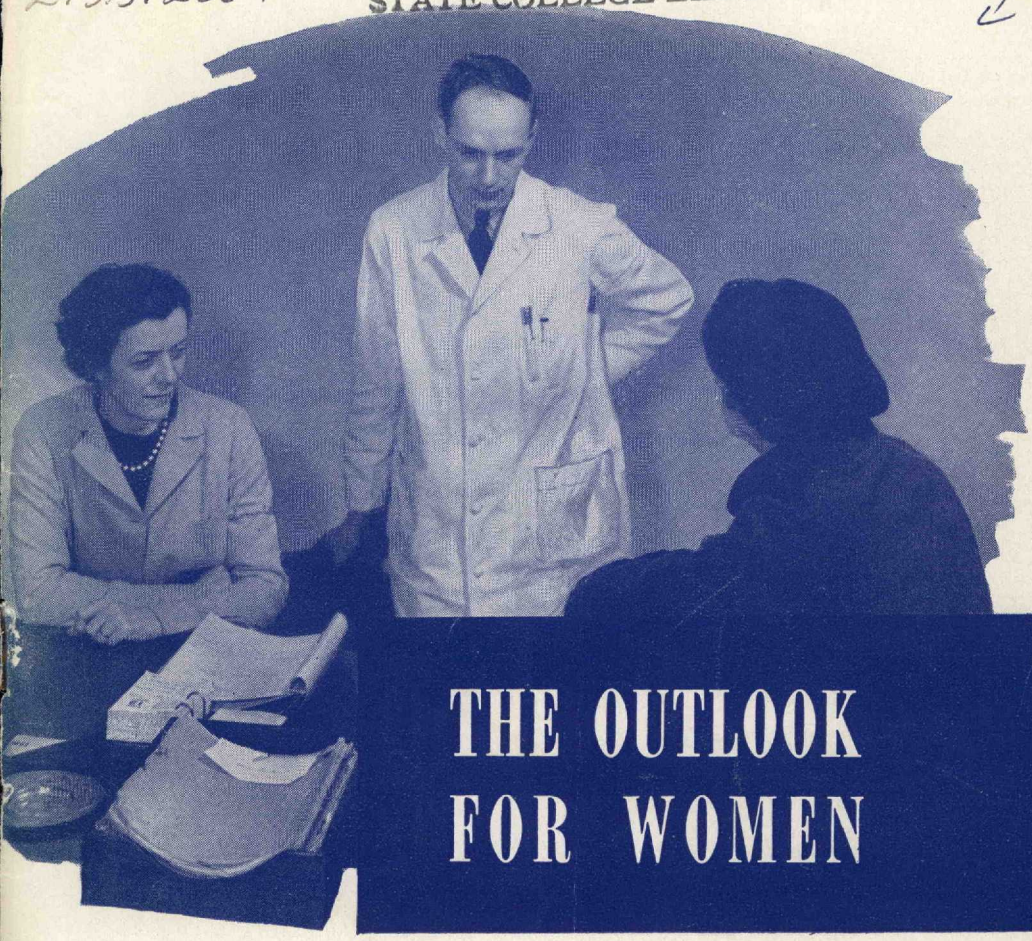

THE OUTLOOK FOR WOMEN

in

SOCIAL CASE WORK IN A MEDICAL SETTING

Social Work Series
Bulletin No. 235–1
U. S. DEPARTMENT OF LABOR
WOMEN'S BUREAU

UNITED STATES DEPARTMENT OF LABOR
MAURICE J. TOBIN, SECRETARY

WOMEN'S BUREAU
FRIEDA S. MILLER, DIRECTOR

The Outlook for Women in Social Case Work in a Medical Setting

Bulletin of the Women's Bureau No. 235–1
Social Work Series

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No. 235–1 *The Outlook for Women in Social Case Work in a Medical Setting.*

LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
WOMEN'S BUREAU,
Washington, January 30, 1950.

SIR: I have the honor of transmitting this report on the outlook for women in medical social work. It is the first of a series resulting from our study of the need for women in the social services.

The study was planned and directed by Marguerite W. Zapoleon, who also wrote this report.

Grateful acknowledgment is made to the many individuals and agencies who cooperated so generously in supplying information and helpful criticism for this report.

Respectfully submitted.

FRIEDA S. MILLER, *Director.*

Hon. MAURICE J. TOBIN,
Secretary of Labor.

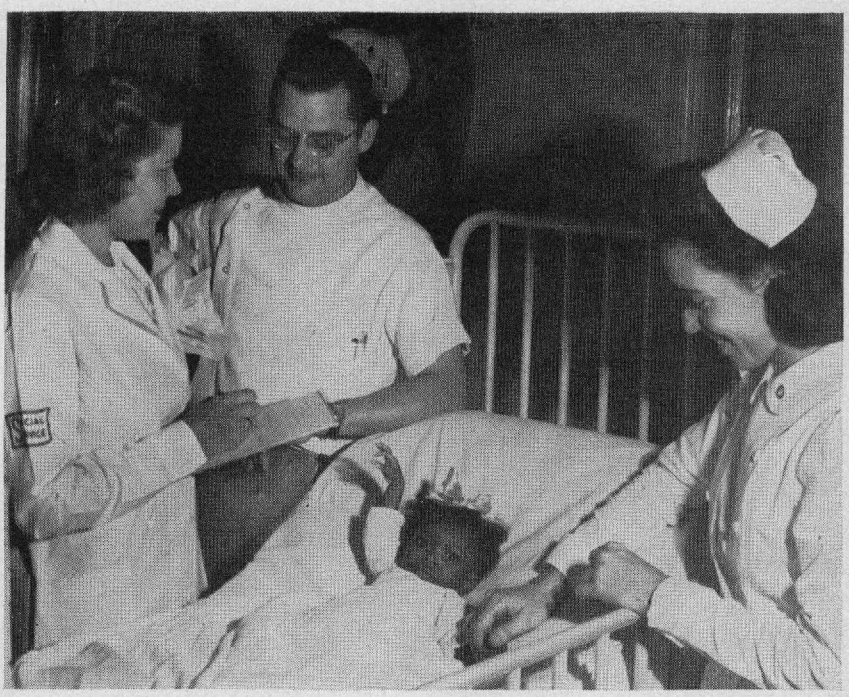

Figure 1.—Medical social worker with physician and nurse planning home care for baby.

FOREWORD

The social well-being of our people, like their health, has received growing attention over the years. Of the increasing numbers in our economy engaged in rendering professional social service, two-thirds or more are women. The story of their progress and the current and future needs for their services have been the subject of a Women's Bureau study which will be reported in a series of bulletins of which this is the first.

Those which follow, like this report on social case work in a medical setting, will describe the employment outlook for women in areas of specialization within the field of social work. The final bulletin in the series will describe the outlook for women in the entire field of social work, showing its relation to other professions of women and comparing the specializations within the field. Unlike the usual monograph which describes an occupation in detail at a particular point in time, this study, like the earlier Women's Bureau series on occupations in the medical and health services and the sciences, is concerned primarily with changes and trends.

Although more than 2,200 books, articles, or pamphlets have been culled for information, the principal information for this series has been obtained from professional organizations, public and private social agencies, schools of social work, and individual social workers. The following sources have contributed to the study thus far:

Thirty-seven national professional organizations. For help on this particular report, the Bureau is indebted especially to the American Association of Medical Social Workers.

Forty-nine schools of social work and other colleges and universities.

Eighty-seven agencies employing social workers, including 23 community chests and councils of social agencies, the American National Red Cross, and 15 non-Federal hospitals.

Thirty-seven Government agencies concerned with social service programs or employment in this field, including international, State, and local agencies, and such Federal agencies as the Bureau of Labor Statistics and the United States Employment Service in the United States Department of Labor; the Bureau of Public Assistance, the Children's Bureau, the Office of Education, the Office of Vocational Rehabilitation, and the Public

Health Service in the Federal Security Agency; the United States Civil Service Commission; and the United States Veterans Administration.

To these contributors the Bureau is indebted for the raw material which made this report possible. Although the reader will recognize gaps in our statistical knowledge of employment in medical settings and the unsurmounted difficulty of distinguishing always those individuals who are fully qualified for the profession from those who are not, it is hoped that she will find here a useful synthesis of existing knowledge on an important field of work in which more women are needed.

Special acknowledgment is due the Children's Hospital in the District of Columbia, which arranged for special pictures to be taken to illustrate this bulletin. Other sources are shown on page 55.

CONTENTS

Social Worker, Medical (Professional and Kindred), as Defined in the Dictionary of Occupational Titles (67)

"Assists in solving social and emotional problems of individuals in relation to illness: Acts as a liaison between patients and *Physicians; Occupational Therapists;* and other medical service workers to facilitate treatment. Discusses cases with *Physicians* so that their understanding of patients' social problems is adequate. Visits homes to assist in preparing proper environment for patients. Assists patients and their families in developing mental and emotional adjustments to illness. Attempts to eliminate fear, prejudice, and other attitudes that are obstacles to acceptance of medical care and continuation of treatments. Facilitates effectiveness of treatments or recuperation by assisting patients to regulate their lives so that harmful factors, such as overwork, strenuous recreational activities, inadequate diet, and worry are removed. Refers patients to community resources that may expedite their rehabilitation. May participate in research programs related to medical-social problems."

Case Worker (Professional and Kindred), 0–27.20, as Defined in the Dictionary of Occupational Titles (67)

"Performs any one or a combination of the following social service duties, usually requiring a college degree and applying techniques acquired through postgraduate training in social service work, in pursuance of a welfare program organized by a public or private agency or organization. Studies physical and social environment of a family, person, or persons in order to determine and execute practical plans for alleviating existing undesirable conditions. Visits persons in need of assistance or receives clients at intake desk of agency. Interviews clients to ascertain nature of their problems. Diagnoses problems, considering factors involved, and plans treatment. Makes necessary contacts to ascertain background and needs of clients and their eligibility for financial, medical, and material assistance. Helps clients understand their situations more clearly and assists them to reach satisfactory solutions for their problems. Refers clients to community resources, such as hospitals, clinics, recreational facilities, and schools which may assist in rectifying the maladjustments. Endeavors to foster self-development of individuals in order that they may successfully meet social exigencies. Follows progress of cases beyond solution of immediate problems. Keeps case histories and other records."

Figure 2.—A medical social worker joins patient and his relatives during evening visiting hour to discuss his progress.

THE OUTLOOK FOR WOMEN IN SOCIAL CASE WORK IN A MEDICAL SETTING

Section I

THE MEDICAL SETTING

To minister to those who are ill is a responsibility that more than 3,500 social workers in 1949, 90 percent of them women, shared with doctors, nurses, and others engaged in health services. An additional 1,500–2,000 worked with the mentally ill, in psychiatric settings. Like all other social case workers, those who work in a medical setting are trained to deal with individuals in need, by helping them to understand what they need and to obtain the help indicated (*60*). Like all social workers, they are skilled in seeing the individual in relation to his family and all the circumstances of his environment and in using community resources to help him work out his problems. But unlike the family case worker and the child welfare worker, the case worker in a medical setting, traditionally called a "medical social worker," works constantly with sick persons (*52*).

The need to which she gears her help is medical-social in nature. It results from the inability of the patient to make the most use of the medical care offered because of personal or environmental difficulties. The background against which she sees the patient, the family, the social environment and the community resources is his particular illness.

She helps a child who has lost his leg in a traffic accident to develop a healthy attitude toward his handicap, by working with his parents to prevent their grief from handicapping the child's future; she eases the strain on the family and the patient for whom the doctor holds out no hope of recovery; she works with uncooperative patients who shy away from treatment or surgery necessary to their recovery; she brings to the doctor from her social study of the patient information about personal relations, attitude, home, and community that will aid the doctor in seeing the relationships between the social and the medical problems involved in the illness (*8*) (*25*). She works with the nurse, the dietitian, the therapist, the teacher, the vocational counselor, and

all others who are assisting the patient to recover from his illness; and, in this work, she is part of a team of which the physician is the head (*15*). Her work is directly with people, interviewing patients and members of their families and conferring with physicians and others within and without the setting in which she works.

The setting in which she is most often found is the hospital, although an increasing number of social workers are working in health departments and other medical settings where physicians carry on their work (*19*). The social worker may be the only professional person in her department, or she may be one of a staff of 25 or 30 in a large hospital system. More often she has 2, 3, or 4 social work colleagues with whom she may share the assistance of a clerical staff and, sometimes, of volunteers (*37*).

Among her social work colleagues she may find one or more who have specialized in work with the mentally ill. These "psychiatric social workers" usually work primarily with patients in the psychiatric wards or clinics, and are discussed in more detail in another bulletin in this series on the social worker in a psychiatric setting. However, there is an increasing interchange between these already close specializations, as the association of physical and mental illness has become fully recognized. In some hospitals there are now psychosomatic wards where patients, whose physical ills are thought to have emotional and social causes, are treated by psychiatrists and medical men working together with either medical social workers or psychiatric social workers. In a few hospitals which have experimental programs there may also be a social group worker in the social service department, who cooperates with the case worker, using the group approach in hastening the recovery of individuals. (Group work is also discussed in another bulletin.)

