EDITORIAL

Sharon M. Keigher

Knowledge Development in *Health & Social Work*

This issue marks the beginning of my second year as editor-in-chief of *Health & Social Work*, and I’ve been thinking a lot lately about “knowledge development,” as in how much I’ve been learning about this complex social work profession and how we develop knowledge for it. Publishing a professional journal requires expertise, commitment, and coordination among dozens of people. Consequently, I am deeply indebted to the dozens and dozens of dedicated people, both NASW volunteers and NASW staff, whose contributions combine to produce this remarkable journal. My goal here is to remove the mystery about how social work knowledge gets “discovered” and brought to you, our readers.

Kudos

Among the NASW Press staff, Paula Delo, publications manager, signs the letters that go out to authors, and Patsy Leslie communicates with authors regarding the status of their submitted manuscripts. (It should be noted that Patsy Leslie is the only staff member who moved with NASW from New York to Washington, DC, and has worked for NASW more than 20 years.) Patsy and Paula maintain the integrity of the “blind” review process in selecting manuscripts. As in a controlled experiment, reviewers (including myself) never know the identity of the authors of the articles they read unless and until they are accepted for publication. Patsy works closely with Hashmine Jaggarsar, administrative secretary, who processes the work in and out. Marcia Roman, senior editor, and Sarah Lowman and Mike Folker, staff editors, edit the manuscripts and work with authors to prepare the manuscripts for publication; Bill Cathey, production coordinator, typesets the pages for the journals. In addition to *Health & Social Work*, these people help produce three other NASW Press journals. India Winstead, administrative secretary, provides secretarial support for the director and handles fulfillment information; and Lori Eatmon, subsidiary rights specialist, responds to requests for permission to reuse materials published by the press. Staff workload is heavy and increasing. We are deeply indebted to each of them along with Cheryl Mayberry, the new director of Member Services and Publications, and Dorothy Davidson, the administrator, for their professionalism. I know how much these hard-working people make the rest of us look good.

Ruth Mayden, NASW’s president, appoints *Health & Social Work* Editorial Board members. Presently the *Health & Social Work* Editorial Board includes King Davis, Colleen Galambos, Vivian Jackson, Ellen Lukens, and Susan Taylor-Brown, each of whom is an experienced researcher and author who reviews manuscripts along with making journal policy. We are particularly grateful to Mary Van Hook and Julianne Oktay, our column editors. For several years now, Mary has been working directly with authors preparing manuscripts for the Practice Forum column, seeking descriptive evaluations of practice innovations, especially from practitioners new to writing for publication. Julianne Oktay coordinates the Books column and recently branched into reviewing health care Web sites. And with this issue we also welcome a new guest editor, Stephen Gorin, who is writing the National Health Line column. Readers are invited to share opinions with any of us regarding policies, form, and content of *Health & Social Work*.

Some 35 very diverse volunteer consulting editors round out the board’s ability to review manuscripts. Some of these reviewers are serving a second and even a third term; their names have appeared frequently among authors over the years. Reviewing a manuscript nearly always requires two and sometimes three or four careful reviews by three to four consulting editors and...
can involve many months of (unpaid!) effort. And with this issue, we welcome the following new consulting editors: practitioner experts Nancy Detweiler, Anita Moore Gander, Wendy Lustbader, and former editor-in-chief Judith Ross, along with researcher academics Candye Berger, Tim Davidson, Marcia Egan, Stephen Gilson, Ellen Netting, Eric Rankin, Jane Thibault, and Deborah Schild Wilkinson.

This brings me, finally, to our authors, and the remarkable content in this journal. The 32 articles published during the past year and the 70 manuscripts currently under review reflect the daunting range and substance of health issues important to social work practitioners today. Authors must have courage, humility, and initiative to put themselves through the peer-review process. Although the journal periodically makes “calls for papers” on topics perceived to be of special interest to the profession, usually what you read reflects what we have been offered. Is this an accurate reflection of our profession? Authors’ conclusions and opinions are their own, after all, but the journal articles represent the best among those that the consulting editors and the editor-in-chief have reviewed.

