

UNSUNG HEROES – THE STORY OF THE BELLEVUE HOSPITAL SOCIAL WORK DEPARTMENT

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I

INTRODUCTION

Every day throughout Bellevue Hospital a well-trained and highly dedicated staff of social service workers provide a wide range of medically related services that facilitate the timely discharge of patients, ensure continuity of care and enhance the ability of the patients and their families to cope with serious and often life-threatening medical and psychiatric problems. It is hard to imagine the hospital being able to function properly without the presence of these workers. Yet there was a time when the social service department did not exist, a time when patients, the vast majority of whom were poor, in distress and often alone, entered the hospital with no one to provide them with the emotional support or even the most basic services to help them in their time of need. Many of the patients were foreigners, most did not speak English and many had serious psychosocial problems, such as inadequate housing, homelessness, social isolation, illiteracy, racial and religious discrimination and unemployment, that directly affected their physical and psychological health and their ability to effectively cope. However, it was not until 1906, one hundred seventy years after the founding of Bellevue Hospital, that a social service bureau employing paid social service staff was organized to systematically identify, assess, and treat the psychosocial problems of the patients who sought treatment at the hospital. This book is dedicated to all the social workers who, over the years, have provided the services that have improved the lives the patients and have left a legacy of care that is a source of pride to this day.

When the social work department was founded in 1906, its mission was defined by three simple yet profound words: Help, Duty and Service. The primary mission of the social service department was thus set forth: to investigate and relieve the misery and distress that go hand in hand with illness.¹ In the ensuing century, Bellevue Hospital has undergone many changes, yet the mission of the social work department remains the same: to provide assistance for the needy and less fortunate and ensure that every patient, including the poorest and most marginalized, is treated with dignity and respect.

¹ Stelzle, Charles, "Twenty Years of Social Service at Bellevue and Allied Hospitals 1907-1926," page 5.

CHAPTER ONE BELLEVUE HOSPITAL – A BRIEF HISTORY

Bellevue Hospital traces its beginnings to a six-bed infirmary that was part of “The Publick Work House and Home of Correction of the City of New York,” an almshouse that was opened by the City of New York in 1736.¹ The first medical officer was Dr. John Van Beuren. His salary was £100 per year, out of which he was expected to supply his own medicines.² In 1795, the city decided that a new almshouse was needed. The money needed to build the new almshouse was raised through a lottery. With the permission of the state legislature the city aldermen issued eighteen thousand tickets at \$10 each. A “free Negro” won the high ticket, and with the city’s share of 15 percent, the city built the new almshouse.³ The new almshouse was a three-story structure facing Chambers Street; when completed, 622 “homeless, sick and insane” were moved in before the next winter. Over 500 of the “inmates” were immigrants.⁴

After deciding that an even larger almshouse was needed, the city aldermen bought the 150-acre Kips Bay farm for \$22,494.50, and on April 29, 1811, took possession of the fertile acres that extended from Twenty- third to Twenty-eighth Streets and from the East River to Second Avenue.⁵ The new almshouse was not completed for five years. When it finally opened in 1816, the new almshouse was a complex of buildings, which included cells for the insane, forty-one rooms for paupers, and two six-room brick hospitals. The three-story blue-stone main building was 325 feet long, with wings at either end (the north wing for whites, the south wing for non- whites); it was the largest structure in the city. The entire facility was enclosed in a ten-foot-high stonewall, for it was still a prison. The facility became known as the Bellevue Institution.⁶ (The name “Bellevue” was derived from “Belle Vue,” the name of the property where the first Bellevue Hospital was opened in 1794.⁷)

During the year ending September 30, 1825, when the annual cost of running the almshouse had climbed to \$81,500 – better than 10 percent of the total city budget of \$780,400 – the number of its inmates in the institution fluctuated from a high of 1,867 to a low of 1,437 (with deaths totaling 495). Ninety-five percent of the inmates were white and were more or less equally divided between men and women, with genders, like races, segregated in their own quarters.⁸ In 1826, the facility housed 1,366 inmates in the almshouse and 336 prisoners.⁹

One of the visiting surgeons at the almshouse was Dr. David Hosack, who was the family doctor of Alexander Hamilton and Aaron Burr. Dr. Hosack performed the first tying of the femoral artery in America. Another visiting surgeon at the almshouse was Dr. Wright Post, who made the first ligature of the subclavian artery for a brachial tumor, a procedure that had never been performed in America and only once, unsuccessfully, in London.¹⁰

Between June 27 and July 7, 1832, 556 cases of cholera were sent to Bellevue, and by August 8, 334 of these had died. Often forty bodies lay in the dead room at a single time. When the hospital administrator, Dr. Isaac Wood, made rounds, he was obliged to step over the dead and dying. Dr. Wood himself caught cholera, but survived.¹¹

In 1835, the Bellevue Institution took on the function of serving as Manhattan's execution ground.¹²

From 1832 until 1847, the position of resident physician was filled by political appointees, favorites of the aldermen. This was an era of corruption. On First Avenue the fence was only five feet high, and over it both employees and inmates did a lively trade of almshouse property for liquor.¹³

The condition of the almshouse, penitentiary, and hospital was horrible enough in 1837 to shock the sensibilities even of the Common Council and move them to investigate it. The commission appointed had as its members Messrs. P. W. Engs, William A. Tomlinson, Z. Ring, James H. Braine, and Peter Palmer. Their report is to be found in Document No. 32 of the "Records of the Board of Aldermen." The commission found no system, no organization, and except in the women's wards, filth that was almost indescribable. In the hospital there were 265 patients, over half of them "insane." In every room, in every ward there was typhus. There were no medicines, no drugs, not even meal for poultices. At the recommendation of the commission, a former resident physician, Dr. Benjamin Ogden, and his two assistants, Drs. Abram Dubois and David L. Eigenbrodt, were asked to return, which they did, giving their services without pay.¹⁴

During the typhus epidemic of 1847, from sixty to eighty patients a day were brought to Bellevue in wagons, buggies, pushcarts and wheelbarrows. Bellevue treated 1,900 cases. At the time the resident was aided by six assistants, each appointed for one year and without pay. Many of the young assistants did not survive.¹⁵ (Between 1825 and 1884, at least 27 medical staff died in the line of duty at Bellevue. Most of them succumbed to typhus. In one particularly tragic incident, two interns in January 1864 died at the same time while one was caring for the other. One of the interns was 23 years of age, the other 24. In 1825, Dr. Belden died from typhus. Dr. Belden's full name is unknown.)¹⁶

In response to letters published in the *Evening Post* describing conditions at Bellevue, the Common Council appointed a committee of prominent medical doctors to report on the almshouse and present a plan for its reorganization. Comprising the committee were Drs. John W. Francis, James R. Wood, Joseph M. Smith, Valentine Mott, James R. Manley, F. Campbell Stewart, Willard Parker, Stephen R. Harris, Gunning S. Bedford, and Benjamin Drake. They reported a plan that was finally adopted. A board of visiting physicians and surgeons was created and placed in authority over the resident physician. The new board met and organized on November 17, 1847. Dr. James R. Manley was chosen president, Dr. Valentine Mott vice-president, and Dr. John T. Metcalfe, secretary. This board finally separated Bellevue from the almshouse; subsequently the death rate dropped from 20 to 9 percent.¹⁷

In 1853 the sum of \$3,000 was appropriated to replace the “noxious dead-house” with a larger and better building. The building was completed in 1857. It was a brick structure, two stories in height. The upper story was designed as a pathological museum. The museum became the Wood Pathological Museum of Bellevue Hospital, which contained rare, interesting, and unique specimens of anatomical dissections and pathological specimens.¹⁸

In 1855, a new wing to the hospital was built at a total cost of \$60,000; it was formally opened on April 23, 1855. The wing had four stories. A fourth story was also added to the main building and a large amphitheater was built that could accommodate 600 persons. Bellevue was then the finest hospital in the city, with an estimated capacity of 1,200 beds; the lying-in ward accommodated about 250 patients yearly.¹⁹

In 1902, Bellevue Hospital was separated from the Department of Charities and was placed under the board of trustees, headed by Dr. J. W. Brannan. The trustees conducted a survey of the hospital, and determined that there was an urgent need for a completely new hospital. The old almshouse, which contained 718 of the 946 beds, was more than eighty-five years old and was completely inadequate for the needs of the patients and staff. In response to the trustees’ report, the New York City Board of Estimate appropriated a sum of money for a new Bellevue Hospital to cost \$3,000,000, and awarded the commission to McKim, Mead and White – Stanford White’s firm.²⁰

During the nineteenth century, many eminent physicians practiced at Bellevue Hospital. The most dynamic surgeon of them all was Dr. Valentine Mott (1776 – 1865). Dr. Mott performed many medical firsts including being the first in history to ligate the arteria innominata two inches from the heart for aneurism of the right subclavian, 1818 (the patient lived for 28 days). In addition, Dr. Mott was the author of numerous books and papers, including Mott’s Velpeau (4 volumes, 820 pages) and the article, “Removal of Thyroid Body weighing Four Pounds, with Entire Success.” Dr. Mott was the father of Dr. Alexander Brown Mott, who was Professor of Surgery and Anatomy, Bellevue Hospital Medical College, 1861 – 1872. Dr. Mott was also responsible for the introduction of the medical chart as a means of recording clinical information about a patient.²¹

Two other notable physicians who trained at Bellevue Hospital were Dr. Charles Stuart Tripler (1806-1866) and Dr. William C. Gorgas (1854 - 1920). Dr. Tripler was an Assistant Resident Physician at Bellevue Hospital in 1826 and later served as the first Medical Director of the Army of the Potomac during the Civil War. In 1920, the Department Hospital, Territory of Hawaii, was designated Tripler Army Hospital in honor of Dr. Tripler.²² Dr. Gorgas served in the 2nd Surgical Division at Bellevue Hospital in 1880 and later, as a member of the Panama Canal Commission, freed the Canal Zone from yellow fever, making possible the construction of the Panama Canal. In 1914, Dr. Gorgas was appointed Surgeon General of the United States Army.²³

Between 1819 and 1970, Bellevue Hospital⁴ was under the control of six different governing bodies: the Board of Commissioners of the Almshouse (1816-1849), the Board of Governors of the Almshouse Department (1849-1860), the Board of Commissioners of Public Charities and Correction (1860-1896), the Department of Public Charities (1896-1902), the Trustees of Bellevue and Allied Hospitals (1902-1929), and the Department of Hospitals (1929-1970). In 1970, Bellevue Hospital became part of the New York City Health and Hospitals Corporation.²⁴

By the late nineteenth century, the antiseptic method was being rigorously followed at Bellevue Hospital.²⁵ Commenting on Bellevue's commitment to medical cleanliness, an observer wrote: "The drug department at Bellevue annually dispenses for use in this hospital alone about 135,000 yards of surgical gauze, 600 pounds of lint, 3,500 pounds of absorbent cotton, 50 bales of oakum, and vast quantities of drugs, including nearly 1,000 pounds of ether. In the cellar about 75,000 bottles are washed annually."²⁶

Bellevue Hospital also delivered medical care at low cost. In 1904, the daily per capita cost for inpatient care at Bellevue Hospital was \$1.18 per day;²⁷ in 1925, it was \$2.97 per day. In 1925, the per capita cost of outpatient care per visit was ten cents per visit.²⁸ In 1934, the average cost per inpatient day for ward service in voluntary general hospitals was \$6.34; in the municipal hospitals it was \$4.38.