The social service department includes all social workers within the institution and is an integral part of the hospital. Its director is responsible to the head of the hospital or to the medical director for the activities of the department, which include: practice of social case work; participation in program planning and policy formulation within the medical institution, in the development of social and health programs in the community, and in the educational program for professional persons; and social research (*5*).

While all patients do not need social service, those with certain illnesses like tuberculosis, cancer, diabetes, and heart disease, need an unusual amount. There is wide variation, therefore, not only in the size of the social work staff but in the number of patients served by a single case worker in the course of a month or year. Although New York hospitals may not be typical of the country as a whole, a 1945 study of 52 medical social work departments in New York

Figure 3.—This picture illustrates the areas in which a social service department in a children's hospital serves the child, the family, and the doctor.

City hospitals illustrates these variations (*37*). In 1945 the number of cases carried each month by a worker ranged from 24 to 144; the average (median) number was 52. Thirty-five cases per month is generally considered a desirable number. However, many social service departments of good standing have found it impossible to restrict case loads to these figures because of the shortage of trained social workers and the increasing demand for them in medical settings.

THE OUTLOOK

All evidence points toward a continued growth in the demand for case workers in medical settings. Current shortages will continue for

several years, until the number trained each year is enough, not only to take care of replacements, but also to fill accumulated vacancies and new positions resulting from expanding public and private programs of medical care. In New York City, a mecca for job seekers where problems of obtaining personnel are usually at a minimum, unfilled positions in hospitals in 1945 were nearly 10 percent of those budgeted. (*37*). A Nation-wide questionnaire study made in 1947 by the American Association of Medical Social Workers indicated that vacancies had mounted to more than 12 percent of the positions reported by 335 departments of social work (excluding Federal agencies and the Red Cross) (*3*). In 1949 requests for personnel from employers far outnumbered members of the American Association of Medical Social Workers seeking positions. The 337 medical social workers graduated by approved schools of social work in 1949, however, encouraged some hope of closing the gap between the demand and supply, which had been widening ever since the beginning of World War II. But, on the basis of the incomplete statistics available, it is more probable that 500–600 new graduates will be needed in each of the next 5 years to meet the needs.

The largest number of medical social workers will probably continue to be needed in hospitals. Partial statistics on members of the American Association of Medical Social Workers in widely scattered districts indicate that two-thirds of those known to be employed were in hospital work. (See table 1.) In 1945 only 13 percent of the hospitals in one of our largest States employed medical social workers. If this is typical of the country as a whole and if more patients need social services, as evidence seems to indicate, the potential demand for medical social workers in hospitals not yet employing social workers is staggering. It is especially so if the growth in hospital admissions is considered. In 1948, excluding births in hospitals, admissions totaled nearly 16½ millions, surpassing the previous peak of 1945 (*35*). If one trained social worker were supplied for every 2,000 admissions, as recommended for ward and dispensary admissions two decades ago by Dr. Haven Emerson (*72*), more than 8,000 social workers would be needed in nonpsychiatric hospitals alone, where admissions in 1948 totaled more than 16 million. One authority has estimated that one social worker is needed for every 500 admissions in the case of chronic disease patients (*14*). The increasing number of aged persons in the population and the fact that, according to one State-wide study, about half of all persons 65 years old and over have some chronic disease or permanent impairment, indicate that these estimates of social work needs are conservative. Domiciliary care for the aged, as in the Veterans Administration for example, requires an increasing number of medical social workers.

Figure 4.—In a station hospital in Japan, a Red Cross medical case worker making an early morning round of the wards.

Table 1.—*Type of Employment of Members of the American Association of Medical Social Workers in Scattered Districts, 1949*

Type of employment	Total employed		New England		Potomac district		Cleveland, Ohio		Denver		Northern and southern California	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total employed [1]	491	100	152	100	115	100	49	100	28	100	147	100
Hospital	326	66	118	78	78	68	37	76	17	61	76	52
Other health and medical agency:												
Public	103	21	27	18	19	17	4	8	10	36	43	29
Private	9	2					2	4			7	5
Nonmedical agency	26	5			9	8	4	8			13	9
Teaching social work	14	3	7	4	3	2	2	4	1	3	1	(2)
Other than social work	13	3			6	5					7	5

[1] In addition to the 491 members whose employment was obtainable from district membership lists, 104 members were not working (including 6 students in addition to those retired, engaged in homemaking, and those unemployed), and there were 57 on whom employment information was not available from the lists. Of the total membership of the 6 districts, 75 percent were known to be employed, as compared with 16 percent in the not working group and 9 percent in the unknown group.

[2] Less than 1 percent.

Potential demand, of course, must be translated into budgeted jobs before it becomes wise to expand supply. The indications are that progress in 1949 was being made in that direction. Reports on medical social work staff obtained by the Women's Bureau from scattered hospitals all indicated that the 1949 staff was larger than the 1940 staff. Many reported unfilled positions, and all commented on the inadequate supply of medical social workers in their areas. The increasing demand for service to private patients and the growing use of social service by hospital physicians also promised expansion. Many physicians became convinced of its value through their first experience with hospital social service in military hospitals during the war (*52*). Greater emphasis in medical schools on instruction in social factors in illness also encourages this trend (*38*). One hospital administrator in 1945 said, "We are . . . rapidly approaching the day when hospital standardizing authorities will include a medical social service department as a prerequisite to . . . approval . . . for, without the social worker, the doctor may find that he is laboring in vain. . . . Moreover, modern medical social service does not limit itself to the poor" (*21*).

Small hospitals, as well as large, need social service, although the supply problem is difficult. Some hospitals are extending home care service, including medical social service, to cancer and other patients to help in their medical care (*28*). Research related to the cause and prevention of patient discharges against medical advice, which constitute a major problem in tuberculosis hospitals, emphasizes the influence which social and environmental factors have on such discharges and the necessity for more adequate social service departments (*70*).

The growing emphasis on adequate hospital facilities, and such provisions for their expansion as were made under the Hospital Survey and Construction Act in 1946, also favor an increase. The Veterans Administration, too, has been authorized to construct 62 new hospitals. Reports from schools of social work confirm the growing demand for case workers in hospitals, as well as the competitive and newer demand for social workers in other medical settings.

The largest single demand outside hospitals will continue to be in public health programs. These programs employed more than one-fifth of all medical social workers, if 1949 partial statistics on American Association of Medical Social Workers members are typical. (See table 1.) In this field the medical social consultant as well as the medical case worker will be in demand. If progress in the next decade compares with progress in the past two decades, as many as one-fourth of the medical social work group may be found in such programs, most of them in State and local departments dealing with health

or physical rehabilitation, the others in Federal service or among the small but growing number in international organizations. The International Refugee Organization already employs medical social workers and the World Health Organization has an obvious interest in this service.

The smaller group employed by private agencies working on public health problems of a general or particular nature will also continue to grow as public support is won. Increasing attention is being paid to disabilities which handicap individuals. The potential demand for workers to serve this group is tremendous, and all evidence points toward continued increases in funds at all levels for rehabilitation programs. Some, like those provided by the 1943 amendment to the National Vocational Rehabilitation Act, are in Federal and State Government; others are being provided through national voluntary efforts like those projected by such agencies as the National Foundation for Infantile Paralysis and the American Heart Association. Information on the number of handicapped persons is incomplete, but authorities estimated in 1940 that more than 2½ million adults had orthopedic handicaps, while a 1944 estimate placed the number of crippled children at more than one-third of a million. In 1947 it was estimated that 800,000 persons wore hearing aids as compared with an estimated 1,600,000 who needed them. Half a million persons were believed to have tuberculosis in 1945, according to the National Tuberculosis Association, and more than one-fourth of a million were blind in 1947. Cerebral palsy afflicted 175,000 children, according to a 1947 estimate; approximately 50,000 persons were institutionalized for epilepsy in 1946; and 13,514 cases of poliomyelitis were reported in 1945. Heart and artery ailments, mainly among the aged, affected between 9 and 10 million persons, and diabetes mellitus at least 1 million (*54*). Medical social services to these groups were noticeably small in relation to the needs, but growing.

The relation of social problems to physical ills, long recognized by leaders in medicine and social welfare, has more recently become a matter of general knowledge. There is increasing pressure for teamwork between specialists in health and social welfare. Initiated in the thirties, the inclusion of medical or health units in departments of public welfare and in private social agencies, and the employment of medical social case workers as consultants in them, has continued to some extent, although the trend in public agencies is toward health department administration of this program. In 1949, 5 percent of the members in scattered districts of the American Association of Medical Social Workers were employed by agencies in which the principal emphasis was nonmedical but which encountered medical problems

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numerous enough to warrant employment of case workers with medical background and experience. (See table 1.)

Additional teachers of medical social work will also be needed if 500–600 graduates are to be produced each year. This group, of course, will remain relatively small in proportion to the total in the field, probably amounting to not more than the 3 percent indicated by the 1949 partial statistics on American Association of Medical Social Work members. (See table 1.) The increasing demand for instruction of additional students of social work of all types will add to the need for faculty to teach basic courses in medical information. The effect of the constantly increasing demand for more instruction in medical social problems, not only for students of medical social work but also for students of medicine, nursing, dietetics, and physical rehabilitation personnel, who are likewise increasing in total numbers, will make itself felt on the hospital social service departments which handle this load through part-time assignments rather than on the full-time faculty members in schools of social work. Both groups will also experience a growing demand for more time devoted to medical-social research. Research is needed, according to the American Association of Medical Social Workers, into the relation of social factors to the prevention and care of illness, into the social aspects of medical care administration, and into special areas, such as convalescence, geriatrics, and chronic diseases, where the need for medical social work is known to be growing greatly (*4*).

Within the specialization of social work in a medical setting, then, the future offers a variety of ultimate choices to women who can complete their training for this field. They extend from intensive social case work with individuals experiencing illness or physical handicaps to the administration of such programs; from the supervision of students and less experienced case workers to consultation service to persons in other specializations who need medical-social interpretation; from the instruction of other professional groups in the relation of social and environmental factors to the cause and treatment of illness and disability to teaching case work techniques and methods applicable to their own professional fields; and include intensive research which will add to existing knowledge in this field where the pressure of immediate problems has deflected attention from research. Work will continue in all types of hospitals, in Government and private agencies, in community and Nation-wide programs.

DEMAND AND SUPPLY IN 1949

Hospital Employment

The largest demand in 1949, as indicated by the number actually employed, was in hospitals. Nearly 500 medical social workers were

Figure 5.—Director of social service department conferring with physicians and head of out-patient department concerning research project.

employed in Federal hospitals alone in 1949, not counting the psychiatric and general case workers also employed there. In January 1949, 355 medical social workers were working in veterans' general medical or tuberculosis hospitals, or in veterans' domiciliary homes, in addition to the 197 psychiatric social workers in neuropsychiatric hospitals for veterans and the large number of case workers in the regional and branch offices of the Veterans Administration. All but 2 of the 43 employed in veterans' tuberculosis hospitals were women, but about one-fourth of the entire social work staff of the Veterans Administration staff were men, some of whom were in general hospitals. Twenty women were employed as medical social workers in other Federal hospitals, such as Freedmen's Hospital, and the marine hospitals and out-patient clinics operated by the United States Public Health Service. In military hospitals in the United States in January 1949 the American Red Cross had 90 medical social workers in addition to 56 psychiatric and 109 "generic" (general) case workers.

A considerably larger number of social workers were in non-Federal hospitals. Probably 500 social workers were working in New York City municipal and voluntary hospitals alone in 1949. The 355 full-time and 8 part-time staff medical social workers located there in December 1945, according to a study by the Russell Sage Foundation,

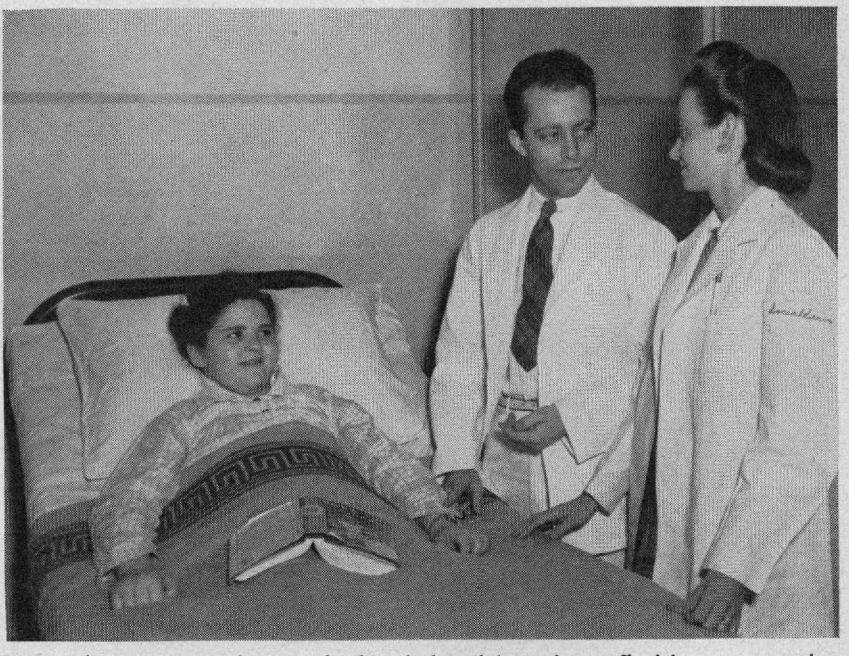

Figure 6.—A case worker on the hospital social service staff visits young patient with physician.

were said to represent more than 80 percent of all medical social workers in such hospitals in New York City at that time (*37*).

