing-the-risks-in-hospital-practice/administrative-procedures>)

5.3 Implications of hospitalization for the patient and his family

Hospitalization, especially for chronic diseases, can have a number of varied effects upon a patient and his or her family members. A number of personal and other problems related to hospitalization are listed. Noted by 84% of hospitalized patients, financial difficulties comprised by far the most often noted problem.

The family role during patient's hospitalization

Family has been already described as an integral system. So, illness of a member can threaten the system. The result of threat of this system can include fear, distress, feeling of weakness, and lack of hope, which can lead to physical and emotional exhaustion.

Top Hospital Quality Problems

- Financial issues.

- Government mandates.
- Patient safety and quality care.
- Staffing concerns.
- Patient satisfaction.
- Access to care.
- Doctor-related issues.
- Population health management.

Retrieved on 14/09/2019 from

5.4 Let us sum up

In this unit you got ideas on hospitals. The goals, technology, structure, and function, departments, administrative procedures, implications of hospitalization for the patient and his family were discussed.

5.5 Unit end exercises

1. How will be the administrative structure of a hospital will be?
2. Discuss the implications of hospitalization for the patient and his family.
3. What is mean by clinical departments?
4. Why departments are needed in hospitals?

5.6 Answer to check your progress

1. Clinical departments usually have large staffs, significant supply and purchasing needs and numerous regulations they must comply with.
2. Occupational Therapy promotes health by enabling people to perform meaningful and purposeful occupations.
3. Organizational Structure refers to levels of management within a hospital. Levels allow efficient management of hospital departments.
4. The structure helps one understand the hospital's chain of command.

5.7 Suggested readings

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Notes

UNIT VI - MEDICAL SOCIAL WORK DEPARTMENT

Structure

- 6.1 Introduction
- 6.2 Medical Social Work Department
- 6.3 Staffing
- 6.4 Organizations and functions
- 6.5 Extension services
- 6.6 Public relations
- 6.7 Let us sum up
- 6.8 Unit end exercises
- 6.9 Answer to check your progress
- 6.10 Suggested readings

6.1 Introduction

This unit gives the reader an understanding about the medical social work department in the hospital which is most often considered insignificant in the Indian Scenario. This department has its own pattern of staffing, functions, and outreach services to be done. This department is the back bone of the whole hospital for its public relations and extensions services.

6.2 Medical Social Work Department

Services

The department provides a range of supportive services to patients, families and those affected by illness and hospitalization. Services include:

- Counselling relating to illness and its impact on their family. Issues regarding discharge from hospital and after-care are also addressed by the Medical Social Worker.
- S/he may help you access services such as further rehabilitation, community supports, respite care, convalescence and long-stay nursing homes.
- Information on welfare entitlements may also be obtained from the medical social work department.
- The department also offers bereavement support and crisis help following traumatic events.
- Liaison with statutory and voluntary groups is also an integral part of our work. There are many support groups to which patients and families can be referred outside the hospital.

Each medical social worker provides a service to one or more hospital consultant.

Psychosocial Assessment

Psychosocial Assessment is used to help determine whether people are experiencing difficulties as a result of illness or admission to hospital. A Psychosocial Assessment includes assessment of patient's social, emotional and environmental circumstances. It enables the Medical Social Worker to assess the impact of illness on a patient or his/her family and plan appropriate supports.

Patient/ Family Support

This refers to interventions by the Medical Social Worker which provide patients and families with general psychosocial and practical support at times of ongoing stress related to illness and hospitalization.

Crisis Intervention

This service can include practical or counselling interventions offered to patients and families at the time of an acute crisis, such as sudden death, admission to Intensive Care, admission following an accident or assault.

Counselling

This is a therapeutic process between a patient or family member and the Medical Social Worker, focusing on adjustment and coping strategies in relation to life crises such as serious illness/trauma or bereavement.

Discharge Planning

This begins at the point of admission. Its purpose is to assess the psychosocial and environmental factors, which can impinge upon the patient's transition from hospital back to their community setting.

Bereavement Service

In addition to bereavement counselling provided by individual social workers, the Social Work Department co-ordinates a parent's bereavement support day, the remembrance service for children who have died in the hospital, and an annual bereavement support programme incorporating a group process.

Retrieved on 25/09/2019 from
(<http://www.beaumont.ie/index.jsp?p=105&n=359>)

Notes

6.3 Staffing

Many healthcare professionals care for you as part of a team when you are hospitalized. A nurse cares for you 24 hours a day, seven days a week and partners with many other healthcare professionals - including your doctor - to meet your varying care needs. On staffing plans, "Direct Caregivers" may include nursing aides, assistants and respiratory therapists, among others. Team members listed in the "Additional Care Team Members" section, such as clinical pharmacists, nutritionists, Intravenous (IV) Therapy Teams and Staff Educators also help coordinate and deliver your care.

There are many variables to consider in terms of what constitutes safe, efficient staffing for a particular hospital unit. Every patient care unit is different based upon the types of patients cared for on that unit, and the way in which care is organized and delivered there; Staffing for

individual units can vary based on the education and experience level of the staff, support from nurse educators and nurse managers on a given unit, as well as on the unique characteristics and mission of the hospital. It is also important to look at hospitals' patient outcomes such as fall rates and pressure ulcer prevalence and Hospital Compare measures - including Heart Attack care and readmission, Heart Failure care and readmission, Pneumonia care and readmission, surgical care, Stroke care and Blood Clot care - in the Performance Measures section of PatientCareLink (PCL).

Know your care team members

First and foremost, each patient has a nurse assigned to him or her at all times - 24 hours a day, seven days a week. This "primary nurse" works closely with your doctor to oversee and coordinate your care. Even when your nurse is on break, there is a nurse assigned to be responsible for your safe care. The nurse develops a plan for each of his or her patients and leads a team that helps with your care. Below is a list of the other professionals who may help your nurse and doctor care for you based on your individual needs. Any questions about your care should be directed to your primary nurse or to the nurse manager.

Nurses

Your assigned nurse (primary nurse) will be most involved in your day-to-day care and oversee all aspects of your stay. There are various kinds of nurses, all of whom are licensed professionals with different levels of training and specialization. These include LPNs with nursing diplomas and RNs with associate degrees, bachelor's degrees and master's degrees. Your nurse may call on other staff nurses to help with your care, including evaluations or treatments.

Nurse Manager

The nurse manager oversees all the care on a particular unit. The nurse taking care of you is supported by the nurse manager.

Staff Educator

These nurses serve as educational resources to staff, giving them the latest information about medication, treatments or technology.

Clinical Nurse Specialist (CNS)

Clinical nurse specialists have master's degrees in a specialty and provide teaching and support to patients in their particular area of knowledge.

Nurse Practitioner (NP)

A nurse practitioner is a registered nurse who has completed additional courses and specialized training. They can diagnose and treat illnesses in their specialty. Some nurse practitioners can prescribe medications. They work under the supervision of a physician.

Additional care team members

Nurses aren't the only professionals caring for you. Here are examples of some of the others who may be part of your care team:

Physician

Your own medical doctor may be taking care of you while you are in the hospital, or may have a hospitalist, a surgeon or a specialist manage your hospital care.

Physician Assistant (PA)

PAs provide diagnostic, therapeutic, and preventive healthcare services, with supervision from physicians. They should not be confused with medical assistants, who perform routine clinical and clerical tasks.

Hospitalist

Hospitalists are doctors who specialize in caring for hospitalized patients. They can focus all their attention on caring for patients inside the hospital, including coordinating and consulting with your other doctors, and keeping you and your family informed

Intern/Resident

Medical school graduate doctors who are gaining supervised practical or specialized experience in a hospital setting may be part of your care team.

Clinical Pharmacist

A clinical pharmacist participates directly with the healthcare team and influences the quality and safety of medication use in a variety of ways. These may include: making rounds on the patient units, reviewing medication orders for safety, providing recommendations, consulting on patient discharge medications and educating patients.

Intensivist/Neonatologist

These specialized doctors are located in the critical care units to support and direct the care of critically ill adults and new-borns.

Therapists

Physical Therapists (PT)

Spend their time focusing on the large motor groups that contribute to walking, reaching, standing and physical activities.

Physical Therapist Assistant (PTA)

PTAs work under the direction and supervision of physical therapists. They help patients who are recovering from injuries and illnesses regain movement and manage pain

Occupational Therapists (OT)

Offer skilled treatment to help individuals achieve independence in all facets of their lives.

Occupational Therapy Assistants (COTA)

COTAs help patients develop, recover, and improve the skills needed for daily living and working. Occupational therapy assistants are directly involved in providing therapy to patients, while occupational therapy aides typically perform support activities. Both assistants and aides work under the direction of occupational therapists.

Speech-Language Pathologists or Speech Therapists (ST)

Speech-Language Pathologists assess, diagnose, treat, and help to prevent communication and swallowing disorders in patients. Speech, language, and swallowing disorders result from a variety of causes, such as a stroke, brain injury, hearing loss, developmental delay, a cleft palate, cerebral palsy, or emotional problems.

Respiratory Therapist (RT)

These individuals perform testing and provide respiratory treatments to diagnose and manage the care of patients with lung and breathing problems. They also monitor and maintain respiratory equipment, and provide patient education.

Intravenous (IV) Therapy Team/Line Access

This team is available to put in IV lines and to troubleshoot IV placement issues.

Recreation/Milieu Therapist (MT)

Recreation/milieu therapists provide planned activities that support patient care on hospital units--most often in psychiatric settings.

Others

Rapid Response Team (RRT)

In some hospitals, Rapid Response Team clinicians provide critical care expertise and respond to a patient's bedside to assist with a serious change in a patient's condition and if appropriate, a change in treatment. All hospitals have some method of rapid response.

Mental Health Counselor (MHC)

Participates as a member of the patient care team in the formulation and implementation of patient care plans including assessment of the patient's mental status and emotional condition, as well as patient behavioral management needs.

Dietitian - Registered (RD)

A registered dietitian (RD) is a food and nutrition expert who provides dietary support, counseling and/or education to patients, family and/or nurses to ensure appropriate nutritional care.

Licensed Social Services / Case Management Workers

This staffs are healthcare professionals who help patients deal with crises, cope with their illness, solve problems, and enhance communication with members of the healthcare team and access hospital and community services.

Patient Transport Team

These staff members take patients and their equipment to and from tests, procedures and appointments within the hospital.

Unlicensed Assistive Personnel (UAP)

Includes nursing assistants, orderlies, patient care technicians / assistants, and graduate nurses not yet licensed who have completed unit orientation.

Patient Observer

A patient observer is like a sitter and maintains constant watch over a single patient for safety reasons.

Retrieved on 25/09/2019 from(<https://patientcarelink.org/healthcare-provider-data/hospital-data/staffing-plans-reports/>)

6.4 Organizations and functions

They play an essential role in many of the non-medical aspects of patient care, including helping patients and their families navigate the medical system, assessing and monitoring patients' and family members' mental and emotional health, providing short term counselling and therapy, and communicating patient needs.

Medical social workers work in hospitals, community clinics, and other healthcare settings to support patients and their families, and to assist the larger medical team in the coordination of patients' care. They play an essential role in many of the non-medical aspects of patient care, including helping patients and their families navigate the medical

system, assessing and monitoring patients' and family members' mental and emotional health, providing short term counselling and therapy, and communicating patient needs and concerns to the larger medical team.

Medical social workers work closely with patients and family members who are experiencing mental, emotional, family, and/or financial stressors due to their or their loved one's medical condition. Because of the type of challenges they encounter and the fast pace of medical settings, medical social workers may find this field to be stressful and demanding. However, many medical social workers refer to the relationships they build with patients, families, and the medical team combined with the knowledge that they are helping individuals, as reasons that they entered and have stayed in the field.

Types of Medical Social Workers

Inpatient Medical Social Workers

Social workers who are employed at hospitals and medical centers, providing specialized social services to patients suffering from chronic and/or acute health conditions that require hospitalization are known as inpatient medical social workers. While some inpatient medical social workers stay within one specific medical unit or department, many spread their time across several units.

Outpatient Medical Social Workers

Outpatient medical social workers work with patients who either do not need hospitalization but still require medical care and guidance, or who are transitioning from hospital care to outpatient care or their home. Oftentimes, these patients grapple with very similar challenges that hospitalized patients do, and therefore require similar services such resource navigation guidance, counselling, and care coordination.

Public Health Educators and Advocates

Medical social workers can also work for public health programs that provide education, guidance, advocacy, and resources to patients suffering from chronic conditions. Alexa Silva, MSW, works for the Alameda County Public Health Department's Asthma Start Program as an Asthma Coordinator. In her role, she provides education to children who have asthma and their families regarding how to detect, medicate, and manage this condition.

What Medical Social Workers Do?

- Performing evaluations on mental and emotional health
- Assessing social, family and/or financial circumstances
- Communicating patient information to various stakeholders in patient's health team
- Providing counselling or psychotherapy to patients and families
- Maintaining confidential patient records
- Connecting patients and families with outside medical and non-medical resources
- Coordination of patient care in collaboration with health team stakeholders

6.5 Extension services

Extension services are the integral part of Medical social Work department. Through extension services they carry out many outreach

programmes in the communities based on their needs. They do medical camps, awareness programme and educate the people in the community

6.6 Public relations

Public relations are the management function which evaluates public attitudes, identifies attitudes and procedures of an Individual and organization with the public interest, and executes programs of action to carry public understanding and acceptance (Scott, 1965).

With the healthcare industry constantly evolving, public relations (PR) are proving to be needed more now than it ever has done. This work is done by the Medical social work Department. It establishes good relationship with various organizations in the society. They should have good public relations and it helps them to do the referral services.

Need for Public Relations

1. It has been estimated that eighty per cent of the problems confronting management have public relations implications.
2. Hospitals cannot serve in isolation and hence it need to assist the society and to gear itself to meet the expectations of the society to give them fullest satisfaction.
3. Good services coupled with sound working practices and fair treatment of employees and medical staff is not enough unless a sound program of public relations is developed and practiced.

<http://www.sesric.org/imgs/news/image/873-presentation-5-1.pdf>

How to Improve PR in hospital?

1. High quality of patient care will ensure simultaneously good public relations---It is a sine qua non (indispensable and essential action, condition, or ingredient).
2. All courtesies must be extended to the patients projecting a good image of the hospital.
3. Receptionist should be available on the right time.
4. Telephone operators should answer calls promptly and politely and promptly respond to the queries of the caller.
5. Environmental sanitation, cleanliness and physical comforts provided to patients create good impression. Well-kept lawns, good surroundings create good impression.
6. Reception, Enquiry and Admission Office should be established as one single unit. The staff for such places should be specially selected

6.7 Let us sum up

In this unit you gained knowledge about the medical social work departments, staffing, organizations and functions; extension services and public relations. This knowledge will help you when u accommodate in a institution.

6.8 Unit end exercises

1. Explain why staffing is important to departments.
2. How a medical social work department works

3. What is an organisation and what all the functions includes in it
4. Describe extension services
5. Define public relations

6.9 Answer to check your progress

Notes

1. A Psychosocial Assessment includes assessment of patient's social, emotional and environmental circumstances. It enables the Medical Social Worker to assess the impact of illness on a patient or his/her family and plan appropriate supports.
2. Occupational therapy assistants are directly involved in providing therapy to patients, while occupational therapy aides typically perform support activities.
3. Environmental sanitation, cleanliness and physical comforts provided to patients create good impression. Well-kept lawns, good surroundings create good impression.
4. Medical social workers can also work for public health programs that provide education, guidance, advocacy, and resources to patients suffering from chronic conditions.
5. Counselling is a therapeutic process between a patient or family member and the Medical Social Worker, focusing on adjustment and coping strategies in relation to life crises such as serious illness/trauma or bereavement.

6.10 Suggested readings

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UNIT VII - IMPAIRMENT DISABILITY AND HANDICAP

*Impairment disability and
handicap*

Notes

Structure

- 7.1 Introduction
- 7.2 Impairment, Disability, Handicap
 - 7.2.1 Causes
 - 7.2.2 Types
 - 7.2.3 Classifications of physical handicaps
- 7.3 Let us sum up
- 7.4 Unit end exercises
- 7.5 Answer to check your progress
- 7.6 Suggested readings

7.1 Introduction

This unit gives the reader an understanding about the basic hairline difference between Impairment, disability and Handicap.

Impairment: any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability: any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: a disadvantage for a given individual that limits or prevents the fulfillment of a role that is normal

As traditionally used, impairment refers to a problem with a structure or organ of the body; disability is a functional limitation with regard to a particular activity; and handicap refers to a disadvantage in filling a role in life relative to a peer group.

Examples to illustrate the differences among the terms "impairment," "disability," and "handicap."

1. **CP example:** David is a 4-yr.-old who has a form of cerebral palsy (CP) called spastic diplegia. David's CP causes his legs to be stiff, tight, and difficult to move. He cannot stand or walk.

Impairment: The inability to move the legs easily at the joints and inability to bear weight on the feet is an impairment. Without orthotics and surgery to release abnormally contracted muscles, David's level of impairment may increase as imbalanced muscle contraction over a period of time can cause hip dislocation and deformed bone growth. No treatment may be currently available to lessen David's impairment.

Disability: David's inability to walk is a disability. His level of

disability can be improved with physical therapy and special equipment. For example, if he learns to use a walker, with braces, his level of disability will improve considerably.

Handicap: David's cerebral palsy is handicapping to the extent that it prevents him from fulfilling a normal role at home, in preschool, and in the community. His level of handicap has been only very mild in the early years as he has been well-supported to be able to play with other children, interact normally with family members and participate fully in family and community activities. As he gets older, his handicap will increase where certain sports and physical activities are considered "normal" activities for children of the same age. He has little handicap in his preschool classroom, though he needs some assistance to move about the classroom and from one activity to another outside the classroom. Appropriate services and equipment can reduce the extent to which cerebral palsy prevents David from fulfilling a normal role in the home, school and community as he grows.

2. **LD example:** Cindy is an 8-year-old who has extreme difficulty with reading (severe dyslexia). She has good vision and hearing and scores well on tests of intelligence. She went to an excellent preschool and several different special reading programs have been tried since early in kindergarten.

Impairment: While no brain injury or malformation has been identified, some impairment is presumed to exist in how Cindy's brain puts together visual and auditory information. The impairment may be inability to associate sounds with symbols, for example.

Disability: In Cindy's case, the inability to read is a disability. The disability can probably be improved by trying different teaching methods and using those that seem most effective with Cindy. If the impairment can be explained, it may be possible to dramatically improve the disability by using a method of teaching that does not require skills that are impaired (That is, if the difficulty involves learning sounds for letters, a sight-reading approach can improve her level of disability).

