THE COHEN INTERVIEWS

MARY SHERLOCK -- **Interview no 16**.

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Each interview is presented as a free-standing publication with its own set of notes. However, readers interested in the Cohen Interviews as a whole and the period discussed are referred to:

(a) the other 25 interviews

(b) the Editors' Introduction,

(c) the select Bibliography.

All of these can be found at
http://www2.warwick.ac.uk/services/library/mrc/explorefurther/subject_guides/social_work

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Mary Sherlock wanted to do medicine but finances would not permit whereas Elizabeth Gloyne (Interviewee no 9) wished to avoid a medical career but both ended up with fine social work careers. Coming from a "sheltered background" she found an early COS placement in Liverpool a daunting experience running for her life on one occasion down Scotland Road. By 1942 she had qualified after a great deal of "sitting by Nellie" training and six weeks of lectures. Some of the former was listening to interviews behind a partition, so with no opportunity to observe any interactions. As with all the interviews there are memorable vignettes as when Mary Sherlock describes trying to conduct an interview during gas mask drill but needing to wear glasses without which she could not see the patient.

In her early twenties she was, like many of the other interviewees, coping with major challenges during the blitz and found this gave her valuable experience that "oiled the wheels for other things". An even greater challenge was to be appointed after two years of war work, as the sole almoner at Doncaster Hospital. It was difficult not least because she was "very isolated", had no colleagues and hence no one to discuss anything with. The contrast between this job and a later one in 1946 in the

skin department at Leeds Infirmary was stark and this often huge variation is a feature of the experiences of all the medical social workers interviewed. But for Mary Sherlock the Leeds experience was to be followed in 1953 by a job in a London Hospital which was "highly unsuitable " and which no London social worker would have applied for. She stayed six months which was longer than the one day that Ilse Westheimer (Interviewee no 22) stayed after an equally dire appointment.

Fortunately a number of locums in major London hospitals restored her confidence and nine years at Hammersmith Hospital followed with opportunities for staff and student supervision. The years in which as she said "social work was nothing if not practical" must have seemed a very different world. Yet she was rooted in the practitioner role finding much of the social work literature "unreadable" and drawing on classic literature, such as George Eliot's novels, for insights. Above all as she said "the patients taught you".

After Alan Cohen's 1959 cut-off date Mary Sherlock had five years with the Council for Training in Social Work which she relished and it enabled her to realise how much she knew. The interview gives us just a glimpse, but an invaluable one, of that knowledge and experience.

A.C. When did you come into social work then, Mary?

M.S. I qualified early in '42, and in those days there was nothing that we would now call a specific training course. It was largely "sitting by Nellie". So I suppose I started training in the Autumn of 1939. I remember that I was rather unusual in that I was selected before I took my social science diploma. Now most students were selected afterwards, and I never quite knew why this was. It may have been to do with money, because money was tight and I think, probably, in those days one's parents were involved as they wouldn't be today. I think probably something was said that if I wasn't going to be selected, I couldn't spend two years doing a social science diploma. I was selected by a committee in Leeds because in those days the Institute of Almoners **[1]** had one or two regional committees so I didn't have to come up to London. I was selected, I remember, by a quite large selection committee sitting round a table: no kind of tea fight or anything like that. That came later. But I was simply selected on interview, and told that if I got the diploma I would be alright. So then I started in on the two year diploma at Leeds.

A.C. Was that straight from school?

M.S. No. At school I managed to get the right number of credits in school certificate but not in the right subjects to get Matric [that is the abbreviation for *Matriculation* which was the term commonly in use for achieving the necessary examination passes for university entry]. So I went to the local technical college at Huddersfield and took London Matric, direct, as an exam and incidentally discovered that it was a great deal more difficult than getting exemption through school certificate. So that I'd had a year there working for Matric on leaving school. Then I had one more year. I took Matric, with a view

to taking an arts degree, and then that began to appear pretty pointless because I didn't know what I was going to do with it anyway. I had wanted to do medicine rather badly, and there never was enough money for that as a possibility. I think I was a bit lost. But I did know I wanted to work in a hospital. I think it came about almost accidentally that I heard of what was then called almoning, and it sounded interesting. But it wasn't at that stage really seen, in a sense, as social work predominantly. It was seen as being in a hospital and very oriented that way at the time. So then I did the social science diploma, and that must have been 1938.

A.C. It was a two years course, you said?

M.S. It must have been a little more than two years because there was the social science diploma for two years and then some practical on top of that. I was getting confused as to why I didn't qualify until June 1942. But of course it wasn't two years; it was more than that. Because in those days you had to do some work with an organisation similar to the COS **[2]** in London. Now most people came to London, but the war broke out in the September that I was due to come, and so I was allowed to go to Liverpool, rather than to London, because it was felt that perhaps the family wouldn't want me up in the Blitz and so on. So I went and did, probably, two months with the Personal Service Society in Liverpool **[3]** with Miss Deed **[4]**.

A friend had done the course with me at Leeds. We both went to the PSS at the same time. One of the things I remember was being absolutely petrified, coming from a rather sort of sheltered background, at large in Liverpool, and because of the war we weren't even allowed any street maps of any kind. So the mere fact of setting out on the first day to find the offices of the PSS was quite an ordeal. We were sharing digs which made it a little easier, the two of us. Four miles out of Liverpool; a tram ride. But what I do remember is that on the first day we were both given four visits each to do in differing parts of Liverpool. Not the faintest idea how to set about it at all. Never had seen tenement flats such as we had to go to. We were both so scared that we both did the eight visits together! But this fact, unfortunately, was discovered and we were sent then to separate offices so that this couldn't happen again. But I do remember a certain amount of drama. I recall being very scared when I witnessed my first street fight in Pitt Street. These were the days when the policemen went together up Scotland Road; but social work students went on their own! I was ashamed to say that I was so petrified on witnessing this fight that I decided discretion was the better part of valour and ran for my life!

I did do <u>some</u> training in London, but that was really very patchy and desultory. I think I was meant to work in a settlement. In fact, I was meant to work at Mary Ward Settlement **[5]**, I recollect. But then you see nobody having told me anything about the geography of London, I'd arranged to stay with relatives out at Wembley, and just plainly refused to work at the Mary Ward Settlement in the evenings, and this I think was quite a black mark which lived with me for quite a bit. I didn't discover this until later. But not being willing to work in a settlement in the evenings was definitely not the right approach to have for a future social worker. But at the time I didn't even know what a settlement was and you really were just thrown in to find out. This was

no doubt good for us, but I'm not sure some of the experience couldn't have been much more constructively used if one had had a bit more understanding about what it was about in the first place.

The social science diploma looked after itself. That wasn't any particular problem. Then we had this bit of practical training but I think I ought to say I was with the first group of students who had the beginnings of the Institute [of Almoners] training other than a just "sitting by Nellie" training. It was held in Leeds, possibly because of the war. I can't recall the exact length but I think it was about six weeks which we had as a group of future medical social workers and it consisted of, in the main, of lectures on various topics. I remember lectures from a paediatrician, and lectures, or a series of lectures, to make sure, believe it or not, that we really knew the facts of life! Very delicately put I recollect. But there was the very, very maternal and nice woman doctor who broke very gently to us some of the more distressing things that we might come across in the course of the job! Well then it was a matter of doing one's practical work.

