by the community agencies best equipped to give the all-round care desperately needed by the family. Case work treatment of this patient at the time she and her daughter gravely needed it might well have prevented the disaster which has occurred in the life of the girl and the physical and emotional damage to the mother and prematurely born infant.

There appears to be prevalent in our culture a callousness underlying much of what we do and what we neglect to do for people who are ill, particularly those who suffer from unsightly handicaps, the aged, and those whose illness disturbs social, family and community patterns. These community attitudes have not failed to affect social work, which naturally cannot disassociate itself completely from this cultural phenomenon.

Hospital social work is relatively freer from some of these attitudes and prepared to interpret to others a more positive attitude toward illness. This is not surprising since medical social workers, in their specialized knowledge and understanding gained through intimate collaboration with doctors and hospitals, are somewhat less fearful about working with individuals who have chronic and sometimes frightening medical conditions. The medical social workers identify with the scientific attitude of the medical profession that even in apparently hopeless situations there is an obligation to assist in making the life of a sick person as fruitful as possible. The cliche "while there's life there's hope" has deep significance in medicine, and it describes also the approach of the medical social worker in carrying out her part of the work.

The medical social worker, therefore, in working with ill people sees in situations of permanent or terminal illness an important opportunity for service. Even in the grimmest and most hopeless situations, understanding and purposeful help encourages not only the sick person, but the entire constellation of his relatives and friends. Salvaging ill people is an encouraging experience for doctors, hospital personnel and case workers. Life has been prolonged and individuals and families helped to face death more courageously by this kind of interest and professional courage. It is the antithesis of the frightened totalitarian philosophy which was afraid to allow ill people to live. More than that, it is an answer arising out of a truly democratic belief in equality and an application of this kind of thinking to the realm of illness.

To the extent that medical social work can effectively interpret this philosophy of service, it makes a contribution to the community. This depends in part upon the quality of its relatedness to the community and an interest on the part of all community agencies in adapting their services to the swiftly changing and unpredictable needs of the ill.

Believing that every individual despite illness deserves a chance to be productive, a united effort of hospitals and community agencies can replace attitudes of hopelessness with new courage.

ROLE OF THE MEDICAL SOCIAL WORKER IN THE CHANGING CONCEPT OF THE HOSPITAL*

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THE basic concept of medical social work is not new, but its application to new areas, to larger groups in the community, to apparently well people as well as to sick individuals, is new.

In dealing with people who are ill, regardless of age, the kind of illness, the duration of the illness, or the communicability of the disease, the medical social worker must understand the role of emotions and the meaning of behavior in illness. She must understand the relationship and influence of social factors on ill health, and she must be able to utilize the community resources that are best suited to the needs of that individual patient and his family. She must function in continuous association with the physician and the other professional personnel in the hospital. This is the basic concept of medical social work, and the medical social worker is always aware of this in her concern with the individual patient and she sees her role as helping that person to live meaningfully within his own environment. The change in the role of the medical social worker is the result of the application of this concept to new areas, to a larger group of people, to the private patients, to the aged group, to the chronically sick, to the group of apparently well people who come within the preventive services, and to the group of patients who are still under rehabilitation supervision.

We have been hearing how hospitals have changed, how they are extending beyond the confines of their physical structures, how they are implementing follow-up home services, how they are now treating new categories of illnesses, how they are emphasizing teaching programs, not alone for internes and residents, but for other professional personnel. We have heard about psychosomatic clinics, with their newer approaches to physical medicine. We know that many hospitals are now admitting patients with chronic diseases and some medical agencies are doing wonderful things in geriatrics. Some hospitals are including preventive services in their programs and others, in varying degrees, are emphasizing restorative programs. All of these changes are reflected in the attitude of the community, and a hospital today is no longer only a place where you go when you are seriously ill, nor is it a "doctor's workshop," but it is a community agency offering many services to apparently well people too.

