Elsbeth Kahn
Interviewed by Elizabeth McBroom
In Dr. Kahn's office on USC Health Sciences Campus
November 23, 1990

Dr. Elsbeth Kahn was a pioneer social worker in the field of health care. Prior to obtaining her doctorate at Brandeis University, she was director of social services at the Los Angeles County Rancho Los Amigos, a major rehabilitation hospital. Here she was innovative and influential in developing processes and resources for providing patients with home care when they no longer needed hospitalization. She subsequently worked with the American Red Cross in the military hospital, taught early interdisciplinary courses in the Vanderbilt Medical School, then joined the University of Southern California School of Medicine, working with physicians in the teaching of students about the impacts of health conditions on the patient and the patient's family, as well as on the emerging physician. Her contributions to medical social work and doctor-patient relationships have been considerable, in the institutions where she was employed as well as in her volunteer activities with cancer, heart, and other health-focused agencies. At her retirement from the USC School of Medicine, she held a joint appointment with the USC School of Social Work.

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MCBROOM: Elsbeth, let's start with how you came to enter the profession of social work.

KAHN: I first had an interest in the problems of disturbed delinquent girls because when we were children, in the summertime, we would stay in an institution in the park for staff children.

MCBROOM: You had come to this country with your father, your twin, Ella, and your brother....

KAHN: But this was long before, in Germany, where my father was a psychiatrist. He consulted there, and as little as I was, we knew that they were delinquent girls. We could tell by their behavior, that they weren't normal children. We also saw that they weren't always treated nicely, and that bothered me. So I made up my mind to get into that kind of work. Then, when I went to college, I really did not know how to get into this. In college I took sociology and graduate work in sociology at Indiana. There I met one Helen Brown, who had been the director of the Kentucky School of Social Work. I had gone to the sociology department to learn how to develop some social work competence. When she heard of my interest, she asked why I wanted to go into social work, then said that I needed to go to the George Warren Brown School of Washington University in St. Louis.

A year or two later, that's what I did. I had one year on scholarship, worked for a few months at the American Red Cross, Midwestern Area, for several months, then had another scholarship. I had become very interested in medical social work and for the next two years, I worked for the Red Cross Military Hospital Service. I had looked at the kind of work that was done with delinquent girls and realized what needed to be done, but decided I didn't have the

fortitude to do that. I found the Red Cross hospital service very interesting and stayed with that. I was very fortunate in that the clinical experiences in the Army hospital were really excellent until the Red Cross changed from the health and medical services only when the civil service took over as did professional social workers. That was when I left the Red Cross, in 1951, and came to Los Angeles; my twin sister was here, and I didn't have a job.

MCBROOM: You and Ella are both social workers?

KAHN: Yes. I looked into some opportunities, including City of Hope, but I wasn't decided. Though I liked the idea after my more than two years with the Red Cross in the Army hospital service, I couldn't get into the City of Hope as I'd hoped, and thought that it might not be a bad idea to go away while I had the opportunity to see other things and places and better myself. When I was ready I went to LA County Hospital--not LA County USC Medical Center--and had an assignment in the medical specialty clinics, taking over for someone who had to be replaced. I really enjoyed that, it was very challenging work. I did a little work in psychiatry, a little in neurology, and hematology, and so on. While I was doing that, I also got involved with the National Association of Medical Workers, in which I was active until the new social workers' organization, NASW, was established in 1957--something I regret even to this date in terms of quality of the profession aspects, the furthering of the professional aspects of social work and health.

MCBROOM: Could you enlarge on that a little, Elsbeth?

KAHN: The NASW was concerned with political matters and that was certainly realistic and was a concern. Didactic social work was probably stronger, but neglected by NASW; I wouldn't say we had much leadership in the development of knowledge and the beginning of some research. There were some strongholds and some fine teachers, some getting into the teaching in medical

schools and public health organizations and participating in patient care in the wards. But more leadership was needed. For instance, when I came to the County Hospital, professional support was needed. I was a member of the Executive Committee of the Medical Social Work Section of the Los Angeles Chapter of the NASW, then also had several periods as member or chairperson of the Educational Committee of the Medical Social Work Section, but there really was no national impetus to help with health concerns. I feel that by the time the NASW woke up, it was much too late and there had to be validation of some issues of practice and education. It was felt that the School of Social Work had to validate what the issues were in medical social work and social work in the health field.