In those days if students looked as if they weren't doing very well in a placement, it was possible to change, as indeed it still is, and that there were some fairly well known, rather alarming, head medical social workers. In those days there weren't people designated in any way as student supervisors. You went to the hospital and you would usually (certainly in my case) go round each department for a few weeks. I must have had about five or six placements, two in Leeds, but not consecutive. One was at the local authority hospital. That was an experience in itself. In those days students had very little status, and I recollect very clearly it took two or three days before I realised why there was a sudden disappearance of all the almoners round about 10.45 into the room of the head almoner, before I discovered that they all went in there for coffee. But not the student! The student was sent down the road to the local patisserie to buy cream cakes and things of which she didn't partake. You just handed them in. That was quite a scary experience, that particular placement, with a rather formidable lady. Well then from there I went to Leeds Infirmary for a quite long placement there, and what I remember most, I suppose, about that one was the head almoner there who kept her hat on all day. Very eminent lady; wore a beige overall and a large brimmed straw hat. I was in trouble on the very first day there because I'd understood that students in those days wore blue overalls, at any rate in that hospital, and I went out and bought myself a really rather snazzy blue overall with a sort of scalloped collar, tight waist and flared skirt and felt smashing in it. On my arrival I was told to take it off, and what was needed was a perfectly ordinary plain blue overall with take-out buttons. That was the end of that.

A.C. So did you have to buy your own overalls?

M.S. We bought our own in those days. But they had to conform. I spent a good deal of time in the Outpatient Clinics and Casualty on that placement. But out of all that, I suppose, one of the most idiotic things that remains with me, was that we had to have gas mask drill. Trying to establish any sort of rapport (I don't think it was called a casework relationship in those days) with a worried client with a gas mask on, took quite a bit of doing, especially

if you wore spectacles as I did, and either you couldn't get the thing on because of the spectacles, or you took the spectacles off and then I couldn't see the patient!

A.C. Was there any teaching about things like interviewing and how you went about doing the job?

M.S. No you watched, and listened and I wouldn't want to in any way deprecate that. I think it had an awful lot to offer. Occasionally, I remember, if there was a very tricky interview being set up, I was sent next door where I could hear the interview over the partition. There was no question in those days about the ethics of overhearing. Because everyone overheard anyway. In other words it wasn't specially set up for the student. The offices were not sound-proof and therefore nothing was thought about it. But I did have, in those days, one extremely good, what we would now call a supervisor, who later became a distinguished Head in that hospital, Miss Royston Brown. I did learn a lot from her in terms of her attitude to the patients, and concern about them, and the time she was prepared to spend with them. These were largely new diabetics. Very worried, very scared. In those days having to weigh all of their food and there were, of course, quite a bit of financial elements involved because in those days part of the job was how much of the things diabetics had to buy; could they afford. Part of it was assessing them for the scales and the syringes and all the things they had to buy to do their tests with and so on. So that there was that element in it too.

Then I went up to Carlisle and I later discovered that this was a kind of rehabilitative experience with a Head social worker who was known for her ability to retrieve people who looked as if they might not pass. My report from Leeds, apparently, gave rise to anxiety, but I was not told why at the time. One never really did know why in those days. Not only did I not see my report, but I didn't know what was in it. But at some point, and I can't entirely recollect how, I did discover that one of the criticisms had been that I laughed inappropriately. That was obviously seen as something that was quite unsuitable for a future medical social worker. However, what was interesting was the experience up in the smaller hospital in Cumberland. It was revolutionary after what I had found at the two other hospitals, in that quite early on I was invited out to lunch with the Head Almoner and her colleague at the cafe down in town. I was treated completely differently. Almost as an equal. For those times, really very modern. And it was obviously an operation entirely designed to build up the confidence which I lacked (I suspect the inappropriate laughter was related precisely to that). That was really quite a happy time, and I did, in fact, alright. What I recollect most clearly I spent a lot of time doing, was writing letters of condolence to the bereaved. Because one of the practices in this hospital was to go through the deaths in the local paper every morning, and pick out any ex-patients who'd been, not patients of the hospital, but patients of the Almoner's department, and then if it was thought suitable, write regretful letters to the relations. I became quite expert at this I may say, a skill which I think I have never lost! Perhaps not the most useful thing from the social work angle, but it's been quite useful in my personal life.

Well that was that. I passed at that point, and was then sent to Halifax where after one week I was left in charge of the department as a locum. There was one other girl there from Ireland, also a student, and between us we ran the department. I've not many memories of that. In fact the only sort of memory I have, quite frankly, that stays with me from that experience was the lady in late middle age who rushed in to have her baby who didn't know she was having one. This was my first experience of someone who really didn't know that they were pregnant. She was I think about 49 or 50 and completely caught unawares. My first job was to go out and buy the layette, and all the things which she would need because she was wholly and totally, in every way, unprepared. The fact that she was psychologically unprepared wasn't anything that came my way at that stage. One was just expected to produce the useful physical things. Indeed, let us be fair, her biggest anxiety at that moment in time, was that she'd got nothing to put on it; this bairn, when it came. I wasn't entirely thrown by this, because during my time at Leeds Infirmary I'd worked in the maternity section, and had done a good deal of rushing round fitting people up from clothing cupboards and this and that.

Certainly in those days social work was nothing if not practical. One was taking people out shopping and buying them clothes and fixing up the homeless. It really was at that sort of level. At that stage I recollect very little directly dealing with people's feelings other than being sensitively aware of them. But one wasn't as it were, working actively in that area. This was a background to the more practical things that you were doing of which, of course, at that stage the most practical I suppose was assessing what they were going to pay. Because these were the days when people paid, and there was assessment for appliances, assessment for almost everything. This was the sort of basic thing one was doing, and it was considered that in the course of doing that, you picked up other problems. Obviously you rapidly discovered if people were in major financial or housing difficulties and so on. As paying for treatment was anticipated by the patients anyway, it wasn't resented. People today might think this would get you off on a bad footing but of course it didn't, because the assumption was that they paid the full cost, and you were seen as the lady who might in fact enable them to pay <u>less</u> than the full cost. They didn't start from the assumption that it was free and you were telling them how much they had to pay. So that you did start, in spite of all this emphasis on money, from a positive footing from that point of view.

A.C. Am I right in thinking there was some discussion amongst the almoners about how they could ditch that part of the job, during the war when ideas about Beveridge **[6]** were being floated?

M.S. Yes I think so. What I remember most will come better later on, which is the anxiety when the health service was set up, about how you would get your patients. I was then rather out of current discussion at that stage, because once I qualified I did this locum at Halifax and then I went to St. Albans and did a locum there. The hospital was the country hospital acting as a base for the Elizabeth Garrett Anderson **[7]**. What I mostly remember there was the really formidable women surgeons, who absolutely petrified me. One doesn't know why they were such dragons, except that of course in those days they seemed to me rather ancient. I suppose in reality they were probably in their

50s or perhaps 60s. One realised they were really the vanguard of women surgeons and that they'd had to fight every inch of the way to get where they were and they hadn't lost the habit! They really were paralysingly frightening to their staff; to the nurses, junior doctors and everybody. It was really an education in itself that.

A.C. It's sometimes said about, probably the generation before you, how lady-like they were and how upper class and so on. It suddenly hit me that (I don't know if you think this is true) unless they had of been of that background they'd never ever have made any impact in the hospital. It wouldn't have been possible to break in to the world of the doctors and the matrons and the sisters unless they had also been of the same social world.

