THE FOUNDATIONS OF SOCIAL WORK IN HEALTH CARE

CHAPTER 1

The Conceptual Underpinnings of Social Work in Health Care

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T HE WRITING OF this text coincides with the centennial of the hiring of the first medical social worker in the United States, Garnet Pelton, who began working at Massachusetts General Hospital in 1905. It seems an appropriate time to consider the history of social work in health care and to assess the degree to which the vision of its founders has been met in its first 100 years. Ida Cannon (1952), the second social worker hired at Massachusetts General Hospital, whose tenure lasted for 40 years, wrote, "basically, social work, wherever and whenever practiced at its best, is a constantly changing activity, gradually building up guiding principles from accumulated knowledge yet changing in techniques. Attitudes change, too, in response to shifting social philosophies" (p. 9). How, if at all, have the guiding principles of social work in health care changed over the century?

This chapter focuses on the development of the profession from its roots in the nineteenth century to the present. This longitudinal examination of the profession's principles and activities should allow for a more complete and accurate view of the progression of principles through time than could have been achieved by sampling at points in time determined by historical events, such as the enactment of major health-care policies.

CHAPTER OBJECTIVES

- Discuss the historical underpinnings of the founding of the first hospital social work department in the United States.
- Describe the forces and personalities responsible for the establishment of the first hospital social work department in the United States.
- Determine how the guiding principles of social work in health care have changed from the time of the founding of the first hospital social work department to the present time.
- Determine how the techniques and approaches of social work in health care have changed from the time of the founding of the first hospital social work department to the present time.

Frequent references to other chapters in this book capture the current conceptual framework of social work in health care.

THE HISTORICAL FOUNDATION OF SOCIAL WORK IN HEALTH CARE

Social work in health care owes it origins to changes in: (a) the demographics of the U.S. population during the nineteenth and early twentieth centuries; (b) attitudes about how the sick should be treated, including where treatment should occur; and (c) attitudes toward the role of social and psychological factors in health. These three closely related phenomena set the stage for the emergence of the field of social work in health care.

A number of events that began in the mid-1800s led to massive numbers of persons immigrating to the United States. In all, 35 to 40 million Europeans immigrated between 1820 and 1924. The Gold Rush, which began in California in 1849, and the Homestead Act of 1862 added to the attractiveness of immigration.

About 5.5 million Germans immigrated to the United States between 1816 and 1914 for economic and political reasons. Over 800,000 arrived in the 7-year period between 1866 and 1873, during the rule of Otto von Bismarck. The Potato Famine in Ireland in the 1840s resulted in the immigration of two million persons during that decade and almost a million more the following decade. Between 1820 and 1990, over five million Italians immigrated to the United States, mostly for economic reasons, with peak years between 1901 and 1920. A major influx of Polish immigrants occurred between 1870 and 1913. Those arriving prior to 1890 came largely for economic reasons and those after for economic and political reasons. Polish immigration peaked again in 1921, a year in which over half a million Polish immigrants arrived in the United States. Two million Jews left Russia and Eastern European countries between 1880 and 1913.

The United States struggled to adapt to the challenge of immigration. The Ellis Island Immigration Station opened in 1892 to process the large number of immigrants entering the country. By 1907, over one million persons per year were passing through Ellis Island. The massive waves of immigration presented new health-care challenges, especially in the Northeastern cities where most of the new arrivals settled. Rosenberg (1967) wrote that 723,587 persons resided in New York City in 1865, 90% on the southern half of Manhattan Island alone. Over two-thirds of the city's population at the time lived in tenements. Accidents were common, sanitation primitive, and food supplies were in poor condition by the time they reached the city. One in five infants in New York City died prior to their first birthday, compared to one in six in London (Rosenberg, 1967). Adding to the challenge, the vast majority of immigrants had very limited or no English language skills and lived in poverty. Immigrants brought with them a wide range of health-care beliefs and practices that differed from those predominant in the United States at the time.

In the late 1600s and early 1700s, persons who were sick were cared for at home. A few hastily erected structures were built to house persons with contagious diseases during epidemics (O'Conner, 1976, p. 62). These structures operated in larger cities and were first seen before the Revolutionary War. As the U.S. population grew, communities developed almshouses to care for persons who were physically or mentally ill, aged and ill, orphaned, or vagrant. Unlike the

structures erected during epidemics, almshouses were built to operate continuously. The first almshouse, which was founded in 1713 in Philadelphia by William Penn, was open only to Quakers. A second almshouse was opened to the public in Philadelphia in 1728 with monies obtained from the Provincial Assembly by the Philadelphia Overseers of the Poor. Other large cities followed, with New York opening the Poor House of the City of New York (later named Bellevue Hospital) in 1736 and New Orleans opening Saint John's Hospital in 1737 (Commission on Hospital Care, 1947). Although called a hospital, St John's is classified as an almshouse because it primarily served persons living in poverty who had nowhere else to go.

By the mid-1700s, persons who became ill were separated from other almshouse inhabitants. They were at first housed on separate floors, in separate departments, or other buildings of the almshouse. When these units increased in size, they branched off to form public hospitals independent of almshouses. Hospitals eventually became popular among persons of means, who for the first time preferred to be treated for illness by specialists outside the home and were willing to pay for the service.

A number of voluntary hospitals were established between 1751 and 1840 with various combinations of public and private funds and patients' fees (O'Conner, 1976). The first voluntary hospital was founded in Philadelphia in 1751 with subscriptions gathered by Benjamin Franklin and Dr. Thomas Bond and funds from the Provincial General Assembly of Philadelphia. The New York Hospital began admitting patients in 1791 and the Massachusetts General Hospital in 1821. In 1817, the Quakers opened the first mental hospital, which began admitting anyone needing care for mental illness in 1834.