Forty years later, the cost of care was still modest. In 1975, clinic patients paid from \$2 to \$36 per visit, based upon family income and size; the average clinic fee was \$4-\$5.²⁹

Bellevue Hospital was always crowded. In 1853, Bellevue Hospital treated 5,564 patients, almost double the number treated in 1847.³⁰ In 1855, Bellevue Hospital had 200 more patients than its proper capacity.³¹ In 1892, 16,541 patients were treated at Bellevue Hospital.³² That same year, 4,539 alcoholic patients, 3,347 who were men, were admitted to Bellevue Hospital (no other general hospital in the city would accept these patients).³³ In 1903, Bellevue Hospital admitted 27,547 patients; in 1904, 28,925.³⁴ In 1925, there were 46,226 admissions to the medical and surgical wards and 1,926 births in the hospital. Also in 1925, the number of outpatient visits was 308,769 exclusive of new cases, which totaled 76,764.³⁵ In 1930, there were 58,026 admissions. That same year 2,349 children were born in the hospital; the Ambulance Division responded to 13,901 calls; 59,627 treatments were provided by the Physio-Therapy Division; and over 27,813 tons of coal was consumed.³⁶ A staff of 102 interns and 67 doctors, assisted by 692 nurses and attendants, handled a total of 454,552 dispensary visits.³⁷ Commenting on conditions in the Tuberculosis Service, the Department of Hospitals, in its Second Annual Report, noted the following: "There has been a steady increase in the number of patients treated annually.... This increase has, of course, placed an increasing burden on the personnel and facilities of the [Tuberculosis] Service, which are now taxed to their utmost capacity."³⁸

The psychiatric department was also crowded. In 1930, 16,036 patients were admitted to the Bellevue Hospital Psychiatric Department.³⁹ In 1935, 21,056 patients were admitted; of that number, 5,850, or 27.8 percent were subsequently committed to state hospitals.⁴⁰ The 1930 annual report of the Department of Hospitals of the City of New York noted the “tremendous overcrowding, particularly in the Bellevue Hospital Psychiatric Department.”⁴¹ Years later, overcrowding still persisted. In 1965, the average occupancy rate in the Psychiatric Department was 115.3 percent.⁴²

Private hospitals had large caseloads, but in the municipal hospitals, such as Bellevue, the caseloads were much larger. In 1934, 134 hospitals in New York City treated a total of 644,729 inpatients; inpatient days totaled 14,160,367. Of these totals, the 24 municipal hospitals, comprising 18 percent of the total number of hospitals, treated over one-third of the inpatient caseload (222,287 patients) and provided over one-third of the inpatient days of care (5,272,635 inpatient days).⁴³ In 1935, Bellevue Hospital alone admitted 61,920 patients and provided 896,450 inpatient days of care.⁴⁴ The United Hospital Fund reported that between 1930 and 1934, “Service (both the number of patients and patient days) increased in general hospitals under all types of control, all of which has increased their facilities, but very much more in the general hospitals under municipal control than in the voluntary hospitals.”⁴⁵

While the municipal hospitals were operating at almost maximum capacity, the voluntary hospitals had thousands of empty beds. The United Hospital Fund reported that “Throughout 1934, the average number of empty beds in voluntary hospitals in New York City was 6,508.”⁴⁶

In the municipal hospitals, the situation was reversed. The United Hospital Fund noted that “In 1934, ten of the thirteen municipal general hospitals, including those representing over 95 percent of the beds in such hospitals, were occupied to 85 percent of their capacity or more; four of the municipal general hospitals were occupied over 100 percent in 1934. Similarly, seven of the eleven special hospitals under municipal auspices were occupied to 85 percent or more of their capacity, including two special tuberculosis hospitals used to more than 100 per cent.”⁴⁷

Not only was the inpatient caseload disproportionately higher in municipal hospitals, the patients remained hospitalized longer. In 1934, the average length of stay in voluntary hospitals was 12.2 days; in the municipal hospitals it was 17.8 days.⁴⁸ In assessing why paying patients spent fewer days in the hospital than nonpaying patients, the United Hospital Fund concluded, “that economic necessity had an influence in determining the length of hospital care of these patients.”⁴⁹

At Bellevue Hospital, as well as in other hospitals in the New York City Metropolitan Area, many of the medical house staff provided their services without pay. In 1935, 3.9 percent of the attending physicians and 2 percent of the interns in municipal hospitals were paid.⁵⁰ For the medical profession, charity care was considered a duty. In 1843, assistant physicians at Bellevue Hospital were paid nothing.⁵¹ The United Hospital

Fund reported that “Physicians very generally have held that the practice of medicine is not to be considered as a business undertaking, but as a personal professional service to which the poor and the well-to-do are equally entitled, and for which they should be willing to pay according to their means or not at all.”⁵²

After his death on December 10, 1930, Dr. Charles B. Bacon, medical superintendent of Kings County Hospital, was praised for his “thirty one years of unselfish devotion to the care of the sick poor of the City of New York.”⁵³

By the mid-1930s, however, the attitude of physicians on the question of payment for services was changing. In 1934, the Public Relations Committee of the Medical Society of the State of New York adopted a resolution that stated: “Physicians are not concerned with the care of indigents for the purpose of gain, but to render needed service in the prevention and treatment of disease. Compensation sufficient to protect physicians against economic loss is rightfully expected and should be provided from public funds.”⁵⁴

A major event in the history of Bellevue Hospital occurred on September 12, 1940, when the Administration building located on First Avenue and East 27th Street was dedicated by the city. The building, which is still being used today, cost \$3,250,000 and was hailed as being part of the “Finest Hospital in the World.” At the dedication, Dr. S. S. Goldwater, Commissioner of Hospitals, declared, “Bellevue stands as an institution that can compare favorably with any in the world.” That same year Bellevue also dedicated a new Jewish synagogue, a Protestant Chapel and a Catholic Chapel, all located next to one another on the first floor of the Administration building. The Most Rev. Francis J. Spellman, Archbishop of New York, presided at the dedication of the Catholic Chapel.⁵⁵

Also in 1940, the artist David Margolis was in the process of completing a series of nine large murals at Bellevue Hospital. These murals, which are located on the ground floor of the Administration building in an area that served as the main waiting room of the tuberculosis department, are still on display today.⁵⁶

In time of war, as in peacetime, Bellevue Hospital answered the call to duty. During World War One, a unit from Bellevue Hospital, designated by the Army as Base Hospital Unit Number 1, organized a 316-bed hospital in Vichy, France. By August 1918, Base Hospital Unit Number 1 could accommodate five thousand wounded.⁵⁷ In World War Two, another unit from Bellevue Hospital, designated United States General Hospital Number 1, was again sent to Europe. General Hospital Number 1 established a hospital outside of London where they treated patients from the Eighth Air Force after bombing missions over the continent and civilian casualties from the buzz bombing of London. Later, as part of the D-Day forces that invaded Europe, General Hospital Number 1 opened a nearly two-thousand bed hospital in France. In April 1945 alone, the surgeons performed 1,142 operations.⁵⁸

While contributing to the war effort, Bellevue continued to provide health care services to the city's less fortunate at home. In 1945, Bellevue Hospital admitted 7,157 alcoholics (during the same period Kings County Hospital admitted 1,998 and Harlem Hospital 509). Male patients were sent to the 28-bed alcoholic ward and female patients were placed in the general wards.⁵⁹

In response to the critical overcrowding in the municipal hospitals, the city on June 26, 1950, opened a pediatric outpatient clinic at Bellevue Hospital. The clinic, which contained fifty-four separate examining, waiting and treatment rooms, provided facilities for the treatment of 25,000 children per year.⁶⁰

In 1979, a special team of micro surgeons headed by Dr. William Shaw successfully restored the severed right hand of a 17 year-old flutist and the nearly severed hand of a 44 year-old chemical-plant employee, and reattached the left leg of a New York City police officer.⁶¹

In 1987, the city opened a 28-bed psychiatric ward at Bellevue Hospital for severely mentally ill homeless patients.⁶²

Today Bellevue Hospital continues to offer a wide range of health care services for all who require care, regardless of ability to pay, providing what the United Hospital Fund has called "an essential public service."⁶²

CHAPTER TWO MARY E. WADLEY

On March 28, 1925, Mary E. Wadley, Bellevue Hospital's first Director of Social Work, gave a public address on the accomplishments of the social work department during the first twenty years of its operation.¹ The speech provided a remarkably candid, detailed and personal account of the origins, organizational structure, staffing, and accomplishments of the social work department, and included several case vignettes offered by Ms. Wadley as examples of how the intervention of the department made a real difference in the lives of the patients they serve.

Mary E. Wadley became the director of social services through a circuitous set of circumstances. While employed as a school nurse, she first came to the attention of Mrs. John L. Wilkie, a member of the board of managers of the Bellevue Hospital Nurses' Training School. Mrs. Wilkie had gone to Boston to gain first-hand knowledge of the Massachusetts General Hospital social services department, founded by Dr. Richard Cabot in 1905. At Massachusetts General Hospital, Dr. Cabot was utilizing a nurse to provide social services for the patients. Impressed with what she had seen at Massachusetts General Hospital, Mrs. Wilkie persuaded the Bellevue trustees to authorize the salary for a nurse with the requisite qualities and training necessary to perform social service work at Bellevue. After obtaining the necessary authorization, Mrs. Wilkie started looking for a nurse. Finding the right nurse was not easy because very few nurses had training in social services. Mrs. Wilkie consulted Lillian Wald, the founder of the Henry Street Settlement and a leading proponent for community-based medical care, who recommended a nurse named Mary E. Wadley, who at the time was taking care of 1,300 school children in the "Italian" section of the city. Mrs. Wilkie invited Ms. Wadley to tea and told her about the position. Ms. Wadley eagerly accepted the job, which she could organize and develop as the situation warranted since the position was entirely new. Also, as a graduate of the Bellevue training school, Ms. Wadley would be returning to Bellevue, which would be like coming home again. As borne out by subsequent results, the decision to select Mary E. Wadley for the position was well founded.²

For Mary E. Wadley, the Social Service Department was more than just "a mere clearing house." Instead the department served a far more sublime and noble purpose – to intervene on behalf of patients, not as "cases" but as human beings, in order to alleviate their anxiety, ease their suffering, elevate their spirit, raise their morale and thereby reclaim and mend broken lives and create a happier and more productive class of citizens.

In the speech, Ms. Wadley discussed the ravages of alcoholism and the Bellevue's determined efforts to directly confront and solve this serious problem. She also discussed the concept of "service" as the fundamental principle that all social workers should follow and called for creation of several new programs, such as practical training for social service workers, prevention of illness through education, service for vulnerable populations, and research on the effects of illegitimacy on the development of the child.

Reproduced here is the complete text of Mary E. Wadley's address.

"The Story of the Years" by Mary E. Wadley, March 28, 1925

To attempt to tell in twenty minutes the story of twenty years of Social Service in that great world of Bellevue and Allied Hospitals is a bewildering task. I can only skim lightly over it; and may I be pardoned if the first person singular is heard frequently in the narrative. In 1906 I was a Department of Health school nurse with four schools up in "Little Italy," with 13,000 pupils to look after.

One day I received an invitation to take tea at the house of one of the Board of Managers of the Bellevue Training School for Nurses, the late Mrs. John L. Wilkie, from whom I was to hear for the first time of the social service work of Dr. Richard Cabot and Miss Garnet Pelton in the Massachusetts General Hospital in Boston.

It was a thrilling story which Mrs. Wilkie gave me of her visit there to learn of their work, and my first impression was one of wonder that no one had ever thought before of the need of such work as an organized supplementary department of the treatment service in all hospitals and clinics.

Tuberculosis work was just beginning and Dr. Henry Dwight Chapin had his discharged babies at the Post Graduate Hospital followed up by a visiting nurse. Dr. Cabot's work, however, was the first attempt to introduce social work as an integral part of medical work in hospitals.

