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Box 1102
One Gustave L. Levy Place
New York, NY 10029-6574

T 212-241-7239
F 212-241-7864
msarchives@mssm.edu
archives.mssm.edu

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LYONS: Is being prepared for the interview with Dr. Helen Rehr. This is Tuesday December 4th in the office of Dr. Helen Rehr. Helen let's see, you spell your name R-E-H-R?

REHR: That's right.

AL: Listen, you were born in 1919. That makes you sixty-five isn't it?

HR: Next month – this month, this month. Yes.

AL: Tell me, where were you born?

HR: Here, in New York City, in the Bronx. Sometimes referred to, in the old days, as a 'Bronx delinquent.'

AL: A 'Bronx delinquent?'

HR: Yes. The reason being is that I was always bucking things. I was a little bit hitting the streets as I was growing up.

AL: Where abouts in the Bronx were you born?

HR: I was born in the old Lebanon Hospital, over in the Southeast Bronx, and we lived in that area for a number of years. And then we worked our way up and moved to the West Bronx for a stretch of time, until I got old enough to think of running away from home. Running away in the sense that one reaches a late adolescent stage, or college, and you think you want to be independent. So, that was it. My parents continued to live in the Bronx, and I moved on down into Manhattan, living in single rooms until such time as I could put together some money.

AL: What did your parents do?

HR: My father was a waiter. He worked in a very well-known vegetarian restaurant on the Lower East Side called Geffners. He had been there for as long as I remember, until his death. He died comparatively early in life. My mother went to work in her mid-years as a salesperson in a bakery. Both of them had a characteristic of the old Jewish world, and that is that they believed that whatever they were working at, that the products also belonged to them, so they would bring it home. [laughs]

AL: [laughs]

HR: My father would bring home food every single day, and so we were always eating the products of the vegetarian restaurant – pierogi and herrings, fish, and so on, and Sunday was always a great day, and so on. And when Mother went to work in a bakery, she also thought that the products belonged to her, so she'd come home with a range of breads,

rolls, and cakes and so on, and that continued as long as I remember with Mom. My mother died at 90, which was something special. My father died at 62.

AL: Where did they come from, originally?

HR: They were both Polish, but from different parts of the country. My mother was from Southern Poland and my father from a little town near Warsaw. When I was quite young, my mother paid a visit back home, and I went twice with her, and I can't remember whether I was thirteen and then again fifteen or fourteen and sixteen. But they were great visits because I met cousins for the first time, had a sense of the Old World, and it was my first taste of travel, which I never lost.

AL: Did you speak Polish?

HR: No. But I did manage – we were there for quite some time, and, as a matter of fact, we were trapped in one of the little towns because of floods.

AL: What year was that about?

HR: In the 1930s. 1934 and 1936. And so, in one of those years – in 1934, I think it was – we were trapped by floods. Remarkably enough, in a relatively short span of time, I picked up enough German in order to be able to converse. Then I took it at school, and when we went back in 1936 --

AL: Did you speak Yiddish?

HR: I had it at home. My parents spoke it so that I wouldn't understand. They had given up Polish completely, so when they didn't want us to understand, they spoke Yiddish. But I picked up an understanding of it, but didn't become fluent in it.

AL: You had brothers and sisters?

HR: I had a brother, who died when he was sixteen and I was eleven. We were five years' difference in age. And beyond that, I've been alone -- I've been an only child.

AL: I noticed that you were a graduate of Hunter College.

HR: Yes.

AL: And then you went to the School of Social Work at Columbia University?

HR: Yes.

AL: Now, I have your curriculum vitae, and I'm not going back over that because that's documented.

HR: Right.

AL: Can you tell me anything about your training, experience --

HR: Why I went into social work?

AL: Yes.

HR: Well, believe it or not, at Hunter I was a math major with an economics minor. I had a kind of fluency in statistics. They were very easy for me and I liked them. It kind of appealed to what I always felt was a systematic mind that I had. And so, that was indeed my beginnings.

You have to recall that I am, in a sense, a Depression product. That is, I come out into the Depression into the work world. And so, I had to make some decisions. While I had an earlier interest in architecture, women weren't going into architecture in the late 1930s. And also, to get into the marketplace in statistics was not easy. But I did have a stint with the federal government for about a year-and-a-half, where I was a junior statistician working out of Philadelphia. I enjoyed it very much. It was during the war years, after college. I had fun. I charted purchases of the purchasing department of the federal government on war – military products – and so on. I got a first glimpse of double purchases, all the interesting things that government will do, and so on. While there – I think, also, I had already had an interest in the social services, and that came out of the economics minor. And then, also I think probably, because I was living through the 1930s, and we had a serious concern with a social problem.

AL: You were living at home at the time?

HR: Not since my first year of college. So, I think also politically, one would say that I was active in circles that were concerned with social issues.

AL: Such as?

HR: Well, the old socialist – young people socialist league and such --

AL: That was the term when Norman Thomas was [unclear]?

HR: Yes, right.

AL: I see. When did you get to Mount Sinai?

HR: I came in May of 1954 and from my point of view, one can't talk about social work at Mount Sinai without talking about Doris Siegel. Doris Siegel had arrived – she had come to be the Director of the department in late 1953. Following a stretch in the department

that had been manned by a woman by the name of Mrs. Fannie Mendelsohn – I believe Mrs. Mendelsohn had been a nurse in her early occupational background, and then had shifted into social work [Director of Social Work at Mount Sinai, 1923-53], which was rather traditional in the 1920s and 1930s for social work in this country.

AL: What do you mean 'traditional?'

HR: Well, social work really, in the healthcare field, was perceived to have grown out of Cabot's interest in Mass. General, and the first social worker who was a nurse by background, and so, what happened was that nurses shifted, because of their concern with key issues about people, into relating to their social problems. So that you had the transition from nursing into social work. That occurred even before Cabot, with Adolf Meyer and so forth, and the historical background of the field in psychiatry. And you also see it in the religious sphere, where nursing moved into what was then considered a social services. So, that's the [unclear].

AL: The church?

HR: The church – yes. And one could say the social services are as old as religion in one way, and that would be my general perception on it, but there is a basic evolution and there is also a formal social work services, and so on. But the healthcare field in this country really starts in the mid-nineteenth century and then begins to evolve. But essentially, out of women nurses and even one or two women doctors.

AL: But you say 'traditional.' Now, in social work, what was the Social Work Department – Social Service Department as it was called when I was familiar with it – what was it that was traditional about it, as compared to what happened after Doris got here?

HR: Well, if you go back to the turn-of-the-century, perhaps to 1910, social work moved down two pathways. One of the pathways was to be very concerned with what was happening in the outside environment. And in that environment, what happened was the physicians who were concerned with the poor, as they were seeing them in hospitals, began to take a look at what was happening outside that was bringing people in. So, you have the Sanitation Movement, the diseases which were occurring, over-crowding, etc., so the people began to take a look at the outside as it effected people, in terms of creating illness. So, you had then the broad social problem action phase, sort of in the social political arena. By the time we begin to get to 1905, we begin to think of the individual, not just to take a look at the general environment and how could that be changed by law or by sanitation or by a range of other things, but how one work with the individual and his or her family back in the community, so that we took a look at who was coming into the institution, what precipitated it, and what that person needed in terms of going back into his own environment.

AL: You're not talking about – is this traditional, you're talking about?

HR: This is traditional. This was the way we looked at it in those early days.

AL: And how about the people who were going to leave the hospital – were going to do, and would they have to go to particular places, or to have help – things like that?

HR: How they would manage? Right. Exactly. The whole range of things.

AL: Yes.

HR: Even then we began to think of the management of the individual in his own environment, one way or another. Over-crowding was a serious issue, and so on.

AL: Yes.

HR: Food, diet, and so on. What happens to social work is not different in the way with what happened to medicine. As the public health arena separated from the practice of medicine per se, social work split, also, into the social policy, social action arena, and also the individual care people – the clinical dimension. And then we had the big burst of the psychiatric field which starts with World War I.

AL: Is that what you mean – that is the break-off? Or the change – or the change in direction, when Doris came?

HR: When Doris came we were already entrenched in dealing with the clinical aspects of social work.

AL: Yes.

HR: And that meant we were dealing with the individuals and their families in terms of how they were impacted by sickness.

AL: Isn't that traditional, too?

HR: We had now become immersed in psychiatric theory, psychological factors. There was then the early conflict about whether everything was judged in psychological terms. We also pushed away the environment for a while and became over-absorbed in the context of the psyche and what individuals did unto themselves, so that one looked to the individual, and if there was fault, then the fault lodged in his psychological make-up, not so much anymore in terms of what was going on on the outside. When Doris came, in 1953, we were just putting the pieces back together again. Now, the old service --

AL: When you say 'putting the pieces back' – what pieces?

