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Despite a long-standing association and promise for a closer alliance in the future, considerable ambiguity surrounds the current participation of social workers in medical education. A nationwide study was conducted to obtain a comprehensive, up-to-date profile of social work faculty employed by medical schools--their total number, demographic characteristics, department affiliations, primary specialties, methods and content areas of academic instruction, etc.[1] An accompanying study focused on the opinions of medical school Deans concerning the present and future status of social work faculty in medical education.[2] Attention has been given to social work education in relation to health care practice.[3] Another study focused on the role of social work faculty in medical schools.[4]

The above studies strongly suggest an increase of recognition and acceptance of the value of social work involvement in medical education. And, if social workers are to practice effectively and efficiently in medical social work settings, we as social work educators and practitioners must know what appropriate knowledge and/or skill areas we should be teaching graduate social work students who desire to become medical social work faculty. We must also know how continuing education programs in graduate schools of social work could help medical social work faculty once employed by medical schools. However, no empirical studies have focused on these two issues. Thus, the purpose of this

article is to present the results of an empirically based research project that will shed new data on these issues.

METHOD

Advisory Board

In August 1976, the authors formed an advisory board which included members from the Association of American Medical Colleges (AAMC), medical social work practitioners, and/or educators, and/or researchers. The board's main function was to increase the validity of the project by formulating relevant questions most closely related to the study's two research areas. The board also aided in refining the opinion questionnaire utilized in this project through the various five drafts.

Instrument

The sixth draft of the questionnaire was pretested by interviews in October 1976, with nineteen non-randomly selected medical social work faculty employed by five different medical schools located in three states. The pretest subjects reactions and comments were utilized to formulate the final questionnaire which contained 41 close-ended and 16 open-ended questions.

No attempts were made to test the reliability for any of the open-ended questions as the authors felt that they were worded in an extremely straight forward manner. To test the reliability of the 41 close-ended questions, eleven non-randomly selected medical social work faculty employed by two different

medical schools located in two states answered each question twice with a 10-day waiting period. A correlation coefficient was generated for each close-ended question from time 1 with time 2. High coefficients were obtained with the lowest $r = .722$, $p = .018$. The 41 close-ended questions mean $r = .812$, and mean $p = .012$, which indicates that the questions were relatively reliable.

Social Work Faculty Population

On January 1, 1977, the AAMC's current data bank indicated that a little over 40,000 individuals were employed as faculty in the 116 accredited medical schools in the United States.[5] Of these, 561 were medical social workers. For the purposes of this study, medical social work faculty were operationally defined as individuals who held a master's degree in social work from a graduate school of social work and was currently employed by a medical school on January 1, 1977.[6] As reflected in the following data analysis, these social work faculty represent the total population of all graduate-level social work faculty employed by medical schools in the United States.

Sample

A 33% random sample was drawn from the 561 social work faculty resulting in a sample of 187. With AAMC providing the mailing labels, on January 15, 1977, each member of the sample was mailed the above questionnaire with an accompanying self-addressed return envelope. Exactly two months later a follow-up questionnaire was sent to those social workers who had delayed forwarding the requested information. From the original sample, 36 (19.3 percent) questionnaires were returned because of incorrect address, transfers, retirements, or terminations

of employment which resulted in a workable sample of 151. Of these, 121 (80.1 percent) social work faculty responded by June 1, 1977, which represents the sample of this study.

Characteristics of Sample

Out of the 121 social work faculty, 47.9% stated that their major area of specialization in their master's program was casework, where 24.0% indicated generic social work. The remaining 28.1% were distributed among eight other specialties with only 4.1% of the entire sample indicating medical social work. Seventy-six percent indicated that their master's program did not offer a specialization in health care, however, 54.9% stated that courses in health care and/or health delivery systems were offered within the school. Only 7.4% indicated that they enrolled in a health and/or health related course(s) outside (seven different departments) their social work graduate school.

The types of agency settings that the social work faculty were placed in for their field practicum/internship while they were enrolled in their graduate program were: hospitals, 33.5%; welfare agencies, 16.5%; family service agencies, 13.9%; psychiatric clinics, 11.7%; mental health centers, 6.1%; community organization planning agencies, 4.8%; public schools, 1.3%; and, other settings, 12.2%.