The invitation which Mrs. Wilkie brought me from Bellevue, my old hospital, was eagerly accepted and I undertook the work then and there. It seems that Dr. Armstrong, then Superintendent of Bellevue, had received a reprint of an article by Dr. Cabot telling of the work being done at Massachusetts General, and he was so impressed by it that he determined to inaugurate this service at Bellevue.

He enlisted Mrs. Wilkie's influence in persuading the trustees of the hospital to establish it. It appealed to them as it had to Dr. Armstrong and social service became an integral part of the institution from which it had splendid moral support ever since.

My first day was spent in visiting Mrs. Wilkie and all the larger philanthropic organizations to establish reciprocal relations with them. On the second day Dr. Armstrong asked Miss Brink (the acting Superintendent of Nurses) to take me on complete rounds of the hospital wards, to introduce me to physicians and nurses and to explain the nature of the assistance I was there to render.

Everywhere the idea was given a most cordial reception and in all these nearly twenty years of service that cordial relationship has been unbroken.

That very afternoon Dr. Satchwell, House Physician of the old Ward 20, called me to my first case, that of a young immigrant girl who had been in the country only two months and whom the doctor felt he could not discharge into the big city with no friends, no funds, no home and an irresponsible temperament. After much difficulty a sister living in the country was located and came for her.

Notices of other cases of very real need of assistance came pouring in until in the first month 110 such had either been referred to me or had been discovered in daily rounds.

Soon the need of an assistant was apparent and the Trustees voted a second salary and an assistant was found. But no sooner was she established than she was drawn away to fill a vacancy in the nursing service.

A second assistant came to fill her place and the same kind of robbery occurred again. At that time we were regarded in some quarters as a frill to the hospital and legitimate prey for other needs.

So, discouraged, I trudged on alone so far as the daily routine went, although devoted volunteer assistance was given in 1907 by Miss Ruth Morgan, who has meant so very much to our work ever since, and who, as general chairman, has for so much of the time come three times a week to our case work conferences; by Miss Georgine Iselin, Mr. Alexander Hadden, Dr. John Elliot, Mr. & Mrs. William Roome and a host of others, to whom I should like to give credit by name. Also in 1907 a group of volunteers from the Free Synagogue offered their services for Jewish patients. Their offer was eagerly accepted for it relieved me of the handicap of trying to do for patients who spoke only Yiddish and whose needs I could therefore not well understand. This group has continued to do a great work ever since under the direction of Dr. Sidney Goldstein and Mrs. Fisher.

In January 1908 an Auxiliary Advisory Committee was formed with Mrs. William Church Osborn as Chairman who gave and continued to give us most generous support, and with Mrs. Elliot Benedict who gave invaluable service as treasurer for sixteen years.

From then on the work developed amazingly.

Sub-divisions were soon formed with members of the original Committee acting as Chairman of the sub-committee, first in the Children's and later in the Psychopathic and Adult Services. Within these services specialties have developed; Cardiac follow-up for return clinics, pre-natal, post natal, etc.

We have been fortunate in having a Finance Committee of business men who have taken a deep interest in our work and who have undertaken to keep our needs supplied – going generously into their own pockets for the purpose of providing a financial secretary to raise our funds.

Harlem Hospital, under Mrs. Lewis Iselin, Fordham, under Miss Mable Choate, and Gouverneur, under Dr. Nan Gilbert Seymour, organized Committees in 1911.

In 1908 a Woman's Auxiliary was formed to support and promote the work with tubercular patients. This same Committee, under the generalship of Miss Blanche Potter, is working today with undiminished ardor. The two Day Camp boats established by the Women's Auxiliaries, one anchored at the edge of the Bellevue lawn and the other at Gouverneur, have accomplished a great work for hundreds of men, women and children from the tuberculosis clinics.

The Settlement House at 306 East 30th Street, also maintained by the Bellevue Auxiliary, has been a wonderful haven for Bellevue tubercular women while awaiting vacancies in Sanatoria.

Our Committees have supplemented the City's work by providing an emergency relief fund which the City's charter does not permit the hospital to furnish, and also extra salaries until now we have altogether a paid staff of 51 workers, all of whom are graduate nurses, and a total privately-paid office force in all divisions of eleven individuals.

Our weekly meetings with the various sub-committees are an inspiration and a great help. Without their enthusiastic moral, and financial support our social service work would have been limited indeed.

Besides the staff members now with us, 240 workers (our Alumnae) have served with us for longer or shorter periods of time. Of these sixty-eight have been or still are holding executive positions; thirteen served in the Great War and five were abroad with the Near East Relief Organization. We have identified ourselves with all local and national organizations of hospital social service workers. Indeed, Miss Rose Johnson and I in 1909 called the first meeting of what has now developed into the North Atlantic District of the American Association of Hospital Workers.

We have taken part in all national and local City exhibits since 1908. We have been a very happy family and realize that we have received in broaden vision and enrichment of spirit much more than we have given. Bellevue has the largest social service department in this country or in the world and yet there are not enough workers even now to cover the needs. We are able to reach only six in every one hundred of the patients who come to the wards and clinics.

By a study made three years ago by Dr. O'Hanlon it was found that Bellevue and Allied Hospitals through its medical and surgical services, without including social service, came in contact with one in every thirty the population in Greater New York.

The development of regularly organized social service departments in New York hospitals in these twenty years has been phenomenal. There are fifty such in Greater New York now and 850 in the United States. First in New York after Bellevue came Mt. Sinai also in 1906; the New York Hospital in 1910; St. Luke's, the Presbyterian, Roosevelt, Vanderbilt, and Lebanon following soon after. The Social Service work in the Department of Public Welfare Hospitals, now under Miss Jessie Palmer as Director, was established in about 1909 or 1910.

Our work is alike and yet not alike, the differing social status of the patients changing the problems encountered.

Many sordid situations confront us in the clientele of the big City institutions.

We have tried to go directly to the mark by doing the common sense things in a common sense way in each case. We have not been satisfied to be a mere clearing house. Where the financial need of a patient has been only a very temporary one it has been the policy of our Committee to meet it (unless he or she is already known to another agency) rather than subject the patient to a duplication of inquiry and visits.

Since the mental, moral and physical are so inter-dependent we have made no great effort to draw the line between general and strictly medical social service. All concern health.

Notwithstanding that policy I find that 250 different organizations have shared this work with us.

During the twenty years of our existence 4,200,000 patients have been treated in the wards and clinics of Bellevue and Allied Hospitals. Our department has rendered assistance of one kind or another to 225,000 of these.

Sometimes that service may have been a very slight one in the effort and time required for it and yet it may have been momentous for the individual in results. In others, watchful care and advice may have extended over a period of years.

A great panorama of patients of all sorts and conditions with every kind of a human problem pass not only before our memory's eye, but hardly a day passes that former patients do not come in for a friendly chat and to tell us what has happened since the early days of our acquaintance. To illustrate, our former head worker at Gouverneur, Mrs. Morse, tells this story of John R, a lad at that time, 13 years old, who was suffering from a tubercular hip when brought to the ward. After a time the surgeon brought him to Social Service saying, "You can do more for this lad than we can. What he needs now is a brace for his hip, plenty of good food and fresh air." Several home visits were made to cramp quarters and dark rooms. John was sent to the country for seven months and improved beyond our greatest hopes. The second summer he was again sent away. At the end of eighteen months he was able to discard his brace. Later, when well enough to work, and having a mechanical turn of mind, he entered a foundry and learned to be a machinist. He advanced rapidly and has become an expert in his line.

He now pays a good income tax, contributes annually to our social service department as he says, "To give some other fellow a chance." He has assisted in putting both his sisters through High School and the family has moved to better quarters. Although ten years have elapsed since we first became acquainted with John we still have friendly visits from all members of the family.

From James T, who was in the old alcoholic ward many years ago with his will to resist temptation strengthened by the interest and faith in him of the social worker, come not only expressions of grateful appreciation of the successful effort but a yearly contribution to our emergency fund. Fifteen years ago Mrs. Elizabeth Lamorte came to our clinic – a broken down nervous cardiac. Deserted by her husband, she was struggling to support herself and three children under fourteen years of age. She was fiercely determined that they should never be sent to institutions, as she had been advised, should be done.

Mrs. Lamorte was of French descent and we soon discovered that she had French fingers and French taste, wholly unsuited to the heavy cleaning she was doing. Temporary financial assistance was given and an

opportunity found for her to make lamp-shade making. Her morale was raised through her pleasure in the work and in a short time she became an instructor in a Fifth Avenue shop earning good pay. We were in constant touch with the family. The children were kept in school beyond the grammar grades. One finished High School and all are a great credit and comfort to her. She recently came in to tell us that she no longer works, that she has moved into a cheerful, new apartment and that she is the home queen and was never so happy in her whole life as now.

Alexander was a sturdy Russian, serving his time in the Russian navy on a ship which came to New York. This was sixteen years ago. He was ill when he arrived but took his shore leave to see the city. He fainted in the street and an ambulance brought him to Bellevue where for several weeks he was delirious and seriously ill with typhoid fever. His ship sailed back without his commandant knowing what had become of him and so he was accounted a deserter.

We had in the Social Service Office a young Russian girl, a protégé of ours, who spoke English and who happened to notice Alexander in the wards.

As a non-resident, public charge, he was in imminent danger of deportation back to Russia when he was ready to leave Bellevue. He discovered this when he saw the agent of the deportation society making rounds in the wards and speaking to foreigners, and he became terribly worried over it since he knew that a return to Russia meant condign punishment because he had apparently deserted before serving his full time in the army and navy, and short shrift would probably be given to his story.

Alexander told the Volunteer of his anxiety and she immediately brought the story to me. A consultation with the doctor showed that if Alexander could get to a convalescent home in the country, where slight dressings would be attended to, he might be discharged at once. He was a fine specimen of earnest, stalwart, young manhood – excellent material for good American citizenship – so between the doctor and social service he was gotten out of Bellevue before the deportation agent's eye lighted upon him.

This is a "tale out of school", and I think that very agent may be sitting in this room now, but as his spirit is perfectly fine in such cases, and as the sin was mine and not his, I know he will rejoice that I did this thing, for Alexander made good in a most commendable way and while later in New York he became a valuable volunteer worker in Social Service. His employment as inspector of dining car service on transcontinental railways took him out of sight, but for ten years he never forgot to send a grateful Christmas message to us. I have lost trace of him since the war. A social worker needs a sense of humor, and that the work has lighter aspects is illustrated by the following letter which was received in response to one of the usual Christmas cards which are sent to members of our cardiac clinics.

“December 26th, 1924. Miss Faul: - I am very sorry to write you but it had to be done.

You know I am not living with my husband Simeon Galotti and why do you write and send him Christmas cards, you know it is not proper. He came and told me you sent him a card, trying to discourage me. If there is any trouble to be made, I will bring this up in court and speak to you. You know right well he is a married man with a wife and child. Writing to him you encourage him along and keep him away from his family. Please do not write to him, write to a single man. He is a good man and belongs with his family but there is someone keeping him away.

Thanking you in advance,

Merry Christmas, Mrs. Galotti”

Another worker received the following in response to a follow-up letter sent asking why a certain patient had not returned to the clinic. The mother wrote, “Don’t bother me any more, my Johnnie is dead.”

Dr. Gregory asked for an investigation concerning home conditions of a bad alcoholic repeater. While attempting to get this information the janitress of the house was interviewed and in response to the inquiry as to whether she though home brew was being made by her neighbor, she replied, “yes, there is, and if you are a good social worker you will go in and tell her that she has no right to charge my husband seventy-five cents a glass – fifty cents is enough.”