**The Role and Mission of Social Work Journals**

Recently the British journal *The Lancet* published what they knew would be a very controversial paper (Ewen & Puszai, 1999), a study of the effects of irradiated potatoes on rats. One of the *Lancet* reviewers had recommended strenuously against publication, contending that the research process was flawed. But the authors already had been speaking widely about their findings and the “food hysterics,” who object to all radiated food, were supporting them wildly. The *Lancet* editors decided that airing the arguably flawed research was more important than trying to suppress a controversy, so they published it. This raises legitimate questions about the potential subjectivity of research, along with the limited ability of the average consumer to judge scientific validity and reliability.

In a related issue closer to home, in March 1999 *Social Work Research* published a somewhat discomfiting article by Aaron Rosen, Enola Proctor, and Marlys Staudt, who measured exactly how little social work research actually generates empirical evidence aimed at improving practice interventions and knowledge of interventions.

They concluded that despite academic preoccupation with research and calls for science to validate intervention effectiveness, very little such intervention research appears in social work publications. *Health & Social Work* was among 13 journals the content of which the authors analyzed from the early 1990s. The authors found that although 47 percent of the articles in all the journals presented research, only 7 percent of all the studies were valid tests of controlled interventions. They presented a compelling argument for stronger researcher-practitioner collaboration that shares understandings of the various knowledge needs of practice, distinguishes between active and passive prediction tasks, and appreciates basic design requirements for testing control knowledge.

The *Health & Social Work* editors could use your advice on such issues. We support airing controversial topics and opinions and seek them to round out coverage of the full range of issues that need to be addressed in this huge field. We also are sensitive to practitioners who argue that “this is not a research journal,” and calls that it “should emphasize practice more.” Does this mean that social workers in health care disregard evidence-based practice? Are practitioners turned off by empirical data? Certainly practitioners have feelings about whether something “works” or does not work, whether the conditions necessary for proof are controlled sufficiently. Certainly research for understanding health issues is as important as research on interventions. And where do social interventions fit these days on the spectrum of prevention, health promotion, medical treatment, and social care? Is our journal’s mission too broad, given the kind of specialized knowledge necessarily encompassed in health care practice?

*Health & Social Work* editorial boards have struggled to define and redefine this journal’s mission. In its first year, 1976, the editorial board adopted the following formal mission statement. *Health & Social Work* would be a professional journal committed to improving practice and extending knowledge in the field of health. Manuscripts [would] deal with social work issues, both general and specific; with descriptions of practice; with innovation and research; with the client and the community; with legislation, social policy and planning—in short, with all aspects of health that are of professional concern to social workers. This
Knowledge Development in Health & Social Work

journal subscribes to the philosophy that physical health and mental health problems and services are indivisible and welcomes manuscripts that embody this concept. (1[4], p. 177)

Health & Social Work, the first “specialty” journal ever launched by NASW, has roots that far pre-date NASW itself. Its mission goes back, in fact, to the turn of the last century.

The Origins of Medical Social Work in Hospitals

In September 1898, eight hospital superintendents met in Cleveland to explore the possibility of forming a national association. Hospitals were being founded throughout the country, and the U.S. proclivity toward “associational life” that Alexis de Toqueville observantly described 50 years earlier emerged as sector after sector in the human services began organizing. The next year the superintendents established the American Hospital Association (AHA); the move to separate medicine from hospital administration had begun (Carleton, 1990). The AHA grew quickly. By 1918 it had more than 1,000 members. In 1919 it had established its national headquarters in Chicago. Inevitably the AHA began supporting the new health professions, of which social work was an important one, practicing in hospitals.