Handicap: Cindy already experiences a handicap as compared with other children in her class at school, and she may fail third grade. Her condition will become more handicapping as she gets older if an effective approach is not found to improve her reading or to teach her to compensate for her reading difficulties. Even if the level of disability stays severe (that is, she never learns to read well), this will be less handicapping if she learns to tape lectures and "read" books on audiotapes. Using such approaches, even in elementary school, can prevent her reading disability from interfering with her progress in other academic areas (increasing her handicap).

7.2 Impairment, Disability, Handicap

Impairment prevents someone from doing something, like how blindness is impairment to seeing. Impairment can also be any change for the worse. People with impairments have trouble doing something. If you have a hearing impairment, you can't hear very well.

- Vision Impairment.

- Deaf or hard of hearing.
- Mental health conditions.
- Intellectual disability.
- Acquired brain injury.
- Autism spectrum disorder.
- Physical disability.

Notes

The words “impairment,” “disability,” and “handicap,” are often used interchangeably. They have very different meanings, however. The differences in meaning are important for understanding the effects of neurological injury on development.

The most commonly cited definitions are those provided by the World Health Organization (1980) in *The International Classification of Impairments, Disabilities, and Handicaps*:

Impairment: any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability: any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

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As traditionally used, impairment refers to a problem with a structure or organ of the body; disability is a functional limitation with regard to a particular activity; and handicap refers to a disadvantage in filling a role in life relative to a peer group.

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Retrieved on 30/09/2019 from
(<https://www.pediatrics.emory.edu/divisions/neonatology/dpc/Impairment%20MX.html>)

7.2.1 Causes

Risk factors for the disabilities:

Communicable diseases (Infectious diseases) such as lymphatic filariasis, tuberculosis, HIV/AIDS, and other sexually transmitted diseases; neurological consequences of some diseases such as encephalitis, meningitis, and childhood cluster diseases (such as measles, mumps, and poliomyelitis) contribute to disability.

Non communicable diseases (NCDs)–

- Chronic diseases such as diabetes, cardiovascular disease, arthritis and cancer cause the majority of long-term disabilities. The increase in NCDs observed in all parts of the world, will have a profound effect on disability.
- Lifestyle choices and personal behaviour such as obesity, physical inactivity, tobacco use, alcohol consumption, illicit drugs that lead to non-communicable diseases are also becoming major contributing factors;
- Air pollution, occupational disease, poor water supply, sanitation, and personal and domestic hygiene, malnutrition also contribute for disability.

Injuries due to road traffic accidents, occupational injury, violence, conflicts, falls and landmines have long been recognized as contributors to disability.

Mental health problems— mental health retardation and mental illness are the causes of mental disability. In more than 50% cases mental retardation has been reported to be caused by serious illness or head injury in the childhood and birth defects. Mental retardation was observed mostly at birth or at very early ages of life while the problem of mental illness is more of an old age problem.

Those with lower education levels, lower incomes, and those who are unemployed were also more likely to suffer a disability.

There is higher risk of disability at older ages.

Retrieved on 30/09/2019 from
(<https://www.aimu.us/2017/02/25/disabilities-causes-diagnosis-and-management/>,
<https://www.disabled-world.com/disability/types/>)

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7.2.2 Types

Disabilities can affect people in different ways, even when one person has the same type of disability as another person. Some disabilities may be hidden, known as invisible disability. There are many types of disabilities, such as those that affect a person's:

- Vision
- Hearing
- Thinking
- Learning
- Movement
- Mental health
- Remembering
- Communicating
- Social relationships

Retrieved on 30/09/2019 from
(<https://www.aimu.us/2017/02/25/disabilities-causes-diagnosis-and-management/>,
<https://www.disabled-world.com/disability/types/>)

7.2.3 Classifications of physical handicaps

Mobility impairment includes physical defects, including upper or lower limb loss or impairment, poor manual dexterity, and damage to one or multiple organs of the body. Disability in mobility can be a congenital or acquired problem or a consequence of disease. People who have a broken skeletal structure also fall into this category.

Visual impairment is another type of physical impairment. There are hundreds of thousands of people who suffer greatly from minor to various serious vision injuries or impairments. These types of injuries can also result in severe problems or diseases such as blindness and ocular trauma. Some other types of vision impairment include scratched cornea, scratches on the sclera, diabetes-related eye

conditions, dry eyes and corneal graft, macular degeneration in old age and retinal detachment.

Hearing loss is a partial or total inability to hear. Deaf and hard of hearing people have a rich culture and benefit from learning sign language for communication purposes. People who are only partially deaf can sometimes make use of hearing aids to improve their hearing ability. Speech and language disability: the person with deviations of speech and language processes which are outside the range of acceptable deviation within a given environment and which prevent full social or educational development

Physical impairment can also be attributed to disorders causing, among others, sleep deficiency, chronic fatigue, chronic pain, and seizures.

Retrieved on 30/09/2019
from https://apps.who.int/iris/bitstream/handle/10665/41003/9241541261_eng.pdf;jsessionid=7EFB71C2608E24219E01E5F07F16CD1B?sequence=1

7.3 Let us sum up

In this unit you have learnt about impairment, disability and handicap. The types causes etc of impairment, disability and handicap were also discussed.

7.4 Unit end exercises

1. Draw out the causes for disability
2. How physical handicap can be classified
3. Mention the types of impairment
4. How the disability, impairment and handicap are connected
5. Give suitable suggestions to reduce disabilities

7.5 Answer to check your progress

1. David's level of impairment may increase as imbalanced muscle contraction over a period of time can cause hip dislocation and deformed bone growth.
2. Disability in mobility can be a congenital or acquired problem or a consequence of disease.
3. Mental health retardation and mental illness are the causes of mental disability.
4. Handicap: a disadvantage for a given individual that limits or prevents the fulfilment of a role that is normal

7.6 Suggested readings

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*Impairment disability and
handicap*

Notes

UNIT VIII – PSYCHOSOCIAL PROBLEMS AND IMPLICATIONS FOR EACH SPECIFIC HANDICAP

Structure

- 8.1 Introduction
- 8.2 Orthopaedic disability
- 8.3 Visual handicap
- 8.4 Aural impairment
- 8.5 Speech disability
- 8.6 Psychosocial problems and implications for each specific handicap
- 8.7 Let us sum up
- 8.8 Unit end exercises
- 8.9 Answer to check your progress
- 8.10 Suggested readings

8.1 Introduction

This unit gives the reader an understanding about the psychosocial problems associated with each handicap and also the implications for each handicap.

8.2 Orthopaedic disability

The definition of an, 'Orthopaedic Impairment,' is one that includes impairments caused by congenital anomalies such as absence of a member, clubfoot, impairments caused by disease such as bone tuberculosis, poliomyelitis, or impairments for other causes to include amputations, fractures, cerebral palsy, burns, or fractures.

Potential causes of orthopaedic impairment include:

- Genetic abnormality (e.g., the absence of a member, clubfoot)
- Disease (poliomyelitis, bone tuberculosis)
- Injury.
- Birth trauma.
- Amputation.
- Burns.
- Fractures.
- Cerebral palsy.

For example: A neuromotor impairment is one that has caused damage to or is considered to be an, 'abnormality,' of the child's spinal cord, brain, or nervous system. Neuromotor impairments are ones that are acquired either at or prior to the birth of the child and many times result in

complex motor issues that may affect a number of their body systems. Neuromotor impairments may include ones such as limited limb movement, a loss of appropriate alignment of the child's spine, or loss of urinary control. Two of the most common forms of neuromotor impairments include spina bifida and cerebral palsy.

Cerebral Palsy is a general term that refers to a number of non-progressive disorders which affect voluntary movement and posture that are caused by malfunctions or damages to a person's brain and occur prior to or during birth, or within the first few years of the person's life. People with cerebral palsy experience involuntary, and/or uncoordinated movements. Four of the more common forms of cerebral palsy include Athetoid, Spastic, Ataxic, and Mixed. Cerebral palsy may also be classified according to the person's limbs that are affected. These classifications include:

- Diplegia - legs affected more than arms
- Hemiplegia - left or right side
- Quadriplegia - all four limbs

Spina Bifida is a form of developmental disability involving a person's spinal column. Spina bifida is characterized by an opening in the spinal column, often in combination with paralysis of portions of the person's body. The disability may or may not involve some level of effect on the person's intellectual function. Forms of spina bifida can include occulta or cystica; occulta is a milder form of spina bifida while cystica is more serious.

Degenerative diseases are comprised of a number of diseases which affect a person's motor development. The more common degenerative disease found among school-age persons is muscular dystrophy, a group of inherited diseases that are characterized by progressive muscle weakness due to degeneration of the person's muscle fibers.

Children may also experience musculoskeletal disorders which are comprised of a number of conditions that may result in varying levels of physical limitations. Examples of musculoskeletal disabilities include limb deficiencies and juvenile rheumatoid arthritis. The particular impact a disability will have on a child's learning is dependent upon the disability and its severity, as well as individual factors. Children with the same diagnosis can have quite different abilities where learning is concerned.

Retrieved on 16/09/2019 from (<https://www.disabled-world.com/disability/children/orthopedic-impairments.php>)

8.2 Visual handicap

Visual impairment, also known as **vision impairment** or **vision loss**, is a decreased ability to see to a degree that causes problems not fixable by usual means, such as glasses. Some also include those who have a decreased ability to see because they do not have access to glasses or contact lenses. Visual impairment is often defined as a best corrected visual acuity of worse than either 20/40 or 20/60.

The term blindness is used for complete or nearly complete vision loss. Visual impairment may cause people difficulties with normal daily activities such as driving, reading, socializing, and walking.

The most common causes of visual impairment globally are uncorrected refractive errors (43%), cataracts (33%), and glaucoma (2%). Refractive errors include near sighted, far sighted, presbyopia, and astigmatism. Cataracts are the most common cause of blindness. Other disorders that may cause visual problems include age related macular degeneration, diabetic retinopathy, corneal clouding, childhood blindness, and a number of infections. Visual impairment can also be caused by problems in the brain due to stroke, premature birth, or trauma among others. These cases are known as cortical visual impairment. Screening for vision problems in children may improve future vision and educational achievement. Screening adults without symptoms is of uncertain benefit. Diagnosis is by an eye exam.

The World Health Organization (WHO) estimates that 80% of visual impairment is either preventable or curable with treatment.^[3] This includes cataracts, the infections river blindness and trachoma, glaucoma, diabetic retinopathy, uncorrected refractive errors, and some cases of childhood blindness. Many people with significant visual impairment benefit from vision rehabilitation, changes in their environment, and assistive devices.

As of 2015 there were 940 million people with some degree of vision loss. 246 million had low vision and 39 million were blind. The majority of people with poor vision are in the developing world and are over the age of 50 years. Rates of visual impairment have decreased since the 1990s. Visual impairments have considerable economic costs both directly due to the cost of treatment and indirectly due to decreased ability to work.

Retrieved on 16/09/2019 from
(https://en.wikipedia.org/wiki/Visual_impairment#cite_note-11)

8.3 Aural impairment

There are three types of auditory impairments; each is a separate special education category:

1. Deafness
2. Hearing Impairment
3. Deaf-blindness

Deafness means a hearing impairment that is so severe that the child is impaired in understanding speech.

Hearing impairment means impairment in hearing, that affects a child's educational performance but that is not included under the definition of deafness.

Deaf-blindness means a combination of hearing and visual impairments which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

The most common cause of hearing loss in children is an infection of the middle ear called otitis media. Another large group of children acquired their hearing loss due to factors such as noise, drugs and toxins. Some acquired hearing loss is a result of heredity.

Special education services

Each state defines the degree of hearing loss which determines a student's eligibility for special education services. Deafness is usually defined as a hearing loss of 70 decibels or greater in the better ear. Hard of Hearing is defined as a hearing loss of 35-60 decibel in the better ear. In addition, to be eligible for special education services, the hearing loss must affect the student's educational performance.

Retrieved on 16/09/2019 from (<http://www.spiritlakeconsulting.com/COPT/intro/auditoryimpairment.html>)

8.4 Speech disability

Speech is one of the main ways in which people communicate their thoughts, feelings, and ideas with others. The act of speaking requires the precise coordination of multiple body parts, including the head, neck, chest, and abdomen.

In this article, we explore what speech disorders are and the different types. We also cover the symptoms, causes, diagnosis, and treatment of speech disorders.

Speech disorders affect a person's ability to form the sounds that allow them to communicate with other people. They are not the same as language disorders.

Speech disorders prevent people from forming correct speech sounds, while language disorders affect a person's ability to learn words or understand what others say to them.

However, both speech and language disorders can make it more difficult for a person to express their thoughts and feelings to others.

Types

Speech disorders can affect people of all ages.

Some types of speech disorder include stuttering, apraxia, and dysarthria. We discuss each of these types below:

Stuttering

Stuttering refers to a speech disorder that interrupts the flow of speech. People who stutter can experience the following types of disruption:

- **Repetitions** occur when people involuntarily repeat sounds, vowels, or words.
- **Blocks** happen when people know what they want to say but have difficulty making the necessary speech sounds. Blocks may cause someone to feel as though their words are stuck.
- **Prolongations** refer to the stretching or drawing out of particular sounds or words.

The symptoms of stuttering can vary depending on the situation. Stress, excitement, or frustration can cause stuttering to become more severe. Some people may also find that certain words or sounds can make a stutter more pronounced.

Stuttering can cause both behavioural and physical symptoms that occur at the same time. These can include:

- tension in the face and shoulders
- rapid blinking
- lip tremors
- clenched fists

- sudden head movements
- There are two main types of stuttering:
- **Developmental stuttering** affects young children who are still learning speech and language skills. Genetic factors significantly increase a person's likelihood of developing this type of stutter.
 - **Neurogenic stuttering** occurs when damage to the brain prevents proper coordination between the different regions of the brain that play a role in speech.
- Retrieved _____ on _____ 16/09/2019
from(<https://www.medicalnewstoday.com/articles/324764.php>)

8.5 Psychosocial problems and implications for each specific handicap

People who experience disability for the first time undergo stress; cope with life transitions, value changes, and experience disability issues across their life spans. From a sociological perspective, people who experience disability for the first time also have to deal with the role of family, cross-cultural issues and adjustments, the consequences of negative demeanor's towards people with disabilities as a whole, and the roles of professionals who work to assist them with adjusting. Their system of life and living has changed in many different ways, meaning they must endure a process of adjustment and self-evaluation.

The experience of an injury that leads to a psychological or physical disability is similar to enduring a mourning process and might be equated to the loss of a loved one; for example. The mourning process can involve adjustment to the disability the person experiences and may be divided into a series of four stages or tasks - shock, denial, anger/depression, and adjustment/acceptance.

The stages are expected, yet are not orderly or neat. People with new forms of disabilities go through these stages at their own paces and might skip whole stages entirely. A difficulty exists when the person has trouble with resolving one of the stages or becomes, 'stuck.' When this happens, further progress towards adjustment and acceptance is hindered.

New Disability Experience and Psychological Intervention

Psychological intervention can help a person with a new form of disability to progress through the stages of disability and assist them with resolving any difficulties they may experience along the way. The result can be an increase in the person's self-esteem and confidence. Cognitive Behavioural Therapy (CBT) is something that may be used to help with assumptions the person might have concerning their appearance or bodily function.

Cognitive approaches through this form of therapy provide a modality for focusing on core issues in the process of adjustment, helping to reduce the person's tendency to magnify risks related to new activities, as well as helping to change any belief systems the person may have that impede adjustment. The amount of time a person with a new form of disability might spend pursuing CBT depends upon the type of disability they experience and the coping ability of the person.

Stages of Adjusting to a New Form of Disability

The stages of adjusting to a new form of disability include four basic ones. These stages include shock, denial, anger/depression, and adjustment/acceptance. People progress through these stages at their own pace.

- **Shock:**

Shock involves a state of both emotional and physical numbness that can last from a few hours to several days.

- **Denial:**

Denial may last anywhere from three weeks to two months and is a defense mechanism that allows the implications of the new disability the person has experienced to be gradually introduced. Denial only becomes an issue when it interferes with the person's life, forms of treatment, or rehabilitation efforts.

- **Anger/Depression:**

Anger and depression are reactions to loss and the person's change in social treatment and status. The person may experience a number of different emotions during this stage and grieve for the changes in their body image, function, loss of future expectations, or former satisfaction based upon any function that has been lost.

- **Adjustment/Acceptance:**

The stage of adjustment and acceptance does not necessarily mean the person is happy about the disability they now experience, although it does allow for the relinquishment of any false hopes, as well as the successful adaptation of new roles based upon realistic potentials and limitations. The person might benefit from interactions with others who experience forms of disabilities, and becomes comfortable with who they are.

Emotional aspects associated with a new form of disability are many times a major factor in determining the person's outcome and the benefits related to rehabilitative efforts. Effective psychological intervention is beneficial where ensuring recovery from an injury that has caused a form of disability is concerned. Many people experience more than four stages of adjustment to a physical disability; in fact - people might experience as many as twelve stages that include:

- Shock
- Anxiety
- Bargaining
- Denial
- Mourning
- Depression
- Withdrawal
- Internalized anger
- Externalized aggression
- Acknowledgment
- Acceptance
- Adjustment

People with Disabilities - You are Still Yourself

In every single way that matters, disability does not change a person. Instead, disability threatens concepts a person has held about who they are. People bring to their disability whatever mix of beliefs, attitudes,

talents, charisma, fears, or social skills they have or have the capacity to develop. Who a person is impacts their ability to adjust to disability.

One of the common questions people with disabilities are asked is, 'What can I do to help' Perhaps the first thing someone can do is to understand that a person with a disability is the same person they were before experiencing their form of disability. It is important not to treat them differently simply because they have a form of disability. Do not expect them to be any weaker or stronger, and do not be surprised if they have found new qualities within themselves that have not surfaced before.

The experience of a form of disability forces the issue of, 'finding one's self.' Some people take pride in the things they learn about themselves through the experience of a form of disability. They appreciate the way disability helps to define their values.

A number of psychological adjustments have little to do with the disability a person experiences; they are issues everyone does. As an example, a person might be frustrated because they are having a hard time finding someone to love and believe it is their form of disability that is the cause of the loneliness they feel. The issue; however, is a part of many people's lives, whether they experience a form of disability or not. It is important for people with disabilities to avoid making disability a scapegoat for issues that might very well have appeared in their lives anyway.

For the majority of people with disabilities, disability does not define who they are; it is something they deal with when it becomes necessary to do so. One person with a disability noted that the entire human race is essentially disabled because we are unable to live together in peace, something that has always been so, and will continue to be so in the future. The question then becomes, 'What is normal'.

The Experience of a New Disability

The majority of people who are able-bodied imagine the experience of a form of disability to be much more negative and hard than it actually is. A person may have no concept of how someone functions with a wheelchair; for example, and it might seem to them that life for a person who uses a wheelchair is completely dependent and extremely difficult. The facts; however, are quite different.