One social worker in Bellevue spends all her time in the Admitting office acting as “hostess”. She has time to reassure and to smooth the way for the stranger who is nervous and frightened at his initiation into the big institution.

Among the varied services which she performed, she makes every effort to identify unconscious patients brought in through accidents. A recent case is that of a young man who fell under a subway train and was brought to Bellevue in an unconscious condition. His pockets contained money but no identifying papers. The only mark she could find was that of a shop in Brooklyn where the necktie was purchased. It seemed an utterly foolish thing to do but she telephoned this store stating the circumstances. The proprietor came to the hospital at once. In the meantime the young man had died but the storekeeper recognized him as a customer who had been coming into his store since boyhood and he knew that he must live in the neighborhood. Three hours later he telephoned that he had located the young man’s brother and mother and that they were on their way to the hospital.

In the earlier years of work, indeed up to seven years ago, one great factor in the problems that came to us was alcoholism.

Sitting on our benches, awaiting out attention it was a common sight to see a woman with a black eye, with little children subdued and nervous clinging to her skirts, a poverty stricken family who had fled in the night from a brutal drunken husband. We seldom see this now.

We used to have famous alcoholic wards in Bellevue that were always full. With the adoption of the 18th amendment the character of our problems almost completely changed for three or four years. We almost

never see nowadays a pile of furniture on the sidewalk with a starved dispossessed family sitting on it. Instead, the children are decently clothed; the men are keeping their jobs better and paying their bills. They do not have to pass the inviting door of a corner saloon on payday. The report today, however, unhappily is not so good as in 1919 and 1920, but much better than before prohibition. The record of admissions for a primary diagnosis of alcoholism stands thus: 1910 it was 11, 307, 1920 it was 2,091, 1925 it was 5,935.

In 1915 the Trustees secured an appropriation for two additional workers to see what might be done for drug addicts. Our Committees were greatly interested and were ready to leave no stone unturned to help remove this curse from those who had become its victim.

No trouble, no money was spared. At the end of the first six months we were greatly encouraged – forty-six patients appeared to have really overcome the habit.

At the end of another six months only one of these original forty-six was standing and he too went under later. Unsparing efforts were kept up for a year and a half. At the end of that time we abandoned the effort having been forced to the conclusion that once an addict always an addict, unless one could be placed for along time, perhaps for years, in careful and close custodial care.

About a year ago in reviewing the work of 1924 I was impressed with the marked showing of fewer intensive cases of the types of earlier years. I was much perturbed and felt that something must be wrong with my teaching of the workers or that the many new workers (for we had a 50% turnover) were lacking in vision and were neglecting their opportunities for service.

I called a meeting of the staff and laid the matter before them. Mrs. Nason, our very practical pioneer member, to whose credit were hundreds of patients who had been set upon their feet physically and economically in the fifteen years she had been with us, said at once, “Why, Miss Wadley, we don’t begin to have such rundown families as we used to have.”

Miss MacFetridge who was with us for three years, then left to go to Turkey and Russia with the Near East Relief Organization, with whom she remained for years, and who at this time had returned to the Bellevue work, was asked to compare present conditions with those she had left. She said, “Indeed I find conditions very different. After I had been back here for about three weeks I was discouraged, feeling that the change was in me and that my experience with the awful conditions in the Near East had caused me to lower my standards so that the home conditions here seemed good, but now at the end of three months I know that it is the conditions that have changed and not I.”

The same testimony came from Miss Fling, Miss Abbott, and Miss Betz after their nearly ten years of service and others. Then we fell to discussing the influences that were working these changes for better living and better health and the following community factors seemed to account

for them. 1. Advances in Medical Science, 2. Recent Welfare Legislation: a. Widows' Pensions b. Restriction of Immigration c. Prohibition d. Rent Laws e. Workingmen's Compensation, 3. Safety Devices in Places of Employment, 4. Clinics in Industrial Plants and Health Clinics where now a nurse attends to a cut or bruise before it becomes infected, 5. The Rise in the Economic Level of Labor, 6. Employment Bureaus for the Handicapped which render cripples, heart cases and arrested tubercular patients partially or wholly self-supporting. 7. Many women of families who were obliged to go to work when their men went to war have continued to supplement the family income (Query: Has their absence from the home contributed to the prevalent juvenile delinquency and crime?) 8. The increased number and the excellent work of the convalescent homes, 9. The Work of the Veterans' Bureau, 10. And lastly, but of prime importance the influence of the educational and the preventive work done in the homes by the visits of hundreds of Nurse of the Board of Health, Visiting Nurse Organizations, Relief Organizations, and the Hospital Social Service Workers of 50 New York Hospitals.

Recently much has been said in the press and elsewhere confirming our impression of improving conditions. However, the millennium is not yet just around the corner and much ignorance remains to be enlightened. Many wage earners are living within "a week or two of destitution" as has aptly been said and the toll of the victims of accidents is a huge one. In this connection it is interesting to note that except during the early Spring season when contagion always flourishes, the census of the babies' wards especially runs down to only a handful. It is a rare occurrence now to have a baby brought in with Gastro-Enteritis (Cholera-infantum it used to be called.) Mothers have been taught to take a child early to the dispensary at the first sign of trouble.

Looking forward – I hope the time is not far away when all medical students and pupils will have social service included in their curriculum. Institutionalism will be a rare thing when the human being takes precedence of the "case".

I hope for a practical training course in Social Service with field work in Hospitals for these graduate nurses who have the right personality for it and the right educational background. I hope the day is not far off when every ward service – medical and others will have their evening return clinics where end results may be studied and work completed.

I hope to see prevention take a greater stride through education of both parents – of fathers as well as mothers, also through general health clinics, especially health adolescent girls under the wise and sympathetic woman physician, and another of the same character for boys, with just the right man in charge.

There still remains a need for convalescent homes for rachitic children, for colored patients, for chronic patients between attacks, for borderline nervous patients, and those paroled from state hospitals need an interim place before taking up life in the strenuous outer world.

I would very much like to see a thorough study made of illegitimate children whose mothers have been forced to keep them. Who has ever asked the illegitimate child, the chief victim of the circumstances whether our usual policy of keeping it with its mother has made for its own happiness, highest character or successful life, or, whether these children, grown to manhood and womanhood today and able thoughtfully to speak for themselves, would not wish we had chosen for them, in cases where the mother wished it, the fairer opportunity of an adopted home in an environment in which their lives might have developed without stigma.

Finally let me say – SERVICE is the watchword of Hospital Social Workers. Not in dollars and cents, nor in the number of garments given, nor the quarts of milk measured can we give a resume of the work. Figures give some idea of the volume of work done, but the friendly human service which touches and helps scores of lives can never be expressed in statistics.

Every wage earner restored to the ranks of industry, every good home kept intact, every mother's health safeguarded, every baby saved, every growing child built strong and fine for the future, every cripple reclaimed IS A SERVICE TO THE COMMUNITY. SOCIAL WORKERS IN HOSPITALS ARE TRYING TO RENDER JUST THIS SERVICE.

CHAPTER THREE The Patients

Bellevue Hospital has always provided care for an ethnically diverse patient population. In the early eighteenth century, the infirmary treated patients from Holland, France, Ireland, as well as Native Americans.¹ During the yellow fever epidemic of 1803, only a small portion of the patients admitted to Bellevue were natives and residents of New York: most were immigrants from Ireland and Germany.² In 1904, almost 53 percent of the patients admitted to Bellevue Hospital were foreign born. Their countries of origin included Ireland, Germany, Austria, Italy, Russia, France, Sweden, and Wales. In 1910, classes for Italian and German-speaking patients were started by the Tuberculosis section.³

The ethnic diversity of the patients reflected the demographic make-up of New York City's population. In 1870, over 44 percent of the population of New York City was foreign born. Their countries of origin included Australia, Austria, Belgium, Bohemia, Canada, China, Cuba, Denmark, England, France, Germany, Greece, Holland, Hungary, India, Ireland, Italy, Mexico, Norway, Poland, Portugal, Russia, Scotland, Spain, Sweden, Turkey, and Wales.⁴ Noting the ethnic diversity of the city's population, Jacob Riis in 1890 wrote: "A map of the city, colored to designate nationalities would show more stripes than on the skin of a zebra, and more colors than any rainbow."⁵

Decades later ethnic diversity still remained a major feature of New York City's population. In 1935, the population of 10,863,527 in the New York City Metropolitan Area was 30 percent foreign-born, 28 percent Jewish and 27 percent Roman Catholic.⁶ In 1960, 20 percent of the white population of New York City was foreign born, and 29 percent of the native born white population had parents who were foreign born.⁷

Bellevue Hospital provided medical care regardless of the patients' ability to pay. Medical care, which was provided on a strictly egalitarian basis.⁸ As one observer remarked: "Every patient went through the same admission process, slept in the same kind of bed, wore the same hospital-issue gown, ate the same food, and followed the same schedule."⁹

In certain years, almost no patients paid. In 1924, the total operating expenses for Bellevue Hospital, General Administration and Allied Hospitals was \$3,082,956.48; receipts for the care and board of patients was \$68,423.07; in 1925, total expenses were \$3,072, 639.76; receipts, \$58,922.25.¹⁰

In New York City, indigent patients were the norm. In 1930, 50.4 percent of the hospital patients in New York City did not pay for their care;¹¹ in 30 government hospitals in New York City (23 municipal, 4 state and 3 federal), income from patients was 2.4 percent of total income with tax appropriations accounting for 96.5 percent of total income.¹² In 1934, the number of inpatients unable to pay for their care was 58.6 percent citywide.¹³ That year, 332,452 such patients were admitted to municipal and voluntary hospitals.¹⁴ Voluntary hospitals were allocated money from the city to provide to medical care for the poor. In 1935, the schedules of rates per diem were:

Infants under five years of age, \$1.15
 Medical and surgical patients, \$3.00
 Tuberculosis patients, \$1.75
 Active cancer patients, \$3.00
 Custodial cancer patients, \$1.75
 Orthopedic treatment of children, \$1.40
 Chronic, incurable or infirm patients, \$1.15
 Maternity care, mother and child, \$35.00 per week¹⁵

Although miniscule by today's standards, these payments were a major source of income for private sector hospitals. In 75 voluntary general hospitals in New York City, income from government payments increased from 4.9 percent of total income in 1930 to 10.1 percent in 1934, an increase of 136.6 percent. During the same period, total revenue at these hospitals decreased by 8.5 percent.¹⁶ The rates paid by the city for care of public charges were insufficient to fully offset the cost of caring for these patients, thus removing the financial incentive for private hospitals to care for poor patients.¹⁷

At Bellevue Hospital, patients were treated for practically every disease and disorder known to medical science. In 1798, patients were admitted for yellow fever.¹⁸ In 1832, Bellevue admitted patients with cholera.¹⁹ In 1843, patients were admitted with delirium tremens, erysipelas, typhoid fever, puerperal fever, phthisis, and pneumonia.²⁰ Bellevue dealt with outbreaks of typhus in 1818, 1825, 1827, throughout the 1850s, and in 1861.²¹ There were puerperal fever epidemics in 1857 and 1874.²² In 1930, Bellevue admitted patients with an almost endless list of medical and psychiatric problems including the following conditions: abscesses, lobar pneumonia, chronic pulmonary tuberculosis, cellulites, syphilis, acute bronchitis, acute appendicitis, vertigo, alcohol poisoning, grippe, acute cocaine poisoning, illuminating gas poisoning, chronic opium poisoning, acute salpingitis, chronic salpingitis, cancer of the digestive system, abortion, normal parturition, gunshot wounds, stab wounds, automobile injuries, trauma from falls, unclassified violence, senility, pellagra, rickets, scurvy, gastric neurosis, anxiety neurosis, senile psychosis, arterial cerebral psychosis, general paralysis of the insane, alcoholic psychosis, manic depressive psychosis, schizophrenia psychosis, psychosis unclassified, mental deficiency, insomnia, hysteria, hypochondriasis, pediculosis, unknown tumors, unknown diseases.²³

