FLORIDA STATE UNIVERSITY

A ROLE DESCRIPTION OF THE PROFESSIONAL PEOPLE INVOLVED
IN THE REHABILITATION AND HOSPITAL INDUSTRIES
PROGRAM IN EFFECT AT THE VETERANS
ADMINISTRATION HOSPITAL,
CORAL GABLES,
FLORIDA

By
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CHAPTER I

INTRODUCTION

The focus of this study is the operation of the Rehabilitation and Hospital Industries Program in effect at the Veterans Administration Hospital, Coral Gables, Florida. More specifically, the study will be focused on the inter-related and interacting professional roles of the team members involved in administering the Program. A review of the literature pertaining to the development of the idea of work as a method of therapy in the rehabilitation of the mental patient will be presented. Interviews with the five team members—Physician, Coordinator, Social Worker, Clinical Psychologist, and Counselling Psychologist—who comprise the study group, will be presented and used as a basis of inductive analysis. The professional roles will be described in detail, both self-perceptions and perceptions of other members of the team.

Purpose

The purpose of this study is to describe the roles of the professional people involved in administering the Rehabilitation and Hospital Industries Program and the perception each of these people has regarding the role of
without clearly defined professional boundaries, it is necessary that members of the team know something about the training, activities and frames of reference of each of their colleagues. In order to be effective, a unit cannot be composed only of specialists in their respective disciplines. The specialists themselves must have an awareness of the purpose of the unit and a realization that the patient may best be served through planned multi-discipline integration. Adelaide Johnson states that it is impossible to achieve much for the patients if, within the team, respect and mutual friendliness are lacking.

Recognizing the fact that teamwork necessitates close association among the team members, it follows then that an understanding of role relationships is essential. While some facets of individual roles may overlap, there must be other areas which are clearly assigned to specific disciplines.

Since the Program which is the subject of this study is a relatively new one, there has been no research directly pertaining to it. However, throughout the Veterans Administration there are programs of this kind and, while

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not in the form of research reports, several are described in the agency's publications. One of these is a mimeographed booklet composed of papers presented at a Workshop on Work as a Therapeutic Agent at the Veterans Administration Hospital, Bedford, Massachusetts, April 24-25, 1958. This collection refers to various aspects of similar programs in Veterans Administration hospitals in other areas of the country. In these papers, mention is made of various activities carried on by the programs and also of the activities of the professional people who are in administrative positions. This material concerning the roles is rather sketchy and role relationships as such are not described.

The topic for this study was chosen during a second year field work placement in the Veterans Administration Hospital, Coral Gables, Florida, and was selected primarily for its value as an educational venture. The interest in the broad aspects of this problem arose from a desire to add to the writer's own ability to make use of a team in a hospital setting. It was hoped that such a study would impart a wider knowledge and deeper understanding of the roles played by the members of a specific team. The specific team was selected when the growing pains of the team administering the Rehabilitation and Hospital Industries Program was brought to the attention of the writer. At that time it was pointed out that social workers, through their understanding of relationships, should aid in establishing
administrative relationships as well as patient relationships. Jahoda says, "The facts found in descriptive studies can serve as a measuring rod against which the effectiveness of social action may be evaluated".¹ It is hoped that this study will enable the hospital administrative staff, and more particularly the subject team, to envisage and better understand the present role relationships of the team designated to administer the Program. If this objective is achieved, the agency will have a factual basis by which to evaluate the operation of the team.

After an initial review of the problems of the team and the formulation of tentative ideas for this study, three basic assumptions evolved. These are:

1. There is a system in the functioning of the Program.

2. Each professional person involved in administering the Program has a perception of his role as it relates to the Program.

3. Each of these people can communicate a perception of the roles played by his colleagues.

From these assumptions came two basic questions:

1. How does each of the professional people involved in the administration of the Program see his role in the clinical team?