FINDINGS AND DISCUSSION

Educational Needs

The first open-ended question asked, "In your opinion, what two instructional knowledge areas covered in your master's program

in social work have proven to be the most helpful to you in your career as a member of the social work faculty?" Only 20 (16.5 percent) social work faculty responded "none" while the remaining 101 (83.5 percent) delineated 29 helpful instructional knowledge areas (N=188) where the knowledge areas were coded into the sequences listed in table 1. The 29 helpful instructional knowledge areas were: interviewing, human growth and development, casework, abnormal psychology, therapeutic intervention methods, health service delivery systems, human behavior, parent and child relationships, group processes, generic social work, psychiatric social work, individual psychodynamics, psychopathology, ego psychology, family therapy, social work in multi-settings, administration, sociocultural factors of behavior, medical or health problems, community resources, hospital administration, systems analyses, research, methods, social welfare policy and services, mental health, community organization, professional identity, and public policy.

The second open-ended question asked, "In your opinion, what two practice skill areas covered in your master's program in social work have proven to be the most helpful to you in your career as a member of the social work faculty?" Only 25 (20.7 percent) social work faculty responded "none" while the remaining 96 delineated 24 helpful practice skill areas (N=166) where the skill areas were coded into the sequences listed in table 1. The 24 helpful practice skill areas were: field practicum, instructions in specific areas, interviewing, patient history development, direct practice, clinical, group work, family casework, communication, problem assessment, social diagnosis, family therapy, casework, active listening skills, family therapy, organizational analysis, community resources, assessment, administration, recording, psychiatry, medical, systems theory, and relationship.

Table 1

PERCENTAGES OF SOCIAL WORKERS OPINIONS OF HELPFUL AND INADEQUATE KNOWLEDGE AND SKILLS AREAS IN THEIR GRADUATE SCHOOLS OF SOCIAL WORK BROKEN DOWN BY SIX BASIC SEQUENCES

	Helpful Areas		Inadequate Areas	
Sequence	Knowledge (N=188)	Skills (N=166)	Knowledge (N=120)	Skills (N=72)
Human Behavior	41.1	.6	10.8	1.4
Direct Practice	28.2	78.9	17.5	47.2
Social Policy	7.4	1.2	12.5	4.2
Community Planning	6.9	9.1	17.5	18.1
Research	3.7	0.0	9.2	8.3
Field Placement	2.1	6.0	0.0	0.0
Other	10.6	4.2	32.5	20.8
Totals	100.0	100.0	100.0	100.0

The third open-ended question asked, "In your opinion, what two instructional knowledge areas did your master's program in social work fail to cover that would have been helpful to you as a member of the social work faculty?" Fifty-one (42.1 percent) social work faculty responded "none" while the remaining 70 (57.9 percent) delineated 28 inadequate instructional knowledge areas (N=120) where the knowledge areas were coded into the sequences listed in table 1. The 28 inadequate instructional knowledge areas were: sociology of professions, health administration, research, psychosomatic medicine, medical terminology, health and disease from medical model, child development, crisis theory, supervisory, psychopathology, learning theory, culture of poverty, self-awareness, history of social work, collaborative health care, biostatistics, administration, institutional issues of authority, systems theory, human behavior, economic efficiency, psychiatry, psychopharmacology, practice theory, family therapy, hospital environment, organizational theory, and social work practice in a non-social work setting.

The fourth open-ended question asked, "In your opinion, what two practice skill areas did your master's program in social work fail to cover that would have been helpful to you as a member of the social work faculty?" Seventy-five (62.0 percent) social work faculty responded "none" while the remaining 46 (38.0 percent) delineated 18 inadequate practice skill areas (N=72) where the skill areas were coded into the sequences listed in table 1. The 18 inadequate practice skill areas were: administration, research, publishing papers, supervision, self-awareness, ethical issues, group work, family therapy, treatment skills, teaching social work to non-social workers, teaching, program planning, conflict resolution model, presentations, diagnostic, community resources, medical language, and interviewing.