Patients were also admitted for seemingly innocuous conditions such as blood donation, normal child infancy, no disease and malingering.²⁴ In 1892, a visitor to Bellevue Hospital wrote: "The twelve hundred beds are always full. Every form of malady that can afflict mankind is seen in these wards in which a constant weeding – out process goes on."²⁵

Along with a wide array of medical and psychiatric conditions, the patients also presented with an equally diverse and challenging list of psychosocial problems. In 1930 the New York School of Social Work published a pamphlet listing these social problems: abandonment, desertion, divorce, loss of children, child caring problem, child training mismanagement, improper guardian, disability of home maker, disability of wage earner, abortion induced, assault, bigamy, desertion, intoxication, non-support, perversion, stealing, wayward minor, forced marriage, family friction, marital friction, parental friction, parent child friction, illegitimacy, interference by relatives, inversion of relationships, irregular sex relations, prostitution, unmarried father, unmarried mother, kinship estrangement, marital dissatisfaction, mixed marriage, family separation, marital separation, parental separation, parent child separation, sibling imbalance, step parent, unwanted child, unwholesome contact, industrial home work, lack of foodstuffs, lack of house furnishings, lack of housekeeping system, lack of privacy, multiple duties, family ill health, family inefficiency, financial strain, foster home problem, homelessness, inadequate home life, insufficient income, irregular income, housing hazard, housing shortage, inconvenience of housing, overcrowding, absence from school, classroom irritation, classroom overcrowding, double time, inaccessibility, illiteracy, multiple duties, school dissatisfaction, school exclusion, school interruption, business mismanagement, compensation difficulty, complex work process, dangerous occupation, confinement at work, exposure at work, lock out, long hours, night work, occupational strain, radical change in occupation, strike, trade changes, trade union difficulty, unskilled labor, irregular employment, casual labor, seasonal employment, migratory labor, underemployment, work interruption, economic dissatisfaction, economic insecurity, insufficient earnings, insufficient income, irregular income, lack of leisure time, lack of play facilities, lack of playgrounds, playground irritation, restricted interests, undesirable amusements, broken church connection, congested district, disorderly house, inaccessibility, isolation, lack of associates, racial barriers, religious barriers, unassimilation (sic), lack of community facilities (cultural, education, institutional), language difficulty non citizenship, non residence, provincialism, public charge, radical change in environment, social resource limitation, social status problem, larger community problems, bootlegging, child labor Imprisonment, lack of social legislation, mendicancy, migration problem, deportation, shifts in population, miscellaneous conditions, and locus hazard. ^{26, 27.}

An especially egregious problem was overcrowding. By the late nineteenth century New York City contained some of the most congested neighborhoods in the world. One area had 260,000 inhabitants to the square mile, in another nearly 300,000; nearly 500,000 persons lived in tenements; one building contained 1,500 tenants. One tenement-house district contained six percent of the population of the entire city.²⁸ Commenting on the people who were forced to live in the extreme squalor found in these areas, an observer wrote: "Ignorant and poor, filthy and

degraded, the low tenement victim drags out an existence which is as logical as it is miserable. Born in poverty and rags, nursed in filth and darkness, reared in ignorance and vice, matured in sin and crime, is the life history of the great majority of tenement-house creatures, and the end must be either the almshouse or the prison, or possibly the felon's death."²⁹

The problem of overcrowding in New York persisted well into the twentieth century. In 1926, one observer wrote: "There are sections [of New York City] so densely populated that if the entire city were equally crowded, all the people in the United States could live within the bounds of New York, with room enough for all of Canada, besides the population of London, Berlin, Paris and Tokio"³⁰

Another prevalent problem in the late nineteenth century was child labor. There was one story of an eight-year old girl whose father was dead and the mother sick, and who for a year had earned three dollars a week in a workshop stripping feathers. She was one of thousands of children, some younger than 8 years old who, in New York City, labored long hours in shops and factories. In a certain sense, New York City was one big sweatshop, which employed tens of thousands of young children in grueling factory labor. Eight thousand children made envelopes at three and a half cents a thousand; one child, twelve year of age, boxed twenty thousand paper collars a day; over ten thousand children made paper boxes. Even girls, as young as six, could be found scrubbing floors.³¹

Patients at Bellevue Hospital ranged in age from newborns to centenarians. In a typical year, 1954, 2,651 babies were born in Bellevue Hospital. That figure represented almost 8 percent of the total born in Manhattan that year.³² The booklet "Twenty Years of Social Service at Bellevue and Allied Hospitals 1907 – 1926," contains photographs of happy, smiling children who received medical care and social services at Bellevue Hospital. One photograph shows a clinic crowded with children and their mothers, another of mothers with their babies attending a baby class, yet another of a large group of children enjoying themselves at a Fresh Air Party at a swimming pool.³³ When the polio epidemic first appeared in 1916, the Bellevue Hospital social service department obtained funding to pay for masseuses to give massages and muscle training for the afflicted children. The baby-feeding clinic, which was staffed by social service volunteers, had an average monthly attendance of over 600 babies, and the education this clinic provided to the mothers resulted in fewer babies being sent to the wards. The children's cardiac clinic had an average of 600 cases on its active list.³⁴ In 1933, the Bellevue Hospital Social Service Department had on file the cases of 677 children known to the Tuberculosis Clinic, 197 boys and girls who were sent to the country, and 1,280 contacts with children on the wards.³⁵

On the opposite end of the chronological scale were the elderly patients. In 1946, Bellevue celebrated the 100th birthday of a patient who was a veteran of the Civil and Spanish American Wars. The patient, who was born in the vicinity of Lexington Avenue and East 50th Street when that

area was farmland, was given a steak dinner, which the patient “polished off” as other “oldsters” looked on.³⁶ A few years later a woman, who was believed to be 105 years old, was presented with a gift, which at the times was considered most thoughtful and useful – two corncob pipes and a tin of tobacco. There was also the elderly man who refused to be admitted until provision could be made for his household pet, which turned out to be a mule, and the eighty-three year old woman who was brought to the hospital after having had a heart attack, and was found to have \$5,365 in crisp new bills in a white cloth bag that she liked to carry with her.³⁷ In May 1973, Bellevue Hospital featured a special month-long program geared to providing information and services to Bellevue’s older patients.³⁸ In 1978, the Bellevue Hospital IMCU (Intermediate Care Unit) patient caseload included an 87 year old female who was in a coma, an 82 year-old confused Russian male who wanted to be discharged back to Russia, an 82 year-old male with a long alcoholic history, a 67 year-old male chronic alcoholic who could no longer care for himself, a 77 year-old male post CVA with a history of walking out of facilities, and a 76 year old male transferee from another hospital and resident of New Jersey, all of whom were awaiting placement in a long term care facility.³⁹

Although Bellevue was known as the “poor man’s hospital,” contrary to popular belief, the vast majority of patients were not derelicts.⁴⁰ Most patients were in fact part of the working poor, those who were gainfully employed and lived responsible lives but had modest incomes insufficient to enable them to afford care at a private hospital. In 1907 the occupations for one group of Bellevue patients included housewife, cook, actor, soldier, salesman, coachman, metal polisher, waiter, domestic, janitor, longshoreman, brakeman, manicurist, bricklayer, painter, and blacksmith.⁴¹ A former patient, hospitalized at Bellevue in 1948, later reported that among his ward mates were a cabdriver, a dishwasher, and an ex-Princetonian.⁴² Out of a total of 3,394 patients admitted in 1933, only 44 were classified as “vagrant and alcoholic” while 1,524 had families. One Bellevue social worker recalled that his father, a hardworking, responsible family man and wage earner, was hospitalized in the 1950s at Bellevue Hospital for a serious medical problem.⁴³

But Bellevue did have its “steady customers” too, such as the alcoholic patient who was admitted at least once a year for fifteen years and twenty-three times in one year. He was one of the numerous homeless, alcoholic patients who repeatedly sought admission to the hospital when things got “too tough” for them on the street.⁴⁴

Bellevue Hospital provided health care for a large Jewish patient population. In 1926 an observer reported that the average number of Jewish patients annually admitted to the wards was about six thousand.⁴⁵ Volunteers from the Free Synagogue assisted social service director Mary E. Wadley with Yiddish-speaking patients.⁴⁶ In 1933, the Social Service Board of the Free Synagogue conducted 11,875 interviews with Jewish patients.⁴⁷ In the first quarter of 1940 alone, the Free Synagogue ministered to 2,045 Jewish patients in the wards.⁴⁸ In 1945, approximately

3,000 patients admitted to Bellevue were Jewish.⁴⁹ In 1947, 2,301 Jewish patients were admitted to the psychiatric wards.⁵⁰ One observer in 1956 wrote that in one year, 12 percent of the patients at Bellevue Hospital were Jewish.⁵¹ While most non-Jewish hospitals did not have Jewish trustees on their boards, Bellevue Hospital had Jewish trustees from the start.⁵²

Bellevue Hospital also provided health care services for incarcerated patients. According to a report in 1956, Bellevue received around 1,500 prisoners each year.⁵³

Thus, from its inception, Bellevue Hospital provided medical services to a culturally diverse and economically disadvantaged population with a wide range of social problems.

CHAPTER FOUR - THE STAFF

Today the Bellevue Hospital social work department is staffed with over one hundred professionally trained and duly licensed social workers. Yet at the time of its founding, and for decades after, the duties of a social worker were performed not by professional social workers, but *exclusively* by nurses. Bellevue's first director of social services, Mary E. Wadley, was a public school nurse. Indeed, the history of nursing and social work is so closely intertwined that one cannot be discussed without mentioning the other.

For much of Bellevue's history there was no professional nursing staff. The care of the patients was entrusted to male and female prisoners from the penitentiary who, according to one account, were mostly rough and rude characters, the dregs of the worse element in a rapidly growing city. The majority of them, too, were foreigners. The patients always had one continuous grievance against the nurses. Whisky and spirits seldom reached their bedsides.¹

The patients who suffered the most were the female patients waiting to give birth. At one point, the death rate for women confined in the maternity ward was 60 to 70 percent. The cause of death was septicemia. One commentator observed: "It was almost a sentence of death to become a mother at that institution [Bellevue]." After the maternity department was moved to Blackwell's Island (later known as Welfare Island, today known as Roosevelt Island) where the women were temporarily sheltered in tents and then in isolated pavilions, the death rate dropped to almost nothing.² (However, according to another account, after the maternity ward was moved to Blackwell's Island, the mortality rate soon exceeded that at Bellevue Hospital, the project was abandoned, and the obstetrics department was moved to a building on East 26th Street in Manhattan, which became known as the Emergency Hospital.)³

The quality of care at Bellevue was so poor and the conditions so grim and notorious that by the 1870s there were some who seriously considered closing down the facility. In 1873, The New York Times, questioning whether Bellevue was fit to continue functioning as a hospital, declared: "But if it shall appear that Bellevue is no longer a credit to the city, but has in fact become a charnel house instead of a hospital, a decent regard for the commonest claims of humanity demands its instant demolition and that the ground be put to other uses." Further venting its indignation, the paper went on to emphatically assert: "If there is anything which is entirely beyond dispute, When examined in the light of competent testimony, it is that Bellevue is a disgrace to our city."⁴