M.S. I think that's true as far as the doctors were concerned. In some hospitals like Thomas's and the big London teaching hospitals, it would also apply to the nurses. Less so in local authority hospitals up in the North. But in some of those it could and did have the opposite effect. Occasionally even I was aware that they were seen as rather standoffish and superior. But I think it was more an educational thing, that these were the people who got to university and so on and then got into this kind of a career. Though of course there weren't the number of graduates in those days. They did tend to have social science diplomas. But there were a number among the better-known Heads of teaching hospitals and so on. Many of them were Oxford graduates. Certainly in my day.

A.C. Am I right in thinking that the problem for the almoner was showing that there were aspects to the job other than that of assessing for payment? And that one of the things one had to do in establishing oneself in the hospital was show that there was something else.

M.S. This was very hard coming. I think the days I'm talking about, in the hospitals I was in, perhaps the provinces were a bit behind London in this respect; it was an intensely practical job. I don't mean just geared to the money, but it was getting them re-housed, seeing they could afford their prescriptions, seeing that they went to see their doctors, seeing that they attended child welfare clinics. It was really very much practical at that time. I then got my first, as it were, permanent job following these two locums, which was in London during the Blitz. Now during those two years much of what social work I did arose from administrative tasks. Because I was in a central London hospital, the West London, and really I would say 50% of the work was getting people down to the main hospital, such as the one I had been at in St. Albans. Now here there were things to be done, certainly, because there was often quite a lot of trauma involved in sending people down to these hospitals away from their families, and there was quite a lot of resistance on their part, and a lot of reassurance was needed, especially if it was children going and so on. I was in the out-patients, so I didn't get too much of this, but a certain amount I did because if people were put on the waiting list, then you had to explain to them they wouldn't be coming into the West London. They would be coming into a hospital 40 miles out, in the Home Counties. And there were a lot of practical arrangements about ambulances, about transport, about getting them there; the everlasting money again. This meant having a lot of knowledge about

resources, about where they could get money from, and being on very good terms with the Relieving Officer **[8]**. I remember being somewhat disappointed at that stage in my career at the amount of administration.

However there was some scope for very much more, because there were one or two out-patient clinics from which you'd get what today we would get called "good referrals". A family problem, usually medically related obviously, a child needing to come in and parents refusing or this type of thing. There were some pretty grizzly things too. I recollect that tonsils and adenoids in those days were done as out-patients and there was some nightmarish things to be arranged, with poor mothers with quite big children aged about seven, left to carry them home in their arms. It was really quite grim. Of course the reality that stays with me in a way, from those two years isn't to do with social work as such, but is to do with the war. And it's very difficult for this not to take over. We all did fire watching. The Blitz was going on, and the particular job that I had to do at that time, was to keep track of people. In other words if they came in as air raid casualties, I had the not very pleasant job of trying to extract their name and address from them before the doctor got there with the morphia, because once they'd had their injection I couldn't find out who they were.

If there was an "incident", it was a sort of mad rush round with some great big buff envelopes (anybody who worked in the war would remember them) and you had to rush with these and get the name and address if you could conceivably get it out of them, gasping, while a doctor stood literally with his syringe waiting for you to finish so he could ease the pain a bit. And in between you rushed round with cups of tea. Then you had to chase up and see what ward they were on and where they were going to be sent next day. Because all this information had to be fed back to some police centre, to keep track of people. Well, was this social work? Not in our current terms. I mean it was really administration plus human kindness and a good deal of spiritual comfort, added-in, in a sense. This was all mixed up. One of the things you certainly had to be was versatile. Because as I said earlier on any one afternoon you wouldn't know whether you were working say with a thyroid clinic, on a perfectly ordinary almoner kind of job, being sent for by the registrar to discuss what could be done about this old gentleman who lived on his own, and really shouldn't be doing so and what about part 3 accommodation, or whatever. And next minute wwooooosh and you were back on the other aspect of the job with the casualties. It was a very strange life.

A.C. You were still in your twenties when you were doing this?

M.S. Oh goodness me, yes! About 24. You fire watched three nights on and three nights off as well. I remember this actually did a great deal for cementing relations with other colleagues, the doctors and sisters.. If you were on fire watch with them, and you were helping the customers, as it were, the casualties, with them, you didn't need to be establishing yourself through your social work. It was the wrong way to do it, I am not recommending this, but it did have a side-effect that would happen in any war time situation, in a sense. Oiled the wheels for other things. After that, after two years of that, I came

back North for family reasons, and took a single handed job as almoner in sole charge at Doncaster. Now this was in the end, I'm bound to admit, was premature. Because I had only two year's experience, and very peculiar experience at that.

I had a difficult time at Doncaster. It was a new department I may say, starting up with its first qualified almoner having had an unqualified lady before, who was socially well-known to everybody, and lived in the district, and my first six months were spent living down my predecessor whom everybody had adored, and trying to get established. I was greatly helped by a Head Physiotherapist, I remember, and this introduced me to a totally different kind of experience which I've never regretted, of working with miners. Because a very high percentage of the work was pit injuries and pit accidents. It taught me a great deal really about attitudes in those days. The hazards of mining were considerable, but I had to come to terms with what was difficult for me, I think, which was the fantastic hostility to employers which went to lengths which in a sense had negative results for the patients. Their attitude was that they wanted the employer to pay, to be made to pay. This was the time when industrial injuries benefit was coming in and you normally got this through your insurance, and I found tremendous opposition to claiming industrial injuries. They all wanted to go to court. I think it was they sued under common law, because they wanted what to them was the pleasure of feeling that the actual pit owner - the money had come from his pocket. It was extraordinarily difficult to convince them, that if they claimed industrial injuries in the normal way their employer had still paid in towards this. They had a very simplistic approach in that they actually wanted to see the chap in court and the money coming out of his pocket. It wasn't at all the same thing to get some money like your sick benefit at an increased rate. And this was still very prevalent at the time I was there.

A.C. It's jolly interesting that it had to be a direct transaction.

M.S. Yes it was very interesting. Obviously I learned both positive and negative things about life in a mining village. There was tremendous loyalty and tremendous courage. I hadn't at all realised the hazards, the number of spinal injuries. I'm not talking about big pit disasters of a magnitude, but I doubt if a day went by when I didn't walk through the casualty department, or the orthopaedic department, and see a black face, and somebody on a stretcher. It was lucky if it was a leg or an arm injury. It was so often a spine. And immediately you knew you were going to have them on your books for the next twelve months. Now an awful lot of my work then was much more approaching "real social work". There was a lot of work in helping them with compensation claims. A lot of long-term patients trying to learn to walk again, patients with wheel chairs, and so on. I got very closely involved with the physiotherapy department, and most of the work I did at that hospital was with the miners and the orthopaedic department, because, although I was the only almoner there, I felt I had to start somewhere and get a foot in the door and build up from getting known and getting accepted in a specific area, rather than trying to cover the waterfront very superficially. In that particular department I think it was quite successful. But I became increasingly aware that I wasn't making the impact I'd hoped for in the hospital as a whole. I think

I underestimated what I was achieving at the time, because, in fact, the department did continue and grew, and it didn't just fold up when I left. But I think I was feeling very isolated. I had no colleague, no one to discuss anything with.

A.C. Did you have no contact with London?