Awareness of the importance of social factors in successful hospital and medical care had led to the establishment of the first hospital social work department at Massachusetts General Hospital in Boston in 1905. By 1915, at the 10th anniversary of that department, its social workers were discussing the need for a national organization to support their work. In the next few years, as social work spread to other hospitals, especially those on the East Coast, social workers in this new specialty began meeting informally at the annual meetings of the National Conference of Charities and Corrections and the new AHA.

Ida M. Cannon, the first director of social work at Massachusetts General and an influential writer and teacher of medical social work, provided a sense of the vitality and excitement of those meetings.

One of our difficulties in pressing for a national organization was the vigor of several local hospital social service organizations that were meeting the needs and expressing the ideas of the worker in some of our larger centers. I remember a sort of fateful refrain, “of course, our local situation is unique” . . . In discussing problems of organization, relationship of social service departments and local social service agencies, and in some of the hospital relationships, even in function, there was considerable variation in experience. I can quite easily recall the more satisfying sense of mutual understanding that we experienced whenever we talked of the problems of patients, for here we were at the very heart of our common purpose, the reason for our being. (Cannon, cited in Stites, 1955, p. 4)

By 1916, at the meetings of the National Conference of Charities and Corrections (later to become the National Conference of Social Welfare) in Indianapolis, a committee was appointed to consider organizing hospital social workers on a national scale. Members included social workers from hospital social work departments in St. Louis, Chicago, Cincinnati, Cleveland, Grand Rapids, Ann Arbor, New York City, Philadelphia, Baltimore, Providence, New Haven, Worchester, Boston, and Montreal.

Organizing was delayed by the shortages of World War I, but somewhat unexpectedly in 1918 at the National Conference meetings in Kansas City, a motion was made to organize hospital social workers formally. The motion passed with enthusiastic support, and thus formally launched was the American Association of Hospital Social Workers (AAHSW), the first professional association of social workers in the United States. Six other professional social work associations would form over the next 30 years.

With strategic support from the nascent hospital association, the AAHSW developed rapidly. By 1919 hospital social work was established in 300 hospitals. In 1920 the AHA appointed a committee “to study social service in hospitals and dispensaries throughout the country to make recommendations as to standards, methods or programs.” Thus began basic activities that still sustain professionalism today: developing basic standards for hospital social work departments, classifying medical social terminology, creating curriculum requirements for medical social work education, circumscribing the functions of hospital social services, developing a knowledge and method base for specialized
practice, collaborating with medicine and medical schools in educating physicians, studying the costs of care, and clarifying the social components of medicine (Carleton, 1990).

Stites (1955) described the people who founded AAHSW as “an eager, vigorous, and heterogeneous group” (p. 4), but Cannon is less sanguine. She attributes their shortcomings to lack of training, reflecting in the association’s Bulletin in 1938:

We were ourselves a rather motley lot so far as professional preparation was concerned. We had come from nursing, teaching, social work, and a variety of life experiences. I believe our focus (service to patients) was clear although our ideas of function and of suitable preparation for our work were certainly hazy, to say the least. I must not imply, however, that there was any lack of conviction on the part of many of our group on these subjects. (Cannon, cited in Stites, 1995, p. 4)

The medical social work literature of that era reveals easily why the social aspects of medicine were of such prominent concern and why physicians were instrumental in supporting the establishment of the profession. Dr. Richard Cabot, who wrote prodigiously about social care and medical social work, was as concerned about the social aspects of medicine as he was about medicine itself. A classic textbook published in 1926, Mary Wulkop’s The Social Worker in a Hospital Ward, describes illnesses and social factors unheard of in practice today. This fascinating book presents narratives about heart disease, tuberculosis, malignancy, and miscellaneous conditions in terms of both the patient’s medical problems and their lives and those of their families. We see that heart diseases were especially prevalent among children and young adults. References are made to “blue babies,” rheumatic heart disease, angina pectoris, syphilis of the heart “communicated to family,” and arteriosclerotic heart disease. Social work activities involved “interpretation to parents of implications of diagnosis,” communication with patients after discharge by letter (!), placement for long stays in convalescent homes, negotiation with local overseers of the poor, obtaining “settlement” (the right to be a public charge), and applications for Mothers’ Aid.