2. How do each of these people see the roles of the other team members?

It was expected that the answers to these questions would be revealed in compiling and analyzing the data.

¹Jahoda, Deutsh, and Cook, p. 58.
Method and Procedures

It has been said that the object of this study is to describe the professional roles of the team designated to administer the Program. With regard to this Jahoda says,

Although any typology of research is inevitably arbitrary, it nevertheless seems possible to classify an investigation crudely in terms of its major intent: (2) as a descriptive or diagnostic study when it has the function of assessing the characteristics of a given situation. . . .

In this light, then, this paper can be called a descriptive study inasmuch as it has the function of assessing the characteristics of a given situation, i.e. the perception each member of the team has regarding his own role as well as the roles of each of his colleagues.

In collecting evidence for a study of this sort what is needed is not so much flexibility as a clear formulation of what and who is to be measured and techniques for accomplishing a valid, reliable, and precise measurement.

"Who" in this instance refers to the members of the Rehabilitation and Hospital Industries team. This team consists of a Physician, appointed head of the team in October, 1958, who is Chief of the Physical Medicine and Rehabilitation Service in the hospital; the Social Worker; the Clinical Psychologist; the Counselling Psychologist; and the Physical Medicine and Rehabilitation Service Coordinator. "What" can

1Ibid., p. 28.

2Ibid., p. 30.
be used to signify the Program and its administration in general.

G. W. Allport once said, "If we want to know how people feel: what they experience and what they remember, what their emotions and motives are like, and the reasons for acting as they do—why not ask them?"¹ In collecting the data for this study, the people were asked. The primary source used was the structured interview. This method was chosen for several reasons, one of which was expressed by E. S. Bogardus:

> Until intimate human attitudes and values are brought to light, no social situation is understood. Attitudes and changes in them may best be secured by the personal interview.²

The responses from these interviews were recorded and notes were taken on impressions. In presenting the data, excerpts from these interviews are used in narrative form and results are shown in tables. From each of these tables, an index is derived which gives an indication of the agreement and disagreement in role perceptions.

In the interview, a skilled investigator has a flexible opportunity to solicit information through questions; in addition, he has the opportunity both to observe the subject as he responds to questions and to observe the

¹Quoted by Jahoda, Deutsch, and Cook, p. 152.
total situation to which the subject is responding.  

Along these same lines, Pauline V. Young states:

The personal interview, when properly conducted is penetrating—it goes to the living source. It makes it possible to go behind mere outward behavior and phenomena. It enables us to study motivations, emotional responses, and social processes as they are reflected in personal experiences and social attitudes. It aids us in checking inferences and external observations by a vital personal account. 

The flexibility of an interview as a research tool is one of its outstanding values. Another point in its favor is that, as mentioned above, the interviewer has the opportunity to observe the respondent as the questions are posed and answered.

It is generally conceded that perhaps the most significant limitation of the use of the interview for research purposes is that the investigator must of necessity rely totally on the memory, retention, and interpretation of the interviewee.

Memory and retention are highly selective processes: the most recent, or the most intense, or the most frequently encountered phenomena are best remembered or retained. . . .

However, in the interviewing for this study, these factors proved to be more nearly assets than limitations inasmuch as the interviewees were in daily contact with the problem and

1Jahoda, Deutsch, and Cook, p. 155.
2Young, p. 245.
3Ibid., p. 245.
were intensely involved in it. Therefore, this adds to the validity of the interviews presented in this study.

This Chapter has presented the problem which is the basis of this study. The need for a study of this nature has been shown, including the use to which it may be put upon completion. Included also was the method by which the data were collected and how they are to be presented.

