H.No - 44213 MRD 14818 DOA 15/2/80 Address c/o Premsadan convent-
Head of Dept - Dr P. Cus chickakamanahalli, B'lore.

St. John's Medical College Hospital, Bangalore-560 034

29.1

THE JOHN Mc CORMACK HEALTH CENTRE

Name Samuel Devaraj Age - 2½ yrs, Sex Male Religion - RC

Ward Mother - Antoniamma Date

Father - Anjayaswamy } coolies workers & some estate

Midnight to Midnight

ending.....19.....

Address - Chickkamanahalli - 8 miles (Bayond Bagur)

6 siblings - ① 16 yrs ♀ ② Rita ♀ 15 yrs admitted today c/o ? Thoracic ③ 12 yrs ♀ ④ ♂ - 9 yrs ⑤ ♂ - 6 yrs ⑥ Annamma 1 yr

Unit & MRD. No.	Name	Condition	Discharged	Admitted	Birth	Death	Remarks

Hist - complaints since birth - not eating well, ↓ ↓ weak
- No diarrhoea 2-3/day. No vomiting
- Fever - 3 days

taken to Yelagere Hospital, (Dr from B'lore) 1 wk - said no bld - gave a Tonic no improve
- slight swelling of face 1 wk ago ↓ ↓ on Tonic
- Mict 4-5/ more at night
- c/o pain in the legs, very clumsy

Hist from Mother (15/2) Inability to thrive, not eating well child is the 4th in a fam. of 6 children. Comes from a very poor socio-economic status. No H/o C.M or passing worms or cough. H/o Loss of Appetite O/E pallor ++, cheeks baggy, hair brownish, skin dry + scaly, small cervical glands + small + discrete. CVS/RS/PA - NAD. Wt 4.2 kg.

Dsis - Sec. Anemia ? Kwashiorkor

Invest (19/2) Hb - 5.0 g%, WBC - 8,400 N38 L62 Normocytic + microcytic, hypochromic RBC's, leucocytes normal, platelets adequate, Bld gp B, Rh positive

Stool Micro (19/2) NAD. ESR - clotted

Mx - ?

Progress - Had fever 103° on 19/2, 101.8° on 20/2, 100.8° on 21/2

Rx 20/2 Inj Imferon ½ cc IM on all days ATD, (15/2) Change for BT / Sound Bld not available

03-003

NOTE: PLEASE ENTER THE TOTAL NUMBER OF PATIENTS AT THE BOTTOM AND SIGN.

Mother's name Antoniamma - Housewife. 5 Siblings - He is No. 4 (5)
L.D - 5 mths.
44095/14775

St. John's Medical College Hospital, Bangalore-560 034

THE JOHN Mc CORMACK HEALTH CENTRE

Ward..... Date..... Midnight to Midnight

Name Antony Cruz. Age 2yrs Sex Male Religion Christian ending.....19.....
Father's name Michael Occup. Coolie Address - Madivala. Blore

DOA - 13/2. Dept Head - Dr A Mks Free case

Unit & MRD. No.	Name	Condition	Discharged	Admitted	Birth	Death	Remarks
		Hypernatraemic Kwashiorkor					

℞ Kaolin 2 tsp 6 hrly.
WR - 5.7 kg

Invest - Hb - 12.2 g%, WBC - 7,400 N52, L44, E1, M3,
ESR - 12 Bld grp O, Rh positive
Stool - A. lumbricoides ova +.

Hist (from chart) 15/2/80 - Loss of appetite, swelling of cheeks + mild pedal edema - 1 month. No H/o measles. H/o having repeated attacks of watery stools 5-6 times everyday. No blood or mucus. Foul smell +

O/E Moderately built, poorly nourished, cheeks baggy, hair brownish, mild pedal edema, skin dry + scaly, CVS/RS/PA - NAD.

Dx Kwashiorkor ā gē

℞ 13/2 Kaolin 2 tsp 6 hrly,
15/2 Tab Decadis 50 mg HS X2 days + Plasma Transf: O+ve 150 ml

Invest Chest X-ray 13/2 Both hilum enlarged, crowding of Bronchial sh... both bases, ? Hyper of. bases + lungs, heart oblique normal type ? Ac. Hilar adenitis Ac bronchitis allergic)
Liver opacity ? small cirrhotic.

03-003

NOTE : PLEASE ENTER THE TOTAL NUMBER OF PATIENTS AT THE BOTTOM AND SIGN.

St. Jhon's Medical College Hospital, Bangalore-560 034

THE JOHN Mc CORMACK HEALTH CENTRE

Ward..... Date..... Midnight to Midnight ending.....19.....

Unit & MRD. No.	Name	Condition	Discharged	Admitted	Birth	Death	Remarks
	Kalai Arasu 1½ yr F	H.No 40899. MRD 13640					
	DOA - 11/12/79. Fathers name - Sundaramurthy. cobbler						
Hist	- Swelling of face & feet since 15 days. not taking feeds & not eating properly. Pigment ↑ & scaliness of skin. Discolour - - - - - since 15 days. child is the 2nd child in the family. still breast fed. No suppl. feeding of						
O/E	Fluid Kwashiorkor child. Discolour of hair & pigment ↑ of skin. Crazy pavement patches of dermatitis all over. Boggyness of cheek. L & S not palpable. WS/RS - clear. Imp. Protein calorie Malnutrition.						
14/12	C+R few glds + liver flare up, expiratory film.						
Rx	- Bld transf / plasma transf / plasma lions / 100 ml. Inj PP4. Aquasol 1 amp. Theogran High prot. diet.						
Invest.	Mx done on 11/12/79 Read on 13/12/79 - ve. Hb 10.0, WBC 13,100 N21, L67, E11, M1, ESR 5 - Normocytic mild hypochromic RBC's Mild eosinophilia. Platelets adq. Bld grp AB + ve. Stool - ve. Urine - NAD. Wt 8½ kg. 10/12/79						

03-003

NOTE: PLEASE ENTER THE TOTAL NUMBER OF PATIENTS AT THE BOTTOM AND SIGN.

St. Jhon's Medical College Hospital, Bangalore-560 034

THE JOHN Mc CORMACK HEALTH CENTRE

Ward..... Date..... Midnight to Midnight

ending.....19.....

Unit & MRD. No.	Name	Condition	Discharged	Admitted	Birth	Death	Remarks

03-003

NOTE: PLEASE ENTER THE TOTAL NUMBER OF PATIENTS AT THE BOTTOM AND SIGN.

Chandrakumar. 9yrs Male H.No - 42773, MRD - 14283.
Father's Name - Ramachander (late) Religion - Hindu
address - 36, 2nd Main road, Mysore road, Padmayanapura, Bilore 26.
Date of admission - 18/1/80 Head - Dr. P. Urs.
guardian - Kumar, Occup - Driver.
Used as Kwashiorkor - OPD + admitted.

History (case sheet) Pain abd - 3 mths
18/1/80 Swelling feet + face - 1 mth
Pt was having intermittent pain abdomen since 3 mths & then passing worms. Subsequently mother noticed puffiness of feet & face. The child is the 9th sibling in a family of 10

O/E very poorly nourished, pallor ++, brown pigmentation of hair +, scanty growth, skin dry + scaly, pedal edema ++, eyes puffy, crazy pavement - wt. 13 kg
WS/IRS - N+D.
PA - L+S NAD.
Dsis - Kwashiorkor - grade III.

Investigations
18/1 - Hb % - 10.5 g %
WBC - 8,200/cmm, N 77, L 23,
ESR - 3 mm/hr (Westergren)
Bld grp + type - 'B' Rh D +ve
21/1 - Stool Micro - Negative
21/1 - Urine - yellow, turbid, protein traces, reducing substances - nil, WBC - 6-8/HPF amorphous sediment, epi cells

18 - Mx done on 18/1, Read on 21/1/80. - ve
18/1 - Chest X ray - small heart, hilum enlarged, hyp - - of bases, emphysematic lungs, skeleton normal, central abd + flanks hazy & small bowel fluid levels ? any patchy diarrhoea - chr. bilat adenitis c/c emphysema c/c periadenitis, mesenteric adenitis, ? fibrocystic dis

Treatment
18/1 - Inj PPHL IM, ATD, OD X 5 days
- Blood transfusion - 200 ml whole blood
21/1 - Fresh plasma - 23/1 - 200 ml.
High protein diet.
22/2 - Rpt + Kaolin wet. 2 hrly PID
Ref. to physiotherapy - To improve joint motion, Both lower limbs - Knees - slight contracture, Tendency to get full contracture of both hamstrings. Advised the mother to keep the legs straightened always
Rx - given active exercises + hamstrings stretching to both legs.
27/1 - Plasma

PTO

29/1 Rpt + furoxone 2 tsp t.i.d.
Metrogyl - 1 tsp t.i.d.
Pot Klor - ½ oz OD.

Enquir

5/2 - blood - just before starting 20 mg Lasix IV + slow infusion
lunir
Hb - 10 g%

progress - Temp - 15/2 - 100°, 16/2 101°, 17/2 101.8°, 20/2 - 101°, 21/2 103°

7/2/80 Name Vijayalakshmi. Age - 2yrs Sex female
H.No - 42313. MRD 14138
Father's name - Hanikam, occ - driver, CGHS
Religion - Hindu
address - Shamanna gardens, Jayanagar, Blore.
DoH - 10.1.80 under Dr. Pillai.
DoD - 1.2.80
History - 10/1/80 - from chart.
fever - 3 mths.
cough & expectoration
loss of wt.
Child was apparently well 3 mths back when it started having fever, low grade mor in the evening & night + subsequently started having cough + scanty expectoration & loss of wt + inability to ambulate.
Child is 2yrs, 3 mths, 5th child in the family, continues to be breast-fed, no supplementary feeds at any time, not immunized except for small pox. Child was shown to NTI where anti TB drugs were started but without any betterment
O/E a very severely undernourished, marasmic child, hair dry & brownish. SC fat lost, cervical glands felt all grps, few small axillary glands felt on (R) side, inguinal glands +.

RS - Harrison sulcus +, Breath sounds (N)
CVS - HS normal
PA - abd. distended, no liver / spleen palpable
Wt - 5.25 kg.
Ds - Marasmus gr IV
c ? PPC.

