CHAPTER II

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An attempt has been made in this chapter to focus on the evolution and emergence of Medical social work practice in India and Abroad with the help of secondary data.

In India the Ayurvedic practitioner who ministered as family physicians, in almost all the homes in village, served both as Physician and Social workers.

Hospitals for the care of the sick was the first organized Medical Social Service for general population in India during the Buddhist era, particularly during the regime of the great King Ashoka in the Third Century B.C. Subsequent records are either missing or only scrappy. In 77 B. C. the King Dattargamini established a hospital and provided it with Medical Staff, Medicaments and food suitable for patients and invalids. In first century A.D. the King Nighevasa of Kashmir and the King Hansha of India in the 7th Century are known to have established hospitals with medicine, physicians and staff. In between, in the Fourth Century the King Buddhadisa established institutions called "Wejjosa; in which he himself nursed the sick people. However, the real hospitals were built from the11th Century onwards. During the 12th Century the King Parakram Bahou opened a hospital containing many hundreds of rooms and provided with male and female attendants, good treatment and good foods. The king himself visited the hospital once a week and distributed new clothes to the patients who are ready for discharge. This progress suffered great set back following occupation of India by the Muslims. It was revived during the 19th Century by British.

Health condition at the time of independence:

Medical social workers appeared on the Indian scene half a century after half its debut, on the contemporary western scene. At the time of independence India ranked among the countries of the word which had the highest infant and maternal morbidity and mortality and cross death rates. The death rate was 27.4 per 1000 and infant mortality 162 per 1000 live births, the life span was only 32.4 years for males and 31.7 years for female. The death rate of mothers at the time of delivery was 20 out of 1000 live births. Many more died due to abortion, miscarriage, and sepsis after

pregnancy and also due to toxemia during pregnancy. Malaria alone was responsible for the suffering of 7.5 crore and death of 8 lakh person every year. Next to malaria, tuberculosis was one of the main public health problems in India. As per the estimate mentioned in the Bhore committee report, there were al at least 5 lakh deaths due to tuberculosis every year. It is difficult to estimate the number of tuberculosis patient since the diagnostic facilities were limited and there was no systems of reporting morbidity. Leprosy was yet another public health problem which was a concern. In addition there were the enormous problems of under nutrition and malnutrition. India was among the lowest per capita calorie consuming countries in the world

Heath facilities, both curative and preventive, were far from satisfactory, as is revealed from the following : there was only one Doctor for 63 ,000 person one nurse for 43,000, one heath visitor for 4,00,000, one mid-wife for 6,00,000 woman and 0.24 beds for thousand population. All the Government and local body hospitals were situated in urban areas leaving the whole rural population at the mercy of private practitioners and quacks of various systems of medicines. There were only 25 medical colleges with admit potential of 2500 annually, Para medical staff trained during the period were much below the requirement.[1]

At the down of independence it became clear that planning as tool was essential to overcome deficiencies in the health service schemes. Besides in a scarce economic, with limited resources, the government had the role of planning the health delivery services as per the order of priority of the country the government of India appointed Bhore committee in 1943 to survey the then existing conditions and health originations in the country and to make recommendation for the future development. A reference to it was officially mentioned in 1946 in the Health Survey and Development Committee's (Bhore Committee) Report recommending appointment of trained hospital social workers in the following words, "we have little doubt the general efficiency of all the large hospitals in India will be greatly influenced by appointing trained hospital social workers on their staff as has been the experience recently in Great Britain and America". This impetus for the development of Medical Social Work in India was also received from other developments in the field of Medical Service. Following the Bhore Committee's Report the newer concept of social and preventive medicine entered into field of medical education in India as also in other parts of the world, Medical Social Work being considered as one of its essential component. Similarly the medical and health services in the country began to feel in an increasing degree the importance of Psychiatric Medicine as a result of

which many hospitals particularly the teaching once established Psychiatric Clinics both as part of teaching programme as well as of service.