When a person suddenly experiences a form of disability due to an injury or a diagnosis of a form of degenerative disease, they bring their prior notions of disabilities to it. It is not surprising that a number of people find themselves experiencing anger, depression, fear, anxiety, and a deep sense of loss during the early stages of their disability experience. Despite how well-adjusted, emotionally strong, or mature a person may be, the experience of a new form of disability is an event that shakes many of a person's basic beliefs about their life. A new form of disability also asks a person to draw upon their coping skills; ones they may have never needed before.

A person's experience with a new form of disability may be marked by fatigue, negative emotions, a sense of powerlessness, or confusion. It is important to remember that there is also the chance to experience confidence and hope as they witness new abilities to cope with what is often a challenging situation. The majority of people who experience a

new form of disability adjust in ways they never believed possible. With positive social support from family members, friends, and society at large the vast majority of people who experience a new form of disability do adjust.

Retrieved on 16/09/2019 from (<https://www.disabled-world.com/disability/social-aspects.php>)

8.6 Let us sum up

The unit will give you the knowledge about orthopaedic disability, visual handicap, aural impairment and speech disability. It will help you when you professionally work on the related settings.

8.7 Unit end exercises

1. Why the disabled persons are psychologically affected so.
2. Mention the implications for specific handicapped.
3. What do you mean by orthopaedic disability?
4. Briefly describe about visual handicapped
5. What are the main causes for speech disability?

8.8 Answer to check your progress

1. Visual impairment may cause people difficulties with normal daily activities such as driving, reading, socializing, and walking.
2. Emotional aspects associated with a new form of disability are many times a major factor in determining the person's outcome and the benefits related to rehabilitative efforts.
3. Developmental stuttering affects young children who are still learning speech and language skills. Genetic factors significantly increase a person's likelihood of developing this type of stutter.
4. Cerebral Palsy is a general term that refers to a number of non-progressive disorders which affect voluntary movement and posture that are caused by malfunctions or damages to a person's brain and occur prior to or during birth, or within the first few years of the person's life.
5. Denial may last anywhere from three weeks to two months and is a defense mechanism that allows the implications of the new disability the person has experienced to be gradually introduced. Denial only becomes an issue when it interferes with the person's life, forms of treatment, or rehabilitation efforts.

8.9 Suggested readings

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UNIT IX – ROLE OF SOCIAL WORKER IN INTERVENTION

Role of social worker in intervention

Structure

- 9.1 Introduction
- 9.2 Role of social worker
 - 9.2.1 Intervention
 - 9.2.2 Physical medicine
 - 9.2.3 Physiotherapy
 - 9.2.4 Occupational therapy
- 9.3 Let us sum up
- 9.4 Unit end exercises
- 9.5 Answer to check your progress
- 9.6 Suggested readings

Notes

9.1 Introduction

This unit gives the reader an understanding about the role of social worker in Intervention. Intervention has always been the essence of Social work. The main purpose of these interventions is to aid clients in alleviating problems and improving their wellbeing. Social work is often divided into three broad practice categories: macro, mezzo and micro. Macro level social work is interventions provided on a large scale that affect entire communities and systems of care. Mezzo social work happens on an intermediate scale, involving neighbourhoods, institutions or other smaller groups. Micro social work is the most common practice, and happens directly with an individual client or family.

The degree to which medical social work interventions are effective is determined by the degree to which client goals and outcomes are achieved. When goals and outcomes are achieved as demonstrated by the results of the work done between the social worker and client, the interventions used are then recognized as effective.

Retrieved on 27/09/2019 from <https://socialworklicensemap.com/macro-mezzo-and-micro-social-work/>

https://shodhganga.inflibnet.ac.in/bitstream/10603/44576/13/13_chapter%206.pdf

9.2 Role of social worker

A Medical Social Worker is a social worker who works in a medical setting such as a hospital, outpatient clinic, hospice, long-term care facility, or community health agency. It is important to note that Medical

Social Workers are most often referred to as “social workers,” but occasionally may have other titles, including Case/Care Manager.

Medical Social Worker

- Assesses a patient’s social, emotional, environmental, financial, and support needs.
- Informs other members of the health care team about these factors, which may affect the patient’s health and well-being.
- Works with the patient’s family and other service provider agencies to develop a plan for care of the patient in his or her home or other living arrangement.
- Typically has a master’s degree in social work (MSW).
- In hospital settings, has a critical role in the area of discharge planning, ensuring that the services a patient will require are in place before the patient is discharged.

Medical Social Workers have specific training in health and behavioural health conditions, health care policy, and systems of providing health care services.

The typical day-to-day activities of a Medical Social Worker vary considerably depending on the health care setting. In the hospital, the Medical Social Worker has a critical role in the area of discharge planning. It is the Medical Social Worker’s responsibility to ensure that the services the patient requires are in place in order to facilitate a timely discharge and ensure that the patient’s needs will be cared for at home.

The Medical Social Worker does a complete psychosocial assessment on all patients referred for social work services by the physician. After the assessment has been completed, the Medical Social Worker works with the patient, his or her family, and other health professionals to develop a discharge plan. When the doctor determines that the patient will be ready for discharge soon, it is the Medical Social Worker’s job to implement the plan by arranging for the home care services, coordinating transportation, working with the family to facilitate the discharge, and providing other appropriate services/referrals for the patient’s care at home.

Due to the high number of patients for whom the Medical Social Worker is responsible and the tight deadlines required to avoid delays in discharge, medical social work is a highly demanding job. In addition, the Medical Social Worker often is confronted with complex cases involving patients with multiple psychosocial issues.

A Medical Social Worker usually participates as a member of a health care team to identify the patient’s needs and develop a treatment plan. Medical Social Workers also provide counselling services to individual patients and their families; provide support groups for patients and/or caregivers; collaborate with other social service provider agencies; link individuals to resources; and help restore individuals, families, and groups to successful social functioning. A major role of the Medical Social Worker is to be an advocate for the patient and, at times, an advocate for broader social causes.

Retrieved on 27/09/2019 from <https://www.ecfm.org/echo/team-psych-msw.html>

<https://www.ecfm.org/echo/team-psych-msw.html>

9.2.1 Intervention

Medical social workers work in hospitals, community clinics, and other healthcare settings to support patients and their families, and to assist the larger medical team in the coordination of patients' care.

Medical Social Workers assist patients and their families with health-related problems and concerns. In some settings, Medical Social Workers work closely with public and private health insurers to determine the patients' benefits and advocate for the patient.

Beyond providing information to patients and their families, hospital social workers provide emotional support during times of crisis. ... Hospital social workers also work directly with patients in a variety of capacities. They might conduct a psychosocial assessment of the patient upon admittance to the facility.

Medical social workers intervention:

- Performing evaluations on mental and emotional health
- Assessing social, family and/or financial circumstances
- Communicating patient information to various stakeholders in patient's health team
- Providing counseling or psychotherapy to patients and families
- Maintaining confidential patient records
- Connecting patients and families with outside medical and non-medical resources
- Coordination of patient care in collaboration with health team stakeholders

Psychosocial Assessments

Medical social workers typically conduct psychosocial assessments of patients (and sometimes their family members) in order to determine their needs and to identify any mental or emotional distress that could exacerbate their condition. A psychosocial assessment is defined as an evaluation of a patient's psychological and physical health, as well as any external conditions (financial hardship, family conflicts, cultural considerations, etc.) that the medical care team should factor into the care of a patient.

Upon completing this assessment, medical social workers communicate the information they have gathered to the larger medical team, which helps other team members (i.e. physicians, nurses, medical assistants, etc.) provide more effective care.

The psychosocial assessments are not just essential in the development of a treatment plan; they are also important in ensuring patients receive the insurance coverage they need for certain services.

Patient and Family Education, Counselling, and Therapy

Patient education is one of the most important responsibilities that medical social workers have in health care settings. Grappling with a disease, injury, or other medical condition can be confusing and deeply stressful for patients and their loved ones. Medical social workers explain to patients the causes, effects, and progression of their illness. After receiving information about patients' treatment options from the medical team, medical social workers also communicate and discuss these options with patients and their families. They also provide updates to patients and their families regarding any changes in their treatment plan.

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Medical social workers also provide emotional support and psychotherapy if needed to patients and family members who are experiencing emotional distress as a result of the diagnosis. Types of psychotherapeutic methods that medical social workers may use to support patients and their families can include supportive psychotherapy, cognitive behavioural therapy, mindfulness based stress reduction, and problem solving therapy. Medical social workers also provide emotional support and psychotherapy if needed to patients and family members who are experiencing emotional distress as a result of the diagnosis. Types of psychotherapeutic methods that medical social workers may use to support patients and their families can include supportive psychotherapy, cognitive behavioural therapy, and mindfulness based stress reduction, and problem solving therapy. Substance abuse counselling and therapy may include methods such as harm reduction techniques, cognitive behavioural therapy, dialectical behavioural therapy, and motivational interviewing.

Resource Connections and Navigation Services

Medical social workers help patients and their families understand the resources that are available to them within the hospital setting as well as in the community.

Crisis Intervention

Medical social workers also implement crisis interventions when necessary, helping patients and their families cope with tragedy, emergency situations, and moments of acute stress. For patients and families who are coping with a terminal illness, medical social workers provide grief counselling, therapy, and referrals to additional mental health support.

In some medical settings, such as the emergency room or the trauma unit of a hospital, patients may struggle with substance abuse, severe mental health issues, conflicts with family, or domestic/sexual abuse issues upon their admittance into a hospital or other medical setting. Specific to these individuals experiencing hardships, medical social workers help patients resolve or manage these issues in the moment and over time.

Care Coordination

All of the responsibilities described above fall under care coordination, which is defined as the effective organization and delivery of medical care to patients. By bringing patients' mental, emotional, familial, and social concerns into their treatment plan medical social workers ensure that patients receive a more holistic, compassionate, and efficient form of care that improves overall health outcomes. Medical social workers are an integral part of the care coordination team in many medical environments.

Other care coordination duties that medical social workers fulfill include serving as a point of contact between different teams within the health care setting, ensuring that facilities adequately serve patients' needs, and coordinating patients' movement from different units or from one medical setting to another.

5 Job Duties of Medical Social Workers

Medical social workers enjoy interesting and rewarding jobs. By helping patients navigate the healthcare system and work towards wellness, you

can feel good about the work you every day working for a hospital or medical office. Although no two jobs in hospital social work are the same, here are five common job duties you'll likely be assigned at some point in your career.

Patient Advocacy

Sometimes, you must stand up for your patients and advocate for their rights to culturally appropriate healthcare. This may mean pointing out that a patient struggles with literacy, financial resources or transportation needs and working with the patient's medical team to overcome these problems. Physicians are often frustrated by patients who don't follow medical orders, but you can help medical workers understand the barriers your patients face.

Mental Health Services

In many healthcare teams, social workers provide mental health assessment and counselling. Rather than call in a psychiatrist from outside of the hospital, doctors may ask a social worker with a master's of social work (MSW) degree to assess a patient's mental well-being. You can serve as a critical first step in connecting your patients to mental healthcare services by deciding if formal psychiatric care is needed. You may also provide on-the-spot counselling for patients struggling with an active mental illness or mental disability as well as family members, patients and even staff who simply need a supporting presence.

Patient Education

One of the biggest impacts you can have as a hospital-based social worker is by providing patient education. Numerous studies have shown that educated patients have better outcomes, but nurses and doctors often struggle with heavy caseloads that prevent them from spending enough time with every patient. You can help patients understand their discharge paperwork, ensure they know how to obtain and use their medications and explain the importance of follow-up visits. You can also connect patients with the additional resources they need to be healthy once they leave the hospital.

Community Organization

Patients often experience self-esteem issues when undergoing treatment. For example, cancer patients may need to actively work to rebuild their self-image after chemotherapy and other treatments. As a medical social worker, you can organize and lead peer groups for patients dealing with the side effects of visiting the hospital. This could be a recovery group for women with cancer, a support group for new parents or a socialization group for parents of children with chronic illnesses. As a social worker in a medical setting, you can help these visitors build vital social connections, improve their mental health and deepen their understanding of the medical process.

Macro-level Interventions

A master's in social work degree splits its focus between macro- and micro-level skills, so you'll graduate with the policy and organizational background to lead changes at the community level. To promote health in your neighborhood, you might partner with a local farmer's market to increase access to fresh produce, convince the bus agency to create more routes to your healthcare facility or work with your school board

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to promote healthy activities for children. Big picture items can affect hundreds or thousands of patients and highlight your employer's commitment to community-level development.

In this field, you'll help new patients every day with small issues like finding a ride home or large challenges like finding food to put on the table. With the high level of variety and personal fulfillment, it's easy to see why medical social workers love their jobs.

Retrieved on 27/09/2019 from (<https://www.socialworkdegreeguide.com/lists/5-job-duties-of-medical-social-workers/>)

<https://www.onlinemswprograms.com/careers/types-of-social-work/guide-to-medical-social-work.html>

9.2.2 Physical medicine

Physical medicine and rehabilitation (PM&R), also known as physiatrist or rehabilitation medicine, aims to enhance and restore functional ability and quality of life to those with physical impairments or disabilities affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. A physician having completed training in this field is referred to as a physiatrist. Unlike other medical specialties that focus on a medical "cure," the goals of the physiatrist are to maximize patients' independence in activities of daily living and improve quality of life.

Physiatrists are experts in designing comprehensive, patient-centered treatment plans, and are integral members of the care team. They utilize cutting-edge as well as time-tested treatments to maximize function and quality of life for their patients, who can range in age from infants to octogenarians.

Practice Settings

PM&R physicians practice in a variety of clinical settings, including inpatient and outpatient facilities. They have a broad range of knowledge including musculoskeletal, neurological, rheumatologic and cardiovascular systems.

Some of the common diagnoses and populations seen by inpatient physiatrists include spinal cord injury, brain injury (traumatic and non-traumatic), stroke, multiple sclerosis, polio, burn care, and musculoskeletal and pediatric rehabilitation. Inpatient physiatrists are often trained using collaborative team skills and work with social workers and other allied health therapists (e.g., physical, occupational and speech) to manage these issues.

Outpatient physiatrists manage nonsurgical conditions including orthopedic injuries, spine-related pain and dysfunction, occupational injuries and overuse syndromes, neurogenic bowel/bladder, pressure sore management, spasticity management, and chronic pain. Outpatient physiatrists are typically found in multidisciplinary groups consisting of other physiatrists, orthopedic surgeons and/or neurosurgeons.

Retrieved on 27/09/2019 from (<https://www.aapmr.org/about-physiatry/about-physical-medicine-rehabilitation>)

9.2.3 Physiotherapy

Physical therapy (PT), also known as physiotherapy, is one of the allied health professions that, by using evidence-based kinesiology, electrotherapy, shockwave modality, exercise prescription, joint mobilization and health education, treats conditions such as chronic or acute pain, soft tissue injuries, cartilage damage, arthritis, gait disorders and physical impairments typically of musculoskeletal, cardiopulmonary, neurological and endocrinological origins. Physical therapy is used to improve a patient's physical functions through physical examination, diagnosis, prognosis, physical intervention, rehabilitation and patient education. It is practiced by physical therapists (known as physiotherapists in many countries).

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In addition to clinical practice, other activities encompassed in the physical therapy profession include research, education, consultation and administration. Physical therapy is provided as a primary care treatment or alongside, or in conjunction with, other medical services.

Physiotherapy Treatment: What Conditions do Physiotherapists Treat?

As professionals, physiotherapists are experts at providing physiotherapy treatment for:

- Preventing injury and disability;
- Managing acute and chronic conditions;
- Improving and maintaining optimal physical performance;
- Rehabilitating injury and the effects of disease or disability;
- Educating patients to prevent re-occurrence of an injury.

Patients may be referred to or seek assistance from a physiotherapist for a variety of health issues and receive valuable assistance.

Physiotherapists offer treatments relating to the following conditions:

- Cardiorespiratory: providing support, prevention and rehabilitation for people suffering from diseases and injuries that affect the heart and lungs, such as asthma.
- Cancer, palliative care and lymph edema: treating, managing or preventing fatigue, pain, muscle and joint stiffness, and reconditioning.
- Incontinence: managing and preventing incontinence and pelvic floor dysfunction.
- Women's health concerns: addressing health issues surrounding pregnancy, birth, post-partum care, breastfeeding, menopause, bedwetting, prolapsed, loss of bladder or bowel control.
- Musculoskeletal: preventing and treating clients with musculoskeletal conditions such as neck and back pain.
- Neurological: promoting movement and quality of life in patients who have had severe brain or spinal cord damage from trauma, or who suffer from neurological diseases such as stroke, Parkinson's disease and multiple sclerosis.
- Orthopedic: helping patients prevent or manage acute or chronic orthopedic conditions such as arthritis and amputations.
- Pain: managing or preventing pain and its impact on function in patients.

Physiotherapy Techniques: What Techniques do Physiotherapists Use?
Physiotherapists employ a variety of techniques, depending on the nature of the injury or problem they are treating. The most common physiotherapy techniques are:

- **Manual manipulation:** Moving joints and soft tissue helps to improve circulation, drain fluid from the body, and relax overly tight or muscles with spasms.
- **Electrical nerve stimulation:** Small electrical currents delivered to affected areas helps to suppress and block pain signals to the brain.
- **Acupuncture:** Needles stimulate the nervous system and work to dull pain, release muscles, boost the immune system and regulate various body functions.
- **Demonstration:** Teaching proper movement patterns allows patients to help heal them.
- **Functional testing:** Testing a patient to assess his/her physical abilities.
- **Device provision:** Prescription, fabrication and application of assistive, adaptive, supportive and protective devices and equipment.

What to expect from a visit?

Each session with a physiotherapist is unique, because it depends on the client's health issues and needs. However, a visit to a physiotherapist generally includes:

- Learning about the patient's medical history;
- Assessing and diagnosing the patient's condition and needs;
- Helping the patient set and reach physical goals;
- Creating a treatment plan that accounts for patient's health, lifestyle and activities;
- Prescribing a course of exercises and necessary devices.

If you are experiencing issues with movement or function or are just seeking to optimize your health, why not check out a trusted resource like a professional physiotherapist

Retrieved on 27/09/2019 from
(https://en.wikipedia.org/wiki/Physical_therapy)
(<https://southvanphysio.com/what-is-physiotherapy/>)

9.2.4 Occupational therapy

Occupational therapy (OT) is the use of assessment and intervention to develop, recover, or maintain the meaningful activities, or occupations, of individuals, groups, or communities. It is an allied health profession performed by occupational therapists and occupational therapy assistants (OTA). OTs often works with people with mental health problems, disabilities, injuries, or impairments.

The American Occupational Therapy Association defines an occupational therapist as someone who "helps people across their lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, injury rehabilitation, and providing supports for older adults experiencing physical and cognitive changes."