Investn - Hb% - 10.8 g%.
11/1 WBC - 11,700 - N22, L72, E2, M4.
ESR - 28.
shows moderate degree of anisocytosis & poikilocytosis. RBC's are microcytic & hypochromic. Microcytic & hypochromic cells are also seen. Polychromatophilic cells increased. Leucocytes normal in number. Predominant cells lymphocytes. Platelets adequate. Imp: Dimorphic Anemia
12/1 Stool Micro - NAD, fat globules -.
Blood grp - 'O' Rh D +ve
18/1 Urine - P. yellow clear, protein, red. sub. abs., budding yeast cells, WBC 2-3/HPF.
: No evidence of PPC Mx -ve
Cxray -
Rx - Anabolin, feeding c full strength milk & 1 plasma transfusion, improved wt by 1/2 kg & started eating well.
1/2 kg & now

adv – proper feeding ē milk, cereals, eggs
& other high protein foods
(2) arabolin – 5 drops OD. X / wk
IM 5ml Decadurabolin 10 mg once a wk
½ strength milk 30z QDH
full cream milk ½ pt – 30z QDH.

Jayaraj 12yrs H.No – 6490.
20449.

- was brought to SJMCH from remand home on 9-8-78 by Br. James Thundayil of Dharmaram College.
- Admitted to Surg. + transfered to Paediatrics.
- H/o fall + injury to spine + 3 yrs ago. was admitted in ? Victoria Hosp.
- Final Δ Traumatic paraplegia. + scabies
  Compl: – Bedsores Quantum
  – urinary tract inf.
  – Salmonella diarrhoea.

- DOD – 6/11/78.
- Invest – Hb – 7.8, WBC 9,450 < N 86 L 14
  Normocytic hypochromic RBC's, WBC normal in number + morphology c neutrophilia platelets adq.
  Stool Alumbicaide +
  Urine – turbid, protein +, WBC 20-25/HPF RBC many/HPF. amorphous sediments + epi cells + (stained on Fuedantin a 4/5/
  Urine c/s – colonies >100,000, Atypical E coli S to Nandetamine & Gentamycin
  MP/MF neg.
  Urine 25/10 – 8-12 WBC/HPF. RBC numerous pus cells + + +
  BUN 13 mg%.
  Urine c/s. 31/10/78 – midstream sample well preserved/labeled.
  Had severe headache/earache + migratory cranial sgl. swellings
- Skull Xray – NAD.
  NIMHANS opinion NAD
  ℞ SysP, Benzyl benzoate, Ampicillin, Penicillin, piperazine, Dodans, furadantin,

Fr thoraco lumbar vertebrae

NIMHANS 4/11/78 No 5181 (OP No.)

Higher func (N) Cr. nerves NAD
No papilloedema
UL - (N)
LL. - paraplegic
weakness gr 0 - 1.
Sensory level D12 - L1.

Some pain over frontal bone & mastoid
But no swelling for this may be
d/to local inf + pus.

Discussed Dr Varsa.
No neurological prob -
Referred back

Makdum Ali Srinivas
~~Chandrashekar~~
~~Vijayalakshmi~~

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Dept. of Community Medicine
St. John's Medical College
Bangalore-560 034.

Class | Roll No.

Semester | Subject

Examination | Date

31/1/80

Padma Raja 2yrs ♂ HNo – 26928 MRD 14421

DOA – 25/1/80 DOB.

History Pt. an old case of Kwashiorkor, admitted last year + has now come back with the same symptoms of cough / fever, swelling of feet, puffiness of face + pigmentation of hands.

O/E R.S. – Bilat crops +

CVS / PA | NAD.

Dx Kwashiorkor

Progress 25/1 – Kwashi on Rx Afebrile

29/1 PP2 concludes Plasma to be given tomorrow

Invest – 28/1 – Hb 10.0 g%, WBC – 10,400 – N41, L52, E6, M1 Normocytic, mild hypochromic RBC's.

29/1 – Stool Micro. – nil

29/1 – Urine – pale yellow, clear, WBC 0-2/HPF, prot + sus. ni reducing

Rx – Inj PP4L IM XS CxR

– Plasma transfusion Bld grping + matching.

Com H 29 : 2

MEDICO SOCIAL CASE WORK IN A HOSPITAL SET UP

Dr S.V. Rama Rao MBBS DPH MPH*

INTRODUCTION

A child is admitted to the Hospital suffering from Pneumonitis, Hookworm infestation, anaemia and malnutrition. The Physician treats the child with sulpha or antibiotic, gives anti hookworm treatment, anaemia is treated with iron and reinforce its diet with let us say powdered milk. The child is cured of the conditions and discharged. File is closed. Six months later the child is seen again in out patients of the hospital - this time with a reinfestation of hookworm, advanced malnutrition and anaemia. This means that the malady in the child is deeper. I_t is not sufficient to treat the disease. Mere treatment cannot give permanent relief to the suffering child. The sick child has to be considered in totality and not merely as a person. Sickness is not due to a single etiological factor. There are multiple factors. The clinician assesses the sick person by his examination in the hospital set up. For a total diagnosis of the condition and complete treatment he needs more information about the individual in his home and his community because they have a bearing on his sickness. Information on the physical, social and biological environment, economic status, education, customs, habits, occupation, religion and a host of other factors which build up his background. This means that the Clinician should have full information on the medico social factors outside the hospital. The Medical Social Worker (MSW) acts as a liaison between the individual family and community and supplies the information by making use of special techniques. The MSW will discover the adverse factors which is particularly responsible for the Social Pathology of the disease. When once this is identified diagnosis and treatment could be taken care of to the best advantage of the sick by the Physician.

Medical Social Work is a form of social service adjunct to the personal service which the physician gives to his patients. It is the art of helping patients who have social problems in sickness. It is the work entrusted to a qualified and trained social case worker in a hospital or community set up. It is concerned with the personal problems connected with illness that trouble the individual patient and may hamper his recovery. MSW is a member of a team.

HISTORICAL BACKGROUND

Western countries - England: Appointment of 'Enquiry Officers' in 1876 who were the fore-runners of 'Almoners' - These Enquiry Officers main task was to enquire about the patient's means. First Lady Almoner was appointed in 1895 at Royal Free Hospital.

U.S.A. 1894. New York Presbityrean Hospital appointed a paid Social Worker. It was, however, Dr Richard Cabot who started the Medical Social Work in the modern sense in the O.P.D. of Massachusettes General Hospital in 1905.

In the beginning, hospital and medical profession were averse to accept the new idea of Medical Social Work. But gradually the advantages were realised. The report of the hospital standardization (1929) of the American College of Surgeons greatly stimulated the development and acceptance of the concept of Medical Social Service in Hospitals.

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*ST JOHN'S MEDICAL COLLEGE, BANGALORE

INDIA: began her Medical Social Work more than 3 decades ago in a few hospitals starting with Tuberculosis Clinic and Maternity services. It was specifically mentioned in the Bhore Committee Report (1946) and a trained medical social worker was first appointed in the J.J. Hospital of Bombay in 1946. Since then MSWs are being employed all over the country in hospitals, special departments, rehabilitation centres, medical colleges etc.

NEED FOR MEDICAL SOCIAL SERVICE

The rapid social changes, demands from patients and complex situations have given rise to problems which were not encountered previously.

Eg: Economic difficulties
Unemployment
Over crowded living
Mental stress and strain
Domestic disharmony (strained inter, intra and extra familial relations)
Increase of delinquency and mental disorders
Rush in hospitals and dispensaries

AIMS OF MEDICAL SOCIAL SERVICE

1. To collect and provide information for arriving at a correct diagnosis, eg. Illegitimate pregnancy, self-inflicted injury, starvation, social conditions, psychological and emotional states

2. Development of Medico Social Programmes within the medical institution

3. Participation in the development of social and health programmes in the community to meet the demands of the hospital

4. MSW to assist hospital authorities in formulating the policies

5. Participation in teaching and research programmes of the hospital/community

M E D I C O-S O C I A L W O R K E R

-social case worker in a medical setting-

Medical Social work cannot be carried out in isolation, and closer the contact and mutual understanding between medical and nursing staff and MSW, the better the results will be.

WORK - concerned with the personal problems connected with illness that trouble the individual patient and may hamper his recovery. His/her functions is first and foremost to help in the treatment of patient. His/her duties vary with the type of hospital clinic or health organisation. But basically the duties can be categorised into three fields:

1. Medical Social Work - connected with the doctor's investigation and treatment of patient's illness

2. Teaching, Research or policy as it affects the welfare of patients within the hospital or organization

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3. Cooperation with other agencies both state and voluntary connected with social aspects of medicine, health & welfare services.

MEDICO SOCIAL WORK

Directly concerns the patient's treatment and after-care. This will be the day-to-day work for most of the MSWs. Two important aspects (a) Nature of work; and (b) Responsibility as a member of the medical team.

(a) Nature of work

i. Social investigation and enquiry
ii. Social treatment
iii. After-care

(i) Social Investigation: Social enquiry is only one of many investigations which are needed. Entails study of the social and personal background of the patient's illness and consultation with the doctor over those factors which may be relevant to diagnosis or treatment

Overcrowding
Bad housing
Irregular working hours
Financial difficulties
Anxieties
Personal maladjustment

The MSWs report may influence as also suggest social treatment. When detailed enquiry of investigations are necessary, information may be obtained not only from the patient but also through other social agencies, from relatives, from employees or other sources. When social enquiry has been completed, social treatment can be carried out. Enquiry and treatment are sometimes both on a small scale. For example - How can an amputated patient discharged from hospital with no convenient bus service attend hospital for subsequent treatment from a remote village?

Social enquiry is concerned with alternative means of transport-"A bullock cart comes every Friday for for market day"."A toddy lorry is running daily"

(ii) Social Treatment: For some patients an explanation is enough to relieve anxiety and to ensure that their needs are fully understood at house or at work.

For others sometimes simple, sometimes costly or those difficult to secure may be necessary.

For yet others help needed may be on a more personal level - here MSW must first gain confidence of the patient, must use all professional skills and experience in helping him to overcome some difficulty in his personal life or to make some social adjustment without which he cannot fully respond to treatment. Broadly speaking aim of all social treatment is rehabilitation - assist in re-establishing the patient in normal life - help him to deal with those factors at home or at work which might lead a

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recurrence of his illness. This may involve contacts with industry or employer. Help needed by the patient is of various nature. Eg. special diet help in the home, rest in a convalascent home, recreation, vocational training, change of employment, friendly contact. The MSWs help will be needed in making the various contacts.

Social treatment is directed at removing obstacles to medical treatment or admission to hospital, smoothing out other difficulties which arise during the course of an illness, solving long term problems which remain when the acute stage of illness is past, and adjusting the social environment so as to avoid where possible the particular conditions most likely to cause relapse.