M.S. No I'd very little contact with London at that time, but I did have contact with Leeds. And once or twice went over there to talk over difficulties, and after two years at Doncaster decided to move. It was secondary, but it was a very long distance from my home. I was doing this job and travelling 50 miles each way each day, on trains which could be anything up to three hours late in the evening because they were the London trains, and one would arrive on the platform puffing at 5.15 to hear an announcement that the train from Kings Cross would be three hours late due to a bomb on the line. And I would sit, never let it be told, playing cards in the bar with the miners and everybody else who was waiting for the train. That was an education in itself too! The one perk I must say of that hospital experience was that when you got a grateful patient, far from trying to give you a present of chocolates or something like that, I used to get little notes slipped into my hand giving me the tip-off for the latest race, especially if the St. Leger was coming up. Because they were great gamblers and the sort of nicest thing they could do for you if they felt obliged to you was to give you a tip for the next race. I think at the end of the two years I about broke even! But I do remember thinking at that point in my career, that some of my previous supervisors would suffer slightly from shock if they actually saw what was going on! Then great fortune came my way. I was invited to apply for a job at Leeds Infirmary as a senior on a staff of about seven or eight. This was in 1946. The job was in the skin department, and this was a new department, new "physically" I mean, in a new block of the hospital, physically very brand new and shiny and lovely offices. Highly desirable, particularly desirable to me because my predecessor had been the same colleague that I'd shared my training with in Liverpool, and I took her job over, as it were.

I knew quite a bit about the job before I took it on from her, both the satisfactions and the problems, of which I was warned, the problem being the autocratic but extremely eminent dermatologist who ran the department. And really the question would be whether I could get accepted by him in the first place. It would be not too much to say that those nine years, in that job, probably was nine years of most excitement for me personally. This was a department which was somewhat separated from the rest of the hospital. Let me say at once that its disadvantage was that it was quite difficult to feel part of the almoner's department. This particular consultant had very much a team approach, and all the staff on his team belonged to him, including his social worker. (By this time we were being called social workers.) And I had to work hard at feeling part of the social work department. Fortunately I had good friends there, I'd got to know them well, but it was very much on a social - with a little "s"- level. In other words I got on very well with my social work colleagues, but very little of it as far as I can recollect, was related to discussion about work. Very little of this seemed to go on in those days. I've hardly ever any recollection much of staff meetings, or any discussion of sort

of policy within the hospital. If there was, I was left out of it. I met them over tea and over morning coffee, and over lunch, and knew them very well indeed, and we did discuss cases to some extent, informally over meals. But I don't remember very much built-in discussion in the early years. I think we were beginning to move into this before I left. Things like case discussions were just beginning to be heard about.

On the whole you did your own thing, and if you got into a difficulty you went to see the Head Almoner and it was discussed with her, but I don't remember very much shared discussion among my colleagues about the job. If I wanted discussion about patients it was within the department I worked in, with the other doctors, with the sister, and so on rather than with other almoners. But this may have been unique to this particular outfit. I wouldn't like to say that this was prevalent, because I simply don't know. This was the negative side. I think I could have benefitted, and everybody could have benefitted, if I'd been more part of the general scene. But this was the age of specialisation within specialisation. Certainly at that hospital we were all attached very closely to teams, and you were an orthopaedic almoner or you were the children's almoner or you were the dermatological almoner and so on. Now this had its satisfactions as well as its pains. I don't know whether this was the era which gave rise to "the doctor's handmaid" kind of criticisms. It may have been, because obviously if you were that closely integrated into a team and the recognised team leader was the consultant, everybody was open to that kind of statement. On the other hand it certainly didn't feel like it, because this consultant though autocratic to the nth degree, had an enormous respect for social work, and used his social worker in a way that I've never ever been used before or since. He was of the school that believes the bulk of skin diseases, other than a few obviously organic things like those with a tubercular origin, are psychologically based. Or if not, entirely psychologically based, are triggered off by stress, by emotional factors and so on.

This was my first introduction, in a way, to this kind of approach, because in training we hadn't had much psychiatry. In fact I'd had none frankly. Human growth and behaviour was not heard of in the days when I trained. I'd had some social psychology lectures in the social science diploma, of the sort of "rats" variety. But nothing related to psychiatry now. One of the very first things this consultant did for me, was to arrange for me to go with the medical students to their psychiatric lectures and at that time that I was there, the Professor of Psychiatry (because it was of course a medical school) and his colleagues worked very closely with this dermatologist and they were forever in and out of the department. And they were more than willing for me to go to their lectures when I had time. This was a very interesting experience for me with Professor Dicks **[9]** and his colleagues, all of whom later followed him to the Tavistock **[10]**. But I was quite closely involved with them and with their psychiatric social worker who was a lot of help to me. But this was a time when I really – if I can put it that way – I myself grew more, and developed more, in those years than in any other period in my life personally. Because far from being a handmaid, I really was regarded, as nearly as possible, as equal with the consultants and the registrars. There is no doubt at all that they listened to what I said. Patients were referred for a report from me on their background, their problems, and so on at a rate of knots.

I mean, I could scarcely cope. So far from worrying about how do I get referrals, how do I get the work, one was absolutely inundated. There was a certain amount of perhaps medical snobbery, satisfaction, as well, because this particular consultant was internationally known and we therefore had a great number of meetings of a rather high-powered kind in the department, when eminent people would come from overseas. I was always involved in these, and was introduced to them in a way which was pretty unusual for social workers in those days. But most of all you see I really learned a lot about people and problems and stress, and the sort of psychiatric origins of skin disease. It's there that I had my first experience of teaching medical students about social work. And this wasn't all that common at that time. But it was arranged that I gave a weekly lecture for six weeks or so to each batch of medical students as they came to the department.

A.C. Did you make it up, or were there texts?

M.S. Oh no I made it all up. There were no texts. It was mostly just a kind of introductory run through about what I thought social work was. But then you see most of it was case-related. I spent most of the time illustrating from the patients that they knew, or patients that we'd had. I also had my first very amateurish experience of group work in that I got together a small group of mothers of children with infantile eczema to talk about the problems they had. Some of this was immensely practical. Indeed most of it was immensely practical. It was to do with how to cope with the frantic scratching. Then even very elementary things like how you tied little gloves on so they couldn't actually draw blood, but could only kind of bang away. One needed to understand the difficulties the patients had, for instance with increased laundry, costs because of ointments that stained clothes. They had practical needs for buying more clothes because they used things like gentian violet in those days, and your clothes were ruined. We had to find ways of getting them special diets because a lot of skin diseases were of that variety. They needed increased vitamins. The financial element didn't go until '48 and I went there in '46, so there was still this in the first years which disappeared later. Although in this hospital assessment for in-patients was done by administrative staff.

If I can sidetrack a minute, this is why I made that earlier point about not lacking referrals. Because in '48 when the Health Service came in there were quite a lot of almoners who were worried as to how they would get their clients when they were no longer seen for assessment purposes and so on. I didn't suffer from that, because my work was thick on the ground, and I wasn't doing any assessing, except I had to do a certain amount about costs of fares and fare refunds and that kind of thing for people coming from a long distance. There were still Relieving Officers about too in those days, and I can remember referring people to them for dietary things. But the infantile eczema children mentioned earlier were quite a major factor and I had to do quite a lot of helping parents with things like suitable toys. I was trying to explain to them that their children were hyperactive because they needed constructive things to do, and encouraging them to give them things to bang, and things to let their aggression out, and not just stuffed toys that they couldn't do anything with. Again it was an immense learning experience for me. I think I would still

say that I think I learnt more there than perhaps I gave. I don't know. I hope not. But I did learn an immense amount. There were some interesting things which were quite amusing to remember. I certainly remember this question of aggression and skin conditions. I remember one boy of about seventeen who we discovered lost his rash completely if he went to a boxing match, and any sort of vicarious aggressive activity and his trouble cleared up! Unfortunately he couldn't live at boxing matches. But there were quite a number of situations of that kind.

