THE COHEN INTERVIEWS

FRANCESCA WARD -- Interview no 20

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This is one of 26 interviews with social work pioneers conducted by the late Alan Cohen in 1980 - 81. The period of social work history Alan wished to explore with the interviewees was 1929 - 59. With one exception (No 24, Clare Winnicott) the interviews were unpublished until this edition in 2013. The copyright is held by the not for profit organisation WISEArchive.
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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Francesca Ward

Although early in the interview Francesca Ward says Alan is taxing her "aged memory" she was probably only in her sixties at the time (1980) though as in many of the interviews the time lines are not always easy to follow. She is however clear that the early hospital social work was a "medley of routine work" and essentially "fringe social work". But her training at the LSE was of "absorbing interest" and the practical placements integrated theory and practice, though she admits she was lucky and not all such placements were good. One of hers was certainly testing in that as she interviewed the almoner stood behind her – there was only one desk!
She was far from dismissive about the first generation of almoners whom she described as "grand old girls who had the intellectual grasp as well as the social background and authority". The latter was crucial as they had to hold their own in a rather class conscious medical world though Francesca Ward did see in the late 1940s a time when "impeccable accents" were no longer an absolute requirement.
Francesca did not endure some of the dreadful jobs that others unwittingly applied for and in fact spent virtually all her career in Oxford, first for three years in the local authority Treasurers Department chasing up money owed by patients and by tenants, which was ultimately recognised as not an almoner's role, but it brought her

into contact with “real poverty”. Then in 1943 she moved to the Radcliffe Infirmary where she remained until her retirement. From her account and others his seems to have been a department that you would have fought to join. She admits it was a “pretty cosy set up” though that applies to the team spirit and intellectual stimulus rather than the work itself.
It was common to see up to 50 patients in a morning and having to assess in five minutes who needed social work help. They worked all hours as they had the liberty to do so because above all they wanted to “demonstrate our point” – their role and value. The war experience came when they received D-day casualties which was a “sort of chaos” but very much had to be fitted in to the normal parts of the job.
Stress was encountered when she moved to the paediatric department and came into contact with the battered baby problem which had not yet surfaced to any extent in this country. But here team work and an outstanding head almoner (Helen Rees) greatly helped.
She ways up carefully the pros and cons of staying so long in one place, perhaps recognising that someone needs to but obviously not everyone. The “norm bearer” is an important role. In her time she witnessed the “fast development” of social work and the value of the new ideas as on a practical level you needed to understand why people behaved as they did and why they responded or didn’t.
Her “first love” remained “the huge rewards of the individual work with patients” and the cases she recounts are a testimony to the value of some staff at least staying put.

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

F.W. I did the regulation Institute of Almoners **[1]** training. I already had a degree in English. So I did a one year course at LSE **[2]** in 1938. Pre-that I did a very interesting month or so at the old Invalid Children's Aid Association (ICAA) **[3]** in Southwark. That was a very interesting and enlightening experience. I had my year at LSE. Then I did the regulation four months placement at the Family Welfare Association, still called Charity Organisation Society (COS) **[4]** in those days. Two months in South London somewhere and two months in Brighton. Then I started in on my hospital practical work under the wing of the Brompton Hospital, including two months in Liverpool, Bootle. Also very illuminating.

A.C. What made you choose social work as a career?

F.W. Looking round while at college, I knew I didn't want to teach. I'd always had a great interest in nursing, related perhaps to some childhood illnesses, also a natural desire to smooth pillows and that kind of thing. My family weren't keen on this and slightly fobbed me off. So did my school. My school wanted me to do something a bit more academic, but I knew I wasn't cut out for an academic career, and I'm sure I was right here. We used to have careers talks at college. We had some from some of the grand old almoning girls of London, while I was there, and this fired my imagination and seemed to slot

into my long-standing desire to do something related to medicine and helping sick people, which nevertheless wasn't nursing, and which in those days, intellectually speaking, was that much more challenging. So it fitted the bill.

A.C. What did these ladies say to you when they came to the college?

F.W. Oh, that's taxing my aged memory isn't it? They gave a description of the work. But I remember getting a pretty lucid account of the kernel of social work with sick and handicapped people, which hadn't really changed. I would like to emphasise that. There was a kernel of the job which had given the original impetus for this, which hasn't significantly changed. Admittedly in the truly pioneer days, going back to the last years of the 19th century, the emphasis had been on the problems of poverty and the inability of people to use medical help because of poverty. Now pre-war, obviously, this still applied. Especially through the very hungry 1930's you saw a degree of poverty then over a general field, that simply doesn't exist still today. Heaven help it won't! But even so you couldn't do this work, even with its focus on poverty, without quickly becoming acquainted with the emotional impact of illness and handicap, without which any amount of practical help was useless. If you neglected it, you could give any amount of financial help but it wouldn't be properly used if you hadn't dealt with the underlying emotional block. This is something which hasn't changed and applies in any field of social work. This came out in these early talks that people had needs, over and above those of poverty, which arose from their illnesses. Or indeed, which might be contributing to them.

The medley of routine work which existed in the hospital social work departments of those days, (the raising money for convalescence, for helping getting appliances that couldn't be otherwise afforded), all the rather deadly routine jobs were what you might call fringe social work. They were welfare in a broad sense for there weren't the statutory means of meeting them that there are today. A vast deal of time went on fund-raising from special societies, such as the Royal Surgical Aid **[5]**, with their special missions for paying for surgical appliances. Deadly things like writing round for letters of recommendation. It's so long ago. The Health Service banished all this, raising money from this and that special fund. We spent an <u>enormous</u> amount of time on those things. The underlying nuisance in most hospitals was assessing the patients' ability to pay towards their treatment. However, I got a full enough picture of what is still the kernel of the work to fire my interest. My year at LSE I found of absorbing interest giving one the background theory to these things. My practical work training was mostly, not entirely, I think extremely useful and helpful in integrating theory and practice. This was luck it wasn't always so good.

A.C. This is the ICAA and COS?

F.W. ICAA., Family Welfare and, yes, also my hospital training at the Brompton. To a lesser extent at Bootle where the emphasis was far more on practical things. The practice was then you did what was called a block training, based on one of the hospitals like the Brompton, you did part of your training at your parent hospital and you did I think, a total of four months in the year of

provincial work at two separate hospitals. And I did my two months at Bootle. And another two months by way of contrast at Tunbridge Wells. Which for me was a signal unsuccess, because the lady there stood behind my desk while I interviewed.

There was only one desk. So either she or I interviewed and either I listened to her, or she listened to me. So you can imagine how helpful that was. However, the war came along and then I had a spell, quite prolonged, at Camberwell with Miss Enid Warren, (Interviewee no 21) who may well be someone you are seeing. She extended my training by two weeks to give me a sense of responsibility. And I don't know whether that succeeded but at least it jolted me. We became very great friends thereafter. I learnt a lot from her. That of course was old St. Giles **[6]**. It was a very different kind of hospital. It was an old LCC hospital and this was one of the issues in my young days. The growing development of the local authority hospitals as they then were. They were already beginning to assume an importance and a breadth of interest that they hadn't previously had, growing out of the poor law soil as it were. And one was beginning to see that some form of state medicine might have the answer in the long run, although the big voluntaries were still in their heyday, although, financially, they lived on their debts really, and their appeals.