No one organization has a monopoly on serving either sick or well people, and

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there is inevitably much overlapping between medical agencies. There is overlapping between hospitals and other medical agencies in the areas of curative services as well as preventive services, and many hospitals are extending their programs beyond the confines of their physical plants. This is particularly true in some tuberculosis hospitals, where programs include not only the curative procedures within that hospital and treatment for a selected group in their own homes, but includes the extension to a large area of the community through programs of preventive services. These may be mass x-ray surveys, educational programs, or a combination of both. Many tuberculosis hospitals include well defined and well integrated rehabilitation services which often means the supervision of the patient long after he leaves the hospital. With all of these changes in the function of the hospital, the medical social worker finds herself in strange new areas. She must be prepared to recognize this "new look," to be aware of all of the implications for the patient and for his family. She must know more about the community itself, and most important, she must be able to help the patient see these new hospital functions so that he can be more accepting of them. A few weeks ago, a patient came into one of our large general hospitals for treatment of numbness of his left hand. Because that particular hospital was interested in preventive services, the patient had a routine x-ray of his chest and before he left the hospital he had a diagnosis of active tuberculosis requiring hospital care for six months or longer, with the possibility of needing to completely change his vocation. Because the hospital is routinely x-raying every one who is admitted, either as an out-patient or as an in-patient, the medical social worker will be faced with other situations similar to this. The disease discovered may be a heart condition, or a lung tumor, instead of tuberculosis, but the need for helping apparently well people to accept longtime treatment will not be infrequent.

Medical social work, until recently, was confined to a hospital setting, but now that some hospitals, like Montefiore, are implementing home services into their program and other hospitals, like some in Chicago and elsewhere, are extending preventive services into the community through x-ray surveys, there has been a refocusing of medical social work to include patients outside of the hospital setting. In this area, as in others, it is most important for the medical social worker to constantly re-evaluate community resources.

Another area, new to many medical social workers, is the private patient group. The concern of many hospitals has always been for all members of the community regardless of economic status, but this concern, for the most part, has been limited to medical treatment. Today more hospitals are offering all of the hospital services to every patient who needs it, and the medical social worker may be called upon to treat the private group, as well as the ward patients. This is particularly true in those hospitals where physicians recognize the relationship between emotions and illness, and where physicians use their knowledge about the social component of illness, only as medical men, and not as medical social workers.

Integration, coordination and mergers are trends today, between hospitals and convalescent homes, tuberculosis sanatorium, nursing homes and homes for the aged. This bringing together of two different agencies usually insures a high

level of medical care, continuous and over a long period of time, but it may also bring new problems to the patient and to his family. A new and different environment, differences in standards of care, differences in food and in traditions, may in the beginning all spell resistances, fears and unhappiness for the patient and for his family. In this area alone, the medical social worker has many new roles, and her understanding of the functions of both agencies is most important. In many of these coordinated programs, the hospital medical social worker is the liaison person and she finds it increasingly important to know about policies, the physical structure, and the whole administrative setup of both agencies. Patients who are transferred from one kind of an agency to a completely different hospital environment, often need a great deal of supportive treatment from the medical social worker at this point.

In these coordinated or integrated new plans, it is of the utmost importance to outline the functions and the responsibility of each agency. I am speaking here, of course, about the responsibility for case work services.

In Chicago, a coordinated chest service, between Michael Reese Hospital and the Winfield Hospital, was established five years ago. Michael Reese is a large general hospital in the Chicago area, while Winfield is a small tuberculosis hospital, situated thirty miles west of Chicago. The out-patient department of Winfield, as well as its social service department, is located in the clinic building of Michael Reese Hospital, in the same building that houses the social service department of Michael Reese, so there is a physical separation of thirty miles between the component parts of this unified service. This unified chest service, with beds at Winfield, beds at Michael Reese Hospital, and an out-patient department at Michael Reese Hospital, are under the medical supervision and direction of one medical director and one joint medical staff. The chest service was established to give patients better unified care, utilizing the resources of both hospitals.

