Vocational Rehabilitation—The Culmination of Physical Reconditioning*

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The practice of rehabilitation presumes that the physician’s care does not end with the acute episode in a chronic disease but extends his responsibility to physically rehabilitate the patient to the point of resumption of gainful employment, or in the more seriously afflicted, to self-care. Vocational rehabilitation is the goal and natural end-product of the physical reconditioning effort. This is of course possible only when the patient himself is motivated to such a goal. Generally if he begins with a serious effort at physical reconditioning he has sufficient motivation to carry through also to return to the work force, or to master self-care and associated activities.

VOCATIONAL REHABILITATION—WHEN?

To many the words “vocational rehabilitation” create the image of a seriously disabled person undergoing special job retraining. Physicians are among these people and they often do not see themselves in this picture, but indeed they are and should be. The inaccuracy is that the patient need not be “seriously disabled” and the return to employment need not involve “job retraining.” Every patient who has the diagnosis of symptomatic chronic obstructive pulmonary disease established as the cause of his dyspnea looks to his physician for care not only to alleviate his distress, but to enable him to return to work. This is true whether the symptoms are mild or moderately disabling and the patient still employed, or seriously incapacitating to the point where he has had to cease work. In the former situation, the doctor must employ the appropriate therapeutic means enumerated in the other parts of this supplement to attenuate or abolish symptoms, not as a goal in itself, but as a means of restoring the handicapped individual to his fullest vocational and economic potential, and not allow him to continue the downhill course that carries him into the category of the “seriously disabled” with necessity for job retraining. The
answer as to “when” to start vocational rehabilitation, or the process of retraining the patient to work, is, then, on the patient’s first visit.

**Avenues of Approach to a Return to Work**

In medical treatment each patient must be considered and evaluated individually, and so he must be considered in terms of his work. In appraising the patient, consider the following possible avenues that might be taken for his “vocational rehabilitation.”

1. **Return the patient to the job he is holding.** This is usually most satisfying to the patient and is easily the most economical of time, money, and effort. It is applicable in many situations where the physical requirements of the work are minimal and where the patient is not too advanced in his disease. To accomplish physical rehabilitation per se is often to accomplish vocational rehabilitation simultaneously. An example might be an overweight man who smokes heavily, coughs paroxysmally, and finds he is very short of wind in his job in the packing department and is unable to perform an occasional requirement to load trucks. Two weeks of hospitalization with total abstinence from smoking, daily endurance type of exercising, weight control, education, abolition of bronchial infection, and proper toilette often results in loss of breathlessness, loss of depression, and dedication to the preservation of physical abilities. This type of patient often may resume his job with little or no disability. These people, exuberant at “feeling well again” often become self-dedicated to maintaining their gain. The physician’s positive attitude can initiate this process, and his continuing support on regularly scheduled visits sustain it.

2. **Return the patient to the same occupational field or plant, but in a different job or location** more compatible with his physical abilities or with consideration to preservation of them. Several years ago we treated a draftsman who was mildly dyspneic from emphysema, devoid of any degree of chronic bronchitis, and a nonsmoker who did, however, have considerable bronchospasm that seemingly was connected to fume exposure. Occasionally his drafting office in the manufacturing plant was subject to fumes that caused little distress except to this fume-sensitive individual. Removing him to a second drafting location in the company’s offices several miles away prevented these attacks and the associated loss of work time. Other patients are able to continue employment when changed from an assembly job requiring the fast handling of moderately heavy parts, to inspection, small parts packaging, etc. An industry whose personnel and medical departments are so oriented are prerequisite.

3. **Change the occupational field to a totally different one where the patient, although not presently employed, may utilize previous training or existing skills** already present, but again more suited to his physical limitations or in consideration of preserving them. Consider the meter reader who was an accomplished music student and reverted to giving private piano lessons; the laborer who was a corpsman in the service and turns to the vocation of hospital orderly or physician’s assistant. If a person such as a foundry worker is only mildly dyspneic at work but exposed to fumes, he may best be served by a change to the shipping or other smoke and fume free department.

4. **Job retraining and reemployment.**
   A. On the job.
   B. At a special institute or school (eg electronics, an art institute, or business school).
   C. At a nearby junior college or university.

In this category the use of professional counseling and available state programs is often necessary and should be taken advantage of. The particular location of the patient and physician may predetermine the extent of these services that are available. The particular state of the labor market, even in isolated areas, often may affect certain categories of job retraining.

5. **Entry into a sheltered workshop program.** Often a problem of availability by virtue of residence.

6. **Retraining in daily self-care with an eye to conservation of effort and efficiency of motion.** This is best conducted under the auspices of a trained team as an inpatient as is described by Berzins, but can be attacked by an awareness on the part of the patient instilled by the physician, by alerted and interested relatives, and by motivated nurses and therapists in the general hospital.