Social workers were found more often in some types of hospitals than in others. Ninety-one of the 135 chief social workers or assistants reported in a 1945 survey of Illinois hospitals were in general hospitals. However, only 1 out of 11 general hospitals there employed social workers. Fourteen of the social workers were in maternity and children's hospitals, of which 1 out of 2½ had a social work staff. Six of the social workers were in tuberculosis hospitals, but only 1 out of 9 hospitals of this type reported social workers. Four of the social workers were in other specialized hospitals; and 20 were in mental hospitals, working in a psychiatric setting, rather than the usual medical one. One-fourth of the Government hospitals covered in this study employed social workers, as compared with one-tenth of all the other hospitals.

This survey in a single State showed little increase in the proportion of hospitals employing social workers when compared with the national average of less than 9 percent reported 20 years before (*72*). A slightly better picture was indicated by the 1949 directory of hospitals affiliated with the American Hospital Association. Of more than 5,600 hospitals remaining after the exclusion of some 500 mental hospitals, one-fifth had some type of social service department (*11*). However, such directories do not define social service departments nor the qualifications of those who work in them. The Tuberculosis Division of the United States Public Health Service, for example, estimated in 1949 that considerably less than half of the social workers in tuberculosis hospitals, exclusive of veterans' and military hospitals, were fully qualified. On the other hand, one-fourth of the 800 institutions listed in the National Tuberculosis Association's Sanatorium directory for 1948 reported social workers on the staff, a marked improvement over 1930, when only 4 percent of the tuberculosis hospitals in the United States employed them (*72*). The need for extending social service to more patients, in hospitals where it was already available to some, was also being recognized.

The growing recognition of the value of social service to hospital patients had resulted in a new demand for service to private patients as well as to those who received free or partially free medical care. In 1947 the American Association of Medical Social Workers reported the results of a special study of medical social case work services to private patients whom it defined as patients who paid their physicians directly, through an insurance policy, or through some organized plan of medical benefits. Questionnaires had been sent in 1945–46 to more than 150 medical social service departments in hospitals known to offer care to private patients, and 65 supplied statistics complete enough

to use. These hospitals ranged in size from 70 to 1,426 beds; the largest number were in the 200–300 bed group. In these hospitals nearly 600, or 4 percent, of the 14,670 patients referred for social service during a 2-month period in 1946 were private patients. Hospitals attached to universities, those used as teaching centers, and those where social work school graduates were employed seemed to encourage such referrals. Many departments reported that they had refused or reduced service to private patients because of inadequate staff, and others reported the possible development of such service, should sufficient staff become available (*42*). The majority of the patients served needed help with environmental problems, while about two-fifths were referred because of emotional or interpersonal problems. The charging of fees for this type of service was reported in only two of the departments. A Detroit hospital, which supplied medical social service to many industrial accident patients covered by workmen's compensation, proved the benefit of such service; but even there the program had to be reduced to the more severely injured and long-time cases because of lack of staff (*42*).

There were reports of a few medical social workers, unattached to a hospital, working on a fee basis for private patients referred by a physician in private practice. Supervision in this case is difficult to arrange, and the part-time nature of the work is not attractive to most social workers.

Employment in Public Health and Welfare Agencies

At the Federal, State, and local level, in January 1949, the demand for medical social workers outside hospitals continued to grow. The Veterans Administration, for instance, employed more social workers outside its hospitals than within them. In addition to its hospital staff, it had 711 social workers, almost one-fourth of whom were men, in administrative and outpatient clinic work in its branch and regional and subregional offices. About half of the women had psychiatric specialization, leaving at least 265 women with medical social work training or experience in this type of work. At the Washington headquarters there were also three women social workers serving as section heads in the Social Service Division headed by a man.

Much of the nonhospital Federal employment of medical social workers, however, was in administrative or consulting work in relation to State and local programs involving health and medical care for which the U. S. Congress had authorized special appropriations. Two of the oldest of these programs, those for maternal and child health and services to crippled children, initiated in the thirties, were administered by the United States Children's Bureau in the Federal Security Agency. In addition to the woman who directed the medical social

work unit in its Division of Health Services in Washington, and an educational consultant, the Bureau, in 1949, employed six women medical social workers in regional offices of the Federal Security Agency, where they worked as part of a health service staff which included a physician, a nurse, a nutritionist, and an administrative methods worker.

A similar national program for tuberculosis control, authorized by the Congress in 1945, was being administered by the United States Public Health Service. In 1949 the Division of Tuberculosis had three women on its medical social work staff, including the director of the unit, and two consultants, including one specialist in research. There were also four vacancies for medical social consultants in this Division, three of which were new openings and one of which resulted from turn-over. The type of consultation service a medical social worker may render, as well as her functions in direct case work service to tuberculosis patients, have been described in a publication of the United States Public Health Service prepared with the aid of an advisory committee of the American Association of Medical Social Workers (*68*).

In 1948 the Federal Security Agency reported that approximately 200 medical social consultant positions had been established in State and local health departments administering programs for maternal and child health, crippled children, and tuberculosis control (*66*). These consultants sometimes gave direct service to patients, but their primary function was to develop the medical social aspects of the program and to assist nonspecialized case workers and others involved in the program with medical social problems.

In the newest of these programs, that of tuberculosis control, the fewest medical social workers were employed at the State level in 1949, but the number was growing rapidly. Some States had already hired social workers who had specialized in work with tuberculosis patients. Louisiana, Massachusetts, Florida, Maryland, Michigan, and Colorado were among those which in 1949 had provided for this work. Other States were planning to provide for medical social workers in tuberculosis control programs. The largest number, however, were employed in work with crippled children, for which all States had made provision, usually in the health department but sometimes in public welfare or education departments or under separate auspices (*26*). At least 40 States had employed medical social workers in this program as early as 1943 (*16*). Sometimes, at the State level, consultants divided their time among two or more programs. For example, 3 of the 37 medical social work positions reported to the Children's Bureau in 23 States in 1947 provided for a division of time between maternal and child health and crippled

children's service (*32*). In large States such as Michigan, which employed 7 medical social workers in 1947 (*47*), and Massachusetts, which employed 12 to 15 in 1948 in its health department alone, some medical social consultants specialized in one type of service, and others worked on a regional basis on all types of medical social problems. Several States, including Massachusetts, Colorado, and Louisiana, have established a bureau or division of medical social services, the staffs of which give a generalized medical social service.

At the local level, too, the work may be specialized or not, depending upon the size of the department and the number of social workers it has. The health departments in Anne Arundel and Washington Counties in Maryland, for example, each had a single medical social work consultant in 1949 to assist staff members faced with social problems connected with any type of health work (*29*). New York City, New Orleans, and Denver were among the larger cities employing medical social workers, most of whom were in generalized service. Seattle, New Orleans, Norwich (Conn.), Los Angeles County in California, and Montgomery County in Maryland, on the other hand, were among the cities and counties which had medical social workers devoted exclusively to tuberculosis work carried on by their health departments.

Figure 7.—A medical social worker and a public health nurse confer in home of child convalescing after long hospitalization.

The employment of medical social workers in local health departments is also considered important, according to a spokesman in the United States Public Health Service, for assistance in solving problems of relationships of patients to providers of the service, and of the latter to the Government. He points out that close-working agreements between health and welfare departments are necessary (*44*). Recognizing this, some local county welfare departments have added medical social workers to their staffs to work with the medical care program. The Kitsap County Welfare Department was the first county welfare department in the State of Washington to employ a medical social worker. It appointed one in 1943 to participate in the joint programs of the health and welfare departments, centering her efforts chiefly on orthopedic services and tuberculosis and venereal disease control. Her work was reported to have drawn both departments closer together (*58*).

The welfare departments of large cities like New York, Chicago, Philadelphia, and Boston usually have medical social workers on their staffs. In 1949, 15 States included one or more medical social consultant positions in their public assistance programs. In the Bureau of Public Assistance in the Federal Security Agency, three medical social work consultants were employed in 1949 to give technical assistance involving knowledge of medical social case work to other staff members and to State and local agencies.

Traditionally more closely allied to education than to social work, Federal, State, and local vocational rehabilitation programs have been employing more medical as well as other social workers since the Federal program was expanded in 1943 to include physical restoration. In 1948, 13 women were listed as medical social work consultants or supervisors in State vocational rehabilitation agencies. The Federal Office of Vocational Rehabilitation has recommended that each State agency include a medical social worker on its staff.

In addition, 17 women were employed as medical social workers or consultants in State agencies for the blind conducting rehabilitation programs, in 1948. They usually were required to have 1 year of hospital work experience. A few medical social workers were also employed in public welfare departments to work with the blind, although family case workers were more often found in such jobs.

Employment in Private Health and Welfare Agencies

No distinct staff pattern had emerged by 1949 in the enormous number and variety of national, State, and local private agencies serving the blind, those with tuberculosis, and others physically handicapped. But some social workers were employed in programs serving these groups, either in case work or in a consulting or executive job likely

to involve community organization work as well. (All social workers in such programs will be discussed in a later bulletin in this series.) In some of the agencies, specialists in medical social work were employed, especially where physical rehabilitation or medical treatment was included in the program. A few of these specialists were in executive jobs. For instance, women trained in medical social work headed at least one local tuberculosis association, one local agency for the blind, and two local heart associations.

Some family and child welfare organizations, as well as local Red Cross chapters and public health nursing services in large cities, employed medical social workers as consultants in special programs for the physically handicapped in 1949. Some sheltered workshops, like the Altro Work Shop for tuberculosis patients in New York City, also employed them (*41*). They also worked in some local rehabilitation centers like the Institute for Crippled and Disabled in New York City and the Cleveland (Ohio) Rehabilitation Center, although the total was very small. If the suggestion made by the Baruch Committee on Physical Medicine is carried out, two medical social workers will be included in the social service sections of community rehabilitation services and centers having a capacity for 50 dormitory patients and 200 outpatients and serving 1,500 patients annually (*20*).

Some medical social workers are found in consulting or case work jobs in agencies working with particular problems, such as blindness

Figure 8.—A medical social worker interviewing a patient in a tuberculosis hospital.

or tuberculosis, although more often such agencies refer medical social problems to medical social workers in hospitals and other agencies. The National Society for Crippled Children and Adults had one medical social consultant in 1949, and at least one of its affiliated State societies had one. The National Tuberculosis Association in 1949 had one medical social worker and two other social workers on its headquarters staff. A number of the nearly 3,000 affiliated State or local tuberculosis associations were financing demonstrations in which social workers were employed, some of them specialists in medical social work and others drawn from other fields. The Wisconsin Tuberculosis Association, for example, employed 10 social workers who were giving direct service to patients and their families and demonstrating social services in hospitals, clinics, and other health settings. The State association in Maryland employed one social worker, who divided her time between a State sanatorium and a local clinic for tuberculosis patients. Local tuberculosis associations in Atlanta, Boston, St. Louis, Louisville, Denver, the District of Columbia, and Houston, Tex., were among those known to employ social workers. Together they employed a total of 9 for work with tuberculosis patients in State sanatoria, or local clinics, or in preventive work. The importance of such work was recognized in a report on the medical social work program of the Denver association and its relation to public health nursing and community agencies, which concluded that social work was essential in tuberculosis control and an appropriate activity for a local tuberculosis society (*61*).

Employment in Teaching and Research

Twenty-three women were employed full time in 1948–49 in instruction in the medical social work curriculum in schools of social work offering training approved by the American Association of Medical Social Workers. Seven additional women were teaching medical social work on a part-time basis in these schools, including two who taught enough other courses to be on the full-time faculty of the school.