We had our more serious conditions. I had to do quite a lot of work with people who were variously terminally ill. I think it's not so commonly known that there are some skin conditions which in fact do lead to this, conditions of fragility where people blister and then get septic and so on. And of course there were still patients with tuberculosis conditions and some malignant conditions, and Hansen's disease: leprosy. But then of course we sent them off to the tropical diseases hospital at Liverpool. I was there during the brief smallpox epidemic that there was in Leeds as well. But that didn't lead to social work particularly. That was just very sad and disastrous. But certainly during those years was where I got my human growth and behaviour teaching if you like, that people now get on a training course, and I got it very well and very easily in the course of the job.

A.C. Were you involved in professional organisations at the time?

M.S. It was during this period that I was the representative from Leeds on to the Institute's [of Almoners] committee. So I was getting involved in London, in policy matters, which didn't so much affect my day to day job, but they did make me aware of developments that were happening all over the place.

I was on the Institute's committee, for instance, at the time when we "blanketed in" what were then known as "C" members, people without the Institute's Certificate, but with long experience. There was a lot of debate at the time. After the war you see, there was also an emergency training scheme for new medical social workers, a crash programme. They came into the Institute as full members and were not identifiable in any way as having taken a shorter scheme. By this time the Institute's training scheme, had come into being and was well under way.

I remember coming up to these Council Meetings as they were called feeling very provincial indeed and this was where I met some of the very formidable Heads of the big London teaching hospitals. This in itself was an education at a quite different level, because it was here that I simply had to begin to look more broadly and more widely at policy issues and medical social work across the country. I remember that almoners in Scotland were always thought in London to be something of a problem. They tended to be very independent even in those days, of what was going on in London and to want to remain so. Quite a lot of the Council time was taken up discussing what we were to do about Scotland. I think I came up quite often. You did a three year stint, as representing a provincial region and coming up to the London Council meetings. And this was invaluable to me of course when I finally came to London because I did at least know that it was a very different scene.

Because you really can't count that two years that I did in the war because it was so atypical, and was as much like war service as social work. So I really relied on my membership of that Council and those meetings, to broaden my whole outlook, to look at things to do, as I say with not just day to day patients, but with the profession as a profession and its development and where it was going and what was happening. That's really where all that bit began.

I came to London in '53, largely at that time, for personal reasons. I came up from the provinces not knowing much about the London scene and applied for and got a job - which turned out to be highly unsuitable - in a hospital which no London social worker would have applied for.

A.C. Didn't the Institute give advice about jobs?

M.S. Only after I'd taken it. I unwisely didn't ask in advance you see. The Institute were invaluable to me during those difficult six months which I was in that post. I saw Miss Steele on a number of occasions, Marjorie Steele .The Institute were extremely helpful and gave me a considerable amount of advice as to how to deal with the situation. At the end of six months I was able to get out of it, but by doing two locums at Thomas's and at the Westminster. This again was a piece of invaluable experience in London teaching hospitals, which I quickly learned were very different from provincial hospitals.

They were learning experiences for me in dealing with consultants, of great eminence, and dealing with ward sisters at St Thomas's where I met the Nightingale Sisters for the first time, and discovered there to my chagrin that after being so highly esteemed in my dermatological department, I was now of little account. The social workers had to watch their step very carefully on the wards. But I think it was here, both at the Westminster and St Thomas's that I first got the feeling of really belonging to a social work department. Now this was another sort of landmark you see, because I'd had the isolation at the West London and Doncaster, then I had an extremely specialised job in a team, but with not much contact, other than social, with other medical social workers. Now both at St Thomas' and the Westminster I was taken right in into the almoners' group, and began to see things from a quite different sort of perspective as what a social work department in a hospital, as a department could do, and what its role, within a hospital, as a department, was. Now this of course would probably be different from other people's experience because it came really quite late on for me. Where I ought to have had it was during training when I was a student, in big departments. Two big departments with eight or nine almoners, but those were the days when a student wasn't part of the department in any sort of way. So really I hadn't operated as one of a team of medical social workers until that time. Those six months as locum really helped a lot and they proved invaluable in view of the fact that my next job was as deputy head in which I was very much expected to be au fait with administration and a whole lot of aspects, that quite frankly I didn't have a lot of experience in.

That was the point at which I moved to Hammersmith with Enid Warren (Interviewee no 21) and in a way became again a generic staff member within

medical social work. In other words I worked with a number of wards, a number of completely different firms, with wards with quite different patients on them. I was a long time there too. Another eight or nine years, which brings me beyond your date of 1959. In the early years there, these were the years in which I think casework with a capital 'C' was at its height. We had an American on the staff. We had during this period, case discussions, staff meetings - staff meetings about policy though, not about clients. What I do remember is that we set up an informal casework group in somebody's flat in our off-time, in order to improve our skills which included the then student supervisor to LSE, plus a senior member of staff who took students from the Institute, plus the American and plus myself. These were not laid on for us. It was a matter of self help, which we wanted to get because we had this American on the staff. I had been, while at Leeds, to two sort of schools, which the Institute ran, at Offley Park and one at Dinton where 40 or 50 almoners met and where there were talks and discussions and group discussions. This was the era of the beginning of providing teaching for qualified people and the beginnings of extra teaching to up-date us. If I'd been in London earlier I'd have been to more of them. But I had been able to come to these two before I came to London. But then the deputy Head job again was different because there was a quite different role including later on where I moved into staff supervision. But I think this was probably after '65 so I'd better not get carried away on the differences between supervising staff and students.

A.C. Can I ask you a fundamental question? Something you haven't referred to all this time? Was it a problem going onto the wards in hospitals? Did you not mind them? During the war it must have been pretty nasty.

M.S. Yes. You mean the kind of traumas?

A.C. Yes. Frightening things to see and unpleasant.

M.S. Possibly those first two years, those war years got me over that. Because that undoubtedly was kill or ease. Air raid casualties were very unpleasant. Remember my earlier comments about wanting to be a doctor. I think that I have never been squeamish. I didn't have a problem over things like patients with colostomies or unpleasant kind of conditions. I had more of a problem with people's personal tragedies. I don't think I had problems about what one saw on wards. I began to see the possibilities for social workers of actually influencing attitudes in hospitals. Within the team in Leeds, for instance, I had been able to get the consultant to change quite a number of small things in the way the department ran which enhanced the dignity of the patients: the way they were called out for and shouted for. In quite small ways I got quite a lot achieved in that department about how you handle people so that they don't feel more humiliated than they need in a hospital situation.

I'd begun to see that something could be done there. This was increasingly so I felt, when I got to Hammersmith. I think above all that was a hospital for obvious reasons which raised ethical questions. It's a post graduate hospital and one of the things one became aware of was that the emphasis was very much on research, very much on high technology. We were having the

earliest kidney transplants, which raised immense questions for families which people don't realise. I well remember one situation in which a member of a family wished to give his kidney to another member of the family but other family members didn't want that member to be the one to give the kidney, because the family dynamics were such that this man was rather the black sheep of the family. He was trying to redeem himself, by giving the kidney. The family were not willing to accept that, and the patient was left out of it. All the discussion went on between the well family members, as to whether this one should or should not be allowed to give the kidney. This was my first introduction to the sort of problems that you begin to get when you move into this kind of area. The research threw up an immense number of ethical problems. Perhaps the commonest was the problem of keeping people in hospital, thinking they were being treated when they could have been back with their families or back on their job. Of course this isn't a straightforward issue. Research needed to be done. Very wavy lines had to be trodden, and it did effect the social worker because you see very often these people were having supplementary finance from various places, or children were being kept in care, while mother was on the ward. One had to weigh up the pros and cons of this, and one's chances of convincing the doctors that their research was less important than Johnny coming home. And was it? It wasn't clear cut. One had this to work out within one's own mind. Had you got a good case? Was it your job to intervene in this kind of way? Was it social work's job or not?