Then came the war and I still hadn't quite finished my training. After my dreadful jolt of two weeks extra, which seemed like the end of the world at the time, (I remember going to the lavatory and crying, terrible wound to my *amour propre*) I did a locum job at St. Giles for a month or so. Then in April 1940, still in the days of the phony war, but only just, I first came to Oxford in a very odd job with the City Council. It was called the City Almoner's Department and it came under the Treasurers', it was manned by two very intelligent graduate women, one of whom had some qualification in social work (academic only) and the other had none, she was a classicist. But our main job was to help recover from people who didn't pay, or couldn't afford, doctors' and midwives' fees. The local ante-natal clinics you have to see in the context of two completely different local authority environmental medicine structures in those days. Added on to that was the very interesting bit of seeing council tenants who got in arrears with their rent. That should have been done by proper Housing Managers of course, and later we sold this idea and it was. But it was a very interesting experience in that it brought you into contact with people who were living in very real poverty and some of them were servicemen's wives. The slum cleared estates from Oxford which were already building up, big estates like Rose Hill and Marston which had some very tough old slum nuts in them.

A.C. That's getting involved in family casework really.

F.W. Yes. And I may say we did this very critically because we didn't think the basis of it was very sound. Another fully qualified almoner came and joined the staff shortly after I did. That was Jennifer Gosling, as her maiden name was, and together we worked very critically on this and kept in touch with Margaret Roxburgh **[7]** at the Institute.

A.C. Can you explain how you mean worked on it critically?

F.W. In that we had our tongues in our cheeks all the time, because we were doing our job of gathering in fees that couldn't be paid, of trying to get people to pay their rent. Even the unhappy task of bringing them to court if they were failing to pay without good cause. (A horrid little chore for a social worker.) Also we collected, reluctantly, contributions from people for special education services. This included surgical appliances for children under Education Authority, long term convalescence, contributions for special schools and this kind of thing. Again it brought us into contact with people who were professionally relevant to us because they had handicapped children of some kind. We also saw people admitted to the local sanatorium. Here again it was primarily to tell them that, (and here the tongue in cheek comes into it), that the tuberculosis service was free but to ask them would they like to contribute towards their treatment all the same. Again in a brace of shakes, with our training behind us, we were learning about their underlying problems, and trying to get these coped with. So having done this, for the best part of three years, talked to Miss Roxburgh and tried to evaluate with her how far this job under the City Treasurers was a suitable one for almoners to be doing, considering that they were by that time very much in demand. When I took the job they weren't, there were barely enough jobs to go round. So one took anything, almost, but with an eye to seeing whether this was something that could be usefully developed. This part of the pioneer spirit still existed. The Institute were very much guiding development all round the country, and if some new and potentially interesting job came along they would look round and see who was suitable and try and inspire someone to take it, and see what she could make of it. Then they would give you some support and help you decide was this something that we should be going on with, or were the conditions just so hopeless that it was a waste of an almoner's training and time.

This applied very much to this job in the City and, as a result, it was broken up and altered on a much better basis. We sent in a report to her and to the MOH and she discussed it with him and a proper medical social work service was set up for the tuberculosis clinics and sanatorium. That was just one of the useful results of this. Some special social workers, though I think, untrained, but really rather good and useful people, worked in the education Department instead of under the Treasurers', and were attached instead to the Care and Attendance Departments. This worked in quite usefully. The rent arrears business was transferred to the Housing Department and for a while they did employ some trained housing Managers. So we felt quite pleased with ourselves, Jenny Gosling and I, and I migrated to the Radcliffe where Helen Rees **[8]** had by then come. And we were a pretty cosy set up in Oxford. We all knew each other, and her arrival was really like a meteor coming down in Oxford, and very exciting.

A.C. Before you go on to that can I just ask you one more thing about the previous experience you've just been describing. You said at one stage “We kept in contact with Margaret Roxburgh to see if it was a worthwhile thing.” Was she working at the Institute?

F.W. She was then Secretary at the Institute. So she was the directing brains. It was not such a big job numerically as it later became, so she also had to do with the training organisation and the placing of students. Everything came under her. Although this was separated off quite soon afterwards.

A.C. How did that work? Did you go to London to see her, or did she come to see you?

F.W. Both. Only occasionally on a very informal kind of basis you know. We were young and we wanted help in evaluating this, and we were working with people who were able but who were untrained and who therefore saw this just as a quite interesting job, but hadn't got the same concern that we had to develop the social work as distinct from the administrative content of the job.

A.C. You said when you moved over to the Radcliffe "We were a very cosy little set up here in Oxford." I wonder whether branch meetings of the Institute knew where jobs were and who was moving where and what? And who you'd be working with and what it'd be like?

F.W. This again was an informal thing. When I first came to Oxford, if I remember rightly, the only such thing there was, was under the wing of Barnett House **[9]**. Miss Violet Sutler who was the tutor in charge of the Social Administration there, which again was a small and cosy little off-shoot of the university. She kept in touch with her old students and took an interest in new social workers of any breed coming to Oxford and we used to have a little club that met so often, and had speakers or little social get togethers and relevant discussions and so on. So that that was a forum in which you met not only your almoner colleagues at the local hospital, which was the Radcliffe. But it meant that we already knew the Radcliffe people through this, and naturally we flocked together a little and made friends. Then Helen came and we began to get much more organised about this, but it was still on a completely informal basis. There was no Institute machinery for local meetings. This grew up later.

A.C. Can you remember what sort of speakers you had to those informal meetings and what were the ideas you were discussing? What were they all about? Can I try a few prompts to see if it stirs up any memories for you? At this time I guess the idea about a National Health Service must have been in the , being floated in early years, I wondered if that might have been a concern?

F.W. I'm sure you're right. What we had when we were still having our little generalised meetings at Barnett House I simply couldn't remember. This may well have come into it because of course Beveridge **[10]** was doing his stuff then. Certainly this became a very major topic a year or two later when we were meeting as a group of almoners. Not instead of the Barnett house meetings, but as well as. We had very serious discussions about this and about the likely implications for social work in hospitals and so on. Of course we all participated with the Beveridge thing. I remember Frank Pakenham, who is now [in 1980] Lord Longford **[11]**, went round and saw us all. I think a lot of us did a bit of form filling even for this. You're right, this was a very overpowering topic.

More narrowly within the hospital field there was this absolute obsession, and it was a reasonable obsession, with this chore of assessment of patients' means to pay, which was a conflict that we lived with perpetually. You were asking people to pay with one hand, and trying to give them help with their problems, (which might even include raising money for them), with the other hand. So that it was essentially a schizoid situation which caused us great discomfort. It was surprising what you could achieve in spite of it, and how you could still sell yourself as a predominantly helpful person, but you worked under a handicap. The other consideration which was really even more important, was the huge volume of work that this entailed. I shudder to think of the number of people that one would see in a hospital morning for instance. You might see on an average between 30 or 40; on a bad day up to 50 patients in rapid succession in one morning; fed to you from several outpatient clinics at a time. Mostly in a pretty public office. All of those you would be finding out whether they belonged to the hospital contributory scheme, which was a voluntary thing, and with relief, if they did, you just snatched a voucher from them. If not, you had to find out what their financial situation was and assess a contribution accordingly and try and extract it from them, and at the same time in the process of your enquiry, you were having a look at the medical notes (which by then Helen Rees had trained the doctors to send along ahead of the patient). So that you could see what kind of an illness they were facing and judge quickly from that whether it was something that was likely to bring social complications in its train. Also in the process of assessment you were gleaning with the other half of you as it were, whether this was something with which the patient likewise might be needing help. Whether this was an illness that was taking them from work. What kind of resources they had behind them and so on. So that in a split second of perhaps less than five minutes per patient, you were sorting out which of these patients needed help on the social work level, and either, if there wasn't too big a queue outside, you were dealing with this and going into it more deeply then, or you were fixing to see them at some later time, (very often a home visit at week-end was the only time we had) when you could go into their social problems. You see this was really handicapping. It was also I may say exhausting and it eroded our free time to a degree that was unhealthy. But the war was on and everyone was working very hard and there was an excitement in this pioneering experimental fever that we still had, under the leadership of someone like Helen Rees first, followed by Elizabeth Turner. She succeeded Helen and had already made her mark as an extremely able pioneer. She was here for very many years, and saw the Health Service in. But there was continuity of policy between her and Helen Rees which had by then been sold to the administration at the Oxford Hospitals too; that these administrative chores should be taken off the social work department as quickly as possible and of course the Health Service when it came, did remove them completely and was a huge relief, and gave us the opportunity to develop on a more satisfactory basis altogether.