These teachers assisted second-year students and postgraduate students specializing in social work in a medical setting in integrating their programs of classroom and field work and in completing required research projects. They usually taught advanced courses in medical social case work. Some also taught, or helped the 26 physicians employed part time in these schools to teach, the medical and health information courses required of all students of social work and related optional courses, such as health problems in social case work or public organization for health service (*68*). In other member schools of the American Association of Schools of Social Work, which did not offer an approved sequence in medical social work, an addi-

tional 8 women and 1 man taught medical social case work part time in addition to the 23 physicians, 1 dentist, and 1 nurse who taught medical and health information courses part time in those schools. Teaching skill, as well as extensive knowledge of medical settings and case work methods, are important in the teaching of medical social work.

A new demand for medical social work faculty in schools of public health was fostered by grants of the United States Children's Bureau to State health departments for maternal and child health curricula for physicians, nurses, social workers, and other professional persons in the public health field. Provision for salaries for medical social instructors in schools of public health were made, and in 1949 the schools of public health at Harvard and Johns Hopkins Universities each had a full-time medical social faculty person under this program. Their duties were primarily instructional, although they participated at need in programs to which public health students were assigned.

Social service departments in teaching hospitals also were participating increasingly in the preparation of medical, nursing, and dietetics students. These teaching programs continued to expand in 1949, as the social implications of illness and disability received greater recognition, new hospital training centers were opened, and students increased in numbers. More instruction on the family and home and human behavior was being included in medical school cur-

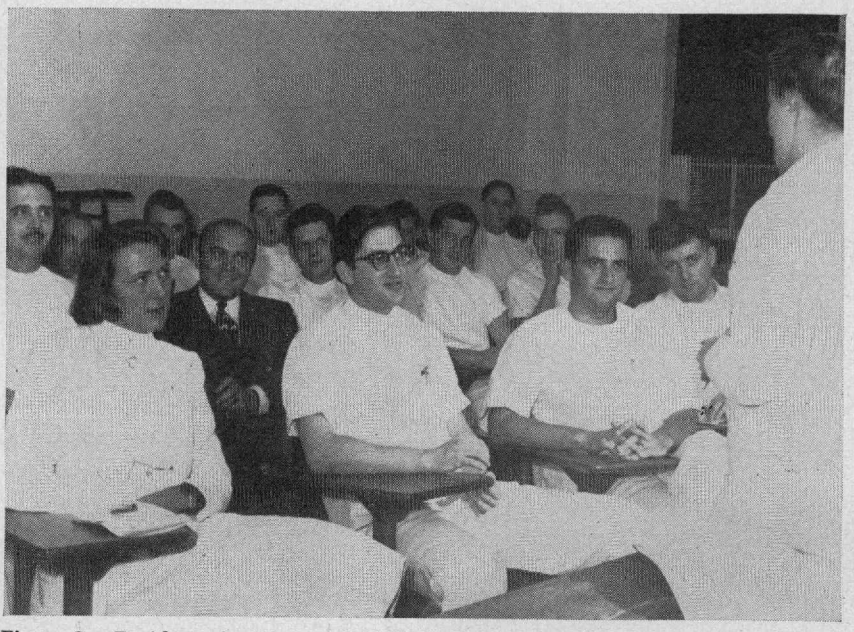

Figure 9.—Resident physicians and medical students attending social service seminar conducted by social service department.

ricula, to make physicians aware of the influence of these relationships on the patient's health. The formal participation of social service departments in such teaching was reported in varying degrees by 15 medical schools in a 1945 study conducted by the Association of American Medical Colleges and the American Association of Medical Social Workers. In 1942, 55 schools had reported that social workers shared informally in the teaching of medical students through clinical and follow-up conferences, assistance in home visit studies, and ward round participation (*38*).

Geographic Variations in Employment

Medical social work positions are as widely scattered as hospitals, but they are less evenly distributed than most medical care services. All studies of medical social service departments, or of social workers employed in them, indicate that roughly half are located in Northeastern States, where only one-fourth of the population of the United States resides.[1] (See table 2.) This concentration cannot be explained completely by differences in medical facilities. In that case, nurses, too, would be affected. But only a little more than one-third of all professional nurses were in these States at the last Census count in 1940. The concentration must be due in part to the fact that medical social work began in the East, and also to the unusual number of medical social work training centers in these States. Boston alone has three.

Table 2.—*Geographic Distribution of Medical Social Work Personnel and Departments Compared With That of Employed Nurses and the General Population*

Region	Members of the American Association of Medical Social Workers, 1949 [1]	Medical social service departments, except Federal, 1942 [2]	Professional nurses employed, 1940 [3]	General population, 1940 [3]
United States	*Percent* 100	*Percent* 100	*Percent* 100	*Percent* 100
Northeastern States	42	53	37	27
North Central States	26	22	29	30
South	17	17	21	32
West	15	8	13	11

[1] American Association of Medical Social Workers.
[2] Study by U. S. Office of Defense Health and Welfare Services, 1942 (*69*).
[3] U. S. Census (*65*). Note: Estimates of population in July 1948 show 31 percent in South; 13 percent in West.

[1] Regions as designated in U. S. Census reports are used throughout:

NORTHEASTERN STATES—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont;

NORTH CENTRAL STATES—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin;

SOUTH—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia;

WEST—Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming (*65*).

The New England district of the American Association of Medical Social Workers in 1949 reported a small but noticeable exodus of medical social workers from the New England States, which, if continued, would reduce the unusual concentration in the Northeastern States. In spite of their relatively better supply, hospitals in New England reported that the demand there, too, was greater than the number of qualified personnel available. All other regions of the United States appeared to have fewer medical social workers in relation to population, with the possible exception of the West. (See table 2.)

Employers like the American Red Cross and the Veterans Administration, which employed social workers at the same salaries throughout the country, reported special difficulty in finding qualified personnel in the Southeastern States and in the States west of the Great Lakes and east of the Pacific coast. More persons were available to meet the demand in such cities as Chicago, Los Angeles, New York, San Francisco, and Washington, D. C., while jobs in small communities or remote areas remained vacant. Tuberculosis hospitals, often located in isolated areas, were particularly difficult to supply. Most of the medical social work jobs that were filled were in large urban centers. In 1930, 80 percent of all medical social service departments were in cities with a population of over 50,000 (*72*).

However, even at that time, interest in rural social work was increasing, especially in the Midwest, and State health and welfare programs which have developed so rapidly since have done much to extend specialized services into rural areas. The need for more general use of medical social workers in county health programs has been stressed. Before such use will become general, however, the need for better medical care for persons in rural communities must be recognized. The Extension Service of the United States Department of Agriculture reports that one State health planning committee has employed a medical social worker to do a community organization job in obtaining better medical care in rural areas. Usually this work is performed by health education or social workers trained in community organization (*31*). Scholarships for students of medical social work who will stay a stated number of years in rural areas have been proposed as one means of remedying the uneven distribution of personnel in relation to need (*30*).

Supply

There were no adequate statistics in 1949 on the number of persons required to replace those who dropped out of medical social work each year, or on the exact number needed for expanding programs. Turn-over of medical social work personnel was reported high, as

Figure 10.—Medical social worker called in by physician in clinic to help mother understand and follow through on treatment recommended for child.

compared with that of other social workers, but was believed to be caused by transfer from one agency to another rather than by withdrawal from the field.

One well-known hospital which was able to attract new employees readily reported a problem of retaining them after they had been on the job 2 or 3 years, because of the opportunities offered in the Veterans Administration or elsewhere. The Veterans Administration, too, experienced difficulty in obtaining medical social workers for case work as well as for supervisory and administrative positions, especially for hospitals in rural communities, and more especially for hospitals in the Southeastern States. Other Federal agencies reported a lack of persons with the required experience available for supervisory or consultative work. Since no civil-service register was available in 1949, the director of the medical social work unit in the Division of Health Services in the Children's Bureau, for example, had to comb the country for appropriate staff. More than 5,000 persons, including 907 social workers already employed in the Veterans Administration, applied to take the civil-service examination for Veterans Administration (psychiatric and medical) social work positions announced in July 1947, but only about 3,000 met the eligibility requirements for the

examination. (See appendix, p. 48.) These were divided unevenly in relation to the demand in particular branches or regions.

Evidence was overwhelming that the numbers trained in past years had not kept pace with the demand. Even before World War II, when shortages in hospital staffs became critical, the supply of trained medical social workers was inadequate. In 1939 public agencies commented on their difficulty in obtaining qualified medical social workers for their expanding programs (*51*).

From 1940 to 1949 schools of social work graduated 2,123 specialists in medical social work, of whom less than half probably became net additions to the 2,250 employed in medical settings in 1940. (See p. 38 for 1940 figures.) The others probably replaced those who died, retired, or for other reasons left the profession in the intervening years. Several hundred additional persons who did not complete the degree course in social work possibly qualified during this period as recognized specialists in the field through a combination of experience or further training accepted as a substitute by the employing agency. The production of medical social workers by schools of social work was obviously too low during this period to fill vacancies, although the oncoming annual supply from approved schools of social work was increasing. In the 3 school years ending June 1947, 1948, and 1949, a total of 791 were graduated from approved curricula in medical social work, which compares favorably with 1,332 graduated in the 7 years ending June 1946. The highest number were produced in 1949, when 337 were graduated, as compared with 133 in the last prewar year of 1941. The number of graduates in 1949, however, amounted to less than 10 percent of the estimated total number of positions in medical social work, while partial studies indicated that vacant positions had been averaging at least 10 to 12 percent of filled positions (*37*) (*3*). Moreover, on the assumption that 5 percent of the medical social workers employed in a given year withdraw from practice during the year (an attrition even lower than the 6.6 rate for nurses in the decade 1930–40), more than half the 1949 social work graduates were needed to replace those who were lost to the profession in 1948 due to death, illness, or other causes.

However, the 1949 production rate of 337 graduates, provided it continues for some years, offers the first hope that the gap between present demand and supply may be closed. Meanwhile, additional demands will probably require an increased production, possibly up to 500–600 graduates annually, that is, if long vacancies are to be avoided. The development of cooperative programs between schools and employers will help to insure not only an adequate supply but one with preparation suited to the special needs of the agency. Scholarships and fellowships, the Veterans Administration's student field work program

and its training program associated with part-time work, and the work of the Children's Bureau in encouraging State agencies to develop medical social training units in cooperation with schools of social work will undoubtedly help to increase the supply in the future as in the past (*10*).

TRAINING

Medical social work training approved by the Education Committee of the American Association of Medical Social Workers consists of 2 years of graduate training in an accredited school of social work, including 1 year of specialization and supervised field work in medical social work in a hospital or clinic (*6*). (See appendix, p. 49, for essential elements included in this training, and appendix, p. 48, for requirements for membership in the American Association of Medical Social Workers.) In 1949, 23 schools of social work in the United States offered this approved curriculum. (See appendix, p. 50, for list.) In the same year the Education Committee of the American Association of Medical Social Workers was reviewing the curriculum in the light of changing needs.

Many persons employed in case work positions in hospitals and a few employed by health agencies in 1949 did not have the approved training, and during the war there was a relaxing of standards because of the shortages. However, new persons coming into the field

Figure 11.—The social service staff in a children's hospital discussing medical social treatment plan for cancer patient. Social work students participate in such conferences in their supervised field work.

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in the future undoubtedly will be required to have the full amount. Those without it in 1949 were being urged and often aided to complete their training through educational leave. Reports on the requirements of various agencies, as well as on the backgrounds of the staffs they employed in 1949, were confirming.

The United States Children's Bureau expected its medical social work staff to have approved training as well as experience and had also recommended that State and local agencies administering maternal and child health or crippled children services require approved training in addition to specified experience in a medical setting. If an individual's training in a school of social work had not included medical specialization, additional subsequent supervised experience in a medical setting for a definite period of time was acceptable as a substitute. Medical social work consultants in vocational rehabilitation programs were expected to have approved training, plus 3 years of case work experience, including 2 in a medical setting, of which 1 was required to be in a hospital or clinic social service department. Of 1,023 social workers employed in the Veterans Administration in 1947, including those in hospitals, 722 had a master's degree, or 2 years of graduate work without a degree, in social work, and 245 had had 1 year of graduate training; no information was available on their graduate specialization. Only 34 had had no graduate training in social work, and of these only 2 had had no social work training in college. For the higher grade social work positions in the Veterans Administration, a master's degree or graduation from a school of social work was required in addition to certain experience.

For social work positions in military hospitals, the American Red Cross required completion of a 2-year course at an accredited school of social work, with specialization or subsequent experience in psychiatric or medical social work, or 1 year of social work training plus 2 years of supervised experience in medical or psychiatric social work.

A 1947 study of announcements of State civil-service examinations showed that graduate training was required more often for medical social workers and for child welfare workers than for other case workers (*55*). A study of requirements for State social work positions in the South in 1946 indicated that completion of an approved medical social work curriculum was a customary minimum requirement for positions as medical social work consultant, and where 1 year or less training was accepted for these or medical social case work positions, additional social work experience in a medical setting was usually required (*39*). For medical social work positions in New York State departments, college graduation and 2 years of social case work experience, preferably in supervised medical social work, are ordinarily required. However, because of the scarcity of qualified

candidates, an examination announced in 1949 called for only 1 year of experience instead of 2.

