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By-Mitchell, James D.; Egerman, Karl

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To compare the physical medicine departments of selected vocationally oriented rehabilitation centers with each other and with centers that are primarily oriented toward physical restoration, six facilities were studied. Conclusions were as follow: nearly all physical medicine departments have staffing problems: quality of service appears unrelated to the physical plant, institution age, or renown of the medical director; departments in urban areas affiliated with hospitals and medical schools appear to view the patient more from the aspect of physical prognosis to the detriment of the client's vocational goals; counselors need more information about the comprehensive nature of vocationally oriented centers; a wider variety of disabilities may be found in university-related departments; the problem of aides or assistants is a recurrent one; vocationally oriented facilities are beginning to treat fewer physically involved clients; one center with below average wages has effective professional training and service programs which attract qualified personnel; and there is a critical need for an examination of provisions for professional staff benefits. (Author/RJ)

RESEARCH AND TRAINING CENTER IN VOCATIONAL REHABILITATION
UNIVERSITY OF PITTSBURGH • 727 GOUCHER STREET • JOHNSTOWN, PENNSYLVANIA 15905 • PHONE (814) 255-4313

A COMPARISON OF PHYSICAL MEDICINE DEPARTMENTS IN VOCATIONAL VS. PHYSICAL RESTORATION ORIENTED CENTERS

by

James D. Mitchell
&
Karl Egerman, Ph.D.

University of Pittsburgh

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I. INTRODUCTION

The process of rehabilitation is exceedingly complex. The procedures that contribute to human restoration are many and varied, and, from institution to institution, are often related only by the fact there is a well-defined common goal. But in nearly every case where a physical disability is present, a major aspect of rehabilitation is concerned with physical restoration. However, in a center that is primarily oriented to vocational education, the position of physical restoration is less clear than in a hospital-based rehabilitation facility. The purpose of this study, then, is to compare the physical medicine departments of selected vocationally oriented rehabilitation centers with each other, and with selected centers that have a primary orientation of physical restoration, as well as to characterize the relationship of physical medicine departments to programs of service in order to develop better integration of the physical restoration aspects of rehabilitation with those other services that lead to restoration of capabilities.

II. METHODOLOGY

The first step was to observe the department of physical medicine in one rehabilitation center (Center A) in order to develop process and procedures for the survey of departments in other centers serving similar as well as dissimilar functions. Next, visits and observations were made of the operating procedures of physical medicine departments in several vocationally oriented centers and also in centers having a primary restorative objective. Concurrently, a survey of existing literature on space, equipment, staff, personnel policies and record keeping as they apply to physical medicine departments in rehabilitation centers was conducted.

III. GENERAL INFORMATION ON EACH FACILITY INCLUDED IN THE STUDY CENTER

The number of staff members of the six facilities studied is listed in Table 1, under the various services which are offered to clients. The figures are included to provide an estimate as to the size of various sections and as a means of comparing one department with another, as well as to provide a clue to the emphasis on, and importance attached to, any particular section. The size of any staff fluctuates, often rapidly, and in many cases people will have dual roles. For example, some of the nursing staff are vocational instructors due to their function as trainers of nurse aides and orderlies as well as members of the physical restoration staff. This is also true of orthotists and other staff members in maintenance and housekeeping.

TABLE I

COMPARISON OF SIX PHYSICAL MEDICINE DEPARTMENTS

Center	Ownership	Clients Served	Types of Service	Conditions Admitted and Restrictions
A	Public	Adults	Nursing beds, dorms, outpatient program	All types but not during acute stage. Patients must be 16 years of age or older. Priority to physical disabilities and state residents.
B	Public	Adults	Nursing beds, patient program. homeservice (program (limited)	All types, not those requiring intensive nursing care. Communicable disease, primary psychiatric disorders, alcoholic problems, drug addiction not acceptable. Must be state resident.
C	Public	All ages	Nursing beds, outpatient program	All types None
D	Voluntary	Children & adults	Nursing beds, dorms, outpatient program (limited)	All types but not during acute phase. None
E	Voluntary	Children, adults, aged	Nursing beds, outpatients	All except emotional disorders, respiratory tuberculosis, convulsive disorders. None
F	Public	Adults	Nursing beds, dorms, outpatient (limited)	Patients must be 16 years of age and have potential to return to work.