The committee reviewed the nation health under:

1) public health
2) medical relief
3) professional education
4) medical research
5) inter national health

Recommendations of Bhore committee:

The report of Bhore committee was published in 1946 before India independences. Its recommendations were as follows.

a) No individual shall fail to secure adequate medical care because of in ability to pay for it.
b) In view of the complexity of modern medical practice, the health services should provide when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnoses and treatment.
c) The health services must, right from the beginning lay special emphasis on preventive work.
d) The need for providing medical relief and preventive health care to the vast rural population of the country is very urgent.
e) The health service should be placed as to as possible to the people in to the community, i.e. the target group.
f) It is essential to secure the active co-operation of the people in the development of the health programme.
g) The report in this long term programme recommended a primary health unit for a population of 20,000, a secondary unit for a population 6, 00,000 and a district headquarters organization for a population of 3 million. In its short term programme the committee recommended a primary unit for a population of 6, 00,000 and a district headquarters for a population of 3 million.
h) A three month tanning in Preventive and Social Medicine to prepare social physicians who would guide people towards a healthier life.
i) Training of 500 hospital Social Workers.

The Bhore committee while giving recommendation about professional education divided the topic of professional education under 2 heads.

a) Certain general question to the subject of professional education which call for preliminary notice and
b) Specific proposal in respect of education for the following types of health personnel:
   i) Medical education
   ii) Training of dentistry.
   iii) Training of pharmacology
   iv) Training of certain types of public health workers
   v) Training of nurse and midwives
   vi) Training of hospital social workers
   vii) Training of technicians

Recommendation on functions of Medical Social Worker according to Bhore committee:

a) Discovering and making available to the medical staff, any factors in the patient environment that may have any bearing on his physical conditions, thus supplementing medical history with social history. This would include any facts of heredity, personality, manner of life, home environment, worry about finances, dependents, characteristic of employment and strains and hazards incidental, recreations and standard of living generally, in short all facts that influence diagnosis.
b) Influencing and guiding patients in carrying out treatment, making the physician's directions simple and concrete and helping them to carry out the plan of the treatment through to completion.
c) Over coming obstacles to successful treatment or recovery particularly in the out patient department, and during convalescence. Under this head also, it may be necessary to see that medical and surgical supplies (instruments, spectacles, dentures etc.) are secured, that social and economic conditions affecting the patient adversely are corrected and that as far as possible , a situation favorable to recovery is secured. This last may mean new employment, temporary financial assistance, relieving patients of responsibilities for care of

children, special assistance with food etc. It will also include the provision of a sanatorium or convalescent treatment where advised by the medical staff.

d) Arranging for supplementary care pf patient. This and the next duty will require a thorough knowledge and the powers and duties of all the available social and health agencies of the country.

e) Educating the patient in regard to his physical conditions in order that he may batter co-operate in the program laid down by the physician ; this programme provided not only for the cure of illness, but the promotion of health with a view to the prevention of illness. Without this service much valuable and expensive treatment would be wasted because of its ineffectiveness.

f) Discussing with patients there resources and collecting, if required to do so, their contribution towards the cost of the treatment given.

g) Checking the abuse of hospitals, both as to out patient and in patient, who on examinations are found to be

i) In a position to pay for treatment.

ii) Persons insured under the national health acts, entitled to the services of a panel doctors and not requiring special hospital treatment.

iii) Beyond the power to benefit by any assistance other them that obtainable through public assistance committee.

Besides giving recommendation about duties, the committee strongly recommended the training of these hospital social workers. The committee realized that there was a lack of training facilities.[2]

Training of Medical Social Worker:

During the same period, professional training for social workers was started by Tata Institute of social sciences (then known as Sir Darobji Tata school of social work). At that time two year graduate course were being given, in addition to the pre –professional and general course. This covered the following:

1) family and child welfare
2) Juvenile and adult delinquency
3) Industrial relation and labour problem
4) Administration of social work
5) Medical lecture for social work

6) Medical hygiene and psychiatry for social workers

7) Social and family case work.