In a 1939 study covering requirements for medical social work positions in public health and welfare agencies, there was general agreement that graduation from an accredited course in medical social work was desirable, that experience in a hospital social service department was considered essential, and that varied experience was valuable (*51*).

Reports from a number of cities where personnel practices in social service departments have been studied, such as Cleveland and St. Louis, gave the standard qualifications for medical case worker as completion of the full graduate curriculum, with approved medical social sequence, in an accredited school of social work; or employment in a medical setting following graduation from an accredited school of social work (*7*) (*56*). In 1945 more than two-thirds of the persons in charge of medical social service, in 33 hospitals reporting on this subject in a State-wide hospital survey in Illinois, were college graduates, and nearly one-third had master's degrees.

Scholarships, Fellowships, and Other Student Aids

To increase the supply of medical social workers needed for work with poliomyelitis patients, the National Foundation for Infantile Paralysis, in cooperation with the American Association of Medical Social Workers, began in 1944 to grant funds for professional education in medical social work. Over $400,000 were made available from 1944 through July 1949, and 267 graduates have been in training under this program. In 1949–50 full and partial scholarships were still available.

A number of other national organizations in specialized fields in 1949 were offering scholarships in medical social work to selected persons who would subsequently engage in social work serving groups in those specialized fields. The National Tuberculosis Association, for example, in conjunction with State and local associations, offered five scholarships for 1949–50. Stipends were $125 monthly plus tuition. The National Society for the Prevention of Blindness also offered scholarships of $1,000 each for second-year medical social work students specializing in the eye field.

Scholarships were also available through some local agencies for qualified persons who would promise to return to work in those organizations. Eight scholarships of $1,000 each for first or second year training in medical social work were offered by the Wheat Ridge Foundation in Colorado to Lutherans who would agree to work for 2 years with the foundation (*10*). Eight work-study fellowships of $90 a month at the graduate School of Social Work of the University of Southern California were available in 1949–50 to selected 2-year

Figure 12.—The director of a hospital social service department (seated behind nurse) works with administrative committee on personnel policies.

students who would serve in the Bureau of Medical Social Service of the Los Angeles County Department of Charities for 1 year following completion of their training.

Other scholarships, fellowships, work-study arrangements, and loan funds were offered in 1949 for specialization in medical social work at a number of accredited schools of social work. For example, at Bryn Mawr College, scholarships and fellowships ranging from $500 to $1,200 were available through Philadelphia agencies and hospitals. At the University of Louisville, the University of Washington, and Western Reserve University scholarships and fellowships or work-study arrangements in medical social work were arranged through funds contributed by local agencies or such organizations as a district group of the American Association of Medical Social Workers. The Minnesota and Illinois districts of the American Association of Medical Social Workers were among those which have offered scholarships or loan funds for graduate students in medical social work (*10*).

Provision for supervised field work in the Veterans Administration hospitals and clinics over the country, either on a paid field work or on an unpaid basis, was also of great help in increasing the total supply of medical social workers as well as in meeting Veterans Administration needs. Under the paid field-work program, begun in 1947, selected students who had completed 1 year in a recognized school of social work, and who had 1 year of case work experience in a health or welfare agency of acceptable standard, were paid for part-time work performed in the Veterans Administration. This work met the second-year field-work requirement of the school of social work in

which the candidate was enrolled for specialization either in medical or in psychiatric social work. Students worked a minimum of 24 hours a week and were paid $1.64 an hour. In December 1948, 232 men and women students from 36 schools were obtaining this part-time experience as their field work. Sixty-eight of these students were in medical settings.

The United States Children's Bureau has approved and encouraged the use of Federal funds, granted to the States under the Maternal and Child Health and Crippled Children's Programs, for the development of State and other agency staffs rendering health and medical services to mothers and children. Educational leave, with stipend, tuition, and travel, has been encouraged for postgraduate training in schools of social work. It is given usually to individuals who have had some training, to enable them to complete medical social specialization. The use of Federal funds for an internship year of supervised experience, in a hospital whose social service department met acceptable standards, has also been encouraged for students who have completed the medical social sequence. Arrangements for educational leave for medical social workers in State programs of public assistance, vocational rehabilitation, and tuberculosis control are also reimbursable with Federal funds. An increasing number of agencies in 1949 were providing preemployment scholarships or educational leave with pay to their employees for training in this field (*71*). But the need for additional scholarship and other financial aid was great. The American Association of Social Workers in 1949 appointed a special committee to explore scholarship possibilities.

EARNINGS, HOURS, AND ADVANCEMENT

A wide range in salaries for medical social work positions was indicated in a partial survey of medical social work positions in the United States made by the Personnel Committee of the American Association of Medical Social Workers in 1947, which covered more than 330 medical social service departments outside the Federal Government and the American Red Cross. Salaries offered for more than 200 vacant positions in all parts of the United States ranged from $1,500 for a medical social work position in Philadelphia to $5,000 for a director of medical social service in Massachusetts. The median salary for 128 case work positions was $2,438; the salary most frequently offered was $2,400 (*3*). This was also the usual salary offered to beginners in New York City voluntary hospital in 1946 (*36*) and the beginning salary for fully trained inexperienced case workers generally in 1948 (*55*).

In a 3-month period in 1947–48 salaries offered for six positions for case workers in a medical center at the Social Workers Placement Service in California ranged from $2,280 to $4,512. The range for a supervisory position was $4,152 to $5,280. In Southern States, salaries for medical social work positions in State agencies in the fall of 1946 were reported to range from $1,500 to $4,200 (*39*). In Illinois in 1948 the range for medical social workers in the State public welfare agency was $2,280 to $3,000; for consultants, $2,940 to $4,380.

These salaries, offered to fill openings, showed improvement over wartime salaries. In 1944 the American Association of Medical Social Workers reported a median salary of $1,836 for medical case workers and one of $2,172 for senior case workers in 50 agencies replying to a salary questionnaire. The report commented on the fact that salaries for medical social positions were frequently lower than salaries for comparable positions in the general field of social work, although medical case workers often had superior training (*2*).

However, a Simmons College School of Social Work follow-up study of the women whom it had graduated with master's degrees from 1936 to 1945 indicated that in 1945 graduates in medical social work were earning as much as other social workers (*24*). Typical was a graduate who began as a case worker in a hospital at $1,200 and who, in 1945, was earning $3,500 as a medical social consultant. Another started at $2,500 and after 6 years was earning $4,200 as director of a social service department. Highest salaries reported by graduates were those of medical and psychiatric social workers employed in the Red Cross or Veterans Administration.

However, reports continued that in some communities medical social workers were leaving hospital positions for better-paying jobs in family agencies. In Cleveland the American Association of Medical Social Workers Chapter in 1947 recommended the following salaries to retain qualified personnel:

> For case workers (with a master's degree in medical or psychiatric social work from an accredited school)—$2,400 to $4,200; for case supervisors with 5 years' experience, including 2 years of supervisory experience—$3,120 to $4,800; for a director of a social service department with 6 years of experience, including 3 years in a medical setting—$4,000 to $6,000 (*7*).

Salaries recommended to the New Orleans Council of Social Agencies in 1949 were similar: $2,400 to $4,500 for medical social case workers, and $4,000 to $7,200 for medical social service directors. The North Atlantic District of the American Association of Medical Social Workers in 1948 recommended a salary range of $2,700 to $3,780 for case workers who had been graduated from a 2-year course in an accredited school of social work, who had special interest in and

adaptability to medical social work, and who, preferably, had specialized in medical or psychiatric social work (*8*).

Salaries often fell below these recommended scales. In late 1946 medical case workers in the city of St. Louis and in St. Louis County were earning from $1,920 to $3,828. Although those in public agencies received the maximum, the average (mean) medical case worker in community chest agencies received $2,268, and in non-chest agencies, $1,980 (*56*). Case work salaries in 30 voluntary hospitals in Boston were reported in 1948 to range from $2,000 to $2,800; while in 1946 in 22 of the voluntary hospitals in New York City salaries for case workers, including allowances for such meals as the hospital furnished, ranged from $1,980 to $3,600. For supervisors the annual salary in New York voluntary hospitals ranged from $2,392 to $4,560; for directors of social work, from $2,400 to $6,720. Among Government hospitals in New York City, Veterans Administration hospitals paid case workers the highest salaries—from $3,397 to $4,150; city hospitals paid the lowest—from $2,160 to $2,750 (*36*). Under the American National Red Cross, in military hospitals, the range, including a $300 allowance for quarters when these were supplied, was from $3,036 to $4,152. The salaries of directors of social work in Government hospitals ranged from $3,290 in city hospitals to $5,905 in a large Veterans Administration hospital.

In 1949 salaries paid medical social workers in the Federal service ranged from $3,825 up to $9,800. (For minimum requirements for beginning positions in the Public Health Service, District of Columbia government, and Veterans Administration, see appendix, p. 47.)

For many years the hours of work of social workers in hospitals, which, of course, operate 7 days a week and 24 hours a day, were longer, more uncertain, and on a less desirable schedule than those in social agencies. However, most hospitals in 1949 had achieved regularity in the schedules of social work staffs. Many had a 38-hour week, the maximum workweek recommended by the American Association of Medical Social Workers; compensatory time off for Saturday, Sunday, evening, or holiday work had become customary. In 28 voluntary hospitals in New York City in 1946, 17 departments had a workweek of 38 to 38½ hours; in the remaining, the range was from 35 to 40 hours. Twenty-two of the hospitals provided for 1 month's paid vacation or its equivalent. Sick-leave provisions were less standard, retirement provisions less customary (*36*).

Advancement has been relatively easy for women to obtain in this field in which the supply has been short and top positions are held by women. There have been almost no men in the field until recent years. The number of men has been increasing, however, as public

Figure 13.—The head of the medical social service department discussing medical-social problems with postgraduate nurses.

health and the Veterans Administration programs have opened up greater possibilities for consulting and administrative work.

After several years as a case worker, a qualified woman may become a case work supervisor, assisting less experienced case workers and participating in the training of students from schools of social work in medical social case work or in the teaching of medical students, dietitians, or nurses. Or she may direct a small social service department in a hospital. Directing a large social service department that employs up to 50 workers is the top job in the hospital field. There are also administrative positions relating to groups of hospitals, as in the Public Health Service and the Veterans Administration.

A position as medical social consultant is usually the top job a medical case worker may reach in public health and welfare agencies, although in some large agencies there are supervisory and teaching positions as well as administrative jobs as directors of social service divisions. Research and teaching jobs in medical social work are areas in which the remuneration is usually higher than that of the case worker but generally lower than that of an administrator of a large department or division.

The relatively high ratio of supervisors and directors to case workers encourages advancement. In 52 New York City hospitals in 1945 there were 2 directors and 1 supervisor for 11 case workers (*37*). The wartime study of medical social work personnel made by the Office of Defense Health and Welfare Services in 1942 found 2 directors and 1 supervisor for 7 staff workers in hospitals. In State and local health departments and other nonhospital agencies the ratio was 1 director, 1 assistant director or supervisor, and 1½ consultants to 6½ staff workers (*69*). In 1947 the American Association of Medical Social Workers, in a partial study of medical social service departments outside Federal agencies or the Red Cross, found 2 directors and 1 supervisor or consultant for every group of 7 case workers (*3*).

Although the largest number in this field, as in others, are found in the lower ranks, at least one-third usually are above the beginning grade. More than one-third of the medical social workers in the American Red Cross in 1949 held administrative or supervisory positions. This was also true of another large employer of medical social workers, the Veterans Administration. Some social workers, in spite of opportunities for supervisory and administrative work, prefer to continue on case work positions, using their growing skill in direct service to troubled individuals.

ORGANIZATIONS

The professional organization of social case workers in a medical setting is the American Association of Medical Social Workers. Many in addition belong to the more inclusive American Association of Social Workers, and some, qualifying also in the psychiatric specialization, belong to the American Association of Psychiatric Social Workers.

The American Association of Medical Social Workers, organized in 1918, had as of January 1949 a membership of 2,555 women and 5 men in the United States and its territories and a membership of 38 in Canada. Membership eligibility is based on educational requirements. (See appendix, p. 48.) Medical social workers in foreign countries who can meet these requirements are eligible for membership.

The purpose of the organization according to its bylaws is "to promote the quality and effectiveness of social work in relation to health and medical care." The Association maintains a national office in Washington, with a full-time executive secretary, a half-time educational secretary, and a small administrative staff. The membership is geographically distributed into 16 districts and 5 less formally organized units, or regions. The executive secretary is responsible for administering the Association's program, for coordinating district

and region programs, and for cooperation between the Association and affiliated health, medical, and social organizations with similar interests. Planning program and formulating association policies are the responsibilities of the executive committee. The content of the program is largely the work of study committees in the areas of practice and education, and of special committees created to meet particular situations. The educational secretary, in cooperation with the American Association of Schools of Social Work, consults with schools about the development of a medical social curriculum, as well as with schools having established courses. The Association's annual meeting is held once a year at the time of the National Conference of Social Work.