A.C. Would it be fair to say then that when you used the word pioneer, you're talking about the almoners, as they were, showing the hospitals just what sort of animal they'd taken on and having agreed to employ someone like that to see what the full potential that was there?

F.W. Yes. You'd be surprised the fun we had with the doctors. I think Helen quickly won over the administration. She was the sort of animal they'd never met before and really knew where she was going, and could challenge anyone on their own ground. Very high I.Q. Sister of Jack Rees **[12]** the famous psychiatrist of particular army distinction, among other things. One of the first heads of the Tavistock clinic **[13]** too. She was that sort of calibre you see. Could dispute with anyone, and win. And Elizabeth Turner was pretty hot stuff in this too. But with their guidance and support it meant that younger and less experienced and less able people as most of us were, could also hold their own with powerful people in other callings: nursing, medical, scientific, academic.

A.C. A very difficult setting to be doing that in.

F.W. Very demanding and very anxiety provoking, and without good leadership we couldn't have done it. But we were welded into a very close and enthusiastic team. Someone like Helen Rees and Elizabeth attract good people and while our department was still small, by which I mean within 10, it was very close knit and this gave us a good base to work from.

A.C. Would it be fair to say that almoners were rather "posh" ladies who came from rather smart backgrounds? It occurs to me that unless - if that is right - almoners did actually come from that social group, they would never have been able to stand up to the doctors and other people in the hospital who presumably were also largely from that background. And unless the almoner could also speak with that authority and incisiveness that comes with that background, you would never have been able to do the pioneering.

F.W. This was changing in my day. It changed so quickly but not without a real awareness on our part. This was relevant in making appointments, particularly, say, up to the end of the 1940's. You really had to consider in making an appointment whether this was someone who would be socially acceptable to the doctors and others you were working with, and would therefore have a fair start in holding their own. But already people with the strength and perspicacity of the Rees's and Turner's of this world, were quick to pinpoint someone who was extremely good value but whose accent was not impeccable, and could say 'this one will get over the social handicap that she has;' and it would be that much more difficult for them. But it happened. And this after all was not only in the in our narrow little almoning world was it? The emphasis was changing all round and I can remember in the early 1950's already with a shock of mild surprise, but also some satisfaction, learning that a socially unprivileged almoner student that I had with me, who was admittedly one of the best students I ever had, was persona grata with a certain very able young house physician whose speech was as impeccable as anyone's, because as he said, she wasn't from the wrong side of the counter. He had the perspicacity to see, albeit I think with some prejudice the other way, that she had a flying start and an extra understanding of most of the patients, which someone with my speech might be expected not to have. I'm not sure he was entirely right, but that's my prejudice! But you see one did reach the point where the lady background could be seen as an actual handicap. And this was when it began, I would say, late 1940's through to

50's, until by now I think you could say that in some ways it always is a handicap. Except I don't know, I've been out of the field for some years. We went through a very militant phase which was very difficult for some of us older ones, and I expect that's settling down a bit now. But it was an inevitable swing of the pendulum wasn't it? But it was very fascinating.

A.C. I understand all that you've said. But I was thinking of the hospitals that I've worked in. They were psychiatric hospitals but I've placed students in general hospitals. It must have been even worse than I've seen it, because I'm comparatively young. A very rigid hierarchical structure, with a lot of deference being handed out here there and everywhere to whatever grade of doctor there was. When you talked about Helen Rees she very clearly was of that world. Was it her brother who was Director of the Tavi? So she couldn't be intimidated by those guys because she'd been in the same house with them. She knew what they were like. And perhaps you needed someone like that who was of that world to stand up initially.

F.W. Oh you did! And go back the generation before, the Miss Marx **[14]** of this world, (she was unique but still), and the famous Miss Cummins **[15]** that I never met, of St. Thomas's and Cherry Morris **[16]**. Miss Nicholl **[17]** who lived with Miss Marx. Dear old Miss Salmon **[18]** of Great Ormond Street. I spent two days of observation with her and she was completely the grand lady who wore her hat in the office, and if a small patient was standing beside her and had omitted to take his hat off, she'd say, 'Where's your cap sonny?' And a frightened mother would say, 'Take your cap off'. Food for parody if ever there was! But they were grand old girls who had the intellectual grasp as well as the social background and authority. The young housemen were as frightened of them as the young staff and patients and this was useful while you were in the establishing period. People like Helen Rees, Margaret Roxburgh, Margaret Coltart **[19]** those of that generation, about 10 years ahead of Jean Snelling (Interviewee no 18) and me, they were already a much more questioning group. They had grown up between the wars, they weren't all from the upper middle class group. Lots were, but the originals all had been. You wouldn't make any distinction here these days, but you did in those days, but they all had had the education, and of course they had just as much grey matter, and just as big a scatter when it came to intelligence among them, as the other group, and similar educational advantages. There had been already that much levelling and these distinctions had largely vanished except among the very old fashioned. So that whereas the early pioneers had often been from, if not titled at least from very upper middle class families, it was a much wider thing already in the 20's and 30's I think, and one no longer looked to see whose father had done what.

A.C. Can you remember any anecdotes or examples of the sort of battles that Helen Rees and yourself must have had within the hospital? You were saying she quickly won over the administrators, but winning over the doctors was another problem. I wonder whether you can remember any of the tussles, 'full and frank discussions'!

F.W. Yes. I can remember one excellent old fashioned physician. He was extremely good and had his difficulties. He was one of the real old Oxford

men who had combined some private general practice, a rather glorified kind of general practice; specialising as a physician with honorary hospital work.) His difficulties arose entirely from his sense of responsibility to his patients. Now this was very valid. He wasn't going to trust another person with information about his patients, until he was quite sure how they were going to use it. This was very good, and the sort of thing that put us on our mettle. But I was forever rubbing this particular chap up the wrong way. One reason was that he spoke rather quietly, I don't hear too well and I often didn't hear exactly what he was telling me. The point was Helen had worked on him, and he could see the potential of what she was saying, but he had a great need to test it out. So he would come with a referral in a challenging sort of way which was rather frightening to the green and new. We on the other hand were firmly schooled to get to know all we could about a patient's illness, before we could make a judgement as to how far, and in what way, we were going to help. This was exactly right too, but it meant that we were going to question the doctor rather closely as to what was wrong with his patient. And this was just where his ethical defences were up. You see there was a real conflict here, which was in a way no one's fault and some of us weren't quite experienced enough to handle this well.

I can quote you two instances of my brushes with this particular physician which Helen had to smooth out. He was a fair man who blushed spectacularly when he was angry, and he really went like a turkey-cock, so he would be crimson and I would be deathly white with fright, while conscientiously holding my ground! Once he came and said he had a patient in one of the wards who was going to need convalescence, that she came from a poor background, she wasn't going to have a chance to get well when she went home. And I very properly said, 'Oh yes, I'd be very pleased to see her, and help her,' Could he kindly tell me what her illness was? And he went up in smoke and said, 'Now what has that got to do with you? I've told you what she needs. You go along and help her.' I would say, going paler and greener every minute no doubt, that unless I know what the illness is, I don't know how much help she's going to need.' He said, 'She wants three weeks convalescence.' I knew there was much more to convalescence than that. That if I didn't sort out her underlying situation, like as not she was going to refuse the convalescence. This kind of thing. So there we were in a frenzy, and Helen came along I think, and we smoothed it all out and both sides were reassured and appeased, and it proved quite a successful operation.