(a) Transport problem is one
(b) Not having money for bus fare is another
(c) Patient may not be able to wait at out-patient for a long time
(d) Difficulties with employers may have to be smoothed out - patient cannot take time off to come to hospital for treatment
(e) How and where can special treatment be obtained?
(f) Mother with an advanced illness needing hospitalization asserts that she can never leave her home leaving husband and children (MSW to look out and arrange for help at home during absence of mother)

(g) An agriculturist acutely ill in hospital was worried about an underground pipe in the field which may be broken while ploughing - MSW sent instructions immediately.

(h) A boy worried about his examination passing, which decided his career was anxious. MSW arranged for his attendance at theory examination.

(i) Financial trouble for treatment - MSW showed resources - Provident Fund or Life Insurance etc.

For problems of this kind,MSW can keep a record of all organizations and institutions which will support cases of this type with financial aid and help deserving cases by using her good offices.

Emergency service includes finding accommodation for the relative of severily ill patients.

Minor services : Advice about puzzling hospital procedure, reassurance when some technical term has been misunderstood, help in cashing salaries or pension, small by themselves but gives peace of mind to the patient.

Long term problems - resulting from illness or injury require the longest, most intensive and most imaginative treatment. For these, the normal way of life has been checked or facing alteration. Some have to face disability for many months or years or even life long.

eg. Mechanic who has lost his right hand;
Youth whose heart is permanently damaged due to rheumatic fever;
House wife with failing eye sight;
Officer with head injury - loss of speech

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An MSW has to use all her skills and expertise to overcome and achieve to the fullest possible extent - independence and functional ability and gainful vocation.

Methods of Social Treatment

More has been said about WHAT MSWs do for patients than about HOW they do it. General outline is furnished.

Before social treatment is instituted, need for it must be discovered and this point needs emphasis, self-evident through it may appear. Sooner the problem is dealt with, better the result. Social problems are so closely linked up with medical matters. It is often from the doctors that initial request for treatment should come. The MSWs work fluctuates strikingly both in quantity and kind according to the interest taken by medical staff. Without medical cooperation, the MSW can achieve very little. Often the staff nurses discover the difficulties of the patients which need MSWs help. They also contribute much for the success of MSWs work.

When once the need is ascertained, the first step of MSW is to consult doctors and find out the diagnosis and prognosis. What treatment will be required and in what way the patient's every day life will be affected.

Final responsibility for the form which her help will take must be accepted by the MSW herself but she/he has to secure the knowledge and approval of the medical staff before taking action.

Her help should not overlap with help of other agencies and she has to keep those agencies fully informed. MSW is only one member of a team. Correct medical information when necessary should be given.

A case of 'manipulation' was mistaken for 'amputation'. Enquiries about medical condition in general must be referred back to the medical staff. When patients and relatives have been told as much about the illness as the medical staff consider it advisable, the MSW can proceed with her task of helping.

Patients are often slow to grasp the practical application of medical recommendations to their daily life and interpreting this to them is an important part of medical social work.

(iii) After-care: The MSW will keep in touch directly or indirectly through some social agency with those patients still attending the out-patients who need help over a long period to ensure that the value of treatment is not lost.

Patients who cannot hope to return to their former activities need help or advice in accepting or overcoming their limitations in order to live their lives as fully as possible (cancer penis, histerectomy after delivery etc)

Responsibility as a member of the medical team: Medico social work is a team work and MSW is a member of the team. It is necessary that MSW should have frequent consultation with medical and nursing staff. Relevant social history (major social problems with which the MSW has to deal are commonly those connected with poverty, loss of income through sickness, with employment, with practical difficulties of domestic care of patient or family with housing, personal disturbances and social maladjustments) should be readily accessible to the medical staff.

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What is the responsibility and role of the MSW in the out patient set up of a hospital? Let us follow a patient who presents himself at the Registration Counter of the Out Patient Department.

Registration —— Doctor ____ Notes down complaint subjective signs, symptoms, history of illness, previous treatment taken if any, _____ Examines and comes to a tentative diagnosis _____ Elicits further history, subjective signs and symptoms for confirmation ____ Writes down investigations to be undertaken and sends patient to laboratory, X-ray or other diagnostic Centre _____ Patient investigated _____ Comes back with results of laboratory investigation ___ Doctor _____ Reviews the reports _____ Confirmation of diagnosis _____ Prescribes and advises (treatment and management) _____ Patient leaves the hospital.

The doctor may need the help of the MSW at any of these stages in the flow chart of the patient in the out patient depending upon the type of disease.

Eg:- (a) Person suffering from tuberculosis has taken treatment previously. The doctor needs to know what treatment was given, for how long and why the patient gave up and came here? Any financial difficulty?

(b) Person suffering from malnutrition - What is the usual diet at home? What are the cooking and culinary practices? How much is spent on food and what type of food is generally used? etc.

(c) A patient is afraid of lab investigation because blood is being taken for testing. Patient needs education

(d) Patient suffering from helminthiasis needs education on personal hygiene etc.

II. TEACHING, RESEARCH AND COOPERATION WITH OTHER AGENCIES

(i) Teaching: Teaching of social implications of illness to medical students and nurses in training as well as to groups of social workers and others concerned with health services - MSW is not necessarily a good teacher. Those who can teach should be given the opportunity to teach. At least one member should be a person who can teach. He/she should be given the special responsibility of teaching and be given time and opportunity for study and preparation of case material involved.

(ii) Research: Where medical staff are engaged in special clinical research, MSW should be asked to share in planning that part of enquiry dealing with social factors. In the field of social medicine MSW has a positive contribution to make. There is a new demand on their knowledge and experience.

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Policy as it affects the welfare of the patients: The knowledge of the patient's point of view which the MSW possesses enables her to contribute in policy making of hospital services.

III. COOPERATION WITH OTHER AGENCIES

MSWs work for individual patients brings her into close touch with other social service and other health organizations - local and national statutory and voluntary. These contacts broaden the horizon and increases her exposure to various types of experience of patient's needs - helps to plan better or modify the existing ones. Involves in attending committees and conferences. Contacts help in closer cooperation with hospital.

ORGANIZATION OF THE MSW's DEPARTMENT
ADMINISTRATIVE DUTIES

MSW is a professional worker. This should be borne in mind.

He/she should be allotted only such administrative duties as relate directly to her function as a MSW (Clerical work, work on assessment of income of patients, visits for administrative purposes, substituting the MSW when Dietetician, Clerk, Store Keeper etc are on leave). Such duties will not only impede the Medico Social Work but gives a false conception of medico social work to others. Medico Social Work and service is their primary function. Any other type of work if entrusted brins about frustration, dissatisfaction in job and finally inefficiency.

Staff: Conditions vary so considerably that no uniform scale of adequate staffing can be laid down but in acute general and teaching hospitals one MSW for 75 beds is suggested. In TB Hospitals one for 200 beds and in hospital for chronic sick one for 300 beds.

Accommodation: Office of MSW should be placed near to the Doctor's consulting room and should allow privacy for interviews. Typists should not work in the same office as the MSW. There should be adequate space for files. Extra room may be required for teaching.

The assessment of the MSW in the discharge of his/her duties must be left to persons who know how to assess the job responsibilities of a MSW.

Many suggestions for the future could be made but one thing is certain. The MSW whatever the details of his/her work may be, must concern herself before all else with the welfare of the patient. Results of her work are not easily measured, but she has it in her power vitally to affect the lives of other people. The future of the profession depends in the last resort upon the quality and inspiration of the people who are attracted into it.

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M. M. Mascarenhas

Com H29:3

Case Study of a Marasmic Child in Rural Punjab

By

D.N.Kakar* , Ph.D; M.P.H.

Introduction:

Protein-calorie malnutrition is perhaps the most widespread and the most important pediatric problem in developing countries. Many authorities believe that it is directly or indirectly responsible for the high infant and childhood mortality in these countries. It particularly strikes the high risk groups such as the children, pregnant women and old people. Children as well as pregnant and lactating mothers have higher nutrient demands and if these are not met, incipient forms of malnutrition develop and the individual catches infection more easily. The synergism between malnutrition and infection attacks the individual consequently diminishing his chances of survival. High child mortality, especially in the age group 6 months to 3 years, seems to be mostly attributable to this synergism. Both biological and cultural factors influence malnutrition. The cultural factors differ from place to place but in general traditional feeding practices after weaning do not ensure the child enough proteins or even a reasonable share in calories. Sometimes, the weaning is so abrupt that it leads to psychological traumata.

The Nutrition Project of the Johns Hopkins University's Department of International Health is making a special study of the relationship between malnutrition and infections among children under three years of age in a selected group of villages in Ludhiana District of Punjab. During the course of our study which involved a weekly morbidity survey of all children under three years of age, we found that marasmus, locally known as "Soka" was the main clinical syndrome of malnutrition in these villages. Nutritional marasmus is a form of severe protein-calorie malnutrition usually occurring in the first three years of life.

The present case study relates to a scheduled caste Ramdasia girl, whose family situation and beliefs about etiology and therapy of marasmus have been studied in considerable details. In order to highlight some important points, certain socio-cultural aspects of the case are briefly presented here.

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* Dr.Kakar is working as an Anthropologist at the Rural Health Research Centre, Narangwal.

Name of the girl: Sinder Kaur
Age: 32 months

Mother's Fertility History

Mother married		at the age of	15
First child	(F)	-do-	18 (died)
Second "	(M)	-do-	20
Third child	(F)	-do-	26
Fourth "	(M)	-do-	27
Fifth child	(F)	-do-	28
Sixth child	(F)	-do-	30
Seventh "	(F)	-do-	33 (Sinder Kaur) died
Eighth "	(F)	-do-	36 (died)
Ninth "	(M)	-do-	38

- -

Sinder Kaur came from a poor family; her father had tuberculosis and was an alcoholic and had been out of regular work for the last five years. Casual labour never fetched him more than Rs.50.00 a month - an amount inadequate to meet the growing demands of his family. Being an alcoholic with considerable leisure-time, he spent a major part of his earnings on drinking country liquor. Continuing deterioration in economic condition became the frequent source of bickerings in the family which caused considerable irritation and annoyance to all members of the family. Sinder Kaur's mother did not yield to the circumstantial pressures and herself went to work in the fields collecting fodder for the cattle and occasionally getting grain for the family. Her eldest son, at 15 took up the job of selling milk from house to house which earned him Rs.40.00 per month. Because of the poverty-stricken state of the family, Sinder Kaur inevitably remained deprived of necessary parental care and affection. She often remained alone in the house for the major part of the day without a bath, inadequately clothed and exposed to flies. Her neglect was purely situational and not the consequence of a general attitude of neglect to female infants.