It was a little bit like the moral issues about strikes and wars. You don't go in for them if you don't think you can win. Did you attack the consultant about this issue "A", and if you did and lost, was it going to affect issue "B" which was perhaps more important. If you ditched yourself in that area it could repercuss and I think it would be fair to say that it was in this kind of area that I began to learn what politics meant. Because it was walking on egg-shells. It so happened that I worked with two teams who were very research-minded and in which quite a lot of swords could have been crossed, and in some cases were. Battles were won and battles were lost. But battles there were, let me say. And no "handmaidens." One went into battle with administrators as well about ridiculous times at which the shop was open for visitors. It wasn't open when they were there; and it was open when they weren't there. All sorts of things like that within the hospital as a whole, which one felt one could do something about. Quite a lot of my effort at that stage was related to trying to do something about the sort of depersonalising that went on because of procedures. And this took a lot of doing. You really had to work at your relationships before you could hope to achieve any change of that kind by getting on such terms with your ward sister, that you really were able to suggest to her that "X" or "Y" wasn't a good idea. You really did have to be careful. But there was a lot of opportunity.

That was the stage at which I had quite a lot of work with patients who were having very traumatic surgery, of an experimental kind. And when you say, "Did I find it difficult?" I think, yes. Yes this period was difficult, not going on the wards in the sense that you meant, but what I meant by the personal traumas of people. Because this was the era of the pituitary implant. It's moved beyond that now, on to chemotherapy but those were some of the

things that were being done to patients with advanced cancer, beyond the stage of radiotherapy, where quite a lot of fairly experimental surgery, of which the outcomes were not wholly known, was going on, and patients needed an immense amount of support. I mean I did a great deal of work with terminal patients who didn't know they w ere terminal. One watched them coming back through the stages of mastectomy and then the next stage, radiotherapy and then pituitary implant, and they very often came very long distances. Interestingly, I remember particularly a patient who came from a quite remote bit of the Yorkshire Moors to whom one used to talk about what they wanted to talk about. But I learnt a lot at that particular period for what it was worth, about working with terminally ill people, in a difficult situation where, as I say, the medical staff were absolutely adamant that they shouldn't know, precisely because they wanted to carry out these very new operations and see what happened, to be honest. One had to come to terms with one's own doubts and feelings about this. But again this was a period of very considerable, although rather belated perhaps, development in this particular area. It just happened that I had so many terminal patients. Because I worked for that particular firm.

Now later on if we move into the post '65 period, then the job changed from my point of view. Then I was moving onto staff supervision. Miss [Enid] Warren disappeared to Australia for six months, leaving me in charge, and the job became altogether more administrative from my point of view, and I learned quite a lot there. I left Hammersmith in '63. So yes, I think it would be '59 or '60 before I was doing staff supervision probably.

A.C. The thing that struck me, Mary is how, as you tell your story, you become an increasingly sensitive social worker. It's clearly there from what you are saying. I wondered where it all came from.

M.S. At Leeds it came from the psychiatry department and from the PSW. But that was very much rather technical stuff. That was really learning about psychiatry about mental illness, rather than dealing with it. Hammersmith did a great deal for me in that direction, because we had a good psychiatric department and a PSW, Mary Lane **[11]**, of some eminence, was part of the almoners department really. We all learned from her, and if we had patients who were referred to the psychiatrist we kept them, so that to some extent I had a number of occasions when I was doing the social work for a patient whom Dr Ackner **[12]** was treating, and I had some experience there. But quite frankly any sort of increased sensitivity or what not came from this small informal group mentioned earlier you see, with this girl from America and Zasha [Zofia] Butrym **[13]** who brought much from LSE because she was student unit supervisor for them --and, let me be fair, from discussions with the students too. By this time I was reading quite a lot. There was always the journals and I did read casework books and so on in my spare time, when one had spare time. One did have a certain amount in medical social work, clinics went on late sometimes, but they didn't go on after 6 or 6.30 which to us was a bit late. But not of course like people today who have to work in the evenings. To that extent one must admit to a degree of protection from harsh realities of today. But I really got a lot from being interested and talking and from discussion. I was a marked non-conference goer. It grew like Topsy.

A.C. Can you remember any of the books that you read? Did they actually influence your practice?

M.S. I always tended to read articles in journals more, and I never lost my medical slant. I tended to read the *Lancet* and the *BMJ* before I read *Social Work Today*, or alongside it! This was probably a disadvantage except that I think I would want to come out saying that physical ill health is underestimated by social workers today, as part of the picture with the clients. Obviously if one has a hospital background, you tend to overstress it perhaps, but I think very much that there's an under-emphasis on the fact that if people are in constant pain, even say from something like arthritis, or if they can hardly get across the room because they are chronic bronchitic, you cannot discount this, and delve into the archives for the source of their problems, when their problems are very much of today. I don't think I regret this medical emphasis because it is one of the ways in which you can get alongside people and suffer with them, if that's not putting too great an emphasis on it. Because you could understand what they were going through physically, this gave you an in, and then you found that you could get alongside them emotionally in their reactions to it and so on. But there's no doubt at all that it's arguable that to some extent it was narrow, though I don't believe it was. This is a criticism that I won't accept about medical social work.

I think we met a cross section of problems, because you had children in hospital, children who were in care, plenty of delinquents! Remember I worked next door to Wormwood Scrubs, so we had prisoners, and quite frankly in terms of meeting a range of problems, you certainly had them. You didn't lose them when they went home, in the way that you possibly do today because you see except for the Children's Department, there weren't the services outside. So you had to follow your cases, to some extent, after they were discharged, because there weren't the local authority social services then, to do it. In terms of the actual problems that you met and the cross section of people that you met, everyone from the consultant's wives to the tramp and everyone, it really did offer very good experience, and the cross section of people was what you would expect. It was just a greater breadth than some people meet today, working with what you might describe as very deprived groups. Well we got very deprived groups but you see this raises the whole question of who's deprived and who isn't, and who's emotionally deprived ... Just as posh boarding schools can be full of deprived kids, so in a way hospitals had the same range. The narrowing factor, if you like, was the world in which you operated, the hospital environment, and the fact that you did, inevitably, have to restrict your work to some extent to those problems that had some relationship to the condition for which they were in. Largely because one of the things you had to learn was that it could become a gross impertinence if you didn't. In a sense that you had a captive client and you rapidly had to discover that it wasn't any good trying to work in the areas where they didn't want you. The work was more difficult, because you had no legislation to operate within. So you had no real rights in the situation and if the patient wanted to tell you to take a running jump, they could. And some of them did. So that you had to win it all. It wasn't presented to you on a plate. By and large you hadn't a lot of goodies to give them, and I think the goodies that you gave them really were trying to help them to stay people. To help

them to stay themselves as individual persons in an institutional setting in which almost everything else was geared to the opposite end. One tried very much to be the person who helped that bit of themselves which wanted to stay independent, stay independent, and this required some fine judgement as to whether it did want to stay independent or whether in fact it was going to help them to be dependent for a while. This was something that took quite a lot of discovery, and learning.