TABLE I continued

Center	Services & Staff Members					Teaching Affiliations
	Physical Restoration	Psycho Social	Vocational	Speech & Hearing	Special Problems	
A	44	10	44	2	Recreation 3 Orthotics Prosthetics	PT, nursing, vocational Rehab., counseling, speech therapy
B	30	8	2	Outside personnel	Recreation 1 Follow-up 1 Social Res. 1 Special Hand Orthotics	Physical medicine residency, PT, OT, speech therapy, dietician, hospital administration residency
C	10	2	1	Outside personnel	Brace Shop Prosthetic	Medical residency program, PT
D	39	3	2	1.5 staff members	Pre-school, elementary, secondary & school trng. Recreation 1 Deaf 24	PT, OT, nursing, social work, special education medicine, research
E	36	4	Outside personnel	Outside personnel	Recreation, elementary school, transportation	Medical and surgical, PT, OT
F	42	11	32	Staff number not known	Psychological testing, prosthetic, orthotic, recreation	PT, OT, rehabilitation counseling

IV. SURVEY FINDINGS

A. Center A

1. Physical Plant

Center A has primarily a vocational training emphasis. In doing the survey of the physical medicine department in Center A (which is about 10 years old), it was discovered that space and equipment planning had been largely copied from departments that already were in existence in general hospitals, and hospitals that had a physical restoration rehabilitation facility. Due to this copying, more emphasis was apparently placed on the use of modalities for acute and subacute treatment of disease and injury rather than in planning for functional activities encountered in a chronic case load or a subacute case load, which is now the normal population of a center with a primary orientation toward vocational training. (Part of this seemingly misplaced emphasis was probably due to lack of insight about the task to be accomplished and part has been the result of the changes in emphasis in rehabilitation due to medical advances, and also to more liberal federal legislation.)

2. Staff

One of the primary factors affecting the staffing pattern of Center A was their difficulty in attaining and retaining staff. This was due in part to the shortage of technically trained persons within the health field. In some of the earlier studies of the problems in rehabilitation, namely the Baruch reports of 1946 and others, the problems that were delineated at that time still exist. In addition to the very real national shortages of personnel for all rehabilitation facilities,

Center A was faced with a geographical problem, located in a somewhat isolated, semirural area. The majority of health workers, particularly those in the so-called "allied health professions," tend to congregate in the larger metropolitan areas where there are medical centers, schools for allied health personnel, and colleges of medicine. However, the larger rehabilitation centers, which are in many cases vocationally oriented, are located in more rural areas, adding to the problems in getting and retaining staff.

Experiencing great difficulty in hiring seasoned staff, Center A tried to recruit new graduates. But Center A found it difficult to recruit to a rural area even when salaries are comparable to those being paid in a major metropolitan area, where the appeal of better recreation facilities, more available housing, and a generally more active private life are tangible "fringe" benefits. In addition, the added advantage of nearby graduate education that can be offered by the urban-based university offers the student opportunities to advance educationally, which they would not have in the type of setting in which Center A is located.

The following is an excerpt from a report on recruiting made at Center A:

> "So much recruitment is being done by so many agencies that letters have become ineffective for the most part. For example in recruitment for the Occupational Therapy Department alone, we have written 88 letters, including 32 personal letters, one to each director of an occupational therapy curricula; 15 letters, one to each graduate of the Richmond Professional Institute; 25 letters, one to each graduate of Western Michigan University. In addition, the Medical Director and I visited several facilities in the New York area including a visit to the Executive Director of the American Occupational Therapy Association. This resulted in numerous other possible applicants, each of whom was

contacted by telephone or letter or both. Over 25 calls in excess of $100 have been made for recruiting purposes. No exact figures are available, but this represents considerable expenditure of time and money. From this process one staff occupational therapist was hired.