Her eldest sister had died of "Soka" (marasmus) at the age of 6 years. Sinder Kaur too was considered a "Soka" child right from the time of her birth. She was extremely lean and thin in appearance and had fever and dysentery. In order to arrive at a reliable diagnosis of "Soka", the mother performed a certain diagnostic test; she picked up a handful of red chillies and burnt them in the domestic "chula" or oven. Since the chillies did not produce the normal irritating smoke causing tears to the eyes, the belief was confirmed that the child was either under the evil-eye influence or had contacted "Parchavan" due to the shadow of a woman whose child had died recently or who had a "Soka" child. However, there were other

possibilities too and therefore the mother decided to contact the easily available "Syana" (the spiritual healer). Incidentally, the "Syana" happened to be the grand-father of the child. He performed "Hath Hola" on the child or blessed the child with his right hand in order to relieve her of the evil influence. As the condition of the child did not improve, the mother took the child to another spiritual healer and when he failed to relieve the child, she resorted to a third spiritual healer, who was considered spiritually more powerful. He took a careful look at the child and then guessed that the child had either contacted the "Parchavan" of a woman whose child had died recently, or had contacted the "Parchavan" of a woman who was pregnant and did not belong to the family, or had been to the site where a woman whose child had died took a bath after the disposal of dead body, or had taken a bath at a place where a menstruating woman had just finished taking a bath, or had contacted the "Parchavan" of a woman having a "Soka" child in her lap. While performing "Hath - Hola", he spelled out a powerful "Mantra", verbal formul.. and then drew certain lines on the ground with his sickle dipped in water and ashes. Then he told the mother that this was a case of spirit-intrusion, where the malignant spirit of a dead child had entered into her body, and this happened when the child contacted "Parchavan". The failure of the "Syana" to relieve the child of "Parchavan" influence was attributed to the greater strength of the malignant spirit, for which a much more powerful spiritual healer was required. Driven by frustration and sorrow, and because of the worsening economic condition of the family, the mother finally left the child to her own fate in a state of neglect and hopelessness.

She was admitted to the Narangwal Health Centre and the details of treatment are given in the Appendix.

<u>The Sequence of Events</u> (First Stage)

1. The Lady Health Visitor was the first to report the case to the Project Doctor.

2. The case was then referred to the Project Officer, who took special interest in the case; she wanted Sinder Kaur to be admitted to the Health Centre at Narangwal.

3. The Officer and the Project Anthropologist met all members of Sinder Kaur's family, including her paternal grand parents. They also met their neighbours, influential people of the locality and the Sarpanch (Panchayat Chief).

4. The Anthropologist collected general information on the Ramdasias, on Sinder Kaur's family situation and on beliefs about the etiology, diagnosis and therapy of the predominant diseases among the children, with special reference to marasmus.

5. After having a detailed discussion with the family members, the Project Officer and the Anthropologist succeeded in persuading the parents of Sinder Kaur to get her admitted to the Health Centre at Narangwal.

6. The most important factor in her hospitalization was that her father was primarily interested in his own treatment. He agreed to be hospitalised with his daughter. Both of them were hospitalised at the same time and they were promised complete treatment.

7. Free treatment was provided to both at the Health Centre.

8. As a result of hospitalization, there was considerable improvement in their health, especially in Sinder Kaur's health.

9. Sinder Kaur continued to get the nutritional supplement from the Lady Health Visitor and her father was being given the injections.

10. Improvement in the health of the child had a good impact on the community and reportedly some other people also approached the Lady Health Visitor for similar treatment.

(Second Stage)

11. However, after she attained the age of three years, she was excluded from the study. As long as she remained a 'study child', she showed signs of improvement. Meanwhile, another daughter was born to her mother, seven months after Sinder Kaur's discharge from the hospital. Owing to deteriorating economic situation of the family, this child too was not looked after properly. Their father continued drinking and mother had to work in the fields.

12. Thus Sinder Kaur again became marasmic and started having fever. This time no medical treatment was provided as it was not demanded.

Outcome:

The result was that Sinder died of marasmus. After her death, her family was again contacted. It was evident from interview with her parents that they continued believing in

supernatural causation of marasmus because Sinder Kaur had ultimately died and they thought that the medical relief was short-lived. After Sinder Kaur's death, her newly-born sister also died as a result of prolonged fever. The ninth child that was born to her mother was a male.

Discussion:

Thus the above case clearly indicates that the death of Sinder Kaur was multi-causational. Inability of Project to provide medical care after her exclusion from the study (unless demanded), coupled with such factors as father's inconsistent and inadequate income, his habit of drinking, mother's working in the fields, a large family size, sex as well as birth order of this child and above all family's strong belief in supernatural causation of marasmus contributed to her neglect ultimately resulting into her death.

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APPENDIX

Abstract record from Narangwal Health Centre

Sinder Kaur Date of Birth: 2.7.1966 File No.601955

This 32 month old girl was admitted into Narangwal Health Centre on 15.11.1968 with history of fever 3 months low grade, more in the evening. No chills or rigor. Marked loss of appetite and weight. No cough, vomiting or diarrhea. Multiple small cutaneous lesions. No respiratory difficulties.

Dietary History -Diet consisted of breast milk, water and sips of tea.

Family History - Father suffered from pulmonary tuberculosis and was admitted into Narangwal Health Centre with the child under the care of Dr.Ian Lawson. Smear and culture positive for A.F.B.(601954).

Other siblings- 1st female child died of marasmus at 6 years of age.

4 others healthy.

Mother healthy.

Findings:

O/E- Markedly emaciated
Weight 4.6 kg.
Marasmic
Pallor
Pulse 75 per minute
Angular stomatitis
Bilateral cervical lymphadenopathy
Small skin abrasions of both sides of neck & right ear
No oedema
Pyoderma over the skin

Heart- Systolic murmur in all areas

Chest- Bronchial breathing right infrascapular area.Few crepitations.

Abd - NAD

Provisional diagnosis- Pulmonary tuberculosis with lymphadenopathy and marasmus.

Investigations

Blood

	Hb	ESR	WBC	P	L	M	E
16.11.68	12g	10mm	9200/ cmm	58%	35%	6%	1%
22.11.68	8.5 g (Project Technician)						
12.12.68	10.6 g (-		10250/ cmm	53%	36%	6%	5%

X-ray

15.11.68 Increased Hilar shadow with increased lung field markings.

9.12.68 Same

Montoux 1 . 10,000 Negative

Treatment: Streptomycin ½ vial OD
PAS 1 gm TDS
INH 50 mg BD
Becadex
B-complex
Betnesal eye ointment

Discharged
12.12.68 - with advice to follow the above treatment.
- weight 7.0 kg (gain of 2.4 kg in 4 weeks)

- -

Follow up at Home

She continued streptomycin, INH, PAS and vitamins. She was advised to discontinue PAS and streptomycin on 6.2.69. She has gained 1.5 kg in 3 months at home. She still cannot walk but can sit steadily. She has been supplied 6 kg dry skim milk powder and 2 kg of coconut oil and 1 kg of Dalia and 1 kg of multi-purpose food which was given by mother under supervision of Health Visitor. No episode of illness recorded during this period.

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Com H29 : 4

CASE STUDY - URCHIN

Name: Shrinath Age: 14 years

Occupation: Channawalla

Native Place: Ghoda Raha, a small village in Uttar Pradesh.

PARENTS:

Down in his Native Place. Father works as a waiter in a Toddy Shop. He has 3 sisters, young, jobless sitting at home, 5 brothers two of which are schooling in a government Free School and 3 are jobless, mother jobless sitting at home.

MIGRATION:

Came to Bombay in 1974.

WHY?

Because his father sent him as there were no job opportunities in U.P.

FIRST EXPERIENCE:

When he first came down to Bombay he did not know what he was going to do; he felt if he got a chance he would run away and go home. He felt rather frustrated. Thinking of his parents and brothers and sisters he decided to stay on and then found a small business like selling channa and groundnuts.

On seeing the beautiful places of Bombay he was quite fascinated and thought it was the best place he ever saw.

HOME IN BOMBAY:

He stays in Thana in a small thatched hut shared with 3 other boys who are in the same business. Its a thatched hut, with a cowdung splashed flooring and walls. He pays a rent of Rs.10/- a month.

HEALTH FACILITIES:

Nil. He does not have enough water to bathe daily.

MEALS:

He has 2 meals a day, one at 12 in the noon and one at 12 midnight, both prepared by himself.

EDUCATION:

He has passed his 5th class in the Govt. Free School but he was forced to leave because he had to help his father to support the house as none of the others were old enough to work.

SALARY: Rs.3 to Rs.5 a day.

SENDS MONEY HOME:

Yes. After 3 or 4 months when he has gathered about Rs.50/-.

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RELIGION:

He was rather quizzy; he finally said that he worshipped Santoshi Ma.

MISCELLANEOUS:

He was scared of political parties cause he felt that they would stop him from his business, and when a Riot broke out he got scared because he thought they would break his hut down and he would be homeless.

He finally said that he would work to the best of his ability and then manage to gather some money, go back and open up a small shop in his Native place.

THE PROCESS OF URBANISATION

To highlight the eco-political conditions operating in the process of urbanisation, let us follow a hypothetical person 'Ramu'.

RAMU IS AN INDIAN, A TYPICAL INDIAN WITH INCOME LESS THAN RS.20/- P.M.

250 million earn
less than Rs.20/- p.m. ('61 prices)
Rs.30/- p.m. ('71 prices)

RAMU WAS A VILLAGER A LANDLESS LABOURER

More than 220 million people living below the poverty line are rural landless labourers

In 60-61 - 52 per cent } of the rural people
67-68 - 70 per cent } lived below the poverty line

IN '51, RAMU WAS A SMALL FARMER

In 1951, out of a 100 Indians

42 were small farmers
9 tenants
13 landless labourers
1 landlord
20 non-agri, workers
6 in commerce
2 in transport
7 in services & Miscellaneous

In 1951 13 per cent were agricultural labourers
1961 16.71 per cent
1971 25.76 per cent

NOW RAMU HAS BEEN WITH A SMALL PIECE OF LAND TO STAY

Distribution of land
The top 1 percent own 16% of the land
5 percent - 40%
10 " - 56%
the lower 50 " - 4 % of the land
bottom 20 " - no land at all

...3

RAMU NEEDS CREDIT. THE BANK? HE DOES NOT GET IT.

Only 30 percent of the rural credit comes from Cooperative credit, Nationalised Banks etc. In '71-'72 - 20 percent of agricultural loan was supposed to be alotted to small and economically weak farmers.