A.C. I was thinking while you were talking, there's an incredible oral tradition in social work. All of the practise wisdom which isn't actually derived from text books, but passed on by word of mouth.

M.S. Yes it is. This is perfectly true and I think we weren't very good about setting pen to paper in those days, like people are today, and an awful lot of it just got passed on that way. Then you passed it on to your students. You see having students was something which you took for granted in those days because it was part of your professional job. You never thought you were being asked something ever so privileged and special. It was just automatic that when you'd been qualified a couple of years you started having students.

A.C. It wasn't regarded as some sort of professional accolade?

M.S. Not in the early days. It became so later on you see. It's very interesting because I had a lot of students at Leeds, but when I got to Hammersmith I was told that because I hadn't been supervised myself, and been through the supervision process I wasn't suitable to have students. So having had, let me hasten to say, some students who are now, or were, eminent head medical social workers at Leeds, when I was much younger, but considered perfectly capable of having students. At a later stage I was sent two particularly difficult older students, perfectly successfully and I think they changed their minds. But that was rather symptomatic of a rather tricky period in the 60's.

But I think you're right, you see, you've been unable to get me say that I got this out of books. In the end I was driven to reading Charlotte Towle **[14]**, but I think I'd better have a burst of honesty, at this point and say that I found American,- there was very little English written material- social work literature virtually unreadable. Partly because I found it difficult to read the jargon, and the language in which it was couched.

In fact, the patients taught you! You say how did you learn this sort of sensitivity. Well you learned it by sheer hard experience and making mistakes and knowing that you had, and registering it, and not doing it again.

A.C. Do you read a lot of literature?

M.S. Yes.

A.C. Perhaps that's where your understanding comes from? Did you make any links between your interest in literature and your understanding?

M.S. Yes I think I did make links I think that I learned a lot about people from literature, from people like George Eliot. I don't mean the people who set out to do it so much. Like Defoe, where the social message is coming across so

loud and clear and they're writing about deprived groups or factory life or whatever with what I call an obvious purpose. This does less for me than reading *Silas Marner* or *Mill on the Floss* or something, where I just get to know people. I don't want a social message specially. It's a process and it's unconscious really. It's only really in later years that I've realised how much it has affected me, in a sense, because it wasn't conscious: it was unconscious. I've always liked words and people. I've always been interested in what makes people tick and this is dangerous. I went through a phase in which this was a danger. This was, I think, the medical thing again, in which I did realise that I could have got carried away with the skills of diagnosis rather than moving on to the skills of what you do about it. I suppose I've always liked detective novels of the old fashioned kind, and there's a bit of me that enjoys the ferreting out. This is one of the things I feel rather passionately about. I think really it was having students taught me this, because I had one or two students very scientifically minded, who tended this way. Again you see the research at Hammersmith which tended to treat people as objects of deduction so to speak or scientific investigation. I became aware fairly early on of the hazards of this, and began to feel quite passionately about it, and that this was a danger. I think it is finding a balance between being sufficiently perceptive, and being good at assessing a situation, then not taking so much satisfaction in that, that you get stuck is quite important: well, very important. Obviously you don't want people who rush in without due assessment and rush into action, but I think the hazard is more that one is paralysed by the pros and cons, and seeing all sides rather than precipitous action. I think the social workers in the late 50s were in more danger of being paralysed, prevented from action, because of their new discoveries. There was this enthusiasm and knowledge, with the sort of psychotherapeutic background, and interest in the psychodynamics and I think there was a brief period of over-analysis: not universal, because some people just never got there. After your comments about the provinces and my early retardation, I think some people missed out on that over-analysis stage and went from not knowing to the more balanced approach. But there were a few <u>in</u> people who for a short period were in danger of thinking so much about all these inner things, that they couldn't actually <u>do</u> anything. But I think it's been grossly exaggerated and I don't think it ever affected more than a small group of rather intellectual people who got on a bandwagon for a short period of time. But it's nonsense to say that this approach actually universally affected either medical social work or other social work. I was still finding people who hadn't heard of casework, at the time when it was becoming old hat!

A.C. That brings us rather nicely on to the first of my two last questions. Some critical things have been said about social workers during this period, like the things you have just been saying really. I wonder what you would say about it all?

M.S. I wouldn't say much more than I've said. I think that there was a very short period when this was all rather new when a small number of people got it out of perspective but the point was that they were the people in what you might call the van of social work, so they were the people who wrote, or were beginning to write, and the people who were heard about. My own feeling is that I wouldn't have known where to go to find a social worker who was so

wrapped up in somebody's psyche that they didn't really notice that they had a housing problem! I really wouldn't have known where to go. I think this was an intellectual stimulus, which did a lot of good in a sense because if it hadn't been for that period, a lot would have been lost. It went along with people becoming more intellectually aware, more able to conceptualise and wanting to get it on paper. Moving away from the oral accounts and beginning to realise that there was a body of knowledge to be passed on. And I think it was at that time when (some people would say that this was negative too), social work was keen about being a profession and therefore was keen about passing on knowledge, about writing. I think it was really in a way only fortuitous that is was the psychotherapeutic bandwagon that they'd got on to. They'd have got on to any new intellectual idea that had been floating about because they desperately needed something to get to grips with at that time. There were a few people who got carried away as any enthusiasts do, but it certainly didn't permeate either medical, and (I ought not to speak for psychiatric social work), it may have been more prevalent there but not among the psychiatric social workers that I met. I don't think it was a pity. I think it was, if you like, a little out of balance but it had enormous assets in terms of making people think and talk and argue and discuss, and it was a stimulus and a challenge to a group that was in a situation where I think we'd reached a kind of stagnation.

A.C. What's the best thing you have done in social work? Looking back.

M.S. I don't know that it was all between your chosen years.

A.C. It doesn't have to be.

M.S. As a practitioner I think probably I did the most interesting work, interesting to me, at Leeds in the dermatology department. But whether or not in terms of client benefit, or the good of social work, I'm less sure. But it certainly was my most interesting and most productive period and best growth period outside of the Central Council for Education and Training in Social Work (CCETSW) **[15]**. Then I think the first five or six years at CCETSW were another very belated, (in view of my age) but enormous period of development for me in terms of growing confidence, growing knowledge of what I really thought about things, and generally kind of consolidating skills. I just think I grew about 20 years in five, in those first five years with CCETSW. It didn't stop with CCETSW.

What I discovered in those five years really, this sounds very immodest, but I think I discovered how much I knew. Because when you are living on the job, day by day, you don't ever put it all together. But when it came to something so different as the CCETSW, there had to be a much more conscious exercise of really putting together in one's mind, what one knew and what one thought, in order to develop a sort of platform from which to operate. I didn't know how much I knew until I was forced into a position in which I really had to look and see what I knew. Of course what I then discovered, to my great surprise really, was how much my social work knowledge, and I'm going to use the dirty word, my casework knowledge, actually enabled me to do the CCETSW job in those early years. Because in fact I found, and I've got to be

very careful here because it's not an analogy which I would want quoted, unless I can put it very carefully, is that what one had learned about human beings in various situations of stress and strain, is transferrable knowledge into any sphere of life because people are people, and I hope nobody will take it amiss if I say that Heads of Department and Principals of Colleges are people like anybody else, and one was able to use – it was unconscious, but one used all the time – the personal relationship skills that one had learned in a different setting, which <u>are</u> transferrable. Therefore if you like the things that I said I learned at Leeds in that micro situation, in that department, and then stored up as it were, over intervening years, suddenly came back again and very much to life when I suddenly took on a very different sort of job.