**Motivation**

It is obvious that the team approach to these problems is highly desirable, and centers for physical and vocational rehabilitation of the respiratory handicapped must be developed at university medical centers, sanitoria, and private installations. Although many physicians and patients are not now within access of such a unit, awareness and concern on the part of the physician (and employers) and determination and motivation on the part of the patient can achieve a great deal. That motivation goes a long way on both the part of the physician and patient is well illustrated by the case described by Petty and associates of the road inspector who...
worked eight hours a day breathing oxygen by plastic nasal prongs from a tank mounted in his truck. Anyone would surely agree that this man with a VC of 36 percent of expected and MVV of 11 liters could be classified as totally disabled! But he was not, primarily by virtue of his own strong motivation and secondarily by the skilled medical support given him. One suspects that such accomplishments are also in part due to the physician's motivation and dedication to total rehabilitation as well as the patient's determination to remain active and return to work.

All authors in this field would seem to agree that any accomplishment in physical and vocational rehabilitation must be accompanied by the patient’s motivation to do so and is proportional to the degree it is present. In chronic obstructive pulmonary disease it is particularly true as progress is made only by dint of hard work. The point to be made, I think, is that the physician must encourage the patient to progress by an ever present positive attitude that the patient almost always will pick up in transference. This is not directly stated but is evident to the patient in the physician’s compliment on effort put forth, on small gains in ventilatory function, on his expectation of the next goal to be reached, etc. The patient’s disabilities are not dwelt on, but his abilities and potential are.

**Personality Characteristics of the Emphysema Patient**

In regard to the above, what actually is the personality of the patient with chronic obstructive pulmonary disease? In 1968 DeCencio and co-workers published a study on this subject correlating their findings with earlier works. The principal characteristic of these patients that was identified was that of depression. The subjects scored higher in a “neurotic” direction than normal, but preferred fewer neurotic symptoms than those patients with other chronic diseases, such as rheumatoid arthritis, MS, etc. Insecurity, self-depreciation, withdrawal, and preoccupation with somatic processes also were noted. Whether these are characteristics of persons who develop emphysema and/or are smokers, or whether it is a result of the disease is a moot point. Regardless it is this profile which presents itself in these individuals and it is to such a person that the physician must address himself in undertaking rehabilitation of any type. That support, a positive attitude, and cheerful outlook must be maintained is quite evident. This is perhaps possible only for physicians with a particularly optimistic personality.

*See Dr. Kimbel’s article in this supplement.

**A General Approach**

Although speaking of rehabilitation in tuberculosis, the remarks of Oppikofer in the Proceedings of the International Conference on Tuberculosis seem appropriate to this discussion. Paraphrased the eight points he made regarding rehabilitation were:

1. As rehabilitation is a difficult task, advance planning should be considered.
2. Measures of rehabilitation should be undertaken at the earliest stage.
3. Patterns of approach should not be adhered to. Strictly individual methods should be employed.
4. The whole personality of the patient, medical, social, and vocational aspects, must be considered to evaluate the practicability of rehabilitation, other conditions that might be aggravating to it, and the approach to the task.
5. Approach each case from the positive standpoint.
6. Although disabilities cannot be removed, they can be modified and compensated for. Vocational training should not be inferior to that given a normal person, and is presented with firmness and resolution but without sentimentality.
7. Whenever possible the patient should find a job on the free labor market.
8. Where the patient cannot by himself find a position suited to his particular skills (and disability) available employment agencies should be utilized.

**Existing Facilities**

Haas and Cardon have published an outstanding study on the physical/vocational rehabilitation program and its accomplishments at New York University School of Medicine. And, although there are other such fine programs in this country, the emphasis put on the general availability of physical and vocational rehabilitation (and the right to it) overseas seems to be much greater than in the United States. The number of articles reflecting rehabilitation in pulmonary disease from West Germany seems particularly large. Anastasia has reviewed her own observations on such centers in an English language article. This advanced state of rehabilitation overseas would appear to be a result of the socialized approach to medical care, as the author notes “Every industrial concern is required by law to employ a quota of physically handicapped persons; if this quota is not complete, they have to contribute to the social insurance fund.” Such legislation must be not only conducive to hiring retrained individuals, but also in utilizing
on-the-job training programs. The instructors in the vocational training institutes and programs are trained by industry not only in Germany, but other European countries as well. It would seem that with continuation of the growing interest in the physical rehabilitation of the pulmonary handicapped, and development of such programs in an increasing number of university medical centers, that the natural outcome will be the development of vocational programs as the final phase of these ventures. Hopefully these efforts will secure the support of industry, union, and government as a solution to wasted skills, the depression of the unemployed handicapped, and the increasing dollar value of disability payments.

"Practising rehabilitation can be very rewarding. It is best appreciated when one meets an ex-patient at some time after his return to work. When one recalls the first interview, when health had been shattered and recovery was beginning, when morale was low and social and economic standards had been reduced. . . . such a meeting after successful placement brings its own reward."

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REFERENCES

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