Of course it was very important to report back how you'd got on. We were very strong on this and about putting, usually reticent, little notes on the medical notes so it could be seen what the social work contribution had been, and why and how. And another similar time this doctor was getting a bit more confident in his referrals. He had tested us out often enough, but he came in with notes from some out-patient session. I can't remember what he was asking me to do in this particular case, but he gave me a very mumbled account that I didn't fully get, and was refusing to leave the medical notes with me, and I objected to that. It turned out that his reason again was I think one which I certainly would have accepted, if I had caught what he was saying. But like many people with dubious hearing I didn't like asking people to repeat (You grow out of that.) In fact he'd been seeing this man about a whole lot of

sexual problems which he rather properly thought it wasn't necessary for me to know, and he wanted trivial help in some other way. And it was I think fair enough for a physician to elect to help his patient in that sort of way, without involving a social worker if he so chose. So again we had a major row which was really quite unnecessary. But these were the sort of things. Good doctors, very often, needing to test out not only the abilities of the social workers but their ethical reliability. And this was right, they had to. On the whole we won our spurs. May I just add, there was one very interesting experiment going on at this time, or before the time of the Health Service. There was an attachment to the Nuffield Department of Medicine, (this was engineered by Helen Rees, in collaboration with Professor Leslie Witts **[20]**) of a social worker attached to his unit on a frankly experimental basis, who was to be totally relieved of all the administrative chores, so that she could really demonstrate what a social worker could achieve, working closely as a member of the medical team. This was extremely successful. A person who was very good academically and with a sufficiency of experience behind her was brought in on this. She was Mrs. Flora Westlake; Beck her maiden name **[21]**. I don't remember how this scheme was financed

A.C. Can we go on to the post war period, and on to finish the chronology, then I'd like to come back to some more general things. You were telling me earlier about visiting people at the weekends and that was the only time you had to do home visits and how this was encroaching on your free time.

F.W. We hardly even bothered to know what we were getting until we'd run out! It certainly never came to anything like claiming overtime. It never would have occurred to us to do so. We much preferred to be completely at liberty to do as much as we needed to. Because unless we worked overtime we were never going to be able to demonstrate our point. You see, with all this enormous mass of routine interviewing and brief record keeping, when do you suppose we wrote up our social records on the patients that really needed help? After hours. Living close to the hospital I doubt if I ever got home by six. And more often it would be nearer eight. Weekends you had about one Saturday in four off, and you often used that to do home visits. However, doing the home visits was quite nice. We all had bicycles and we'd combine it with a picnic and perhaps go two together, and it's a lovely way to get to know the country while there wasn't much traffic. So I can't say that that was a great hardship, but you see you couldn't take the time out of the working day, and we would never have demonstrated what our contribution potentially could be, unless we'd been prepared to work these absolutely gruelling hours.

But then came the 'D' day operations, and wounded men were flown in, then we did take a lot direct from the receiving airports and when a consignment was expected we had an 'on call' system. If we were 'on call' and we heard the signal go, we might have been out hearing nightingales or something, but we rushed back, helping to sort out identities and get hold of relatives, and enable relatives to come and link up with the relevant service organisations. You can imagine the sort of chaos these men were in. But this was an entirely additional job which could happen at any time of the day or night. Wasn't frequent but it could have been.

A.C. I think it was Jean Snelling was talking about that period, and saying something about the nurses and the doctors finding it quite intolerable up on the wards. Having seen such terrible injuries and having to come off the ward and find someone to talk to, just to get some relief, and coming down to the social worker offices.

F.W. I can't remember that with so much emphasis as clearly she did. But I think as soon as you become accepted as a member of a ward team this almost automatically happens. Those of us who carried on working in that tradition, and here we would come to that post-war period, we soon came to recognise this as, not only inevitable, but quite a desirable part of our job, being a bit of a safety valve for the very great stresses of ward work. I'm sure this applied to these wards taking these soldiers, most emphatically, and it may so happen that Jean had wards that had more of them than I did, and this is why it's more impressed upon her because we were there at the same time then. But I later worked entirely in paediatrics from 1947 onwards and the stresses there were often very great. Nursing children with terminal illnesses or with dreadful congenital handicaps. These are terribly distressing things for nurses.

A.C. Did you gradually get used to the stress of working where it’s really very distressing? I mean the whole of hospital work can be distressing in all sorts of ways can't it? It can also be distasteful as well as very upsetting because of the nature of the injuries. Children particularly.

F.W. There's always a distress content. It's the old old story. Each had to deal with this emotionally in her own way. Familiarity takes the edge off it up to a point, but woe betide the worker, be she nurse, doctor or social worker, who lets familiarity really blunt her feelings, because you won't help people as much if you're really defending yourself from the impact too much. What you do learn is to see things with a certain objectivity, and I think to tolerate your own distress. Certainly if you're working closely as a team you help each other and it may be that the social worker is dealing with a flood of emotion, say from a ward sister or from a young houseman, or something like that, but nevertheless the members of the other disciplines will be in different ways helping her by spelling out a bit what you expect to happen in this particular illness perhaps. Or by their more acute realisation of the part that drugs were playing in reducing suffering. It becomes very much a team process in which the separate contributions of each are very clearly recognised and marked out, while yet there's a little field of overlap which you really can share. This I consider is team work at its healthiest and most helpful. And I've been very sorry to see it diminish. It seemed to me the ideal way of working with sick people, however.

A.C. Were there ever times when you had to force yourself to go onto a ward?

F.W. I'm sure this must apply to some but I think I was one of those people that always had a sufficient interest in hospital life and medical things, and I didn't find this.

A.C. You'd been in hospitals as a child you said.

F.W. Yes, this could work the other way couldn't it? But it didn't, though I know this applied to some of my students and junior workers that I've helped. It's an individual thing. I don't think I've ever had very great difficulty in facing either something physically nasty, or in stealing myself to see someone who I knew was in great distress. I've had more difficulty about facing hostility and criticism, but on the whole have been able to school myself to do this, with increasing confidence. This I think is partly an age thing isn't it? All young people I think find hostility and criticism difficult. But I never thirsted to see an operation done as some people did. I didn't feel I needed to see the part of things that the patient didn't know. But I used to go on the teaching ward rounds with the senior paediatrician for years and years and years. And this was because of my teaching contribution you see. I hadn't got a special little bit to say, but I would be drawn in if she knew that there was much social content, whether on an individual level or because of the nature of the illness. Or I was perfectly free to stand up and contribute if there was something I knew about this particular patient I thought the students should know and so on. But this meant that I also was involved in, and witnessed many physical examinations of every conceivable kind. Children with colostomies or bits of gut hanging out. Dreadful burns and all these kinds of things. Although I suppose I winced as much as anyone I never found I couldn't face this. But this was individual to me. I don't think I would have liked to do the dressings, that's different. I think the nurses have to learn to do this.

A.C. We're coming into the post war period and a lot of things started happening in British social work in the post war period didn't they? There was that initial development of service with the new welfare state legislation wasn't there?

F.W. There were the Children's Departments in the local field - a very big innovation. I perhaps see this as extra big because I was already in the paediatric field, but this really did spell a different concept in the care of children.

A.C. How did that impinge on you then?

F.W. Oh there was someone you could turn to more readily if you needed help with children who were really coming to grief at home and this kind of thing. Well we didn't talk about battered babies in those days, but these things still happened. It was a very great help to have people with a special assignment for children, other than people who were just vaguely attached to the public assistance institutions who catered for homeless children and this kind of thing. That was one of the big things.

A.C. How did you refer to battered babies then? What was the term?