A third type of medical establishment, the dispensary, began to appear in the late 1700s. Dispensaries were independent of hospitals and financed by bequests and voluntary subscriptions. Their original purpose was to dispense medications to ambulatory patients. In time, however, physicians were hired to visit patients in their homes. The first four dispensaries were established in Philadelphia in 1786 (exclusively for Quakers), New York in 1795, Boston in 1796, and Baltimore in 1801.

Nineteenth-Century Efforts toward Public Health Reform

The last half of the nineteenth century saw efforts to reform hospitals and dispensaries, many of which were led by women physicians. Dr. Elizabeth Blackwell, unable to find employment in hospitals because of her gender, established a dispensary for women and children in New York's East Side in 1853. The East Side had seen a massive influx of immigrants from Europe and was becoming increasingly crowded. Blackwell's dispensary provided home visits and by 1857 had secured a few hospital beds for its patients. The dispensary, which later became the New York Infirmary for Women and Children, provided home visits to 334 African American and White American patients in 1865 (Cannon, 1952). The following year, Dr. Rebecca Cole, an African American physician, was hired as a "sanitary visitor." When visiting families, Cole discussed topics such as hygiene and how to select and cook food and addressed issues of education and employment. In 1890, Mrs. Robert Hoe provided funds to the New York Infirmary for Women and Children to employ a full-time home visitor to work under the direction of Dr. Annie

Daniels. Dr. Daniels kept records of family size, income, and living expenses in the manner of social workers of the time such as Jane Addams, who founded Hull House in Chicago in 1889.

The first medical resident to work with Dr. Blackwell in New York, Marie Zakrzewska, moved to Boston and in 1859 became the first professor of obstetrics and gynecology at the New England Female Medical College. Dr. Zakrzewska established a dispensary and 10-bed ward in Boston in 1862, the New England Hospital for Women and Children. It was the first hospital in Boston and the second in the United States (after the New York Dispensary for Women and Children) to be run by women physicians and surgeons. As had the New York Dispensary for Women and Children, the New England Hospital for Women and Children featured home visiting, with increased attention to social conditions. For many years, home visits were part of the education of nurses and physicians in training.

In 1890, Dr. Henry Dwight Chapin, a pediatrician who lectured at the New York Postgraduate Hospital and the Women's Medical College of the New York Infirmary for Women and Children, established a program in which volunteers visited the homes of ill children to report on conditions and ensure that medical instructions had been understood and implemented. In 1894, he appointed a woman physician to do the job but soon replaced her with a nurse. Chapin's efforts led to a foster-care home for ill and convalescing children whose parents were unable to care for them adequately (Romanofsky, 1976). He founded the Speedwell Society in 1902 to encourage foster care. The Speedwell Society would have ties to the social work departments later established in New York hospitals.

A close partnership between the Johns Hopkins Hospital and Baltimore's Charity Organization Society at the turn of the century served as a breeding ground for ideas about how to merge social work and medicine. Four persons involved in these discussions were instrumental to the establishment of formal social work services in hospitals. Mary Richmond, Mary Wilcox Glenn, Jeffrey Brackett, and Dr. John Glenn, who became the director of the Russell Sage Foundation, were actively involved in the application of social work to medicine.

HOSPITAL ALMONERS IN LONDON

The first social worker, called a *hospital almoner,* was hired by the Royal Free Hospital in London in 1895. This occurred when the Royal Free Hospital came together with the London Charity Organization Society through Charles Loch. Loch was a very religious man who had served in the Secretarial Department of the Royal College of Surgeons for 3 years. He was appointed Secretary of the London Charity Organization in 1875 and brought with him a strong interest in the social aspects of health. While on the Medical Committee of the Charity Organization Society, Loch addressed a growing concern that patients might be misrepresenting their situations to receive free care. In 1874, the Royal Free Hospital asked the Charity Organization Society to screen patients to determine how many were indeed poor. They found only 36% to be truly eligible for services. Loch thought that individuals requesting care should be screened by "a competent person of education and refinement who could consider the position and circumstances of the patients" (Cannon, 1952, p. 13). Loch fought for many years to have an almoner appointed. He addressed the Provident Medical Association in 1885 and was called to testify before a committee of the House of Lords in 1891.

In 1895, Mary Stewart was hired to be the first social almoner at the Royal Free Hospital. Prior to assuming the position, Mary Stewart had worked for many years for the London Charity Organization Society. She was stationed at its entrance because her principal function at the hospital was to review applications for admission to the hospital's dispensary and accept those who were deemed suitable for care. Her secondary duties were to refer patients for services and determine who should be served at dispensaries (Cannon, 1952).

Stewart was given 3 months of initial funding by the London Charity Organization Society. Although by all accounts her work was considered productive, the Charity Organization Society refused to renew her contract until the Royal Free Hospital agreed to pay at least part of her salary. Ultimately, two of the hospital's physicians agreed to pay half of Stewart's salary for a year and the Charity Organization Society covered the other half. From that point on, social almoners were part of hospitals in England. By 1905, seven other hospitals had hired almoners.

In 1906, the Hospital Almoners' Council (later the Institute of Hospital Almoners) took over the training of almoners. The Institute for Hospital Almoners was responsible for the expansion of the almoner's repertoire to include functions such as prevention of illness. The first years of its operation saw the development of classes for prospective fathers, a hostel for young women with socially transmitted diseases, and other programs (Cannon, 1952).

The First Social Service Department in the United States

Garnet Pelton began work as a social worker in the dispensary of the Massachusetts General Hospital, 10 years after Mary Stewart was first hired to work at the Royal Free Hospital in London. Ida Cannon, who replaced Pelton after she became ill 6 months into her tenure and who held the position for 40 years, described "a special bond of fellowship between the English almoners and the medical social workers of our country" (Cannon, 1952, p. 20). She also described her own 1907 visit with Anne Cummins, an almoner at London's St. Thomas Hospital.