HR: We were putting the environment back in, the psychological factors, the impact of the illness, the issue of what was opportunity, what did people have.

AL: You mean some kind of structured way of looking at it?

HR: We began to put multiple theories together, and to re-integrate a concept of how you work with people.

AL: Now, you were here at the time?

HR: Yes.

AL: Before Doris Siegel?

HR: No. I came – Doris hired me.

AL: I see. Where were you before that?

HR: I came immediately before that from the New York City Health Department, where I worked in Maternal and Child Health Care in an assignment that dealt with auditing quality care program.

AL: This is right after Columbia – is that it?

HR: No. Immediately after Columbia, I worked with Sydenham Hospital and then at Grasslands [Hospital], where I had a stint --

AL: As a social worker?

HR: Yes, supervisor social worker in tuberculosis. And then I was at Bellevue for five years, where I was also working as a supervisor. But just prior to coming here, I had done a stint with New York City Health Department, and that was a very exciting year because I got a perspective again of the public arena. I have a small bias that says that I think that professionals in the health care field have some responsibility to the public arena, and ought to do a stint of service in the public area. Now, I don't know that I was conscious of doing it at that point for that reason, but I did. And one of the things is that you see how public programs and public monies are utilized on behalf of social health programs. Now, when Doris came in 1953, and I came about six months after she did to be her second-in-command, you have to bear in mind, she came from an old-fashioned department, by our standards.

AL: At the time who was Head?

HR: Fannie Mendelsohn.

AL: And Fannie Mendelsohn had been a nurse [Mount Sinai Hospital Training School for Nurses, Class of 1913]?

HR: She had been a nurse first, and then moved into --

AL: The head of the Social Services Department?

HR: Yes. And had been for many years.

AL: And who were the social workers at that time?

HR: We had a handful of nurses, old-time nurses. And some other relatively untrained people.

AL: But they were just doing social work?

HR: They were then doing social work. There had been a study done at the department, at the request of the Women's Board --

AL: The Women's Auxiliary [now the Auxiliary Board]?

HR: Yes. And at some point, one probably needs to talk about the Women's Auxiliary Board [founded as the Social Service Auxiliary in 1916], as one looks not only at the history of social work in this institution, but at the history of many innovative programs that the institution has, such as recreation and --

AL: Well, maybe this would be the time to talk about the history of the social service in this institution as related to the --

HR: Women?

AL: Well, the Women's Auxiliary, but also elsewhere. For instance, what was Mount Sinai's position? Where did it stand in the stream of social service? Was Mount Sinai like other departments? Was Mount Sinai different? Was it ahead in some things, behind in others? If you were writing a history of social service at Mount Sinai --?

HR: Well, let me tell you a story and that will give you a picture of where I thought it was at that point, and I think that Doris would have concurred but on differences in personality and style of working as very evident in –.

Remember I said to you that I have a style of being relatively systematic in a way of looking at things in terms of gathering together information, and what does it tell me. So, I have a curiosity of what does it mean. Well, she [Doris Siegel] had asked me to do a survey of the department within a year of the Fall of my coming, and I did. And I arrived in her office with a report one day and a recommendation. And the recommendation

went something like this: Let's get rid of all the untrained people and we will then go out into the marketplace and hire only professional social workers and people with Master's degrees in social work, and we will begin to develop a professional department. And she was a very remarkable lady with a lot more experience that I had, although we weren't that much different in age. And she said, "Golly, that's a very good idea, and I think that you're right, that we need to have a professional department," and I'd made a number of suggestions about how to do it. She said, "But I think we'll go about it a little more slowly." And what she then decided to do was to open the doors to all the people on the staff who had not had professional training, to take advantage of going back to school. She managed to get the Auxiliary Board to put up some money to do it, so they could have scholarships and not lose an excessive amount in salary, and then she planned it over a span of ten years.

Now, the thing that I learned out of that experience was that if we had done it my way, we probably would have had five years of chaos, during which time we would have liquidated the staff, gotten new people on, and nobody would have trusted anybody. Having done it her way, we did it very slowly over five years, and there were, as I recall, easily a half-dozen of the people who availed themselves of the opportunity for further training. One or two came back. Some went elsewhere. And those who stayed on, stayed on until such time as they retired. And what it did do was to build a stability into the department.

AL: Let me ask you, if I may, what was it that the professionally trained people had that those who were social workers before, some of whom I knew and some of whom had helped me when I was in surgical practice, and who helped with the – both the formation and the development of the ostomy clubs and so on that we set-up – what did they have to offer that the others didn't?

HR: Well, I think in those days, the way we proceeded was that people were working without having a clear – what we call 'social diagnostic awareness' of the individual and the families they were working with. They were really working with doing tasks which they had kind of formulated. If a child came in, and there was an issue of taking the medication, then they would lecture a parent about the importance of the medication and so on. Now, the thing that the more professional worker would have done is to assess what were the impediments in that family structure that was making the difficulty for the mother and/or father to pursue supporting a child [unclear].

AL: You don't think that somebody with experience in taking care of such families would – out of common sense – look at that?

HR: Well, the thing that we were seeing is that there was more of a rote approach to care than there was a dynamic approach. And as the professionals came on board, we really

began to individualize people, and as they began to individualize people, the therapeutic direction took shape.

AL: But they did have case study – there was still a case assigned. I remember Lucille Leary.

HR: Right. I remember her, too.

AL: She was one of the old-timers and was not one of the professionals.

HR: Right.

AL: Who really held together whole families, whole populations of people who had been on the surgical service. So, I was rather startled – I can tell you, at the time – when I discovered that these people were not going to stay. Well, Lucille --

HR: Lucille did stay.

AL: Yes she developed – She got to retirement age.

HR: Yes.

AL: But I'm interested to hear you say all this because I never was quite sure what this --

HR: Well, you remember people like Miss Dixon who stayed on, until such time as she retired.

AL: Yes.

HR: And then, of course, the one who is the most famous of all, and whom I eventually got to love, was Jean Bernhard, whom you will remember. I remember in the early days, my own concern about Jean was – again, Jean, Miss Dixon, Leary – came out of the nursing field and moved into social work. My early concern with Jean, who had been assigned to me when I came on – you have to bear in mind that I was kind of a young whippersnapper, and she was a mature lady, who had been around with a lot of experience for quite some time. Jean was remarkable for what she independently undertook, irrespective of working with anyone. If she perceived something, she did it, and so on. She worked in quite a fascinating fashion, and it took me several years to learn to love and respect what she eventually did. And also, for me, Jean was what I maybe – not validly, referred to as a natural. And that is, that her perception of people, working with physicians, passing on educationally what she learned in the course of a lifetime of experience of working with people, was as rich as any professional could bring. And she was great. But this was not true of many of the others. And the many others worked in a rote fashion. I'm not saying that there weren't one or two people –

maybe even a few more – who stayed on with us, but they stayed on because they had a gift. And I would say that if you think back historically, you have to say that the people who moved either out of nursing or out of religious circles into wanting to serve others, had to have a certain sensitivity about those others. But as formal education began to be introduced, it also began to bring in a base knowledge.

AL: Was Sinai about in the same position that other institutions were in at that time?

HR: Well, Columbia-Presbyterian was ahead. They had formulated, probably, one of the earlier professional departments. Mass. General was ahead of Sinai in many ways. Sinai came into – bear in mind, we're now talking about the 1940s and 1950s.

AL: Yes.

HR: Came into full being in the late 1950s, after Doris came on. And Doris' intent was to make it a totally professional department. That was the reason she was hired by the committee.

AL: She was here about how long, all together?

HR: Doris lived from 1954 to 1971, when she died here, at Sinai. She was the Director of the Department. She came from the Children's Bureau in Washington, where she had been the Director of Social Work Services for a number of years, and had come as a result of a study with the Auxiliary Board an requested that a woman by the name of Celia Moss Hailperin had done. She was a full professor. Celia had come from Pittsburgh, where she had been a professor, and the Board had requested that she do a survey of the Department, and what she recommended was that the Department become professionalized by hiring someone. I think it was she, maybe, who had even referred the board to Doris and Doris came in to take a look at it. Now, Doris was unique because she also had had clinical experience, supervisory experience, and also had been in federal service, where she was implementing maternal and child health [unclear].

AL: In addition to bringing professionalism in the sense of having professionally trained people make-up the Social Service Department -- it was still called Social Service Department then, wasn't it?