MCBROOM: Do you recall any special issues that they were overlooking or ignoring?

KAHN: The schools were so into mental health and psychiatry, yet they didn't see the psychiatric aspects of medical work; we know better now. The opportunities were there for social work, but we didn't get into them enough because we didn't train people to deal with health issues. We didn't help students enough to understand the culture of medical care, the culture of medicine, or how to tolerate illness and disability, or how to look at the medical profession--how to get along with the medical profession and understand them. I know how difficult the medical people are to work with, but understanding helps. The schools did not support medical social work, nor did they see the opportunities for research until much later. What's going on now is very nice, but I was lucky. At the end of the last terrible epidemic of polio, at the request of the National Foundation on Infantile Paralysis and with its help, then, the County used Hospital Rancho Los Amigos for a rehabilitation program, and assembled an outstanding staff of physicians and nurses. I was very fortunate, for in its second year, I became the Director of Social Work; that was a truly professional team. The doctors came from Boston and knew how to work with social workers

and knew what to expect.

MCBROOM: Medical social work was much more a tradition in the New England area.

KAHN: I really feel that I had a wonderful opportunity, and I think also, that sometimes I must have been terrible as a boss because I expected so much. We set high standards, and the staff knew that could be a problem. Many have told me over the years that their best experience in social work, their years at El Rancho were really wonderful years. Anyway, at El Rancho I also had the opportunity to teach. I really wasn't prepared to do that, and it wasn't my major assignment, which was in administration. I taught issues of rehabilitation to nurses and social workers and once, even to a group of social work faculty members. I liked teaching, and I decided I had to do more in that. That's what got me interested in returning to school to get my Ph.D. It was a hard decision because it was such a nice program at El Rancho, but I knew that I would never be satisfied until I obtained that degree and finally, I chose Brandeis University. I was at El Rancho for 13 years, until 1966.

MCBROOM: What was the basis for your decision, Elsbeth?

KAHN: As you know, I took a couple of courses at USC to see how to see how I would do. I thought it would not be good to go to a school where I was well known already. So I gave up the idea of USC; UCLA was never in the running for me. But I applied to Bryn Maur and Brandeis. I liked Brandeis because I thought that I was a very good clinician and knew related theory and such. I had kept up with the broadest theoretical issues in social welfare, but I really had missed policy, and I understood that was great at Brandeis. So I went to Brandeis in 1966. It was very hard as I think I have mentioned to you. I had to take courses in administration that were required courses.

MCBROOM: Yet you had been an administrator.

KAHN: The only problem was that I didn't recognize principles of administration in practice; I didn't know for half a semester what we were talking about, the theory sounded so foreign.

MCBROOM: What sort of thing were they talking about in the course?

KAHN: Taylor, I think, a lot of exchange theory.

MCBROOM: And it was highly theoretical, more than practice?

KAHN: It was highly theoretical and we considered that famous experiment among telephone workers. It had to do with understanding worker satisfaction and so on. It was a totally different level; it was research-oriented but, anyway, I finally got that under my belt, though I thought it was hard for me in particular.

MCBROOM: Have you gotten some value from it since? Or was it just a futile exercise?

KAHN: This particular course?

MCBROOM: Yes.

KAHN: It's what sticks least in my mind. I guess everything, even exchange theory, came mostly from sociology. I loved my sociology courses. Part of the problem, I think, really was that our professor couldn't stand women. She had been the queen bee there. There were only two women students.

MCBROOM: Was she your advisor?