Garnet Pelton, Ida Cannon, and Dr. Richard Cabot were central to the establishment of the social work department at Massachusetts General Hospital. Relatively little has been written about Pelton or her short tenure at the hospital. Cannon (1952) briefly described Pelton's nurse's training at Massachusetts General Hospital and her contribution to the Denison House Settlement. While at the settlement, she brought Syrian immigrants from her South End Boston neighborhood to the hospital for treatment. Pelton was hired by Dr. Richard Cabot to work at Massachusetts General Hospital and began on October 2, 1905. She worked from a desk located in a corner of the corridor of the outpatient clinic at Massachusetts General Hospital and resigned after 6 months when she developed tuberculosis. The poor received treatment for tuberculosis in the outpatient department because they could not afford the sanitarium treatment. There is some question about whether Pelton contracted tuberculosis through her work in the outpatient department. At any rate, Cabot arranged for her treatment at Saranac Lake, New York, and later at Ashville, North Carolina.

Pelton was succeeded by Ida Cannon, who published two books and several reports on medical social work and about whom a fair amount of biographical information is available. Cannon was born in Milwaukee into a family of means. She was trained as a nurse at the City and County Hospital of St. Paul and worked as

a nurse for 2 years. She then studied sociology at the University of Minnesota, where she heard a lecture by Jane Addams and became interested in social work. She worked as a visiting nurse for the St. Paul Associated Charities for 3 years prior to enrolling in Simmons College of Social Work. Cannon met Richard Cabot through her older brother, a Harvard-educated physiologist, at the time that Cabot was organizing social services at Massachusetts Hospital. She was hired to replace Pelton in 1906, began working full-time after graduating from Simmons College in 1907, and was named the first Chief of the Social Service Department in 1914. She retired from Massachusetts General Hospital in 1945.

Dr. Richard Cabot was an especially prolific writer and has himself been the subject of scholarship over the years (see, e.g., Dodds, 1993; O'Brien, 1985). Cabot was a Harvard-educated physician who had a great deal to do with the establishment of social work and other helping professions in U.S. hospitals. He was active professionally from the 1890s through most of the 1930s, a time when professions were being defined (see, e.g., Flexner, 1910) and medicine was the standard for what it meant to be professional.

Cabot's paternal grandfather, Samuel (1784 to 1863), made his fortune in trading after first going to sea at 19 years of age. Samuel Cabot married Eliza Perkins, daughter of Boston's most successful trader, and eventually took over his father-in-law's firm. He is described as a practical man who believed primarily in action and hard work and favored commerce over culture (Evison, 1995).

Cabot's father, James (1821 to 1903), studied philosophy in Europe, trained as a lawyer, taught philosophy at Harvard, and was a biographer and friend of Ralph Waldo Emerson. He considered himself a transcendentalist, holding that, "the transcendental included whatever lay beyond the stock notions and traditional beliefs to which adherence was expected because they were accepted by sensible persons" (Cabot, 1887, p. 249). The transcendentalists questioned much of the commercialism of their parents' generation and were particularly critical of slavery. The Civil War, which began when James Elliott Cabot was 40 years old, was in part waged due to the sentiments of this generation. Cabot's mother, Elizabeth, bore most of the responsibility of raising the couple's seven sons, yet shared with her husband the transcendentalist's questioning of stock notions and traditional beliefs. Elizabeth Cabot said of women, "it seems to me that very few of us have enough mental occupation. We ought to have some intellectual life apart from the problems of education and housekeeping or even the interests of society" (Cabot, 1869, p. 45). O'Brien describes Elizabeth Cabot as "warmly maternal and deeply religious" and "tirelessly philanthropic" (O'Brien, 1985, p. 536).

The Civil War demoralized the nation and spawned a new conservatism and materialism. The publication of *Origin of the Species* by Darwin in 1859/1936, which brought an appreciation of the scientific method, and growing concern about the number of immigrants arriving in the country, added to a shift to realism from the idealism of James Elliott Cabot's generation. In the wave of social Darwinism that ensued, charity was seen as naïve and potentially harmful to its recipients. It was into this post-transcendentalist atmosphere that Richard Cabot was born in 1868.

The tension between his generation and that of his parents shaped Richard Cabot's vision. He took a radical centrist position based in philosophical pragmatism, taking two opposing views, and helped to locate a middle ground between the two. Rather than considering either side as right or wrong, he held that a

greater truth could emerge through creating a dialogue between the two sides. Throughout his career, Cabot saw himself as an interpreter or translator, able to find the middle ground between extremes.

Cabot first studied philosophy at Harvard and then switched to medicine. He rejected philosophers who observed rather than acted and for that reason was drawn to the philosophy of John Dewey. Evison writes, "action drew him; Jane Addams and Teddy Roosevelt appealed to him because they did something" (1995, p. 30). Cabot held that knowledge was gained through problem solving, even when hypotheses were not supported. Like Addams before him, he believed that people can learn from failure.

Cabot's senior thesis used epidemiologic methods to examine the efficacy of Christian Science healing (Dodds, 1993). By the time he had completed medical school in 1892, the germ theory of the 1870s and 1880s had taken hold, and the roles of technology and laboratory analysis had gained in salience. Cabot initially followed the trend by completing postgraduate training in laboratory research and a Dalton Research Fellowship in hematology. He turned down an appointment as the first bacteriologist at Massachusetts General Hospital, and in 1898, 4 years after completing his fellowship, accepted a much less prestigious appointment in the outpatient department.