"It is our contention that the best recruiting comes from advertising of another type; namely, reputation for excellent patient service, interesting work, good salary scales, and an active teaching program. We are shifting our recruitment emphasis to these factors. We are demonstrating excellent patient service by film, as well as personal visits from and to respected professionals in the various disciplines. We are stimulating work interest by involving all staff personnel in teaching assignments, inservice workshops, professional short courses and formal teaching assignments in various college curricula whenever possible. The more personal contact our people have in their own and related fields, the more they are stimulated. If they create a favorable impression on their peers, they also serve a valuable recruitment function. To further improve work interest, a higher percentage of cases with good prognosis for physical restoration is necessary. Particularly is this important in order to stimulate and promote the student clinical affiliations that have been established.

"Salary scales are adequate at present; however, the increasing competition for personnel is rapidly raising base salaries and in many cases, experienced staff therapists are not being increased as rapidly as are the base salaries. When this happens, the senior therapist who is only one pay grade above a recent graduate, feels compelled to change jobs in order to advance himself. Constant evaluation of the entire salary structure is necessary."

The second report from this same center follows up the general problem of shortage of qualified personnel.

"Due to the shorage of qualified physical and occupational therapists, and the difficulty in maintaining a full complement of each, much emphasis must be placed on the duties performed by the aides and attendants. For the past six months, the entire program in occupational therapy has been conducted by these aides and attendants. While the scope of the program has been curtailed, the quality of the program that does exist is very good. This is due in part to the excellent

> inservice training program that was conducted, and in part to the interest and initiative demonstrated by these employees. Many of the duties performed by these employees are at a much better level than are required in the job description of the positions that they now hold. Examples of such duties are: instructing trainees in Activities of Daily Living, which includes dressing, transfer activities, bowel and bladder training and other personal hygiene; the designing and construction of such adaptive equipment as is necessary to accomplish these activities. In addition, wheelchair repair and salvage which includes ordering and accounting for new parts, utilizing old parts from discarded chairs, and general repairs, has become a function of the aides. In the absence of professional staff these employees have accepted the responsibility of providing orientation courses for student nurses, intern counselors and field counselors concerning the aides area of competence."

The report goes on to discuss the job description, the pay category, and the training of the individuals who are in essence carrying on the program in the absence of the qualified individuals who would normally have this function.

In the excerpts of these two reports we can see some of the pressures created by the chronic personnel shortage. Aides and attendants are being placed in positions of responsibility for which no formal training has been provided; nor can these aides realize appropriate compensation when they do adequately perform mere responsible duties. This situation creates pressures of a different type on the professional workers and supervisors who are still present. They must assume more patient service, more research, more teaching responsibility, as well as more liability in the event of injury to a patient as a result of the action of an aide or assistant.

3. Evaluation of Case Load and Referral Source

In Center A, with primary orientation toward vocational training, we evaluated the case load and referral source of the physical medicine

department. Depending upon the particular type of client involved, a case load of 12 to 20 patients per therapist is considered about average for Center A's physical medicine department. This will vary according to degree of disability involved with each individual patient and also the additional duties that are assigned to the therapist, such as training of aides, research projects that may be ongoing in the department, and other duties of a similar type.