HR: Yes. It currently is called the Social Work Services Department, but it was the Social Services, and that was traditionally so, I would say, for most departments in the country, in hospitals, probably up until the mid-1970s, when we began to shift.

AL: And here, in this institution, the Social Work Services – is that what it was called?

HR: The Department of Social Work Services.

AL: The Department of Social Work Services started – do you happen to know which year?

HR: It started in my regime --

AL: But you're not sure which year?

HR: That was after Doris' death.

AL: I see.

HR: Right.

AL: Well, in addition to – as I started to ask, in addition to the professionalism which you described, what else did Doris do with the Department?

HR: Well, we began to implement a number of things. One is that we began to impact all services irrespective of income status. Now, you have to bear in mind that traditionally, this institution concentrated its social work services on the poor. And those poor derived from many neighborhoods. East Harlem but the East Side and so forth. It consisted of different minorities and so forth. Now, in the mid-1960s, when the federal government began to move toward the implementation of what we referred to Titles 18 and 19, which are Medicare and Medicaid – and they have them in reverse order --

AL: That was together?

HR: They came at the same time – 1965 or 1966. We had already done a series of studies, and I'll take you back a little earlier in a moment. But at that point, we had already demonstrated that whether you had money or didn't, the nature of the problems that you faced were comparable.

AL: When you say 'we' you mean one?

HR: One. Yes. I meant the department – the professional department had already begun to –

AL: [unclear]

HR: Right, now, one of the things we had begun to experience from the early 1960s and maybe even in the late 1950s – I'm no longer recalling – was that we were getting requests from our attending physicians to serve the people who may be sitting in their own offices. Would we? And as we began to develop a more and more professional department, the doctors who were teaching on the floors in the old Sinai days, or working as attendings would reach out to us on request so that we began to develop – even as early as the early 1960s – a direct service to the patients of our doctors.

AL: Do you have any idea of numbers -- for example, when Doris came and afterward? Or you have – no?

HR: Well, I'll tell you that now we are serving in the neighborhood of twelve thousand families.

AL: No, no. I mean the members of the Department.

HR: Oh! Yes, I remember clearly. When Doris came, we had a total of, I think, thirty-one members, and that included everybody: secretaries and clerks and social workers at all levels. At the point that I stepped down from being the Director of the Department, which was in 1979, when I returned from sabbatical, we had a hundred and twenty-eight full-time equivalent members of the Department, and I would say that Dr. [Gary] Rosenberg, who is the current Director of the Department, probably has just under one hundred and thirty. And I remember, Albert, at that point, we were probably running a budget somewhere maybe between thirty and thirty-five – forty thousand dollars a year – if that much – for the people we had. When I stepped down we were already into two-and-a-half million.

AL: But, of course, a lot of those dollars

HR: Well inflated --

AL: came [unclear] compared, costs are different, so, salaries different, so.

HR: Yes. But we're also talking about numbers.

AL: Yes.

HR: Now, when we demonstrated in 1965, 1966 and 1967 – and this is very important, I think – that the demand for services came from anyone and everyone irrespective of class and state of affluence or what-have-you, and the requests were coming from our physicians across-the-board. We had now what we thought was a professional department. The other thing that you may need to remember is that the cost for reimbursement for care had then become a plus factor. And David Pomrinse, who was then Associate Director [of the Hospital] with Martin Steinberg – we translated cost plus for social work services to mean that we could build the department because all those funds would be allowable in reimbursement.

AL: From this government.

HR: From the government, and through third party payers, irrespective of the source of third party payers. So, that in a span of maybe five years, we jumped to a department that was over a hundred.

AL: Now, was this when you came?

HR: Yes. Doris and I introduced this, starting in the mid-1960s, and up until the time of her death in 1971. Now, of course, again, concurrently you do remember, we had already developed a medical school.

AL: I want to come to that in a minute because I do want to find out about the medical school. But first, cost plus, in this instance, meant what?

HR: We were reimbursed. It didn't matter how many we would have, so we went from thirty-one --

AL: In other words, you paid the costs, and what does the plus mean?

HR: Well, it meant you were allowed a cost plus an over factor – which took in some extra. But let's assume you had, just for the sake of discussion, an eight-hundred-thousand-dollar labor package. You were allowed the fringes, plus, and so forth, so that you were allowed a million dollar reimbursement. Nobody challenged you. Now, what we did then – David Pomrinse and I – because Doris allowed me to develop this. I kept demonstrating we needed services in all the private services then. The buildings that we had at that point – the private services.

AL: You mean private patients?

HR: Yes, in the private patient arena, so that we put workers on every floor and so on. And they were in heavy demand. The cost of the service was reimbursed on the in-patient per diem irrespective of --

AL: It was figured into what the hospital was reimbursed for, by whatever government agency was giving the money?

HR: Yes. But it was not limited to Medicare. It also included other third parties.

AL: I understand. It was once said that it cost four hundred and twenty-seven dollars a day for a patient. That meant it included what was paid for Social Services.

HR: About let's say – whatever – five dollars on that. Now, we were one of the first hospitals to implement that concept and therefore we were by leaps and bounds.

AL: The concept of --?

HR: The fact that the funds were there for the services.

AL: And that you used the funds for services to private patients.

HR: To anyone who needed it.

AL: To anyone who needed it.

HR: And what happened was that we created an expanded department, and other places in watching what we did, began to do the same.

AL: Now, were you here when the Neustadter Home was here?

HR: Yes.

AL: Could you tell me something about that because it doesn't appear anywhere Helen, that they have real good information on. The Neustadter Home was a --

HR: Convalescent home.

AL: A convalescent home in Yonkers, and I remember we used it a great deal.

HR: Well, you have to remember – and you probably do, Albert – that there was a time in the care of people – interestingly, we're returning to it – when we believed that people needed a transition period post-hospital. And that that transition period should be in a somewhat protected, sheltered, and medically controlled environment. And so, we had in those days, convalescent centers, residential centers, we had them for children and for adults --

AL: And 'we' again – you mean generally, in the field?

HR: Yes. The field. In general – in what was then referred to as the medical field, which currently I refer to as the social health field – had a concept of the continuum of care – the continuity of care – into a convalescent period. It was felt then that people would develop their strengths, and could return to earlier responsibilities and chores and so forth. So, there were many people, depending upon what their conditions were – their medical conditions – and their social situation, where we referred. And Neustadter was one of the leading convalescent homes in Yonkers, and it was one of the well-known convalescent centers. And because it was affiliated with Sinai, it had an open door in accepting referrals from our own institution. We used it a great deal, and then you may recall – and I can't place the time, Albert – but there was a period when convalescence went out the window.

AL: Why was that, do you think, Helen? Was it due to the fact that reimbursements were not given for it?

HR: I think that was a major factor, although there was still private money around – voluntary, charitable money – to maintain them. But they began to fall into disuse. I think the

general pattern was that people were coming out of the institutions and we needed to safeguard every return quickly into their own environment, back into occupational situations, or homemaking, housekeeping, a wife. And we began to find that this just wasn't being used. I think it was a transitional phase that we went into in terms of our concept of health status. Now, I notice that we are reopening it, but in a different way, particularly for the elderly, where we have introduced the concept of extended care now, one way or another.

Now, the other thing that did happen, too, is that we began to believe that people should go home faster, and we began to create – again 'we' in the collective sense – in the public arena, new kinds of services. Home maids, homemakers, the visiting nurse service began to flourish. And in many ways, we picked this up from our European counterparts, where these programs had begun to grow, particularly in the north countries, in the Scandinavian countries, and in England, where very respectable programs of supporting people in their own environment – the belief was, they had to go home anyway, and in going home with supports, they would get to do what they had to do faster. I remember, also, Bud Sweet [Avron Sweet, MD, Head of Mount Sinai's Jack Martin Poliorespirator Center in the 1950s] was here at that point, and you may remember the old Polio Program, and we learned from that. We had a remarkable Polio Program here, and Bud Sweet and Esther White, who worked with him, where our first expectation was 'how soon could people go home?' even if they had to go home with respirator equipment. And the goal always was to make them as self-sufficient as possible. So that the concept of self-care, self-sufficiency began to evolve probably in the 1960s and well into the 1970s. I think that the recessions that we had in the late 1960s and early 1970s also contributed to that kind of concept.

AL: Well, now, Helen, you came into the directorship of the Department in 1971, after Doris died.

HR: Yes.

AL: What do you think, as you look back on it, was your contribution?