Patients were treated in the outpatient department at Massachusetts General Hospital rather than in the wards when their cases were considered uninteresting or hopeless (Evison, 1995). Because no treatment existed for conditions such as tuberculosis, typhus, and diabetes, patients with these conditions usually were treated in the outpatient department, especially if they were poor. Medicines prescribed were largely analgesic (antibiotics were not developed until the 1940s). Many patients were immigrants who presented with language barriers and infectious diseases such as typhus. Adding to the bleakness of the situation was the depression of 1893, the worst that had been experienced to that date.

Cabot described the speed with which physicians saw patients when he first arrived in the outpatient department: Referred to by some physicians as "running off the clinic" (Evison, 1995, p. 183), a physician pulled a bell to signal a patient to enter the room. The physician would shout his questions while the patient was still moving and have a prescription written by the time the patient arrived at his desk. He would then pull the bell for the next patient.

Cabot began to see that social and mental problems often underlay physical problems and that purely physical afflictions were rare (Cabot, 1915). He held that it was not possible to restore patients to health without considering what he called the nonsomatic factors, such as living conditions. He described one case as follows:

> One morning as I was working in the out-patient department, I had a series of knotty human problems come before me . . . that morning I happened to wake to the fact that the series of people that came to me had pretty much wasted their time. I had first of all to deal with a case of diabetes. That is a disease in which medicine can accomplish practically nothing, but in which diet can accomplish a great deal. We had worked out very minutely a diet that should be given such patients. We had it printed upon slips which were made up in pads so that we could tear off a slip from one of these pads and give the patient the best that was known

about diabetes in short compass. I remember tearing off a slip from this pad and handing it to the patient, feeling satisfaction that we had all these ready so that the patient need not remember anything. . . .The woman to whom it had been given did not seem satisfied. I asked her what was the matter. . . . She looked it over and among the things that she could eat she saw asparagus, Brussels sprouts, and one or two other things, and she called my attention to the fact that there was no possibility of her buying these things. We had, in other words, asked her to do things that she could by no possibility do. (Cabot, 1911, pp. 308–309)

Cabot's exposure to social work came first from his relationship with Jane Addams. In 1887, he took a course at Harvard entitled "Ethical Theories and Social Reform" from Francis Greenwood Peabody. Many who took the course went on to work for the Boston Children's Aid Society, as did Cabot when he became a director there in 1896. It was there that he was exposed to the case conference approach.

Cabot viewed the relationship between medicine and social work from his radical centrist perspective. He thought that each profession possessed the element that the other most needed. For medicine this was empiricism and for social work it was breadth. Cabot thought physicians' enthusiastic acceptance of empiricism had made them far too narrow in scope, ignoring social and psychological factors in health. Social workers possessed the breadth that physicians lacked, but relied too heavily on good intentions. They needed to become more scientific and systematic to ensure that their methods were effective and to develop a theoretical base for their work. Each profession could gain from association with the other.

Cabot set about reforming the treatment process in the outpatient clinic. He hired Garnet Pelton to fulfill three functions: (1) to critique while helping to socialize medicine, (2) to act as a translator between the physician and patient and family, and (3) to provide information on social and mental factors. Cabot described the critical role by saying, "she will not be there primarily as a critic, but nevertheless she will be far better than the average critic because she will be part of the institution and will be criticism from the inside, which I think is always the most valuable kind" (Cabot, 1912, pp. 51–52). Pelton kept records of every case, which were used for instruction and to identify trends that would be published in regular reports. Prior to Pelton, no records of patient visits to the outpatient department were kept at Massachusetts Hospital.

Cabot viewed social workers as translators of medical information to patients and families in a way that they could understand. He said, "the social worker . . . can reassure patients as to the kind of things that are being done and are going to be done with them. There is no one else who explains; there is no other person in the hospital whose chief business is to explain things" (Cabot, 1912, p. 50).

Cabot also saw social workers as translators of information about patients and families to physicians. Social work's role in providing social and psychological information to physicians is described in a quote from Ida Cannon:

While she must have an understanding of the patient's physical condition, the physical condition is only one aspect of the patient to which she must take account. As

the physician sees the disease organ not isolated but as possibly affecting the whole body, so the hospital social worker sees the patient not merely as an isolated, unfortunate person occupying a hospital bed, but as a member belonging to a family or community group that is altered because of his ill health. Physician and nurse seek to strengthen the general physical state of the patient so that he can combat his disease. The social worker seeks to remove those obstacles, either in the patient's surroundings or in his mental attitude, that interfere with successful treatment, thus freeing the patient to aid in his own recovery. (Cannon, 1923, pp. 14–15)

Cabot thought that social work could best fulfill this role because nurses had "lost their claim to be a profession by allowing themselves to become mere implementers of doctor's orders" (Evison, 1995, p. 220). He defined social work's expertise as diagnosis and "treatment of character in difficulties," which he saw as encompassing expertise in mental health.

The hospital did not initially support Pelton's hiring, so Cabot paid her salary with his own funds. To convince the hospital's superintendent Frederic Washburn that Pelton was a good addition, Cabot set about documenting that her hiring was cost-effective. He calculated that the hospital had spent $120 on a baby with gastrointestinal problems whose mother brought her to the hospital on four occasions over a short period of time because the family was unable to provide the nutrients prescribed for her. Cabot did not want administrators to view social work's primary role as preventing misuse of hospital services but instead to save money by helping to make treatment more effective. He viewed medical social workers as distinct from hospital almoners.

Ida Cannon took over for Garnet Pelton in 1906 when Pelton went to Saranac Lake, New York, to receive treatment for pulmonary tuberculosis. Cannon was named the first chief of social work in 1914. She shared status with the chief of surgery and the chief of medicine. Cannon developed training programs for social workers at Massachusetts General Hospital, including medical education. Cannon hired Harriett Bartlett to be the first educational director in the Social Work Department. Other programs begun during her tenure included a low-cost lunch counter for patients and staff; a committee to investigate the social correlates of tuberculosis, which produced the first comprehensive analysis of tuberculosis in the United States; interdisciplinary medical rounds with social workers; and clay modeling classes for psychiatric patients. Cannon and Cabot together developed systems for evaluating the effectiveness of social work interventions and included this information in medical records.