Chapter II presents a history of work as a therapeutic agent. This includes early records of the use of work as a method of patient care, the rapid development of rehabilitation consciousness during and after World War II, and medical rehabilitation in the Veterans Administration. The development of the Rehabilitation and Hospital Industries Program at the Veterans Administration Hospital, Coral Gables, Florida, will be described in Chapter III, which also includes the setting itself. In addition to the development of the Program, some concepts of roles and teams will be discussed. The data are presented and discussed in Chapter IV. Chapter V comprises the findings and implications as derived from the presentation in Chapter IV.
CHAPTER II

BACKGROUND OF WORK AS A THERAPEUTIC AGENT

Work therapy has been defined as "any work or recreational activity, mental or physical, definitely prescribed and guided, for the distinct purpose of contributing to and hastening recovery from disease and injury," and consists of jobs selected and prescribed for each individual patient with his or her particular needs in view.¹ This was devised as a special form of treatment to aid in hastening recovery in patients suffering from physical, surgical, and mental disorders. Work therapy is only a link in the chain of general therapy and its aim is to help in the psychological, physical, social, and economical rehabilitation of the patient.

Early Records

It has been the premise of some that work as a therapeutic agent began in the Garden of Eden when God sent Adam forth to till the soil, but others have maintained that Adam would have recovered from the depression caused by his

eviction from an easy life by other means, and that the objective was punitive rather than therapeutic.¹ Looking again at the Bible, it is found in a later period that David played his harp to dispel the "black" mood of King Saul, which has been labeled a passive form of treatment. However, for more concrete records of work as therapy, we must move still forward to another period of history—the period concerning the Egyptians.

Ancient records are evidence that the idea—occupation or diversion of some kind is beneficial to the sick—is one which appears frequently throughout the history of medicine. About 2,000 B. C., the Egyptians dedicated temples where "melancholias resorted in great numbers in quest of relief." Games and recreations were instituted in the temples and all the patient's time "was taken up by some pleasurable occupation." About 30 B. C., we find Seneca recommending employment for any kind of mental agitation. In A. D. 182, Galen, the Greek physician, wrote "employment is nature's best physician and is essential to human happiness."² In the Middle Ages, in communities such as convents and other refuges established by religious orders, it is probable that the occupations necessitated by such


²Haworth and Macdonald, p. 3.
communal living may have brought solace to the entrants into such places and they gained a happier and more contented or philosophic viewpoint toward the troubles which had caused them to seek sanctuary.¹

**Evolution Toward Modernity**

With the establishment of hospitals and sanitariums for mental patients centuries later, the employment moved from diversional to more practical occupations. From the beginning of the nineteenth century, work was recognized for its curative effect and patients took an active part in the various industrial activities of each hospital. Still the work attached to these various activities was not planned on a definite therapeutic basis and could only be described as "industrial occupations." Too often, perhaps, these included work utilitarian to the hospital and it is probable that economic factors determined the placement of a patient in the laundry or kitchen, or at farm work, rather than the idea that by such work or occupation the patient might benefit. The primary therapeutic purpose became submerged by the more attractive economic aspect and the affected patients were considered largely in terms of the reduction of hospital costs. In justification, it should be remembered that hospitals for mental patients and almshouses were considered to be an enlargement of the idea of the family

¹Dunton and Licht, p. 3.
unit, each member of which, if physically able, should contribute some service to the general welfare. 1

Mention should be made that prior to the eighteenth century, sufferers from mental disease were treated as outcasts. Insanity was regarded as a punishment, a visitation from God. Those affected were deemed the victims of demoniacal possession and exorcism was rampant as the sole form of treatment. No special provision was made for proper segregation and generally those unmanageable were confined to prisons, chained and manacled, and often cruelly and barbarously treated. This was the degraded position of the insane which Pinel in France, Reil in Germany, and William Tuke in England, devoted most of their time to reform. The chains and manacles were dispensed with and special institutions of the insane were established. 2

During the latter half of the eighteenth and beginning of the nineteenth centuries we have records of work being used as a form of treatment in Italy, France, Spain, America, and England. In Italy at Aversa, it was found that "moderate work combined with amusement" provided the best means of cure and patients were employed in printing, translating, music, husbandry and in manufacturing woolen cloth; in France at Asile de Bicetre where, according to Pinel, 1791, an atmosphere