F.W. I don't remember any very early things that were clear cut. That they existed I know because when we got more geared to looking for these things on an objective level you began to see quite clearly that the things that had earlier been suspected as maltreatment, almost certainly had been, whereas before you left it an open question and just dealt with it medically. You talked to the social worker in the field and got their help in supervision, or in placement away from home, which in those days one did rather more readily than one does today, and so on. But you very rarely got things sorted out in a clear cut

way. The Courts weren't alerted to this either, and I knew later older children with disabilities. One I have particularly in mind who was said to have fallen downstairs and got a head injury which deafened and impaired his mental capacity and vision: a really bad head injury. And I absolutely know, indeed the father told me much later, that this was what his sick mother had done, but it was all covered up at the time. She was dying of tuberculosis, anyway. That's just one example I remember and one or two others like that. But it wasn't until a good deal later I can remember very clearly some cases.

The first child that I really became suspicious of myself, was this little thing whose mother had a child guidance history which I was able to unearth because there was an old almoner's record, where she'd been up to the children's clinic and been referred to child guidance. Helen Rees had seen her in the first place, and this history proved very valuable. But she had two children, was unmarried and she had changing consorts. This tiny girl came in first at two months with an injury which wasn't very satisfactorily explained. Not a very desperate one; a greenstick fracture. She came in about two months later with another and this time I think she wasn't admitted. She was seen by the accident service in out-patients, and by accident I heard of this and tied it up with the earlier one. The earlier notes were not available. I tracked them down at the Nuffield Orthopaedic Centre, where she'd been treated for an intermediate injury. I'd no sooner got them back here than she was presenting at the orthopaedic centre with yet another. By the time she'd had seven in under two years, we in the paediatric department, who'd only treated her for about two out of these seven ourselves, had realised something was happening and began to try to get the ball rolling to get this dealt with. It was extremely difficult to do because there was still very great reluctance on the part of anyone outside to admit that this was deliberate injury. There was always a story of some kind, and in some ways this was a warm-hearted mother, but she lashed out, and she always had done. Her child guidance treatment had been for pathological tempers. You looked up her history of the other child and that had been in for one or two, but this was the one that particularly copped it. We learned a great deal on that poor little girl, working in cooperation with child guidance and the children's departments, too. But not no doubt, before her psyche was badly damaged. Well this was again in the period when people were becoming much more aware of these things, when the chap whose name I forget in America **[21a]** had first begun writing about non-accidental injuries. He was the one who put it on the map in writing wasn't he? And very helpfully too. There really is an objectivity in the study of these things which is possible.

A.C. Coming back then to this post war period, section 28 of the Health Service Act [1946] allowed local authorities to employ almoners: that was another development wasn't it?

F.W. Yes. Not quite so new here because you see we already had this in the chest clinics as a result of this early work that we had done between 1940 and 1943.

There'd also been one at the local authority hospital, Cowley Road before it was stepped up as a geriatric hospital. This of course was partly the war

though. It was also an emergency medical service hospital. That was one of the processes by which the local authority services began to get upgraded. They were designated, if they were good enough, emergency medical service (EMS) hospitals, and some of their wards were designated for war casualties or others that couldn't be accommodated in the hard-pressed voluntary general hospitals. So that was their beginning as general hospitals in their own right as distinct from Poor Law hospitals, and they began getting social workers attached who began to deal with both sides of it. So this idea in the 1946 Health Service Act wasn't as revolutionary as it sounded, but it nevertheless stepped up the number and provided a closer link-up with the shared services like the services for the blind, and the children and the deaf and these kind of things. The links were very close.

A.C. You get a proliferation of social workers, because the new services required the employment of a social worker. The man who'd been known as the Relieving Officer (RO) **[22]** previously, suddenly found himself either social welfare officer or mental welfare officer, and thought of himself as some kind of social worker.

F.W. Oh yes. This obviously had its rubs, but so often these were people we already knew very well, and had developed quite friendly relationships with. If it was an old Relieving Officer that we knew well, and we knew was really rather good, he had his point as a social worker wearing a different hat, (weaknesses too), but it didn't work too badly. Some of them were very good.

A.C. I suppose the other thing was getting into the 1950's, was the debate that developed in social work circles about genericism versus specific training. I wondered whether that impinged on you or not?

F.W. That certainly did. It impinged on our training courses. The universities (I think Southampton and LSE were about the first) began running these courses, financed in the first place by the Carnegie Trust **[23]**, which gave generic training but of a very high standard. And we got some very good people in from there. They had an initial weakness in working in a hospital setting in that they couldn't see, as the Institute trained people did, the impact of the medical situation and the demands that it would make. They were extremely good over sorting out the basic social problems, and would want to treat them regardless of hospital relevance, you see. Now in terms of what you realistically could and should cope with, you had to limit yourself to medical relevance up to a point.

A.C. You mean they didn't understand agency function adequately.

F.W. No. This was a weakness in many of them, though they had very great strength on the other hand and intellectually they were all very good people. They were handpicked. If we could just revert a moment to the hospital service itself, this being what I knew best, I would say that apart from some interest in, and experiment with, a broader based training and a recognition of the value of this, as well as its weaknesses, the big positive development in the hospital social service which the removal of administrative chores permitted for the first time, and which we developed very fully in Oxford, was this team assignment of workers. This really was very successful. You can

overdo it because a young person, pitchforked into a powerful team, can be in danger of becoming a 'yes woman'. We had a well run department which provided for support so that people weren't left floundering on their own. Different newcomers to the department, unless they were very experienced, were always attached to a senior with positive responsibility for helping them and supervising up to a point, and they were their first port of call if they were in difficulties of any kind. And this meant that they had some support if they had to make a stand about something. The danger of becoming so involved in your medical team that you lost your social work identity and weren't really making your full contribution, therefore, this was mitigated, and I don't think it happened too much.

Some departments like paediatrics had two workers (a senior and a junior) that applied to one or two other departments, and there was always a principal covering (after the health service) the group of hospitals, and a deputy too. And then heads in the individual hospitals as well. So that the supervisory in-training support, was pretty good and well structured. Most of the medical chiefs became very interested in this and participated in the appointment of new people to their teams. We did not then go in for any intake system. The allocation was strictly dependent on which team it came under. Often there'd be an overlap and we'd decide between us who would carry it. Someone could be under two different firms with different workers, and it would be desirable for the same worker to continue. We considered very carefully things like transferring. Suppose a maternity worker had been doing close work with a parent who then went onto another department, perhaps paediatrics, we discussed and structured the transfer. At this stage you weren't so overloaded that you couldn't do this. We were always busy, Parkinson's law applied, but I think we were very usefully busy. We developed this in a way that was very well used by the majority of medical staff, so that they became a great support to us too.

A.C. All during this time you were at the Radcliffe right from the middle war years, right through to your retirement, and do you think that has had advantages? The thing you described just now, has that come about because someone like yourself puts in a long stint, in the hospital, and is well known and this becomes part of the tradition of the hospital?

F.W. That plays a part. I think that you can achieve it up to a point without such long stayers as I was, if you've got a good chief directing policy. I do think that to have too much swift movement of seniors is a positive disadvantage. I'm perfectly sure that it may be wrong for many people to stay too long. You <u>can</u> stay too long. This again is very much an individual thing and how it takes you. I think juniors have got to be expected to move fairly fast. But if they work for what, 18 months to two years, goodness me I've seen even students there for less than six months accepted as members of the team, if that is the habit. But obviously the longer the stay the more complete this is. But then other members are changing too. I can't think how many ward sisters I've seen come and go in my day. And the junior nurses certainly and junior doctors; the senior paediatricians went on and I went on, which was a slightly unusual situation.

A.C. And in staying on you become a norm bearer within the institution. New people coming in will look to you and say "Miss Ward will know." She was here during that time.

F.W. This had its disadvantages too of course because it sometimes permits people to get away without learning how to find out. It also means that the relic gets an undue case load because over the years there's been so many people she's known. There are so many that there's a good reason why she should carry on with them. Of course you have to deal with the desire of the senior medical people always to refer to the senior rather than to the junior. The really good and understanding ones would help in a selection of what they referred and what they didn't. If you firmly said 'I'm going to ask so-and-so to carry this. I'm sure she could,' they might wince and make a face, but they'd take your word for it that so-and-so could if you said so. I mean the relationship was close enough. But if you have someone who's there two or three years, this is still long enough to maintain a tradition that's there. And a really good person will build up a good team.