'73-'74 - 30 percent
'74-'75 - 40 "
Actually in '73-'74
6 out of 24 Coop. banks gave 20 percent
9 out of 24 Coop. less than 5 percent
3 out of 24 Coop. less than 5-10 percent.

SO HE GETS IT FROM THE MONEY LENDER.

70 percent of rural credit was unaccounted for by money lenders, many at an interest of greater than 300 percent p.a.

RAMU LOOKS FOR A JOB.

Out of a rural population of 436 million, 151.5 million (34 percent) are agricultural labourers.

IT IS DIFFICULT

In '50, 331 million were unemployed/under employed
'70 4.069
'71 5.1

HE GETS A JOB. WAGES: RS.2 A DAY.

Minimum Wages Act ..... Rs.3/- per day

BUT HE IS STILL UNEMPLOYED FOR A MAJOR PART OF THE YEAR.

Labourers are required in the field only during ploughing, sowing and harvesting.

HE DOES NOT FIND EMPLOYMENT IN GOVERNMENT PROGRAMMES.

A 50 crore Govt. prog. to benefit a 1000 persons in each district at 12.5 lakhs each totally affecting only ½ million rural unemployed/under-employed.

IN '71, '72, '73, RAMU WORKS ON A GOVT. RELIEF PROGRAMME - METAL BREAKING.

In '71, '72, '73, Maharashtra was hit by 3 years of continuous drought. Massive Govt. relief projects were not enough to relieve the people.
The cattle die, the men starve...

A RELATIVE OF HIS IS DOING FINE IN BOMBAY AND CALLS HIM TO THE CITY TO FIND A JOB.

Sample percentage of workers of rural origin in Bombay according to relatives working in mills

Close relatives	66.6 percent
Relations	16 percent
Villagers	17.2 percent
No relations/villagers	1.2 percent

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SO RAMU MIGRATES	In 1941 - 51 1 million people migrated to Bombay. In 1951 - 61 ½ million people migrated In 1961 - 71 ¾ million people migrated.
HE MEETS PEOPLE	1941 - % of urban population was 13.9 51 - % of urban population was 17.3(3.4% in) 61 - % of urban population was 18.0(.7% in) 71 - % of urban population was 19.9(.9% in)
& MORE PEOPLE	1931 - 71 total urban pop. incr. by 230% in 4 cities 400% Delhi 706%
& TOO MANY PEOPLE	In 1961 Population density in Calcutta-28,759 'C' ward, Bombay 1,74,187
PEOPLE FROM TOWNS	In 1941, 35 % of class 1 city migrants came from small towns In 61 - 42 percent In 72 - 52.4 percent.
HE LOOKS FOR A JOB	Before 1st 5 yr plan 33 lakhs unemployed End of 1st " 53 " " End of 2nd " 71 " " End of 3rd " 96 " " End of 4th " 176 " "
SOME OF HIS COMPANIONS ARE 'PUSHED BACK' TO THE VILLAGES.	In India 8.2% of non migrants unemployed 6.4% migrants In Bombay 7.1% non migrants 4.5% migrants
SO, RAMU IS A CITY MAN, AN URBAN WORKER	108.8 million urban people in India 32.2 million (30%) blue collared 28.6 (20%) white collared.
RAMU GOES IN SEARCH OF A HOME	Annual deficit in housing in India 1 million In 1961 deficit of houses 6.58 crores 71 8.57 To provide these houses the Maharashtra Govt. would have to spend Rs.30,000 crores.
IN THE CITY	10 % have to live in one room tenements 1 % have to live in skyscrapers
IN THE SLUMS	There are already slum demolishing proceedings in 5 wards in Bombay. 19,750 families are alloted place in Dharavi 24,650 in Deonar Each family has been alloted 15 sq. mts. and have to build a solid structure costing Rs.2,500 - 3000. Even with a 80 percent loan - they must have about 600/-.

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Imagine a family earning Rs.3/- to 5 a day repaying a loan of Rs.2500 - 3000.
They will never more, as all families will not get place and in some of these allotted places there already exist large slums.

ON THE PAVEMENT

3 out of 5 pavement dwellers live with the sky above their heads.
The other two in 'dilapidated set-ups'.

RAMU COMMUTES FROM HIS SLUM TO TOWN

40 percent of the total employed in Bombay are concentrated in Fort area, a radius of 2 kms. where the density is 1,75,000.
This area has only 30 percent access to other parts of the city.
The BEST has 1318 buses, of which more than 50 percent have completed their life span.
This provides 2.5 million journeys as compared to the 4.6 million undertaken by people.

RAMU IS A CASUAL LABOURER IN A FACTORY. WAGES RS. 3-50 PER DAY.

The DD Mills in Bombay pays Rs.3-50 a day for unskilled workers.
Only 1 out of 25 workers is permanent.

RAMU JOINS A UNION.

Union of DD units is affiliated to the Mazdoor Mills Sabha.

RAMU GOES ON STRIKE.

300 workers go on strike on Sept. 24th '73.
Union comes to terms with the management.
The workers are dissatisfied. They join the other union affiliated to INTUC.
The strike is on. Everything is peaceful.
On Nov. 25th the workers are attacked by some high goondas. Seven workers are seriously injured. Many arrested.

NO WORK, NO INCOME, DRINKING, GAMBLING, LOAN?

DIE IF YOU WISH, YOU MISGUIDED COMMON MAN!

Com H 29:5

A CASE STUDY: A Tale of Manyfolded Exploitation

This story was told to us by a farmer from Madurai District in Tamil Nadu.

The farmer was operating a power-sprayer; this was his job. But he was not the owner of the sprayer: it was owned by one of the big landlords who in his turn hired it to other farmers. The lease included the worker.

The man with the sprayer carried on his back told:

-I'm only doing this job because I need the money. How can a man survive without work? I get on an average 5 Rupees a day, and more during the busy season when I'm payed on piece-rate. I know it is a very dangerous job - but that's why I have to do it and that's why the owner himself refuses to. I have no choice - I must take any job I can get.

-I have to carry the sprayer and the tanks directly on my back. I have no cover on my body. My brothers also worked with sprayers. They are dead now; they died because of the spray. I know I will die soon also; these sprayes kill a man. Just to be alive a little longer I go to the Doctor every day and he gives me injections. He has told me not to eat food that is fat, not to have cooking-oil for example. I don't know exactly why he told me this, but it had something to do with the poison in the spray.Some days I have to spend 12 Rupees on medicines alone because of this work that I do. Everybody knows that it's dangerous, but what can a poor man do? I have to bring rice to my family!

-The owner is leasing the sprayer to any farmer who wants his fields coated. My work is included in the lease the farmers pay to the owner. They have to pay 1 Rupee for each tank that I manage to spray. In the busy season, when I'm paid at piece-rate, I can manage up to 30 tanks during one day of work. I get 25 paise for each tank, so a good day can give me 7.50 Rupees. But the owner takes the 75 paise balance for each tank, so he gets 22.50 Rupees for my work during the same day. The more I work, the more he gets.

-I only wish that this rich man who had money enough to buy the sprayer which costs 1,000 Rupees, that he could also buy a uniform for me. They are available in the market; they cost only 150 Rupees. That is nothing for him. It is told even that you have to ware this uniform to be protected from the dangerous things in the spray, but I cannot afford this protection. And the owner doesn't care - he is not spraying these things himself anyway...

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HAMID, THE DHOBIE.

Hamid had been the head dhobie for a number of years in a middle-sized hospital. He was considered to be a good employee. Hamid rarely took Casual Leave and if he did, he replaced himself with a family member so the work did not suffer. He came to the notice of the hospital management only during the monsoon season when, due to lack of washing and drying facilities in the laundry shed and the small inventory of linen in circulation, he could not keep up with the demand for clean dry linen.

This hospital was called a 200 bed general hospital by the president of the society. The Medical Superintendent talked of 175 beds and the Business Manager in his reports listed 160.

The hospital was founded as a women's and children's hospital by a missionary shortly after the turn of the century and no one could remember nor is it recorded just how and when a conscious decision was made to expand the facilities to admit male patients. For years the hospital was considered to be one of the best in the area, and funds were available, not only through the organization, but also by contribution from abroad channelled through individuals. The hospital had been "turned over" to the indigenous church, and subsidy was decreasing by Rs.5,000/- per year as per the Church plan. By December 1973, the outside help had been reduced from Rs.50,000/- to 30,000/-

The organizational structure under which this hospital operated was typical of a number of church hospitals in India. Firstly, the church Executive Council was to decide on policy matters and the selection of the three "appointees", namely the Medical Superintendent, the Nursing Superintendent and the bursar in each of 4 church hospitals. Secondly, there was a Medical Board which made recommendations to the Executive Council regarding salary scales and financial requests and very often ratified or rejected minor decisions which were made by the local hospital committee. It was not uncommon for all these bodies to spend much of their time on agenda items such as retaining a laboratory technician who was no longer wanted in a certain hospital.

The three appointees (M.S., N.S., Bursar) were to have equal status and were to concentrate on their own area of work which, of course, often overlapped. No one holding these positions had any administrative training for the job, with the exception of the Nursing Superintendent, and often there was a considerable amount of tension between the three because the job descriptions had been written at least fifteen years previously. Depending on the personality of the individuals involved, the position of Director was informally decided but resented by the other two persons in charge.

In this hospital, there was a Nurses Training School with its own Director of Education who controlled the budget for the school. The students, of course, were trained in the wards and OPD of the hospital. Most of the Class IV workers including the dhobies were supervised by the Nursing Superintendent (Service)

All the X-ray, lab technicians and the compounders reported directly to the Medical Superintendent. The office staff and ground personnel were supervised by the Bursar.

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In January 1974, the Hospital Committee sent a request to the Medical Board for permission to increase the salaries of all employees. Increases ranged from Rs.75/- per month for the medical staff to Rs.5/- per month for class IV workers. Because salary scales were uniform in all 4 church hospitals the Medical Board set up a special committee to study the proposals which were to be submitted at the next quarterly Board Meeting. No decision was made at the April Board Meeting.

The Hospital sent a request to the July Medical Board meeting seeking permission to give an ad hoc increase of Rs.2/- per month to the Class IV workers, effective July 1, 1974. This request was approved by the Medical Board and sent on to the Executive Council for final sanction. The overall salary request was not finalized however.

In October 1974, the Executive Council approved the Rs.2/- ad hoc increase with the proviso that it be made effective October 1, 1974, and that this ad hoc allowance of Rs.2/- be deducted from any wages increase in the future. The hospital started paying the Rs.2/- in October 1974.