Typically, occupational therapists are university-educated professionals and must pass a licensing exam to practice. Occupational therapists often work closely with professionals in physical therapy, speech therapy, audiology, nursing, social work, clinical psychology, and medicine.

Areas of practice

The broad spectrum of OT practice makes it difficult to categorize the areas of practice, especially considering the differing health care systems globally. In this section, the categorization from the American Occupational Therapy Association is used.

Children and youth

Platform swing with tire used during occupational therapy with children

In 1951, Joan Erikson became director of activities for the “severely disturbed children and young adults” at the Austen Riggs Center. At that time, “occupational therapy” was used “for keeping patients busy on useless tasks.” Erikson “brought in painters, sculptors, dancers, weavers, potters and others to create a program that provided real therapy.”

Occupational therapists work with infants, toddlers, children, and youth and their families in a variety of settings including schools, clinics, and homes. Occupational therapists assist children and their caregivers to build skills that enable them to participate in meaningful occupations. These occupations may include: feeding, playing, socializing, and attending school.

Occupational therapy with children and youth may take a variety of forms. For example:

- Promoting a wellness program in schools to prevent childhood obesity
- Facilitating handwriting development in school-aged children
- Providing individualized treatment for sensory processing difficulties
- Teaching coping skills to a child with generalized anxiety disorder

Occupational therapists work in the school setting as a related service for children with an Individual Education Plan (IEP). “Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes.” As a related service, occupational therapists work with children with varying disabilities to address those skills needed to access the special education program and support academic achievement and social participation throughout the school day (AOTA, n.d.-b). In doing so occupational therapists help children to fulfill their role as students and prepare them to transition to post-secondary education, career and community integration (AOTA, n.d.-b). Occupational therapists have specific knowledge to increase participation in school routines throughout the day, including:

- Modification of the school environment

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to allow physical access for children with disabilities • Provide assistive technology to support student success • Helping to plan instructional activities for implementation in the classroom • Support the needs of students with significant challenges such as helping to determine methods for alternate assessment of learning • Helping students develop the skills necessary to transition to post-high school employment, independent living and/or further education (AOTA, n.d.-a)

Health and wellness

The practice area of Health and Wellness is emerging steadily due to the increasing need for wellness-related services in occupational therapy. A connection between wellness and physical health, as well as mental health, has been found; consequently, helping to improve the physical and mental health of clients can lead to an increase in overall well-being. As a practice area, health and wellness can include a focus on:

- Prevention of disease and injury
- Prevention of secondary conditions (co-morbidity)
- Promotion of the well-being of those with chronic illnesses
- Reduction of health care disparities or inequalities
- Enhancement of factors that impact quality of life
- Promotion of healthy living practices, social participation, and occupational justice

Occupational therapist conducting a group intervention on interpersonal relationship building

Mental health

Mental health and the moral treatment era have been recognized as the root of occupational therapy. According to the World Health Organization, mental illness is one of the fastest growing forms of disability. OTs focus on prevention and treatment of mental illness in all populations. In the U.S., military personnel and veterans are populations that can benefit from occupational therapy, but currently this is an underserved practice area.

Mental health illnesses that may require occupational therapy include schizophrenia and other psychotic disorders, depressive disorders, anxiety disorders, eating disorders, trauma- and stressor-related disorders (e.g. post traumatic stress disorder or acute stress disorder), obsessive-compulsive and related disorders such as hoarding, and neurodevelopmental disorders such as autism spectrum disorder, attention deficit/hyperactivity disorder and learning disorders.

Productive aging

Occupational therapists work with older adults to maintain independence, participate in meaningful activities, and live fulfilling lives. Some examples of areas that occupational therapists address with older adults are driving, aging in place, low vision, and dementia or Alzheimer's disease (AD). When addressing driving, driver evaluations are administered to determine if drivers are safe behind the wheel. To enable independence of older adults at home, occupational therapists perform falls risk assessments; assess clients functioning in their homes, and recommend specific home modifications. When addressing low vision, occupational therapists modify tasks and the environment. While working with individuals with AD, occupational therapists focus on

maintaining quality of life, ensuring safety, and promoting independence.

Visual impairment

Visual impairment is one of the top 10 disabilities among American adults. Occupational therapists work with other professions, such as optometrists, ophthalmologists, and certified low vision therapists, to maximize the independence of persons with a visual impairment by using their remaining vision as efficiently as possible. AOTA's promotional goal of "Living Life to Its Fullest" speaks to who people are and learning about what they want to do, particularly when promoting the participation in meaningful activities, regardless of a visual impairment. Populations that may benefit from occupational therapy includes older adults, persons with traumatic brain injury, adults with potential to return to driving, and children with visual impairments. Visual impairments addressed by occupational therapists may be characterized into 2 types including low vision or a neurological visual impairment. An example of a neurological impairment is a cortical visual impairment (CVI) which is defined as "...abnormal or inefficient vision resulting from a problem or disorder affecting the parts of brain that provide sight". The following section will discuss the role of occupational therapy when working with the visually impaired.

Occupational therapy for older adults with low vision includes task analysis, environmental evaluation, and modification of tasks or the environment as needed. Many occupational therapy practitioners work closely with optometrists and ophthalmologists to address visual deficits in acuity, visual field, and eye movement in people with traumatic brain injury, including providing education on compensatory strategies to complete daily tasks safely and efficiently. Adults with a stable visual impairment may benefit from occupational therapy for the provision of a driving assessment and an evaluation of the potential to return to driving. Lastly, occupational therapy practitioners enable children with visual impairments to complete self care tasks and participate in classroom activities using compensatory strategies.

Adult rehabilitation

Occupational therapists address the need for rehabilitation following an injury or impairment. When planning treatment, occupational therapists address the physical, cognitive, psychosocial, and environmental needs involved in adult populations across a variety of settings.

Occupational therapy in adult rehabilitation may take a variety of forms:

- Working with adults with autism at day rehabilitation programs to promote successful relationships and community participation through instruction on social skills
- Increasing the quality of life for an individual with cancer by engaging them in occupations that are meaningful, providing anxiety and stress reduction methods, and suggesting fatigue management strategies
- Coaching individuals with hand amputations how to put on and take off a myoelectrically controlled limb as well as training for functional use of the limb

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- As for paraplegics, there are such things as sitting cushion and pressure sore prevention. Prescription of these aids is the common job for paraplegics.
- Using and implementing new technology such as speech to text software and Nintendo Wii video games
- Communicating via telehealth methods as a service delivery model for clients who live in rural areas
- Working with adults who have had a stroke to regain strength, endurance, and range of motion on their affected side.

Travel occupational therapy

Because of the rising need for occupational therapists in the U.S., many facilities are opting for travel occupational therapists—who are willing to travel, often out of state, to work temporarily in a facility. Assignments can range from 8 weeks to 9 months, but typically last 13–26 weeks in length. Most commonly (43%), travel occupational therapists enter the industry between the ages of 21–30.

Work and industry

Occupational therapists work with clients who have had an injury and are returning to work. OTs performs assessments to simulate work tasks in order to determine best matches for work, accommodations needed at work, or the level of disability. Work conditioning and work hardening are interventions used to restore job skills that may have changed due to an illness or injury. Occupational therapists can also prevent work related injuries through ergonomics and on site work evaluations.

Occupational justice

The practice area of occupational justice relates to the “benefits, privileges and harms associated with participation in occupations” and the effects related to access or denial of opportunities to participate in occupations. This theory brings attention to the relationship between occupations and health. The skills of an occupational therapist enable them to serve as advocates for systemic change, impacting institutions, policy, and entire populations. Examples of populations that experience occupational injustice include:

- Refugees
- Prisoners
- Homeless persons
- Survivors of natural disasters

For example, the role of an occupational therapist working with refugees could include:

- Addressing developmental delays and psychological trauma of children through participation in the occupation of play
- Training workers at refugee camps who work with children on common issues associated with child forced migration and strategies to address these issues through occupation
- Educating and lobbying politicians and the public on the effects of forced migration on children and what can be done

Community based therapy

Community Based Treatment refers to a specific integrated model of treatment for people affected by drug use and dependence in the community which provides a continuum of care from outreach and

low threshold services, through detoxification and stabilisation to aftercare and integration, including maintenance

- Home-Based Counselling for Children & Families
- Home-Based Counselling for Adults
- Intensive Treatment in Foster Care for Children & Youth

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Good Practice: Community-Based Interventions and Services

- Strengthening families and neighbourhoods
- Improving institutional services
- New Academic Approaches
- Vocational Education and Employment And Training Programs

<https://www.nap.edu/read/2113/chapter/12#215>

As occupational therapy (OT) has grown and developed, community based practice has blossomed from an emerging area of practice to a fundamental part of occupational therapy practice (Scaffa & Reitz, 2013). Community based practice allows for OTs to work with clients and other stakeholders such as families, schools, employers, agencies, service providers, stores, day treatment and day care and others who may influence the degree of success the client will have in participating. It also allows the therapist to see what is actually happening in the context and design interventions relevant to what might support the client in participating and what is impeding her or him from participating. Community-based practice crosses all of the categories within which OTs practice from physical to cognitive, mental health to spiritual; all types of clients may be seen in community based settings. The role of the OT also may vary, from advocate to consultant, direct care provider to program designer, adjunctive services to therapeutic leader.

Occupational injustice

In contrast, occupational injustice relates to conditions wherein people are deprived, excluded or denied of opportunities that are meaningful to them. Types of occupational injustices and examples within the OT practice include:

- Occupational deprivation: The exclusion from meaningful occupations due to external factors that are beyond the person's control. As an example, a person who has difficulties with functional mobility may find it challenging to reintegrate into the community due to transportation barriers.
- Occupational apartheid: The exclusion of a person in chosen occupations due to personal characteristics such as age, gender, race, nationality or socioeconomic status. An example can be seen in children with developmental disabilities from low socioeconomic backgrounds whose families would opt out from therapy due to financial constraints.
- Occupational marginalization: Relates to how implicit norms of behavior or societal expectations prevent a person from engaging in a chosen occupation. As an example, a child with physical impairments may only be offered table-top leisure activities instead of sports as an extracurricular activity due to the functional limitations caused by his physical impairments.

- Occupational imbalance: The limited participation in a meaningful occupation brought about by another role in a different occupation. This can be seen in the situation of a caregiver of a person with disability who also has to fulfill other roles such as being a parent to other children, a student or a worker.

- Occupational alienation: The imposition of an occupation which does not hold meaning for that person. In the OT profession, this manifests in the provision of rote activities which does not really relate to the goals or the interest of the client.

Within occupational therapy practice, injustice may ensue in situations where in professional dominance, standardized treatments, laws and political conditions create a negative impact on the occupational engagement of our clients. Awareness of these injustices will enable the therapist to reflect on his own practice and think of ways in approaching their client's problems while promoting occupational justice.

Retrieved on 27/09/2019 from
(https://en.wikipedia.org/wiki/Occupational_therapy)

9.3 Let us sum up

In the unit you will get knowledge on role of the medical social worker in intervention, physical medicine, physiotherapy and occupational.

9.4 Unit end exercises

1. Why the role of social worker is important in occupational therapy
2. Describe what a social worker does in physical medicine
3. Briefly describe the role of social worker in intervention.
4. What a social worker can do in a physiotherapy centre

9.5 Answer to check your progress

1. Physical therapy is used to improve a patient's physical functions through physical examination, diagnosis, prognosis, physical intervention, rehabilitation and patient education.
2. Occupational therapists often work closely with professionals in physical therapy, speech therapy, audiology, nursing, social work, clinical psychology, and medicine.
3. Community-based practice crosses all of the categories within which OTs practice from physical to cognitive, mental health to spiritual; all types of clients may be seen in community based settings.
4. Patient education is one of the most important responsibilities that medical social workers have in health care settings
5. The practice area of occupational justice relates to the "benefits, privileges and harms associated with participation in occupations" and the effects related to access or denial of opportunities to participate in occupations.

9.6 Suggested readings

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Notes

UNIT X – REHABILITATION

Structure

- 10.1 Introduction
- 10.2 Objectives and types; Rehabilitation: definition, concept
- 10.3 Principles
- 10.4 Process
- 10.5 Role of the medical social worker in rehabilitation planning
- 10.6 Resource mobilization and follow up
- 10.7 Let us sum up
- 10.8 Unit end exercises
- 10.9 Answer to check your progress
- 10.10 Suggested readings

10.1 Introduction

This unit gives the reader an understanding about the objective, types, principles and process about rehabilitation and also the role of medical social worker in rehabilitation planning, resource mobilization and follow-up.

The noun rehabilitation comes from the Latin prefix re-, meaning “again” and habitare, meaning “make fit.” When something falls in to disrepair and needs to be restored to a better condition, it needs rehabilitation. People seek rehabilitation after an accident or surgery to restore their strength, or to learn to live without drugs or other addictive substances or behaviours.

Rehabilitation is the act of restoring something to its original state, like the rehabilitation of the forest that had once been cleared for use as an amusement park. The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically.

10.2 Objectives and types; Rehabilitation: definition, concept

Definition

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

Purpose

The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically. It is prescribed after many types of injury, illness, or disease, including amputations, arthritis, cancer, cardiac disease, neurological problems, orthopaedic injuries, spinal cord injuries, stroke, and traumatic brain injuries. The Institute of Medicine has estimated that as many as 14% of all Americans may be disabled at any given time.

Precautions

Rehabilitation should be carried out only by qualified therapists. Exercises and other physical interventions must take into account the patient's deficit. An example of a deficit is the loss of a limb.

Description

A proper and adequate rehabilitation program can reverse many disabling conditions or can help patients cope with deficits that cannot be reversed by medical care. Rehabilitation addresses the patient's physical, psychological, and environmental needs. It is achieved by restoring the patient's physical functions and/or modifying the patient's physical and social environment. The main types of rehabilitation are physical, occupational, and speech therapy.

Each rehabilitation program is tailored to the individual patient's needs and can include one or more types of therapy. The patient's physician usually coordinates the efforts of the rehabilitation team, which can include physical, occupational, speech, or other therapists; nurses; engineers; physiatrists (physical medicine); psychologists; orthotics (makes devices such as braces to straighten out curved or poorly shaped bones); prosthetics (a therapist who makes artificial limbs or prostheses); and vocational counsellors. Family members are often actively involved in the patient's rehabilitation program.

Physical therapy

Physical therapy helps the patient restore the use of muscles, bones, and the nervous system through the use of heat, cold, massage, whirlpool baths, ultrasound, exercise, and other techniques. It seeks to relieve pain, improve strength and mobility, and train the patient to perform important everyday tasks. Physical therapy may be prescribed to rehabilitate a patient after amputations, arthritis, burns, cancer, cardiac disease, cervical and lumbar dysfunction, neurological problems, orthopaedic

injuries, pulmonary disease, spinal cord injuries, stroke, traumatic brain injuries, and other injuries/illnesses. The duration of the physical therapy program varies depending on the injury/illness being treated and the patient's response to therapy.

Exercise is the most widely used and best known type of physical therapy. Depending on the patient's condition, exercises may be performed by the patient alone or with the therapist's help, or with the therapist moving the patient's limbs. Exercise equipment for physical therapy could include an exercise table or mat, a stationary bicycle,

walking aids, Altair, practice stairs, parallel bars, and pulleys and weights.

Heat treatment, applied with hot-water compresses, infrared lamps, short-waveradiation, high frequency electrical current, ultrasound, paraffin wax, or warm baths, is used to stimulate the patient's circulation, relax muscles, and relieve pain. Cold treatment is applied with ice packs or cold-water soaking. Soaking in a whirlpool canes muscle spasms and help strengthen movements. Massage aids circulation, helps the patient relax, relieves pain and muscle spasms, and reduces swelling. Very low strength electrical currents applied through the skin stimulate muscles and make them contract, helping paralyzed or weakened muscles respond again.

Occupational therapy

Occupational therapy helps the patient regain the ability to do normal everyday tasks. This may be achieved by restoring old skills or teaching the patient new skills to adjust to disabilities through adaptive equipment, orthotics, and modification of the patient's home environment. Occupational therapy may be prescribed to rehabilitate a patient after amputation, arthritis, cancer, cardiac disease, head injuries, neurological injuries, orthopaedic

injuries, pulmonary disease, spinal cord disease, stroke, and other injuries/illnesses. The duration of the occupational therapy program varies depending on the injury/illness being treated and the patient's response to therapy.

Occupational therapy includes learning how to use devices to assist in walking (artificial limbs, canes, crutches, walkers), getting around without walking (wheelchairs or motorized scooters), or moving from one spot to another (boards, lifts, and bars). The therapist will visit the patient's home and analyze what the patient can and cannot do. Suggestions on modifications to the home, such as rearranging furniture or adding a wheelchair ramp, will be made. Health aides to bathing and grooming could also be recommended.

Speech therapy

Speech therapy helps the patient correct speech disorders or restore speech. Speech therapy may be prescribed to rehabilitate a patient after a brain injury, cancer, neuromuscular diseases, stroke, and other injuries/illnesses. The duration of the speech therapy program varies depending on the injury/illness being treated and the patient's response to therapy.

Performed by a speech pathologist, speech therapy involves regular meetings with the therapist in an individual or group setting and home exercises. To strengthen muscles, the patient might be asked to say words, smile, close his mouth, or stick out his tongue. Picture cards may be used to help the patient remember everyday objects and increase his vocabulary. The patient might use picture boards of everyday activities or objects to communicate with others. Workbooks might be used to help the patient recall the names of objects and practice reading, writing, and listening. Computer programs are available to help sharpen speech, reading, recall, and listening skills.

Other types of therapists

Inhalation therapists, audiologists, and registered dietitians are other types of therapists. Inhalation therapists help the patient learn to

10.3 Principles

Notes

There are seven principles of rehabilitation; principles are the foundation upon which rehabilitation is based. This mnemonic may help you remember the principles of rehabilitation: ATC IS IT.