A.C. When we were speaking earlier on I noticed several times you used a psychoanalytic vocabulary and I wondered at what point you hit on that. You talked about 'schizoid' something being 'quite schizoid.' Some split you were trying to describe.

F.W. Yes I know. It was the money versus the help. The giving and the taking with alternate hands. I couldn't give you any date about this kind of thing. I don't think these terms were used much in my training days. I don't remember them. I think the tendency grew. The recognition that psychoanalytic concepts were relevant to social work. This was growing all through this time of fast development. The time when first we were making a very big effort to think, to rationalise in the best sense of the word what was happening to our patients. Why people behaved as they did. Now this is a very practical problem that must always rear its head in social work, and it's simply unrealistic to ignore it. Why do some patients constantly refuse the help which objectively they can be seen to need? This is an oversimplification, but you could apply this again and again in multiple contexts. I think the attempt to get to grips with this sort of thing, to explain the aberrant behaviour which constantly presented itself as a block to getting the right help to the right patient at the right time led us into psychoanalytic fringe-lands shall we say? It could be over-done. I think the increasing interest in theory to explain and back up our practice, led to an increased tendency to read. And here of course the American writers, greatly enlarged our jargon.

A.C. Did if affect your practice?

F.W. Oh yes ! We had a lot in common with them. A lot of interchange of visits. Some of the grand old girls of America; Harriet Bartlett **[24]**and people like that. Going back further still of course, I don't know whether anyone reads dear old Mary Richmond **[25]** anymore, but her spelling out of the elements of casework is still very hard to beat. The need to get your knowledge of the patient before you can diagnose the problem and so on. This is something that has been almost brushed aside in later years, but it's still the kernel you

know. These grand old girls knew a lot, whatever language they couched it in. But of course this has been the age of jargon and I know social work comes in for an extra share of criticism here, but others do it too. You've only to listen to any programme on the BBC to know what a jargon age this is, and to tot up countless examples of the use of language to obscure meaning which is what jargon comes to. This happened to us quite badly, irritated our colleagues in other disciplines a great deal. But they do it too.

A.C. What would you say were the most influential ideas during this time?

F.W. The most influential ideas. Now I can't put this in terms of any particular psychoanalytic theory. I think, on the whole, unlike the Americans who may subscribe to one school or another, we've been like the urban fox going to dustbins, we've taken pickings wherever we could, you know, anything that we found useful in practice. I would say that the most influential thing that was going on was a search for the underlying concepts on which we could build a truly useful professional body of knowledge. We were drawing on anything that could help us, and the most neglected area earlier on had been the understanding of human behaviour except in the most limited and empirical way. It arose out of the very practical need to understand better, what we were doing to, for and with people, why people behaved as they did, why they responded or didn't respond in the ways they did or didn't.

A slightly different consideration applied in the hospital field. In what ways would we expect different illnesses and disabilities to hit different people? I'll give you a very obvious illustration that I encountered many times. A child is diagnosed as diabetic at any age, say between six years into its teens. Some will do very well. Some will never learn to cooperate. Hindsight teaches you what, had you known enough about them at the beginning, you could have foreseen. It depends on the existing emotional make up of the child and its place in its family. The child that's already deprived and jealous sees every restriction in the diabetic regime as something it must fight against. The child that is well based, used to being loved and not feeling anti in any way, will accept and grow into it, and cooperate. You can apply this sort of thing to almost any disability that hits any one of any age. Who makes a good amputee and a bad one and why. It pays, at a very early stage, and this is what distresses me in the way things get missed out in the hurly burly of today, to sit down with people and get to know about their past in a good old Mary Richmond way. People are everlastingly surprising: but within certain limits you can have foresight. You can see which parents are going to be hopeless at managing a child with a damaged heart, if you know what this particular child meant to them. The parent who rejects a child with something relatively trivial, but with cosmetic implications like a nasty hare lip. If you know what they specially wanted of their child; a lovely looking little cherub and why, you'll know how to help them get over what' s especially hit them. I could enlarge forever on that theme.

A.C. Did you read Mary Richmond? *What is Social Casework* or *Social Diagnosis*' or both?

F.W. I probably read both, but such a long time ago.

A.C. You're the second person who's talked at length about Mary Richmond and said it still holds today.

F.W. Do they still read Harriet Bartlett who wrote *The Common Base?* She also wrote something whose title I forget, about practice in the hospital field too, which spells these things out. Of course we are not the only ones. Dear old Spock **[26]** has a splendid book on *Helping Your Handicapped Child.* What he didn't know wasn't worth knowing.

A.C. I was thinking when you were talking it was like hearing echoes of a conversation I'd had with Robina Addis (Interviewee no 1) who worked in the mental health field, and she was saying that an exciting discovery for them, when she was doing the mental health course, was the sudden realisation that it's not what happens to you, but how you take what happens to you. And she expounded on that in the same way as you have just done.

F.W. Then it's serial isn't it, because how you take what happens to you, depends in part, though not in whole, on what has happened to you before. You can go back and back! Heaven forbid we try to go back to the uterus but often it would be useful if we could. I think I got a special line on this because prior to going to the paediatric department I'd worked for about 18 months in maternity, and in that I got a very good view of the different ways people approach pregnancy and children, and the different things that children are going to mean to their parents.

A.C. Some rather critical things have been said about social workers during this period. By 1959 Barbara Wootton's publishing *Social Science and Social* Pathology **[27]** with a big attack on social workers in there. And I just wondered what you'd say about all the criticisms?

F.W. I remember the furore about this, and I think what we felt on the whole that first of all she did not, though she knew quite a lot about social work as a function, she didn't <u>really</u> know about people, and what was happening in the day to day interaction between a worker and a client. On the other hand we thought that a good many of her criticisms were probably valid in some contexts.

A.C. I suppose the nub of it was that social workers did for their clients what a solicitor or a lawyer would do for a wealthier person. So all you needed to be really, was a well-mannered secretary. She also said that social workers made incredibly omnipotent claims and that it was very difficult to understand why when the world got itself into a pickle, that the people involved weren't just referred to a social worker and that would then sort out the matter. That social workers were overly concerned about the contribution the individual makes to his predicament, and not enough concerned about social circumstances that had produced the predicament. So that the individual was having to carry the blame, in a sense, for adverse circumstances. The growth of what she calls the psychiatric approach, and the use of psychoanalytic notions.

F.W. I think this is where lots of us thought she had something but that she had it a bit out of balance. One has to see this as the need for the pendulum to swing

too far before it can settle, it's just a perpetual pattern isn't it? We had neglected the psychoanalytic aspects before, and been very environmentally concentrated. We've been so concentrated on understanding the individual, that we felt less involved and less responsible for modifying poor external conditions that were contributing to the problems. Now those of us who were grounded in the 1930's, couldn't quite lose sight of that. But those that found themselves plunged into a relatively affluent society in their early working years, could afford to ignore these things a bit more. And I think this did happen. A corrective I think was sometimes to go and work in a big industrial area like Glasgow or Newcastle, where there were still environmental problems of poor housing and this kind of thing, that were much in excess of anything we had down here for instance, But I think this was a valid criticism of Barbara Wootton's, up to a point. I think on the other things she missed the bus completely. There's a grain of truth in the omnipotent claims. Again this was something that almost had to be as we were beginning to understand and measure the influence that we could have and the importance of knowledge of an individual. Also the impossibility of expecting rational behaviour from people with fulminating emotional problems and so on. When it comes to reforming the world, well someone like Hitler had fulminating emotional problems but I don't think any social worker would have claimed they were the ones to sort him out. Wootton's was a rather facile criticism in a way, that, but I can see what it had its roots in.

