PIONEERING MEDICAL SOCIAL WORK
AT
E.W. SPARROW HOSPITAL IN LANSING, MICHIGAN

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This is a story of how I seized the opportunity to pioneer the first Medical Social Work Department in a hospital in Lansing, Michigan. Pioneering, in this instance, refers to one who is first or earliest in any field of inquiry, enterprise, or progress.

Background

My husband, Joseph Meites, PhD, and I moved to Michigan in 1947. Joe had accepted a professorship at Michigan Agricultural College (MAC). I wanted to obtain work in a hospital setting as I held a Masters Degree in Medical Social Work from Washington University, St. Louis, Missouri, and had been a clinical social worker at Washington University Clinics and Allied Hospitals and at St. Louis County Hospital. I also had experience as a social worker with the USO Travelers Aid and American Red Cross (counseling soldiers and their families) and had taught graduate social work at the University of Missouri.

I applied to the four hospitals located in Lansing. They were E. W. Sparrow Hospital with a bed capacity of 250 and three smaller hospitals: St. Lawrence Hospital, Lansing General Hospital, an osteopathic hospital, and Ingham County Hospital, a small public hospital for patients with tuberculosis. I soon learned that none of these hospitals had a Medical Social Service Department. I then decided that it was important to develop medical social work in Lansing hospitals. I once had a supervisor who evaluated my professional performance and said I had administrative skills, so I began to think seriously about how to proceed.

I found that three of the hospitals had no intention of adding social services. Glen Fausey, Director, at E. W. Sparrow Hospital, gave me an interview. He expressed interest but did not follow through. Later, I met a local social worker whose father was on the Sparrow Board of Trustees. He suggested that I seek employment elsewhere as Mr. Fausey and the Sparrow Board of Trustees were not ready to begin this service.

I found a position as the Ingham County Child Welfare worker. Within six months I was transferred to the Michigan Department of Social Services as State Supervisor of Michigan’s Foster Care Program. During this time, I also taught a course in Medical Social Work at Michigan Agricultural College School of Social Work. My husband and I wanted to start a family, so I resigned in 1953 to pursue that goal. I then was asked to have my name placed in nomination to be the President of the local branch of the American Association of University Women. Joe and I thought that would not be too strenuous, and there would be a Vice President if I became pregnant, so I found myself elected as President. At that time, the membership was just a little over 300. This gave me an opportunity to meet university women from all of the greater Lansing area, including the wife of the Governor, G. Mennen Williams and the wife of the President of Michigan Agricultural College, John Hannah. I found the members to be a good sounding board for promoting medical social work for Lansing. This experience broadened my skills as we had study groups plus many branch activities. Many members have remained close friends all these years.
Between 1947 and 1961, I made many contacts with local community leaders relative to the need for social services in hospitals. I also made observations as to why social services were not top priority at local hospitals. Sparrow Hospital had evolved as a result of the superhuman efforts of the Sparrow Women’s Board of Managers and the contributions of Edward W. Sparrow, a Lansing business man and philanthropist. The buildings were quite old and in need of remodeling and/or rebuilding. According to Bill Vincent, Facilities Development Department, retired, the main building was built in 1911, the Chapin Wing in 1919, the Post Wing in 1928 and the Potter Wing (nursing school residence) in 1930.

According to Social Security Online, Social Security History, financing hospital and medical care was a mix of private pay, workman’s compensation, some federal grants to states for public health services, care of the indigent elderly, and child and maternal health programs. Federal grants to states for health care were for the indigent. Private hospital insurance was approved in 1933 which led to the establishment of Blue Cross Blue Shield. There was some coverage for veterans, with service connected conditions, in VA hospitals. The Social Security Act was passed in 1935 but without health insurance coverage. Independent insurance companies lagged behind in offering health insurance coverage for individuals and families.

Local hospitals were dependent on the local community to raise funds for capital expenditures. Funds for capital expenditures usually were raised by local industry, labor unions, local merchants, and individuals. In 1946 the Hill-Burton Hospital Survey and Construction Act was passed. This act provided some funds for capital expenditures and some coverage for the care of the indigent. The concept of floating bonds to cover capital expenditures came later.

There was something of a population explosion after World War II. Many people were moving to Lansing to work in the automotive industry, state government, and Michigan State College. As labor unions became more organized and demanded better wages, employers developed benefit packages which included some health insurance coverage.

During a fund raising campaign in 1952, the Sparrow administration and board formed committees of community members and asked for their ideas as to what kinds of care and services Sparrow should provide. I served on a committee which addressed the need for medical social services. We recommended that Medical Social Work be added. But, this was not done.

In 1955, Joe received a Weizmann Institute of Science Fellowship at Rehovot, Israel. I accompanied him on a one year sabbatical leave to Israel. While there, I was invited by the Israel State Health Department to assist in introducing medical social work to Israel’s hospitals. This involved making contacts with hospital chief executive officers and schools of social work in Jerusalem and Tel Aviv. The hospital administrators were interested but thought hospital social workers should have some medical social work education. The schools of social work arranged for me to teach several courses at the Tel Aviv School of Social Work for students who understood English. I also helped students obtain scholarships to study graduate social work in the United States of America. After we returned home in late 1956, I followed this development, and within a few years, the schools of social work in Israel had developed medical social work courses and hospitals opened Medical Social Work Departments. I still was not pregnant, so several months after our return from Israel I began working part time at the Family Service Agency as Supervisor of Intake.

In June 1956, the Military “medicare” program was enacted, providing Government health insurance protection for Armed Forces dependents. In June 1960, congress reported
Social Security Amendments including a new program for Federal grants to the States for medical services to the “medically indigent” elderly. In January 1965, Congress passed legislation as part of the Social Security Amendment authorizing Medicare and Medicaid.

About 1960, Dr. Joseph Rozan was appointed Chief of the Medical Staff. He and the executive of the then Community Services Council, Perry Katz, formed a committee consisting of three physicians: Dr. Rozan, Dr. Mahlon Sharp, Dr. Richard Bates; and three executives of community social service agencies: Mr. Perry Katz, Community Services Council, Mrs. Gladys Spaulding, Family Service Agency and Gordon Aldrich, PhD, Head of the Michigan State University (MSU) School of Social Work. (MSU became a University in 1955.) They finally convinced Donald Pound, the new hospital director at Sparrow, to add social services. I knew several of these committee members but none mentioned that the committee had been formed. It was only after Donald Pound agreed to start social services that Perry Katz shared this information and asked if I still wished to apply. I did so and was hired as Director of Medical Social Services.