Avoid aggravation

Timing

Compliance

Individualization

Specific sequencing

Intensity

Total patient

- **A: Avoid aggravation.** It is important not to aggravate the injury during the rehabilitation process. Therapeutic exercise, if administered incorrectly or without good judgment, has the potential to exacerbate the injury, that is, makes it worse. The primary concern of the therapeutic exercise program is to advance the injured individual gradually and steadily and to keep setbacks to a minimum.
- **T: Timing.** The therapeutic exercise portion of the rehabilitation program should begin as soon as possible—that is, as soon as it can occur without causing aggravation. The sooner patients can begin the exercise portion of the rehabilitation program, the sooner they can return to full activity. Following injury, rest is sometimes necessary, but too much rest can actually be detrimental to recovery.
- **C: Compliance.** Without a compliant patient, the rehabilitation program will not be successful. To ensure compliance, it is important to inform the patient of the content of the program and the expected course of rehabilitation. Patients are more compliant when they are better aware of the program they will be following, the work they will have to do, and the components of the rehabilitation process.
- **I: Individualization.** Each person responds differently to an injury and to the subsequent rehabilitation program. Expecting a patient to progress in the same way as the last patient you had with a similar injury will be frustrating for both you and the patient. It is first necessary to recognize that each person is different. It is also important to realize that even though an injury may seem the same in type and severity as another, undetectable differences can change an individual's response to it. Individual physiological and chemical differences profoundly affect a patient's specific responses to an injury.
- **S: Specific sequencing.** A therapeutic exercise program should follow a specific sequence of events. This specific sequence is determined by the body's physiological healing response and is briefly addressed in the next section of this chapter.
- **I: Intensity.** The intensity level of the therapeutic exercise program must challenge the patient and the injured area but at the same time must not cause aggravation. Knowing when to increase intensity without overtaxing the injury requires observation of the patient's response and consideration of the healing process.
- **T: Total patient.** You must consider the total patient in the rehabilitation process. It is important for the unaffected areas of the

body to stay finely tuned. This means keeping the cardiovascular system at a preinjury level and maintaining range of motion, strength, coordination, and muscle endurance of the uninjured limbs and joints. The whole body must be the focus of the rehabilitation program, not just the injured area. Remember that the total patient must be ready for return to normal activity or competition; providing the patient with a program to keep the uninvolved areas in peak condition, rather than just rehabilitating the injured area, will help you better prepare the patient physically and psychologically for when the injured area is completely rehabilitated

Retrieved on 01/10/2019 from
(<https://us.humankinetics.com/blogs/excerpt/employ-the-seven-principles-of-rehabilitation>)

10.4 Process

The rehabilitation process is a comprehensive treatment, provided by a multi-professional team comprising: a physician specializing in rehabilitation, nursing staff, physiotherapist, occupational therapist, speech therapist, psychologist and social worker.

The rehabilitation process consists of three stages:

1. Diagnosis and evaluation – the team receives the patient and performs initial diagnosis and evaluation to determine rehabilitation objectives, including a preliminary prognosis as to the individual's ability to improve his functioning level. During evaluation the professionals recommend how treatment should proceed, whether it should be conducted in the hospital or in the community, and what kinds of treatments are most suitable.

Patients hospitalized following an illness or trauma is evaluated prior to their release by a geriatric or rehabilitation specialist, in consultation with a therapist from one of the health professions, such as a physiotherapist or social worker.

2. Rehabilitation – the rehabilitation itself includes: medical monitoring and a structured medical program for balancing risks and preventing complications; therapies as needed – occupational, physical, speech and/or others; a social worker who follows the patient's progress, helps him/her obtain all relevant services and rights from Bituach Leumi, and eases his/her return to the community. Throughout the process the multi-professional team monitors progress and helps the patient and his/her family prepare for the new lifestyle to be expected at home, which is suitable for the patient's condition and capabilities after rehabilitation.

3. Evaluation and conclusion – the evaluation and conclusion of the rehabilitation process include recommendations for continued treatment as needed. The multi-professional team evaluates the rehabilitation's outcome, formulates recommendations for continued treatment and instructs the patient and his/her family with regard to the patient's new needs. This summation is recorded in writing and a copy is given to the patient's family.

Retrieved on 01/10/2019 from (<https://www.reutheshel.org.il/en/what-is-the-rehabilitation-process/>)

10.5 Role of the medical social worker in rehabilitation planning

Notes

Social Work for Inpatients

Social workers meet regularly with patients at Rusk Rehabilitation during their hospital stay to address any concerns related to the emotional and physical impact of an illness or disability.

Through a combination of individual, family, and group treatment sessions, the social worker provides support and assists you and your family in adjusting to your new needs and challenges.

Licensed clinical social workers also serve as Rusk Rehabilitation's link between the hospital and the community, coordinating at-home care for patients, and encouraging you and your family to actively participate in formulating a discharge plan that meets your immediate needs. Social workers also talk with you about planning your long-term recovery after you leave Rusk Rehabilitation.

A social worker can help to identify any financial concerns you and your family may have, and work with insurance carriers and community resources to ensure the smooth delivery of healthcare services. This assistance includes exploring and assisting in applying for financial entitlements, helping in long-term care planning, and making recommendations and referrals to available community resources such as home care, support groups, and transportation assistance.

Social Work for Outpatients

As part of Rusk Rehabilitation's outpatient program, patients and their families continue to learn about and adapt to the changes that follow illness or injury. Our social workers have specialized knowledge of neurologic and orthopedic rehabilitation. They are available to provide psychological counseling to patients and families in order to address any concerns related to the emotional impact of the patient's illness and disability, including the effects of prolonged caregiving.

To help patients and their families address difficulties in adjusting to illness or disability that can otherwise lead to anxiety and depression, the Rusk Rehabilitation social work staff teaches strategies that emphasize inner resilience, self-advocacy, and drawing on one's own strengths.

Social workers also help identify practical solutions that use available community resources, such as support groups, wellness programs, and respite care for caregivers, as well as provide education and assistance in applying for government-sponsored financial entitlements and programs. As part of the rehabilitation team, a social worker facilitates discussion between patients, their families, and our treatment staff to formulate a discharge plan that addresses the patient's needs and can help maintain the gains made during their outpatient treatment.

The Role of Social Workers at Inpatient Rehabilitation Facilities

To serve as a social worker means to serve in a variety of roles – usually on a daily basis. That's certainly true of social workers who serve in inpatient rehabilitation facilities.

With March being National Social Work Month, it's a great time to take a closer look at the many ways the nation's more than 600,000 social

workers serve the healthcare industry. And in an inpatient rehabilitation setting, where patients are recovering from disabling diseases, injuries, and chronic illnesses, social workers are an integral part of the medical team.

Social Workers in Inpatient Rehabilitation Facilities

Social workers are key contributors in the rehabilitation and recovery of patients in inpatient rehabilitation facilities. Their roles may include:

- The initial screening and evaluation of patients and families.
- Helping patients and family members deal with the many aspects of the patient's condition – social, financial, and emotional.
- Helping patients and families understand their illnesses and treatment options.
- Acting as an advocate for patients and families – including as an advocate for the patient's health care rights.
- Aid and expedite decision-making on behalf of patients and their families.
- Educating patients on the roles of other members on their recovery team – including physicians, nurses, physical therapists, etc.
- Crisis intervention
- Providing a comprehensive psychosocial assessment of patients.
- Educating patients and families about post-hospital care.
- Helping patients adjust to their inpatient rehab setting.
- Coordinating patient discharge and continuity of care following discharge.

Serving as a Patient/Family Advocate

As mentioned, one of the key roles that social workers serve in an inpatient rehabilitation setting is as a patient advocate. The importance of helping the patient understand and adjust to hospital procedures, understand medical plans, and assisting the patient's family with financial planning is crucial.

The social worker's role as an advocate also includes maintaining open lines of communication between the patient, family, and other members of the health care team. He or she also will learn each family's dynamics while understanding its strengths – and encouraging the use of these strengths.

Indeed, the pressure on families as a loved one moves through the health care system can be intense and there's a lot to learn in a short time. Social workers ease this pressure on all levels, whether it regards the plan of treatment or financial needs.

Studies have shown that the more informed the patient, the better healthcare decisions he or she will make during their treatment and post-recovery. In turn, this results in better long-term health outcomes while also saving money.

While some healthcare facilities will have trained volunteers serving as patient advocates, social workers are more qualified to serve in an advocate role based on their education, training, and experience. At Ernest Health Systems, we believe that social workers are an essential part of a patient's recovery team.

Retrieved on 01/10/2019 from (<https://nyulangone.org/locations/rusk-rehabilitation/rehabilitation-social-work-services>)

10.6 Resource mobilization and follow up

Notes

After inpatient hospital treatment

treatment or rehabilitation takes place either on an outpatient or inpatient basis. Follow-up medical treatment is aimed at restoring lost functions and abilities and works towards coping with the strains of everyday and professional life. Medical rehabilitation takes place directly or at the latest 2 weeks after discharge from inpatient hospital care. The treatment usually lasts for 3 weeks and can be extended or shortened.

Requirements for follow-up medical treatment / follow-up rehabilitation

The hospital decides whether follow-up medical treatment is necessary. The hospital's social services help to apply. There are generally two routes to receiving follow-up medical treatment or follow-up rehabilitation:

1. Patient will be transferred directly to the rehabilitation facility without having to wait for the insurance company's decision (Health Insurance Company or pension insurance company).

2. If direct transfer is not possible, patient will be transferred as soon as possible to the rehabilitation facility once the insurance company (Health Insurance Company or pension insurance company) has made a quick decision regarding your application. Outpatient or Inpatient?

Follow-up medical treatment or rehabilitation includes diagnosis and information on the respective illness and the impaired functions. The treatment goals are developed together by the clinic and patient. Patient will learn coping strategies to overcome everyday problems that have at work.

Retrieved on 01/10/2019 from
(<https://www.mediclin.de/en/Zielgruppen/P-A/Patients-and-relatives/Your-path-to-rehabilitation/Rehabilitation-measures/Follow-up-medical-treatment-Follow-up-rehabilitation.aspx>)

10.7 Let us sum up

In this unit, you have learnt about what the rehabilitation is, what are all the objectives, types, principles, process, role of the medical social worker in rehabilitation, planning, resource mobilization and follow up

10.8 Unit end exercises

1. Trace out the important steps to be included in rehabilitation planning
2. How did follow up is needed in rehabilitation
3. Write down the objectives of rehabilitation
4. Mention the principles of rehabilitation
5. Draw out the process involved in rehabilitation

10.9 Answer to check your progress

1. The main types of rehabilitation are physical, occupational, and speech therapy.
2. The rehabilitation process is a comprehensive treatment, provided by a multi-professional team comprising: a physician specializing in rehabilitation, nursing staff, physiotherapist, occupational therapist, speech therapist, psychologist and social worker.
3. A social worker can help to identify any financial concerns you and your family may have, and work with insurance carriers and community resources to ensure the smooth delivery of healthcare services.
4. The whole body must be the focus of the rehabilitation program, not just the injured area.
5. The patient's physician usually coordinates the efforts of the rehabilitation team, which can include physical, occupational, speech, or other therapists; nurses; engineers; physiatrists (physical medicine); psychologists; orthotics (makes devices such as braces to straighten out curved or poorly shaped bones); prosthetics (a therapist who makes artificial limbs or prostheses); and vocational counsellors.

10.10 Suggested readings

1. Seltzer, Judith B. "What is Resource Mobilization". Health Communication Capacity Collaborative. Management Sciences for Health.
2. John D. McCarthy and Mayer N. Zald, The Enduring Vitality of the Resource Mobilization Theory of Social Movements in Jonathan H. Turner (ed.), Handbook of Sociological Theory, 2001
3. Diana Kendall, Sociology In Our Times, Thomson Wadsworth, 2005
4. Steven M. Buechler, Social Movements in Advanced Capitalism, Oxford University Press
5. McCarthy and Zald (1977). "Resource Mobilization and Social Movements: A Partial Theory" (PDF). The American Journal of Sociology. 82 (6): 1212–1241. doi:10.1086/226464.
6. Edwards and McCarthy (2004). The Blackwell Companion to Social Movements. Massachusetts: Blackwell Publishing. pp. 116–152. ISBN 978-0-631-22669-7.
7. Deric., Shannon (2011-01-01). Political sociology : oppression, resistance, and the state. Pine Forge Press. ISBN 9781412980401. OCLC 746832550.
8. Deric., Shannon (2011-01-01). Political sociology : oppression, resistance, and the state. Pine Forge Press. ISBN 9781412980401. OCLC 746832550.
9. "MoveOn.Org | Democracy In Action". MoveOn.Org | Democracy In Action.

UNIT XI – SPECIFIC NEEDS AND PROBLEMS OF PATIENTS AND THEIR FAMILIES

Specific needs and problems of patients and their families

Notes

Structure

- 11.1 Introduction
- 11.2 Specific needs and problems of patients and their families
- 11.3 Need for assistance
- 11.4 Let us sum up
- 11.5 Unit end exercises
- 11.6 Answer to check your progress
- 11.7 Suggested readings

11.1 Introduction

This unit gives the reader an understanding about the specific needs and problems of patients and their families when they are hospitalised.

11.2 Specific needs and problems of patients and their families

- Psychological - including relatives' psychosocial needs, changes in condition of care and anticipatory needs;
- Cognitive - knowledge of treatment, quality of information and access to information;
- Physical and personal comfort.

Psychosocial needs- Assisting residents to meet their basic needs includes their emotional and mental well-being, also called psychosocial needs.

Major psychosocial issues included family problems, depression, anxiety, substance abuse, sexual abuse, and violence. Women were more likely to have suffered violence while many of the men had problems dealing with their own aggression toward others.

Retrieved on 03/10/2019 from (<https://www.nursingtimes.net/clinical-archive/critical-care/meeting-the-needs-of-families-of-patients-in-intensive-care-units/205503.article>)

11.3 Need for assistance

Patients need lot of assistance from the hospital, family and the community. Some of them are mentioned below:

- Needs regarding treatment
- Need of mental support
- Regarding discharges

- Need to information
- Needs relating to leading a healthy life for the patients.

Needs of hospitalized patients

Need for trust / communication- Fulfilment of the need for trust is essential for the harmonious relationship between patients and health professionals and is largely important for their good cooperation. More specifically, accomplishment of an effective communication, starting from taking the medical history of the patient to implementation of any medical / nursing practice helps to reduce the patients' anxiety and ensures their cooperation.

The communication between health professionals and patients is a dynamic and interacting relationship. For example, the health professionals need accurate information from the patients in order to assess the disease state, to provide an accurate diagnosis, and to choose the appropriate treatment. On the other hand, through an effective communication, the patients are able to understand the medical instructions in detail, to accept their medical condition, and to comply with the treatment.

Need for information- the doctor was the person to decide for the patient's treatment therapy, and the degree and the kind of information given to the patient, always taking into account what is 'best' for the patient. This was done in order to promote autonomy and for recognition of the patients' right to be informed clearly about their health condition. The patients adopted a more critical attitude towards health care provision and there was a significant change in the way and type of information provided by the physicians.

Need for education- The idea behind an effective educational program is the change of the patient's behaviour towards more self-control, more active participation and decision making, development of self-care, assessment of personal risk factors, the implementation of realistic goals and expectations, and generally more efficient managing of their health and quality of life. The education of patients concluded that health professionals pay more attention to issues relating to the anatomy, psychology, medication and even sexual lives of the patients, whereas the patients need to be educated about more practical issues regarding their health condition and prevalence of complications

Need for self-care- Participation and self-care is defined as the extent to which the patient is involved in the treatment and in decisions concerning it. Providing quality care requires apart from meeting the patients' needs, to investigate and improve the extent to which they can participate in their treatment therapy with the ultimate aim to be the improvement of the prognosis and their quality of life. The degree of involvement of patients in their treatment therapy varies. Sometimes patients are reluctant to participate actively because of lack of knowledge or even lack interest for the progress of the disease, and sometimes they question the treatment and its effectiveness.

Need for support- Regarding the need for support, it is widely accepted that both the sudden hospitalization and the frequent rehospitalisation are stressful conditions where the patients need support from their family and the health professionals in order to cope with the disease.

Also, most patients experience various problems mainly after discharge from the hospital, and need help and support.

Retrieved on 03/10/2019 from (<https://www.nursingtimes.net/clinical-archive/critical-care/meeting-the-needs-of-families-of-patients-in-intensive-care-units/205503.article>)

Specific needs and problems of patients and their families

Notes

11.4 Let us sum up

From this unit you have achieved ideas on specific needs and problems of patient and their families and the need for assistance. This knowledge will help you to increase the practical skills while you work professionally in settings.

11.5 Unit end exercises

1. What all are the problems that can be caused to a patient?
2. Why the family members of the patient need assistance?
3. Mention some needs of a patient and family

11.6 Answer to check your progress

1. The patients can develop psychosocial problems and their needs are varied.
2. The degree of involvement of patients in their treatment therapy varies.
3. The idea behind an effective educational program is the change of the patient's behaviour towards more self-control, more active participation and decision making, development of self-care, assessment of personal risk factors, the implementation of realistic goals and expectations, and generally more efficient managing of their health and quality of life.
4. Fulfilment of the need for trust is essential for the harmonious relationship between patients and health professionals and is largely important for their good cooperation.

11.7 Suggested readings

1. Schacter, Daniel (2012). Psychology. United States of America: Worth Publisher.
2. Adapted from: Cipolle RJ, Strand LM, Morley PC. Pharmaceutical Care Practice: The Clinician's Guide, 2nd edition. New York: McGraw-Hill, 2004 Adapted by: Carla Dillon, Kimberly Duggan

UNIT XII – ROLE OF SOCIAL WORKER IN OUTPATIENT AND ICU

Notes

Structure

12.1 Introduction

12.2 Role of the medical social worker in the following settings:

12.2.1 Outpatient unit

12.2.2 Intensive care unit

12.3 Let us sum up

12.4 Unit end exercises

12.5 Answer to check your progress

12.6 Suggested readings

12.1 Introduction

This unit gives the reader an understanding about the role of social worker in outpatient and Intensive care Unit (ICU).

12.2 Role of the medical social worker in the following settings:

12.2.1 Outpatient unit

Medical social workers belong to a group known as health care social workers. Although a medical social worker typically works in the hospital setting, some may also work in outpatient settings such as medical clinics, outpatient care centers, primary care settings and mental health clinics. Although the role may vary from one organization to another, some common characteristics do exist.

Dual Functions and Psychosocial Issues

Health care social workers may be direct service or clinical social workers. The latter are mental health professionals who diagnose and treat mental illness. Direct-service social workers help people with problems to deal with the issues facing them or make connections that will get them the help they need, such as financial assistance or jobs. In either case, one of the important roles for the social worker in the outpatient arena is to identify psychosocial problems that might not be noticed by primary care or specialty medical personnel, who are dealing with other issues. The social worker in a fertility clinic, for example, is likely to be the professional who deals with a patient's depression over her reproductive problems.

Prevention

In the outpatient setting, the emphasis is on prevention, according to the National Association of Social Workers. The social worker in a primary

care clinic, for example, becomes familiar with issues related to chronic disease, such as depression, anxiety and grief. She will try to intervene early to prevent more serious problems, such as suicide. Social workers in specialty clinics often become experts in issues related to that field, and they can help educate patients and families and support both patients and the other professionals involved in care. Along this line, the social worker should recognize the potential for burnout, in her or other health care professionals, and intervene early.