Finally in April 1975, fifteen months after the initial request the Executive Council approved a Rs.5/- increase for the Class IV workers, but it was to be effective January 1, 1975. (See Exhibit 2 for summary of dates).

The workers were quite happy that they were going to get a Rs.5/- per month increment. Hamid, the Chief Dhobie, immediately borrowed money to buy two new tyres and tubes for his bicycle. However, the peon who learned about the increase from the pay roll clerk and who told his fellow class IV workers, did not know that the increase was effective January 1, 1975 and not retroactive from October 1, 1974 as expected. Furthermore, no one was informed that the Rs.2/- ad hoc amount was to be deducted from the increase and they were to get only Rs.3/- more starting January. However, the office peon did inform his co-workders that the doctors received Rs.100/- per month increase.

On April 30 when the workers received their pay it included the January to March increase (Rs.3 x 5) less the ad hoc allowance already paid (Rs. 3 x 2) for the same period. The Bursar was out of station and the payroll clerk took no responsibility for explaining the reasoning behind the difference in their expectations and what was actually realised. There were a number of angry exchanges. The Medical Superintendent was unaware of the problem, and in any case was very busy in the operating room all day.

The Bursar returned a few days later and when approached by three employees: Hamid, the gateman, and the gardener, about the small pay package, promptly told <u>them</u> that the policy was fair. Furthermore, the hospital did not have a lot of money and in any case this was a church decision and he could not do anything, about it. He also told them, "Do not be so foolish. I should have deducted the Rs. 2/- per month which you got from October to December. If you continue to make trouble, I will do that also."

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The dhobie, Hamid was more persistent than the others and tried a number of times to explain to the Bursar, Medical and Nursing Superintendents that he had borrowed money in anticipation of a Rs.5/- per month increase. The response by all the three officials was that he should be careful as they were not satisfied with his work and he did not have to worry about the increment as they were looking for another dhobie to replace him.

In the next few days, Hamid was seldom in the dhobie shed but was seen talking to small groups. The gate was not opened on time at the beginning of visiting hours. On one occasion, an emergency patient was taken to another hospital because the gateman could not be found. The work suffered. Some ward Ayahs refused to empty the bed-pans. The linen returned from the dhobie still dirty and an increase in torn sheets was noticed. The officers were not very concerned as they considered that replacing of the dhobie would remove the only troublemaker. However, when several previous applicants for the dhobie job were approached, they all refused to accept an appointment although better terms were offered. The hospital officers could not understand why the old faithful workers were so sullen and difficult to get along with. The Business Manager drew up a list of what he considered over-age workers, but he could not establish their age as there were no personnel records.

Approximately 3 weeks later, a notice was sent to the Hospital Superintendent by the local Labour Officer that a hospital union, to represent the 4 church hospitals had been registered with the Government. The hospital authorities were summoned to a meeting to discuss the union demands which were enclosed. The newly recognized union had as president an influential lawyer and local political leader.

The Medical Superintendent became angry and told the Bursar in front of the office staff, "These Class IV Workers are a terrible lot and show no gratitude at all. From now on, we will stick to hospital policy. No free treatment will be given to the members of the workers' families. Just last week, we sent that gardener's sister to a specialist at the medical college hospital and we paid the transportation expenses. We will not do that again for any of them, and especially that Hamid."

The Bursar replied, "I agree that Hamid is behind this mess. But we don't have to worry about these foolish demands. When the Labour Officer sees our large, accumulated financial deficit he will reject their demands immediately."

Exhibit: 1

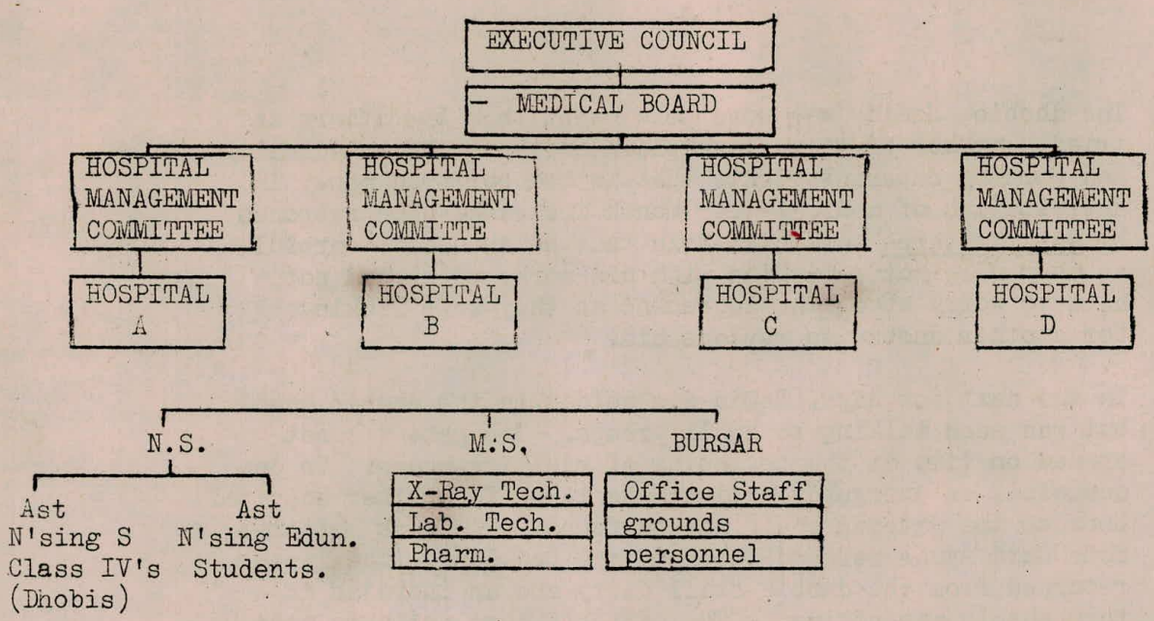

Exhibit: 2

Hamid the Dhobie.

Summary of Medical Board and Executive Council meetings.

January	1974	-	Hospital Committee sends request to the Medical Board Medical Board sets up a "Salaries Review" committee.
April	1974	-	Medical Board takes no action.
July	1974	-	Hospital Committee requests an ad hoc increase to be effective July 1, 1974 Medical Board recommends the Rs.2/- ad hoc increase and submits to Executive Council for sanction.
October	1974	-	Executive Council sanctions the ad hoc Rs.2/- effective October 1 - This ad hoc allowance to be deducted from any future increase in the salary scale. Hospital pays the ad hoc starting October 1, 1974
April	1975	-	Executive Council approves a Rs.5/- increase for Class IV and Rs.100/- for the medical staff - new salary scales to be effective from the entire new salary scale was approved ranging from Rs.5/- for Class IV up to Rs.100/- for Medical Staff, to be effective from January 1, 1975.

ComH 29 : 7

PATIENT : DEANNA D'NAZARETH WIFE OF VINCENT D'NAZARETH

AGE : 37 Years

Married : 15 FEB 1960

CHILDREN: FOUR
1. Annie 13 June 61
2. Sonno 21 April 63
3. Dolla 8 Nov 64
4. Jeru 5 Feb 66
) Now in Boarding Schools.

HUSBANDs POSITION : Is an Employee of English Electric in the Erection Department that needs absence from home for long periods. Usually Project work. No stable place of stay. Sick leave in hope of cure of wife now amounts to 3 months due to end this week end . If not reporting back for duty - Loss of employment. Effect - Destitution of Husband, Wife & Children.

PRESENT URGENT NEED : Institution/Hospital that will accept wife in present state and also effect a cure, as it is not humanly possible for Husband to take Wife along with him and look after in her present condition as well as attend to his duties. Being in the Erection Department also not sure where he will be posted on reporting for duty.

CASE HISTORY :

POSTED TO KANPUR - JAN 68 - CONDITION : O.K.

EVENTS: BACK TO TARENTAL HOME : MAR 68 . Husband not able to work for 6 months due to sickness.

Wifes Condition - Hands shaky.

SEP 68 Husband posted to Bombay. Left Wife under Mother's care for 1 Year 4 Mths, during which she used to starve 4 to 5 days when disagreement with mother. Condition further deteriorated. Also suspicious husband running after some other woman at Bombay. Wrote letters to this effect.

JAN 70 Husband took wife and youngest child (placing older 3 children in Boarding schools) to Bombay. Since accomodation was not available at Bombay was staying with a newly married couple (Relation) sharing a flat. Looking after household, Cooking etc done by relation as wife unable to do anything. When Wife was taken to Bombay, Relation said that Wife's condition was deteriorated because she was left in Husbands Parental Home and Wife was madem much of by them. Treatment started in Happy atmosphere. Ailment diagonised as Berry Berry. Tonics, Injections and Vitamin Tablets given. Responded to Treatment and state of shakiness left completely within 3 months and condition stabalized, and was bodily normal.
Since Husband's job at Bombay was of a nature in

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which he left home at 6am and returned at 11 pm Wife was advised to have Breakfast, Lunch & Dinner with Relation and not wait for him, which was being done.

EVENTS :

APRIL 70 — One day on Husbands return home at 11 he noticed Wife's limbs going back to old condition (shaking). On asking wife, what had happened, ther was no reply. On questioning Relation, husband was told that she is not eating. Further questioning revealed that Wife had starved for past 4 days;

REASON : A boy was engaged for alternate washing of clothes of the two families. One day the Relation told Wife . Todsy I am not giving Clothes, you give the clothes. Wife Replied : Today is not my day. You give it. In short none gave. The next day both gave the clothes and the Relation told the boy not to wash Wife's household clothes, but only hers. This led to her attitude of Starvation for 4 days, and continued to be adamant even after Husbands requests to eat. On seeing condition of Wife, husband took wife next day to the Doctor. He got an appointment with Dr.Iulla Hon.Psychiatrist - Nair Hospital - Bombay. He had a sitting. He gave some tablets. The Tablets were given on that day (5th day since starvation) and the following day at about 5 pm she told husband she was hungry. Said that she would only eat on condition that Husband cooks the food and not her Relation. Husband started to cook the food from that day onwards for wife and Psy Treatment was carried on as an Out Patient (12 APR 70 - 2 NOV 70). The relationship between Relation and Wife became strained and constant fault finding by Relation culminating in being ~~aske~~ constantly asked to shift. Shift of abode took place on obtaining one in Bombay (JULY 70).

12 APR 70 to 2 NOV 70 NAIR HOSPITAL BOMBAY

TREATMENT : Neurosis check up
Skull EK Ray
Blood Tests.

Slight shocks was given on the Temple every other day for 1 ½ week. Since no improvement was found a Total of 15 ECTs were given and Drugs Eskazine, Pacitone and Largactil administered.