When did Medical Social Work Begin?

I was asked by many hospital staff, patients and lay people when and why social work in hospitals started and what we did. I explained that by the 1900’s medical care had moved from home visits by the physician to private practice to hospitals. I usually referred to a book written by Frances Upham, entitled A Dynamic Approach to Illness. She wrote: “In the early 1900’s, Dr. Richard Cabot, an eminent physician of Boston, was one of the first to recognize that although he and his colleagues were able to provide the best in hospital and medical services for their patients during the time they were under observation and treatment at Massachusetts General Hospital, they were unable to treat the patient as effectively as they should, due to lack of information regarding the environmental and social factors affecting the patient prior to, during and following the period when s/he was under care in the clinic or hospital. Under Dr. Cabot’s leadership and guidance there was added to the professional staff of the hospital a group of workers whose duty it was to bring attention of the physician information regarding the patient which would be helpful in the proper care and management of the patient. Such workers now constitute the professional group of medical social workers and have long since become an essential part in the provision of modern medical services in this country…”

I further explained that the American Hospital Association developed a Policy Statement on Provision of Health Services and a Patient’s Bill of Rights. The American Hospital Association and the Psychiatric Association followed through on Dr. Cabot’s observations. They jointly developed a statement on Psychosocial Aspects of Health Care, the Hospital’s Responsibility which asserts that “…the care we give must be humane and it must be comprehensive. It means a giving in our system of everything our people need in the proper place and at the proper time. No illness is limited to its physical manifestations, recognition of the psychosocial elements of illness is imperative. When a patient is hospitalized, his primary illness is often compounded by increased anxiety, reactions to separation from family and familiar surroundings, fear of the unknown, and inability to understand what is happening to him. In addition, certain cultural and ethnic beliefs affect his attitude toward illness and the attendant hospitalization.”

In 1957, Harriet Bartlett wrote a booklet entitled 50 Years of Social Work in the Medical Setting. She reported that “…in 1905 the first social worker was employed at Massachusetts General Hospital. In 1909 a Social Service Advisory Committee was established and first year social work students were accepted for field work. In 1912, second year social work students
were accepted for specialized training in hospital social work. In 1919, the first Social Service Department was organized as a part of the hospital. In 1938 Social Summaries on medical records was begun. In 1949, Hospital Policy was formulated which required that social workers be included in clinical research projects.”

The American Hospital Association and the National Association of Social Workers prepared a statement of Standards for Hospital Social Services that was approved by Joint Commission on Accreditation of Hospitals.

Establishing the Department’s Foundation

Before reporting for work I developed a brochure which outlined the initial plan for the department. It briefly listed the functions of a Social Service Department, the social worker’s areas of concern, the purpose and objective of the service, the referral plan, reporting to the physician and information needed by the social worker. This brochure was distributed throughout the hospital, to physicians and to the public.

I reported for work September 2, 1961. On September 28, 1961 the Lansing State Journal announced that a Medical Social Service Department for counseling patients and families was a reality at E. W. Sparrow Hospital. The October, 1961 Sparrow News introduced the service to hospital personnel and physicians.

I was surprised that office space had not been allocated for the department. Instead, I was given the option of two locations. One was in the basement of the old building, and the other in the Potter Wing that had been vacated by the Sparrow School of Nursing, which had been transferred to Lansing Community College. I selected two offices on the second floor of the Potter Wing. Then I was directed to the store room where previously used office furniture was stored. I selected the necessary furnishings. Then I was directed to the store room for office supplies and obtained needed supplies. Shortly thereafter telephones were installed. I wrote a job description for a secretary, and the personnel director provided some candidates. I hired Joyce Lindo, who started immediately.

I developed a form to facilitate referrals, and a form for reporting psychosocial findings in the medical record. Next, I wrote a Social History Outline, which served as a guide for all reports placed in the medical record. Other forms were developed to maintain the office records required. Policies and Procedures were written to accompany the forms. All of this material was placed in an office manual, and I continued to add to it until it met the requirements of the Joint Commission on Accreditation of Hospitals.

I was advised that I would be responsible to the administrative assistant, Forrest Karl Neumann. The committee that initiated the establishment of the department offered to serve as an advisory board. In October, 1962, Donald Pound, the Director, resigned to take a position abroad. Karl Neumann assumed the responsibilities of the Director and I was assigned to Tom Plasman who became an assistant to Karl. Later I was responsible to Ray Bishop. I was given a rather free hand in developing the department.

I spent time getting acquainted with the hospital policies, procedures and practices, and meeting with hospital staff and physicians. Attendance at patient conferences, which included nursing staff and physicians, was especially helpful in further demonstrating what social workers do. The purpose was to establish myself as a professionally respected member of the health care team.
Shortly after I started services, Donald Pound invited me to present a report to the Sparrow Men’s Board of Trustees. I asked what he thought they would like to hear and he suggested giving them some statistics. I found they were more interested in what I was doing. One board member asked me to describe one day’s activities.

I had just returned from the Intensive Care Unit where I had evaluated the psychosocial problems of a young mother of two who had attempted suicide. I described how important it was to determine the cause of this desperate action, what her mental state was at the time and determine what treatment was needed. I explained that I had arranged for her to be evaluated by a psychiatrist and had requested a local mental health clinic staff member to visit her at the hospital so she would have a community resource that could provide treatment on an outpatient basis.

I also described another patient who had been referred because she claimed she was dying even though the physician had determined that she was not. She refused to talk with anyone and lay in bed with her eyes closed. She did not respond to me either, so I reached over and held her hands for a while and said the doctor thought she had some family problems. I advised her that if she did not want to talk today I would return the following day. When I returned early the next day, the patient was sitting on the side of the bed, had bathed, had breakfast and was ready to discuss her problems.

As I was leaving the meeting, one of the Trustees approached me and said “I am very glad Sparrow has such a service. One of my relatives attempted suicide and had family and depression problems, and I know how important it is to find the care needed.”

The basic principle in hospital social work is that social services be available to all patients, their families, and significant others, and the social worker is to do case finding. But, I made the conscious decision to use the referral system, as I knew I could not provide services to all without adequate staff. Also, my experience at other hospitals had taught me that some physicians did not approve having the social worker involved unless he made the referral. Since social service was new to local physicians, I wanted them to focus on the fact that I was a part of the team.