Cannon did not take the same radical views of hospital social work that were espoused by Pelton and Cabot, with whom she clashed often during their first years of working together. Cannon thought social workers should accommodate hospital mechanisms rather than being critics or reformers of medicine, as Cabot had advocated. Nevertheless, the two worked together until Cabot accepted a commission of major in the Medical Reserve Corps in 1917. He returned to the outpatient department of Massachusetts General Hospital in 1918, but he then left to chair Harvard's Department of Social Ethics in 1919. Shortly before he left the hospital, its board of directors voted to make the Social Service Department a permanent part of the hospital and to cover the full cost of its functioning. Prior to that, Cabot had covered the cost of up to 13 social workers with his personal funds.

Ida Cannon was named director of the new Social Work Department in 1919. She retired from Massachusetts General Hospital in 1945. At the time, the hospital employed 31 social workers. Several former social workers at Massachusetts General Hospital went on to direct departments in other hospitals, such as Mary Antoinette Cannon (the University Hospital of Philadelphia) and Ruth T. Boretti (Strong Memorial Hospital of the University of Rochester School of Medicine and Dentistry).

THE GROWTH OF HOSPITAL SOCIAL WORK DEPARTMENTS

In 1961, Bartlett described the course of social work in health care as spiraling, "in which periods of uncertainty and fluidity alternated with those of clarity and control" (Bartlett, 1961, p. 15). She said that in its first 30 years, growth was linear as social work spread from one hospital to another. Methods were simple because social work in hospitals "almost alone carried the responsibility for bringing the social viewpoint into the hospital" (p. 15).

The success achieved at Massachusetts General Hospital eventually drew the attention of the American Hospital Association and the American Medical Association. Johns Hopkins Hospital hired Helen B. Pendleton, who had worked with the Charity Organization Society as its first social worker in 1907. As had been the case with Garnet Pelton at Massachusetts General Hospital, Pendleton remained on the job for only a few months. The position remained vacant for 4 months, then she was replaced by a graduate nurse. At Johns Hopkins, social workers were initially housed in a room that was also used for storing surgical supplies. They were not allowed on the wards, which were controlled by nurses (Nacman, 1990). Social workers, however, controlled access to medical records by physicians and nurses and had to approve all free medical care and prescriptions for medicine that was to last longer than 1 week (Brogen, 1964). The department prospered, as had the department at Massachusetts General Hospital, and by 1931 had a staff of 31.

Garnet Pelton completed a survey of social service in hospitals in the United States in 1911 at the behest of John M. Glenn, the first director of the Russell Sage Foundation and a strong proponent of social work in health care. She was able to locate 44 social service departments in 14 cities, 17 of which were in New York City alone. These departments provided a range of services, all focused on the provision of assistance to the patient (Cannon, 1952).

New York City, which housed nearly 40% of the country's hospital social service departments, organized the field's first conference in 1912, which was called the New York Conference on Hospital Social Work. The conference was held regularly between 1912 and 1933. A quarterly report entitled *Hospital Social Service* documented conference findings and highlighted the progress of various hospital social service departments.

By 1913, 200 U.S. hospitals had social workers. Ruth Emerson, who left Massachusetts General Hospital in 1918, established the social service department at the University of Chicago. Edith M. Baker, who left Massachusetts General Hospital in 1923, established the social service department at Washington University in St. Louis.

THE PROFESSIONALIZATION OF THE FIELD

The first training course in medical social work was held in 1912. Cannon (1932) wrote that the growth of such courses was slow and lacked coordination until 1918, when the American Association of Hospital Social Workers was established in Kansas City. The association, which employed an educational secretary, had a twofold purpose: to foster and coordinate the training of social workers in hospitals and to enhance communication between schools of social work and practitioners. Although the American Association of Hospital Social Workers was the first national organization of social workers in health care, it was preceded by local organizations in St. Louis, Boston, Philadelphia, Milwaukee, and New York. Stites (1955) says that prior to the establishment of the American Association of Hospital Social Workers, medical social workers in health care for some time had congregated at meetings of the National Conference of Social Work (formally called the National Conference of Charities and Corrections). The burning question at the first meeting of the American Association of Hospital Social Workers in 1918 was whether the group should orient more closely with social work or medicine. Eight of the 30 women who signed the association's first constitution were graduate nurses.

The American Association of Hospital Social Workers published a study of 1,000 cases from 60 hospital social work departments in 1928. According to the report:

> The social worker's major contributions to medical care, gauged by frequency of performance, are: (1) the securing of information to enable an adequate understanding of the general health problem of the patient; (2) interpretation of the patient's health problem to himself, his family and community welfare agencies; and (3) the mobilizing of measures for the relief of the patient and his associates. Briefly then, the basic practices of hospital social work exhibited in the study under consideration can be described as discovery of the relevant social factors in the health problems of particular patients and influencing these factors in such ways as to further the patient's medical care. (American Association of Hospital Social Workers, 1928, p. 28)

This description does not differ appreciably from the way that hospital social work was conceptualized by Cannon and Cabot at Massachusetts General Hospital.