Tuberculosis infected spines, hips, or peritoneum, as well as lungs, and occurred and required treatment during pregnancy. Work with tuberculosis patients required knowledge of legislation and imposition of “coercive treatment,” dealing with resistance, and awareness of potential contagion, engaging family members who had to “become breadwinners,” keeping patients’ spirits up, and extensively interacting with local doctors, hospitals, nursing homes, and district nurses.

Malignancies usually were seen in advanced metastatic states. Other conditions requiring medical social services were fractures, attempted suicide, “feeble mindedness,” infectious arthritis “with chronic tonsillitis,” arteriosclerosis, and more. Conditions often were complicated by dependency, “old age,” “meagre finances,” “no relatives or friends, no money,” and “dependence on relatives”—not so different from today—but the carefully written case studies include medical commentary by Dr. Cabot on the medical implications of each patient’s disease.

AAHSW worked closely with the National Tuberculosis Association, the American Society for Control of Cancer, the Catholic Hospital Association, the American Red Cross, the Veterans Bureau, and other social health organizations. In the 1930s, with the nation mired in the Great Depression, AAHSW flourished as it expanded to help social services open in dispensaries, clinics, and public hospitals, incorporating practice standards into each new public medical service. In 1934 the association voted to change its name to the American Association of Medical Social Workers (AAMSW), and a Commission on Medical Care in Community Health was established, a direct result of expansion of social work to public hospitals and the new public relief agencies. It sought medical social work requirements for education and experience as high those as required elsewhere and civil services coverage of such positions (Stites, 1955). Experts on the social aspects of medical care, AAMSW formulated standards for social work in the new federal Crippled Children’s Services and the new Public Health Service and its Venereal Disease Control Division.

The Growth, Formalization, and Consolidation of the Social Work Profession

The six other social work professional associations formed before 1950 included the American Association of School Social Workers in 1919.
and the American Association of Social Work in 1921. In 1926 psychiatric social workers, who had traditionally provided aftercare to patients from psychiatric hospitals, pulled away from AAMSW. Having never felt entirely at home with medical social work, they formed the American Association of Psychiatric Social Work (AAPSW). Later organizations to form were the American Association of Group Workers (1936), the Association to Study Community Organization (1946), and the Social Work Research Group (1948).

By the 1950s AAMSW had matured with a steady membership of 2,500. Both AAMSW and the AAPSW had established their own journals: Medical Social Work and the Journal of Psychiatric Social Work, respectively. A strong ethic was established within these “professions” about the need to share knowledge through publication to build on evidence and develop theory for professional practice. AAMSW offered a full educational program and its own methods of study, set standards for education and practice, and made its own contributions to social work literature (Stites, 1955). They advocated strongly for the uses of theory and sound empirical evidence for practice.

Consequently, the proposal in the early 1950s to consolidate all social work interests among the seven national organizations into a new National Association of Social Workers (NASW) was not embraced easily by the AAMSW. Health care social workers held out for a long time because of strong convictions about the specialized knowledge required to practice competently in medical settings. After much prolonged discussion, however, they joined up.

By 1956 the new NASW, with 22,027 members, launched Social Work, its flagship journal. Twenty years later NASW finally agreed that a specialty health care journal was still a necessity and Health & Social Work was launched in 1976. NASW had 62,500 members by then; one-third practiced in health care, and nearly all were concerned about health in their practice. At that formative point the obvious individual to serve as the journal’s first editor was Beatrice Phillips, the previous editor of Medical Social Work, who was still the director of social work for the AHA.