The member of Bhore committee had met Dr. Kumarappa, the than director of TISS and had discussion with him regarding the training of social workers. The committee felt that these courses were too specialized and restricted and would require considerable modification and expansion in order to meet the needs of hospital services.

In 1948, specialization in field of medical and psychiatric social work under the leadership of Ms. Gouri Rani Banerjee was begun. Ms. Banerjee brought about an excellent amalgamation of knowledge from the east and west in the training aspect of social work. She had her Ph.D in Sanskrit and had a very good understanding of Indian culture, customs and religion. She had the opportunity of being trained in the USA. She helped her students to understand social problem related to health fields with a scientific perspective.[3] However, trained Medical Social Worker was first appointed by the J.J. Hospital of Mumbai in 1946. In Delhi, the first trained Social Worker was appointed in 1950 in Lady Irwin Hospital. This was mainly a squeal to the influx of refugees, following the partition of country in 1947. Thereafter other hospitals gradually, though slowly, began to appoint them in their hospital staff and subsequently social workers have been appointed in the State Health Services of Maharashtra, Gujarat, Punjab, Delhi, Madhya Pradesh, Andhra Pradesh, Bihar, West Bengal, Rajasthan and Madras. Due to the shortage of fully 2 years trained Medical Social Workers some of the States appointed even partially trained worker or those who are trained in general social work only.[4] There was realization that the medical social worker, to be effective, must have specialized knowledge about people who are physically ill, about their social condition and psychological reactions to illness. The country at this time was going through a critical period. Industrialization affected economic life, there by brining about changes in the roles and relationships of the families. Because of the partition of the country, people had to suffer from unforeseen calamities like the mass exodus from either side causing physical and emotional stress to the people. They required psycho social support, and this was provided by social workers.

Subsequent Committees like the Mudaliar Committee (1961) and the Shrivastave Committee (1975) did not make any mention of Medical social Workers in their report.

Though historically Medical Social Work in India began in hospitals, it has gradually spread over a period of time to Clinics, dispensaries, rehabilitation center, Research institutes, Public Welfare agencies and Community Health Programmes. However, a majority of them still work in hospitals. Due credit must be given to the pioneering social workers who demonstrated the valuable contribution they can make in prevention and treatment of illness and rehabilitation and who paved the way for the growing body of professionals in this field.

History of Medical Social Work in Egyptian and Arabian Countries:

During the Pre-Christian era treatment was given in temples. In 610 A D. John, the Almsgiver opened a Maternity Hospital in Alexandria and other institutions for the sick in Ephesus. Their doors were opened for foreigners, Pilgrims Old people, Cripples, Widows, Orphans, sick persons, lepers and convalescents. In the Arab lands the first hospital and a University were established in 529 A.D. in Jundi-shaper (Persia). By the 10th Century every Muslim town had its own hospital. The great hospital in Cairo was opened 1283 A.D. by Sultan El Mansur. Both men women were cared for in separate rooms where the air was cooled by playing fountains. This hospital had well organized Medical Service with nurses (male and female) kitchen store rooms, dispensary, library, herb garden, latrines room and common room for doctors, story tellers and musicians were employed to amuse the patients. This hospital was opened to the rich and the poor, the free and the bound (slaves) and to men and women alike. Assistance in the form of money was also given at the time of discharge, Doctors also made domiciliary visits and distributed food and medicine. Obviously this hospital had all the components of a modern hospital even as far back as 8th Centuries ago.