There is no national union in this specialized field, although some medical social workers in public hospitals belong to the C. I. O.'s State, County and Municipal Workers of America, to the A. F. of L.'s American Federation of State, County and Municipal Employees Union, or to the independent National Federation of Federal Employees.. Some in private agencies have affiliated with the Social Service Employees Union of the United Office and Professional Workers' Union of the C. I. O.

SUGGESTIONS TO THOSE CONSIDERING TRAINING FOR MEDICAL SOCIAL WORK

The American Association of Medical Social Workers asks those who are interested in this field if they are: naturally interested in people, able to assume responsibility, flexible, imaginative, sympathetic, tolerant, well-poised, happy, and healthy (*6*). These characteristics are considered important in most social work positions. Some interest tests now include an area of social service, so that it is possible to compare your interests with those of successful persons in social service and with those of successful persons in other fields of work. If others often come to you for help and advice and if, further, you can face illness and physical disfigurements in others with equanimity, you might find happiness in medical social work, provided, of course, you can develop the other qualifications for it. One of these is an understanding acquired through training and experience of why individuals act as they do, and how these actions relate to their illness.

A medical social worker must also acquire skill in working out problems in close daily cooperation with other professional persons, particularly with the physician, who is always the leader of the team on which she works. She must understand the ethics and practice of such related professional fields as medicine, nursing, and dietetics, in order to work effectively with others for the welfare of the patient.

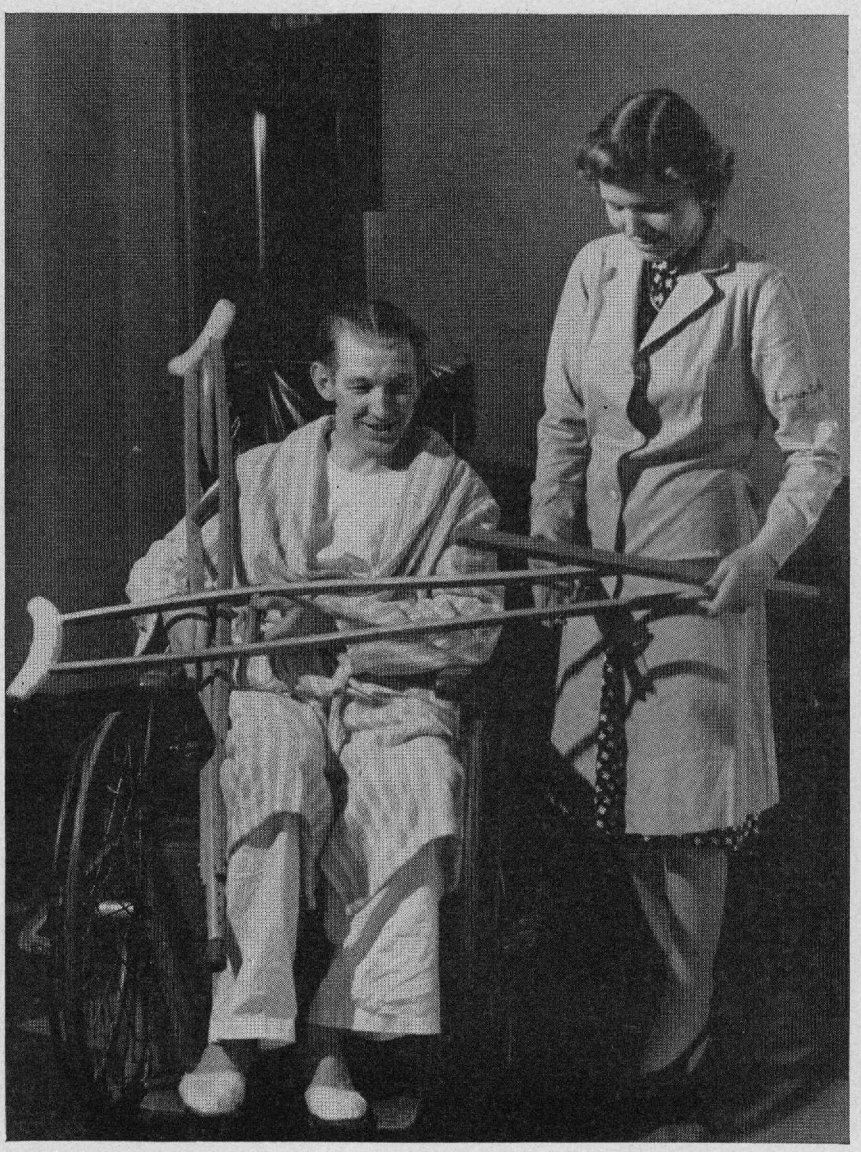

Figure 14.—A social worker encourages patient to learn to live with a handicap.

Practically everyone in this field stresses adequate training as essential for success. In spite of this, 15 or 20 college graduates with a little training in sociology or perhaps a major in social science, but without any specialized training in social work, apply every week or so at New York hospitals for social work positions and cannot understand why they are not immediately accepted. For those who

cannot obtain 2 years of graduate social work training before employment, plans for completing the training through scholarship or work-study arrangements within a limited period of time are recommended. Some schools of social work limit the amount of time allowed for completing requirement for a degree. Thorough case work experience before taking a supervisory job is considered important, although, because of shortages, recent graduates of schools of social work in 1949 were often offered quick advancement to such jobs.

No rigid requirements have been set by the American Association of Schools of Social Work for undergraduate preparation that would correspond, for example, to the premedical or prenursing curricula required for entrance to colleges of medicine or collegiate programs of nursing. However, a sound foundation in general education, a concentration in the social sciences and closely related fields, and some orientation to the field of social work through a course or courses with social work content have been recommended (*9*). Individual schools vary in their requirements. Some heads of schools say they prefer to accept persons with varied backgrounds, and that those who have majored in art or English may be as acceptable as those who have majored in social science. On the other hand, one school in 1949 specified as an entrance requirement 20 semester hours in the social and biological sciences, including 6 semester hours in biology, anatomy, physiology, chemistry of foods, or nutrition. Some require 30 semester hours in the social and biological sciences.

The American Association of Medical Social Workers has listed the following fields in which undergraduate courses are especially useful to those who plan to become medical social workers: Anthropology, biology, economics, education, ethics, government, history, physiology, psychology, philosophy, religion, and sociology (*6*). Some authorities also urge taking available courses in such specialized subjects as social statistics, labor problems, the family, and introduction to social work. More attention is now being given in many colleges to preprofessional preparation, and counselors and advisors are available on many campuses to work out suitable programs. They can also be useful in helping determine your fitness for a field of work that needs many more well-qualified women who will enjoy this means of contributing to the health and welfare of their fellowmen.

Section II

EMPLOYMENT BEFORE WORLD WAR II

In Hospitals

The demand for social workers in hospitals grew steadily following 1905, when they were first used in Boston, New York, and Baltimore. Dr. Richard C. Cabot, of Massachusetts General Hospital, who early saw the relationship of the patient's physical and psychological environment to his disease, is usually given credit for being the first to add social work to the functions of a hospital. In 1919 he reported that social work had been started in about 200 hospitals in the United States, some of which employed as many as 40 to 50 social workers (*23*).

Ten years later about 1,500 social workers were employed in about 500 hospitals, according to a study of the American Association of Social Workers (*46*). In 1930 the White House Conference on Child Health and Protection reported medical social service departments in 529 hospitals in the continental United States and Hawaii (exclusive of those in hospitals for nervous and mental diseases) (*72*). However, these represented less than 9 percent of all hospitals (other than those for nervous and mental diseases). They were of all sizes and types, but some types had relatively more departments than others. More than half of the children's hospitals and almost one-fourth of the orthopedic hospitals had social service departments, whereas only 4 percent of the tuberculosis hospitals had them. In the 4,268 general hospitals, which comprised over two-thirds of the total (exclusive of nervous and mental hospitals), only one-tenth had social service departments. The conference reported an unfilled demand for medical social workers, not only in the hospitals where departments existed, but also in those without departments.

During the depression of the 1930's the growth of hospital social service was retarded by budget problems. Nevertheless, in the early thirties, the American College of Surgeons recommended that there be medical social service departments in all large hospitals and that the service be available in the community for all hospitals. In 1941 nearly 3,000 paid social workers were reported employed in all hospitals reporting to the American Medical Association, but some of these were in psychiatric hospitals, and some were not trained social workers although named as social workers in the reports (*34*). Even in Federal hospitals under civil service, some women social workers with specialized training and some without were employed in sub-

professional categories. Many in private hospitals were primarily admitting officers rather than trained social case workers. Many hospitals continued to operate without any social service departments. Some Veterans Administration hospitals were without them, although all psychiatric hospitals for veterans had one. There was, however, a growing demand for trained workers which by 1941 had exceeded the supply. In December 1941, 90 vacant positions for medical social workers were reported by hospitals reporting in an inquiry conducted by the United States Public Health Service in cooperation with the American Hospital Association. Additional vacancies amounting to twice that number were anticipated in connection with planned expansion of facilities to meet defense needs (*49*).

In Other Health and Welfare Agencies

Meanwhile medical social work outside the hospital setting was growing, hastened in part by the depression of the thirties, prior to which there were only two places in the United States where medical social workers were employed in a health department setting. One of these was the Los Angeles County Health Department, where medical social service work was introduced as early as 1927, and where by 1939, 13 medical social workers were working in addition to the director. One devoted full-time to tuberculosis patients, while the others attacked varied medical social problems encountered in the county health districts to which they were assigned (*51*).

The employment of medical social workers in health departments was expanded and stimulated by the provisions for maternal and child health services and for services to crippled children made under the Social Security Act in 1935. The Act made funds available, not only for the employment of medical social workers, but also for their training. By March 1939 all States had established divisions of maternal and child health in their health departments and had developed services for crippled children, usually in the same department (*16*). Although not all States hired medical social workers, and some had only one, others employed them throughout the State on a district basis. Some States, like Illinois and Louisiana, used Federal funds for training additional medical social workers for public health and medical care programs.

Another new area was the employment of medical social workers in public welfare agencies, usually in special medical units. In June 1933 the Federal Emergency Relief Administration authorized medical care for persons on Federal relief. The Cook County Bureau of Public Welfare in Chicago at that time set up a medical relief service with a medical social worker in charge, and by 1939 it employed 28 medical social workers (*45*). In New York State, too, by

1939, about 60 medical social workers were employed in public relief agencies throughout the State, and the welfare commissioners of two large counties and one city were searching for medical social workers to fill new positions. The demand for trained and experienced medical social workers in public relief was reported far ahead of the supply (*53*).

The medical social worker's place in regular, as opposed to emergency, relief programs was recognized by the Federal Government when the Social Security Act provided for the extension of such activities under way in State and local public assistance programs (*33*). Louisiana, where at least one-third of the recipients of public assistance were in need of some type of specialized medical care, was among the States which followed through in 1938 by adding a medical social consultant to the staff of its Department of Public Welfare (*22*).

The varied use of medical social workers in State, county, or city health or welfare agencies was reported in a 1939 joint study made by the American Public Welfare Association and the American Association of Medical Social Workers. Fourteen agencies in the East, Midwest, and West were studied, and 129 social workers with medical social training were found employed by them in the following types of service: medical care to recipients of public assistance; services to crippled children; services of a public health and preventative nature in cancer, tuberculosis, and venereal disease control; maternal and child welfare; aid to the blind; and in health units in a decentralized health department service. In all the public health and specialized programs, with one exception, the services were directed by a physician. This was also true of most of the medical bureaus in public assistance agencies. Of the social workers with medical social training employed in the health and welfare agencies studied, 10 were assigned to hospitals, 101 were regular staff workers in the agency, 13 were supervisors and consultants, and 5 were directors of social service. The preceding decade, according to this report, had seen a great increase in the recognition of health factors in the administration of public welfare, an extension of health department facilities to include curative services to groups with special handicaps, and the establishment of special commissions for service to such groups, all of which resulted in the employment of medical social consultants in these services. Even in the face of reduced budgets, Chicago, New York City, and Los Angeles County had increased their medical social personnel (*51*).

In December 1941 the United States Public Health Service reported 26 budgeted vacancies for women medical social workers in State and local health departments and 122 additional vacancies for women in planned expansion of facilities. In these agencies, also, medical social

work positions were opening up for men, 6 immediately and 24 in the anticipated war expansion (*49*).

Paralleling the development of special programs under public auspices for persons with disabilities was the introduction of medical social work in voluntary agencies interested in prevention and cure. The National Society for the Prevention of Blindness, for example, added a medical social worker to its staff to aid in the development of medical social service in public and private eye clinics. The National Foundation for Infantile Paralysis and the Cancer Society were others typical of this group.