A.C. What do you look back on as the best thing you did in social work? What do you look back on with the greatest pride or pleasure?

F.W. I couldn't possibly say on an individual level because I think it's desperately difficult to judge the long term results of what you do. You get come-backs that teach you both ways. What did help and what just washed off in no time. This is another advantage of having worked for many many years in one set up, you get your children and grand children coming back and you learn a very great deal that is salutary from that. Also a great deal that's very rewarding. Both. I don't know what to say on that.

I think I got great rewards from contacts with medical students, some of whom I know used that. This was part of the working closely with the team that always was teaching of course. You were involved in a very informal way, so that you discussed things on ward rounds. You sometimes did special projects with the students. That I think was something that I would say had lasting success with some individuals I know. On the whole I want to think the thing I took most pride in was the general developing and build-up of the job in the paediatric department in this particular group of hospitals. Of the traditions of working together, the traditions of discussion and sharing knowledge so that you're really each benefitting from each other's specialism. And there were no barriers in what you taught each other. I think apart from the very huge rewards of the individual work with patients, which remained my first-love, and made me refuse to carry heavy administrative responsibilities I think that the clinical team build-up was my other great satisfaction. It's awfully difficult to say. Very difficult.

A.C. You did say you have had some feedback from people that you've helped in the past. Can I tempt you into sharing a bit of that?

F.W. Yes I think so. I can quote a girl with a severe congenital heart disease I knew from infancy upwards. This was in the days before heart surgery was as clever as it is now, and she had some early surgery which could only be palliative. She was an only child of a very anxious doting mum. She was very bright and quickly learned to manipulate mum. You had all the adolescent problems multiplied that grow out of such a situation. Mum felt a real need to protect and restrict, and the child kicking against this, running circles round the parent. All through her childhood this was what you might call a running battle of picking up the pieces, trying to anticipate the next problem before it came in order to mitigate it. Being very available to mum to let off steam. Gradually working up an independent relationship with the child as she got older, so that I could offer her individual help separate from mum. This was a relationship going on for years and I kept this girl on after she reached adult life. And she married, has two nice children, has needed help with crises such as pregnancies, when her heart went bad on her again. It did go bad on her quite lately, after I'd retired this was, and I did get other help for her then. She had major corrective surgery, and I'm still in touch with her on a social level. She's very well, and except that she over-eats, she's very well adjusted. This is the relic, the real emotional relic, and she knows it is. She's a very intelligent young woman. Very delightful. She's running a pub now with her husband in the neighbourhood, I go there sometimes. But considering the formidable disability, both social because of her superior intelligence to her mother's (this was one of her troubles) and being an only child, all this concentrated on her. An only child of not so young parents. This is one, I can only say that considering all, she's done most extraordinarily well and is living a very good life.

One or two others rather like that I can think of, children of very limited capacity who have nevertheless managed to get into comfortable niches through constant help, where the families were breaking up around a mental deficiency or difficult behaviour problem. When I say difficult behaviour I mean one of organic origin, brain damaged children, this kind of thing. There's one living not very far from here who was the most ghastly problem. He's one of few children who had a hemispherectomy. They used to nip out half your brain if your fits were bad enough once, you know. As a matter of fact it did him a power of good. But he was never going to be very bright, and he was always going to be a bit hemiplegic but he got a job helping a very nice groundsman on a big estate. He's still at it. He's comfortable and acceptable at home and keeps the hens and markets the eggs. I never thought he'd be able to count enough to market the eggs, but he does. That's just one or two. But goodness me I had so many. I'm sure there were some less nice stories. You don't get an idea of all that goes on. It's <u>serial</u> you see with these children. The long term disabilities were the ones that took most of my time. The other group needed short term crisis help, might take a tremendous amount of time for a short while, but there'd be no need for a continuing link. But the people facing long term things whose impact is going to vary as a child grows up, they really need a long term contact, but with periods of varying intensity.

A.C. Thank you very much indeed, Miss Ward.

EDITORS' NOTES TO THE WARD INTERVIEW

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 in 1970.

2 **The London School of Economics and Political Science** (informally, the London School of Economics or **LSE)** was founded in 1895, the moving Fabian spirits being Beatrice and Sidney Webb, Graham Wallas and George Bernard Shaw. The initial finance came from a bequest of £20,000 from the estate of Henry Hunt Hutchinson, a lawyer and member of the Fabian Society. He left the money in trust to be put "towards advancing its [The Fabian Society's] objects in any way they [the trustees] deem advisable". The aim of the School was the betterment of society through the study of social science subjects such as poverty and inequality.

The important role of the LSE in the development of social work education is referred to in several of the Cohen Interviews. The Charity Organisation Society (COS) sociology department - that had provided some theoretical training for social workers - was absorbed in 1912 into the LSE's new Department of Social Science and Administration. The range of courses later provided by the Department was described by David Donnison in 1975: "The Department was teaching about 300 students at this time (1956): about sixty were taking the Social Administration options in the second and third years of a course leading to an honours degree in sociology, ninety were taking a course leading to a Certificate in Social Science (later renamed the Diploma in Social Administration) and twenty five graduate students were taking the same course in one year. The Department also provided four one-year professional training courses designed in the main for graduates in social sciences: the Personnel Management course for about twenty five students, the Mental Health Course [established in 1929] for about thirty five students training for psychiatric social work, the Child Care Course for about twenty students training to work in local authorities' children's departments and involuntary child care organisations, and the Applied Social Studies Course for about twenty five students entering various branches of social work. A number of graduate students were reading for higher degrees, and various

others were temporarily attached to the Department.” The School ceased to offer professional social work qualifications in 1998.

3 **Invalid Children’s Aid Association (ICAA).** Founded in 1888 by clergyman Allen Dowdeswell Graham to assist children in poverty and children with disabilities. The volunteer workers delivering home supports were gradually replaced in the 20th century by health professionals. Following the improvements in health services post 1948 the focus of ICAA switched to running specialised schools with disabilities and special needs. Detailed records are lodged in the National Archives.

4 **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)

5 **Royal Surgical Aid Society** was formed in 1863 and is now called Age Care. Its work is described in the BMJ Dec. 1934

6 **St. Giles Hospital** The Camberwell Workhouse opened in 1818 and became an Infirmary in 1875. The London County Council took it over in 1930 and it joined the NHS in 1948 renamed as St. Giles Hospital. It closed in 1983.

7 **Margaret Roxburgh** was Secretary of the Institute of Almoners. With her colleague, Marjorie McInnes, she submitted a minority report to the Cope Committee which had recommended that all health auxiliaries, except doctors and nurses, should be regulated by one body with doctors in the majority. The almoners wanted a “different basis of association” and the Minister accepted their argument.

8 **Helen Rees** (1903-1989) influenced important developments in social work education in England and Australia. She read English at Newnham College, Cambridge and then in 1928 trained as a hospital almoner, serving for five

years at Sheffield City Hospital. She went to Australia in 1933 to take up an appointment as Almoner at the Melbourne Hospital and as Director of Training at the Victorian Institute of Hospital Almoners. She held four important posts in Australia from 1935 to 1941 when she returned to England to study medical social work under wartime conditions and its role in post-war reconstruction. For the next twenty five years she was strategically involved in most of the major British developments in social work education and practice. From 1942-46 she was Head Almoner at the Radcliffe Infirmary in Oxford and then became Director of Studies at the Institute of Almoners in London until 1958. (Source: *Australian Social Work* March 1990, 43 (11), 46-47.)

9 **Barnett House** was opened in Oxford in 1914 as a memorial to Canon Barnett, a former Warden of Toynbee Hall. It was a centre for study, training and debates on social and economic issues. By 1961 the House was fully absorbed into the University as the Department of Social and Administration Studies.