During this period Wife found to be expecting One - two months . DNC was per ormed since wife found to be unfit to look after self.

LAST PSYCHIATRIST SITTING - MIDDLE NOV 70

Questions asked to Wife at Sitting

PSY : Who is doing the cooking ?
Wife: Points out to husband.

/Psy.

Psy : Who is doing the Marketing ?
Wife: Again points to Husband.
Psy : Dont you find that your husband is pulled down in health ? Shouldnt you do the cooking or should he divorse you ?
Wife: Replies No.
Psy : Should he keep another woman to look after you and himself?
Wife: Replies No.
Psy : Are you going to do the cooking ?
Wife: Question is ignored. Just turns her head away and does not answer.

Husband asks the Psychiatrist why she has not answered this question.

Psy : SCHIZOPHERNIA - They believe that they are living in a make-believe world of their own in which they want expect everyone to help them but they wont help themselves. NO Improvement . Carry on Treatment.

Hearing these words Husband stopped treatment.

CONDITION OF WIFE AFTER TREATMENT :
Could walk on road, Climb steps with assistance. and in the house, Boil milk, wash utensils, go to Toilet, wash face and Brush teeth (Husband doing the cooking).

EVENTS :

DEC 71 Christmas Season - 4months leave taken by husband. Children brought by well wisher to home (Bombay) for holiday from Madras. Wife does not like love and attention of husband shared between her and children. Becomes self centred.

Before 15 days of children due for departure to Madras, Husband mentioned to wife that he would have to book tickets for self and children for Madras - going back to school, and wanted her to remain with friends for a period of 4 days. She didnt like the idea of her being left at friends place and husband leaving for Madras with children. Husband left home at 10 am for booking tickets. On return at 6.30 pm the children on the top 3rd floor were shouting 'Daddy we are hungry'. As husband walded up half way he heard his children scream 'Mummy is Burnt'. On hearing this and rushing into the room found a Dekshi of Boiling Water spilt on the floor and wife was saying 'Vincy, Hot water has fallen on me'. She rubbed her face and skin peeled off. The Doctor down stairs was immediately informed. He instructed that he was coming but in the meantime all ber clothes be removed and oil applied. The Doctor came immediately but Wife was smiling. He prescribed some ointment and sid in case she complained of pain he was to be informed. Wife did not complain of pain and no injections given. Ointment procured same night

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and applied. The face was swollen next day and eyes were closed and it was feared that eyesight affected. On the 3rd day, swelling subsided and Wife could see. Scabs formed within 13 days and as husband was packing bags to take ~~patien~~ wife to friends house for leaving her there, she screamed out "I will not go" and scratched scabs on her face and started howling like a maniac. Blood was streaming. Hands had to be bound at the back for fear of further injury. Husband told her that he would only release her hands providing she promised that she will never hurt herself. She promised and was realeased. Had calmed down. Next day husband took wife along with children to friends place. After leaving wife with friends, left for Madras with 4 children. On return from Madras after 4 days his friend told him that wife had not given any trouble. She was taken back home.

EVENTS :

JAN 71 — Husband transfered to Ujjain & other places. Takes Wife along. Condition - As before, eat,drink, wash face, brush teeth, go to toilet (except Bathe) without aid. Develops extreme suspicion. If Husband speaks to anyone - would complain that he is discussing her faults.

OCT 72 — Husband transfered back to Bombay

17 NOV 72 — Wife admitted as In Patient at J J Hospital Bombay

ECT 8
Electronarcosis and Drugs.

22 FEB 73 — Discharged from Hospital saying nothing much can be done. Carry on treatment as Out Patient and advised to administer Drugs

Tab Eskazine 10 mg 1 a day
" Pacitone 2 mg 1 " "
" Largactil 50 mg 1 " "

Above drugs given for 2 months.

Condition was much deteriorated on discharge from Hospital. Wife passing Urine & Stools in Bed and could not walk on her own.

Was nourished and got back health. Could manage to go on own to toilet etc. but did not like others company.

EVENTS :

NOV 73 — Husband transfered to Bihar. Day before leaving, Husband obtained from Doctor Sedatives which should be given only one per night. One was given on the night before departure and Bottle left on Dining Table. After giving he Bath and bringing her to the dining table, Husband had fried an egg and gi

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to Wife and as he had turned to fry another, something made him turn around and he saw that she had emptied the whole Bottle of 24 tablets into her mouth. Normally when she eats she keeps food for a little while in her cheek. He put his finger in and drew out all the tablets from her mouth and found that 4 had been swallowed. The Doctor was immediately brought and a bad situation averted. WhenW Wife was asked shy she did this. There was no reply. Same evening left for Bihar with Wife. Since the climate was very cold at Bihar in Nov - Jan, Exercises like walking outside home was curtailed. Wife's movements became slightly worse.

EVENTS :

APRIL 74 — Husband transfered to Bombay.

Husband found Afternoon meals left untouched, On return from work 7 pm and would only ea eat on Husband telling her to do so. Seeing this condition, Husband got worried and got her admitted in Govt Mental Hospital - Kilpauk.

25 JUL 74 — GOVT MENTAL HOSPITAL @ KILPAUK (Wife admitted)

MAR 76 — Husband transfered to Madras.

5 MAY 76 — WIFE DISCHARGED FROM HOSPITAL Husband told that Wife has to be taken home and looked after. Condition deteriorated to present condition. Husband took leave for 40 days and took wife out of Hospital. Massaged and exercised found slight improvement but could not extend leave.

EVENTS :

JUNE 76 — Husband transfered to Mysore.

Husband left for work sited with wife. But looking after wife in present Condition and working led to Mental and Physical strain & breakdown leading to collapse at work. Applied and was granted sick leave. Went to Angamali with Wife on Sick leave on assurance and hope of Complete cure of Wife as Priest in Charge of Mar Ignatius Mental Hospital - Angamali was ~~said~~ endowed with mireculous power of curing such cases.

26 AUG 76 — Wife admitted in M I M HOSPITAL

Unfortunately Priest met Car Accident 3 or 4 days Before arrival and Husband kept wife at Hospital personally attending on her in hope that the Priest would be able to attend on Wife on getting well. But hopes all dashed to the ground as Priest is still in a critical state. Husband's Sick leave has now come to an end having availed all types of leave

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and has to report in 10 days time or lose his job. Further extensions impossible.

11 NOV 76 Wife DISCHARGED FROM M I M HOSPITAL -ANGAMALI

PRAYER TO INSTITUTIONS/HOSPITALS

In this hour of Desperation, We beg that help be extended in accepting Wife in present state, where necessary care and treatment towards her recovery, so that Husband can report in time and hold on to his employment with peace of mind and a consolation that wife is in responsible hands.

SGT E.J D'Nazareth Brother of HUSBAND

My address :-

Sgt. EJ D'Nazareth
Band Section
Air Force Station Jalahalli West
Hospital Town West P. O.
Bengalore - 15

15 NOV 76

CASE DISCUSSION:

From the i) History of the complaints
ii) Socioeconomic history
iii) Physical examination
iv) Clinical Investigation -

we can come to a diagnosis of :

1) Malnutrition:(Protein-calorie type) - precipitated initially by Measles and in the last few months by acute gastroenteritis. -
Associated with -
a) Anemia
b) Ascariasis
c) Upper Respiratory infection
d) Urinary Tract infection

Complicated further by the socioeconomic factors of:

1) Poverty- a general term which includes poor-housing, congested environment, poor water supply and latrine facilities and inadequate nutrition.

2) Illegitimacy: and Maternal Deprivation

3) Lack of Psychosocial Stimuli necessary for normal development.

The diagnosis is based on:

1. Age of onset
2. Dietary history
3. Clinical findings of -
   i) Child's Height and weight are far below standard.
   ii) Physical and mental development is retarded.
   iii) Generalised odema but mainly of lower limbs.
   iv) Changes in skin,and flaky paint dermatosis and hair.
   v) Liver enlargement.
4. Low Hb and serum protein levels.

Since this is a xxx social case conference I will not go into the discussion of a differential diagnosis suffice to say that pathological conditions like -

i) Chronic dysentery or malabsorption syndrome.
ii) Abdominal tuberculosis
iii) Coeliac disease

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iv) Fibrocystic disease of the pancreas
v) Ankylostomiasis
vi) Nephritis can also produce similar signs and symptoms. Also in every case of apparent malnutrition these can be associated aggravating or precipitating factors.

A small note may be made about the skin manifestation in this case. Though like infantile pellagra it is mainly on the exposed parts of the body it was not diagnosed as pellagra because :

i) the lesions are not photosensitive
ii) they appeared in the ward as the odema cleared.

Next I must discuss the most important aspect of this case and that is the question of management. For purposes of convenience I shall divide management into two sub divisions:

I - Hospital management
II- Follow up care. It must be understood that though they may appear to be two different entities altogether they are closely related and either one without the other would be incomplete and bound to result in therapeutic failure.

The Principles of hospital care are:

1) Resuscitation
2) Dietary therapy
3) Anti-infective therapy.

1) Resuscitation - is of utmost importance especially in the first 24 -48 hours after admission since most of these cases come in with -
i) Dehydration, ii) Electrolyte imbalance, iii) Acid-base disturbances, iv) Severe anemia.
Dehydration is corrected by oral and or intravenous fluids. Blood transfusions are given if the Hb is less than 6 gms. Acidosis is corrected by administration sodium bicarbonate 4% solution 4ml/kgm hypo-

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Hypoglycemia by oral or Iv glucose. and electrolyte imbalances by administration of K and Mg supplements 4-5 mEqr/Kgm and 2-3 mEqr/Kgm. respectively.

2. Dietary Therapy :- is the next step and the most important step - Patient is started on glucose saline and ¼ str. milk feeds which are gradually increased to full strength milk feeds. Within a week or as soon as associated diarrhoea is controlled solid foods are started with special stress on their protein content, vitamin and iron supplements must also be started simultaneously.

3. Anti-Infective Therapy :- Malnutrition is most often associated with one or more of the following - TB. malaria, Helminthias, Giardiasis, Ankylostomiasis, respiratory and urinary tract infections. Infections because of their marked debilitating effect on already malnourished children must be diagnosed early and actively and adequately treated.

All these principles were followed in this case during the present hospitalization.

1. In this case Iv fluids were not started because :-

   i. Patient was tolerating oral fluids very well.

   ii. She had generalized oedema.

However 200 ccs of whole blood transfusion were given. Lasix was given for the oedema but with poor results probably because the cause of the odema was primarily hypoproteinemia.