HR: I have to say first that Doris and I had developed a complimentarity that was very important to me, and her death was probably one of the most impactful experiences of my life in many ways, so that for the first two years I didn't touch a thing of whatever we had created together. It was my belief that it was the continuing monument to her. I think my contribution, essentially now – I have to take you back again to the fact that the [medical] school was created, and in the creation of the school, we developed a division of social work and a Department of Community Medicine. Again, the only one of its kind in the country. And while we had negotiated early with Dr. [George] James [Dean and President of Mount Sinai, 1965-72 and first Chairman of Community Medicine, 1965-68] and Cecil Sheps, who was then the Head of Community Medicine or worked with Dr.

James, to create a full-fledged Department of Social Work Services, and by that I mean comparable to Medicine, Surgery and so forth. We lost the battle.

AL: What do you mean?

HR: Well, Doris and I negotiated with Dr. James, through Dr. Sheps --

AL: Dr. George James?

HR: Yes. That Social Work Services would stand as an independent Department in the Medical School, comparable to a Department of Medicine. We had hoped that nursing would, and so on.

Now, the thing that I also need to tell you is that Doris had been successful in the early 1960s in securing a place on the Medical Board. We secured a place for social work and a place for nursing. [The Directors of these two services were invited, non-officio members starting in 1962. They became official, voting members in 1974, under Dr. Rehr.] Again, almost the first teaching hospital in this country, and represented by women. In a way, Doris and Cynthia Kinsella, I think it was, who was then the Director of Nursing. What happened was we focused, worked with the Chiefs of Service, and finally got them to include in the charter a place for social work and nursing on the Medical Board. Unheard of. It was a non-medical – you know, two non-medical departments.

AL: This was innovative.

HR: Innovative.

AL: What happened at Mount Sinai.

HR: Yes. Dr. Steinberg supported that, and we really worked to secure that.

AL: But you were asking for something else, if I understand you. You wanted an actual teaching medical school department?

HR: When the medical school was created – yes, but we had already been well invested in teaching and in a range of education. We had affiliations with Columbia and Hunter Schools of Social Work. And what we were now seeking was a full accredited department and we lost that battle.

AL: You kept it as a department, but not as a faculty.

HR: No, we created a faculty, but not as a full-fledged department; as a division in another department.

AL: You were a division under Community Medicine?

HR: Yes, under Community Medicine.

AL: I see.

HR: And that was George James' department, as you remember.

AL: Yes. Dr. George James, who was the first Dean and President.

HR: Yes. And his commitment was, as you know, to Community Medicine.

AL: Yes.

HR: I think we lost that battle – and here you have my biases – because the physicians were unprepared to let a non-medical section stand alongside the medical. And that battle still exists, even today.

AL: Well, what would be the advantage now, as you look at it?

HR: Well, I think if one believes as I do, that the concept of health care in this country is really a social health care concept, meaning that one doesn't deal exclusively with the organic, with the organ structure, with the system structure, but one deals with the full human cross structure. And that as we're dealing with illness, and the maintenance of health, we must deal with the social factors, the human factors, the psychological factors that integrate that with a medical factor.

AL: Isn't that going on now, as an arm of a Community Medicine Department, of which Social Services is a part?

HR: I think it's going on in teaching, and I think we're having a major set-back because of change in public policy at the present time. And the change in public policy is not limited to the Reagan Administration, but even into the Carter Administration, has been to deal with the financial reimbursement of care in a political arena that closes down on the broader social plus concerns.

AL: Helen, I think we're getting close to the end of this first side of the tape, but you continue and when it stops we'll turn over and go on. Go ahead.

HR: Well, as I was saying, I think if one takes a look currently in 1984, we're back to a more restricted concept of serving people, and that is again, we're going back into looking at the medical services rather than a concept of social health. And while we have spent all of my professional life in trying to introduce the broader concepts of social care into medical care for medical students, and the reverse of social work students at the hospital administrative level, I think now that while it's still being done –

[end of side one, tape one]

HR: I think what I was finishing up saying was I think we're having a set-back in the conceptual base that many of us have worked for over time, and you were one of the leaders in that. And I think if you take a look at medical care now, with its competitive elements and its dollar consideration, not that I don't believe that you have to consider that, but I think that now the intent is more toward the denial of that comprehensive focus than it is to include it in the way we had done in the 1960s and early 1970s.

AL: But aren't you doing it now, even though, with your division of the Community Medicine Department?

HR: We're introducing educational content with the medical students. We're working with social work students so that they can work comfortably with physicians, and to understand how to work with families. Our students get exposed to families, but when all of them enter the broad marketplace, the impact of public policy now, unfortunately, forces them to push aside what they have learned.

AL: But how about in the institution? Would there be any different service given to the medical students and to the staff if you were a so-called separate department, independent of the Community Medicine Department?

HR: Oh, you're going back to the thought as to whether we would have been.

AL: Yes.

HR: Well, we would have been independent. We would have had a full vote in the deliberations, anything that dealt with either the academic and/or the hospital. We did achieve at least one vote on the Medical Board. We would have carried physicians a little differently in the institution.

Now, the thing that we did achieve that both Doris and I held to, and fought and have won, and that is the maintenance of a centralized department and a centralized division. And by that I mean there are no social workers in this institution who do not belong to the department. In many institutions, what happened was the different Chiefs hired their own people. The disadvantage of that in my opinion, and I think Doris held a belief, too, is that workers then became subordinate to the medical components and lost a piece of their --

AL: Is that still present?

HR: Yes, it is. And it's particularly present in places that hold psychiatry as a so-called independent structure. We fought that battle here and won it.

AL: Did Community Medicine back you up on that?

HR: Yes. But I have to say that the true backing came first from Dr. George James and Dr. Cecil Sheps, and also from Dr. Pomerinse. We had in writing – and when the issue came up at the point of the Search Committee in looking for the Edith J. Baerwald Professorship, and we may want to talk about that – a person to fill that. And the many candidates at that point – the Department of Psychiatry was early on insistent that either the person be a psychiatric social worker or there be a split, and so on. And we were able – I think Dr. James had already died – we were able to bring out the old documents, and even brought them up during Dr. Chalmers' regime when the issue came up again. So, we have been able to sustain a centralized department, a centralized division, so there are no social workers anywhere in this institution who are not responsible to social work administration.

AL: They are assigned to different departments and so on, yes.

HR: Yes. And they have a skill of being able to work well collaboratively within all departments, but at the same time, taking their knowledge base and being accountable to one central place for their professional practice.

AL: Helen, there were three areas that you alluded to, and I would like to take them up separately so we can have some record of information on them. One is the old Women's Auxiliary that you were going to talk about, and the other was your own personal activities through these years, including your sabbatical. And then, the founding of the Medical School and things related to that.

HR: I also want to mention the fact that we created an Applied Social Work Research Center, and again, that's the only one in the country in the Medical School.

AL: Well, maybe, you take it up as you wish. Now, let's start first with something we really belongs in the past, but I may like to get it in, and that is something you may be able to give us on the Women's Auxiliary or [unclear].

HR: Well, at some point, if we may, I would hope that alongside of this documentation, that we might put into the record *Milestones in Social Work and Medicine*, which was the third Doris Siegel Colloquium.

AL: *Milestones in Social Work and Medicine, Social Health Care Concepts*, edited by you, Helen Rehr, and it was --

HR: In 1981 --

AL: In 1981. And it was part of the –

HR: Doris Siegel Memorial Colloquium. It was the third one. And there is a paper that I gave, which dealt with the history of social work and medicine, it's parallel and overlapping arenas, here at Mount Sinai. And rather than to repeat that --

AL: Oh, yes, that would be great. Somebody could look it over.

HR: Yes. Let me then submit it because it does offer the history on the Ladies Auxiliary, in terms of their responsibilities for social work services. Also, their relationship to nursing services. And also, their many, many contributions to this institution, not only with money, but with their labor and energy in developing a socially structured institution, in my opinion.

AL: Now, the Ladies Auxiliary, in a sense, has to be considered in almost the same breath as the Board of Trustees.

HR: They are now a sub-order of the Board of Trustees, but for years I think they saw themselves as a spinoff as the old Board of Trustees, with the women who came into the institution in the 1860s and 1870s.

AL: They were often relatives of the members of the Board of Trustees.

HR: Of the Board of Trustees, but not of the medical staff when it finally came to be a formal structure, which must have been during World War I. And one of the first members was Mrs. Herbert Lehman, and Mrs. [Alfred] Cook – Mrs. Janet Cook – who helped to create the department – the Auxiliary Board and I --

AL: Mrs. Herbert Lehman, who was the wife of the Governor of the State.