The social work faculty indicated that the instructional knowledge areas in the human behavior sequences, and the practice

skill areas in the direct practice sequences helped them the most in their careers as medical social work faculty. They also felt that even though the direct practice sequences were providing most of their practice skills, the direct practice sequences were still not adequately providing enough of them.

The field placement sequences only represented 6.0% of the helpful practice skill areas as expressed by the social work faculty. This result may contradict the common importance of field placements within graduate schools of social work. Many graduate schools of social work place a heavy value on field placements as an opportunity for teaching students practice skills. In fact, the grades a student earns in the field placement sequences are usually given high priority when it comes to evaluating the student's total progress within a particular program. However, the authors feel that field placement grades may be worthless as most students earn an A or B. The grade variance within the field placement sequence is usually low due to the fact that an unusually large number of A's are given. The study's results indicate that 13.2 times more helpful practice skills for medical social work faculty are within the direct practice sequences than the field placement sequences. This finding was unexpected since 33.5% of the social work faculty had at least one field placement/internship in a hospital during their master's program in social work. One would assume that their field instructors would teach the practice skill areas necessary to function competently as social work faculty within medical settings. It may be that their field instructors were not employed by the medical schools but by graduate schools of social work who were supervising students in medical settings without fully knowing the exact functions of medical social work faculty.

None of the social work faculty expressed that the field placement sequences were inadequate in any instructional knowledge

areas or practice skill areas. One would logically assume that if a particular sequence had a high percentage in a helpful area it would have a relatively low percentage in the inadequate area and vice versa. However, this was found not to be true in this particular study.

The sequence "other" represented 32.5% of the inadequate instructional knowledge areas. This is an unusual finding in that the responses the social work faculty delineated could not be coded into the six sequences listed in table 1. This may suggest that we may not be teaching the appropriate knowledge areas for medical social work faculty within our graduate schools of social work. This may also hold true for the practice skill areas as "other" represented 20.8% of the inadequate skill areas. It has become obvious that the number of social work faculty in medical settings is constantly increasing.[7] And, if we are going to prepare social work students for medical settings, we may need to take a closer look at our total curriculum and start revising the areas that need improvement upon such as teaching the appropriate knowledge and skill areas.

Continuing Educational Needs

An open-ended question asked, "In your opinion, what do you feel are your two most important needs for continuing education?" Thirty-one (25.6 percent) social work faculty stated "none" while the remaining 90 (74.4 percent) indicated 23 need areas (N=157) where the need areas were coded into the following six categories: direct practice, 37.6%; research, 13.4%; community planning, 10.2%; social policy, 5.1%; human behavior, 3.8%; and, other, 29.9%. The 23 need areas were: family therapy skills, administration skills, clinical treatment skills, functioning in a complex institution skills, psychoanalytic skills, research skills, grantsmanship

skills, supervisory skills, group work skills, teaching skills, casework skills, keeping up with new knowledge, compare knowledge with other educators, medical knowledge, knowledge of women in treatment, knowledge for competition with Ph.D.'s and M.D.'s, ethical knowledge, social work knowledge, human behavior knowledge, organizational knowledge, casework knowledge, knowledge of health delivery systems, and knowledge gained by refresher courses.

These findings indicate that the social work faculty were relatively active in pursuing their continuing educational needs through a variety of outlets. A majority (74.4 percent) of the social work faculty were participating in professional conferences, institutes and workshops. This may suggest that schools of social work should continue to and perhaps develop more conferences, institutes and workshops with the needs of the medical social work faculty in mind.

An open-ended question asked, "In your opinion, in what two ways could a school of social work best help you meet your own needs for continuing education?" Surprisingly, fifty-two (42.9 percent) social work faculty stated "none" while the remaining 69 (57.1 percent) indicated 22 areas (N=106) where the areas were coded into the following five categories: workshops, 38.7%; extension courses, 32.1%; doctoral programs, 7.5%; consultations, 5.7%; and, other, 16.0%. The 22 areas were: on-site consultation, workshops, new areas of social work courses, broader range of courses, case seminars, better reputation, extension courses, post graduate courses, doctoral programs, administration courses, course in dynamics of human behavior, organizational planning courses, courses in social work in medical education, speakers, summer institutes, traveling programs, train teachers, more in tune with common needs, courses on applied administration, courses on drug abuse, courses on

publishing research, and consultations. These findings may indicate that the social work faculty view graduate schools of social work as being very versatile in nature where they could meet their continuing educational needs through a variety of ways.