With proper hydration the Hb which was 9.4 unbelievably high and probably due to haemo-concentration came down to its actual figure of 4.8 gms.

2. The patient was given ¼ str. and then full strength milk till the diarrhoea subsided and soon started on a solid diet which at present consists of

   i. 3 large glasses of milk daily (750 cc's)

   ii. 1 Egg

   iii. Meat curry twice a day - mixed with NPF (a produce of CFTRI containing high protein groundnut flour and Bengal gram).

   iv. Rice, Bread

   v. Plantains and sweet lime 1/each daily

   vi. Protein biscuits

In addition she was started on a standard Multivitamin syrup and Iron syrup (Tonoferron)

For the angular stomatitis a Vit. B Complex syrup was added in addition with good results.

3. Anti-infective Therapy :- The diarrhoea was controlled with proper diet and Mixture Bismuth kaolin. A dose of anthelminthic syrup was given for roundworms. (Piperazine 15 ml.)

The upper respiratory infection and hand infection was treated with Procaine penicillin injections and Ephedrine nasal drops. And for the urinary tract infection sulphas started (sulfatriad ½ tab/6th hrly).

With this treatment the patient made a clinical improvement shown by :-

i. Marked reduction in odema.

ii. Initial ~~loss~~ gain of weight due to ~~gain~~ loss of odema fluid and then a gradual increase related to a protein intake.

iii. Increase in Hb - to 9 gms.

iv. Clearing up of urinary tract infection as shown by a clear urine micro examination.

v. Healing of angular stomatitis.

This brings us to the main question in todays social case conference i.e. How is such a case followed up after discharge from hospital or how does one present the recurrence of the above clinical story by tackling the socio-economic factors involved.

We all realise by now that if Marina after making adequate clinical improvement is sent home to the same conditions described in detail by Kumar - she is bound to return within a matter of few weeks with some other infections and the exacerbation of the previous symptoms of malnutrition. If this were to happen that one is bound to question as to what has been the use of the present treatment in the hospital. In our hospital oriented medical education this is a question worthwhile asking before we discharge many of our other patients with similar background. For Marina's case to be completely tackled the second subdivision of Management ie. Follow up care is very important and must consist of the following :-

1. Regular weekly or fortnightly check up of the patient to detect.

i. continued improvement in general health

ii. early signs of infection - which should be adequately treated.

2. Checkup of other members of the family especially the three other children for malnutrition, TB, lice, scabies and other infections always associated with such socio-economic circumstances. These should be treated not only to improve the general health of the family but also to prevent Marina from getting reinfected or developing some new infection.

3. Education of the particular member of the family in this case the grand-mother - in sound nutrition in relation to their economic status and environment They should be asked to introduce groundnuts, pulses, ragi, and green vegetables most of which will not unnecessarily strain the family budget. An egg a day would be ideal but may not always be practical. MPF which is only Rs. 150/kgm (monthly need of a child) can be introduced with good result

3/ Groundnut
1/ Bengal gram

4. Rehabilitation :- This is an important aspect and can be tackled in each individual case by close cooperation by the Pediatricians, Medical students, Medical social workers and Local voluntary or govt. social welfare agencies. These would include :-

1. Free treatment of Marina and her family by the hospital (which is already being done)
2. In this particular case since the children are illegitimate they could be admitted into one of the well run foundling homes or orphanages in the city so that : i. we could lessen the burden on the grandparents.
   ii. ensure them (the children) of a better future.
3. With the help of our social workers to :-
   i. find employment for Marina's unemployed uncle who is a mechanic so that the family income could be increased.
   ii. Rehabilitate the epileptic aunt in some harmless profession or in an institution for such cases.
   iii. Had her mother been here it would have been necessary to rehabilitate her in one of the local institutions for women so that : a. she could again restart a normal life
      b. possibly give the children though illegitimate the maternal love that they so urgently require.
   iv. Arrange to send the ~~other~~ children to school so that they do not by the force of circumstances become future delinquents.
4. They always welcome effort made by individual students, doctors and institution to try and help the family temporarily or permanently through monetary aid, clothes and other necessities of life. Though this may be called charity, this can beclassified in this case under the important term of "Medical Social Work".

5. While considering the above measures a very important question arises and that is "What are the chances of Marina and probably the other children having permanent mental and physical retardation since they did not get valuable proteins so necessary for normal development in the most active periods of growth". I am not in a position to answer this except that I would like to read a small paragraph from a Summary of a conference on the prevention of Malnutrition in Preschool children, held in Washington D.C. in 1964 under the auspices of the National Research Council.

"Preschool malnutrition permanently impairs physical growth and probably causes irreversible mental and emotional damage. It is a serious deterrant to progress in developing countries; it weakens the productive capacities of adults suffering from irreparable damages incurred in childhood. "Further knowledge is needed, before such far reaching statements can be fully accepted. But even if only partly true they show the great importance of this question of long term ill effects.

Com H29:8

V SOCIAL CASE CONFERENCE

29th JANUARY 1972

CASE: PROTEIN CALORIE MALNUTRITION

Presented by: Kumar G. Belani

Discussion: Dr. Ravi Narayan

Chairman : Dr. R.K. SETH,
Professor of Pediatrics.

SOCIO-ECONOMIC CASE CONFERENCE

Discussion held on 29th Jan. '72

Details of the case are as follows :-

I-HISTORY :-

Particulars of the Patient :-

Name : MARINA

Age : 3 years

Sex : Female

Religion : Roman Catholic

Address : C/o. Mrs. W. Smith
4th Cross,
Hutchin's Road Extn.
Door No. 6,
BANGALORE - 5.

Hosp. No. 60364

M.R.D. No. 19415

Admitted on 23rd Dec. '71

PRESENTING COMPLAINTS :-

Failure to gain weight ---------- 1 year

Loose motions with blood & mucous ---------- 2 months

Swelling of face and limbs ---------- 1 month

Passing scanty urine ---------- 3 weeks

H/O Present Complaints :-

Patient was quite alright till 2 months ago when she developed loose motions 4 - 5 times a day with blood and mucous. She was treated with Streptomycin and sulphaguanidine. Following this patient continued to have diarrhoea but no blood and mucous. The stoools were brownish in colour watery, large in amount and foul smelling. A few days later patient developed swelling of the face, upper and lower limbs. The swelling increased progressively and soon became associated with scanty micturition.

Systemic Review revealed H/O passing roundworms orally and in stools

H/O failure to gain weight since a year

No H/O fever, cough, throat or joint pains or abdominal pain

Past History :-

The patient is a 4th para full term normal delivery. Birth weight could not be ascertained. The milestones were within normal limits but since the illness the patient has become tooweak to either sit up or walk without help. She was immunized against small pox but no BCG, triple vaccine or polio vaccine were given. She was breast fed till the 10th month after which she was started on part of the family diet, which consisted of coffee, rice and curry.
She had an attack of measles when 1½ years old.

Family cum Socio Economic History :-

1. The patient is an illegitimate child who was left with her grandparents by the mother when she was 10 months old. Her mother has 4 illegitimate children of which the 1st and 3rd are also staying with the grandmother. The 2nd child died of starvation.

2. Her grandfather aged 63 years is the head of the household. The other family members are :- the grandmother and

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a. An uncle aged 22 years

b. An unmarried aunt aged 27 years, (an epileptic since childhood)

c. Another uncle aged 13 years and

d. A cousin aged 7 years.

The occupations and incomes of the persons in the family are as follows :-

1. Grandfather - Retd. watchward getting a pension of Rs. 40/- p.m.
2. Grandmother - Works in a School and gets a salary of Rs. 60/- p.m.
3. The 13 year old boy who works for a family gets Rs. 5/- p.m.
4. The other uncle and aunt are both unemployed and therefore in addition to the 3 children are dependents of the family.

Marina's mother is at present working in a Convent in Tripura (Assam) and does not send any money for the upbringing of the children.

The total income therefore is Rs. 105/- p.m. of which Rs. 25.- p.m. goes for rent.

Educational Status of Family :-

1. Grandfather - 5th Std.
2. Grandmother - Middle school
3. Uncle - Trained Automobile mechanic
4. Aunt - Has done few years of schooling
5. None of the children are going or have gone to School.

Housing :-

The family stays in a house consisting of 2 bed rooms about 6' x 6' and a smaller kitchen. They use a common bathroom , shared by 8 families. Ventilation and lighting are sub standard.

Kitchen : They use firewood as fuel.

Water supply : is from a private tap for which they pay Rs. 5/- p.m.

Nutrition :-

The family cooks once a day. The meal consists of rice and vegetable curry. In addition they have coffee 3 - 4 times a day. They eat beef once a week. Eggs, milk and fish do not form part of their diet due to the factor of cost.

Health of the Family members :-

Grandfather is fit.

Grandmother suffers from Angina.

Aunt is an epiletic.

All children are undernourished.

II - PHYSICAL EXAMINATION :-

The patient is a girl of build and nutrn. far below average Ht. - 74.5 cms. (29.25 ins.)
Afebrile
Normal decibitus. Wt. - 7 kgs.

Since the patient is a case of malnutrition, the physical examination may be subdivided into 2 subgroups.

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1. Nutritional Assessment from External Signs :-

The Hair is thin, brown, lacks lustre and is easily pluckible.

The Face shows diffuse depigmentation. There is scaling of skin and rhinitis.

The eyes demonstrate a pale conjunctiva but there are no Bitots spots.

There is angular scarring of the lips indicating a healed angular stomatitis.

The tongue is smooth and pale.

There is tartar present over the teeth. The gums are not spongy and there is no bleeding.

Neither the thyroid nor the parotid glands are enlarged.

The skin is brown and scaly and there is flaky paint dermatosis.

Skin over vulva shows a vulval dermatosis.

The nails are pale, flattened and widened.

The subcutaneous tissue demonstrates peripheral oedema with loss of subcutaneous fat in nearly all parts of the body. Biceps girth - 4"

Thigh girth - 6.5"

There is marked muscular wasting but there is no frontal or parietal bossing. The fontanelles are fused.

There is swelling of the right index finger (foll. trauma)

2. Internal System Survey :-

The gastrointestinal system reveals a just palpable liver and fluid thrill.

The Nervous System is clinically normal.

C.V.S. - P.R. 120/min. No cardiac enlargement. There is a short systolic murmur in the apical region. B.P. 120/70 m.m. Hg.

The R.S, is clinically clear.

A CLINICAL DIAGNOSIS OF PROTEIN CALORIE MALNUTRITION WAS MADE AND ROUTINE AND PERTAINING INVESTIGATIONS WERE CARRIED OUT.