HR: Yes. And I felt very privileged in having met both of these women. They were still alive while I was here at Sinai, and their contributions were fantastic. This is a group with a maximum of thirty women, who come – well, they're by-and-large of Jewish background. They come out of families whose concept is to contribute to the charity of care and so forth, and they have devoted.

AL: They were mostly from families of means?

HR: Yes.

AL: Tell me now --

HR: It's a shifting concept now, but that was the general pattern.

AL: It's shifting now?

HR: Yes. I think that they will open to men in the not-too-distant future. They are now a formal structure of the Board of Trustees. They have made major dollar contributions to the institution as well as programmatic [unclear]. I would say they're responsible for fostering the professionalism of the Department of Social Work Services and others as well, but certainly ours.

AL: Well, in the chronologic sequence first, let's deal with leaving the Medical School separately because I would like to deal with that separately. When you came here in 1971 --

HR: 1954. But as the Director of the Department --

AL: No, no, I meant as Director of the Department. 1971.

HR: 1971.

AL: When was your sabbatical?

HR: 1978-1979.

AL: What did you do in that sabbatical?

HR: I served as the Kenneth L.M. Pray Professor at the University of Pennsylvania School of Social Work.

AL: What did you do there?

HR: I taught social work in health care and applied social work research methods.

AL: To whom?

HR: Social work students. I also did one or two in the School of Business Administration – lectures, that is, and in their Gerentological Center. I also delivered the Pray Lecture, which is an expectation. I took a one-year sabbatical and spent the year at the University of Pennsylvania. It was very exciting.

AL: Though I noticed in your curriculum vitae, in 1979: Special Assistant to the Vice President at Mount Sinai Medical Center. In the first place, which Vice President?

HR: Well, Sam Davis.

AL: In other words, the person acting as the Director of the Hospital?

HR: Yes. He was the Director and Vice President of Operations.

AL: I see

HR: And when I returned, I was appointed as his Special Assistant. In that role, I have served to represent the institution in the broader community, and the broader community having to do in late years – that is, more recently – with the development of institutional projects and their receptivity by our East Harlem residents in the local political arena, the city in relation to its health care formulations for policy and --

AL: You still occupy that position?

HR: I still occupy that. I serve for the institution. For instance, even in the deliberations on the current CON – the Certificate of Need – which deals with a major request for funds for total new reconstruction of the hospital, I have been working on that on behalf of the institution.

AL: What is your present position here?

HR: At this point, I have retired from running the Department of Social Work Services.

AL: Since?

HR: Since 1979-1980 – 1980, to be exact. I am the Edith J. Baerwald Professor of Community Medicine in Social Work. That chair was created by Mr. and Mrs. Jack Aron, who have been major benefactors to the institution at both the financial and also in terms of policy and thinking. Both have been members of the Board of Directors for years. They created what is still the only chair for the social work division in a medical school in the United States or anywhere in the world, as far as I know, and having the chair has had many advantages. It has committed us to make a contribution into the school with regard to the content that we think is essential, and in 1973 or 1974, Mr. Murray Rosenberg was gracious enough to give me a grant to create the first applied social work research center in a medical school, and I refer to that as the Murray Rosenberg Applied Social Work Research Center. We used the income from that endowed fund for seeding projects. We seed projects that deal essentially with enhancing our knowledge in how to serve people in the social context around illness and health.

AL: Let me go to the medical school, its foundation and development. The idea of a medical school probably came into existence sometime in the 1950s, but from your standpoint, recite what you can recall or see in the steps that have to do with the medical school [unclear] in relation to the social work, sure, but in a more broader sense, so we can have some records here that later can reconstruct it, perhaps, when a history of the medical school is written. Keep it personal and refer to anybody you want.

HR: You will recall that the beginnings of the school probably indeed began in the late 1950s. Certainly from the time I arrived on the scene, and perhaps by the early 1960s, we were already talking about the possibility of a school. Very controversial.

AL: Now, why do you think that impetus was there?

HR: Well, as I understood it at that point, it was felt that an institution such as Mount Sinai, if it had an academic base, would then be in a position to enhance not only the quality of its care. It would leave an imprint on the future practitioners – health care practitioners, physicians, in particular – and that it would permit it to enter the research arena in a way that it had not. You will remember, Albert, that we were one of the few non-medical school teaching institutions that had as many grants as we did for research. But I think the chiefs at that point felt very strongly, that if they could put together an academic structure, they could impact the future direction of the institution.

AL: Now, you mention the fact that there was some objection.

HR: Yes, there was.

AL: One of the most articulate of the objectives was Leo Gottlieb.

HR: Yes.

AL: Who actually wrote a critique.

HR: Yes.

AL: Unfortunately, he no longer has it. I don't find any record of it, and in my conversations with him, he says, actually, that he thinks he was wrong, but it seemed to me at the time, that his main objection was that he thought that the focus in the institution would be away from patients, and its efficiency would be not in the care of patients, but would be in research and in teaching and in training. And while he thought that these were very good objectives, he did not feel that in this place it would end up on the whole of being beneficial. Now, that may be a simplification of what he said.

HR: Well, that was a major factor that was introduced. There were many people – and not Dr. Gottlieb alone – who felt very strongly that the introduction of a major academic enterprise would take away from patient care.

AL: Do you think it did?

HR: Yes and no. I believe that the pulls in this institution had gone in many directions. If I recall our beginnings, and I think we were privy to the pulls ourselves in social work. I remember very well with Doris, we had to think of creating an academic structure out of

a group of practitioners. Here we were, a bunch of social workers, who had lived in the clinical atmosphere, and learned only how to practice. We now had to make the translation into an academia for ourselves, working both with medical students, social work students, nursing students, and then even with other health care professional students. Now, two things begin to happen. One is that it forces the clinician to begin to conceptualize in educational terms – great. It's a great educational experience, and in my belief, ultimately, it enhances the practice. And many people say that when you have a quality academic setting, it enhances patient care. But on the other hand, we were all one person wearing two hats. And in the wearing of two hats, we drained energy from one direction. And in draining that energy over time, we had to place the concentration in an area where we thought we had to go. And what I saw was the chiefs placing a major concentration on the academic. And when they did, their energies were diverted from patient care. And I say we were just as guilty at that point. And in so doing, I would say there was an era in which we pulled away from quality patient care. Then I would say there was an era when the Board of Directors – probably pressed by the Medical Board – where it believe it wanted to have a great Nobel Prize setting, and as such, it had to make certain decisions as to how would this be expressed. And I think there was a great deal of feeling that it had to be expressed in the research arena, that it was less clear in the patient care arena. So, I think the pulls were there. I don't say it was overall. I think there were areas where you could always see the quality of patient care, but there were areas where you could see it went downhill or it shifted.

AL: Well, did we create the grants and the amount of research?

HR: Yes, we did. Yes, we did. And I would say we became the leading institution. Now, there is always the sociological problem of translating the product – the finding of grants into practice. And I would say we never developed a quality – what I call bridging professional – who could bring it out into the findings, out of the research, into the practice. We were always behind in that and slowed up. Now, on the other hand, we have had people on board who have brought some innovative programs first, and then have translated that into the educational component. So, as I said, Albert, it's gone down two pathways. Some of it has come together. I would say, also, we've had some – a period when the issues of being accountable became very prevalent, and with that, the quality of care had to be looked at in a particular way.

AL: When you say 'accountable,' you mean by third parties?

HR: We had the introduction in 1966, having a review factor that was built-into the Medicare/Medicaid reimbursement formula that was kind of handled loosely. It was reintroduced in 1971, 1972 and 1973, when it became a major concern in utilization review. Those were again the beginning signs of a change in the way we dealt with admissions and inpatient care and discharges of patients. And I would say that that trend has continued right now into 1984, leaving many problems alongside the trending.

AL: On the whole, do you think it was the correct thing to do, to have a medical school?

HR: To have a medical school? Yes.

AL: For Mount Sinai?

HR: Yes, I do believe that. I would say that we could not have sustained the nature of the institution that we were in 1950 if we hadn't introduced the medical school. I think we would then have remained – or had become – a community hospital rather than the great teaching, educational center, the teaching hospital and the educational center. Yes, I believe that it had to be. And probably like Mr. Gottlieb, one would be wrong in having thought the earlier way. But, I have to say, I was on the earlier bandwagon for a medical school, but with reservation. I was a little afraid of it. I did not subscribe to the belief that a great academic setting made for better patient care. I would say it takes fifty years for that to become an integrated phenomenon, and we haven't reached it yet. But we have introduced remarkable programs of quality care over the time.

AL: Such as?

HR: Well, I think the Adolescent Health Care unit was a great program that they illustrated the problems of adolescence. Was not – adolescence was not being dealt with under the health care…

AL: Under which department was that?