In spite of these efforts, I recall two episodes that demonstrated the need for caution. I had been counseling a Sparrow employee who was not performing adequately on her job. She was complaining of abdominal pain and was seeking strong pain medications from improper sources. She also had been to a surgeon who scheduled her for abdominal surgery. I contacted the surgeon to apprise him of the fact that I had been counseling her relative to her psychosocial problems. I asked if he thought her physical condition required immediate surgery or if it could wait for a short time so we could work together in her interest. I had already contacted a psychiatrist, and we were awaiting his diagnosis. We were concerned about psychosomatic possibilities and drug overuse. The surgeon became very angry, claimed I was questioning his ability and judgment, and threatened to report me to the administrator. I found him unwilling to discuss the matter further so I advised him that if he went to the administrator, I would too. In fact, I went directly to the administrator, Karl Neumann, and explained the situation. Karl was supportive and said that this happens to staff members. In short, it is a part of working in a hospital. Some days later I was waiting for an elevator and the Chief of Surgery, whom I knew, was there. He walked over to me and apologized for the other surgeon’s behavior toward me. I realized Karl must have discussed the incident with the chief, and I felt relieved and glad I had handled the matter immediately.
The second episode occurred with one of my staff who was fairly new. A referral of a patient involving an abortion was received in the Social Service Department from the local police. My staff member responded to the referral without contacting the physician. He was angry and let the staff member know he thought she acted inappropriately, and he did not want her on the case. I was unable to reach the physician, so I wrote a letter to the Medical Director of the Obstetrics and Gynecology Department, whom I knew quite well, and asked that the physician on that service not mistreat my staff. This reflected how cautious physicians and administrators become when a possible legal issue is involved. It also required clarification of the role and responsibility of the social worker when outside agencies referred. Actually, the relationships throughout the hospital remained comfortable throughout the 18 years I was at Sparrow.

Some of the early referrals indicated that nurses and physicians thought the only two functions of medical social workers were to find financial resources to pay the hospital and to assist with discharge planning. I found that the business office did a good job of assisting with financial matters. But, they found patients who fell between the cracks and needed help to find appropriate financial resources. I soon found how limited funds were and made attempts to develop more. Many of these patients needed counseling related to their health problems, and building a support system. I was able to communicate to everyone that discharge planning was only a part of a total patient care plan and that early referrals would enable me to address the psychosocial situation, and be of more assistance to patients who were concerned about understanding and coping with their illness and care plans when they left the hospital.

Developing Community Resources for Health Care

One of the functions of the social worker is to determine what community resources are available and to assist in developing health care resources. The need for clarification of the hospital’s relationship to the community came to my attention very early. One example was the lack of community resources for elderly patients who could not be cared for at home.

An elderly woman had been referred for discharge planning. She had been cared for by an elderly family member who was physically unable to continue to be the caregiver. I scoured the community for an appropriate care plan, but there were no facilities in existence. I found one private home that reportedly might take someone, so I drove the patient there. This was a false lead, so she returned to the hospital. Her length of stay in the hospital had exceeded what was medically necessary. One of the administrators became involved because payment for the overstay was not approved. I explained that the Lansing area did not have adequate community health care resources to care for its population, and the hospital staff should seek community leaders to see what could be done. The administrator’s response was that the hospital is not a service organization. I asked the administrator to authorize more staff for me so I could work with the community. He declined.

I decided to pursue this issue, even without additional staff. I called this gap in community health care services to the attention of the Community Services Council. The executive was Perry Katz, a qualified social worker, whom I knew quite well. He responded by holding evening meetings for community leaders to inform them of this issue and to seek solutions. This meant I worked overtime. Fortunately, my husband was very supportive. There were occasions when he made comments like: “It was mighty lonely here tonight” and “I sure missed you tonight.”
Gradually, the community responded, and the first nursing home was built on Mary Avenue. However, the usual problem of how to pay for this care arose. Also, the nursing home had restrictions as to who could be accepted.

The need for facilities for the severely injured, ill, and handicapped children and adolescents arose. There were two child placement agencies and some private day care homes for children, but none accepted children who needed health care. There were six state hospitals for the mentally ill, but their admissions were limited to children who had been diagnosed as mentally ill. From 1959 to 1962, I had served on the State Legislative Committee for the American Association of University Women, and we had made a study of the care of children in these hospitals. We had found the care woefully inadequate and had succeeded in getting legislation passed to build children’s units to house, treat and educate the children, and return them to their families when possible. The placement of children in these hospitals was due to lack of local community resources, funding for providing the care was not readily available, and communities had turned to publicly funded agencies as a last resort. The St. Vincent DePaul Society eventually built a residential facility for children.

Obstetrics/Gynecology

Physicians began referring parents who needed assistance because their newborn had been born with physical abnormalities. I found parents who were quite distraught because the physician had recommended that the child be sent to institutional care. The institution was located about 65 miles from Lansing. Most parents wanted to see, hold, and bond with the infant. If the child was not to live long, they wanted to be with the newborn and go through the grieving process. This was a turning point for the physicians, as the parents gained enough strength from counseling to make their wishes known. Along with my interpretations of the parents’ wishes, physicians began to hear the wishes of the parents and accepted change as resources became available. This, of course, raised other concerns. It meant that we evaluated their total situation at home, their understanding of the care needs of the infant, and their ability to cope with their future needs. It also meant the infant usually stayed in the hospital longer while the family and home situation was established, and some children died within a short time.

Another example was when the infant was diagnosed with Downs Syndrome. Again, interviews with parents revealed they wanted to keep the infant and rear it. Parents wanted to understand the condition and how to cope with it. This meant building in a strong family support system, along with community resources for children who might live to adolescence. Therefore, counseling and education by the physician, nurse, and the social worker were needed and provided.

The parents also were concerned about having more children for fear they would be abnormal. Another example of change was the fact that parents expressed the desire to see and work through their feelings about having a stillborn child. Through counseling, they expressed the desire to see, hold and take the newborn through the burial and grieving process. In the 1960’s, the school system did not accept handicapped children. The school system eventually accepted some of these children. Another facility, which still exists is known as the Beekman Center.