History of Medical Social Work in European Countries:

Early Christian Communities built houses called "Hospitia" for the reception of Travelers, abandoned children and sick people. The first Christian hospital was in Rome founded by Fabiola in the 4th Century A.D. when the Churches were authorized to established charitable institutions some of which were also opened to the sick. By the 8th Century several "hospices" (guest house), Lazar Houses (poor house), charitable orders and asylums were built and a group of pro-hospitals under various

Church Orders (e.g. S.T. Mary, S.T.Bavthelmew, S.T. John, S.T. Anthony etc.) were established in Europe and England between the 11th and 14th Centuries. These hospitals had many defects and not until the 17th Century a clear distinction could made between institutions where treatment was provided and those where sheltered were given to the aged, the blind and the poor and not until the 18th Century that the Hospitals in Europe really began to treat acute cases seriously.[5]

In England and America, the concern of Medical Science for the patient as a person, influenced by Social and other factors; and consequently who's Medical Care should include also his social needs, became formalized at the start of this century. Five important stages may be recognized in the development of this new Medical social Work. The first of them dates back to about 1880 when an organization called the Society for After care of Poor Persons Discharged Recovered from Insane Asylum was established in England to keep friendly supervision over the Insane during the process of their readjustment to community life. Such a organization was formed also in New York and these organizations may be regarded as the fore runners of the plan for after care of patients which is now accepted as an important part of hospital social service.[6]

The second and probably the most important contribution to hospital social work came through the organization of Almoners in England. In 19th Century Voluntary Association sometimes were raising funds for helping the helping patents in hospitals or even at their homes. In 1876, many London hospitals appointed Enquiry Officer's (fore runner of Almoners) to enquire about the patient's means, from the point of patient's welfare. In 1894, the New York Presbyterian Hospital appointed paid social workers to serve the babies ward. A recommendation from the House of Lords select Committee on abuse of hospitals in the metropolis, instigation of Sir Charles Loch (1892) led to the first almoner's appointment in (1895). This post occupied by Mary Stewart, on second ment from the Charity Organization Society (now the Family Welfare Association) was set up at the Royal Free Hospital, London. Other hospitals followed this approach employing almoners to assist with high demands and to check needs and resources of the patients, partly to prevent the abuse of charity and party also to help the patient of the poorest class to obtain the prescribed treatment and diet. Their other functions were to promote access, treatment and public health among those in need. Early work centered on maternal and child services. The same year a similar post was created in the Charity Hospital, Berlin and in 1904 the first Post Hospital Relief Service was established at the Presbyterian

Hospital of New York. Next year, a welfare service was started in the Massachusetts General Hospital by Richard Cabot, an orthopedic surgeon, who believed in the interdependence of physical, psychological and social factors and there influence on the origin, duration and after-effects of illness,. He was the first American to realize that a trained person besides obtaining information about financial position of the patient could go to his home and secure information which would be of inestimable value to the patient in increasing the effectiveness of treatment and in even going so far in some cases as to reorganize home. The social worker was to make sure that the good done in the wards is not undone in the first few weeks at home. Some ideas of the scope and usefulness of the work at the time could be had from the report published by Dr. Cabot in 1906. Soon afterwards the Belle Vue Hospital of New York and a few other Eastern hospitals established social service departments.[7]

The work of almoners quickly became professional with the introduction of Hospital Almoners Council to oversee training and recruitment in 1907, and the London School of Economics awarding certificates for training in 1912.

During World War 1, the role of almoners was encouraged in relation to the casualties of war. The 1920 focused again on means testing, but almoners also identified themselves with the emerging social work profession, particularly its work with children. The Hospital Almoners Association was formed in 1922 with 51 members, including those from outside London. The Royal Commission on lunacy and Mental Disorders (1926) advocated a similar system to that of almoners for mental health the genesis of psychiatric social work.

The almoner, a reserved occupation during World War II, was freed by the creation of NHS from financial assessment. The institute of almoners (a registered body formed in 1945) urged the employment of only qualified almoner. The Younghusband Working Party (1959) on training recommended a two years training programme, followed by the 1962 Act to oversee training. In this post war period, almoners developed psychodynamic case work approaches to social problems as well as relating of Medical and social circumstances of patients in general or specialist health care setting.[8]