Retrieved from (<https://careertrend.com/roles-medical-social-worker-outpatient-unit-43015.html>) on 04/10/2019

12.2.2 Intensive care unit

Social work's role in end-of-life care in the intensive care unit (ICU) varies widely across and within hospitals. Social workers can be a valuable asset in the provision of end-of-life care. They are trained to provide support to patients and families, improve communication between medical providers and patient/family, advocate for their wishes as well as being attuned to cultural needs (Eicholz Heller and Jimenez-Bautista 2015; Saunders et al. 2015). Where the ICU team is generally busy and time constrained, the social worker can take the necessary time to listen, educate and advocate for the patient and family as well as serve as a bridge between the patients, families and medical team. Yet, despite all of these advantages, social workers in many institutions do not have a formal role in the ICU (Gonzalez 2013).

Demographics and the 'cost' of ICU care at end of life

"Approximately 10% of patients admitted to the ICU will die in or shortly after they leave the ICU" (McCormick 2011, p. 54). Statistically, 20% of all deaths in the United States occur in ICUs (Curtis 2005; Gries et al. 2008). Between 11.5% and 30% of U.S. hospital cost is in the ICU, and roughly half of the patients who have a length of stay longer than 14 days in the ICU eventually die (Rose and Shelton 2006). In the ICU as many as 95% of the patients are incapacitated due to illness or sedation (McCormick et al. 2007; Truog et al. 2008), which results in the family making treatment decisions and participating in goals of care discussions with the critical care clinicians (Curtis and Vincent 2010; Rose and Shelton 2006). Due to biomedical advances and technical skills, patients' lives are often extended, which can lead to prolonged suffering (Christ and Sormanti 1999).

CU environment stressors

Admissions to the ICU are often decided by non-critical care physicians and many times are unexpected and emergent (Delva et al. 2002). Additionally, end-of-life care is frequently not discussed with patients or families prior to the decision to admit to intensive care (Rady and Johnson 2004). This can create a level of tension between the ICU team and the family, patient and prior medical team. Critical care physicians are often unfamiliar with a patient's prior medical history, do not have an existing relationship with the patient and family and hence are not fully prepared to discuss end-of-life decisions. This can lead to a medical treatment plan that is incongruent with the patient's wishes.

Notes

In the ICU, there are many providers involved in each patient's care. This can lead to conflicting and confusing information being relayed to the patient and family. Additionally, because the ICU is a complex environment, levels of stress, anxiety and depression increase. Additionally, death is a deeply personal experience and each individual interprets the event very differently depending on their cultural and religious backgrounds and life experiences. For, example, someone with strong Catholic beliefs may be unable to accept the futility of ongoing life support, despite no chance of survival.

Also contributing to stress, families must balance managing their life outside of the ICU, including such responsibilities as: caring for children, paying bills, going to work, and at the same time caring for and supporting their dying loved one (Abbott et al. 2001). This results in caregiver burden, and can impact their ability to understand and interpret medical information provided, the decline of their loved one, and can escalate conflicts with the medical team. Families often feel stress, confusion, depression and helplessness. Many suffer from symptoms of acute stress disorder, post-traumatic stress disorder (PTSD), or posttraumatic stress reaction (Carlet et al. 2003; McAdam and Puntillo 2009; McAdam et al. 2010). Family members in ICUs are usually in a state of crisis (Delva et al. 2002; Mann et al. 1977) and feel unprepared to act as the patient's decision maker (Rose and Shelton 2006). These factors can affect their treatment decisions for the patient as well as their satisfaction with the quality of care received in the ICU (Abbot et al. 2001).

Role of ICU social worker with patient and family

ICU social workers play a key role in end-of-life care, acting as case managers, counsellors, teachers, mediators and advocates (Bomba et al. 2010; Csikai 2006). They are trained to work with the whole person, and understand diverse cultural, ethnic and socioeconomic backgrounds (Heyman and Gutheil 2006; Saunders et al. 2015). Master-level social workers receive training in the foundational skills needed to engage, assess and intervene through the use of critical thinking, active listening and strong communication skills. They are also trained in more advanced skills such as crisis intervention, strengths perspective, cognitive restructuring, person-in-environment as well as individual and family therapy (Hartman-Shea et al. 2011; Kondrat 2013).

Social workers can help families navigate the ICU environment through understanding how it functions and the roles of the staff involved in the care of the patient (McCormick et al. 2010; Rose and Shelton 2006). "Families require accurate, clear, and timely information presented in a language that invites a beginning integration not only of the issues at hand but also of the potential outcomes" (McCormick 2011, p. 54). Social workers develop coping skills with families to deal with the stressful environment, clarify medical information regarding prognosis, decision-making options (e.g. do not resuscitate, artificial hydration/nutrition, mechanical ventilation, antibio-tics, renal dialysis, etc.), and the difference between supportive/comfort care and life-maintaining care (Heyman & Gutheil 2006; McCormick et al. 2010). Hartman-Shea et al. (2011) found that psychosocial counselling and support was one of the most frequent social work activities most linked

to family satisfaction and the reduction of anxiety. The social worker has the ability to assist with those needs through spending time with families to review the medical information and process their emotions. Assessments are crucial in the ICU team's ability to partner and work with families. The ICU social worker is able to assess how the family responds to crisis situations, the family dynamics and their communication patterns, which aids the medical team in providing a more empathic, compassionate and effective means to communicate with the family (Hartman-Shea et al. 2011). It is imperative that families of ICU patients understand and are aware of the different end-of-life care options; including how and where the patient's death can occur and the process surrounding the death in order to make decisions congruent with the patients' wishes (McCormick et al. 2007). Hartman-Shea et al. (2011) identified twenty-four medical social work interventions

Social workers are often the most knowledgeable and comfortable discussing end-of-life care and hospice choices. They can guide the family and patient in understanding and making meaning of the different end-of-life options appropriate and available, as well as what each of those options means to the patient and family through an examination of the potential benefits or burdens (Csikai 2006, p. 1307). The social worker fills in the gaps that ICU medical providers may leave for families, working as 'context interpreters' for family members (Cagle and Kovacs 2009). The ICU social worker is able to help the families take the most important and relevant information and put it into context while also working through the feelings and reactions families have from this information (Cagle and Kovacs 2009). Due to their work with families, social workers decrease family members' feelings of helplessness in the ICU (Miller et al. 2007) as well as their acute stress.

Role of social worker on interdisciplinary team

Cagle and Kovacs (2009) and McCormick and colleagues (2010) stress the significant impact social workers have on improved communication between patients, families and healthcare providers. Social workers spend time speaking with families directly, discussing the family's perspective on the patient's condition, clarifying information, organising and attending family conferences and providing relevant psychosocial information to the ICU medical team (Rose and Shelton 2006). ICU clinicians are trained to assess and treat critically ill patients. Their bias is to treat and support, which can, in some instances, lead to futile treatment, prolonged ICU stays and patient and family suffering. The social worker can advocate for the patient and, as the palliative care literature clearly demonstrates, improve adherence to patient/family wishes and outcomes (May et al. 2015; Cassel et al. 2010). Social workers "can encourage health professionals to understand and clarify their own role in the decision-making process, promote communication and problem solving, and identify and improve systems that may interfere with optimal communication and problem solving regarding such sensitive problems as end-of-life decisions" (Werner et al. 2004, p. 34).

Family conferences are an effective strategy for medical providers to discuss end-of-life care and have been linked to the reduction of the family's symptoms of PTSD, anxiety and depression (Browning 2008;

McAdam and Puntillo 2009). The social worker plays a key role in family conferences, from arranging the meeting to ensuring that the key family members are present and available for the meeting, as well as acting as a context interpreter and clarifier during the meeting. The social worker can provide support to the family after the meeting. Retrieved from (<https://healthmanagement.org/c/icu/issuearticle/making-the-case-for-social-work-practice-in-the-care-of-critically-ill-icu-patients>) on 04/10/2019

12.2 Let us sum up

The role of a medical social worker in outpatient and intensive care unit will be cleared from this unit. This theoretical knowledge will help you to enshrine in the professional

12.3 Unit end exercises

1. Write the significance of intensive care unit

12.4 Answer to check your progress

1. Social workers in specialty clinics often become experts in issues related to that field, and they can help educate patients and families and support both patients and the other professionals involved in care.

12.5 Suggested readings

1. Segen's Medical Dictionary and Medical Dictionary for the Health Professions and Nursing
2. Kunders, G.D. (2004). Hospitals: Facilities Planning and Management. Tata McGraw-Hill Education.
3. "NHS outpatient's service 'stuck in the 18th Century'". BBC. 9 November 2018. Retrieved 9 November 2018.
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UNIT XIII – DEPARTMENTS IN HOSPITALS

Departments in hospitals

Structure

Notes

- 13.1 Introduction
- 13.2 Pediatric ward
- 13.3 Maternity ward
- 13.4 Abortion clinic
- 13.5 Family planning centre
- 13.6 STD clinics
- 13.7 HIV clinics
- 13.8 Orthopedic department
- 13.9 Cardiology department
- 13.10 Blood bank
- 13.11 TB sanatorium
- 13.12 Cancer hospitals
- 13.13 Let us sum up
- 13.14 Unit end exercises
- 13.15 Answer to check your progress
- 13.16 Suggested readings

13.1 Introduction

This unit gives the reader an understanding about the different departments in hospital and its activities. Mainly of paediatric, maternity, abortion, STD, HIV, clinics etc.

13.2 Pediatric ward

Paediatrics (Children)

The paediatric department provides care for children from birth to 17 years of age, for all illnesses. The department consists of the general paediatric wards, the neonatal intensive care unit, paediatric outpatients and the children's day surgery unit.

General Paediatric Wards

We have two wards, incorporating an assessment unit, a high dependency unit and a Paediatric day unit:

- **Acorn Ward** which has nine cubicles now operates as the assessment unit and short-stay ward, as well as providing specialist care for very young infants.

- **Oak Ward** has four bays of four beds each, as well as seven cubicles, three of which are equipped to look after Oncology patients. It provides care for older children, elective admissions and those expected to have a longer stay in hospital.
- **Pediatric Day Unit** has six beds and is used for most elective Pediatric day-case admissions, including blood tests and minor treatments.
- **High Dependency Unit** has two fully-equipped beds for the provision of high dependency care, such as patients after complex surgery or those requiring respiratory support.

Neonatal intensive care unit

The neonatal intensive care unit is located in the maternity block, this unit provides care for infants from the age of 24 weeks gestation onwards, including full intensive care. The unit has four intensive care, four high dependency and 10 special care cots.

Paediatric outpatients

This is a specialist outpatient department for children, located adjacent to the general pediatric wards in the Old Building of the hospital. The hospital are working towards ensuring that all children seen by any specialty as an outpatient will be cared for in this department.

Children's day surgery unit

Children who are admitted for day-case surgical procedures are either admitted to the pediatric day unit, or directly to this specialist surgical unit, which is part of the day surgery centre. Care is provided by trained pediatric staff.

Retrieved from ([https://www.tsft.nhs.uk/wards-and-departments/departments-services/paediatrics-\(children/\)](https://www.tsft.nhs.uk/wards-and-departments/departments-services/paediatrics-(children/))) on 04/10/2019

13.3 Maternity ward

Because the needs of expectant mothers are different than other patients--they aren't sick--maternity wards are designed to focus on them. Some hospitals provide rooms that are different for expectant mothers, with more home-like atmospheres. Maternity wards also may have specific delivery rooms rather than operating rooms. These wards also provide facilities for the newborn infants, including incubators and other special needs.

Retrieved on (<https://www.livestrong.com/article/24730-types-hospital-wards/>) on 04/10/2019

13.4 Abortion clinic

An abortion clinic is a medical facility that provides abortions. Such clinics may be public medical centers, private medical practices or non-profit organizations such as Planned Parenthood.

Anti-abortion protests

Operation Save America members protest in front of an abortion clinic in Jackson, Mississippi, during their 2006 National Event in that city.

Abortion clinics have frequently been the site of protests by anti-abortion activists. Protesters often engage in what is known as "sidewalk

counselling", in which they warn people entering the clinic about alleged risks of abortion, attempt to offer alternatives to abortion or show pictures of fetuses. In 1985, 85% of abortion providers were experiencing either picketing, clinic blockades or invasion of the facility, with 19% of providers receiving bomb threats and 16% were picketed at their homes. In 2000 82% of facilities received protests with 61% receiving 20 or more pickets.

The 2007 film *Juno* contains an example of such protest. The protagonist enters a clinic with the purpose of procuring an abortion, but sees a fellow student protesting outside the clinic who tells her that the foetus "has fingernails". This causes Juno to change her mind about having an abortion, and she leaves the clinic, with her friend calling out to her, "God appreciates your miracle."

Another tactic in which protestors film or photograph patients entering the clinic utilizes the societal stigma surrounding abortion and attempts to expose or shame women who are seeking the procedure. Anti-abortion activists have also attempted to access abortion clinic medical records by breaking into dumpsters, proposing state legislation that would require clinics to provide information regarding their patients to the government and hacking online databases containing confidential patient information.

In some countries, a buffer zone is enforced to prevent protesters from standing within a certain distance of the clinic entrance. In the United States these buffer zones have been the subject of many lawsuits and legislative actions on both state-wide and national levels. In 2014 the Supreme Court struck down a Massachusetts bill that had legalized a 35-foot buffer zone around abortion clinics in the state in 2007.

Anti-abortion violence

Main article: Anti-abortion violence

Abortion clinics have frequently been subject to anti-abortion violence. The *New York Times* cites over one hundred clinic bombings and incidents of arson, over three hundred invasions, and over four hundred incidents of vandalism between 1978 and 1993, and the National Abortion Federation, an organization of abortion providers, cites over 300 attempted or completed instances of bombing or arson, thousands of invasions and vandalism incidents, as well as other attacks, between 1977 and 2009. According to the NAF, the first instance of arson at an abortion clinic took place in March 1976 in Oregon, and the first bombing was in Ohio in February 1978. Some notable incidents are:

- In 1993, Dr. David Gunn was shot and killed outside as he arrived at his clinic.
- In 1993, Dr. George Tiller was shot in both arms by Shelley Shannon outside his clinic. Tiller would later be murdered in church by another opponent of abortion rights.
- In 1994, Dr. John Britton, another doctor, and James Barrett, his escort, were shot and killed by Paul Jennings Hill as they arrived at a clinic. Barrett's wife June was also wounded.
- In 1994, John Salvi shot and killed two abortion clinic receptionists, Shannon Lowney and Lee Ann Nichols, and wounded five other people.

- In 1998, a remote-controlled pipe bomb that Eric Robert Rudolph set outside a clinic killed security guard Robert Sanderson and maimed nurse Emily Lyons.
- In 2001, Peter James Knight shot and killed a security guard, Steven Rogers, at the abortion clinic where Rogers worked.
- In 2015, a shooting incident occurred at a Planned Parenthood clinic in Colorado Springs, Colorado which resulted in three fatalities, including a police officer, and in multiple injuries to other clinic workers and patients.

In the United States, the Freedom of Access to Clinic Entrances Act was passed in 1994 in response to acts of violence at clinics, which prohibits the use of force or obstruction to interfere with a person's attempt to obtain or provide reproductive health services, and the intentional damage of a reproductive health care facility such as an abortion clinic.

Retrieved on 04/10/2019 from https://en.wikipedia.org/wiki/Abortion_clinic

13.5 Family planning centre

Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved".^[1] Family planning may involve consideration of the number of children a woman wishes to have, including the choice to have no children, as well as the age at which she wishes to have them. These matters are influenced by external factors such as marital situation, career considerations, financial position, and any disabilities that may affect their ability to have children and raise them. If sexually active, family planning may involve the use of contraception and other techniques to control the timing of reproduction.

Other aspects of family planning include sex education, prevention and management of sexually transmitted infections, pre-conception counselling and management, and infertility management. Family planning, as defined by the United Nations and the World Health Organization, encompasses services leading up to conception. Abortion is not considered a component of family planning, although access to contraception and family planning reduces the need for abortion.

Family planning is sometimes used as a synonym or euphemism for access to and the use of contraception. However, it often involves methods and practices in addition to contraception. Additionally, there are many who might wish to use contraception but are not, necessarily, planning a family (e.g., unmarried adolescents, young married couples delaying childbearing while building a career); family planning has become a catch-all phrase for much of the work undertaken in this realm. Contemporary notions of family planning, however, tend to place a woman and her childbearing decisions at the centre of the discussion, as notions of women's empowerment and reproductive autonomy have gained traction in many parts of the world. It is most usually applied to a female-male couple who wish to limit the number of children they have

and/or to control the timing of pregnancy (also known as spacing children).

Retrieved on 04/10/2019 from
(https://en.wikipedia.org/wiki/Family_planning)

13.6 STD clinics

Sexual health clinics are also called sexually transmitted disease (STD) clinics, sexually transmitted infection (STI) clinics, venereal disease (VD) clinics, or genitourinary medicine (GUM) clinics.

Sexual health clinics differ from reproductive health and family planning clinics. Sexual health clinics offer only some reproductive health services. Reproductive health clinics, such as Planned Parenthood, offer most of the services of sexual health clinics.

Services

Sexual health clinics provide some or all of the following:

- Information about safer sex, birth control, reproductive health and general sex education
- Condoms
- Sexual health examinations
- Tests to detect some sexually transmitted infections
- Antibiotics to cure chlamydia, gonorrhoea, and syphilis
- Medications and other treatments
- Vaccinations
- Counselling and education
- Emergency contraception
- Urine test for pregnancy
- Referrals for additional information or services

Many clinics provide vaccinations to prevent infections from the hepatitis A and B viruses. Young women may receive vaccinations to prevent infection from some strains of the human papillomavirus (HPV). Many clinics provide interpreting for the hearing impaired or speakers of other languages.

Many clinics will help patients tell their sexual contacts if they have a sexually transmitted infection, anonymously if needed.

Public governmental and non-profit clinics often provide services for free or adjust the fee based on a patient's ability to pay.

Sexual health clinics often offer services without appointments. Some clinics open evenings or weekends.

Some clinics have separate hours or facilities for men and women. Some clinics serve only specific populations such as women, men, MSM, youths, LGBT, ethnic groups, the poor, or students.

Examinations

With the patient's consent, a clinician will inspect the patient visually and by touch. If needed, the clinician will take samples to test for sexually transmitted infections.

In a private room or space, the patient will partially undress.

The clinician may inspect the patient's:

- Throat and lymph nodes of the neck for inflammation
- Pubic hair for lice
- Lymph nodes of the groin for swelling

- Genitals, anus, and surrounding areas for sores and warts
- The clinician may swab the patient's:
- Throat to test for gonorrhea and possibly chlamydia
 - Cheek, inside, to diagnose HIV
 - Sores of the genitals, anus, and surrounding areas to test for herpes^[3]
 - Urethra to test for gonorrhea and possibly chlamydia
 - Vagina to test for chlamydia and possibly gonorrhea
 - Cervix to test for cervical intraepithelial neoplasia (a Pap test)
 - Rectum to test for gonorrhea and possibly chlamydia

The clinician may take small blood samples by pricking a finger or from a vein to test for HIV, syphilis, and possibly herpes and hepatitis C.