For years society stigmatized girls who became pregnant prior to marriage and they were urged to place the baby for adoption. However, the federal medicaid laws changed about 1970. Then girls could apply for Medicaid when they reached the age of 17. There was a noticeable increase in the number of girls who kept their babies following these changes. Of
interest was the fact that some of the girl’s parents were supportive of keeping the baby as s/he was their grandchild and should be a part of the family. Occasionally there were referrals when the unwed mother decided to keep the baby, but the physicians thought she was not competent to give proper care. State law stipulated that children could not be removed from the parents unless there was evidence of mistreatment or neglect. Thus, the treatment plan had to be changed to assist the unwed mother in building a support system, and to gain some understanding of how to care for a baby when there were family relationship issues and problems with financial support. As more unwed mothers kept their babies, counseling and arranging for them to continue their education was needed. Occasionally, private adoptions had been agreed upon between the mother and adoptive parents, prior to hospitalization. These arrangement had not been done through the probate court. These adoption arrangements were not legal and were referred to me. This required working with the Probate Court to clarify the situation and protect the newborn. The probate judge usually did not allow the adoption to be legalized. These prospective adoptive parents and young mother usually went through a traumatic experience. Some of the unwed mothers already were negotiating with an adoption agency so coordination with that agency was helpful.

When I began having contacts with community resources, I also began developing policies and procedures which defined liability responsibilities and interdepartment-interagency responsibilities. Liability statements dealt with negligence, invasion of privacy and libel. Interdepartmental-interagency responsibilities dealt with responsibilities within the hospital, to patients outside the hospital, and to other agency resources.

**Alcoholism Ward Established**

On July 17, 1961, Sparrow administration announced the opening of the [first Alcoholism Ward](#). The patients had been scattered throughout the hospital prior to that time. Dr. Richard Bates was the Medical Director. He requested full social work coverage, so I provided as much service as I could and assigned some students to assist with evaluations, therapy and group sessions.

The Alcoholism Unit was located on 3 East and consisted of thirteen beds, a day room which was used for group sessions, recreation and dining, and a well stocked kitchen. Group sessions were held twice daily and some evening sessions. Leaders of these sessions included physicians, clergy, social workers, and AA. The Rehabilitation Center provided occupational therapy.

**Staffing, Student Teaching, and Expanding Service**

Funding for sufficient staff was not readily available and qualified social workers were in short supply. I realized the importance of participating in the education of prospective staff. In 1962, the School of Social Work at Michigan State University sought internships for their graduate social work students who were available three days per week.

The first student was Roberta Green, a second year graduate. She received the Masters in Social Work degree in 1963. Phillip Brockmeyer, a senior at MSU was the second student. Upon graduation, he entered the graduate school of social work. In 1963 Judy Lynch, a second year graduate student completed requirements for the Masters in Social Work. In 1964, Edith Silverman, also a second year graduate student completed the requirement for the Masters Degree. In 1965, two graduate students were interns in social work. They were Diane Cromwell and Dwayne Wilson who were assigned to various parts of the hospital and
participated in group sessions with the alcoholism unit patients. These students required supervisory time but were very helpful in reaching more patients.

**Grant money for adding first staff**

In 1962, I learned that a separate State Alcoholism Department had been established. I knew the Executive Director, Ralph Daniel and consulted with him about the services of that Department. He revealed that the Department had grant money available for treatment centers to hire social workers. I applied for a grant to cover the salary of one social worker and received the **first state alcoholism treatment grant for social workers in 1963**. I hired Mrs. Denise Coburn, MSW as the first staff member in the department. She was assigned to the Alcoholism Unit as well as other parts of the hospital. Later, I applied to the **Sparrow Women’s Board of Managers** and received a grant to support a part-time staff member, Mr. Ward Wood. Ward was assigned to work evenings when family members were more readily available.

**Adolescent Services**

Further expansion of services continued as referrals increased. Services to the adolescent population included counseling for school age children who were hospitalized for fairly long periods of time. Some had serious injuries, and some needed to have their chronic illnesses diagnosed, treated, and stabilized. It became clear to me that they needed to keep up with their school assignments. I made contacts with the school system, and a hospital teacher was added.

A number of emotionally disturbed adolescent girls were referred who needed intensive counseling. It was found that they lacked parenting from their families and wanted desperately to have someone care for them and give them close guidance and relationships. In short, they needed loving parents who would teach them how to grow and take care of themselves.

One 16-year-old girl was having dissociation episodes while in the hospital, so the nursing staff called me when this happened. I provided counseling, and encouraged behaviors that would build self-confidence and self-esteem. Her mother and stepfather were concerned about her, but both were a bit mentally limited, and her stepbrother was quite mentally limited and needed lots of care from the parents. This girl was bright, showed evidence of understanding, ability to take control of her own life, and develop even though her family situation was difficult.

An 18-year-old girl was suicidal and was seen in the emergency room after an attempt to end her life. After interviewing her, I asked a psychiatrist to see her and accept a referral. After seeing her, the psychiatrist said I should not refer her, as this would be another rejection and she would be at higher risk of suicide. Her mother was a depressive alcoholic who had not been able to provide parenting, and the father was not in the home. This girl was bright and wanted to have a better life.

I followed both of these patients through the years and found they had married, had children whom they had parented fairly well, and they had learned even more about parenting to help rear their grandchildren. Both of them thanked me with this comment: “I am what I am because of you.”
Emergency Room Referrals

There were referrals of adolescent children who sought care in Emergency, but there was no one to give consent for examination or treatment. This required contacting responsible family members and finding a way to let them know their child was at the hospital without unduly upsetting them. I also saw them in the emergency room and determined whether further services were needed.

Some college students who felt suicidal called the hospital and were referred to me, so I found ways to talk them through their feelings and get them to Olin Health Center or the student Counseling Center at Michigan State University (MSU). Later, a community emergency hotline was established, and this made services available day and night. Other students who were drug abusers were referred. Since they were enrolled at MSU, I referred them to the Counseling Center and/or Olin Health Center. Social histories for these patients revealed a very serious and dangerous problem as many had family relationship problems, or were abusing drugs to the point they could not function. Most had become addicted and required much more treatment than Sparrow was able to provide. Eventually, the State Alcoholism Program included a more comprehensive definition and substance abuse was considered a mental illness, so referrals could be made to the local Community Mental Health Services.

Young children, who were found to be abused, were seen in Emergency and psychosocial evaluations were done. I always reported to the physician when I found indications the child may have been abused previously. Eventually, state laws were passed requiring the police to be involved and responsibility was given to the Department of Social Services to investigate and process the case.

Occasionally, domestic abuse was recognized by the Emergency staff and referrals increased. As the community became more aware of the extent of domestic violence, more referrals were received and community resources were developed so that women would have a safe place to go while solutions to their needs could be established. As physicians and staff were informed about the nature of domestic abuse, there was much more concern and attention given to these patients.