Thus in the early part of this century both in England and in America a special category of Personnel called "Almoners", a poor replica of the Monastic Almoner of the Middle Age, whose chief objective was to give such aid as could not be avoided at a minimum cost was brought into being. However, there were few who possessed in their make-up Cabot and Loch, some measure of human kindness and who realized

that though driven to seek doubtful charity, these indigent patient needed and deserved protection and treatment as human beings. It is round these kinds of patients that the present medical social service organization in the hospital has grown, and now it has become one of the most important steps towards the most benevolent and beneficial services that the hospital can give.[9]

The third contribution of the development of the hospital social service movement seems to have come from the functions of a visiting nurse. Long before hospital social service was established, a visiting nurse was an accepted part of medical care in the homes of the sick poor. Usually attached to some charitable society, her function in the beginning was regarded as chiefly medical. The provision of skilled nursing to poor patients in their homes when they were discharged from hospital to ensure more satisfactory results from the medical and surgical work done by a hospital. She however, soon discovered that nursing the sick and the poor in their homes was different from nursing them in hospital wards, to make the best medical aid really effective, it was necessary for her take into account the patent's mental, economic and other social problems, thus approaching very closely the field of medical social work.

The forth factor was the social training given to the medical students of the Johns Hopkins University, Dr. Charles P. Emerson of the University believed that the training of medical students must include an understanding by him of the background and standards of living of the patient; he may be called upon to treat. Dr. Emerson's work differed from the present hospital social service in that he was dealing with the education of the medical students not with the chief motive of serving hospital patents. His students used to visit many people who were not sick and thus it is evident that their work had no special application to the medical clinics.[10] Dr. Emerson recognized that truly effective medical training must include an understanding by a physician of the background and the standards of living of his patients.[11] .In 1927, the eminent Dr. Francis Peabody, professor of Medicine of the Harvard Medical School, lectured to his medical students as follows:

"Now the essence of the practice, of medicine is that it is an intensely personal matter, and one of the chief differences between private practice and hospital practice is that the latter always tends to become impersonal when the general practitioners goes into the home of the patient, he may know the whole background of the family life from past experience, but even when he comes as a stranger he has every opportunity to find out what is spoken of as a "Clinical Picture" is not just a

photograph of a man sick in bed, it is an impressionistic painting of the patient surrounded by his home, his work, his relations, friends, his joys, sorrows, hopes and fears. Now all of his background of sickness which bears so strongly on the symptomology is liable to be lost sight of in the hospital. When a patient enters hospital the first thing that commonly happens is that he loses his personal identity. The trouble is that it leads more or less directly, to the patient being treated as a case of mortal stenosis and not as a sick man" In this lecture Dr. Peabody is presenting what he calls the "larger view" of the Medical profession.[12]

The Fifth factor are the notable forerunners in social services for sick people were physician such as Elizabeth Blackwell, whose dispensary developed into the New York infirmary for woman and children and Rebecca Cole, an African American Physician who, in 1866 became a "Sanitary Visitor" (Cannon, 1952), Jane Addams organized a Medical Dispensary at Hull House Settlement in 1893 (Bracht, 1978), but except for isolated instances, social workers were not permitted in hospitals until several years later. One of these instances occurred at City Hospital in Cleveland. During the evolution of City Hospital ,from almshouse to hospital in 1891, Fred Golden Bogen of the Cleveland City Welfare Department was assigned to set up records at City Hospital so that patients could be identified by name and relatives could be notified in case of death (Wagner, 1951). Then in 1900 William Kenny, Director of the City Outdoor Relief Department assisted the Hospital in clearing wards clogged by Chronic patients and by homeless Civil war Veterans thereby demonstrating the value of Social Services to the hospital by freeing beds "Occupied by unwelcome boarders" Kenny also "protested the indiscriminate giving away of the illegitimate babies born at City Hospital on a casual, fit come first served basis.