KAHN: I think she couldn't have taught me anything if she tried. One time she invited me and the other woman student to her house and we talked a little bit about getting different clothes for the Boston winter, so different from where we had come from. She said, "Our students here don't need anything, you can made do with what you have." I thought, "Oh no! I can't believe this." In retrospect I think I was really depressed about my first year; it was taking too much from me. I wanted to look neat, not sloppy, but I decided I couldn't do anything about it and so I wore slacks

and I didn't care that I was cold.

MCBROOM: You and the other student were quite the pioneers as the first women in the Brandeis doctoral program.

KAHN: We had a good time.

MCBROOM: You were congenial with each other, supported each other.

KAHN: Yes, but also the men were very good to us. We had a very nice class; most of the courses were great; I loved even statistics. I had to take two such courses and did very well in them. It was the attitude of a professor who said, "Don't worry. You think it's going to be terrible, but don't worry; we're going to have fun and you'll all pass." I thought he thinks I can learn, and so I did. The mental psychology was really wonderful. It was not all theory; it was so applicable, and I could understand it in relation to where I had come from. In retrospect I understood things much better than what I got in that woman's presentation of administration theory. Then I did my dissertation on aging.

MCBROOM: What was the subject of your dissertation, Elsbeth?

KAHN: Activity and morale in the elderly. I did a major study and my thesis advisory said I really had developed something novel. Unfortunately, I realized its valuable contribution. Just about the time I got my degree, I agreed to do a paper for the Council of Social Work Education. I got a call from Dean Francis Howe of Vanderbilt University Medical Center in Nashville, Tennessee. He said, "I hear you are coming out, that you have your degree. How would you like to come to talk to us? We have a program that is an introduction to clinical medicine, and you might like to teach in it." I said, "You know how those doctors are; they don't want to work with social workers." He said, "No, that's not true. You should come and talk to us." I felt I should talk to him; why not? I went there on June 17th. I found it would be very

interesting to work with Vanderbilt. It was a private university hospital and it was also in the South. I stayed there for two years. I felt a little bit bad about leaving so soon, but I also knew that I would not be able to find what I needed in the South, which was far behind us. Therefore, I came back here and have been at the USC Medical School, first in the Department (Or Institute) of Community Medicine, and then in the Department of Family Medicine. I became Associate Professor of Medicine in 1971 and taught a variety of courses in the first and second years and also seniors. All of a sudden, twenty years have passed.

MCBROOM: Amazing.

KAHN: I've been on the Medical School's Admission Committee, and I have interviewed regularly applicants to the School, screening some of the applicants. I have counseled medical students from 1972 on, and with primary care physician-assistant students from 1981. I have chaired the Lorin Stephens Memorial Lectureship Committee, worked with the Medical Faculty Women's Organization and the USC Faculty Women's Professional and Political Development Committee. I served on the executive committee and as chairperson of the Committee for Liaison with Women Students, and have been a member of the Medical School Sex Education Committee for a number of years. Through these years I was constantly aware of Bob Morris' comment before I left Brandeis to the effect that some things in medicine will never change because doctors are all a bunch of individuals standing next to each other with no one extending a helping hand.

MCBROOM: That's kind of a gloomy prediction. Looking back now over your career, what experience has really been gratifying to you? Professionally or personally? Two or three things, maybe, that stand out as really high. Maybe the seminar at El Rancho for the social work faculty?

KAHN: Yes, I think that was very important.

MCBROOM: Can you say a little bit more about that?

KAHN: It was then an effort to interest social work faculties in social work rehabilitation and long time care. It was about a week long, it was planned as if it were for physicians or anybody in the medical field.

MCBROOM: You were continuously doing training of physicians and other professionals?

KAHN: Yes. We had lectures by doctors. We talked about the role of the social worker, and I think they saw social workers' participation in a way they had not seen it before. I interviewed a totally paralyzed patient who had only an electrically-operated arm for any movement at all. He conveyed the feeling of how he could communicate and what a challenge that was. People went away with the idea that social work can really be educational and encouraging.

I think El Rancho financed its students and that was the good thing. The problem wasn't so big in El Rancho, it was much bigger in other places. And at el Rancho we had many groups of students--even from UCLA--who came for the experience.