In Teaching and Research

At the outbreak of World War II there were 13 schools of social work offering graduate training in medical social work approved by the American Association of Medical Social Workers. Each of these schools employed at least one full-time faculty member to train students specializing in medical social work. Many practicing medical social workers were teaching part time in cooperation with schools of social work. In 1939, 14 separate projects were reported in which medical social workers were teaching in medical schools, usually in association with medical instructors (*18*). Sometimes medical social workers cooperated in hospital and medical research projects involving medical-social factors.

Most of the teaching and research in this field was done by social workers whose major function was the practice of case work or the administration of a social service department in a hospital setting. The growing shortage of staff workers placed a limit on their time for teaching, in the face of greater need for instruction.

Altogether, there were probably about 2,250 social workers employed in hospitals and other medical settings in 1940, exclusive of those in psychiatric hospitals. The United States Census of 1940 found 300 men and 2,680 women social and welfare workers in medical or other health services (*64*). Probably one-fourth of these were in psychiatric wards, hospitals, or clinics, since another 1940 report of the Census reported more than 500 full-time social workers in mental institutions in the United States, excluding those in military, county, city, and private hospitals, and in the psychiatric wards of general hospitals (*63*). Although hospital admitting officers were classified by the United States Census as social and welfare workers, their number in the group was probably offset by those who worked in medical or health units within an employing organization that was given a nonmedical classification by the Census. In any event, it is certain that there were at least 2,000 social workers in medical settings in 1940 and, more probably, some 2,250.

WARTIME CHANGES IN EMPLOYMENT

The shortage of social workers trained to work in a medical setting was intensified by World War II. The initial impact came from Army and Naval hospitals, for which the American Red Cross supplied case workers. The expansion was so sudden and so great that the Red Cross found it impossible to limit its hospital staff to case workers who had worked or been trained in medical or psychiatric settings. The staff of 94 medical and psychiatric Red Cross social workers in Army general hospitals and in Naval hospitals at the outbreak of World War II was increased by 1944 to 1,083 case workers on duty in domestic military hospitals alone, of whom about 270 were trained medical social workers. An additional 281 social workers were working in overseas hospitals, where the number grew to 445 a year later and included from 70 to 75 medical social workers. About 345 social workers trained in a hospital setting for medical social work were thus drawn into military hospitals during the war. The Veterans Administration, too, expanded its staff of psychiatric and medical social workers, from 94 before the war to 115 in December 1944. Of these, 113 were women, and more than half were employed in general medical or tuberculosis hospitals or in domiciliary

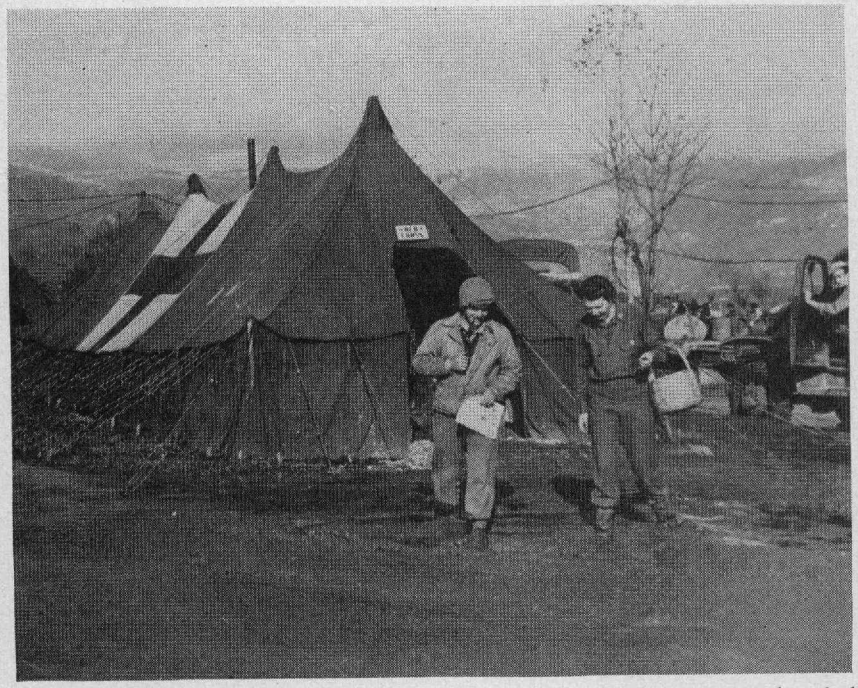

Figure 15.—A medical social worker on war time duty at an evacuation hospital in Italy.

homes, while the remaining were in neuropsychiatric hospitals or regional offices. Unfilled positions continued to exist in spite of all-out efforts at recruitment.

Other special demands stemmed from such wartime programs as the emergency maternity and infant care program for the wives and babies of servicemen, the medical care of merchant seamen, the relocation of the Japanese-Americans, and the social protection and venereal disease rapid treatment program.

Some of these programs employed relatively few social workers, but, combined, they swelled the drain on the already short supply. The United Seamen's Service Medical Division of the War Shipping Administration, set up in major ports to serve seamen on ships carrying the United States flag, included not only a physician but a medical social worker in each unit. At least 16 persons were employed under the title of medical social worker in 1944 in this program, which was supervised by a woman (*27*) (*48*).

The Social Protection Division of the United States Federal Security Agency urged that medical social services be provided by agencies operating venereal disease clinics, which numbered more than 3,700 in 1944, and by centers giving rapid treatment therapy for venereal diseases (*59*). Sixty of these rapid treatment centers were in operation in 1944.

Medical social workers were also used in cooperation with Selective Service. Although most of this work was done by trained workers on a volunteer basis, workers were sometimes loaned on a full-time basis by local agencies, and some were attached to the information staff at the induction center (*40*) (*73*). More than 300 volunteer medical social workers participated in a New York City project sponsored by the North Atlantic District of the American Association of Medical Social Workers to interest men rejected from military service in remedying their physical defects (*57*).

At least three medical social administrators served the Navy as WAVE officers, and undoubtedly some from this specialization were among the 80 WAVE officers who were professional social workers at the time of their assignment, but whose special field was not recorded. There were no medical social work positions as such in any of the women's military services during World War II.

Early in World War II concern over the growing shortage of social workers prompted the Family Security Committee of the United States Office of Defense Health and Welfare Services, in cooperation with the American Association of Medical Social Workers, to send a questionnaire in 1942 to all members of the Association who were directing medical social work programs. Four hundred and eight medical social service units, in 41 States, the District of Columbia, Hawaii,

and Puerto Rico, were covered by the replies. Almost 2,000 medical social workers were employed full time in these units, 55 percent of them in Federal, State, or local governmental units. (See table 3.) Seventy percent were case workers; the others were in administrative, supervisory, or consulting positions. Vacant positions in these units totaled 251, three-fourths of them in Government units. Eighty percent of these vacancies were staff positions; 20 percent represented supervisory, consulting, or administrative work. Estimates of additional positions to be added during the next year totaled 412, of which four-fifths were under public auspices (*69*).

Table 3.—*Medical Social Work Positions Occupied in 408 Medical Social Service Units in the United States, Apr. 1, 1942, by Type of Employer and Position*

Positions	Total	Hospitals		Government departments	Other private dispensaries and clinics	Private health and other agencies	American Red Cross headquarters and area offices
		Government	Private				
Total	1,958	757	762	[1] 331	57	36	15
Staff worker	1,363	524	557	222	40	20	----
Director	331	132	146	27	12	13	1
Assistant director	109	57	28	6	2	2	14
Case work supervisor	86	40	28	15	2	1	----
Consultant	69	4	3	61	1	----	----

[1] Includes 163 in State departments of health, 140 in State departments of welfare, 20 in other State agencies, and 8 in Federal bureaus.

Source: U. S. Office of Defense Health and Welfare Services and American Association of Medical Social Workers (*69*).

In Hospitals

Four-fifths of the social workers employed in the reporting medical units in 1942 were in hospitals, dispensaries, and clinics, and almost four-fifths of the vacancies were hospital positions, more than half of them in Federal hospitals. New hospital positions expected in the following year were estimated at 299, more than 200 of them in Federal hospitals (*69*).

Although the spectacular wartime expansion took place in military hospitals, the fact that vacancies were reported in all types of local government and in private hospitals indicated the growing need for hospital social service to civilians.

In Other Health and Welfare Agencies

Meanwhile, health and welfare programs continued to grow. In 1942 the Office of Defense Health and Welfare Services had already reported 315 full-time paid positions for medical social workers in State or local government agencies in addition to 40 vacancies (*69*). Some of these posts were in programs of maternal and child health services and services for crippled children. In 1943, 40 States em-

ployed medical social workers in such programs, according to the Children's Bureau, which also employed medical social consultants in headquarters and regional offices to supply consultation (*46*).

The demand for medical social workers in State and local government agencies was further increased when, in 1943, the Vocational Rehabilitation Act of 1920 was expanded and physical restoration was added to vocational training, counseling, and other services in rehabilitating disabled persons. War casualties placed renewed emphasis on the rehabilitation of civilians as well as veterans.

In sight conservation alone there was a slowly increasing demand for specially trained social workers. In July 1944 there were 18 official State programs for the prevention of blindness, in addition to those of 29 voluntary societies and 20 State medical society conservation of vision committees (*43*).

In local welfare programs, too, the use of medical social workers continued. The addition of medical social workers to public assistance staffs did not stop with the end of the depression. St. Louis, for instance, added a medical social worker to its public assistance staff to work on cases where, in spite of plenty of jobs, unemployment persisted because of illness or physical disability of the wage earner. In 1942, 30 urban areas of the United States spent more than $650,000 for medical social service rendered in connection with public assistance. New York City appropriated more than $60,000 to be spent in 1 year for "medical social workers in welfare centers, veterans' relief, and nonsettlement divisions" in the Department of Public Welfare, and under the Department of Education (*59*).

Private health and welfare agencies, as early as 1942 had reported 36 positions occupied by medical social workers and 3 vacancies, according to the Office of Defense Health and Welfare Services study. These vacancies probably underrepresented the need, because questionnaires were sent only to heads of medical social service units who were members of the American Association of Medical Social Workers, and private health and welfare agencies were more likely to be under other administrators (*69*).

In Teaching

Although the teaching and training of students in medical social work was declared to be an "essential service," schools of social work found it difficult to retain faculty members during the war, as they were recruited for an array of tasks (*1*) (*50*). In addition, the training programs developed in such agencies as the American Red Cross created an additional demand, both in schools of social work which were used for special institutes, and in the American Red Cross itself, where a training specialist was added to the national hospital service

staff and educational consultants were employed in each of five areas to orient and train both domestic and overseas personnel. On the staff of the Personnel Training Unit for Services to the Armed Forces, three medical or psychiatric workers were employed full time, in addition to others who were used for special lectures.

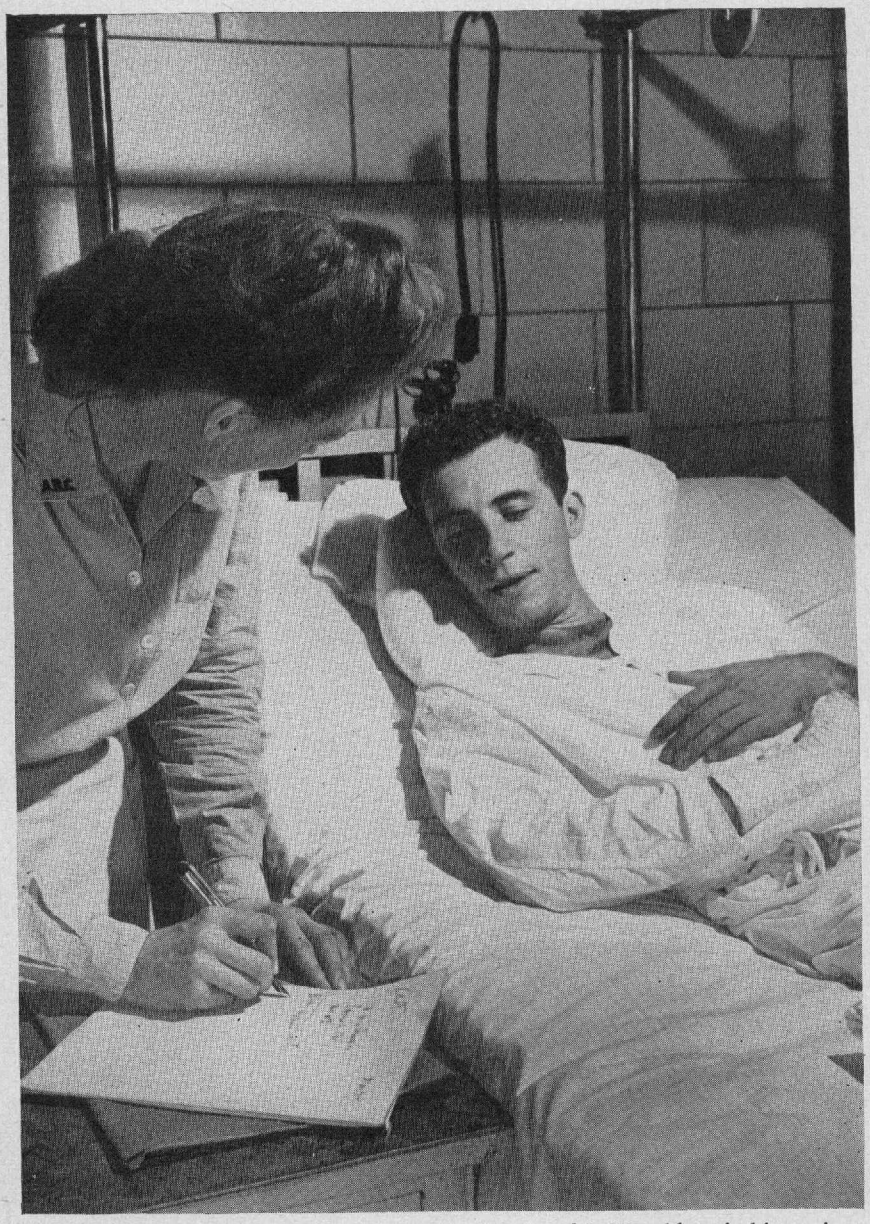

Figure 16. —A Red Cross medical case worker stationed in Naval hospital interviews patient for social information that will aid physician in planning treatment.