A.C. Thank you very much, Mary.

<u>EDITORS' NOTES TO THE SHERLOCK INTERVIEW</u>

1 **Institute of Medical Social Workers (IMSW)** was the main professional body for social workers attached to hospitals in the United Kingdom. It was established from two separate associations of hospital almoners. The Almoners' Committee was established in 1903 and successively changed its name to the Hospital Almoners' Committee in 1911, the Association of Hospital Almoners in 1920, and the Hospital Almoners' Association in 1927. The Hospital Almoners' Council was established in 1907 to handle the selection, training and employment of almoners and changed its name to the Institute of Hospital Almoners in 1922. The two amalgamated as the Institute of Almoners in 1945, and this changed its name to the Institute of Medical Social Workers in 1964. Merged with others to form BASW in1970.

2 **The Charity Organisation Society (COS)** was founded in London in 1869 and led by Helen Bosanquet (1860–1925), social theorist and social reformer and Octavia Hill ((1838–1912), housing and social reformer. It supported the concept of self help and limited government intervention to deal with the effects of poverty. The organisation claimed to use "scientific principles to root out scroungers and target relief where it was most needed". It organised charitable grants and pioneered a volunteer home-visiting service that formed the basis for modern social work. The original COS philosophy later attracted much criticism though some branches were much less doctrinaire than others.

Gradually volunteer visitors were supplanted by paid staff. In 1938 the COS initiated the first Citizens' Advice Bureau, and continued to run CABx branches until the 1970s. The COS was renamed **Family Welfare Association** in 1946 and still operates today as Family Action a leading provider of support to disadvantaged families. [For more information, *see* Charles Loch Mowat *The Charity Organisation Society 1869-1913* (1961), Madeline Rooff *A Hundred Years of Family Welfare: A Study of the Family Welfare Association (Formerly Charity Organisation Society) 1869–1969* (Michael Joseph 1972) and Jane Lewis *The Voluntary Sector, the State and Social Work in Britain* (Brookfield 1995). Michael J.D. Roberts, in an article *'Charity Disestablished? The Origins of the Charity Organisation Society Revisited, 1868-1871'* in the Journal of Ecclesiastical History (CUP 2003, vol 54).

3 **Liverpool Personal Social Services Society (PSSS)** was founded as a voluntary organisation in 1919 to address the social needs of the city in the aftermath of the first World War. From the outset it was a pioneering organisation and it initiated several movements that became established nationally and were highly valued: for example Citizens Advice Bureau, legal aid, and home helps.

4 **Miss Deed.** Was Training Supervisor and Assistant Secretary to Liverpool Personal Social Services Society. For some years was special tutor in practical social work in the Social Science Department of Liverpool University.

5 **Mary Ward Settlement** was founded in 1897 in Tavistock Place by Mrs. Humphrey Ward (known as Mary), funded by John Passmore Edwards. Provided adult education and social service. The work continues though the adult education has separated from other services.

6 **Beveridge Report, 1942.** The war-time Government appointed William Beveridge to chair the Inter-Departmental Committee on Social Insurance and Allied Services in 1941. The Report was a best seller on publication and is remembered as a foundation document of the post-war "Welfare State". It identified 'Five Giants' that had to be overcome by society: squalor, ignorance, want, idleness and disease. The solution offered by the Report was a contributory social insurance scheme combined with: financial support for families with children; full employment and a national health service free of charge at delivery. Cecil French is correct in saying that the Beveridge themes were very much "in the air" in the 1930's in addition to keenly felt problems such as housing and education. See *The Five Giants: a Biography of the Welfare State* by Nicholas Timmins. 1995.

7 **Elizabeth Garret Anderson Hospital** developed out of St .Mary's Dispensary which began in 1866 to provide poor women with medical help from females. Anderson was appointed in 1866 and stayed 20 years. Was renamed in 1918 as the EGA hospital and became part of University College Hospital in 2008.

8 **Relieving Officers** were employed by the Poor Law Union to receive applications for relief and make payments when approved by the Board of Guardians. They could also issue orders to admit people to the workhouse.

9 **Henry Dicks** (1900 -1977) worked at the Tavistock 1928-46. He was the first Nuffield Professor of Psychiatry at Leeds 1946-48 and then returned to the Tavistock as deputy director until 1965. From 1966-70 he was a senior research officer at Sussex University.

10 **The Tavistock Clinic** was founded in 1920 by Hugh Crichton-Miller (1877–1959) and other pioneering psychotherapists , social workers and psychologists concerned to provide treatment for adults and children experiencing psychiatric illness. These professionals served on a voluntary basis and this enabled the services to be offered free of charge. The Clinic opened a Children's Department in 1926 and thereafter the wellbeing of parents and children remained a central focus of the work.

Prior to the second world war the services included psychological assessment projects for the Army, industry and local government. However, the Government's post-war plans to launch a free National Health Service compelled the Tavistock

Committee to devolve that type of work in1946 into a separate Institute and to position the Clinic as a skilled psychiatric service for out-patients in the new NHS.

John Bowlby (1907 -1990) and a few fellow psychiatrists from the Army medical service joined the Clinic in 1946. According to Eric Trist, a former Chairman of the Committee, "not many of the people at the time were analysts – but they were psychoanalytically inclined". The Clinic established a high reputation for new approaches and original thinking, particularly in the field of preventive psychiatry. Bowlby's development of "attachment theory" and the observational work with children of Jean and James Robertson in the1950's attracted international attention and had lasting impact of policy and professional practice in the UK and elsewhere.

In succeeding years the Clinic continued to expand its range of services within the NHS: a specialist Adolescent Unit was established in 1959; multi-disciplinary approaches developed; and teaching, training and research relationships established with a number of academic bodies; and in 1994 a formal merger with the Portman Clinic to form a NHS Trust.

11 **Mary Lane.** PSW and an active member of the APSW**.** Vicky Long (2011) cites two articles by her: *The Effect of Leucotomy on Family Life*. (BJPSW, 1956) and with Elizabeth Howarth, *Social Workers*, (BMJ, 1956).

12 **Brian Ackner** (1918-65) Trained at Guys and the Maudsley. Physician at the Maudsley 1948-65 and also held the post of Physician in charge of the Department of Psychological Medicine at Hammersmith Hospital. Was an authority on mental nursing.

13 **Zofia Butrym** was lecturer in social work at the LSE 1958-74. Wrote *Social Work in Medical Care* (1967); *The Nature of Social Work* (1976); and *Health, Doctors and Social Workers* with John Horder in 1983.

14 **Charlotte Towle** (1896-1966). Social work leader and scholar. Her major accomplishments included her work in creating a generic casework curriculum, her study of the educational process of training social workers and other professionals in human service. She worked in the Institution for Child Guidance in New York City where she supervised students and in 1932 became a full time faculty member at the University of Chicago School of Social Service where she taught until her retirement in 1962. Her most famous publication was *Common Human Needs* (1945), a manual written for public assistance workers.

15 **Central Council for Education and Training in Social Work (CCETSW)** was established on 1 October 1971 under the Health Visiting and Social Work (Training) Act 1962. It replaced the Central Training Council in Child Care, the Council for Training in Social Work, and the Recruitment and Training Committee of the Advisory Council for Probation and After-Care, and also took over certain functions of the Association of Psychiatric Social Workers and the Institute for Medical Social Work. The responsibilities of the Council were: the promotion of education and training in social work; accrediting academic courses and awarding qualifications throughout the United Kingdom.