A survey of schools of social work published in 1929 (Cannon, 1932) listed 10 schools that offered formal courses in medical social work and 18 that were in the process of planning medical social work curriculum:

- The University of Chicago
- The New York School of Social Work
- Tulane University
- Washington University
- The University of Indiana
- The University of Missouri
- Simmons College
- Western Reserve University
- The Pennsylvania School of Social and Health Work
- The National Catholic School of Social Work

In all, medical social work was considered to be graduate-level work. A second survey that year was sent to social service department heads in hospitals asking them to query their workers about their training and experience. Of the 596 respondents, 70% had taken at least one course in general social work, and 48% of those had received a diploma or certificate between 1899 and 1930. Interestingly, 38% of respondents had completed at least one course in nursing and 86% of those had received a certificate or diploma in nursing. The survey listed six activities of medical social workers:

1. Medical social case management,
2. Securing data,
3. Health teaching,
4. Follow up,
5. Adjustment of rates, and
6. Medical extension of transfer to convalescent home, public health agency, or medical institution.

In 1954, the year before the American Association of Medical Social Workers merged with six other specialty organizations to form the National Association of Social Workers, 2,500 persons attended its annual meeting. The American Association of Medical Social Workers was the largest of all social work membership organizations. The current major specialty organization for social workers in health care on the national level, the Society for Leadership in Health Care, boasts 1,300 members (Society for Social Work Leadership in Health Care, 2005). This organization, which changed its name from the Society for Social Work Administrators in Health Care in the 1990s and is affiliated with the American Hospital Association, was founded in 1965. Other current national organizations include the American Network of Home Health Care Social Workers, the Association of Oncology Social Work, the Council of Nephrology Social Workers, the National Association of Perinatal Social Workers, and the Society for Transplant Social Workers.

DEFINING MEDICAL SOCIAL WORK

By 1934, the American Association of Medical Social Workers (the American Association of Hospital Social Workers changed its name that year) published a report prepared by Harriet Bartlett (1934). The report defined medical social work as a specific form of social case work that focuses on the relationship between disease and social maladjustment. Bartlett wrote, "it is an important part of the social worker's function to concern herself with the social problems arising directly out of the nature of the medical treatment. In this way, she facilitates and extends the medical treatment" (p. 99). Emphasis was placed on surmounting social impediments to health, "providing some occupation or experience for the person jolted out of his regular plan of life by chronic disease, to offset what he has lost and to make him feel that he has still a useful place in the world" (p. 99).

A series of problems was highlighted in the American Association of Medical Social Worker's 1934 report as requiring particular attention. They were: (a) the integration of psychological concepts, defined in part as needing to know more about human motivation in general and in relation to illness; (b) problems of

functional and mental disease, specifically the need to integrate the study of the organism with that of the personality; and (c) problems of methods of thinking, which had to do with balancing the study of personality with a consideration of the person in his social situation.

This competition for attention between personality and social environment gained salience with the advent of psychiatry and psychoanalysis in the United States. Although popular in Europe in the 1880s and 1890s, mental treatment in hospitals did not at first take hold in the United States. Courses in psychotherapy began appearing in medical schools in 1907, and Freud made his first tour of the United States 2 years later.

The emergence of psychiatry and psychoanalysis into medicine had two major effects on social work in health care. First, psychiatry's emergence into medicine is tied to the appearance of other professionals in hospitals, such as psychologists and social scientists. Their presence meant that the social and mental domains of health were no longer exclusive to social work and that medical social work for the first time had significant competition for a role in health care.

A second effect of psychiatry's emergence into medicine was the impact of psychoanalytic theory on how social workers in health care approached cases, namely, from a more person-centered perspective. The confusion between a focus on personality and on social environment remained after psychiatric social work separated from medical social work. The separation is often attributed to 1919, when Smith College developed a course for psychiatric aides attached to the U.S. Army during World War I (Grinker, MacGregor, Selan, Klein, & Kohrman, 1961), although the Psychiatric Social Service Department was not established at Massachusetts General Hospital until 1930. Mary Jarrett (1919), the associate director of the Smith College Training School for Social Work, argued for a more psychiatric approach to case work in her address to the Conference of Social Work in 1919:

> One by-product of the psychiatric point of view in social case work is worth consideration in these days of overworked social workers, that is, the greater ease in work that it gives the social worker. The strain of dealing with unknown quantities is perhaps the greatest cause of fatigue in our work. . . . More exact knowledge of personalities with which we are dealing not only saves the worker worry and strain but also releases energy which can be applied to treatment. . . . Another result is that impatience is almost entirely eliminated. No time is wasted upon annoyance or indignation with the uncooperative housewife, the persistent liar, the repeatedly delinquent girl. . . . I know of social workers who looked with suspicion upon the careful preliminary study of personality, because they feared that all the worker's interest might go into the analysis, and that treatment might be neglected. I believe that fear has been something of a bugaboo in social work. (p. 592)

The implication of Jarrett's address is that a focus on personality allows the social worker to get at the client's problem with ease, thus saving time for treatment.

Another possible source of social work's attraction to psychoanalytic theory was Abraham Flexner's 1915 address to the National Conference of Charities and Corrections, in which he said that social work was not a profession. Flexner defined professions as: (a) involving essentially intellectual operations, (b) having large individual responsibility, (c) deriving their raw material from science and learning, (d) working up their material to a practical and definite end, (e) possessing

educationally communicable techniques, (f) tending to self-organization, and (g) becoming increasingly altruistic in motivation. He said that although social work had a professional spirit, it failed to meet all of the criteria for a profession because its members did not have a great deal of individual responsibility and lacked a written body of knowledge and educationally communicable techniques. Flexner's address had a profound effect on the field. Some social workers viewed medicine as a model profession and an intrapersonal approach as more professional than one focused on social and environmental factors.