1Ibid.

of silence and tranquillity prevailed as a consequence of the patients being supplied with employment by the tradesmen of Paris.\(^1\)

William Tuke, in 1792, founded the first "asylum" in England, known as The Retreat near York and it is still so named. A book, written in 1813, by Samuel Tuke, a grandson of the founder, entitled a Description of the Retreat, expounded the principles of treatment adopted in this York Hospital, giving due prominence to the curative side of occupations: It is noteworthy that, with the introduction of such humane reforms in all countries, work and occupation were mentioned prominently as therapeutic aids.\(^2\)

The American psychiatrist, Dr. Benjamin Rush, recommended many homely tasks for their therapeutic effects. Sewing rooms and shops for wood work were established early in the nineteenth century.\(^3\) In 1798 Dr. Rush in a mental hospital in Philadelphia prescribed "spinning, sewing, and churning" for his women patients, "grinding corn, gardening, and cutting corn" for the men. From the correspondence of Samuel Tuke, a physician at the York Retreat, with the founders of a hospital for the insane in New York in 1815, we learn that one of the leading features of the hospital

\(^1\)Haworth and Macdonald, p. 3.

\(^2\)O'Sullivan, p. 6.

\(^3\)Dunton and Licht, p. 3.
was to be the introduction of employment for the patients and reference is made to a hospital in Spain (also mentioned by Pinel) receiving patients of all ranks, where the recovery rate was much higher among the lower classes who were employed in the work of the hospital than among the idle grandees.

Older psychiatrists can recall that frequently patients showed such a strong desire for occupation that they set tasks for themselves rather than be content to sit idle and vegetate as was too often the habit of their associates. Instances are recorded of women patients who unravelled out their stockings in order to obtain thread with which to knit, using straight hair pins of an old fashioned type for needles.¹

**Development During World War II**

World War II provided a tremendous impetus to the movement toward rehabilitation. In 1943 the Baruch Committee on Physical Medicine was established as an aid to the advancement of the science of physical medicine. Under the leadership of Dr. Howard A. Rusk and Dr. Henry H. Kessler, programs of physical medicine and rehabilitation were developed in the hospitals of the military establishments for severely

¹Ibid.
injured members of the armed forces. ¹

During the critical period of the early war years, it became obvious that, with the thousands of men lying in military hospitals, some action would be necessary to restore these patients to physical fitness and to shorten their period of convalescence as soon as possible. Col. Howard A. Rusk, then stationed at Jefferson Barracks Air Force Hospital in Missouri, instituted a program in an effort to accomplish this. He began, as soon as his patient's temperature was down or 24 hours after surgery, graduated exercises for the patients and brought a military training program to the hospital wards. This later became known as the Air Force Convalescent Training Program. As soon as the soldier's acute illness was over, he was transferred to a convalescent ward where he began the prescribed exercises and military education classes. The intensity of the Program was increased as fast as possible until the patient was ready to be discharged to full duty. ²

This program was soon adopted by the military and was utilized throughout the expanse of American Army, Navy, and Air Force hospitals.


²Ibid., p. 27.
Medical Rehabilitation in the Veterans Administration

The Veterans Administration medical care program began a new program of medical rehabilitation in January of 1946. Prior to that time, the activities of the Physical Medicine and Rehabilitation Service in Veterans Administration hospitals were confined largely to occupational and physical therapy. In a few hospitals, such programs were adequate, but in many cases occupational therapy was conducted for the benefit of the hospital rather than the patient. Men shoveled coal, cut grass, and repaired furniture for the hospital and even the homes of the hospital staff members. This was known as "work therapy", but the primary emphasis seemed to be on the work without much regard to the therapy.¹