10 **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.

11 **Frank Pakenham, 7th Earl of Longford** (1905-2001) was a campaigning Labour peer especially on prison matters. He was a Labour peer from 1945 as Baron Pakenham and Lord Longford as from 1961.

12 **J. R. Rees** (1890 –1969). British physician and psychiatrist, Jack Rees was Fellow of the Royal College of Physicians and a wartime and civilian psychiatrist and became a brigadier in the British Army. He was a member of the group of key figures at the original Tavistock Clinic (more correctly called the Tavistock Institute of Medical Psychology) and became its medical director from 1934. This group specialised in the new 'dynamic psychologies' of Sigmund Freud and his followers, and in particular the 'object relations' http://en.wikipedia.org/wiki/Object_relations theory of Ronald Fairbairn and others.

Rees encouraged training in psychiatric social work and child guidance. In the 1930s the Tavistock Clinic was eclectic, with Jungian, Adlerian, and other psychotherapists of many persuasions. Its leading figures were James Arthur Hadfield and Ian Suttie, whose 1935 book *The Origins of Love and Hate* had an important impact in British psychotherapy. Both John Bowlby and Donald Winnicott acknowledged this influence. Suttie attempted to integrate the individual, the social, and the spiritual. Among the staff in the 1930s was

Wilfred R. Bion, who treated Samuel Beckett. Henry Dicks, for many years his colleague, described Rees "as a natural unselfconscious leader and originator."

13 **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 in 1946 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 the 1950'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.

14 **Miss Marx** was an almoner at Brompton Hospital and was elected in 1935 to serve on the Executive Council of the Institute of Hospital Almoners.

15 **Miss Ann Cummins** was appointed in 1905 as the first Lady Almoner at St. Thomas' Hospital in London and this coincided with the foundation of its social work department. It was said that she had been "the effective professional leader of the Institute of Almoners for some time". Her aim was to establish 'a complete system of medical social work touching all the patients and not a selected few, a system which should be part and parcel of the hospital, functioning as an ancillary service to the medical, nursing and administrative services"'. She was able to expand the scope of her work by means of the Cecily Northcote Trust. When she retired in 1929, she was succeeded by Miss Cherry Morris.

16 **Cherry Morris.** Succeeded Anne Cummins in 1929 as Head Almoner at St Thomas' Hospital in London. Twenty years later she was in post as Almoner at the National Hospital, Queen Square, London. Author of *An adventure in Social*

Work: The Northcote Trust 1909-1959 and Editor of *Social Casework in Britain.* (Faber, 1950). Including chapters by: :

- Cormack, U. M. and McDougall, K. *Casework in Social Services* and *Casework in Practice*
- Snelling, J. *Medical Social Work***.**
- Hunnybun, N. *Psychiatric Social Work*
- Deed, D. M. *Family Casework.*
- Britton, C. *Child Care*
- Minn, W. G. *Probation*
- Reeve, B and Steel, E. M. *Moral Welfare*
- Younghusband, E. *Conclusion*

17 **Miss Nicholl** was an almoner at University College Hospital and in 1935 was elected to serve on the Executive Council of the Institute of Hospital Almoners.

18 **Miss Janet Salmon** was the first almoner at Great Ormond Street Hospital appointed in 1908 and stayed until 1937. She wrote a History of the Hospital Almoner's department, a typescript 1936, which was updated in 1955 by Margaret Mayfield. It is in the Hospital archives.

19 **Margaret Coltart** was elected to the Institute of Almoners in 1941 while serving as Almoner at North Middlesex County Hospital. Later she was Head Almoner at the Brompton Hospital London and co-author of *Social Work in Tuberculosis*, 1960**.**

20 **Professor Leslie Witts** was the Nuffield Professor of Clinical Medicine.

21 **Flora Beck's** book is *Ten Patients and an Almoner* (Allen and Unwin, 1956).

21a The chap was almost certainly Henry Kempe whose published work from the

1960's onwards on the "battered child syndrome" attracted much attention in the medical and social work professions in the UK.

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

23 **Carnegie (United Kingdom)Trust :** a grant giving foundation endowed by Andrew Carnegie – a Scots émigré who made a substantial fortune in the USA. Supportive in the 1940's and 50's of training needs of social workers and commissioned the two committees of inquiry that were chaired by Eileen Younghusband, interviewee no 26.

24 **Harriet Bartlett** (1897-1987) was an American who obtained a social the science certificate at the LSE in 1920. 1921- 45 she was employed by the Social Services Department of Massachusetts General Hospital. From 1942- 44 she was President of the American association of Medical Social Workers. Her last post was as Professor and Director of Medical Social Work at Simmons College School of Social

Work, Boston. She was on many Commissions and wrote widely with *The Common Basis of Social Work* (1970) regarded as the summation of her position.

25 **Mary Ellen Richmond** (1861-1928), American social work pioneer and author. In 1888, she applied for a job as Assistant Treasurer with the Charity Organisation Society that also operated in several U.S. cities). She was trained to be a "friendly visitor," which was the term for a caseworker. She visited the homes of people in need and tried to help them improve their life situation. She began to develop many ideas of how casework could best be conducted to help those in need. In 1909 she helped establish networks of social workers and a method by which they did their work when she became the director of the Charity Organizational Department of the Russell Sage Foundation in New York. Books she wrote included *Poor, Social Diagnosis* (New York: The Free Press, 1917) and *What is Social Case Work* (Russell Sage Foundation, 1922). She believed in the relationship between people and their social environment as the major factor of their life situation or status. Her ideas were based on a social theory and that social problems for a family or individual should be looked at by first looking at the individual or family, then including their closest social ties such as families, schools, churches, jobs, etc. Her focus was mostly on children, medical social work, and families. Her ideas were influential over a long period but her emphasis on focusing on the family did not go unchallenged by a number of critics who were more concerned with the shortcomings of the state and social institutions.

26 **Benjamin Spock** (1903-88) was an American paediatrician whose book *Baby and Child Care* (1946) is still in print. The book referred to here is probably *Caring for your Disabled Child* (1965)

27 **Barbara Frances Wootton,** Baroness Wootton of Abinger (1897–1988). Eminent economist, criminologist and social scientist. After leaving Cambridge, Wootton took up a research studentship at the LSE and later worked for the research department of the Labour Party and the Trades Union Congress. She was Principal of Morley College from 1926, and Director of studies for tutorial classes at London University from 1927 until she became Reader at Bedford College in 1944 and Professor in 1948.

She published widely and her *Social Science and Social Pathology* (with Vera G. Seal and Rosalind Chambers. Allen & Unwin, 1959) remains a classic in the application of utilitarian philosophy and empirical sociology to the enlightened management of society. It is a wide ranging 400 page book and Alan Cohen, in his interview questions, concentrates on a chapter ("Contemporary attitudes in social work") that was very critical of some approaches to social work and the claims made about what social work could achieve. It would be difficult to find more trenchant and sustained criticism of the attitudes, language and assumptions of the selected social work writers and academics quoted – in particular of the claims made for the more high-flown psychoanalytical approaches to solving human problems. These she ridicules and claims that they do a great disservice to social workers in their daily tasks. It is clear from the edited transcripts that Alan Cohen was keen to gather the views of his interviewees about the impact of the Wootton bombshell and most of them give a response.

From 1952 to 1957 she was Nuffield research fellow at Bedford College. She was

created a life peer in 1958 and was the first woman to sit on the woolsack in the House of Lords; and later held several senior public appointments. Her reputation as a fiercely independent thinker was sustained during the following years of public service.

Accounts of her life and work are available from her autobiography, *In a World I Never Made* (1967) and Ann Oakley's biography *A Critical Woman* (2011).

(*Sources:* Personal Papers of Barbara Wootton, Girton College Archive, Cambridge; and the books cited above).