To prevent overlapping of functions, and to delineate the responsibility of each social service department, there was joint thinking and planning in this area when the plan was first proposed. We knew that if this unified chest service were to function well, with the minimum of confusion for the patients and for the doctors too, it was necessary to clearly define the areas of responsibilities. In this situation, it seemed best to transfer the complete social responsibility for all patients coming to the chest service, to the beds at Michael Reese Hospital, to Winfield, or for out-patient care in the clinics, to the social service department of Winfield. This has meant close contact with the various departments of Michael Reese Hospital, administrative as well as social service, and now after five years of this integrated service, we think the plan is working well in all areas. Each hospital is autonomous, with its own board of directors, its own budget, its own personnel policies. Even though both social service departments are housed under one roof and often appear as one department to the patient, the plan works in practice because there was careful thinking and joint planning in regard to areas of responsibility. The yardstick used was not "who can give better case work services," because both departments could function equally in that area, but rather, which department could help to make the overall plan work best.

In this joint coordinated chest service, another plan for social services might have worked as well, but the important thing is that our medical staff, as well as those of us at the administrative level, recognized the need for early planning on the part of both social service departments, so that each would know what their function in this new setup was to be.

The medical social worker must constantly learn new things, not only in her own field, but in related fields. The constant publicity of the so-called miracle drugs, of new cures, of new antibiotics, brings many questions to the medical social worker and she must be prepared for interpretation, for factual information and for relieving misinformation. While primarily this is not a function of the medical social worker, because of her close contact with patients and their families, this is a problem that comes to her attention often. In some situations, it is closely tied up with finances, and in others, with complete change in the patient's attitude toward his illness. In tuberculosis, the advance publicity about streptomycin and the wrong kind of newspaper releases have made it imperative that medical social workers in the field be well informed about what this drug can offer, under what conditions it should be given, and why it cannot take the place of hospital care.

The medical social worker finds herself drawn into educational programs. The modern hospital today is concerned with teaching programs for many groups of personnel, through in-service training programs as well as post-graduate clinics and courses. There are many hospitals that provide educational opportunities and training for students who are still in the school of medicine, for nurses in the public health field, for affiliate nurses from other hospitals, as well as accepted programs for internes and residents. For all of these, the medical social worker has a real contribution and she should share with other staff members the responsibility for participating in the training programs for all of the professional personnel. Of course, she has a primary responsibility for supervising the medical social service students assigned to the agency for field work practice.

The role of the medical social worker was first accepted in the area of curative services, and patients were first referred to her for such obvious needs as convalescent care, help in providing better housing, financial aid, and for other such manipulative services. Today, while these problems are still the responsibility of the medical social worker, insofar as they affect the medical treatment picture and are related to it, it is in the area of the emotional problems that the medical social worker makes her best contribution. The medical social worker knows that there is a direct relationship between emotional problems, not only in the area of diagnosis, but in treatment as well. She pays a great deal of attention to such things as how the patient feels about his illness, how he adjusts to his illness and its limitations, and how accepting he is of treatment. She recognizes the relationship of emotional problems to illness and it is in this area that the medical social worker is making her most meaningful contributions as a member of the medical team that is treating illness.

With the acceptance of psychosomatic medicine by many doctors, there is greater acceptance on the part of the medical staff to using the services of the medical social worker and to recognize her contributions in both the diagnostic and treatment states. The emotional component of illness is not a new concept in medicine, nor is it new to medical social workers, but with this newer approach to physical medicine, more doctors are becoming aware of the contributions that the medical social worker makes in the area of emotional problems, and are asking for her services for their patients.

With the concept of rehabilitation as part of medical treatment being accepted by many hospitals, the medical social worker finds herself in strange areas, which are both challenging and exciting. In these areas, there are no precedents nor rules, and little training—there is only the growing acceptance on the part of hospitals for responsibility for complete rehabilitation services. There are approximately 22,000,000 handicapped people in this country. It is estimated that 1½ million of these can be aided to the point of gainful employment. A large proportion of this group eventually finds its way into hospitals and it is for this group that rehabilitation is most important.