Some women who came to Emergency seeking help for what appeared to be injuries and abuse actually were found to have been raped. They were referred to the department as they did not require hospitalization but needed counseling and referral to community resources. Counseling was provided and community resources developed.

There were frequent referrals of individuals and families who needed services but did not require hospitalization. Social service determined what was needed and made referrals to other community resources.

Office Space and Plans for New South Wing

About 1963, the office space I had selected was needed for administrators, so I was moved to other rooms in the Potter Wing. In 1964, I was advised that the Potter wing would be torn down. Sparrow had bought some of the private homes to the west of the hospital, and my offices were moved to the third floor of one of those houses. The rooms were tiny and were just about filled when the furniture was installed.
I remember having quite a challenge when a young male patient, who had been referred while in the hospital, came to this office without an appointment. His behavior was rather bizarre. I knew from previous contact that he got a thrill out of harassing people so as to frighten them. He showed me a knife he was carrying which had a sheath and carvings on the handle. He talked about following people in the park, and about scaring his mother with the knife. He was standing in the only space through which I could possibly escape, so I was careful to appear calm and interested. I asked him if he ever thought of using the knife on anyone and he said “yes, especially in the park.” Since I could not make an exit, I asked if he would give me the knife, as I was sure he did not want to hurt anyone. To my surprise and relief, he gave it to me. I recommended he follow through with his physician, and seek counseling at the mental health clinic. I then contacted his physician about the patient’s behavior.

The new office location presented other challenges. I had to carefully plan my day by taking care of anything that needed to be done in the office, assigning work to the secretary, and then organizing my patient load so that I could spend whatever time I needed to see patients in the hospital. This meant I had to be paged while in the hospital when needed. It was difficult for some patients to reach the third floor to my office, and some had difficulty finding the office.

In 1964, the administrator asked me to plan office space and staff for the Medical Social Service Department for a 500-bed hospital instead of for 360 beds, as the South Wing plans were underway. Space, he said, would be provided for the Social Service Department on the first floor. As might be expected, I underestimated the need for space and staff. As the South Wing was being constructed, I visited the area designated for the department. I found there were strips of glass for windows, about 12 inches wide, and that they were at ceiling level. The rooms were all enclosed with walls and did not look inviting. I requested larger windows that would give natural light and a feeling of not being enclosed. There were a few changes, but they were not significant.

There was no way to know in advance how much the population would grow in Lansing and the surrounding area, or how much the practice of medicine would change. We found that the College of Human Medicine was being established at Michigan State University in 1964, and in 1969, a College of Osteopathic Medicine opened at MSU. The university did not receive approval to build its own hospital, so both medical schools used local hospitals for patients and teaching purposes. Specialization in medical practice resulted in special floors and special units being established with medical directors for each kind of service. In addition, some of the special units developed outpatient care. Most of the medical directors wanted full social service coverage.

When the South Wing was completed, in 1967, I began to add staff and students, but it was difficult to find qualified staff. I wrote job descriptions for fully qualified staff, for the director and assistant director and for associates. I also developed personnel practices, statements which dealt with hiring practices, working hours, breaks, overtime, absences, tardiness, vacations, sick time, holidays and evaluations. Office space soon became inadequate. Since no other space was available in the hospital, it became necessary to place two staff members in each office and students were kept busy with patients and writing reports. This left staff without space for interviewing family members. It was difficult to find space on the patient floors for private interviewing. This drastically compromised confidentiality. Originally, the department space included a small waiting room, but this was lost to the department when the Family Practice Center was opened next door.
Planned Parenthood Clinic

In 1967, Dr. Maurice Reizen, Director of the Michigan Department of Public Health, opened a Planned Parenthood outpatient clinic at Sparrow. Dr. Reizen requested social service coverage for these patients who required a variety of services and education relative to family planning.

The First World of Childhood Program

Although Denise Coburn was assigned to the Alcoholism Unit, she was interested in developing a special program for children on Pediatrics. Originally, referrals involved children whose parents needed counseling about the child’s care, about family relationships and planning for continuity of care.

Denise started developing a proposal to initiate an unstructured play program for children. The nursing staff and volunteers had already recognized that hospitalization and separation from family is particularly traumatic for children, and they developed a Play Lady’s Program using volunteers. Mrs. Coburn’s proposal combined the efforts of the medical and nursing staffs, the Volunteer Play Ladies, the Medical Social Service Department, and parents. The purpose of the play program was to relieve the fears and anxieties that are experienced by most hospitalized children and to avoid possible resultant, severe emotional disturbances. This was to be done by involving the children in unstructured play and staff who could respond to their reactions. Play materials consisted of toys that were miniatures of the things doctors and nurses use in their care, along with other toys which enabled children to express their feelings and concerns about what was happening to them. The planning phase for the program took more than a year.

Mrs. Coburn took a leave of absence in 1966 to accompany her husband to Thailand. Since the planning phase was almost completed, I assumed responsibility for starting the play program and working with the children in the play area. Volunteers worked with the children who were bedridden and could not be in the group. The program was opened while we still were in the old hospital. There was no separate room we could use so the children were placed in a hallway which was near at least one room where bedridden children could participate. Later, Jane Bopp, a student of child development at Michigan State University, was hired and remained until she completed her master’s degree and took another position. Dess Overholt, MSW, had just graduated from MSU with a Masters in Social Work and she was hired to fill this position in 1968.

Another feature of the World of Childhood Program was that parents were given open visitation, were encouraged to participate in the play program, to visit their children, and to stay with them, if this was indicated. At first, a few physicians expressed the view that such services were not needed, but soon were writing orders in the charts asking that the child be referred to the play area as soon as physically able.

When the South Wing was completed in 1968, the play program was given a separate room. We soon outgrew it, and 1972 marked the opening of a long awaited and planned for pediatric playroom expansion, which also included an outdoor play area. This was made possible by funds donated by the Sparrow Hospital Guild. The expansion doubled the floor space, allowing many more patients confined to their beds and wheel chairs, and ambulatory patients to participate.
Gloria and Ted Bouterse donated a tree which was planted in the outdoor play area in memory of their daughter Nelle Marie. Gloria Bouterse was a graduate of the Sparrow School of Nursing and, after retirement, was a member of the Women’s Board of Managers at Sparrow.

Dess Overholt-Johnson was transferred to Pediatrics and the Neonatal Intensive Care Unit and Elizabeth Claggett, a child development specialist, was hired for the play program. When Elizabeth resigned, Brooke Bartholameau, another child development specialist, was hired. In 1978, the World of Childhood Program was transferred to Pediatrics and was established as a separated program. The other local hospitals developed unstructured play programs for children shortly after we started.