HR: That was done under Pediatrics. Community Medicine had a piece. I was fortunate and privy to have written that first grant with Dr. Joan Morganthau, who was the head of Adolescent Care [Center].

AL: Under the Pediatrics Division?

HR: Under the Pediatrics Division and out of that --

AL: Was Horace Hodes the head of that, yes?

HR: Yes. And out of that we created probably one of the best Adolescent Health Care units in the city, well supported and so on.

We have, here at Sinai, perhaps with strange motivation, created the Methadone Clinic [Narcotic Rehabilitation Center]. By strange motivation I mean that perhaps the physicians in charge were more interested in the impact of drugs on the individual from the scientific point of view, rather than the direct therapeutic. But in very short order, they put the scientific and the therapeutic into a package that allowed a Methadone clinic to surface here at Sinai.

AL: Is this one of the large methadone clinics?

HR: It's not one of the very large, but it is a comprehensive drug abuse – substance abuse – and more broadly based than methadone, and, I think, given the nature of the social times, a major factor in social health care. I think in the not-too-distant future, we will begin to take a look at even trauma and accidents and those kinds of things.

AL: As a separate --?

HR: As a separate service in ambulatory and emergency care. We are expanding the basis for a range of reasons.

AL: Because, you know that Elmhurst City Hospital, which is the arm of this institution – an integrated arm – is striving and may have I think been approved, but I'm not sure of that, as a primary trauma center. But I'm not sure. At any rate, the trauma that the students and the house staff get – their training in trauma – is mainly at Elmhurst City Hospital.

HR: But I think also, the feature of having created the concept of the complex [Medical Center], Albert, was a very important educational design. Elmhurst, with its multi-dimensional programs. Beth Israel with its programs.

AL: But that wasn't necessary for the school. By that I mean, you didn't have to have a school for that. Isn't that true?

HR: There would have been no reason to have created the complex if you didn't have the school, in my opinion.

AL: I see.

HR: The academic structure lent the nature of the relationships amongst these, and I think that's what made for the value of the tie-in, and I do have to remind us, I think, that the complex is a phenomenon which occurs with and after the creation of the school.

AL: Do you have anything else to say about the positives of --

HR: Of the Academic Center?

AL: Of the school?

HR: Well, with all the difficulties that exist amongst the different institutions – by that I mean the difficulty in creating a quality coordination, and putting faculty from each of them in comparable status – I would say that having students, having an academic base, has enhanced the status of each of the institutions by-and-large. And certainly I can tell you for social work, having the faculty of social work, what I didn't mention is that the Division

of Social Work draws on social workers from each of the institutions who carry faculty status, teach alongside of the Mount Sinai people, teach in their own institutions, and carry basic educational responsibilities.

AL: These are?

HR: Social workers in Beth Israel, Elmhurst, [unclear].

AL: Yes, yes. The other sister institutions, yes.

HR: Yes.

AL: Tell me, do you have any either deficiencies that you see or weaknesses or other aspects of the complex that you can comment on?

HR: Well, let me give you an illustration. I am now in the process – we have just completed an evaluation of a ten-year program, educating for social work in health practitioners. That was a program that we developed with the Hunter School of Social Work, which is part of City University, as we are. And that program had begun while Doris was still alive in one way, and then we'd receive funding for it. Now, the intent of that program early on was to see whether we could develop conjoint educational opportunities for medical students and social work students alongside of each other. That is, a classroom where they would sit together, develop a language that they could understand together, perceive patients and families in a comprehensive way, so that we could integrate and cross-fertilize with each other. That failed. We initiated and had a year-and-a-half of it, or two, and it failed.

AL: When was that?

HR: The first introduction was in 1974 and 1975. We dealt with the formulation of the program at the highest level, the Provost at City University, the Dean here, who then --

AL: When you say it failed, you mean it did not come to pass?

HR: It didn't come to pass, and it didn't come to pass for a range of reasons. We have just analyzed that and will come out with a book in early 1985 -- it's ready been accepted for publication – analyzing it. What failed is a phenomenon that I think we see, not limited to medicine and social work, but the autonomy of professional education wins out all the time. And in this, the power of medical education, pulled for its own direction. And while social work would probably have been more collaborative and cooperative and willing to sit, as it did, alongside of medical students, the medical educators – there was no money, there was no support for it.

AL: Well, where would they sit? In which courses?

HR: Well, let me remind you, Introduction to Medicine, which is one of the most important courses, in my opinion, that we created in the early 1970s – in the 1960s. I know, I was part of it, and I carried a one-month assignment over a period of three years, where the students were assigned with social work students. We went out to visit families. They saw families in their own home, our own patients, who were now at home. They had to analyze the social medical problem, work with our own physicians, deal with social agencies on what the problems were, come up with a social, medical diagnosis and assessment, offer a plan of treatment, and initiate the treatment. This was done with a doctor and a social worker, and the two types of students. The marks we got for that course were some of the highest I have ever seen, and when the accreditation group came through, at the end of the second or third year, they gave this one of the highest --

AL: Well, what happened?

HR: Well, the medical chiefs threw it out – they threw out Introduction to Medicine. Not only that section.

AL: You mean they kept up the Introduction to Medicine --

HR: But not in the way it was.

AL: They changed it?

HR: They changed it – yes.

AL: And the social work --

HR: --component was thrown out.

AL: Thrown out?

HR: Right.

AL: Was there any reason, do you think? I mean, if they got such high values, I mean expressions on the part of the students, I assume.

HR: Yes.

AL: Because, you know, everything here is evaluated. They get questionnaires. We will say that about the medical school.

HR: Yes.

AL: Tell me --

HR: Why? Well, I think that's also an old battle, Albert. It's a variation of the old battle to introduce concepts of social health into medical care. And that struggle still goes on.

AL: You've spoken to the chiefs about this?

HR: You mean when they began to struggle against it?

AL: Yes.

HR: We spoke to the chiefs in terms of trying to offset the problem. But they made the claim on the hours of teaching, and they won.

AL: I see. When the new Dean comes -- and it's pretty definite now, remember, we talked about that?

HR: Yes. I would say that it will continue as is, and if they have their way, they may even make more inroads into the hours Community Medicine has held on to over time, as they have over the last ten years.

AL: And you figure that's bad?

HR: I think of it as detrimental to medical education, yes. I'm not talking about whether social work students have to be taught alongside medical students. The major thing that happens now is that the social work practitioner learns concurrently with the house staff. I happen to believe it's a little late in the educational process. It should occur earlier. But nobody has been able to link the issue of conjoint education.

AL: Well, have you anything to say about the curriculum in general in the medical school that you have knowledge of?

HR: No. I don't think I'm familiar enough with the nature of it.

AL: How about the students, the medical students? Have you got any observations on the medical students that we have?

HR: Well, we have a changed group from when we first started.

AL: In what way?

HR: Well, again, I have to remind us both that our first students came – were products of the 1960s.

AL: Well, they came after two years in another medical school. That was the very first.

HR: That was the first – yes. We got a lot of them from Rutgers and, you know, the New Jersey institutions. But I remember, also, that you have to bear in mind that the social activist communities that we had – cross country in the late 1960s and early 1970s – and having worked with those students over the first five to eight years – five years, in particular – I recall well that was a very different group of students. Very excited by the ideas that I talked about, in going out to meet families and sitting in the emergency room, having developing a – not a laying on of hands, but a perception of the human factor in the first year. And that was a very exciting dimension. I tell you, they were very different students. They were socially committed. They had a sense of working with the poor on behalf of the poor, and so on. And I would say, Albert, we're now back to -- when I first came on the scene – we're now back to an affluent medical student body, which is a variation on who was coming into medicine when I first began to come into the field.

AL: I take it you look with fondness on those early students?

HR: Yes, I do.

AL: Do you see anything about those early activist students, which you find not to your liking?

HR: I remember those students being both very bright and still very committed.

AL: Were they committed?

HR: Yes. But I would have to say that four years of medical school eliminated the commitment. [laughs]

AL: I have to tell you --

HR: Half the time, they turned out to look like other physicians. [laughs]

AL: [laughs] Which sounds to you as not appetizing.

HR: Well, I have some reservations about the total nature of --

AL: Which are what?

HR: …people who come into medicine.

AL: Which are what?

HR: Currently, I'd say it's that medicine is rife with problems, with its major focus now on rapid affluence. Things I see which I don't like: multi-visits that are unwarranted, the extraordinary cost of medical care.

AL: Of course, you know that a lot of those are physicians who were trained in the 1960s – the very 1960s of which you speak.