Bellevue Hospital was in desperate straits. At stake was its very survival. In 1872, Miss Louisa Lee Schuyler formed the State Charities Aid Association for the improvement of public institutions of charity. A branch of this association was the Bellevue Hospital Local Visiting Association, a group of sixty women chosen for their ability and social position. Mrs. Joseph Hobson was chairman of the subcommittee that was to visit

the surgical wards for women. When the four members of the committee visited the wards, Mrs. Hobson was so overcome by the smells that she nearly fainted and could remember very little that she had seen. The next day Mrs. Hobson went alone, determined to control her nausea, and made a proper inspection.⁵ At the first meeting of the Local Visiting Committee held in March, the reports showed that: "Bellevue was a hospital where patients were neither nursed, fed, nor clothed as humanity demand."⁶

This report shocked the committee, which brought their concerns to the attention of the Commissioners of Charities and Corrections, the department responsible for Bellevue's operation. The Commissioners were surprised that no dissatisfaction had been expressed by any of the visiting physicians, but invited the Committee to continue making visits. At the Committee's second meeting, emphasis was made on the deficiency of the nursing department. The Committee found that there were no trained nurses. Instead, nursing care was still being provided by illiterate women assisted by prisoners from Blackwell's Island and by convalescing patients who were using the hospital as a home, as had been the case at Bellevue for years.⁷ The Committee also reported that: "Medicines were casually given to the patients to take as they liked, the food was most unappetizing and only those who had money to pay for service received any attention."⁸

The Committee's demand for improvements in the quality of care led to the founding of the School of Nursing, which opened on May 1, 1873. Most of the doctors were opposed to opening a school of nursing. One distinguished surgeon said the class of patients was so difficult to deal with that any intelligent woman such as they hoped to train would lose heart and leave.⁹ (It must be noted that the "difficult" patients referred to by the surgeon included a large number of female patients in confinement. In 1870, there were 598 births in the hospital; in 1873, 449 births.¹⁰) Nevertheless, by the time the first class was graduated in 1876, nurses were accepted as part of the institution. Miss Euphemia Van Rensselaer was the first nurse to enter an operating room. Miss Frances Root became the first forerunner of the modern social service nurse. Miss Root was convinced that the poor should have competent nursing and knowledge of social hygiene, as well as material aid and sympathy.¹¹

It took many years for conditions in Bellevue Hospital to improve. As late as 1884 there was still no plumbing inside the hospital, except in the main building where the hospital Warden and his family resided. By 1886, thirteen years after The New York Times had called for the facility's closing, Bellevue was still in the planning stage regarding the installation of an effective heating and ventilation system, which was urgently needed to prevent the further death of patients and staff. After a series of unfortunate and tragic events, such as the case in 1880 of the body of a "young married woman" whose remains were found in the hospital "shockingly mangled ... fresh from the dissecting room," the case of the patient in the throes of delirium tremens who murdered another patient in 1883, the outbreak of typhoid in the hospital in 1884, the case of the 17 year-old boy who was transported to Bellevue and then died, and the case

of the injured 8 year-old boy who a Bellevue doctor allegedly refused to transport to the hospital, all highly publicized stories which further eroded the hospital's already tarnished reputation, the Warden, William B. O'Rourke, was summarily fired for "gross mismanagement" and "lax discipline." As evidence of Mr. O'Rourke's alleged incompetence, the Commissioners of Charities and Corrections cited three cases, one involving a patient who had his coat valued at \$35 stolen, another of a patient who had to pay 5 and 10 cents for a glass of milk, and the third involving one of the hospital orderlies who used his position to give "trade" to an undertaker who just happened to be the orderly's brother. Mr. O'Rourke responded by claiming that he was never brought up on charges and attributed his dismissal to "politics." When asked if one of the attendants in the hospital was earning \$125 over his salary by assisting at operations, Mr. O'Rourke said that the attendant only received presents from the doctors at Christmas. The Commissioner said that there would be no public investigation of these matters because "there was too much to do" and described the state of affairs at the hospital as "very shocking." The Commissioner did say, however, that there would be further inquiry into possible collusion between the keeper of the morgue and the attendant who was giving business to his brother the undertaker.¹²

From this background of corruption and mismanagement at the hospital, the School of Nursing was organized. Between 1876 and 1886, the school produced 244 graduate nurses, of which "only" five had died, twenty-two had married and twenty-eight had responsible positions in hospitals.¹³ The first Director of social services at Bellevue, Mary E. Wadley, was herself a graduate of the school and during her tenure as director had 51 graduate trained nurses on her staff.¹⁴

The course of training was based on the principles developed by Florence Nightingale, at the St. Thomas's Hospital in London. One of the house surgeons at Bellevue Hospital, Dr. W. Gill Wylie, traveled to England to study the Nightingale method and shared his findings with the Committee.¹⁵ In a letter to the Bellevue Committee, Miss Nightingale explained the purpose of a nurse: "Nurses are not medical men – on the contrary, nurses are there, and solely there, to carry out the orders of the medical and surgical staff, including of course the whole practice of cleanliness, fresh air, diet, etc. The whole organization of discipline to which the nurses must be subjected, is for the sole purpose of enabling them to carry out intelligently and faithfully such orders and such duties that constitute the whole practice of nursing. Their duties can never clash with medical duties, and for this very purpose, that is, in order that they may be competent to execute medical directions, to be nurses and not doctors, they must be, for discipline and internal management, entirely under a woman – a trained superintendent – whose whole business is to see that the nursing duties are performed according to this standard."¹⁶

Students were taught a set of values – discipline, duty, organization, competence, independence, professional autonomy, gender equality, and clarity of purpose – that would later be adopted and incorporated by the social work profession and would directly influence the nature of social work practice. As the “careful, kind, and intelligent” nursing given under the school resulted in the more rapid recovery of the patients, doubts about their effectiveness were dispelled and the presence of professionally trained nurses on the wards became fully accepted by the medical staff and firmly established at Bellevue Hospital.¹⁷

By 1906, the nursing service, by now an integral part of the hospital’s organizational structure, was ready to take on new responsibilities in what was then considered the experimental subspecialty field of medical social work. Nurses performed medical social work duties well into the twentieth century. In 1934, the staff of the Social Service Bureau of Bellevue and Allied Hospitals included 57 registered nurses plus clerical and administrative staff.¹⁸ In 1945, the director of social work services was a registered nurse and registered nurses comprised half of the staff. That same year, out of a total of 25 social workers only 3 had graduated from a school of social work.¹⁹ In the 1930s, medical social workers employed at Bellevue and other municipal hospitals were chosen by noncompetitive examination under civil service requirements specifying graduation from an accredited *school of nursing* with one year of experience in *public health nursing* or in a “social agency.”²⁰ According to a survey of hospital social workers employed in public and voluntary hospitals in New York City, published in 1937, 66 percent were graduate nurses with no other academic or professional qualifications, 10 percent were college graduates with full certification by a school of social work, and 9 percent had no college degree whatsoever.²¹ Out of 123 social workers employed by the New York City Department of Hospitals, one had graduated from a school of social work.²²

Several factors contributed to the dearth of qualified professional social workers. First, nurses were already recognized as being qualified health care professionals who were available to do the work and had the aptitude and experience, if not the formal training, necessary to perform the duties required of the job.

Second, there were persistent doubts over whether social workers had a relevant role in the medical field. Considered as interlopers who could not relate to physicians, many health care facilities did not want to employ social workers. Some hospital administrators were convinced that the introduction of social workers would lead to the expansion of charity care in their facilities. Others felt that attending to the social needs of the patients was a job for city agencies. And others believed that their institutions already had the resources, such as religious orders, auxiliary committees and *nursing* personnel, who could attend to the social needs of the patients.²³ (This belief has persisted. The results of a survey of physicians and nurses published in 1992 found that: “Only 1.1 percent of

physicians and 1.5 percent of nurses believed that assessing emotional problems belongs to social work, and only 6.3 percent of physicians and 8.9 percent of nurses believed that helping find solutions to those problems belongs to social work.”)²⁴

Third, there was confusion over whether social work was even a profession. In 1915, Abraham Flexner said that social work was not a profession because it lacked “an educationally communicable technique.”²⁵

Fourth, social work departments, including Bellevue Hospital’s, received little funding and could not afford the salaries necessary to attract qualified professional staff. Out of the total amount of money spent by voluntary and public hospitals in New York City in 1934, \$62,733,106, \$663,163 or 1.1 percent was spent on medical social work departments. This figure represented a *decrease* of 7.4 percent in the voluntary hospitals and a *decrease* of 27.3 percent for the special hospitals from 1930. For the 22 municipal hospitals *together*, the *total* amount of money expended on medical social services was \$188,847, which was a decrease of one-tenth of one percent from the total for 1930.²⁶ At Bellevue Hospital, two workers in 1920 were withdrawn from the venereal disease service for lack of funds.²⁷ Decades later, funding for social work service was still miniscule. During the period 1958-1959, out of an operating budget of \$15,359,026, Bellevue Hospital spent a total of \$203,343, or approximately 1.5 percent of the total budget, on salaries and wages for the fifty employees (social work staff and related titles) in the social service department.²⁸ (When considering these sums, it must be recalled that New York City received little if any federal or state funding to offset the cost the providing health care services for the huge number of indigent patients who could not afford to pay.)

Fifth, salaries were *low*. During the period 1935-1936, the *annual* salaries paid to medical social service staff in the municipal hospitals were as follows:

Headworkers – \$2,600 to \$2,799
 Senior caseworkers – \$1,599 to \$1,799
 Caseworkers – \$1,400 to \$2,399
 Dispensary workers – \$1,400 to \$1,799
 Others – \$1,600 to \$1,799.²⁹

During the same period, out of 202 workers in the voluntary and municipal hospitals, only three workers received salaries of as much as \$3,000. These salaries, especially for the headworker positions, which called for “serious responsibilities as well as well as for arduous administrative work in intricate professional organizations,” were described as “modest compensation.” The salaries for the other positions were found to be “at the minimum level for professional workers in New York City.”³⁰ This was the case at a time when salary standards for other forms of social work were rising steadily. Twenty-three years later, salaries for the social service staff at Bellevue were still low. For the period 1958 – 1959, the salary ranges were as follows:

Supervisor (Medical Social Work) – \$6,710
 Psychiatric Social Worker – \$4,550 to \$5,990
 Medical Social Worker – \$4,550 to \$5,990
 Assistant Medical Social Worker – \$4,250 to \$5,330³¹

Sixth, the work was difficult and emotionally and physically taxing. Social service staff was responsible for huge caseloads and were expected to perform a myriad of tasks that had nothing to do with direct care (see chapter five).