Nacman (1990) notes that, by the 1940s, psychosocial information was increasingly being used by medical social workers to make medical diagnoses and treatment plans. This was in contrast to its use, in Ida Cannon's words, "to remove those obstacles, either in the patient's surroundings or in his mental attitude, that interfere with successful treatment, thus freeing the patient to aid in his own recovery" (Cannon, 1923, pp. 14–15). The work of Helen Harris Perlman countered the tendency to use information primarily to make medical diagnoses and plans by emphasizing social science concepts over psychoanalytic and refocusing on society and environment. A focus on environment was reinforced in the 1950s by the community mental health and public health movements (see Chapter 4 of this text) and the civil rights movement of the 1960s.

SOCIAL WORK IN HEALTH CARE: BEYOND THE HOSPITAL

After World War II and the passage of the Social Security Act, social work in health care began to branch out from its hospital base. Social work programs were established in the U.S. Army and Navy and the Veterans Administration. The advent in the mid-1960s of Medicare and Medicaid, and titles XVIII and XIX of the Social Security Act, provided coverage for persons who might otherwise not have been treated. These two programs further increased the need for social work services.

The number of social workers in health care increased with the variety of work settings. Between 1960 and 1970, the number of social workers in health care nearly doubled (Bracht, 1974). By 1971, social workers were employed in a wide range of settings. A Medicare report from that year reported 11,576 social workers in 6,935 participating hospitals, 2,759 in 4,829 extended-care facilities, and 316 social workers in 2,410 home health agencies (U.S. Department of Health, Education, and Welfare, 1976). Social workers also could be found in state and local health departments and in federal agencies such as the Department of Defense. Social workers entered new health-care arenas such as preventive and emergency services. Techniques were added to the social work repertoire to address these new settings and arenas. Interventions appeared based on behavior, cognitive, family systems, crisis, and group work theories. Because health costs were growing at an alarming rate, the federal government began to institute measures to control costs. In 1967, utilization review measures were enacted that required Medicare providers to demonstrate that care was necessary and that its costs were reasonable. In 1972, Congress enacted the Peer Standards Review Act (PSRO), which required the peer review of medical billing to ensure that services had been utilized appropriately.

Neither utilization review nor peer standards review proved as effective as was hoped. Another attempt to control costs took its cues from a long history of prepaid health-care arrangements provided to workers around the country, the

first of which was a rural farmers' cooperative in Elk City, Oklahoma, in 1929. The best known of these arrangements was the Kaiser Permanente Health Plan. In 1973, the Health Maintenance Organization (HMO) Act was passed by the Nixon administration. The Act authorized $375 million in federal grants to develop HMOs. Initially, employers saw HMOs as a less expensive way of providing insurance to their employees. In recent years, state governments have used managed care in their Medicaid programs. By 1993, 70% of Americans with health insurance were enrolled in some form of managed care. Cornelius (1994) distills the perils of managed care for social workers by saying, "the social worker becomes an agent of managed care and agrees to serve the public within the corporate guidelines and not necessarily according to the assessed needs of the client. . . . If the social worker practices outside the protocols, . . . the client is denied coverage and the social worker is denied reimbursement; money becomes the carrot and the stick" (p. 52).

Another major cost containment effort had a profound effect on hospital care. The prospective payment system, based on a set of 500 diagnostic-related groups (DRGs), each with its own specific payment rate, was instituted in 1983 to replace traditional retrospective reimbursement for hospital care. The rates were developed based on the nature of the illness, accepted treatment procedures, whether the hospital was a teaching facility, local wage scales, and the hospital's location (Reamer, 1985, p. 86). This standardization was intended to provide an incentive for hospitals to become more efficient.

Under DRGs, patients entered the hospital sicker and left sooner (Dobrof, 1991). This impacted hospital social work services in two major ways: Hospitalization was seen as a failure of the system and every effort was made to avoid it; thus, those who were admitted were quite ill. Also, because hospitals were paid a specified rate, it was in their best interests to keep stays as short as possible. Because patients entered more ill and stayed for a shorter time, less comprehensive care could be provided in hospitals. Although there is debate about the extent to which social workers were cut from hospitals (see e.g., Coulton, 1988), many social work forces in hospitals were downsized or reconfigured during this period. Some were merged with other departments, others self-governed, and in other cases, social workers and other professionals were organized by service rather than by department.

It is clear that hospital social workers found less opportunity to spend time with patients because patients were there for less time, and much of the social worker's time was taken by helping to prepare sicker patients and their families for recuperation at home or in other facilities, such as extended care facilities. Dobrof (1991) describes "hospital-based social workers confronting larger caseloads of sicker patients with increased need for home care services or placement in nursing homes" (p. 44).

Both HMOs and DRGs affected how social workers in health care practiced. HMOs restricted social workers ability to practice based on their own assessment of needs. DRGs limited the time that social workers in hospitals had to work with patients and forced an emphasis on discharge planning. This limited social workers' ability to perform in the manner outlined by its founders, such as Bartlett's, "to concern herself with the social problems arising directly out of the nature of medical treatment" (1934, p. 99), or Cannon's, "to remove those obstacles . . . that interfere with successful treatment" (1923, pp. 14–15).

New techniques have been developed in response to time limits on treatment. Task-centered case work (Reid & Epstein, 1972) emphasizes the goals of treatment, and a number of brief treatment techniques have been developed (see, e.g., Mailick, 1990). Social workers have helped to adapt intervention theories for use in health settings, such as stress inoculation from cognitive theory (see, e.g., Blythe & Erdahl, 1986).

Claiborne and Vandenburgh (2001) define a new role for social workers as disease managers. As patients live longer with disease conditions or survive conditions once considered fatal, such as cancer, issues of quality of life arise. Survivors of cancer, previously expecting to die, need assistance with learning how to live. Those with long-term health conditions, such as rheumatoid arthritis, require guidance on how to live a full life with their condition. As a rule, disease management entails "a team of professionals that integrates and coordinates care across an array of services to maintain optimal patient functioning and quality of life" (Claiborne & Vandenburgh, 2001, p. 220). These teams often operate across facilities. Claiborne and Vandenburgh see social workers as key members of disease management teams due to their ability to work across health systems and managed care settings. Chapters 8 and 18 of this text discuss mental health issues in chronic illness.