Concerned about environmental conditions and the life circumstances of their patients, these Physicians invited social Workers into their dispensaries. At Massachusetts General Hospital in 1905, Miss Garnet Pelton and 13 Volunteers assistants were permitted to set up tables and chairs in a corridor known as "The Corner". Dr. Richard C. Cabot assigned these social Workers to the outpatient department to work primarily with mothers and children. During the last decades of the nineteenth century, Boston and other urban areas saw large population shifts, the result of the wave of immigration, particularly from Ireland, Germany and Eastern Europe. Crowded Housing, inadequate nutrition, poor hygienic facilities and economic plight were social problems that Cabot perceived as indivisible from the physical complaints and illnesses presented by the poor in his clinics.

Special mention is always made of Dr.Cabot in history of Medical Social Work. What makes the event noteworthy is not so much the involvement of Social Worker in health care, but rather the legitimism of social work within the hospital system. Prior to that point, first in England, and then in the United States, the nineteenth century settlement movement launched numerous programs and advocated innovative health policies to Combat the danger of pollutants and dirt in the environment. Impure water, vermin, accumulated garbage, poorly ventilated houses, windowless rooms and negligent reporting or no quarantine or cases of communicable disease were all problems attached by health reformers and settlement leaders. By sanctioning the social worker, Cabot opened the door, so they speak to a broader view of patient care. Just two years after social work was introduced at Massachusetts General Hospital, Jane Addams addressed the American Hospital Association, the first time a social worker appeared before that organization of hospital administrators. In as paper entitled "The Layman's view of Hospital work among the Poor", Addams detailed for her audience the "failure of hospital personnel to see the patient as a person". Ida Cannon. Who subsequently became the first Director of Social Services at Massachusetts General, recorded some 35 years later that historic occasion and commented "Her (Addam) characteristically courageous, frankness must have created quite an ordeal for the hospital administrators"[13]

Ida Cannon was responsible for establishing the first Social Work Department in a Hospital in the United States. Convinced that Medical Practice could not be effective without examining the link between illness and the social condition of the patients, Cannon diligently worked at creating the field of Medical Social Work. During her long course she worked as a nurse, a student of sociology, a Medical social Worker, Chair of Social Services at Massachusetts General Hospital, author of Seminal Book in the Medical social Work field, Consultant to hospitals and City administrations, throughout the United States, Professor and designer of a training curriculum for Medical Social Workers. Cannon saw the emergence of Medical Social Work as part of the Progressive movement, because it sought to humanize Medical Practice.

Realizing the need for an education in social Work to add to her training and experience as a nurse, cannon enrolled in the Boston (Simmons) School of Social work. Ida's brother Walter Cannon may have been his sister's original inspiration to study medicine. He had attended Harvard Medical School when Ida was a child and went on to become a World renowned Physiologist. It was through her brother

Walter, that Cannon met Richard Clark Cabot, who was developing a program in hospital Social Services at Massachusetts General Hospital. This was to be the first organized Social Work department in a hospital in United States History.

Ida Cannon began work in the Social Services department as a Volunteer and soon become the department's Head worker. The department operated as part of the hospital's out patient clinic, dealing with health and social issues as varied as unmarried pregnant women and girls, children with orthopedic problems, tuberculosis and venereal disease. Patients at the clinic were often poor immigrants who spoke little or no English. Cannon struggled to ensure that they understood the nature of their illness and prescriptions. With Cabot, Cannon systematically studied patients presenting industrial diseases in Massachusetts General Hospital. In 1915, Cannon was made Chief of the Social Service Department, a position she would hold for thirty years until she retired in 1945. The outstanding success of the Social Service Department brought about its integration into the inpatient services of Massachusetts General Hospital.

Ida Cannon's work at Massachusetts General Hospital constitutes only a fraction of her professional commitment. Determined that Medical Social Work Department exits in every hospital, Cannon traveled around the country giving speeches and meeting hospital directors and Staff.

In order to professionalize Medical Social Work she developed a specialized training programme in conjunction with the Boston School of social Work and her own department at Massachusetts General Hospital. This programs led to the training Cannon felt every Medical Social Worker should have a combination of Medical and Social Work expertise. She held a teaching position within the programme for the rest of her career and advised institutions and hospitals around the country on how to create their own Medical Social Work Departments and training Programmes.

