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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tossed about without ever reaching the shore of professionalism.

In these days of changing concepts of hospital function, it is not enough for school and field to rely on established medical practices for the knowledge they impart to students. Intra-mural social work is now only a part of medical social work practice. The medical social worker of a nearing tomorrow will be involved in group medical practice, home care programs, public health measures, and medical social research. The goal of training must be to equip the student with enough fundamental understanding to enable her to relate to practice not only as it exists at present but to a future as yet more envisioned than real.

Basic to the ability to offer case work service effectively in any setting is the understanding of human behavior. Good student training encompasses not only an understanding of the client-patient's behavior but thorough self-knowledge as well. Schools of social work through their "Personality Development," psychiatry and case work courses broaden the student's vision by enabling her to see the relationship between overt behavior and inner feelings. As her knowledge of others deepens, the student begins to view her own development in a new way so that theoretical material becomes personalized to her. It is important for the field supervisor to know at what pace the school is moving, so that she does not expect more from the student than the student is being prepared to give. Criteria for the student in each quarter of training as have recently been developed by the schools of social work serve as a helpful guide to the student supervisor. I cannot emphasize too much the importance of the student supervisor's identification with school as well as agency in successful student training. Knowing what the school expects from the student is another means of clarifying for the student supervisor what the school expects from her and gives focus and purpose to her job. There is perhaps no more reassuring moment in the professional life of the student supervisor than that in which the student volunteers that what is being said in supervisory conferences coincides with what is being taught in the classroom, for it assures her of the accuracy with which she times her contributions to the student's learning. To the student the visible evidence of correlation between field and school serves to strengthen her concept of professionalism and gives her confidence in the goal to which she aspires.

The student in a medical setting is expected to achieve understanding of ill people as well as generalized understanding of human behavior. The specific, however, grow out of the general. Unless, for example, the student understands the dependency—independency drive in all personality development, she cannot evaluate the way in which hospitalization may serve to enhance this conflict, nor know how she herself relates to the dependency inherent in illness and supervision. The school can only point up the forces that serve to make and keep people ill. The student supervisor, through the cases assigned to the student, can make the concepts described in the classroom live as they are demonstrated by Mrs. L. or Mr. Z. Even the medical content of the school courses in disease and public health take on, for the student, real meaning only as she identifies symptomatology with a particular patient whom she knows.

We are all geared to the term "psychosomatic medicine" these days and would certainly see the acceptance of its principles as vital to medical social work practice. Sometimes, because the student is so intellectually oriented to the validity of such medical thinking, she is disillusioned when she finds that doctors are less ready than she is to accept the relationship between emotional factors and illness. While certainly the school has a responsibility to share with the student the psychogenic origin of illness, that responsibility extends to pointing up the controversial aspects of this philosophy as well. Medical social work is still in the formative stage of working out its own part in the practice of psychosomatic medicine, and, in the application of it to individual cases, can move only as fast as the physician is ready to go. The student needs to know this and to learn to accept the sometimes grim reality of the doctor who cannot see beyond what the fluoroscope and x-ray reveal, or hear more than what his stethoscope tells him.

School and field must both recognize the meaning that medical authority can hold for the student and help the student see how she is using it. I have found in my experience as student supervisor that learning to be comfortable with doctors is, oftentimes, the most threatening aspect of placement to the medical social student. While the school can discuss intellectually the differences in doctors as human beings, only through working with a variety of doctors can the student appreciate just how human and different doctors can be. As the student gains security in her own place in the hospital, she grows able to articulate her job to the doctor. She begins to develop a respect for her own professional convictions even when the doctor, because of the difference in his orientation, questions them.

Often times, the medical social student tends to minimize the so-called "little things" in medical social work, such as braces and dentures, and yearns for the more exotic as represented in the patient who refuses surgery or cannot accept psychiatric help. I think that all of us, in our zeal to jump on the psychosomatic band wagon, have erred in the emphasis we have put on medical social work function as being related primarily to emotional factors in illness. That goes for field and school alike. In the selection of case material for classroom use, I would make a plea for more frequent discussion of the dynamics of helping the patient secure an appliance or arrange convalescent care as a way of preparing the student for what the field of practice will offer her. If we are agreed that the giving of medical relief calls for the same careful evaluation of individual need as any other case work service, such classroom discussion is vital to sound preparation for medical social practice. This does not remove the student supervisor from responsibility. In selecting cases for the student, she must be aware that good learning can spring from any source germane to the medical social work job. I am sure that any one of us here who has supervised students must know the temptation to select for the student the case that exemplifies the most esoteric aspects of case work practice. Only as we ourselves come to accept the fact that the ability to deal with environmental factors effectively requires skill and understanding can we impart to students similar satisfaction in a simple job, well done. The reality is that not only do teeth and braces and eye glasses make up a large part of the patient's living with his illness, but actually I know of no better approach to the psyche than through the soma. Often the patient cannot be comfortable in dis-

cussing his deeper problems until he is offered alleviation of some of his environmental difficulties. The student can best acquire sensitive hearing through being helped to see that the patient's attitudes toward any aspect of his medical care reflect his general attitude toward himself and his illness.