**Group Therapy**

Denise Coburn returned from Thailand in 1967 as assistant director to the department. She initiated a group therapy program for parents whose children had asthma and frequented the emergency room. This program brought a new dimension of family, physician, hospital and community interest and concern for the care and treatment of allergic patients and for their families. Dr. James Saker was Medical Director for patients with allergies. He also was appointed Chief of Medical Services and was advisor to the Social Service Department for allergy patients. Denise Coburn resigned in 1969 to take a position as assistant professor of social work at MSU. Ruth Clausen, MSW, assumed responsibility for the group therapy program. Joan King was appointed Assistant Director of Social Services to replace Denise Coburn.

**Regional Neonatal Intensive Care Unit (RNICU)**

Technology and increased knowledge about babies who were born prematurely or were considered high risk created a need for the Neonatal Intensive Care Unit. Barbara Abbey, RN was the Head Nurse. The program plan included coverage for families whose baby is in RNICU, outpatient OB/GYN clinics, patients identified as being at risk, and pediatric follow through when the baby is transferred to the Pediatrics floor. The purpose was to provide quality comprehensive care to patients and families.

Parents of these babies often were confronted with unexpected trauma and difficult decisions. Social Services were provided from the beginning and were available when outpatient clinics were in session. Sr. Mary Christine Cremin, RN, MSW, was assigned to the outpatient clinic. Since the babies often were in the unit for some time, there was opportunity to meet with parents, determine their needs and assist with their concerns about the baby’s development, about the loss of a child and about their concerns in general.

**Nephrology, Hemodialysis and Transplants**

In 1964, Dr. Martin Jones opened a three bed unit on three Foster for Nephrology patients. The hemodialysis unit was on the lower level. He requested social service for these patients. I assumed responsibility for these services until I could find other staff to do so. When the South Wing was completed, the program was increased and an outpatient unit was established in the South Wing basement.

Kidney failure can be life threatening and treatment could extend life, but patient and family situations needed to be carefully evaluated before accepting them. That is because the intent was to place a dialysis machine in the home and train the family member to provide the
care. It was necessary to determine whether the patient and family had the internal strength and ability to develop the technical knowledge to operate the kidney machine at home. It also meant the home environment had to be conducive to such a difficult and responsible task. Housing and appropriate community resources were essential, especially funding and a visiting nurses service.

In the early development phase, it was found that Medicare, Medicaid and Blue Cross did not cover the cost of these treatments. I made an appointment with the Ingham County Board of Supervisors and arranged for Karl Neumann, Director, and Dr. Martin Jones to accompany me to request funding through Medicaid. Approval finally came through. Joan King contacted Blue Cross/ Blue Shield and they agreed to start a “pilot program” of coverage. Joan also contacted the Visiting Nurses Agency and arranged to have them informed about the machines and make their service available to the family on the day the patient was to be on the kidney machine at home. Once these issues were addressed, we were able to concentrate on providing counseling and educational services, and be available to assist with emotional reactions of patients and families.

A surgeon was added to the Nephrology team. This enabled patients to be considered for kidney transplants. Again, careful screening was required for any patient who wanted to be considered. In addition, kidneys had to be available. We became involved with the newly developing Michigan Kidney Foundation, as they held promise of becoming a helpful resource.

The responsibilities faced by patients and families were very stressful for them and they required considerable counseling and community support. One example of the need for community support involved a woman patient who had a husband and six children. She was able to be on the dialysis program if the home environment was suitable for the dialysis machine and if her husband could operate the machine. I sought help from the Ingham County Department of Social Services, and succeeded in getting the family into the model cities housing project. Workers in the construction and plumbing unions donated time so the home could be equipped with the artificial kidney unit. The Society of St. Vincent DePaul, contributed a washing machine and dryer (purchased through Sears) and technicians did the installation. Hadassah Women donated clothing, bedding and furniture.

After being on the program for some time, some patients would request to stop treatments. This meant they had decided to die. This was difficult for Dr. Jones and the staff to deal with this emotionally, but they shared their feelings, counseled the patient and allowed the patient to make the decision.

Rehabilitation Program (RMC)

Patients who were treated on the RMC Program included strokes, spinal cord injuries, neurological and other chronic illnesses and injuries. To qualify for care on the unit, the patient required the care of a physiatrist, nurse, physical and/or occupational therapists, speech and hearing and social services.

According to a brief History of The Rehabilitation Program, (author unknown) the definition of rehabilitation was reached about 1946. It was “to achieve the maximal function and adjustment of the individual and to prepare him physically, mentally, socially and vocationally for the fullest possible life compatible with his abilities and disabilities.”
At the end of World War II, Michigan’s health professionals found the number of patients with spinal cord injuries, other injuries, polio, and tuberculosis had increased greatly. Some attempts were made to meet the needs of the patients but the small facilities were scattered throughout the community. Physical and occupational therapists and speech and hearing specialists had to be trained as these disciplines did not exist. None had social workers until arrangements were made with Michigan State University School of Social Work to have student social workers available two days per week.

In 1956, the Ingham County Rehabilitation Services (ICRS) became a joint venture with E. W. Sparrow Hospital. In 1958, E. W. Sparrow Hospital matched funds with the Office of Hospital Survey and Construction (Hill-Burton Act) to build two additional floors on the Foster Wing of Sparrow hospital for the rehabilitation program. The sixth floor was for inpatients, with 43 beds. The seventh floor was to house the therapy facilities of PT, OT, Speech and Hearing, a dental unit, offices for social workers and a business office. The facility was opened in November 1959.

By 1974, there was a severe economic recession and the Rehabilitation Medical Center could not obtain liability insurance. A new insurance company was founded under the title “Michigan Hospital Association.”

E. W. Sparrow Hospital offered to assist and insure the continuation of the RMC, if the RMC would dissolve its corporation and transfer services, staff and assets to E. W. Sparrow Hospital. In June 1975, the corporation was dissolved and transfer of services, staff and assets was made to E. W. Sparrow Hospital.

Social work students from Michigan State University had been providing some of the social services to RMC but the arrangement was not a part of the Medical Social Work Department. The students were available two days per week and were supervised by a faculty member.