Cannon authored the seminal text of the Medical Social Work field, Social Work in Hospitals. A contribution to progressive Medicine becomes the first comprehensive analysis of the development and principles of the field. She produced comprehensive report on her survey of New York City's Social Service Organizations and needs.

She helped to establish the American Association of Hospital Social Workers and served as President from 1920 to 1922. Cannon represented her profession as delegate to the White House conference on child Health and Protection in 1930 and 1931. She declared in her deeds and words that there should be within the hospital

someone definitely assigned to represent the patient's point of view and to work out with the Physician an adaptation of the Medical treatment in the light of the patient's social condition.

In her desire to share her experience of Medical Social Work, Ida traveled extensively. During the 1930's she presented a paper at the International Conference on Social Work in Frankfut, Germany and also attended the Third International Conference in London. International visitors came to learn at the Massachusetts General Hospital Social Work Departments. Her Leadership as likewise evident in her was preparing others for Leadership in Chicago and Saint Louis as well as with the United States Children's Bureau and in relation to other nations, including China and Japan.

In 1938 Social Workers first began to include social summaries in Medical records. Beginning during World War 2 and growing thereafter were Weekly Conferences between Social Workers and Physicians and Nurses. Her speaking and writing for publication continued to strengthen the development of social work as a profession. The Social aspects of illness were recognized in ways which fostered team work in patient care. Ida Cannon created a durable model of social Work which has spread throughout the World.

In recognition for her labours in successfully building the Medical Social Work field, she was awarded an honorary doctor of Science degree from Boston University and an honorary Doctor of Humanities Degree from the University of New Hampshire.[14] From 1918 to 1932, as bio-medical research led to technological advances and hospitals became strategic centers of Medical Practice, the role Medical Social Work evolved. The American Association of Hospital Social Workers was formed during this period and from 1918 until 1948 focused on developing a knowledge base, undertook a series of practice studies and set a standard for scholarship. In the Mid 1920's the American Hospital association (AHA) produced the first formulized articulation of Medical Social Work. By that time Social Work was established in 300 hospitals. By 1930 the number of more than 1000 some with only one Social workers and others with as many as 50 Social workers. Cabot's conception that social workers "augment the Physician's treatment of Patients by studying, reporting and alleviating, to the extent possible, the patients social problems that interfered with the plan for Medical Care" was expanded. Two additional roles for Social Work were defined – i) to serve as liaison between physician and patient and between physician and community resources required for supplementary care and

ii) to enlist co-operation with the medical treatment plan through patient education. Demand for Medical social Workers grew with the passage of the federal Emergency Relief Act of 1933 and the Federal Security Act of 1935 and the establishment of the Federal Crippled Children's services, which included Social Work Services.[15] Within a few years first at Bellevue and then at Johns Hopkins, other hospitals began to include social workers whose chief role was that of interpreter between patient and physician, patient and hospital. Hospital Social Service department have flourished since their initial beginning, so that today some 75 percent of the hospitals with more than 200 beds have social service department. Their growth and the leadership provided by their directors are still another fascinating chapter in the history of Medical Social Services. Although it is beyond the scope of this Chapter to detail that history, the social work in health care should be familiar with the leader who helped to shape medical social work: Many Antoinette Cannon, Edith Baker, Janet Thoentan Eleanor Cockrell, Elizabeth rice and for conceptualizing Medial social Work practice, Gardan Hamilton and Harriett M. Bartlett.

Paralleling development of Medial Social Work, Psychiatry turned to Social Workers for help in understanding the relationship between emotional factors and the individual problems in coping with the environment, problems that resulted in difficulties on the job, discontent within the family, and dissatisfactions with inter personal-relationships. As early as 1910, two years before they opened the doors to the first patients, Boston Psychopathic Hospital included social service as part of initial plan when the hospital opened in 1912 under the directorship of Dr. E.E. Southard, Mary C. Jarrett was appointed Director of Social Service. Miss Jarrett developed the first in service program for special social work training, introducing a new term psychiatric social work. Quoting from "The Kingdom of Evils" coauthored with Dr. Southaral, Miss Janett said...