MCBROOM: What was really so innovative about El Rancho's program after dealing with the polio epidemic? What did they do for some of the young mothers and wives and so on who had polio patients to care for?

KAHN: I think the highlight for me really was in clinical practice, psycho-social services. Among the things that we did in El Rancho that I should mention is participation in the political process, which I don't mean to knock at all, but I think the success that we had as a department was through the psycho-social services--that was maybe the most important thing I ever was involved with. For example; when I came there, we had a hundred and sixty patients who couldn't go home. El Rancho developed a home care program so that patients could go home and get all the medical and nursing supports they needed outside the hospital. The Lasker Foundation paid for some people, not for all. And that could be costly, about $300 at that time to have someone at

home. Even then it was about a third or fourth of the monthly cost in the hospital. Elizabeth McLatchie from the State Department of Social Work, had come to Rancho to talk with me. The State Aid for Disabled was in her Department. I talked to her at length about the need for money for attendant care for the poor families. I held that a mother could still be a mother even if she couldn't do the housework. I told her that physically speaking, the difference is that some people don't do any housework because they are rich, and others don't do any housework because they can't move. What's the difference if neither is doing anything around the house? Providing attendant care would help a few people go home who needed to leave the hospital. This was not always easy, for sometimes values of the staff were in the way because hospital staff gets very controlling and very over-protective, forgetting that people have rights even when they are disabled. I think of a man who went home whose wife would have nothing to do with him, but she gave him half the house. That was good enough for him. He had the kitchen and nothing else. And he was happy at home for several years.

There was a group of young men in their 18s to 20s. They had terrible problems and wanted to go home, but there wasn't enough money to care for these disabled in their own homes. Finally they did go home, with the help of the medical director, who was just terrific about such issues. He knew it cost less for them to be at home than the services they had to have in the hospital. Once a nurse came to me, terribly excited; she had visited these young men, and their place was so dirty. I said, "Look. If it's not endangering their health, I think they should remain at home. I don't think we have the right to decide that for them if there is not a medical need." Another patient eventually was sent home, although we thought he was a behavior problem. He wasn't motivated to do his occupational therapy. I asked why isn't he doing it? "Right now," the nurse said, "we haven't got a wheel chair for him to do it, and we don't think he would do it

even if he had one." I couldn't believe it. I said that if he wanted one, and I get it for him, will the nurses try to train him? But they insisted he won't want one. I talked with him and the only thing he wouldn't do, and he was very proud of this, he did not want to cry. I said that's okay, to let me see if I could get one. He was too embarrassed to come for it himself, so I got the wheel chair for him--and that was the beginning of his rehabilitation. See what little ways can make the difference.

We had wonderful relationships among the staff. If we had a recommendation, I might not always gain my points, but I was always listened to.

MCBROOM: You gave a lot of status to social workers at Rancho.

KAHN: The last yearbook is out, the centennial yearbook. It has some nice things about social work; a beautiful book.

MCBROOM: We have a copy of that in our archives. I'm sure.

KAHN: That was a thrill to see and what was even nicer; do you remember Ruth Brownings?

MCBROOM: Yes.

KAHN: She wasn't so sure about me and was very competitive. Anyway, she called me just before I went up north to a seminar and said she had gotten the centennial book for me and thought I ought to leave it that day, before I went up north. So she brought it to Rancho from Woodland Hills, and I was very touched.

I have to say I have had wonderful times teaching here in the Medical School.

MCBROOM: Tell me about some of those.

KAHN: A particular teaching highlight for me was when Larry Stevens, the orthopedist, ran the Center for Rehabilitation for the School. When I came, he was one of my interviewers, and he invited me to join the School. Not only that; he also gave seminars, and he invited me to co-teach

those. He was a wonderful man and I worked with him until 1972 when he died.

MCBROOM: That was a great loss to the Medical School.

KAHN: Well, we were all colleagues, real colleagues.

MCBROOM: It was not a hierarchy?

KAHN: No.

MCBROOM: And that made it a unique medical school!