Staffing problems have persisted. Most pressing has been the department's difficulty in retaining qualified staff. In recent years, the turnover rate has been high. Out of 86 staff employed in the Social Work title on November 22, 1989, 12, or almost one out of every seven, had left by September 1990, a 13.9 percent turnover of line social work staff in a ten-month period; out of 49 staff employed in the Social Work title on August 5, 1996, 13 had left the department by August 18, 1997, a turnover rate of 26.5 percent in a one-year period.³² In 2001, the turnover rate for MSW staff was 34 percent; in 2002, the figure was 22 percent; and in 2003, 17 percent.³³ The turnover rate decreased after salaries were raised to levels competitive with voluntary hospitals and other city agencies. During the period January 25 – June 2, 2005, there was no turnover of line social work staff.³⁴

Broad banding, that is, performance of identical duties by multiple titles, also continues to pose challenges for the department. Although nurses no longer are employed as social work providers, other non-social work staff, such as community liaison workers, social health technicians, case workers, and addiction counselors, continue to provide a wide range of psychosocial services. In March 1996, out of a total staff of 171, there were 31 caseworkers, 13 community liaison workers, 8 addictions counselors, and 2 social health technicians providing clinical care.³⁵ In June 2005, nine years later, the department continued to employ 22 caseworkers and 13 addictions counselors in various clinical roles.³⁶ One social worker recalled sharing an office with a community liaison worker and then later with a caseworker, both of whom, working under the supervision of a professional social worker, interviewed patients, completed psychosocial assessments and performed other clinical tasks.³⁷ Regarding the utilization of non-social work staff, the Social Work Department found that given the size of the department and the scope of its mission, a "skilled mix of titles" was required to provide a sufficiently wide range of services to meet the psychosocial needs of the patients. According to the social work department's staffing plan, "Differential utilization of social work staff and the range of their roles and activities are based upon the scope of the individual clinics ... as well as the specific needs of clinical service areas and special populations."³⁸ Thus, non-social work staff members continue to be assigned to the medical and emergency departments, inpatient services, ambulatory care, maternal/child health service, and substance abuse services, depending on the needs of the patient population.³⁹

Another enduring feature of the social work department has been the cultural diversity of the staff. In January 2002, the languages spoken with in the social work department in addition to English were as follows: Yoruba, Swahili, Hausa, Arabic, Hebrew, Cantonese, Mandarin, Taishanese, Fukonese, Tagalog, Hindi, Punjabi, Urdu, Italian, Polish, Russian, French, Ukrainian, Creole, Spanish.⁴⁰ In addition to performing their other duties, many of these staff persons proficient in languages beside English volunteer their services as translators, providing an invaluable service for those patients whose primary language is not English. In the pediatric/newborns service alone, in 2004, between 52 and 71 percent of the cases in any one month needed interpreter service. Among these cases, 721 required a Spanish-speaking interpreter, 403 a Mandarin-speaking interpreter, and 27 a Bengali interpreter.⁴¹

To ensure that the social services staff is kept apprised of the latest developments and breakthroughs in the field of clinical social work, the social work department routinely presents seminars and in-service training on a wide variety of topics relevant to social work practice. In 1996, the list of topics discussed included patients' rights, aged related competency, welfare reform, violence in the workplace and other safety issues, emergency disaster preparedness, "Latinos, Machismo, and Alcoholism," and "Children and the Family Court," in 1997, the department offered presentations on "Social Work Competencies & Realities: Issues Facing Social Workers," "The Social Worker of the Future: Are We Truly Prepared?" and "120 Years of Child Protection by The New York Society for the Prevention of Cruelty to Children."⁴² Yearly presentations are given by guest speakers in recognition of African-American History Month. The Social Work Department also has a key role in organizing the Performance Improvement and Mandates Fairs that have become a regularly scheduled feature of the hospital's staff development and training program, and has taken the initiative to ensure that social have the opportunity to attend a wide range of educational courses offered by other hospital services. These training courses have contributed immeasurably to furthering the professional growth and development of the social work staff.

Social work staff has also responded to the call of duty in time of war. In 1917, thirteen workers were given leave of absence for overseas war service during World War One.⁴³ And although not officially a social worker, Miss Sara Jane Delano, a graduate of the School of Nursing, class of 1886, and later became the superintendent of the school, served as the commander of the Army Nursing Corps and later as head of the American Red Cross Nursing Service, and is buried in Arlington National Cemetery.⁴⁴

CHAPTER FIVE THE JOB

The primary function of a medical social worker is to provide a human service. This means that the patient is treated not as an object, or as a customer, or as a consumer, but as a person who enters the hospital with feelings, a life history, and the need for genuine support, counseling, friendship, and possibly "material assistance." It also means that the medical social worker works efficiently, effectively and conscientiously on behalf of the patient, and places the needs of the patient ahead of all other considerations. To achieve these aims, the medical social worker must possess the necessary clinical skills and personal temperament to quickly establish an effective therapeutic relationship with the patient that will win the patient's trust, instill within the patient a feeling of confidence in the social worker, and thereby render the patient receptive to the social worker's intervention, treatment and care. This is a challenging and daunting task. Often, the first time the medical social worker meets the patient is when the patient is in the midst of a crisis, at a time when the patient is experiencing severe pain, often both physical and emotional, and may be feeling overwhelmed, frightened, angry, bewildered or totally confused. It is the social worker's duty and responsibility to overcome these obstacles so that treatment can begin without undue delay.

For time is of the essence. At Bellevue Hospital any delay in the delivery of services can quickly translate into lost revenue. Something as seemingly mundane as a patient needing a pair of trousers can lead to a major crisis if a particular social need is not promptly diagnosed, assessed and treated. Such oversights can lead to costly delays in discharge as well place patients at risk. At Bellevue Hospital, the social work staff deals with these situations throughout the hospital on a daily basis.

The job of the medical social worker consists of seven fundamental tasks: 1. Obtain hospital data. 2. Learn the patient's medical or surgical condition; 3. Make inquiry through Social Service Exchange to find out what other agencies may be interested; if any, confer with them. 4. Make a visit to the home, or if a home visit cannot be made, to meet with the patient's family at the hospital to assess the patient's level of functioning in the home and community and to gain more data regarding the patient's current living conditions. 5. If assistance is needed, or if a case presents unusual problems, confer with a committee. 6. Cooperate with outside agencies. 7. Carry the case to its conclusion.¹

Historically the sheer number of cases assigned to the social work department has been staggering. For the period 1906-1925, there were 815,701 admissions to Bellevue Hospital and 831,044 dispensary visits. During that same period, the Social Service Bureau assisted 225,000 different cases, made 379,586 visits and placed 45,889 patients in convalescent homes for complete recuperation.² The social work service estimated that if an average of two days' sickness in the hospital were prevented for 15,000 patients in a year, then, at a rate of \$3.35 per patient cost per day, the total amount saved would be \$100,500.³ But the needs of

the patients were so complex and the number of cases requiring service so large, that the Social Work Bureau, with its limited financial resources (an annual budget of \$96,215 in 1926) and staff (51 salaried workers and 60 volunteers), could assist but only a small fraction of the total number of patients requiring social work intervention.⁴ Mary Wadley reported that the Social Service Bureau was able to reach only six in every one hundred patients.⁵ By 1945, the average caseloads in 52 departments at Bellevue Hospital varied from 24 to 144 *active cases* per social worker per month.⁶

In 1946 the Social Work Department conducted a comprehensive study to determine the actual number of social workers that were needed to comprise an adequate staff. At the time, the social work staff consisted of the Director, an executive assistant, 2 supervisors, one medical social worker for intake, and 20 medical social workers assigned to various medical services. The study found that the size of the staff was inadequate to meet the hospital's social service needs. The study cited a 1936 report from the Medical Superintendent, Dr. William F. Jacobs, who had stated that the number of social workers "should be increased approximately 100 per cent."⁷ The study also included these other findings:

1. The number of patients who received social service in 1945 was approximately 7 percent of the total number of patients admitted.
2. An additional number of patients estimated to have been in need of social service was 15 percent of the number admitted.
3. The size of the staff was the *same as it was thirty years before* while at the same time 1,600 beds had been added to the general hospital and clinic attendance had more than *tripled*.
4. The staff at present was not only unable to meet the need for social service but was also unable to give sufficient time to the patients who received service.
5. The average yearly caseload was 466 patients per social worker; a reasonable yearly caseload was estimated to be 330 patients.⁸

A half-century later, inadequate staffing continued to be a problem. One social worker recalled being routinely directed in the mid-1990s to cover two or more inpatient units on the medical/surgical service, each unit comprising between 28 and 34 beds. In 1995, the Social Work Department experienced a 25 percent reduction in staff, placing further strain on those remaining.⁹

Exacerbating the problem of high caseload was the incessant demands placed on the social workers to perform duties that bore no relationship whatsoever to actual casework. Medical social workers historically were expected to perform a myriad of tasks that had nothing to do with clinical work.¹⁰ In 1937, the United Hospital Fund reported that: "Some [medical social work] departments have been regarded as general utilities to which was assigned any job that did not seem to fit logically into the rest of the hospital's organization, irrespective of its bearing on social study and treatment."¹¹ Some of the numerous tasks that medical social workers performed included: indiscriminant mass relief work (milk, food,

clothes, ice, coal, etc.), obtaining blood donors, obtaining permissions for autopsies, providing information about the operation of the hospital, and “a vast number of other duties” that lacked “any logical relationship to medical social service.” The United Hospital Fund also reported that the “practice of [medical] social case work” was “exacting and exhausting” and that the social caseworkers “were fatigued by overwork ... tired ... and harassed.”¹²

In the 1940’s Bellevue Hospital took measures to relieve the social service staff of many of these non-clinical tasks so that they could devote more time to performing actual casework duties. The department also improved the physical environment in which the social worker performed their duties by providing each social worker a desk in the central office, a desk in a separate room at the clinic location (except in three clinics, where the social worker’s desk was in a corner of the waiting room), and a room in the central office containing several desks with portable screens set aside for interviews. In addition, medical records needed by the social workers were requested by a clerk and telephone service was facilitated by a special clerk in the Social Service Division who received all calls for the social workers. Telephone booths for incoming and outgoing calls were located in the main office.¹³

Yet the performing of non-clinical tasks by social workers continued. During the 1980s and 1990s, the social workers hand-delivered clothing to the patients, filled prescriptions in the pharmacy, routinely utilized fax machines, escorted patients to the community (one social worker recalled being “asked” to escort a 77 year-old patient with multiple medical and psychiatric problems to an adult home for an interview entirely because no one else was available to perform the task), manually placed social work forms (the “green sheets”) in the patients’ medical charts (unlike the medical and nursing staff, whose forms were placed in the charts for them by clerical staff), hand delivered documents to other locations in the hospital, interfaced directly with hospital-based *clerical* staff to secure services for the patients, and personally dispensed cash to patients, all of which were time-consuming activities that significantly reduced the amount of time left to perform actual clinical work. Moreover, social service staff continued to work in cramped offices located in the middle of busy and noisy wards where they were afforded little opportunity for privacy and were frequently interrupted by patients, visitors and other staff, causing even more disruptions and further delays in completion of mandated duties. And despite the introduction of computer technology, social workers continued to handwrite their notes into the charts.¹⁴

Currently social service staff is assigned to inpatient units, outpatient clinics, emergency rooms and special programs located throughout the hospital. In each location the social worker functions as part of a multidisciplinary treatment team, consisting of medical staff, nursing staff, physical and occupational therapists and other health care specialists, all working collaboratively to provide care to the patients. Despite the team

format, the social worker was often isolated. One social worker recalled how the medical doctors and nurses performed their work in groups while he, as the lone social worker assigned to the unit, performed his work alone.¹⁵

Nowhere in the hospital is the role of the social worker more subject to scrutiny than on the inpatient units where the hospital stands to gain or lose millions of dollars per year. As the multidisciplinary team member responsible for assessing the patient's psychosocial needs and ensuring that an appropriate discharge plan is in place by the time the patient is medically stable, the social worker is the key player in the discharge planning process. When the process is successful and patient leaves the hospital on schedule with an appropriate discharge plan in place, all is well. But if the process fails and the discharge is delayed, which frequently occurs for reasons outside of the social worker's ability to control, then the social worker, as the discharge planner, bears the full brunt of the blame. For it must be remembered that a delay in discharge, even for one day and involving just one patient, can cost the hospital thousands of dollars in lost revenue from Medicaid, Medicare or other third-party payers, money that the hospital needs to operate and meet its expenses, and which can never be recouped. When this type of loss occurs, it is usually the social worker, as the discharge coordinator, who must explain why the patient's discharge has been delayed.