The clinician may ask for a small urine sample, given in private, to test for chlamydia and possibly gonorrhea.

The inspections and taking samples don't hurt, but swabbing the urethra and cervix, and a finger prick blood sample feel uncomfortable.

Women will often receive a pelvic exam, both external and internal, but usually less thorough than a reproductive health exam.

A patient can choose a female or male clinician if available. A patient can have a chaperone. Some clinics have separate hours or facilities for men and women.

Privacy

Medical confidentiality is an important part of the medical ethics of a doctor–patient relationship. Sexual health clinics follow local standards of medical confidentiality to protect the privacy of patients. Some clinics provide anonymous services or protect confidentiality by having a patient use a number or a pseudonym.

Additional privacy protections sometimes apply to matters of sexuality and reproduction, since these areas are sensitive in many cultures. The diagnosis of HIV/AIDS has legal restrictions in patient confidentiality, and some clinics use rapid antibody tests to provide results to a patient within 30 minutes, without holding the patient's records. In the United States, clinics receiving federal funding from Medicaid or Title X of the Public Health Service Act must treat all patients confidentially. Thus minors can receive services without parental notification or consent. Additionally, medical records for all patients age 18 and above are strictly confidential under HIPAA.

Consent

Medical standards of informed consent apply to sexual health clinics. A patient needs information about the purposes and consequences of examinations, tests, treatments, and other procedures. A patient may then choose whether to consent to these procedures.

A minor may consent to receive some or all of the procedures at many sexual health clinics.

Retrieved _____ on _____ 04/10/2019
from(https://en.wikipedia.org/wiki/Sexual_health_clinic)

13.7 HIV clinicsWhat is HIV testing?

HIV testing shows whether a person has HIV. HIV stands for human immunodeficiency virus. HIV is the virus that causes AIDS (acquired

immunodeficiency syndrome). AIDS is the most advanced stage of HIV infection.

HIV testing can detect HIV infection, but it can't tell how long a person has had HIV or if the person has AIDS.

Why is HIV testing important?

Knowing your HIV status can help keep you—and others—safe.

If you are HIV negative:

Testing shows that you don't have HIV. Continue taking steps to avoid getting HIV, such as using condoms during sex and, if you are at high risk of getting HIV, taking medicines to prevent HIV.

If you are HIV positive:

Testing shows that you have HIV, but you can still take steps to protect your health. Begin by talking to your health care provider about antiretroviral therapy (ART). People on ART take a combination of HIV medicines every day to treat HIV infection. ART is recommended for everyone who has HIV, and people with HIV should start ART as soon as possible. ART can't cure HIV, but HIV medicines help people with HIV live longer, healthier lives.

A main goal of ART is to reduce a person's viral load to an undetectable level. An undetectable viral load means that the level of HIV in the blood is too low to be detected by a viral load test. People with HIV who maintain an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative partner through sex.

Who should get tested for HIV?

The Centers for Disease Control and Prevention (CDC) recommends that everyone 13 to 64 years old get tested for HIV at least once as part of routine health care. As a general rule, people at higher risk for HIV should get tested each year. Sexually active gay and bisexual men may benefit from getting tested more often, such as every 3 to 6 months.

Factors that increase the risk of HIV include:

- Having vaginal or anal sex with someone who is HIV positive or whose HIV status you don't know
- Injecting drugs and sharing needles, syringes, or other drug equipment with others
- Exchanging sex for money or drugs
- Having a sexually transmitted disease (STD), such as syphilis
- Having hepatitis or tuberculosis (TB)
- Having sex with anyone who has any of the HIV risk factors listed above

Talk to your health care provider about your risk for HIV and how often you should get tested for HIV.

Should pregnant women get tested for HIV?

CDC recommends that all pregnant women get tested for HIV so that they can begin taking HIV medicines if they are HIV positive. Women with HIV take HIV medicines during pregnancy and childbirth to reduce the risk of mother-to-child transmission of HIV and to protect their own health. For more information, read the AIDS info fact sheet on Preventing Mother-to-Child Transmission of HIV.

What are the types of HIV tests?

There are three types of tests used to diagnose HIV infection: antibody tests, antigen/antibody tests, and nucleic acid tests (NATs). How soon

each test can detect HIV infection differs, because each test has a different window period. The window period is the time between when a person may have been exposed to HIV and when a test can accurately detect HIV infection.

- **Antibody tests** check for HIV antibodies in blood or oral fluid. HIV antibodies are disease-fighting proteins that the body produces in response to HIV infection. Most rapid tests and home use tests are antibody tests.

- **Antigen/antibody tests** can detect both HIV antibodies and HIV antigens (a part of the virus) in blood.

- **NATs** look for HIV in the blood.

A person's initial HIV test will usually be either an antibody test or an antigen/antibody test. NATs are very expensive and not routinely used for HIV screening unless the person had a high-risk exposure or a possible exposure with early symptoms of HIV infection.

When an HIV test is positive, a follow-up test will be conducted. Sometimes people will need to visit a health care provider to take a follow-up test. Other times the follow-up test may be performed in a lab using the same blood sample that was provided for the first test. A positive follow-up test confirms that a person has HIV.

Confidential testing means that your HIV test results will include your name and other identifying information, and the results will be included in your medical record. HIV-positive test results will be reported to local or state health departments to be counted in statistical reports. Health departments remove all personal information (including names and addresses) from HIV test results before sharing the information with CDC. CDC uses this information for reporting purposes and does not share this information with any other organizations, including insurance companies.

Anonymous testing means you don't have to give your name when you take an HIV test. When you take the test, you receive a number. To get your HIV test results, you give the number instead of your name.

Retrieved on 04/10/2019 from (<https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/47/hiv-testing>)

13.8 Orthopaedic department

Orthopaedic surgery or **orthopedics**, also spelled **orthopaedics**, is the branch of surgery concerned with conditions involving the musculoskeletal system. Orthopaedic surgeons use both surgical and nonsurgical means to treat musculo skeletal trauma, spine diseases, sports injuries, degenerative diseases, infections, tumours, and congenital disorders.

According to applications for board certification from 1999 to 2003, the top 25 most common procedures (in order) performed by orthopaedic surgeons are as follows.^[13]

1. Knee arthroscopy and meniscectomy
2. Shoulder arthroscopy and decompression
3. Carpal tunnel release
4. Knee arthroscopy and chondroplasty
5. Removal of support implant

6. Knee arthroscopy and anterior cruciate ligament reconstruction
7. Knee replacement
8. Repair of femoral neck fracture
9. Repair of trochanteric fracture
10. Debridement of skin/muscle/bone/fracture
11. Knee arthroscopy repair of both menisci
12. Hip replacement
13. Shoulder arthroscopy/distal clavicle excision
14. Repair of rotator cuff tendon
15. Repair fracture of radius (bone)/ulna
16. Laminectomy
17. Repair of ankle fracture (bimalleolar type)
18. Shoulder arthroscopy and debridement
19. Lumbar spinal fusion
20. Repair fracture of the distal part of radius
21. Low back intervertebral disc surgery
22. Incise finger tendon sheath
23. Repair of ankle fracture (fibula)
24. Repair of femoral shaft fracture
25. Repair of trochanteric fracture

Notes

A typical schedule for a practicing orthopaedic surgeon involves 50–55 hours of work per week divided among clinic, surgery, various administrative duties and possibly teaching and/or research if in an academic setting.

Retrieved on 04/10/2019 from

https://en.wikipedia.org/wiki/Orthopedic_surgery

13.9 Cardiology department

Cardiology is the medical speciality dealing with the diagnosis and treatment of diseases and disorders of the heart.

Cardiologists are specialists in diseases of the heart. The biggest area of heart disease treated is coronary artery disease e.g. angina. Also treated are abnormal heart rhythms, heart failure, high blood pressure and some rarer conditions.

Cardiologists usually treat heart disease with drugs. Some of them are also able to provide treatment for coronary heart disease with coronary angioplasty (a procedure by which the arteries of the heart are widened). If heart surgery is required, a cardiologist will refer you on to see a cardiothoracic surgeon who would perform the surgery.

Grown-up Congenital Heart Abnormalities (GUCH) and Cardiac Electrophysiology Clinics

A congenital heart defect is an abnormality of the heart that has been present from birth. Children born with heart disease, who once would not have survived, now reach adolescence and adulthood as a result of advances in cardiac surgery and medicine. These types of conditions are called Grown-Up Congenital Heart Abnormalities or GUCH.

If an abnormality is found, a cardiologist will carry out a full medical examination, arrange for an electrocardiogram (ECG), a chest x-ray, an echocardiogram and possibly blood tests. He will then be in a position to discuss with the patient what sort of treatment, if any, is required.

Some people may need more than one heart operation. If an artificial valve or plastic tube is inserted in the heart as a child, this will need replacing as the patient outgrows it. This can occur several times. Sometimes just ageing and growth can reduce the effectiveness of the first surgery. Regular follow-up is needed, even if the patient has had successful surgery and is leading a very normal life, because changes may occur within the heart. Cardiac surgery is relatively new and nobody knows what long-term effects there may be and it is important, for future generations, that records are kept.

Retrieved on 04/10/2019 from ([https://www.wyvalley.nhs.uk/visitors-and-patients/county-hospital-\(acute\)/a-z-departments/cardiac-services/cardiology-department.aspx](https://www.wyvalley.nhs.uk/visitors-and-patients/county-hospital-(acute)/a-z-departments/cardiac-services/cardiology-department.aspx))

13.10 Blood bank

A **blood bank** is a center where blood gathered as a result of blood donation is stored and preserved for later use in blood transfusion. The term "blood bank" typically refers to a division of a hospital where the storage of blood product occurs and where proper testing is performed (to reduce the risk of transfusion related adverse events). However, it sometimes refers to a collection center, and indeed some hospitals also perform collection.

Storage and management

Whole blood is often separated, using a centrifuge, into components for storage and transportation

Routine blood storage is 42 days or 6 weeks for stored packed red blood cells by far the most commonly transfused blood product, and involves refrigeration but usually not freezing. There has been increasing controversy about whether a given product unit's age is a factor in transfusion efficacy, specifically on whether "older" blood directly or indirectly increases risks of complications. Studies have not been consistent on answering this question, with some showing that older blood is indeed less effective but with others showing no such difference; nevertheless, as storage time remains the only available way to estimate quality status or loss, a first-in-first-out inventory management approach is standard presently. It is also important to consider that there is large variability in storage results for different donors, which combined with limited available quality testing, poses challenges to clinicians and regulators seeking reliable indicators of quality for blood products and storage systems.

Transfusions of platelets are comparatively far less numerous, but they present unique storage/management issues. Platelets may only be stored for 7 days, due largely to their greater potential for contamination, which is in turn due largely to a higher storage temperature.

RBC storage lesion

Insufficient transfusion efficacy can result from red blood cell (RBC) blood product units damaged by so-called storage lesion—a set of biochemical and biomechanical changes which occur during storage. With red cells, this can decrease viability and ability for tissue oxygenation. Although some of the biochemical changes are reversible after the blood is transfused, the biomechanical changes are less so, and

rejuvenation products are not yet able to adequately reverse this phenomenon.

Current regulatory measures are in place to minimize RBC storage lesion—including a maximum shelf life (currently 42 days), a maximum auto-hemolysis threshold (currently 1% in the US), and a minimum level of post-transfusion RBC survival in vivo (currently 75% after 24 hours). However, all of these criteria are applied in a universal manner that does not account for differences among units of product; for example, testing for the post-transfusion RBC survival in vivo is done on a sample of healthy volunteers, and then compliance is presumed for all RBC units based on universal (GMP) processing standards. RBC survival does not guarantee efficacy, but it is a necessary prerequisite for cell function, and hence serves as a regulatory proxy. Opinions vary as to the best way to determine transfusion efficacy in a patient in vivo.^[28] In general, there are not yet any in vitro tests to assess quality deterioration or preservation for specific units of RBC blood product prior to their transfusion, though there is exploration of potentially relevant tests based on RBC membrane properties such as erythrocyte deformability and erythrocyte fragility (mechanical).

Many physicians have adopted a so-called "restrictive protocol"—whereby transfusion is held to a minimum—due in part to the noted uncertainties surrounding storage lesion, in addition to the very high direct and indirect costs of transfusions, along with the increasing view that many transfusions are inappropriate or use too many RBC units.

Platelet storage lesion

Platelet storage lesion is a very different phenomenon from RBC storage lesion, due largely to the different functions of the products and purposes of the respective transfusions, along with different processing issues and inventory management considerations.

Alternative inventory and release practices

Although as noted the primary inventory-management approach is first in, first out (FIFO) to minimize product expiration, there are some deviations from this policy—both in current practice as well as under research. For example, exchange transfusion of RBC in neonates calls for use of blood product that is five days old or less, to "ensure" optimal cell function. Also, some hospital blood banks will attempt to accommodate physicians' requests to provide low-aged RBC product for certain kinds of patients (e.g. cardiac surgery).

More recently, novel approaches are being explored to complement or replace FIFO. One is to balance the desire to reduce average product age (at transfusion) with the need to maintain sufficient availability of non-outdated product, leading to a strategic blend of FIFO with last in, first out (LIFO).

Long-term storage

"Long-term" storage for all blood products is relatively uncommon, compared to routine/short-term storage. Cryopreservation of red blood cells is done to store rare units for up to ten years. The cells are incubated in a glycerol solution which acts as a cryoprotectant ("antifreeze") within the cells. The units are then placed in special sterile containers in a freezer at very low temperatures. The exact temperature depends on the glycerol concentration.

Notes

13.11 TB sanatorium

Tuberculosis is a treatable, communicable disease that has two general states: latent infection and active disease.¹ With few exceptions, only those who develop active tuberculosis in the lungs or larynx can infect others, usually by coughing, sneezing, or otherwise expelling tiny infectious particles that someone else inhales.

A **sanatorium** (also called **sanitarium** and, rarely **sanitorium**) is a medical facility for long-term illness, most typically associated with treatment of tuberculosis (TB) in the late-nineteenth and twentieth century before the discovery of antibiotics. A distinction is sometimes made between "sanitarium" or the east-European "sanatorium" (a kind of health resort, as in the Battle Creek Sanitarium) and "sanatorium" (a hospital).

The first suggestion of sanatoria in the modern sense was likely made by George Bodington, who opened a sanatorium in Sutton Coldfield in 1836 and later published his essay "On the Treatment and Cure of Pulmonary Consumption" in 1840. His novel approach was dismissed as "very crude ideas and unsupported assertions" by reviewers in the *Lancet*, and his sanatorium was converted to an asylum soon after. The rationale for sanatoria in the pre-antibiotic era was that a regimen of rest and good nutrition offered the best chance that the sufferer's immune system would "wall off" pockets of pulmonary TB infection. In 1863, Hermann Brehmer opened the Brehmersche Heilanstalt für Lungenkranke in Görbersdorf (Sokołowsko), Silesia (now Poland), for the treatment of tuberculosis. Patients were exposed to plentiful amounts of high altitude, fresh air, and good nutrition. Tuberculosis sanatoria became common throughout Europe from the late-19th century onward.

Aim of Sanitorium

The **aim of TB sanatorium** is: To cure the patient of **TB**; and. To minimize the transmission of *Mycobacterium tuberculosis*, to both immune suppressed and immune competent persons.

13.12 Cancer hospitals

Social workers in oncology wards will provide psychosocial assessments and **treatment** to patients and their families related to illness adjustment, coping mechanisms and discharge planning. They act as patient advocates by recommending resources for patient's needs, such as **social** support and financial assistance.

Social workers help with a wide variety of issues and are a wealth of knowledge when it comes to resources that can help patients and caregivers during treatment. Some of the areas they can help with include:

- Recommending and facilitating support groups

- Counselling for anxiety and depression, and, on the deepest level of face-to-face contact, help with all the complicated emotional and psychosocial aspects of cancer diagnosis, treatment, and survivorship. These emotions are unique to every patient, just as every patient's cancer is unique.
- Explaining diagnoses to friends and family
- Mediating patient-caregiver conflicts
- Referrals to financial assistance organizations
- Information on spiritual counseling
- Transportation to and from treatment
- Counselling for physical changes and body image and identity issues
- Providing information about a patient's disease

5 Job Duties of an Oncology Social Worker

An oncology social worker is a health care professional who provides psychosocial services to patients, families and others who are facing the impacts of potential or actual cancer diagnoses. Here are their five major employment responsibilities.

Clinical

Social workers in oncology wards will provide psychosocial assessments and treatment to patients and their families related to illness adjustment, coping mechanisms and discharge planning. They use their training to provide age, cultural and spiritual specific care to their clients. They obtain this knowledge to identify each patient's unique treatment, self-management and discharge planning needs. The comprehensive psychosocial assessments that they perform ensure that paediatric, adult and elderly patients receive age-specific services. They use psychiatric assessments to formulate accurate diagnostic impressions that are used to facilitate treatment and discharge plans. They act as patient advocates by recommending resources for patient's needs, such as social support and financial assistance.

Collaborative

These social workers maintain effective communications with health care providers related to the patient's psychosocial and psychiatric needs. They maintain positive working relationships with all hospital departments and management to provide optimal patient care. They maintain a clear understanding and adherence to designated oncology policies and procedures. They work with physicians, oncology nurses and treatment teams to develop and deliver the patient's plan of care. They promote patient and family education to ensure best treatment outcomes are achieved. They maintain the necessary documents for licensed clinical social workers' scope of practice. They also provide clinical information for placement referrals to outside agencies.

Discharge Planning

One of their main duties is discharge planning. They provide relative information and referral services to patients, caretakers and families related to community resources and state agencies. They manage a case load of independent patients, which requires constant follow-up and communication with external clients. They stay up to date with knowledge of the current eligibility criteria for a wide range of community services and resources. These social workers build positive

working relationships with community agencies and initiate contact with private, county and state resources to facilitate discharges that require less restrictive levels of care. They develop customized discharge plans for patients with special needs.

Documentation

Social workers provide clear, concise, accurate and timely documentation in patient's electronic medical records according to departmental policies and state regulations. They must maintain clear and consistent documentation of their daily assessments of patient care in order to help physicians provide proper medical care. They must document a variety of activities, such as the initial psychosocial assessment, the proposed care plan, all collateral contracts, insurance reviews and discharge planning efforts. They must ensure the confidentiality and secured storage of all privileged communication with patients and families. Oncology social workers must follow Clinical Social Work Practice documentation guidelines.

Program Support

Social workers in oncology departments are members of patient care units who perform case management duties, which includes utilization review, quality improvement and community resource development activities. They participate in departmental, committee and community meetings. Senior social workers will develop and evaluate patient care policies and procedures. They will also coordinate resources and develop collaborative service relationships with similar oncology departments in other hospitals. They provide psychosocial education and perspectives to subordinate health care providers and interdisciplinary team members. They interpret and provide analysis to treatment leaders on how relative laws and regulations affect discharge planning and proposed treatments.