HR: Well, it's like you said, Albert. After four years, they begin to look like all of the other doctors I knew. Now, again, there are always exceptions in this.

AL: So, your objection to the medical profession at the present time, using general brush strokes, is that they are too oriented toward earning a living?

HR: I would say that's putting it mildly. I would say they are extraordinarily oriented toward getting there fast.

AL: And they weren't in the past?

HR: I used to see in 1940s, when I first came into the business, that there were still social values that physicians held. I would say they have begun to fast disappear in general – not in total, but in general – by the mid- to late-1950s. Now, some of it may be just nostalgia and sentimental feelings and so on.

AL: Well, what do you base this conclusion on?

HR: Well, I think I see a different breed of physicians in the 1970s and 1980s from what I saw in the 1940s.

AL: You mean young physicians who have just been graduated?

HR: Well, some of the older ones, who are now twenty years in the business.

AL: And you feel that before –

HR: I would say the group of physicians I saw when I came in in the 1940s --

AL: Not just medical students, but physicians?

HR: Yes, physicians. Because I didn't know the medical students except in a peripheral sense. But those with whom I worked.

AL: You don't think that a lot of my colleagues and my chiefs and the rest of them were not hell-bent-to-heaven to achieve quickly and have a high position and develop big practices and make lots of money?

HR: Yes, I think they were. But then, I thought there were physicians like you, who also had a basic commitment to certain kinds of [unclear] and --

AL: But hasn't that always been, Helen?

HR: Yes. But I think – I would say the numbers are now such to obscure those with the ideals. The numbers who are hungrier. I think I saw a great deal. The thing that I refer to historically are the great programs of this institution of the past. I'm not sure I'm seeing great social health programs now, and I don't know that we'll see many in the 1980s.

AL: Because we're recording this for a record – and I don't think it will appear anywhere else – I'm certainly not going to take the time of the interview – I do want to tell you, since you talk about the students of the 1960s, two things. Do you remember the very first graduation ceremony?

HR: Yes, I do.

AL: It was the two-year students.

HR: Yes.

AL: There were only about thirty of them, weren't there?

HR: Just about, yes.

AL: I remember the valedictorian got up at his time to speak, and he castigated the school and the founders of the school of having reneged on their promises and have not – this is only after two years! The school had just been founded! They had not developed these broad views or these humanistic attitudes that they were supposed to have had, and he gave a very strong condemnation, and all the students – those thirty students – the first three rows – I think it was in Hunter College Auditorium --

HR: Yes.

AL: They stood up in their caps and gowns and applauded this person.

HR: Yes. But that was the old third-arm concept that had been evolved, the so-called Hans Popper tripod [the Mount Sinai Concept].

AL: Yes. You stated.

HR: Yes. The third arm was the community medicine.

AL: Yes. Well, now, the speaker was the Dean of San Francisco Medical School, I believe, who, incidentally, died not so long after. But I remember he came to the podium. He took his manuscript and he dropped it on the lectern and he said, "That was my speech. And I cannot stand here and listen to this." And I remember the things he said. And among the things he said was that the great criticisms that this student had made did not contain one single item of commitment himself, to anything. That's one little incident.

The other is when I gave my first course in the History of Medicine – by the way, that was in response to students. And I had to move it from a little room where I scheduled it – you know, one right here, on this floor – because it was a new idea and out of curiosity as well as anything else, I have a feeling, so many students enrolled we had to go to the thirteenth floor auditorium. I remember at the first session, I gave a brief statement of what the course would consist of, and how I was going to try to run it, and I regretted the fact that there couldn't be an interchange because there were so many students, but that we would have time at the end. And one student got up in the back there and he said, "Who are you?" [laughs]

HR: [laughs]

AL: This was at the height of the activism, you see?

HR: Yes. Rude they were! [laughs]

AL: Well, a couple of the people in front turned around and I don't know whether they made noises or not. I suppose he was a [unclear] done that. This kid never finished, by the way, I found out later.

HR: Oh.

AL: But, at any rate, I said, "Okay, I'll tell you who I am." And then he asked me again, "Why are you teaching the course?" And that was easy for me to answer. I said, "Because nobody else will!" [laughs]

HR: [laughs]

AL: And secondly, because students have asked, and because I had given some – and so, I said that. And I told him what my background was, and also what I did not have. And then I asked him why *he* was here. Well, he didn't expect it. And it wasn't a very good answer. I'm sure if he had thought about it, he would have given a better one. I might add that a few minutes later, he left. But this was a chance that I had to make a statement, and I bring it up because I think it was one of the things that I tried to urge George James and the others in control to have, in relation to the activist students and the policy of the school.

HR: Yes.

AL: I said that it was really not important whether the student who just spoke – or any of you – really cared for me at all. That it was only important for me to care about them, and that that meant that I had to do what I thought was right for them, even if I was wrong, maybe, it would turn out to be. I was eager through the years to hear from them what they liked or didn't like, or would like to see change – not an open class, because that

takes the time away, but that's important. But I said, "It wouldn't matter to me if you all walked out" so long as two remain there, because if it was only one, he could come to my office. But that we would do it. In other words, I felt that this attitude of being afraid of the students, was destructive both to students and ourselves – not here – just alone here – but all over the country. And I asked George James to come out in firm statements to indicate that the students were not to be in control, and that if they didn't like it, they shouldn't come here. He said, "But Al, you know, we won't get any of the top students." I said, "Yes, but then you'll get motivated students." Anyway, it was my view, and I thought I would bring it up because there are incidents which did occur in the school.

HR: Right.

AL: Helen, do you have anything else you would like to say?

HR: I would want to just conclude with something, Albert, that goes something like this: That no matter what I say, in terms of, you know, where I may have some reservations about where medicine is going, and that medicine is being impacted by social and federal policy, which may be [unclear], problematic and so forth, I do think that in its strange way, Sinai has inched along. While it may have gone back, it's been inching along. And I can only again speak from a social work service point of view. Before I retired from running the department, the concept of a socially oriented institution had begun to expand here, and we had already absorbed the recreation department and the volunteer department, and at this point, social work now has a leadership in a conceptual base of human resources approach in the institution, and the institution has begun to look at itself from the point of view how to make [it] more humanistic with people who lay on hands. That is, not only the physicians, which is a major concern of ours, but its other providers, even down to those who are in the dietary [unclear].

AL: What do you mean by humanistic, Helen?

HR: Well, the feature that I think is the most important is how one who is in a proximal relationship with an individual who is sick – how that person is responding to the individual. And we have had now, in the last fifteen or so years, serious problems with the alienation of the American worker and so on, including physicians who have been alienated from their jobs, from their social responsibilities – [tape off/tape on]

AL: Side two.

HR: What I was saying is that healthcare institutions such as these have suffered from what has happened in the broader climate. Now, what we have begun to do is to become very conscious of how to deal with our employees in terms of job satisfaction, and to deal with the users of our service in terms of how to administer better care. And I think the

institution has been moving more and more toward the development with programs on how to make it more humanistic in terms of care.

AL: Now, I gather from your explanation of humanistic, you're referring to it in larger area, community, not one on one.

HR: Community, interrelations, one on one, yes.

AL: Well, doesn't the department of psychiatry have something to do with that? We have liaison psychiatrists who meet with the house staff and with the students all the time.

HR: Yes. But I don't think that they deal with the broader arena of employees that we have, who also affect the nature of care.

AL: Oh, you mean the-

HR: Anyone.

AL: —the ancillary.

HR: Yes. The paraprofessional, the ancillary and the physician and so forth. And I think also that the way I see psychiatry, it deals with people who have more mental health problems than what I believe is the general impact of illness and hospitalization on people, which also requires very sensitive handling during a period of hospitalization.

AL: I have to tell you that in the surgical service, just as an example, because you know, we've had a liaison psychiatric idea ever since I've been a resident here and a psychiatrist meet—who's assigned to the surgical service makes rounds on the surgical service and meets with the house staff and they discuss the various patients on the surgical service. These aren't people in the ordinary sense to consider mentally ill, except to the extent that everybody who is in a hospital or is having things done to him or her has mental aberration.

HR: You're talking about rounds that occur in certain areas.

AL: Well, every one of them I think has, every department I think has a liaison psychiatrist.

HR: It's every section and this, I think we have to credit the Moe Ralph Kaufman.

AL: No, it came before Ralph to set the record straight. Lawrence Kubie.

HR: Yes, Kubie did it.

AL: Did start it and of course he didn't have a well organized department. It is also true that M. Ralph Kaufman elevated it in a sense to an actual structured assignment and it was extraordinarily useful endeavor.