The services most frequently arranged by the social workers to facilitate discharge are transportation, home care, petty cash, replacement of clothing, placement in shelters and placement in long-term care facilities. Often the patient requires a combination of these services. Failure to arrange for these services expeditiously can lead to an immediate delay in discharge or to a discharge deemed inadequate and improper.

Obtaining these services for the patients often entails immense red tape, requiring the completion of multiple-page forms that must be signed by the medical doctor and the social worker, even though many documents, such as the M11Q and the MAP 2015, are medical forms. For example, during the 1990s placing a homeless patient in a shelter required a 23-step process.

1. Complete a psycho social assessment.
2. Meet with the patient to discuss the plan for placement in a shelter.
3. Obtain the patient's verbal agreement to be placed in a shelter.
4. Inform the treatment team that the patient is homeless and will need placement.
5. Submit an M11Q to the medical staff for their completion.
6. Receive the completed M11Q from the medical staff.
7. Review and signs the M11Q.
8. Refer the case by phone to the Medical Review Team (MRT).
9. Fax the M11Q to the MRT.
10. Call the MRT to confirm receipt of the faxed M11Q.

11. Repeat step 9 and 10 if needed.
12. Make follow up calls to the MRT to ascertain whether the patient had been medically approved for placement.
13. After the MRT confirmed that the patient was medically cleared for discharge, go to the main social work office, located in another part of the hospital, to retrieve the notice of approval faxed by the MRT.
14. Await a telephone call from the Placement Review Unit (PRU) confirming that the patient was cleared for placement in a shelter.
15. Receive a telephone call from the PRU informing that the patient was cleared for placement in a shelter and note the name, address and telephone number of the shelter approved for the patient.
16. Inform the other members of the treatment team that a shelter has been found for the patient.
17. Provide the patient with a written referral to the shelter.
18. Provide the patient a copy of the M11Q.
19. Provide the patient clothing if needed.
20. Provide the patient carfare or arrange for transportation if needed.
21. Manually place the M11Q in the patient's medical chart.
22. Make a written entry on the social service continuation form.
23. Manually place the social service continuation form in the patient's medical chart.¹⁶

Processing just one of these cases could monopolize much of the social worker's work day, but for the seasoned Bellevue Hospital social work "veteran," managing a multitude of such cases on a daily basis is routine. The results of a One-Day Homeless Study Survey conducted on March 17, 1989, found that 435 inpatients, or 42 percent of the adult inpatient population in the entire hospital, were homeless, with the highest percentage of homeless being in Psychiatry Service (69 percent). Males comprised 70 percent of the homeless patients.¹⁷ As a result, the social work staff has to expend hundreds and maybe thousands of hours of work trying to place these patients in shelters, while at the same time providing services for patients in other high-risk categories, of which the Social Work Department lists twenty-four such categories.¹⁸

In 1996, social workers identified 142 cases of suspected child abuse or maltreatment. These tragic cases involved children who presented to the hospital with fractures, subdural hematomas, internal injuries, lacerations, burns, scalding, excessive corporal punishment and the effects of neglect and sexual abuse.¹⁹ The social work staff intervened to preserve the lives of these children. Nor did large caseloads prevent the social workers from taking the necessary measures to ensure that the patients leaving the hospital were appropriately attired and had the financial resources necessary to enable them to arrive at their destinations and obtain, free of charge, medical equipment and other services critically needed to ensure the patients' survival. In 1995, direct assistance included the purchasing of glucometers for diabetic pregnant women, airfare to Puerto Rico for a crime victim, securing a place to store the belongings of an undomiciled

patient, providing cleaning services necessary for discharge home for a terminally ill female patient, carfare for an African torture victim to attend a special Bellevue clinic, purchasing a refrigerator for a diabetic patient, paying rent arrears, and purchasing medical equipment for uninsured patients. In 1996, direct cash assistance was provided for the following: Airfare to Canada, Thailand, San Francisco, San Diego, Florida, South and North Carolina, Indiana and Ohio to return psychiatric patients to their families, bus fare and train fare to Pennsylvania, Massachusetts, Albany, Syracuse, Yonkers, Long Island and New Jersey to return psychiatric patients to their families, paying a patient's rent to avoid eviction, carfare for torture victims to attend counseling at Bellevue, eyeglasses and partial burial assistance for two Geriatric patients, flowers for a funeral of an MMTP patient, renting a wheelchair and purchasing a standard walker for indigent non-Medicaid eligible patients, and purchasing an Accu-chek machine and a pelvic binder for OB/GYN patients.²⁰

During the period 1991-1996, the Social Work Department filled 40,233 requests for clothing at a total cost of \$240,617.²¹ Every request was initiated by social service staff who identified these cases, determined that the patients needed clothing, and then acted to ensure that the clothing was provided, often saving the hospital thousands of dollars which otherwise would have been lost due to delays in discharge if the social workers were not there to do this vitally important work. In 2003, a total of 8,093 patients were provided clothing; that same year a total of 3,640 patients were provided petty cash totaling \$24,634.^{10.22}

The following are seven case vignettes offered as examples of how the clinical services provided by the social work staff improved the lives of the patients.

Case 1 – A 37 year-old African-American male admitted to the psychiatric service in April 2005, with a diagnosis of schizoaffective disorder and substance abuse. When admitted the patient was experiencing auditory hallucinations. The patient also had a long history of serious social problems including chronic homelessness and lack of benefits, which exacerbated the patient's psychiatric disorder and affected the patient's ability and motivation to comply with treatment. After completing an initial psychosocial assessment, the unit social worker provided the patient with educational material about mental illness and psychiatric medications and of the need to comply with treatment. The patient was placed in a therapeutic MICA residence, thereby improving his chances of remaining psychiatrically stable.

Case 2 – A 35 year-old Caucasian female admitted to the psychiatric service in January 2005, 2o to the patient having jumped into a lake in an apparent suicide attempt.. This patient, who was originally from Illinois, had a history of childhood trauma 2° to parental conflict which had led to

an acrimonious divorce. The patient had run away from home, started abusing drugs, and for the past four years had been homeless, wandering between New York, New Jersey and New Hampshire. She also had a history of previous hospitalizations for psychiatric and substance abuse problems. When admitted to Bellevue Hospital, she had no benefits. After completing an initial psychosocial assessment, the unit social worker provided the patient insight therapy and education on mental illness. The social worker also arranged to re-united the patient with her mother in Illinois and for the patient to return to Illinois, where she entered a drug rehabilitation program near where her mother lives.

Case 3 – A 37 year-old Bengali female, no prior psychiatric history, who was admitted to the psychiatric service in April 2005, 2° to the patient exhibiting psychiatric decompensation, which involved head banging and screaming derogatory statements about herself. The patient, who has two children, was brought to the hospital by her husband. During the psychosocial assessment, the unit social worker discovered that the husband was misinterpreting the patient's glances at other men as being evidence of her infidelity. The unit social worker met with the patient and her husband, provided both with education regarding the nature of mental illness and, utilizing a culturally sensitive approach, supportive counseling. The social worker also assisted the patient in obtaining benefits through the Medicaid medication grant program and referred the patient to a mental health clinic in the community where she lives.

Case 4 – A 40 year-old homeless African-American female, with AIDS, was admitted to the psychiatric service in April 2005, 2° to substance-induced psychosis. The patient had a history of multiple psychiatric hospitalizations and had four children, all of whom were in foster care. The patient contracted AIDS 2° to a brutal rape when she was 15 years old. After completing an initial psychosocial assessment, the unit social worker provided the patient education on the need to take her psychotropic and antiviral medications, and referred the patient to the Division of AIDS Services which arranged for the patient to have adequate housing after discharge from the hospital.

Case 5 – A 41 year-old Caucasian female, born in Colorado, with a history of substance abuse, was admitted in June 2005, to the medicine service with End Stage Renal Disease. The patient was unemployed, owed six months' rent; the electricity had been shut off in her apartment, she had no benefits and was estranged from her family. The unit social worker wrote a letter to the landlord, called Con Edison to restore the electricity, and referred the patient for SSD and Medicaid. The social worker also counseled the patient regarding the need to stop abusing drugs.

Case 6 – An 88 year-old Caucasian female, born in the United States, domiciled, living alone in an apartment in Manhattan, was admitted in April 2005 to the medicine service for failure to thrive. The patient was found on the floor of her apartment. When admitted, the patient was emaciated, unable to walk and unable to care for herself. The patient's husband and daughter were deceased and the patient had no other relatives. The patient, however, did have a health care proxy and also had Medicare. The social worker arranged for the patient to be placed in a sub-acute facility for further rehabilitation with the goal of eventual return to her own apartment with services.

Case 7 – A 78 year-old Caucasian male, domiciled, living alone, admitted to psychiatry service in January 2002, for cognitive impairment with behavioral features. The patient also had multiple medical problems – CHF, HTN, Glaucoma, Spinal Stenosis, and CAD. The patient was labile, delusional, irritable and hostile. The social worker maintained contact with the patient's lawyer, who, at the patient's request, was kept informed of the patient's progress on the unit. Subsequently, the social worker arranged for the patient to be transferred to a skilled nursing facility in the Bronx. ²³

A further example of the kind of cases the social work staff routinely assess and treat, can be found in this February 2001 case summary.

“SUBJECT: PATIENT REPORTS HE WILL “FLIP OUT”

“On February 20, 2001, a male patient on 16 west told me that he was going to “flip out.” The patient also reported that during childhood he was treated with the medication Ritalin for hyperactivity and had a history of drug abuse and had been in several rehab programs. The medical staff was informed of patient's statement that he will “flip out” and the patient's statement was documented in the patient's medical record.

“The patient reported that he was recently released from Riker's Island prison after a one-year incarceration and was supposed to go to a drug treatment program called Villa. However, the patient reported that he was told that he is not eligible for admission to Villa because of lack of health insurance coverage. Subsequently, the patient reported, prison officials told him to go to Beth Israel Hospital to get himself admitted and was given six tokens. The patient said that he was told that if he was admitted to a hospital, then the hospital staff could assist him with getting into a program. The patient went to Beth Israel and from there went to Bellevue Hospital where he was admitted for pneumonia. The patient also reported that prior to admission he was on 30 mg. methadone, but is presently not taking methadone because he wants to be “clean” when he enters a rehab program.

“Being denied admission to Villa has been a source of much frustration for this patient, especially since he was ordered to enter that program by a judge. The patient has repeatedly stated that he does not want to violate the judge’s order. SARP assessed this patient and recommended a referral to the Manhattan State Hospital ATC and that the referral be made by the unit social worker. In accordance with SARP’s recommendation, a pre-application form was submitted to Manhattan State Hospital. Efforts to help the patient cope with his frustration are complicated by the patient’s anger, low-frustration tolerance, and impulsivity. Ventilation of feelings seems to reduce his anxiety temporarily, but given this patient’s substance abuse history and his history of hyperactivity, in addition to his major social problems – recent incarceration, homelessness, lack of income, lack of benefits – it seems that this patient should be evaluated by psychiatry service to assess his current mental health needs, with emphasis on treatment to reduce his level of anxiety.

“The patient reported that he is one of eleven children; his father lives in Puerto Rico; his mother is deceased. Patient reported that his father was treated at Creedmore State Hospital for alcoholism. Patient said that he was in foster care from ages 7 to 14; he ran away at age 14. Patient reported that he has four children – two in New York City and two in Michigan. Patient said that he does not want to have contact with his family because he does not want his relatives to see him in his current state. However, patient reports that he has contact with an aunt who has advised him that he should be admitted to the Villa Program because he was ordered by a judge. Patient reported that for several years he lived in Puerto Rico where he was involved in illegal gambling operations involving slot machines. Patient claimed that in one week he made \$20,000. Patient said that he lost all his money because of ‘drugs.’”²⁴

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