In considering referral source, Center A is an integral part of the State Bureau of Vocational Rehabilitation. Each of the administrative BVR districts located in close geographical proximity were requested to break down physical restoration referrals made both to Center A (belonging to the Bureau), and to other rehabilitation facilities which offered physical restoration services. It was discovered, through this survey, that there had been a shift in emphasis over the past several years in the type of client that was being referred to Center A. The districts had a tendency to use other rehabilitation facilities, i.e., those offering only the service of physical restoration, for those cases needing physical restoration, and to refer to Center A itself those cases that had essentially completed their programs of physical restoration and needed only vocational or counseling services. Furthermore, an increasing number of the mentally retarded and persons having a primary diagnosis of emotional disturbance were now being referred to Center A. This survey of referral source further indicated that less than one quarter of the total patient intake were actually persons in need of physical restoration, either as an active program or merely as a maintenance program. The survey further

indicated that only 10% of those clients being served by the immediately adjacent geographical districts were being referred to Center A, while approximately 90% were being referred elsewhere for physical restoration services despite the need for physical restoration cases demonstrated at Center A.

Due to this shift in emphasis by the referring source, the case load in the physical medicine department had deteriorated to the point where more and more maintenance work was being done rather than primary physical restoration. As a result of this survey, it was possible to point out this diminishing use to the appropriate administrative officials. (This example strongly suggests the need for communication and a clear understanding for district counselors of how a comprehensive rehabilitation center offers a wide variety of services, encompassing the total spectrum of rehabilitation needs contributing to an overall program of rehabilitation.

V. COMPARISONS WITH OTHER CENTERS

B. Center B

Center B is designated also as a state rehabilitation agency. However, in contrast to Center A, it is a university-based rehabilitation facility with emphasis on physical restoration. One of the institutional objectives of this center is to serve as a teaching affiliate for a college of medicine. This teaching function includes students in schools of physical therapy, occupational therapy, and a physical medicine residency training program, providing a large outpatient treatment program for the training of students. In the program as carried out at Center B, the patient is the raw material upon which the therapist or physician perfects his skill. Of primary importance in Center B is the type of patient, the disability and degree of involvements, and variation in case load, so that the learning process for students may be varied and may take place as rapidly as possible. It should not be construed that the services provided the patient are of inferior quality; however, as a point of emphasis the needs of the patient for service is secondary to the needs of the institution for patients with specific types of disability to be used in the training function.

This center reported no staffing problems. In fact, they had a surplus of applications for a number of years. Salaries were below normal, and well below those reported for Center A. But fringe benefits included nearby graduate study, and the opportunity to work in a teaching center.

An unpublished study done at Center B on all amputees treated during a nine-year period had the following to report about the rehabilitation

process and employment: The majority also listed lack of skills and training as their greatest vocational problem. In both the pre-discharge interview and the post-discharge follow-up a large majority of those persons responding saw their disability as primarily an economic and vocational handicap, thus giving exactly the same response in both pre-discharge interview and post-discharge follow-up. Most of the studied group, when evaluated by the staff at Center B, were considered to have slight to moderate handicap in all areas. Their potential work handicap, presuming a normal rehabilitation experience, was predicted to be slight. It appears that there is some confusion over the definition of "normal rehabilitation experience." Frequently, a prognosis for vocational potential is overly optimistic, and does not consider those factors which are very real work handicaps. By definition, the rehabilitation process includes vocational training; however, only 20% of the subjects in this study reported having received vocational training after discharge. This example at Center B indicates that what might be of prime importance for staff in a teaching center is not always in the best interests of the recipient of the service.

In the two cases so far described, it appears that programming has had a very definite effect on recruitment practices and maintenance of personnel. At Center A, the client or recipient of rehabilitation services was not considered in terms of his impact or benefit to the learning needs of the staff. This may suggest a constricted range of disabilities sought out and served, with the staff experiencing a repetition of the same type of case load. Perhaps a more varied case load would improve the staff's potential at Center A to cope with a wider number of disability problems,

and thus improve their overall capability for future clients. In the case of Center B, the case load has been so heavily problem oriented that not much thought has been given to the overall affect of rehabilitation on the recipient. There appears to have been little coordination of other aspects of rehabilitation, thus inhibiting a cohesive program of service. In the case of Center B, the client cannot be expected to bridge the gap between his work situation prior to physical restoration and successful employment following the provision of physical restoration service regardless of how successful these procedures may be, unless there is concurrent vocational training. The deterioration of employment skills during the time required for physical restoration may be vocationally incapacitating, requiring additional and prolonged training.