Leonard Face, RMC’s administrator, advised me that the social work students were being transferred to the Medical Social Work Department. However, he said that RMC was asking that all patients receive social services throughout the week instead of for only two days. I discovered that these students still would be available only two days per week, would be under the supervision of the faculty member, and there would not be the full weekly coverage that RMC desired. Since the University wanted to keep their student training plan intact, they moved to another facility. It was then possible for the Medical Social Work Department staff to provide all of the services and on a full weekly basis.

Since 1961, the Medical Social Service staff also provided some services to RMC. In the 1970’s, Ollie Brown, MSW, was the assigned social worker on the Rehabilitation unit. She developed group therapy programs for stroke and arthritic patients and families. There was collaboration with state wide resources such as the Michigan Heart and Arthritis Associations. They provided excellent educational materials. Joan King, MSW, organized a support group for heart patients and families.

**Burn Unit**

The Burn Unit was established in 1972 with Dr. Errikos Constant as the Medical Director. Since patients were in isolation, to protect them from infections, most social work services were provided for family members. The need for Social Service had been researched
for several years as the department had provided services to burn patients and their families in other parts of the hospital.

The social worker’s study of patient needs found that the crisis following a severe burn had a duration of two to three weeks. Assessments were made of the patient and family situation and assistance with the family’s emotional, social and financial needs was provided. Conferences with staff, physicians and family were provided so a comprehensive plan of treatment could be implemented. Continuity of care plans included the development of an outpatient follow-up program.

Staff and Students

Space and funding for additional staff did not occur until the South Wing was completed. Since the quality of the services is no better than the quality of the staff, I mainly hired personnel who had completed the master’s degree in social work. During summer vacation periods I hired some temporary staff. Beginning in 1969, the following staff members were hired: John Taylor, Dianne Kraus, Ollie Brown (all B.A. degrees). In 1970’s, I added all MSW’s: Ting Young, Marilyn McBride, Marjorie Gardner, Pat Hughes, Ronald Penfield, Pilar Monta, Steve Anderson, Mary Lou Bonduki, Michael Tootel, Barbara Barclay, Mary White, Elizabeth Claggett and Brooke Bartholomae. Three of these left the department but, but the staff remained fairly stable until I retired. Every effort was made to maintain enough staff to meet the requests for service from all parts of the hospital and out patients.

From 1962 until 1978 we had seventeen graduate students from Michigan State University and the University of Michigan Schools of Social Work. They were assigned to various staff members who supervised their experience for a period of one year. Most of them were second year students who completed the Masters Degree in Social Work.

Michigan Society of Hospital Social Work Directors

I became a member of the Michigan Society of Hospital Social Workers about 1963. Monthly meetings were held in the Detroit area. The purpose of this organization included professional development through sharing knowledge, advancing sound social policies, and promoting quality services to patients and families. In 1973 I was elected Vice President of the organization. In 1974, I was elected President of the Michigan Society of Hospital Social Work Directors. Since we were aware of the emphasis on accountability and peer review, we concentrated on developing guidelines for hospital social workers.

Awards

In 1969, five members of the Medical Social Service Department entered the Hospital Achievements Contest sponsored by the Michigan Hospital Association and Michigan Blue Cross. The purpose of the contest was to promote exchange of ideas among hospitals that save money, improve operating methods and bring better and more effective service to patients and the family. We received the first award of $500.00. The entry described the department’s comprehensive approach to health care planning. Our approach took into account the physical, emotional, financial, and environmental needs of the patient and coordinated the essential community resources to meet their needs. Our efforts also resulted in saving hospital days and time for physicians and hospital staff.
In 1970, the department entered the contest offered by the National Association of Social Workers, Lansing-Jackson Chapter. This contest offered an award that recognized “Innovative Programs for the Year.” Entries which won the awards were: the Group Therapy Program for Parents of Asthmatic Children, The World of Childhood program, the Hemodialysis Program, and the Aftercare for Handicapped and Geriatric Patients program.

Accountability

After the economy went into a downturn, about 1974, the hospital administration required all departments to do time studies. Each department was asked to create a forms flow which would enable staff to keep certain required data. I was aware of the downturn in the economy. Also, I was an ad-hoc member of the Utilization Review Committee so was aware that third party payers were questioning more and more admissions and lengths of stay. The basis for hospitals to receive reimbursement was that all physicians should chart justification for medical necessity for admission and length of stay. I also was aware that although insurance companies provided health care policies, as did Medicare and Medicaid, they found the cost of care was increasing at such an accelerated rate that third party payers set rates at which they would reimburse the hospital. They had set rates at cost plus a certain profit allowance. Also, there were studies that had kept data relative to length of stays and whether it was medically necessary for the patient’s length of stay. The somewhat rapid rate of adding new technology or replacing old technology also entered the picture.

I suggested to Sparrow administration that we become proactive. I suggested that we review medical records of patients currently in the hospital if a nurse could be available to help read and interpret the medical charting. This was approved. Our study revealed that physicians, in some instances, had not recorded adequate medical necessity for admission and/or length of stay. Physicians were enabled to take corrective action while the patient was in the hospital, instead of after the discharge.

In other instances, I was asked by the business office to review charts of discharged patients to determine why the hospital had been denied reimbursement. I found the physician sometimes charted that the patient had reached a plateau, condition had stabilized, patient lived alone, etc. At those points reimbursement had been denied. Also, I was asked to review charts from the Alcoholism unit. Reimbursement had been denied for a number of medicaid patients because the federal coding of the illness had been changed, making alcoholism a mental health illness. Sparrow was not classified as a mental health facility and the business office and physician had not known about the change.

The Social Service Department was required to develop Peer Review for social work. The department staff concentrated on this requirement and established some guidelines for auditing records, and did some audits. We found that our main issue was lack of recording in the medical record. Time was spent reviewing recording requirements and taking the necessary corrective action.

The above changes brought considerable change in the atmosphere in hospitals. It appeared that hospitals and physicians had lost some of their independence and control because third party payers were calling the shots. In short, it began to feel more and more like a business.

There was a noticeable increase in referrals to assist with discharge planning. Social workers assisted with referrals to nursing homes, adult foster care and other long term care
facilities. The social worker was responsible for determining the wishes of the patient and family, the source of payment, the type of facility best suited for the patient’s care and the availability of resources. Long term care facilities had their own requirements for acceptance and medicare did not pay unless the patient required skilled care. Even when skilled care was required, it usually did not last more than two weeks. This meant the patient would have to pay privately or qualify for medicaid. If the patient did not qualify for either, and if any family member was in the picture, we determined what plan could be worked out for home care. This was difficult for many families as most of them worked outside the home.