"We claim no novelty or originality for the social work of the Psychopathic Hospital, but rather, we would claim to have created the part that the social worker is to play in the mental hygiene movement and to have given it a name psychiatric social work. The bases of this new division of social work are the principles common to all forms of social case work. It is the application of old methods in a new field. It will, we expect, develop some new methods, which will in time be applied in the older fields."

Her definitions of the functions of the psychiatric social worker still have relevance for practice today. Had her vision of social work function been adhered to, subsequent narrowing of the workers perception of role psychiatric settings and with

in the clearage that followed between the Medical and psychiatric Social Worker might not have occurred. Janett emphasized.

1. dealing with social problems
2. working with the patient for return to community and normal living
3. Assuming executive duties for the purpose of efficient management.
4. Educative functions in the community, including the promoting of an understanding of mental illness.
5. Research.

It was Jarrett's early training of social workers at Boston Psychopathic Hospital that paved the way for the introduction of first course in Psychiatric Social Work at Smith College in 1918. However, even before formal courses were introduced into Schools of Social Work, Psychiatric Social Service Departments were formed in State Hospital and Psychiatric Clinics. Within a few years the child guidance Movement was under way. The impetus behind the movement was Dr. William Healy's early research (1902) in Chicago with delinquent at the Juvenile court. Then, in 1917, Dr. Healy and Dr. Augusta Bronnerr started a Children's Clinic in Boston under the name of the judge Baker Foundation, the name to be changed in 1933 to the Judge Baker Guidance Center.

Following World War I, the Surgeon general of the United States Public Health Service asked the Red Cross to assume responsibility for organizing social service departments in federal hospitals. Later, the Veteran's administration assumed responsibility for veterans' hospitals.

During World War II,"A Psychiatric Social Work consultant service was established for the Military through the efforts of Maida Solomon and the American Association of Psychiatric Social Workers."

More recently, we have seen an emphasis on primary health care holistic approach to patient care, one in which the physician or health team assesses not only the physical but the psychosocial needs of the patient. With the Social Worker as a member of the team, the model blurs the strong demarcation between Medical and Psychiatric Social Work functions and calls for a health social worker. Such a worker has knowledge abut physical illness and emotional stress and can address the social components of the patent's problem as they affect the patient's Medical and/or Psychiatric complaints.[16]

If we assess the roles and functions of both Medical and psychiatric social Workers, the commonalities and differences are quite clear. As generalization the

"marriage" between Psychiatry and Psychiatric social Work has been less fraught with problems of status and function than that between medical social work. Harriett Bartlett has observed.

'While both Medical and psychiatric social Work function within Medicine, Psychiatric Social Work and Psychiatry seem to be largely within same framework, whereas Medical Social Work and Medicine (in spite of overlapping in the social area) seems to be operating in different frameworks. It has not been sufficiently recognized how greatly the problem of integration of service is increased by the degree of such differences, and at the same time, how much greater is the opportunity to make a significant contribution of something new because of this very difference".[17] Although the hospitals and the medical profession in general were slow to accept this new idea in the earlier part of this century it was greatly stimulated by the following statement published in 1929 in the "Report of Hospital Standardization" of the American Colleges of surgeons.

"The American College of Surgeons, in its survey of hospital is directing attention to the development of Medical Social Service activities in relation to the physical care of the patient before, during and after hospitalization. It is now fully realized that the trained medical social worker, co-operating with the physician in attendance, is of Valuable assistance in diagnosis treatment and follow-up, not to say anything of the many advantages directly to the general welfare of the patients, and to the more efficient administration of the hospital rendering its fullest community service. The Social workers thus becomes an important link in the hospital system, particularly in rounding out the service rendered to the patient".[18]

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