KAHN: We had a group in the School that worked on the way to teach about and understand behavior. It was so outstanding. The impulse of most of the doctors was to deny the role of behavior because they are uncomfortable with this, but Larry was comfortable so he would look at the issues and if he was doubtful about anything, he would give you a good reason. Often Terry, who was the dean, came in and he would ask about my thoughts about this person, what do you think the problem is?

MCBROOM: You were a very complementary teaching duo, the two of you.

KAHN: There have been other instructors since then but none like Larry. I think the reason is that they need more to protect themselves; that's what I find to be a great and perplexing problem.

MCBROOM: Would you say that's a major obstacle in teaching in the Medical School? Have you been able to achieve any of your goals?

KAHN: There are different levels at which I related to the doctors, and they related to me. We had very nice relationships here; with my colleagues at ICM. The extent to which I could get into any of the problems when I am with a group and the instructor is there, varied very much when we got into psycho-dynamics.

MCBROOM: It's kind of like an avoidance or a retreat.

KAHN: And I also learned to pace myself better at some point. My attitude has been that it's

much better not to be afraid; if you are aware of things that upset you, then you can be prepared the next time.

MCBROOM: You've taught in community medicine too, haven't you?

KAHN: Yes.

MCBROOM: Would you say something about that?

KAHN: When I came to the Medical School, I had to be put into a department with unavailable appointment and so they put me in the Department of Community Medicine (ICM). I didn't understand for a long time that it is offensive to any department chair to have somebody in it that they did not choose. In ICM I didn't look for a role in community medicine exactly, but after a while, I was accepted, and I worked in aging and social control. I think those were my major seminar subjects.

MCBROOM: I think it would be very interesting if you could describe the introduction to clinical medicine.

KAHN: The purpose is to introduce the students to the unified concept of disease, meaning physical and social impact, psychological and spiritual as well, and to do this in such a way that the students are aware of the significance of the patients' experience and the doctor-patient communication and is involved in that because our own experiences influence and make us more or less sensitive. The course teaches special themes such as dying, substance abuse, aging--the major focus being for students to learn about doctor-patient interaction. We think that's more important than the psychological or the social aspects or the course. I think that all three are basic to the understanding. That's a broad statement, but we are not interested in teaching bedside manners or humanistic aspects. We want to teach about relationships. We think the best thing we have done in that regard is to go to the Medical Center to interview patients and let things roll.

After we've seen the patients, the students present their summaries and then we get into interview issues, like social or cultural issues. Sometimes a young student or the older black student is not very communicative. We would discuss the fact that it is important to understand and respect those who come from different cultural and ethnic backgrounds. We also use video tapes to teach not only interview skills, but to provide opportunity for students to think about their own feelings and reactions. For example, we have a wonderful tape on AIDS. AIDS is one of our specialties in teaching and death and dying because of AIDS.

MCBROOM: Were the students very actively involved with AIDS patients at County?

KAHN: We reviewed the patient's history, their personal state. Then we get into feelings about communicable disease, homophobia, lifestyle--all those things. People expect to express themselves and some of the expressions aren't edifying unless you let students bring out their beliefs no matter how we may feel about them. We show one wonderful tape on a patient dying of cancer, to identify family issues and, also, to get students to identify with the person in the pictures. Sometimes we can get many to talk about them and state that they are sorry about the patient, but most of all, the concerns are for themselves and then they begin to face up to themselves. It's quite a blow to them, and has to be worked through, if they are going to be around such sick patients all the time. I talk about the fact that not everybody is going to be working all the time with the cancer patients, and that most can learn to tolerate some situations when they understand themselves a little better. And I make a major effort in general to teach that the doctor doesn't just contribute by making something better because, especially with chronic illness, it's not possible without tremendous support. That's not something that is so hard for them to believe, but it will come back to them three years from now. Now the seed has been planted.