Three following close-ended questions asked, "How are you currently meeting the above needs for continuing education?" Only 14 (11.6 percent) social work faculty stated that they were doing nothing to meet their needs, however, 107 (88.4 percent) indicated that their needs were being met by one or more of the following three ways: participating in professional conferences, institutes, and workshops, 74.4%; participating in in-service training programs offered by the medical school, 43.8%; and, taking courses offered at a graduate school of social work, 11.6%.

With the above findings in mind, one may start to wonder where social work medical faculty would obtain the knowledge and skills necessary to function effectively and efficiently in a medical setting. The authors feel that very little knowledge areas and skill areas that are needed by medical social work faculty are taught in graduate schools of social work. This study revealed that only one-third of the study's sample interned in a hospital setting while enrolled in a graduate school of social work. The authors strongly feel that social workers who practice in medical settings be fully equipped with the necessary knowledge areas and skill areas to function adequately in a medical setting.

It would be interesting to find out what knowledge and skill areas physicians think are necessary for medical social work faculty. This finding could then be compared to table 1. This in turn would have sociological implications as then we could get a clearer picture of exactly how social work faculty

are viewed within the organization. It would also be interesting to find out how physicians and medical social work faculty differentially perceive their roles. If there is a large difference, then steps could be taken to develop measures that would integrate the two separate professions so that each would benefit the other.

The above paragraph suggests that medical social work faculty and the physicians have specialized roles. They do. With every technical advance in medicine, new specialists have appeared, each requiring a separate department. As a result of this knowledge explosion, the same patient may be dealt with by a number of physicians, both inside and outside the hospital, as well as by other persons in auxiliary medical professions, and in social work and similar services. Problems arise of how to allocate responsibility for the patient, and who is to exercise final authority for his case. The goal of treating the whole patient, and ministering to all the needs, physical, psychological, and social, that bear on his medical problem, is often lost within the restricted aims and authority of the specialists' departments which share responsibility for the patient.[8] If we knew how the physicians viewed medical social work faculty we may be able to integrate the two professions much better. Then, we could also work on ironing out our differences and building on our similarities.

Another sociological concern is to define exactly what and who is to teach the medical social work faculty the knowledge and skills they must have--the social workers or physicians? And, who (what profession) is going to define these knowledge and skill areas--the social workers or physicians? The social workers are working in a medical setting and maybe the physicians should govern what is to be taught to social work faculty. However, would social workers govern what is to be taught to physicians when they work in social work settings? Probably not.

The above questions raise sociological issues when dealing with two separate specialties. However, we must note that the Deans of medical schools view the social worker's role in medical education as quite valuable.

SUMMARY AND CONCLUSIONS

The results of this study indicate that graduate schools of social work are relatively effective in providing helpful knowledge and skill areas for their students who become medical social work faculty. The social work faculty were relatively active in continuing education programs and viewed graduate schools of social work as versatile institutions for providing this education. Even though the social work faculty felt that their graduate schools of social work were providing appropriate knowledge and skill areas for them as medical social work faculty, they delineated very important knowledge and skill areas that they did not obtain in their master's program.

Future research could focus on the effectiveness of medical social workers as viewed by themselves, non-social work faculty, and medical students. Research could also be executed on their job responsibilities and on their opinions of the interdisciplinary collaboration concept as utilized by their medical schools. Studies could also be executed on their perceptions of the major contributions of social work to medical settings. It is hoped that this exploratory study will encourage further research into medical social work. It is also hoped that the needs and concerns of the medical social work faculty as indicated in this project will be given serious attention to by social work educators, practitioners, and researchers.

NOTES AND REFERENCES

* The authors wish to express their appreciation to Cheryl Chambers who served as a research assistant to this project.

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