13.13 Let us sum up

From this unit you will get ideas on paediatric ward, maternity ward, abortion clinic, family planning centre, STD clinic, HIV clinic, orthopedic department, cardiology department, blood bank, TB sanatorium and cancer hospitals.

13.14 Unit end exercises

1. What were the formalities included in blood bank?
2. How a cancer hospital works?
3. What is an abortion clinic?
4. How a family planning centre works
5. What is blood bank?

13.15 Answer to check your progress

1. Maternity wards also may have specific delivery rooms rather than operating rooms. These wards also provide facilities for the new-born infants, including incubators and other special needs.

2. The term "blood bank" typically refers to a division of a hospital where the storage of blood product occurs and where proper testing is performed

3. Social workers in oncology wards will provide psychosocial assessments and treatment to patients and their families related to illness adjustment, coping mechanisms and discharge planning.

13.16 Suggested readings

1. Elgood, Cyril (2010). *A Medical History of Persia and The Eastern Caliphate* (1st ed.). London: Cambridge. pp. 202–203. ISBN 978-1-108-01588-2. By writing a monograph on 'Diseases in Children' he may also be looked upon as the father of paediatrics.

2. Clarke, Cath (23 November 2007). "Just don't say the A-word". *The Guardian*. Retrieved 12 February 2012.

3. Enger, Eldon; et al. *Concepts in Biology' 2007 Ed.* 2007 Edition. McGraw-Hill. p. 173. ISBN 978-0-07-126042-8. Retrieved 23 November 2012.

4. "What Is Cancer?". National Cancer Institute. 17 September 2007. Retrieved 17 August 2009.

UNIT XIV - TRAINING OF THE VOLUNTEERS TO WORK WITH THE CHRONICALLY ILL IN THE COMMUNITY

Structure

14.1 Introduction

14.2 Training of the volunteers to work with the chronically ill in the community

14.3 special focus on rural/ tribal areas

14.4 Let us sum up

14.5 Unit end exercises

14.6 Answer to check your progress

14.7 Suggested Readings

14.1 Introduction

This chapter gives the reader an understanding about the training the volunteer need to work in the chronically ill in the community

14.2 Training of the volunteers to work with the chronically ill in the community

The use of volunteers in caring for chronic psychiatric patients in the community is very significant. Thorough training of volunteers can be expected to enhance the quality of care they provide and help them to maintain interest in their role. It increases volunteers' knowledge of mental illness, improve the quality of care they provided, and stimulate interest in the volunteer role.

Managing chronic illness in the community presents a profound challenge to the social work profession, not only because of the myriad formal and informal services required by the increasing number of chronically ill but also because the caregivers, too, require our support and empowerment. As professionals, social workers experience first-hand the effects of the met and unmet patient needs, which brings with it a responsibility to insure that practice and policy decisions give full recognition to the impact of psychosocial aspects and services that provide total care to chronically ill and their caregivers in the communities.

Characteristics of Chronic Illness as they Impact the Social Work Role

Three important characteristics of chronic illnesses need to be considered as they affect the social work role and function.

1. Many serious illnesses has changed from an acute terminal course to a much longer chronic period, with episodes of exacerbations and remissions interspersed with extended periods of good functioning in the communities.

2. Advanced chronic and terminal illnesses has changed from a relatively brief period to a longer period in which both curative and palliative treatments are combined. Research suggests that a long, advanced chronic illness can be highly stressful for both patients and their families in the communities.

3. The increase in the total number advanced chronic and terminal illnesses will require more curative and palliative care being provided in the home, with greater reliance on provision by family members in the communities.

The specific role of social workers in communities is to address psychological, behavioral, and social factors by (1) assessing patient and family psychosocial health needs, (2) providing interventions required to address their psychosocial needs and promote their adaptation to illness and disability, and (3) developing and implementing effective models of health services delivery.

In recent years, and as part of current social and demographic developments, politicians and nonprofit or community-based organizations have become increasingly convinced that volunteers should be qualified to carry out their work. As part of these developments, some publications have addressed training structures and contents, and their evaluation . However, information on how to train volunteers in care has not yet been published in sufficient detail.

The primary aims of this systematic review were to (1) identify evaluated approaches that employ trained volunteers who provide one-on-one support to chronically ill, multimorbid elderly at the interface between hospital and domesticity, and (2) investigate the patient-related effectiveness of these approaches. Our secondary aims were to (3) present the characteristics of the volunteers in these evaluations, and (4) present the underlying teaching and training concepts that were used to enhance the skills of volunteers.<https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1130-2>

Community health workers are frontline public health workers who have a close understanding of the community they serve. This trusting relationship enables them to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Community health workers also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. (American Public Health Association, 2008)

Community health workers are dedicated individuals who function along a continuum ranging from individual and community development to service delivery and promoting community empowerment and social

justice. They often help link people to needed health care information and services.

Community health workers work in all geographic settings, including rural, urban and metropolitan areas. Although their roles vary depending on locale and cultural setting, they are most often found working in underprivileged marginalized communities where people may have limited resources; lack access to quality health care; lack the means to pay for health care; speak regional fluently; or have cultural beliefs, values and behaviours different from those of the dominant Western health care system. In these communities, community health workers play an integral role in helping systems become more culturally appropriate and relevant to the people the systems serve.

Community health workers typically have deep roots or shared life experiences in the communities they serve. They share similar values, ethnic background and socio-economic status and usually the same language as the people they serve. The community health worker serves as a bridge between the community and the health care, government and social service systems.

The community health worker's responsibilities may include:

- Helping individuals, families, groups and communities develop their capacity and access to resources, including health insurance, food, housing, quality care and health information
- Facilitating communication and client empowerment in interactions with health care/social service systems
- Helping health care and social service systems become culturally relevant and responsive to their service population
- Helping people understand their health condition(s) and develop strategies to improve their health and well being
- Helping to build understanding and social capital to support healthier behaviours and lifestyle choices
- Delivering health information using culturally appropriate terms and concepts
- Linking people to health care/social service resources
- Providing informal counselling, support and follow-up
- Advocating for local health needs
- Providing health services, such as monitoring blood pressure and providing first aid
- Making home visits to chronically ill patients, pregnant women and nursing mothers, individuals at high risk of health problems and the elderly
- Translating and interpreting for clients and health care/social service providers

Community health workers go by many titles, depending on where they work, who they work for and what they do. Common titles include health coach, community health advisor, family advocate, health educator, liaison, promoter, outreach worker, peer counsellor, patient navigator, health interpreter and public health aide. In Spanish-speaking communities, community health workers are often referred to as health promoters.

The role of the community health worker started as a societal position, appointed by and responsible to the community's members. Advocates

and activists dedicated their time and talents to ensuring that local people received the health information, resources and health care services they needed.

The success of their efforts has caused many government agencies, non profit organizations, faith-based groups and health care providers to create paid positions for community health workers to help reduce, and in some cases eliminate, the persistent disparities in health care and health outcomes in underprivileged communities. The organizations benefit by gaining access to information about health care needs in these communities, which they can use to improve the design of health services.

Retrieved from <https://explorehealthcareers.org/career/allied-health-professions/community-health-worker/>,
<https://www.ncbi.nlm.nih.gov/pubmed/2759580>. on 05/10/2019

Training of the volunteers to work with the chronically ill in the community

Notes

14.3 Special focus on rural/ tribal areas

Health of the people is not only a desirable goal but is also an essential investment in human resources. The National Health Policy (1983) reiterated India's commitment to attain "Health for All (HFA) by 2000 A.D". Primary health care has been accepted as the main instrument for achieving this goal. Accordingly, a vast network of institutions at primary, secondary and tertiary levels has been established. Control of communicable diseases through national programmes and development of trained health manpower have received special attention.

Many spectacular successes have been achieved in the country in the area of health. Small-pox stands eradicated and plague is no longer a problem. Morbidity and mortality on account of malaria, cholera and various other diseases have declined. The Crude Birth Rate and Infant Mortality Rate (IMR) have declined to 29.9 and 80 (1990 SRS data) as compared to 37 and 129 respectively in 1971. Life expectancy has risen from a mere 32 years in 1947 to 58 years in 1990. However, HFA is a long way off. Disease, disability and deaths on account of several communicable diseases are still unacceptably high. Meanwhile, several non-communicable diseases have emerged as new public health problems. Rural health services for delivery of primary health care are still not fully operationalised. Urban health services, particularly for urban slums, require urgent attention due to changing urban morphology.

Rural Health Programme

Development and strengthening of rural health infrastructure through a three tier system of Sub-centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) for delivery of health and family welfare services to the rural community was continued during the Seventh Plan. But, lack of buildings, shortage of manpower and inadequate provision of drugs, supplies and equipment constituted major impediments to full operationalisation of these units.

Approach and strategy for rural health would be:-

- i. Consolidation and operationalisation, rather than major expansion, of the network of Sub-centres, PHCs and CHCs so that their performance is optimised. This would be achieved through -

- a. strengthening of physical facilities including completion of building of the centres and staff quarters;
 - b. provision of essential equipment as per the standard list;
 - c. filling up of all vacant posts within a defined time frame and in-service training of staff;
 - d. ensuring supply of essential drugs, dressings and other material
- ii. To monitor the progress of implementation of MNP at the District, State and National levels, a health information management system will be developed and used.
 - iii. The targets regarding setting up of Sub-centre, PHC and CHC on the basis of population norm are indicative only. The States will be given flexibility in establishing these units as per the local needs depending on geographical and population considerations, resources, manpower availability, etc. In opening new centres the needs of tribal population and communities living in difficult and inaccessible areas will be given first priority.
 - iv. The rural hospitals and dispensaries will be suitably modified, equipped and staffed to convert them into Sub-centres, PHC, CHC as the case may be, thereby integrating them into primary health care system.
 - v. The backlog of Sub-centres, PHCs and CHCs in many States is staggering and the resources required to meet the targets are astronomical and as such unachievable in near future. In view of this the entire policy of establishment of Sub-centre, PHC and CHC with the present norms will be reviewed and new policy options developed to make the primary health care accessible, acceptable and affordable to all. Re-organisation of the Indian Systems of Medicine and Homoeopathy (ISM and H) dispensaries/hospitals in rural areas to create ISM and H health centres is one such option. This would be in line with the Government's accepted policy of promoting ISM and H. Reorientation of existing personnel of these dispensaries/hospitals, provision of additional facilities and/or staff, redefining the roles and responsibilities would be some of the pre-requisites to put the concept of ISM and H Primary Health Centres and Sub-centres in an operational mode.
 - vi. Mechanism will be developed to make the rural health services responsive to the needs of the rural masses and accountable to the community. Panchayati Raj system would become an effective instrument for eliciting community participation in the health programme and providing supervision and support to primary health care infrastructure.
 - vii. Linkages will be developed with the sub-divisional and district hospital to provide referral back-up.

There were about 635 tribal groups and subgroups including 75 primitive communities who have been designated as 'primitive' based on pre-agricultural level of technology, low level of literacy, stagnant or diminishing population size, relative seclusion (isolation) from the main stream of population, economical and educational backwardness, extreme poverty, dwelling in remote inaccessible hilly terrains, maintenance of constant touch with the

natural environment, and unaffected by the developmental process undergoing in India. There is a heavy burden of communicable, non communicable and silent killer genetic diseases prevalent in tribal communities. Many of the infectious and parasitic diseases can be prevented with timely intervention, health awareness, and information, education and communication (IEC) skilled activities.

According to the World Health Organization (WHO), the definition of health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The health status of any community is influenced by the interplay of health consciousness of the people, socio-cultural, demographic, economic, educational and political factors. The common beliefs, traditional customs, myths, practices related to health and disease in turn influence the health seeking behaviour of autochthonous people. Health is an essential component of the well-being of mankind and is a prerequisite for human development. It is found to be much poorer compared to the non-tribal counterpart. The health status of tribal populations is very poor and worst of primitive tribes because of the isolation, remoteness and being largely unaffected by the developmental process going on in India. The United Nations (UN) members met in 2000 and set themselves eight goals to be achieved by 2015. Of these goals, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases related to the health segment were included. The first goal 'of eradicating extreme poverty and hunger' also contains a nutritional element which is health related. In the developing world, death rates in children under five are dropping, but not fast enough. Eleven million children are still dying every year, from preventable or treatable causes. More than half a million women die each year during pregnancy or childbirth. Tribal communities in general and primitive tribal groups in particular are highly disease prone. Also they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. Their misery is compounded by poverty, illiteracy, ignorance of causes of diseases, hostile environment, poor sanitation, lack of safe drinking water and blind beliefs, etc. The chief causes of high maternal mortality rate are found to be poor nutritional status, low hemoglobin (anemia), unhygienic and primitive practices for parturition. Average calorie as well as protein consumption is found to be below the recommended level for the pregnant as well as lactating women. Some of the preventable diseases such as tuberculosis, malaria, gastroenteritis, filariasis, measles, tetanus, whooping cough, skin diseases (scabies), etc. are also high among the tribals. Some of the diseases of genetic origin reported to be occurring in the Indian tribal population are sickle cell anemia, alpha- and beta-thalassemia, glucose-6-phosphate dehydrogenase deficiency, etc. Night blindness, sexually transmitted diseases are well known public health problems of tribals in India.

Tribal health culture

Tribal communities are mostly forest dwellers. Their health system and medical knowledge over ages known as 'Traditional Health Care

System' depend both on the herbal and the psychosomatic lines of treatment. While plants, flowers, seeds, animals and other naturally available substances formed the major basis of treatment, this practice always had a touch of mysticism, supernatural and magic, often resulting in specific magico-religious rites. Faith healing has always been a part of the traditional treatment in the Tribal Health Care System, which can be equated with rapport or confidence building in the modern treatment procedure. For example, the doctor priests of the Saora tribe utilize several herbs and roots in conjunction with their magico-religious rites in Orissa. Health problems and health practices of tribal communities have been profoundly influenced by the interplay of complex social, cultural, educational, economic and political practices. The study of health culture of tribal communities belonging to the poorest strata of society is highly desirable and essential to determine their access to different health services available in a social set up. The common beliefs, customs, traditions, values and practices connected with health and disease have been closely associated with the treatment of diseases. In most of tribal communities, there is a wealth of folklore associated with health beliefs. Knowledge of folklore of different socio-cultural systems of tribals may have positive impact, which could provide the model for appropriate health and sanitary practices. The health culture of a community does not change so easily with changes in the access to various health services. Hence, it is required to change the health services to conform to health culture of tribal communities for optimal utilization of health services. Health is a universally cherished goal. Health cannot be forced upon the people. The organization of health services to all people is considered to be the key step towards development. It is an important input for the development of man and, thereby, to social and economic development of the country. Health is widely linked with development. A rapid and equitable economic development is a good health input and an adequate and equitable health care system stimulates development with improving human productivity. This is the reason; why the investment in health is, sometimes, called an investment in human capital.

Tribal health problems

The primary health care infrastructure provides the first level of contact between the population and health care providers and forms the common pathway for implementation of all the health and family welfare programs. It provides integrated promotive, preventive, curative and rehabilitative services to the population close to their hearth and home. A majority of the health care needs of the tribal population are taken care of either by the trained health personnel at the primary health care level or by their own traditional 165 165 indigenous health practitioners at village level. Those requiring specialized care are referred to secondary and tertiary sector. The tribal population is not a homogeneous one. There are wide variations with regard to education and health status, access and utilization of health services among the tribal populations. Keeping in view that most of the tribal habitation is concentrated in far flung areas, forestland, hills and remote villages, and in order to remove the imbalances and provide better health care and

family welfare services to scheduled tribes, the population coverage norms of establishment of rural infrastructure have been relaxed. The primitive tribes in India have distinct health problems, mainly governed by multidimensional factors such as habitat, difficult terrains, varied ecological niches, illiteracy, poverty, isolation, superstitions and deforestation. The tribal people in India have their own life styles, food habits, beliefs, traditions and socio-cultural activities. The health and nutritional problems of the vast tribal populations are varied because of bewildering diversity in their socio-economic, cultural and ecological settings.

The health care services and challenges in rural and tribal areas are a complicated phenomenon such as: ·

- Concept of health and disease is rather traditional which results in their not seeking treatment at an early stage of physical maladjustment and frequent refusal of preventive measures in rural areas and their idea of medical care is some treatment not easily accessible and available.
- Lack of motivation of people for availing medical care at the initial stage of the disease.
- Limited paying capacity or habit of getting treatment always free of cost. Comparative inaccessibility of medical care services due to under-developed communication and transport facilities.
- Non availability of qualified medical practitioner in the village.
- Qualified health workers and professional medical and paramedical staff do not want to work in rural and tribal areas because of professional, personal and social reasons.
- Non availability of private or governmental doctor as and when need arises. A look into the pattern of rural health services shows that the scarcity of trained manpower for health is a major problem and obstacle to the extension of health services to rural and tribal areas.
- Moreover, the qualified health workers do not want to work in rural and tribal areas because of professional, personal and social reasons.
- The health problems of rural and tribal populations cannot automatically be overcome by establishing more primary health centres and sub centres and also imparting training to more health personnel or providing integrated health services by a single authority or by a number of agencies.
- An integrated health services would be operated on a teamwork basis by division of labour so that the greatest possible use of professional skills could be made.
- Managerial skills and controlling power of the doctor to coordinate various activities and maintenance of infrastructures including vehicles and procurement of equipment, medicines, vaccines, etc. on regular basis are highly desirable.
- There is a complete lack of managerial training, financial empowerment and facilities available to the doctor to efficiently and effectively monitor and carry out public health duties in the rural setting and tribal areas.

- This drastically affects the well-being and tribal health in the state. Frequent transfers and absenteeism of the staff, favouritism and corrupt practices hinder the smooth functioning of the Primary Health Centre (PHC), which have adverse health effects on the tribal population.

Retrieved on 04/10/2019
from <https://www.nirth.res.in/publications/nsth/22.RS.Balgir.pdf>

14.4 Let us sum up

From this unit you will get ideas about Training of the volunteers to work with the chronically ill in the community and with specific focus on rural and tribal areas.

14.5 Unit end exercises

1. What is the role of volunteers working with chronically ill people at rural and tribal level?
2. Discuss about the health problems in Tribal communities.

14.6 Answer to check your progress

1. Community health workers have to learn about the community and their prevailing health problems. They have to make a survey about the chronic illness present and train the volunteers according to it.
2. The tribal communities have many communicable and non communicable diseases. They have poor access to PHCs and other health services.

14.7 Suggested Readings

<https://www.nirth.res.in/publications/nsth/22.RS.Balgir.pdf>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4673775/>
https://mohfw.gov.in/sites/default/files/Tribal%20Health%20Expert%20Committee%20Report_Executive%20Summary.pdf