CHANGES IN TECHNIQUE AND APPROACH THROUGH TIME

The settings in which social work is practiced in health care have changed through time. From 1905 until 1930, medical social workers practiced almost entirely in hospitals. Harriet Bartlett (1957) described the course of change during that period as linear, with the number of social service departments increasing steadily and their claim to the social and mental domains largely unchallenged by other disciplines. With the advent of psychotherapy, however, professionals such as psychologists and other social scientists began to work in hospitals, and for the first time social workers had to compete for roles.

The period of linear growth was followed by an expansion into previously unimagined settings. Federally imposed cost containment, beginning in the late 1960s, posed challenges to social workers in health care and forced a great deal of flexibility and creativity. In some respects, the competition with other disciplines that social work experienced in its most recent 70 years in health care and its failure to define a niche that was exclusively its own since that time (see, e.g., Lister, 1980), prepared social workers to remain viable in a changing health-care environment. They have adapted well to these changing environments.

How do the visions of Ida Cannon and Richard Cabot hold in the current health environment in which social workers practice? At a time when the changing demographics pose problems of communication in health care, Cabot's idea of social worker as translator or interpreter seems modern and as salient today as it was in 1905. In 2000, 1 in 10 U.S. residents, over 28.4 million persons, was born outside the country (Lollock, 2001). These figures do not include persons born in other countries who are living in the United States without benefit of legal residency.

The current 10% of U.S. residents who were born outside the country compares to a high of 15% between 1890 and 1910, the years during which Mary Stewart

was hired in London and Garnet Pelton and Ida Cannon were hired in Boston. The percent born outside the country in 2000 is higher than it was for the decades that immediately preceded 2000. According to U.S. Census Bureau records, 7% of the population was born outside the United States in the 1950s, 5% in the 1970s, and 8% in the 1990s (Lollock, 2001).

As outlined in Chapter 9 of this text, communication is the key to the provision of effective health care. Clinical encounters are more problematic when providers and patients are from different racial or ethnic groups or different socioeconomic statuses. A report by the Institute of Medicine (2002) implicated physician behavior in health disparities in the United States, and researchers (see, e.g., Johnson, Roter, Powe, & Cooper, 2004) have noted different communication patterns among White American physicians when they are dealing with African American versus White American patients. It is unlikely, however, that these biases are limited to physicians. Although empirical studies to date have centered on the behavior of physicians as the time that providers are able to spend with patients decreases, the opportunity for mental shortcuts that can lead to bias increases (Burgess, Fu, & von Ryn, 1990). Clearly, the translator or interpreter role first defined by Richard Cabot in 1905 remains important in health care today. Likewise, the idea that social workers are in the best position among professionals in health care to interpret information from patients and families to providers and to interpret and explain information from providers to patients and families holds true.

Cannon's dictum that the social worker see the patient "as a member belonging to a family or community group that is altered because of his ill health" (Cannon, 1923, p. 15) also seems germane to the current challenge of disease management. Cannon was writing at a time prior to the development of treatment advances such as antibiotics, chemotherapy, and radiation therapy, when patients did not live for long periods of time with chronic health conditions. Her words seem even more salient today when a growing number of patients face living with chronic conditions.

Cabot's belief that social workers should become more scientific and systematic was evidenced with the advent of research in social work in the late 1960s and early 1970s. He and Cannon would be heartened by the success of evidence-based practice and the active incorporation of research in social work practice in health care. Social workers with health-care backgrounds now head research teams and serve as program directors and other key positions at the National Institutes of Health and other federal agencies.

Although they initially disagreed about the role of social workers as critics or agents of socialization within hospitals, both Cabot and Cannon would doubtless be impressed by the growing number of social workers who serve as administrators of hospitals and health-care agencies and institutions across the United States.

Ida Cannon's statement that social work, when practiced at its best, "is a constantly changing activity, gradually building up guiding principles from accumulated knowledge yet changing in techniques" (1923, p. 9), still holds true. Social work in health care has been through a great deal in 100 years and has weathered seemingly insurmountable challenges through time. Nevertheless, its guiding principles remain in force and are as strong today as they were in 1905.

SUGGESTED LEARNING EXERCISES

LEARNING EXERCISE 1.1

The persons involved in establishing the first Social Service Department at Massachusetts General Hospital (Ida Cannon, Garnet Pelton, and Richard Cabot) were all White Americans and came from families without financial difficulties. Cabot was from a very privileged background. Cannon's father was a railroad administrator in Minnesota. That Pelton was able to obtain nurses' training at the turn of the century suggests that she had means. The subsequent century of social work's involvement in health care has seen the inclusion of persons from a number of racial, ethnic, and socioeconomic backgrounds. How do you think the narrowness of the backgrounds of the founders of social work in health care affected its guiding principles and approach, if at all? Have changes in the diversity of persons involved in social work in health care had a demonstrable influence on how the guiding principles and techniques of social work in health care have changed through time?

LEARNING EXERCISE 1.2

The first hospital almoner in England (Mary Stewart) and the first hospital social worker in the United States (Garnet Pelton) were both women whose hiring was championed by men with influence in medicine (Charles Loch and Richard Cabot). Who should be credited for the development of social work in health care? To what extent do you think that the development of social work in health care is attributable to the vision of Loch and Cabot? Were Loch and Cabot necessary catalysts for the development of social work in hospitals rather than pioneers? To what extent was the development of social work in health care due to the vision and efforts of women like Pelton, Cannon, and Stewart? Would social work in health care eventually have developed on its own absent the vision of influential men?

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