The emphasis I have thus far put on the importance of school and field's being attuned to the reality of practice may seem to negate the earlier definition of the goal of student training as developing vision broad enough to encompass a widening medical social future. It is my feeling, however, that no program of the future is unrelated to the past and present, but represents instead an evolutionary process. Group medical practice has come into being out of a growing awareness of the inequalities in the distribution of medical care; hospital home care programs were inspired by the realization that the building of more hospital beds was not the total answer to the problem of the increasing demand for hospital care; the use of medical social work in the treatment of private patients has developed out of the cognizance that money alone cannot alleviate the anxiety illness creates. Unless the student shares in the conceptual thinking on which these developments are based, unless she is made aware of the negatives as well as the positives in present day medical practice, she is in the doubtful position of the child who begins to walk without having learned to crawl. It is, to my mind, a serious error to fail to give the student stimulus for developing her own ideas about what is good and what is bad in our present social scheme of things. The school can stimulate the student to think in terms of social programs by introducing such controversial subjects as socialized medicine, private social case work practice and group insurance plans into the curriculum. Similarly, the student supervisor can help the student in her understanding of the inner workings of hospital and community by exposing her to the realities of practice as influenced by present social conditions.

It is no small charge to ask that the schools incorporate into their programs the developments in practice, particularly these days when the tempo of change is such a rapid one. There are, however, several ways in which the field itself can contribute to curriculum making. We are all oriented to working with the schools on an individual student basis. We are accustomed to share with the field consultant the problems we are encountering in working with a particular student and in seeking from her help and reassurance for going on with the student's training. We talk more frequently of case than program. Yet we expect the schools to be aware of the problems in practice itself and often times accuse the schools of dwelling in a never-never land. If we feel a responsibility for medical social education, don't we have a like responsibility to contribute to its content? I recall the satisfaction expressed recently by a student at Montefiore when her classroom instructor asked her to report on the Montefiore Home Care Program. Not only did she gain status from her close identification with a new program, but the program itself gained status from the school's interest in it. Because we at Montefiore felt that we were embarking on a new course in our home care program, we discussed its step-by-step development with the faculty of the New York School, inviting the field consultant to attend a regular departmental meeting, sending the school the literature we

were developing on the subject of "home care" and making material available to students who expressed interest in writing their school projects on some aspect of home care.

The whole area of the relationship between field and school in the student project is one that might well be explored further. The research project is too often both a headache and a bore. It is not unusual to see a student who has blossomed steadily during her training period begin to wilt as the last quarter approaches and the unfinished project looms ahead. The student supervisor may question what more she can do, in this trying time, than to tolerate and reassure. If so much trauma has set in, it may indeed be too late for anything more than a supportive role. If, however, the agency is program-minded, it can play a preventive role in warding off project-panic by helping the student to choose a project related to the student's interests, the agency's practices and of sufficient value to the agency to make the work involved seem worthwhile. What better way of bridging the gap between agency and school than through the student herself?

From the school's point of view, the project can serve as an excellent means of preparing the student for participation in medical research. While psychiatric social workers have for some time played an important role in psychiatric research, medical social workers have more recently begun to function in this area. Since there is much in medical social thinking that can add greatly to present-day investigations of social factors in illness, the school and field should encourage interest in research and give students sound preparation for investigatory activity.

The correlation of agency and school program this paper suggests is dependent on the development of a sound working relationship between school and field. The school, in such a working relationship, would view its student supervisors as part of its faculty, drawing them into curriculum planning, encouraging them to contribute their thinking to the school program, sponsoring meetings of the student supervisory staff where ideas are freely shared. If the student supervisor were to derive from the school a sense of the significance of her contribution to student training, she would be readier to assume a dynamic part in the educational process and to think beyond the individual student to the whole of student training. The student supervisor is, after all, a practitioner. Her daily work experience serves as a continual testing of the theory the school propounds. Because she herself is a part of the changing function of the hospital, she is in an excellent position to help the school keep up with change, for she has first-hand awareness of change as it is needed and takes place.