Shortly after the end of the war, tens of thousands of soldiers from the services were being discharged to Veterans Administration hospitals. A tremendous expansion program was put into effect under the responsibility of General Omar N. Bradley and Major General Paul E. Hawley. General Hawley ordered that every injured veteran should have the advantage of a complete psychological, physiological, social, and economic program, and that it must start in the hospital. Thus, the Physical Medicine and Rehabilitation Service was established and carried out a program in every

hospital in the Veterans Administration.¹

Under the direction of Dr. Donald A. Covault and his successors, Dr. A. Ray Dawson and Dr. A. B. C. Knudson, the Veterans Administration medical rehabilitation program was broadened to include more physical and occupational therapy, corrective therapy, educational therapy, and manual arts therapy, and special programs for patients with spinal cord injuries, the blind, the tuberculous and those with hearing difficulties.

Up until the time of the inauguration of the medical rehabilitation program, the majority of all educational and vocational rehabilitation activities of the Veterans Administration had been limited to those with service-incurred or service-aggravated disabilities. When a veteran entered the hospital, his treatment was confined to medical care alone. After he was discharged, he could, if eligible, participate in the vocational rehabilitation program. But from the date he entered the hospital until the time of his discharge, his period of convalescence was dead space as far as educational or other training was concerned.² At the present time, rehabilitation is conceived of as beginning when the patient enters the hospital. "Work as a therapeutic agent is

²Rusk and Taylor, p. 36.
prescribed as indicated when the patient is acutely ill and continues to be a therapeutic agent as the patient improves and comes closer to leaving the hospital.\textsuperscript{1}

In a program geared to meet the needs of the whole man, the social, vocational, and educational problems receive concomitant attention with the medical needs of the patient. Medical planners in the Veterans Administration have recognized that the great majority of patients have psychological, personal, and family problems which need to be resolved as well as their medical or surgical problems.\textsuperscript{2}

The Veterans Administration has proven that rehabilitation is not only right from the humanitarian standpoint, but it is also medically and economically sound. Not only have thousands of veterans been able to leave the hospital earlier, but also they have certain knowledge that they will be able to go back to a job or to a vocational training school which would enable them to accept and hold a job. Millions of man-hours have been saved as well as millions of tax-payers' dollars.\textsuperscript{3}

\textsuperscript{1}U. S. Veterans Administration Hospital, Bedford, Massachusetts, "Area Medical Conference; Papers and Summaries of Workshops on Work as a Therapeutic Agent," April 24-25, 1958, p. 19.

\textsuperscript{2}Rusk and Taylor, p. 36.

\textsuperscript{3}U. S. Department of Health, Education, and Welfare, p. 28.
The contents of this Chapter have been focused on the history and development of work used as a therapeutic agent. This was done in an effort to acquaint the reader with the vast strides in the direction of the therapeutic use of this tool, but at the same time to point out the reality that as yet the method is not so firmly esconced as to preclude further steps toward its greater utilization to a more beneficial end. It should be noted that, for the most part, the Veterans Administration has been foremost in developing physical medicine and rehabilitation services. However, even in extensive program planning such as that of the Veterans Administration, there are individual differences.

Chapter III presents a brief description of the efforts of one Veterans Administration Hospital in seeking to utilize effectively the method of work as a curative agent. Encompassed also in this Chapter is a review of various concepts of team and role relationships as related to a functioning, multi-disciplinary team. It is hoped that, by recounting some of these ideas, an understanding will be gained into the basic dynamics which are revealed in the presentation of the primary data.
CHAPTER III

FORMULATION OF FOCUS

It has been brought out in Chapters I and II that the use of work as a method of patient care in psychiatric hospitals is of long duration. For many years, it was used for the good of the hospital. Although the patient was often exploited to facilitate the operation of the hospital, the benefit of work activity to the patient did not remain unrecognized.

During World War II, there was a tremendous upsurge of thinking concerning rehabilitation theories. Out of this came the gravitation of General Medicine and Surgery hospitals toward the idea of using hospital industries to meet two specific needs of their patients. The first of these needs was the therapeutic need, and the second was to maintain or prepare patients for vocational or economic independence after discharge from the hospital.