HR: Extraordinary. And an important contribution-

AL: Very important.

HR: —To the psychiatry coming into the non-psychiatric sector of hospitals and a major contribution to the field.

AL: But you don't mean that when you say humanism.

HR: No. I mean it in—when I think of having made the rounds with psychiatry and medicine and surgery, I think that they're looking at the more psychological impact of illness on the individual. And what I'm talking about really are the social environmental phenomena that exist within the institution, which affect the way the individual is responding to care.

For instance, just the phenomenon of admission in itself is impactful. That is not normally dealt with under psychiatric consideration, but it needs to be dealt with, the phenomenon of how people are met at say Entity Institute I guess.

AL: You're right. But who should be responsible for that? Isn't that the director of the hospital who is really?

HR: Well, I'm now saying that there's begun to be the introduction of programs to bring a more humanistic, social humane approach to the general care of people, not in the psychiatric context, but in the environment of the institution, per se, not limited to in-hospital care, but also post-hospital care. And we've begun to look at that more than we'd ever had.

AL: Do you think that the presence of the medical school is favorable to that or is it sort of a impediment, or does the presence of a medical school act actually as in a neutral capacity. In other words that has nothing to do with whether such an idea is implemented or not.

HR: Well, I think it's taught in some of the classrooms within the medical school. I think also as the students come onto the floors, it's demonstrated through the presence of team and comprehensive the available practitioners. The hope is that it will be carried through for students and so on.

I think that at this point, as I said, despite what I'm saying about physicians, we're now beginning to see more and more that the institution is having it carry over flavor. Now, if it's doing it ultimately, because it has to come into seeking the generation of new funds

or new income and so on by creating new neighborhood programs or new ambulatory care programs or aftercare programs, it may do it.

But the reason for it is secondary to me over and above the fact that they are now creating these things. And we are seeing a whole range of a market of new services in social healthcare care that's going to make life very different for the physician and for the rest of us, patients too.

AL: You know, what I've left out, what we've left out.

HR: What's that?

AL: Comments on nursing, which is perhaps the most important of the areas in a hospital.

HR: Yes, I think we will see a whole new era of nurses coming on. We've already begun to see them.

AL: What is your attitude toward the present training of nurses, education and training of nurses. You see, let me explain my question. When I was a resident and throughout my practice, we had nursing schools in which the patient one-on-one, you might say was the focus of all the training. Then the schools were abolished because of the need, wish to upgrade the position of the nurse and therefore forgetting degrees.

And of course, in my view and view of those who are contemporary, this lost a great deal because you began to train people to be supervisors and teachers, but not practitioners. Now I say that, that may be a prejudicial view because we also have developed what is known as nurse practitioners in that process, which is extraordinary of the, an extraordinarily advanced contribution to patients. Wouldn't you say so?

HR: Yes, absolutely.

AL: Do you think we'll see more of that?

HR: Yes. I think we will see a primary healthcare practitioner in the form of nurses. In the field we're already seeing that out in the community. We have seen the public health and the visiting nurse carrying responsibilities far greater than they ever did. And I think that what we used to call the handmaiden to medicine, both the nurses and social work has now fast disappeared.

And what you will see is the competitive nature of all of the healthcare professionals coming into an arena of healthcare. And it'll take a while for the turf to be clearly demarked as to who will carry what, and we will go through a comparable period to what I described earlier, when you shift into a academic arena from a hospital, things are not always as smooth. And what we will see is unreal competitive in the marketplace with

multi-professionals, carving out similar pieces, but different pieces. And when the roles will be clarified and the responsibilities we will begin to have good services interlink.

AL: What is your present view of the education and training of nurses?

HR: I think it's better than what it's been. I remember when I did my doctoral dissertation in Albert in 1967. I must have interviewed and surveyed about 300 nurses in six institutions. And I was appalled at the level of knowledge at that point. I did a comparative analysis of nurses, doctors, and social workers. And there was no question that the nurse in the sixties was a product of rote education. By that, I mean, it was rote memory education.

Judgment was lacking, decision-making, capabilities was lacking. The ability to problem solve was not there. It was frightening to think that if the nurse pushed the wrong button in her, inadvertently that you would get the therapy that was not related to what that patient needed. That was the way nursing practices. I think now we have begun to see the development of a professional educational base for nurses, which is based on a conceptualization of care and so on. I think that what we've lost is a little of the one on one laying out of hands. But I think that some of those functions can be carried by other personnel.

AL: Do you think, for example, mistakes by nurses, I'm not talking you know, about the operating room or the intensive care units or the special intensive care units or the nurse practitioners. I'm not talking about that, but in the regular nurses on floors or what's called private duty nurses, you feel, you think that their mistakes are—

HR: Less than what they've been?

AL: Mm-hmm (affirmative).

HR: I don't know, I have seen some studies that leave something to be desired in regard to what's happening, but I think we didn't have the studies in the forties and fifties and the extent of problems that must have been ramping.

AL: How does a nurse get training to take care of a patient, of people if they have a few weeks with amounts to worry, even for a couple of months in the field, the rest of the time is in an academic environment, in a college or some other kind of school, not a professional school, how do they get it?

HR: I mean, I can't answer that question, but I do think that there is a content that has to be laid on the nurses in terms of knowledge, in contrast to what was that traditional two-year education, which was [unclear] rote.

AL: [Coughs] How long were they nursing? They were three years, weren't they?

HR: Two and three years.

AL: Two and three year of the nursing school.

HR: Yeah, I don't think we knew enough in study fashion to know the degree of problems that were coming out. I think now since we've introduced studies, we are seeing some of the problems. I think it's good because out of it, we learn how to deal with that differently. I think the professionalization of the nurse is really in the interest of all of us, from what I used to see when I came into the field.

Now in many ways I should have some reluctance about it because there's some competition with social work between nurses and social work at this point. On the other hand, I think as I've mentioned that there will be a clarification of roles in the course of time, there has to be, because we simply can't survive stepping on each other's toes. So while we will begin to clarify who does what best, we will carve it out. I think there'll be overlap of the turf in some areas, but by and large, we will ultimately have to reconcile who's doing what.

AL: Well, let me ask you one last question. I take for granted first that there is a general opinion that the amenities of patient care, let us call it that way, which is personal attention, various individual services and so on. Behavior and reassurance and so on has declined in this institution and all over the country, as far as I can judge, to what do you ascribe that?

HR: Well, you remember, I did say at one point and I think the phenomenon of the alienation of the American worker

AL: Alienation of the American worker.

HR: Yeah, and what I mean is that he's become alienated from what his job responsibility are, commitment, the value of working.

AL: It's all about the nurses.

HR: Everybody, I'm talking about everybody.

AL: As well.

HR: I'm talking about the laundry worker, the nurses, I think even to a certain extent, social workers, certainly physicians and so on. When I used to go home on the bus in the forties, when I came into this field with a physician, I don't say it was good, but he was exhausted from having been on duty for 24 hours.

When I go home now with a young physician, he's been on for seven hours and he's talking. And about being abused and overtaxed and so on, the physician I went home with in the forties while he might have been exhausted, he wasn't talking. What he was saying is, "Boy, what I learned today."

Now I'm not sure that the kids today are saying what I learned today. What they're saying is I got responsibility to my home, I want to be with the kids, I want to be with the family, I need more bugs and so forth. Now maybe the guy in the 40 was naive. I don't know. Maybe this young man today will do something that's better. I say, I don't know what it's like, I'm just saying we're in new times and new responsibilities and new commitments. And I think these people have the right to know family and be responsible and carry on in certain terms of life.

I don't think that people should have to work 24 and 36 hours to accomplish the goals. But I think it's, as you said, if you don't learn to lay on hands early, when are you going to learn it? Well, maybe we learn it through experience, maybe the process is different and so on. It is different medicine today from the medicine that I know. It's a whole new era, we have new things, strange new things. I think we're going to be attacked on the technology of medicine in terms of its costs and to whom it's available. Because you are aware that the technology of medicine has availability to limited numbers in contrast to the vast phenomenon of medicine, which is the encountering of people in offices every single day, in their launch numbers.

As against the patient who comes into the hospital and is exposed to some technology. Now, if the physician loses out there in that one to one, somebody else is going to come in and take that on. If he's going to be a highly specialized technician, then somebody's got to hold the hand on that patient through the process. I don't know what it's going be, but I think we're in the midst of major changes that we'll see between now and the end of the decade. And certainly by the year 2000, I may not be around to see it, but it's going to be a different arena of social healthcare.

AL: Helen, thank you very, very much.

HR: Thank you.

[End of Interview]