C. Center C

Center C is a physical restoration oriented center located in conjunction with a medical college in a central southern state. The physical medicine facilities of this center have been completed within the last five years and, as far as space, equipment, and materials, it is a well-planned, well-organized department. The following quote is taken directly from the statement of policy made by the coordinator of the physical medicine department:

> "The physical medicine department is located in the medical center building which includes the colleges of medicine, denistry, and nursing; a 500 bed general medical and surgical hospital; an outpatient department; and a physical therapy school. The hospital admitted its first patient in April of 1962. To date, 200 beds have been activated. The rehabilitation service is headed by a board-qualified internist. A physiatrist is to be recruited in the near future to be his associate. Administratively, we are under the chairman of the department of medicine. This administrative line-up seems to be a new trend in the past three or four

> years in some of the newer facilities. Early indications point out that it is going to provide an excellent relationship for rehabilitation and for the rest of the hospital and medical center. The rehabilitation services now consist of physical therapy and occupational therapy. In the near future we expect to have speech, hearing, pre-vocational testing, and a brace shop. Eighteen beds will be directly assigned to the rehabilitation services in the hospital on the same floor as physical therapy. The type of patient is varied and complicated, and ranges from pediatrics to geriatrics. Of the patients seen so far, there really has not been an easy one. Each one pushes you to the limits of your ability to see that he gets good rehabilitation. With the multiple disabilities, it takes the coordinated efforts of our section, and all the services available in the hospital, to see that they have the finest medical care possible. The medical center has developed one of the finest libraries in the South. The physical therapy section of the library has over fifty volumes and is expanding."

A personal visit was made to Center C. Since the author is well acquainted with the administrator of the physical therapy department, it was possible to get an accurate picture of problems and future planning. As was mentioned in the report dated September 1964, two years after opening the hospital, only two hundred beds had been activated. It has been the philosophy of the administration of this medical center to open only those sections that could be properly staffed and to provide a service only when it could be of high quality. It is significant to note that the rehabilitation area is under an internist and directly under the department of medicine administratively. This reflects the overall philosophy in this center: that any basic treatment specialty of medicine should be close to the academic mainstream of medicine. In order to accomplish this, the particular team of physicians and allied health personnel who originally see the patient follow him through his entire course of treatment at the hospital, be it surgical, physical medicine, pediatrics,

or any other area of specialty. This is true also of the therapists. Therefore, they have a wider scope of experience. Not only do they gain from the contacts with specialties in medicine other than surgery, neurology, orthopedic surgery and physical medicine (the most common areas of contact), but they also acquaint other medical specialties with skills that are available in rehabilitation and what these might have to offer. From what has been observed, this information exchange has been accomplished very successfully.

The salary ranges in this institution for allied health personnel are a few hundred dollars below national averages and yet they have had few problems in recruiting personnel.

The mention of libraries in the above quotation is significant. In many cases, money for physical plant is readily available; but in these areas of staff enrichment, such as libraries, short courses, and travel, sufficient funds are often not available to stimulate a progressive program. Furthermore, the availability of a high-quality, professional library has frequently been used successfully for recruitment purposes.

In the first few years of operation, the relationship between Center C and its state Bureau of Vocational Rehabilitation was loosely structured. Both parties--the university medical center and the state bureau--recognized this as an inherent weakness in the program. To correct this weakness, a single rehabilitation counselor was assigned to the university hospital with essentially a carte blanche status. He is responsible not only for the purchasing and provision of rehabilitation services, including physical restoration, but also vocational services that are purchased outside of this facility. This has admittedly been a major job for one person; however, he has had the total support of his bureau in this pilot project

to determine client needs in terms of personnel and finances.