AIDS is a very good example of what our course is about. About four years ago it became apparent to me that students were seeing AIDS patients very soon after the school year started in September. They weren't prepared; they were very upset in a few circumstance. So I suggested that we develop an elective course in family medicine. Our course was a medical lecture with professor Rubens about the understanding researcher. She interviews patients with whom she has had a lot of success. The second is a social lecture, followed by an hour of students in small groups talking about their personal experiences with AIDS. We recruited one of the local agencies, called Meaning of Life, to help us, and the students get to hear from persons with the disease, how they are coping on the outside. Then I offer an experience where we see a film first and then get one patient from the ward so they can talk to him. Of course, they all have the same experience; it is hard for some to talk, and that is always very moving for them. Then they really get into the swing of it, and after the patient is finished, I ask how difficult it is for them. They answer that it is okay. The video tape I then show is one made by kaiser about the AIDS consumer. It has a panel of patients and a simulated interview. The doctors express their views honestly, and so the students who can see that the doctors are not perfect; they have different opinions and they are a little afraid of AIDS also. I also try to work with the faculty and let it be known that if you disapprove of someone that person will not hang around.

I think attitudes change in time. The students who don't make that much progress and need more time, I can monitor as other things are being taught them. I think workshops are more expedient to reach the objective.

MCBROOM: You mentioned to me once that the medical profession would never change. Do you think some of these students going out now will change some?

KAHN: That's a very interesting question, and my answer is: a little. Some people say that

since more women are coming in--fifty percent--there will be change. The women are more compliant, more willing to work with patients and to work with the patient's family.

MCBROOM: You've seen this proportion change a lot with twenty years that somehow have slipped by.

KAHN: I wish I could say yes, they are going to make it. But I've seen that even in the early 1970s, the students were so turned on and wanted nothing to change. I feel there is much power in the new HMO system and all the doctors of course won't take it lying down, though I don't know what else they can do as it all slips through their fingers.

MCBROOM: Elsbeth, when I came in, you were taking the referral of a troubled student you will take into counseling. Would you say something about that role of yours in the Medical School.

KAHN: I talk both with medical students and physician's assistant students who are feeling troubled. Those who know me refer them to me. This was a family member of the students who is in trouble and needs referral. I see someone to make the decision as to whether they should be seeing a psychiatrist or go to a family agency for private counseling, etcetera.

MCBROOM: Do you have student counseling on the Health Science Campus? Part of the student health service?

KAHN: Yes, we have psychiatrists.

MCBROOM: Do you refer some of the students to them?

KAHN: Yes, we do, to psychiatrists.

MCBROOM: So it's really quite brief referral.

KAHN: The most I see a person is six times.

MCBROOM: And for some of them, that's what they need, and others need more.

KAHN: They come around when exams are happening, like now. But some have deeper problems.

MCBROOM: Just turning away from your job, can you tell about any of the extra-curricular things you've done, social movement activities you've been involved in outside the job, profession, or the community?

KAHN: Outside of the School of Medicine, I worked with a number of organizations, some professional, like the National Advisory Social Work Committee, and the National Ad Hoc Committee on Psycho-social and Behavioral Research. Among the organizations where I served either on the board or on a committee, are the Home Health Agency of California Hospital Professional Advisory Board, the Board of Directors of the American Institute of Community Health, the Southern California Health Council, the County Heart Association, the American Hospital Association, the American Cancer Society, and others.

I was given an award for service by the American Cancer Society, and a teaching award from Los Amigos, the support group of the School of Social Work.

I did things on ethics and some workshops on stress.

MCBROOM: Where did you do the workshop for stress?

KAHN: I think one or two were at UCLA and some elsewhere.

MCBROOM: Were you involved in the hospice movement?

KAHN: Well, my role in that was as a consultant with support groups. Hospices have tremendous potential for helping those who are terminally ill to stay at home, to die at home and with some dignity. My experience is that a very special type of nurse is interested in hospice work, not so much social work although I've known some social worker to work with hospice care.

MCBROOM: How would you describe such a nurse?