It was difficult for many patients and families to accept nursing home placement. I recall one 80 year old woman who had a broken leg. Her children wanted her to go to a nursing home and she did not agree. I was in her room when her orthopedist came to the door and said “Mrs. A, we are sending you to a nursing home today.” Her prompt reply was “Dr. S. you are not sending me anyplace. I am going home.”

I attended a meeting of the National Association of Hospital Social Work Directors in Chicago in 1975 which caused me to wonder where medical social work was headed. The meeting focused on social workers as participating only in utilization review and discharge planning. I found this alarming and discussed my concerns with the executive director of the national organization. I explained that the discussions in the meeting did not reflect the full range of services of a social worker and too narrowly defined us as discharge planners. The national executive did not seem to comprehend this, which alarmed me even more.

Meites Retires

I retired at the end of 1978 as I was 65 years old. Some staff members expressed concern about the changes in medical care and the role of social work and urged me to discuss this with administration. I had spent a considerable amount of time discussing the role of social work with the consultant, but found he was reporting to the administrators who were the ones who would make the final decisions.

I have always felt very fortunate to have had the opportunity to develop the Medical Social Service Department as it was something I very much wanted to do. I had an opportunity to impact the lives of many people, to assist them to achieve maximum functioning, to learn to cope with their illnesses, and to participate in developing community health care resources.

The Medical Staff Executive Committee presented me with a plaque which read, in part:

“The Medical Staff of E. W. Sparrow Hospital extends its sincerest appreciation for your many years of distinguished and dedicated service. Through your efforts, the first Hospital Social Service Department in Lansing was established and has come to be recognized as an essential component in the care of patients. Your successful leadership was based on the highest professional standards and incorporated strong creativity, initiative and resourcefulness, while tempered with generous portions of compassion and understanding. Please accept our gratitude and best wishes for the years ahead.” Signed by James H. Saker, M.D., Chief, Medical Staff and S.P. Fortino, M. D. Secretary, Medical Staff
Medical Social Work Department Disbanded

A few years after I retired, I learned that the department had been disbanded as a department. Instead, three services were combined into one unit. Namely: Utilization Review Coordinator, Discharge Planning Nurse and Social Work. This unit became known as Care Managers.

Sometime later, I met an administrator socially and asked why the Utilization Review Coordinator, the Discharge Planning Nurse, and the Social Work Department had been combined into one. The reply was: “patients are not here long so they don’t need social services.”

I wondered if administrators remembered Dr. Cabot’s concern for patients and the commitment made by the American Hospital Association and the American Psychiatric Association in their written Policy Statements. While I tried to understand what was happening to the changes in attitudes about patient care, I felt this was the ultimate in lack of concern for patients and families as such short stays indicated even more reasons patients needed psychosocial factors addressed by hospital social services. The sources of funding medical care, such as Medicare, Medicaid, and private insurances, played an important part in such decisions. Limits were placed on what kinds of services would be reimbursed to hospitals.
MABLE EMILY RUMBURG-MEITES

Mable Rumburg was born at Ellington, Missouri, November 29, 1913 to Albert and Minnie Rumburg, the 9th in a sibship of eleven children. Mable graduated from grade and high school and received the B.A. Degree from the University of Missouri in social work in 1942 and the Masters in Medical Social Work from Washington University School of Social Work in St. Louis, Missouri, in 1946. Mable Married Joseph Meites, in 1943.

Mable was a clinical social worker at Washington University Clinics and Allied Hospitals, the St. Louis County Hospital, the American Red Cross and the USO Travelers Aid. She was an Instructor at the Graduate School of Social Work at the University of Missouri, at the Tel Aviv, Israel School of Social Work, helped introduce Medical Social Work in Israeli hospitals and lectured about Medical Social Work in China.

In Michigan, Mable was a clinical social worker with the Ingham County Foster Care Program and was Supervisor of Michigan Foster Care Program with the State Department of Social Services. She was Intake Supervisor at the Family Service Agency in Lansing. In 1961, Mable pioneered the first Medical Social Work Department in Lansing, at E. W. Sparrow Hospital. She retired in late 1978. Mable was elected Vice-President of the Michigan Association of Hospital Social Work Directors in 1973 and was elected President in 1974.

After retirement from E. W. Sparrow Hospital, Mable established a private health care consulting and teaching service. She taught health care courses at Lansing Community College. Mable was a consultant at Jarvis Acres Nursing Home. After St. Lawrence bought the facility, Mable was consultant on social work issues and started the first medical social work department at that facility. She also became consultant to the administrator and assisted in updating the content of medical records, policies and procedures and quality assurance program.

From 1985 until 1998 Mable was a volunteer lobbyist for the American Association of Retired Persons in Michigan. She served on several committees and coordinated the Capital City Task Force. She represented AARP on an Ad-Hoc Committee on Long Term Care, the Governor’s Prescription Drug Education Program, the Health Care Systems Work Group, The Health Care Planning Council, the Patient Self Determination Workgroup, and the Governor’s Death and Dying Commission. She also represented AARP in various coalitions to promote legislation to reform the health and welfare systems and was co-chair of the Michigan Senior Legislative Council at the Capitol.

Mable became “caregiver” when her husband developed cancer in 1995 and had to curtail volunteer and other activities. Learning to cope with the health care system as a patient, and to be an advocate for her husband, was a challenging experience. Her latest activities include gardening and genealogy. She has done family genealogy and is writing memoirs of her life and that of her husband, Joseph.

Awards and honors include: The Lansing Branch of the American Association of University Women named an International Fellowship Grant in Mable’s name. She and her staff received awards from the Michigan Hospital Association and Michigan Blue Cross, and for four innovative programs at Sparrow, including Comprehensive Discharge Planning, Hemodialysis, World of Childhood and Group therapy for parents of Asthmatic Children from the National Association of Social Workers. She received a Leadership Award from the Michigan Association of Hospital Social Work Directors and from the National Association of Social Workers. Mable received the Diana Award from the YWCA in 1992 and the Zonta Woman of Achievement Award. She is listed in Who’s Who of American Women, Who’s Who of the Midwest, and Who’s Who Among Human Services Professionals. She received a Certificate of Merit for Michigan’s Senior Citizens’ Day which read: “this volunteer exemplifies how life as an older adult can be active, full of purpose and highly rewarding.” At retirement, the Sparrow Medical Staff Executive Committee presented Mable with a plaque entitled, Resolution of Tribute in appreciation for her distinguished service.