The drain on the teaching group of medical social workers, however, was small compared with the loss of medical social workers to hospitals, where shortages of all personnel became alarming.

Efforts To Increase the Supply

During the war the American Association of Medical Social Workers cooperated with other professional membership organizations in the field of social work in efforts to recruit college graduates, as well as persons who, with refresher training, might become available for wartime service. The Association also worked with agencies like the American Red Cross in setting up training and scholarship programs which would insure the quality as well as the quantity of personnel needed in a given period of time (*17*).

The American Red Cross scholarship aid program was open to students eligible for the second year course in schools of social welfare offering approved curricula in medical or psychiatric social work. These scholarships, of which 75 were made available annually, provided full tuition and an allowance for maintenance over a period of 1 academic year to those who met the qualifications and who agreed to serve 2 years with the American Red Cross following completion of training.

Later, because of pressing demands, grants were made to beginners for graduate social service study, and the length of required service following completion of training was reduced to 1 year. From December 1, 1942, through June 30, 1945, 207 individuals were trained under this program, about two-thirds in medical social work and one-third in psychiatric social work. The program was continued until August 15, 1947, by which time 475 had completed training and 22 were still in school (*12*).

Attempts to augment the supply also included the employment of less skilled assistance and the extensive use of volunteers. The American Red Cross, for example, employed "hospital workers" (with a minimum of 2 years of college and 2 years of experience in a hospital social service department, or with a college degree and no experience) to do case work on simpler problems under more intensive supervision than that given a case worker. In this category were also some individuals with 1 year of training in social work and no experience.

VOLUNTEERS AND PAID AIDES

Volunteers

Volunteers, to assist social workers by performing some of their nonprofessional duties, were also recruited by the American Red Cross for wartime service, and some have continued to serve since the war.

In 1949 they were being used as social welfare aides. They had to be at least 21 years of age, to have a high-school education or its equivalent, and to supply three references as to their emotional stability, ability to deal tactfully and helpfully with people, and respect for confidential information. Those assigned to hospitals or clinics were also required to present a physician's statement of physical ability to carry out the required duties. Before serving a probationary period of 10 hours, which preceded final assignment to the job in which the volunteer case aide agreed to serve the minimum number of hours of service set by the local chapter, the volunteer was given instruction which covered Red Cross orientation, an introduction to social welfare service, and specific training by the field director in cooperation with the medical and social work staff of the hospital where she was to serve (*13*).

Volunteer case aides have also been used extensively by individual hospitals. Even before World War II many hospital social service departments had used volunteer services for clerical, transportation, and other duties, and a few had been used to assist in certain aspects of case work. During the war, however, when shortages became especially serious, additional volunteers were actively recruited.

An interesting project of community cooperation in recruiting, training, and utilizing volunteers as aides to medical social workers was developed in New York City under the United Hospital Fund of New York and the North Atlantic District of the American Association of Medical Social Workers. After most of the volunteers trained in a 6-lecture orientation course failed to continue service, a 13-week program of theoretical training and practical experience in a hospital social service department under experienced professional medical social workers was developed. Those taking the course were required to pledge at least 240 hours of service within the first year. In the first two groups trained, 56 women, mostly between 35 and 40 years of age, were graduated and placed. Less than one-fourth withdrew before giving service, half of these because of ill health. A full description of the program and its successful operation has been published for use of other communities (*62*).

In 1945 a group of 24 voluntary and municipal hospitals in New York City reported a total of 77 volunteers in social work (*37*).

Volunteers sometimes become interested enough in social work to go to a school of social work, and so are a source of supply of trained social workers, as well as a means of spreading the usefulness of trained social workers by giving them volunteer assistance. Many also render invaluable service on boards and social service committees and aid in interpreting social work and human needs to the community.

Paid Aides

A New York City hospital, Mt. Sinai, since March 1943 has been training paid case work aides to assist case workers with clerical and routine work and to handle simple uncomplicated contacts with patients' families, staff personnel, and agencies. In 1949, with one exception, the paid aides were college graduates, most of whom had taken a pre-social-service course. Other qualifications were: Interest in and warmth for people, emotional maturity and stability, ability to work in an atmosphere of illness without being upset by it, readiness to accept routine and clerical tasks, and intention to stay at least 1 year. Volunteer case aides who did not report daily were also used. At least seven other social service departments in New York City voluntary hospitals in 1946 employed case work aides who were paid, including allowances for meals, from $1,620 to $2,640 a year for their services (*36*). This type of experience, too, offers a try-out opportunity for college graduates who are undecided about training for hospital work.

APPENDIX

Minimum Requirements for Beginning Position as Medical Social Worker in United States Public Health Service and in District of Columbia Government [1]

(As taken from Civil Service Announcement No. 99 (Assembled) issued May 4, 1948, amended September 21, 1948, closed October 5, 1948)[2]

Age: Eighteen years of age or over but under 62 (waived for veterans).

Education and Experience:

1. (*a*) Completion of the following work in a college, university, or school of social work of recognized standing: Two courses in social case work theory and principles, one course in medical or psychiatric information, 500 hours of supervised field work in social case work, and six additional courses in one or more of the following fields: Child welfare, juvenile delinquency, probation and parole, social legislation, labor problems, social group work, community organization, public welfare administration, or social research. (A year of study in an accredited school of social work, including supervised field work, will be accepted as meeting this requirement.) PLUS

(*b*) One year of experience in medical social work;

OR

2. Completion of 2 years of study in an accredited school of social work.

Physical Requirements:

A physical examination is required before appointment. Amputation of arm, hand, leg, or foot will not disqualify an applicant for appointment, but loss of foot or leg must be compensated by use of satisfactory prosthesis. Vision with or without glasses must be sufficiently acute, and near vision, glasses permitted, must be acute enough for reading printed material the size of typewritten characters without strain. Applicants must be able to hear the conversational voice, with or without a hearing aid. Applicants must be free from emo-

[1] In November 1949 the beginning salary on this position was $3,825. A lower grade position at $3,100 a year did not carry the medical social work title; it required only 1 full year of study in an accredited school of social work or a year of experience in social case work following college graduation or 5 years of experience in social case work or equivalent combinations of training or experience.

[2] For more complete and later information consult latest announcements of the Civil Service Commission in first- and second-class post offices.

tional instability and have no history or presence of serious mental diseases. Any physical condition which would cause the applicant to be a hazard to himself or others, or which would prevent efficient performance of the duties of the position, will disqualify for appointment.

Minimum Requirements for Beginning Position as Medical Social Worker for Duty in the United States Veterans Administration [3]

(As taken from Civil Service Announcement No. 60 (Unassembled) issued July 15, 1947, closed August 12, 1947) [4]

Age: Eighteen years of age or over but under 62 (waived for veterans).

Education and Experience:

One year of training in an accredited school of social work, including supervised field work and courses in psychiatric or medical information.

One year of experience in social case work in a health or welfare agency or in the armed forces. One year of training completed in an accredited school of social work, beyond the training used to meet the above educational requirement, may be substituted for this experience.

Physical Requirements:

A physical examination is required before appointment. Duties require moderate physical exertion involving prolonged walking. Arms, hands, legs, and feet must be sufficiently intact and functioning, and vision sufficiently acute, with or without glasses, to perform the duties. Applicants must be able to hear ordinary conversation, with or without a hearing aid. Emotional and mental stability is essential. Any physical defect which would cause the applicant to be a hazard to himself or to others, or which would prevent efficient performance of the duties of the position, will disqualify the applicant for appointment.

Minimum Requirements for Membership in the American Association of Medical Social Workers, 1949

Full Membership:

(*a*) Completion of a full graduate curriculum including a medical social sequence approved by the American Association of Medical Social Workers and developed in a school of social work accredited

[3] In November 1949 the beginning salary on this position was $3,825.

[4] For more recent and complete information consult latest announcements of the Civil Service Commission in first- and second-class post offices.

by the American Association of Schools of Social Work. (See p. 50.)
Or,

(*b*) Completion of a full graduate curriculum with a sequence of courses in social case work in an accredited school of social work, followed by 12 months of supervised experience in medical social work.
Or,

(*c*) Completion of a graduate basic curriculum in an accredited school of social work, followed by 36 months of supervised case work experience, of which 12 months must have been in medical social case work. (NOTE: A proposal to delete this provision will be voted on by the Association prior to April 1950.)

Junior Membership:

Completion of the academic requirements specified for full membership under (*b*) or (*c*), and in the process of completing the experience requirement under the particular provision under which the candidate qualifies.

Essential Elements in Education for Medical Social Work in a Professional School of Social Work, as Recommended by the Education Committee of the American Association of Medical Social Workers, 1949

A 2-year graduate program leading to a master's degree in a school of social work approved by the American Association of Schools of Social Work, including:

(1) Completion of the basic social work curriculum as defined by the American Association of Schools of Social Work, covering:

(*a*) Instruction in case work, group work, community organization, public welfare, medical information, psychiatric information, research, and administration.

(*b*) Four hundred hours of field work.

(2) Instruction covering:

(*a*) Advanced case work, on the second-year level, as applied to the medical setting with special emphasis upon its peculiar features.

(*b*) Group work to provide sufficient understanding of the dynamics of the group process, to enable the student to plan and work effectively with social group workers within the medical setting.

(*c*) Administration including principles as applied to hospital and medical care programs and a social service department as a social agency and also as a unit of a multidepartmental organization.

(*d*) Community organization and related activities.

(*e*) Consultation, supervision, and contribution to education of collaborating professions.

(3) Field work of at least 450 clock hours extending over at least a 6-month period, in a hospital or other agency offering medical care

meeting the standards established by the American Association of Medical Social Workers. This should be preceded by a first year of field work in a social case work agency, not a hospital.

(4) Completion of a research project concerned with medical social subject matter or problems of health and medical care.

Schools of Social Work in the United States Offering Curricula in Medical Social Work Approved by the American Association of Medical Social Workers, July 1, 1949

Boston College,
School of Social Work,
Boston, Mass.

Boston University,
School of Social Work,
Boston, Mass.

Bryn Mawr College, Graduate Department of Social Economy and Social Research,
Bryn Mawr, Pa.

Catholic University of America,
The National Catholic School of Social Service,
Washington, D. C.

Fordham University,
Graduate School of Social Work,
New York, N. Y.

Howard University,
Graduate School of Social Work,
Washington, D. C.

Indiana University,
Division of Social Service,
Indianapolis 4, Ind.

Nashville School of Social Work,
Nashville, Tenn.

The New York School of Social Work of Columbia University,
New York, N. Y.

St. Louis University,
School of Social Service,
St. Louis, Mo.

Simmons College,
School of Social Work,
Boston 16, Mass.

Tulane University,
School of Social Work,
New Orleans, La.

University of California,
Graduate School of Social Welfare,
Berkeley, Calif.

University of Chicago,
School of Social Service Administration,
Chicago, Ill.

University of Louisville,
Raymond Kent School of Social Work,
Louisville, Ky.

University of Michigan,
Institute of Social Work,
Detroit, Mich.

University of Minnesota,
School of Social Work,
Minneapolis, Minn.

University of Pittsburgh,
School of Social Work,
Pittsburgh, Pa.

University of Southern California,
Graduate School of Social Work,
Los Angeles, Calif.

University of Washington,
Graduate School of Social Work,
Seattle, Wash.

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