KAHN: They are almost too involved, and expect a certain amount of return from the patient in terms of recognition, shall I say, of psychological issues. The most important part of adequate care is appropriate medication; this is one of the major features of a hospice. Hospices are staffed by wonderful people who have to understand that the patient is expected to die within six months. I think that absolutely it is a matter of ethics. A strong-willed person may not die, but there now is a question in my mind, whether you can program patients to die. The doctors do that in their attitudes of knowing and not knowing.

MCBROOM: Elsbeth, what's your view about the way professional social workers can affect some programs and policies? Can they do that more effectively than maybe other professionals?

KAHN: Well, that reminds me to say that I taught in the School of Social Work for a couple of years, and I truly enjoyed that. Social workers should understand and accept that no one understands how to manage relationships as well as they. It is up to us to do that. Ethical social workers who are well trained would understand what access to resources must be available to help these people who are discharged. Without enough access to psycho-social care they soon came back into institutional care, which is a net loss of money to the taxpayer and a psychological--sometimes physical--loss to the patient.

MCBROOM: You think it's a matter for schools of social work to really teach social workers about the health care systems, especially the medical care professions. If you don't understand or, even, if you don't want to understand, you won't make it; you'll be disappointed; the patient will be hurt.

You have asked me what has given me satisfaction. I did a lot of consulting with people here, some of whom have just retired. They followed many of my suggestions about working with and understanding people, and that's very satisfying.

MCBROOM: You could see your influence spreading out.

KAHN: I think that's a fair statement. And that's very gratifying, but I can't know for sure about my successes, for I'm not an M.D.

MCBROOM: Elsbeth, a bit earlier you mentioned Elizabeth McLatchie coming down from the State office to see how things were done at El Rancho. Are there other instances where you think your work has some impact state-wide, nation-wide? Programs and Policies?

KAHN: Well, to the extent that social workers have come to seminars I have given, I have had some influence; in developing care homes, to really help handicapped children who are in El Rancho.

MCBROOM: We were going to talk a little bit about your cancer work. Would you say what that was about?

KAHN: Well, I really involved myself in cancer education matters for a long time. That's what it really was. Several years of participation in institutes and in education committees locally, at the state level, and the national level.. I found the American Cancer Society very social, politically mined, and geared toward working with volunteers. And my contributions were professional contributions. In the National Cancer Foundation days--really, the American Cancer Society--we had fabulous interdisciplinary conferences and that was one of my specialties. In those meetings there would be representation of all the professions, and I think I made considerable impact on doctors from rehabilitation centers by what I said about social work functioning. That's what really got me a lot of the attention.

MCBROOM: Elsbeth, another backward glance. When you think of social work when you entered the field and social work today, what significant changes have you seen?

KAHN: That's a tough one. When I entered the field, I was starry-eyed about clinical social

work, particularly long-term services like tuberculosis and cancer. And because I had such wonderful experience and diversity in hospitals, I thought all doctors wanted to work with social workers. As a Red Cross social worker, I did very well. I got along with the doctors, and they really worked with me and listened to some of my recommendations, but when I came here, I found it tough, very tough. Aside from that, I saw political changes and changes in financing and the social workers were unprepared to deal with the hospital settings, to adjust more than they did. Discharge planning, for example, used to be a social work function. It was part of the whole job. It was service to the patient. At Rancho much competence was required. The nursing in many places have to do that. What that really means is that nurses want to go into the psycho-social aspects, but they don't have the same concerns.

I am critical of the fact that we didn't get anywhere with measurement; that's something that Eleanor Klein and I wrote about. By and large, I went to many meetings and wrote papers, but that wasn't good enough. Not enough progress was made. In 1972, I did a position paper in which I predicted some progress.

MCBROOM: Social workers haven't always been aggressive, not really demonstrating their role.

KAHN: I've seen that, and I don't mean we've done ten of this and fifteen of the other and this is what we saw and this is what we have to say, and we are not doing it yet. But I think some feel defeated. Nurses are not good in social work because nursing just has a different philosophy. Documentation would be useful, I think, of some of the issues and some of the differences in discharge planning.

MCBROOM: I hope your message gets heard. Elsbeth, I really want to thank you.

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