The program at Center C appears to combine a good blend of the strengths that have been noted in Center A and Center B; and yet at the same time, some of the pitfalls noted in each have been avoided. This has probably been due in part to recognizing that a rehabilitation facility must combine an effective training program with an effective service program, utilizing the best features of the state Bureau of Vocational Rehabilitation, the university school of medicine, and a hospital service program.

D. Center D

Center D is a large rehabilitation center, located in the northeastern part of the United States, whose primary orientation is toward physical restoration. This center, located in a very isolated rural area, has problems not only in staffing, but also in providing medical consultants as are needed. This center is very well endowed. Salaries are at the national average or slightly above. They have affiliations with several schools of physical and occupational therapy, and they have a varied case load in physical restoration with both adults and children. However, despite this, the major problem of the physical medicine department has been to recruit and keep staff. About 50% of the staff stay for one year or less. The remaining 50%, other than the supervisor, have been there for less than two years. In the last five years of student affiliations, not one student has returned as an employee. They use the standard recruitment methods of approaching all schools, and personally contacting every graduate with whom they come in contact. It is again significant to note that this center does not provide for any short term education courses and they do not allow their staff any travel expenses for conferences or conventions. Time off with pay is allowed, but the staff member must pay

all expenses. Most staff members leave, according to the supervisor, for increases in pay and for better working and living conditions. These better conditions include both a community with more social activity and a better working atmosphere where staff members are able to further their education and increase their experience. At present, half the budgeted positions in the allied health professions are vacant.

E. Center E

Center E, a large facility oriented toward physical restoration, is located in three separate and distinct general hospital settings. Administratively, however, it is a single unit. According to the administrator of the department of physical medicine, they have problems in attracting people to the community. The center attempts to compensate for this problem of staffing by having a community-oriented program of local citizens who are involved in volunteer work at the center. Much publicity is given to all center activities throughout the community, and local people are hired whenever possible.

Since services are housed in three separate hospitals, it is possible to provide three separate administrative sections within each of the various disciplines, which can be clearly delineated. In addition, there is a very definite ladder of progression for all classes of employees. Salaries are slightly above national averages but not significantly so; the expressed philosophy is that good personnel cannot be bought.

Center E has student affiliations with three universities. The relationships are not only good for recruitment, but they help maintain high staff morale and pride in maintaining high quality treatment. In addition, the medical director and administrator make periodic lectures on organization, administration, and accounting within physical medicine departments.

They are very liberal in paying for short courses and other forms of continuing education. In addition they pay one-half of the cost of the visit of a prospective employee, and if the employee comes to work at the center, they pay the complete cost. Staffing problems exist within this center, but they do not appear to be as acute as the problems that exist nationally. A comparison between Centers D and E would indicate that factors such as community involvement, organization and administration (including liberal personnel policies, continuing education, and opportunity for growth within an organization), can do much to overcome some of the problems in recruiting and keeping staff members.

F. Center F

Center F is a large, vocationally oriented rehabilitation center in the eastern United States. It, too, is located in an isolated rural setting. This center is housed in what were federal buildings of the army hospital type. However, space and equipment are adequate for the needs of the various areas within the physical medicine department. New buildings have been completed for dormitories; other buildings, to house all other programs of the center, are under construction or planned.

The physical plant has caused many problems in providing a comprehensive rehabilitation service. In fact, an official report of this center written in 1963 had this to say:

> "The facilities had to be used as an expediency; and as a result the program of the center had to be adjusted to the fixed limitations of the building forms. As the program expanded, it became obvious that it would be impossible to provide for truly comprehensive services within the existing structure without defeating the real function of the center.