Topics covered in the first issue of Health & Social Work in 1976 foreshadowed the modern era of medicine in which we find ourselves today. It included articles on social work in hospital emergency rooms, facilitating communication between physicians and patients, cardiac transplantation, psychotherapy with people with developmental disabilities, the “health care crisis,” development of a quality assurance program, and an article on social work and self-help groups by Joann Mantell. Appreciatively, I can report that Joann is still actively contributing to this journal 25 years later, currently as a consulting editor.

**Health Care Practice Today**

The relevance of social work to health practice remains every bit as broad but specialized today as it was in 1955. Today NASW has 155,000 members, even with the existence of more than 30 social work specialty organizations in health care (Keigher, 1996) and dozens of relevant scientific and advocacy organizations nationally.

But in some important ways, health care practice is radically different today. Hospitals no longer dominate the field. Indeed, they have become remarkably limited, providing mainly specialty treatment and highly technological diagnostics, using everything from lasers, radiation, and chemotherapy to massage and behavioral treatment. Hospitals advertise medical miracles, but today’s faith in physicians is tempered by public cynicism toward their whole inflationary business.

Today’s cost-conscious emphasis is on primary, community-based, and in-home care of all types; service dispersal; and local delivery. Geographic information systems, or mapping, can track health indicators and help organizations and communities set objectives, measure performance, and monitor outcomes. But today there is national gridlock because of systemic dilemmas in health care financing, accessibility, design of care delivery, and government policy. There are growing concerns about inaccessibility to comprehensive health care by populations disadvantaged by income, ethnicity and culture, age, sexual orientation, and geographic isolation; the numbers and proportions of people without health insurance have increased for the past decade, despite all the discourse about reform.

This has led to more rhetorical concern, if not yet budgetary support for prevention, risk reduction, and health promotion. The worst problems facing advanced industrial nations today are the “diseases of affluence” (Wilkinson, 1996), which include being overweight, which
leads to hypertension, diabetes, and high cholesterol, as well as getting inadequate amounts of physical activity and exercise, which precipitates functional impairments, vulnerability to accidents, and premature disability. The *Journal of the American Medical Association* (Fauber, 1999) recently reported on an “obesity epidemic.” The proportion of the population defined as dangerously overweight increased by 50 percent between 1991 and 1998. States with a population of at least 15 percent obese have increased from four to 37, and from 12 percent to 17.9 percent of the population. Obesity is but one of the rapidly increasing illnesses precipitated by distinctively social factors.

Social work has seen health practice broaden to fully encompass the definition of health propagated by the World Health Organization. As Brody (1976) pointed out in the first issue:

There is now increasing acceptance of the view that ‘the real measure [of health and disease] is the ability of the individual to function in a manner acceptable to himself and the group of which he is a part.’ The World Health Organization’s classic definition of health calls for the maximizing of social, mental and physical well-being, reinforcing the concept of an outcome measurement of health factored to individual levels of functioning. (p. 19).

Thus, Brody concluded, achievement of the goals of health are coterminous with the goals of social work. If only society would stop finding new ways to turn success on its head!

Today readers of *Health & Social Work* rarely find articles promising magic, cheap, or easy answers. You will, however, recognize the problems presented here and possibly the solutions that have been tried and tested as part of the accretion of knowledge our profession is still developing. But knowledge development in this profession continues to be, just as it was in 1905, 1918, 1934, 1955, 1976, and in 1990, a shared obligation.

Practitioners are, and have always been, “too busy” to write. But this profession is being poorly served when its “knowledge”—its theories, practice approaches, and evaluations—come too much from academics who never see in person that individual person-in-environment whose complex needs, diseases, and strengths are visible only by the careful eye of a skilled practitioner. Please think about that. When reading this journal, consider responding in writing, sharing your visions for and lessons learned in the practice of health in social work with others. Your thoughts are welcome in the form of regular articles, research reports, Practice Forums, and Viewpoints opinion pieces. Social workers are our most important audience. Knowledge development in health care in this new century means we all keep learning together and valuing each other’s essential contribution.

**References**