In some hospitals, there is responsibility for the cardiacs, for the polios, for the spastics, for the tuberculous and for others in the group of long term illnesses. Some hospitals have programs of occupational therapy, physical therapy, some have teaching services, some have in-hospital training, and a few have established relationships with state departments of rehabilitation. Few hospitals have rehabilitation directors, and fewer still have a coordinated program. I believe that the medical social worker has a big stake in rehabilitation programs and that she is particularly fitted to coordinate the parts of the rehabilitation program, in an orderly fashion, so that step two comes after step one. To do this, she will have to have a good understanding of the part that each professional person plays in the program.

Rehabilitation is not the job for any one person or one specialty. It requires a unified integrated program, with the concept that successful rehabilitation restores the patient to a useful, satisfying, self-maintaining life. It is a continuous process, from the time of diagnosis through discharge.

Rehabilitation means many different things in different hospitals. In some it is called physical restoration, with its emphasis on physical rebuilding. In others, there is no definite plan, but sporadic, isolated services are offered long term patients. In some tuberculosis hospitals there are established departments of rehabilitation, with complete programs of in-sanitarium training as well as post-sanitarium training. In Winfield, we have a formal relationship with the state department of rehabilitation, which includes both in-hospital as well as post-hospital training. The physician, the medical social worker, the occupational therapist, the physical therapist, the teachers, the vocational counselor who functions as a member of the staff of the Jewish Vocational Service, and others are all included in the rehabilitation program.

The conference method is used for a discussion of each patient, and all of the professional personnel who work with the patient are included. The purpose of the meeting is to pool information which will be helpful in treating the patient. We try to clarify his medical status, his own vocational objective, his intellectual or vocational capacities, his physical limitations, his work capacity, and those social factors which are likely to assist or hamper his program. Then

a plan, based on all of these findings, is made. Preparing a patient for this meeting might take weeks or even months, and it is the medical social worker who, together with the physician, knows at what point the patient is emotionally ready for such planning. Planning for each patient is done on an individual basis, and in our plan our medical social worker acts as the coordinator and we believe that she is best qualified by training and by experience to do this job. The most important single factor in any plan is that the patient be accepting of the program which is being planned for him, and be ready to participate in it. No matter how good the plan is, if the patient is blocked because of emotional problems, the benefits of the plan are lost, no matter how excellent the program is.

In our particular plan, we believe that the success of our program is due, in a large measure, to the contribution the medical social worker is making as a coordinator. She sees her role here, as she does in all other areas, as helping each individual patient to live meaningfully within his own normal environment.

THE RELATIONSHIP BETWEEN FIELD AND SCHOOLS OF SOCIAL WORK IN TRAINING FOR THE NEW FUNCTION OF THE HOSPITAL*

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MEDICAL social work for many years was the step-child of social case work practice. Its rise in status, in recent years, can be attributed directly to the growing importance that the medical profession itself attaches to social and emotional factors in the study and treatment of disease. It is no longer enough for the medical social worker to know about the patient and his environment. She is now expected to use her knowledge of the patient dynamically toward helping him effect a recovery commensurate with his functional capacities. A goal so allied with treatment calls for a thorough understanding of disease process and the meaning of illness to the individual patient, an appreciation of the environmental situation which the patient faces, and a comprehensive knowledge of the resources available to him. Medical social work training must thus of necessity be generic in terms of developing understanding of human behavior and social forces and specific in terms of offering the student special knowledge of sickness and sick people and familiarity with hospital procedures.

To decide who has the greater responsibility in training of this nature—field or school—is as equivocal as the old chicken-egg controversy. The fact is that the two areas share a mutual interdependency and together make of the whole of student training a configuration more meaningful than its component parts. Like all reciprocal relationships, that between school and field proves most effective when it is most clearly defined.

Student training, as it has been established in the schools of social work, combines two major areas—theory and practice. The field work placement is the alleged proving ground for the theoretical knowledge supplied by the classroom. In medical social work it offers, in addition, actual exposure to the setting in which the medical social worker operates, a setting which the classroom cannot be expected to reproduce. A coordinated approach to student training thus imposes the necessity for practice to keep up with theory and vice versa. Where a dichotomy exists between the two areas, the student can only be caught up in a whirlpool of confusion and

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