> "With respect to the acceptance of existing buildings offered to any agency as a basis for starting a rehabilitation center, it is important to point out certain problems which normally arise. The location itself may not be completely satisfactory with respect to the proximity of public transportation. The area of the site may turn out to be inadequate for the ultimate needs of the program and for the buildings necessary for its development. The cost of making major alterations in an existing structure to provide for minimum physical facilities within which to develop a rehabilitation program is usually quite high. Any or all of these factors may force the adoption of compromises in the development of the total program and result in reducing its ultimate effectiveness."

Center F at this time is very much like Center A in size, ownership, staffing pattern and philosophy of rehabilitation. Center F is more isolated by being in a much smaller community and having less public transportation by way of rail, bus and airlines. Center F was opened in 1947 under the limitations of location and physical plant listed above. Center A was opened in 1959 with few limitations imposed by any pre-existing physical facility.

In comparing the physical medicine departments of these two centers, many similarities were noticed and several striking differences were apparent. As has been documented, the physical plant of Center A is quite superior to that in Center F. However, the overall programs of physical restoration are better established and better coordinated in Center F. There are several factors that may account for this:

1. The medical director at Center F is a well-known figure in rehabilitation and has given considerable impetus to various programs; his reputation and that of the center's are linked. In contrast, the medical director at Center A was a general practitioner with limited experience in rehabilitation medicine. The programs were developed

under the direction of the supervisors in the various disciplines with limited communication and coordination of activity.

2. Center F has a position of coordinator-administrator who is responsible to the medical director for coordination of all medical activities including the therapies, prosthetics-orthotics, and the infirmary. Center A has just established such a position, but it doesn't include any official administrative tie-in between the physical medicine department and the other medical services except through the office of medical director, which seems to be too far up the administrative ladder to be as effective as it is in the case of Center F. Also, the Center A medical director is tied up with a multitude of minor administrative details which do not allow for the best or most economical use of his time or skills.
3. Center F is located in a geographic area with no other agency nearby offering services in physical restoration. Center A is located in an area that has at least five other rehabilitation facilities within a 75 mile radius offering physical restoration services. Therefore, there is more competition for cases in Center A than in Center F.
4. Center F has been able to maintain numerous clinical affiliations in several disciplines with nearby universities. Center A has had limited affiliations. Several factors are involved in this, but the casual relationship is not clear.
5. Center F has a more stable, or loyal staff; whether this is due to to the affiliations and their inherent value in recruitment, or whether it's because of the increased challenge of a work situation that includes teaching programs is not known; it is probably a

combination of both factors.

6. Center F has the reputation of providing better physical restoration services than does Center A. But in this author's opinion, this reputation is due more to time in the profession rather than to real program differences.

In summary, when Center F opened in 1947, each rehabilitation program they established was a good program; they have grown and kept abreast of changes and maintained that good reputation. Center A has been plagued with certain problems of an internal political nature that have hampered the growth and reputation of a basically sound physical medicine program.

VI. CONCLUSION

Based on the results of this brief survey of physical medicine departments in either a vocationally or physical restoration oriented setting, the following may be concluded:

1. Nearly all physical medicine departments have staffing problems. That one which does not apparently has solved this problem by establishing a highly professional, training environment, in which the employees have ar. opportunity to learn. Those which do have a staffing problem are either (a) located away from educational opportunities; (b) do not compensate staff for travel to training programs; (c) have not maintained affiliations with universities or other training centers.
2. Quality of service appears to be unrelated to the physical plant, the age of the institution, or the renown of the medical director.
3. Physical medicine departments in urban areas, affiliated with university hospitals and colleges of medicine appear to view the patient as a training medium for students interested in the physical prognosis, to the detriment of the client's vocational goals or objectives.
4. Clear channels of communication will help to inform rehabilitation counselors of the comprehensive nature of vocationally oriented centers, to provide both physical restoration and job training.
5. A wider variety of disabilities may be found in university-related physical medicine departments, thus contributing to a wider learning experience on the part of personnel working in these settings.

6. The problem of aides or assistants is a recurrent one, which becomes more serious depending on the scarcity of professional people in physical medicine departments. Those centers which have a severe professional personnel shortage and who do not have cooperative arrangements with community volunteer agencies are especially concerned about the development of trained aides.
7. Vocationally oriented comprehensive facilities appear to be undergoing a transition from treating physically involved clients to treating clients who need little in the way of restorative physical medicine (like the mentally disturbed and retarded; the public offender; etc.). Adequate planning for adjusting to this current trend (and the future trends it portends) is not being made.
8. At least one center demonstrates that in spite of below average wages, qualified personnel will apply for employment. This is due no doubt to the center's combining an effective professional training program with an effective service program, utilizing the university medical staff and the BVR's service facilities to achieve both a high quality of training and service.
9. There is a critical need for the directors of personnel, or the administrator, or whoever may be the responsible agent, to carefully examine the needs of the staff for benefits which should accompany a professional level job, such as attendance at professional meetings and conventions, time and reimbursement for attending appropriate training sessions, and other types of benefits commensurate with education and level of responsibility.

As a means of ascertaining the advantages and disadvantages of hospital-based physical restoration facilities, the Association of Rehabilitation Centers' "Study of Rehabilitation Facility Organization Patterns" states the following:

> "Increasingly, physical restoration emphasis rehabilitation facilities are being established in hospitals. In a recent survey of 175 members of the Association of Rehabilitation Centers, 62 facilities were identified as units of university medical centers or of large general hospitals. This trend is natural, desirable, and expected to grow rapidly over the next few years. Presence of a rehabilitation facility in a hospital promotes awareness of its value and availability and makes its resources readily available at the onset or at the earliest possible date following the disability. A broad array of essential medical and related services are already available in the hospital.
>
> "At the same time there are disadvantages and potential problems that should be considered and provided for by any hospital considering a rehabilitation unit. The advantages and disadvantages for establishing a rehabilitation unit in general hospitals are listed as follows:

<u>Major Advantages</u>

1. Training of professional personnel
2. Mutual exchange of ideas which stimulates professional growth
3. Provides atmosphere for the team approach
4. Consolidation of physical facilities may reduce cost of operation
5. Service to patients from students under supervision
6. Source of personnel for affiliating centers
7. Encourages recruitment of students
8. When directly affiliated with a medical school, the center may have direct and subtle impact on the teaching curriculum
9. May facilitate earlier development of the total rehabilitation services to the patient
10. Center may release hospital beds designated for acute care
11. Broaden the scope of operation of the center
12. Provides opportunity and material for research

13. Prestige
14. May benefit from special grants and endowments

Major Disadvantages

1. Danger of overemphasis on the physical aspects of disability
2. Acute hospital atmosphere may not be conductive to the philosophy of total rehabilitation
3. May limit expansion of physical plant
4. May increase cost of operation
5. May cause loss of referrals from the physician not affiliated with the hospital
6. May affect the relationship and support of community agencies
7. May affect established endowments, legacies and memorials
8. May be a sacrifice of staff time for teaching purposes
9. Instances may arise where obligations for special services will interfere with a comprehensive rehabilitation program
10. May cause the center to lose its identity as a special facility"

Wherever the physical restoration department is located, it is important to consider how it is to function within the total agency program. If it is to be largely a training facility, their university affiliation is mandatory. If it is removed from the proximity of the university influence, then the personnel who work in it must be provided a means for achieving new knowledge and experiences (through professional meetings and training programs). Finally, if the overall facility is concerned with comprehensive rehabilitation, then the physical medicine department must necessarily compensate for the changing patterns of disability groups which are referred to such facilities, and successfully modify its role from largely a restorative to a maintenance service.

Hopefully, the information contained in this article will assist those responsible for the physical medicine department, or for the entire rehabilitation agency, to better understand and plan for the changes which departments and personnel undergo as a result of the various situations described.