Setting

The setting of this study is the Veterans Administration Hospital, Coral Gables, Florida. The building was originally the Biltmore Hotel, having been built in the mid-twenties, and was used by the U. S. Army Air Corps
during World War II as a hospital. Later it was used as an Army General Hospital. In July of 1947, the building was turned over to the Veterans Administration and designated for use as a General Medicine and Surgery hospital.

The Beginning Phase of the Program

Occasionally since the existence of the Veterans Administration Hospital at Coral Gables, Florida, patients have offered their services in a voluntary capacity for various types of work. This was not requested of, nor indeed even suggested to, the patients, but came about as a result of the patients' own boredom from lack of activity. The work done by these patients consisted mainly of ward work—feeding other patients, changing water pitchers, and other such duties—under the direction of ward personnel. It was a non-organized program; there was little if any direction in it.¹

With the arrival of a Counselling Psychologist, the move toward an organized program for the psychological rehabilitation of patients began. This program grew out of the need for some kind of constructive activity for patients, particularly those on the psychiatric and tuberculosis wards. At that time, no member of the staff had had any previous experience in a program of this kind and they found a dearth

¹Interview with Charles A. Stenger, Ph. D., Chief, Clinical Psychology, October 31, 1958.
of literature concerning the development of such a program.\(^1\)

In the fall of 1957, one of the group therapy sessions for neuro-psychiatric patients was used in a hospital project involving care of the hospital grounds. In October of the same year, a radio station called to ask if some of the patients could help them by copying schedules and timetables. The tuberculosis patients were chosen for this and were paid at the rate of $1.25 per hour.\(^2\) The results from this project evidenced the fact that while work in itself was a good activity, reward (in this case, salary) was an added incentive.

The hospital Occupational Therapy program collapsed in January of 1958, leaving the patients with no activity at all.\(^3\) This resulted in more disturbance on the neuro-psychiatric ward and generalized restlessness on the medical and surgical wards. By March of that year, it became apparent that constructive activity for the patients was needed, preferably in the form of work, since it seemed that the patients were more at ease and felt better when doing something for someone else rather than themselves. March 14, 1958 marked the first planned group, consisting of eleven psychiatric patients, being taken off the ward for work.\(^3\)

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\(^{1}\)Ibid.

\(^{2}\)Interview with Mabel Gibby, Ph. D., Counselling Psychologist, November 12, 1958.

\(^{3}\)Ibid.
In a report compiled by Dr. Charles A. Stenger, Chief Clinical Psychologist, it was pointed out that the goal of the Program is the psychological rehabilitation of patients through constructive work activities. He states that almost every type of work activity "from unskilled labor to technical skills, from clerical to the trades, is done by the 'rehab' patients." This report was written August 15, 1958, at which time the pilot program had been in operation for five months. Approximately 100 patients, coming from all wards of the hospital, had participated in the beginning phase of the Program.

Two months later, on October 7, 1958, a memorandum was issued by the Manager of the hospital which formally established the Program as an activity of the hospital. It is notable that, in this memorandum, the Chief, Physical Medicine and Rehabilitation Service, was designated with the responsibility for conducting the Program. Historically, such programs have been the responsibility of said service. Prior to this time, the Program was conducted by the Chief

1Appendix B.
2Ibid.
3Appendix C.
Clinical Psychologist, with the assistance of the Counselling Psychologist.

When the memorandum was issued, a new hierarchy was established in administering the Program. Whereas the Chief Clinical Psychologist had served as its administrator since its inception, the new policy stated that the Physician who is Chief of the Physical Medicine and Rehabilitation Service would be the new captain. This is in accordance with some views expressed at the Area Conference on Work as a Therapeutic Agent. Dr. Delilah Riemer stated at that time, "... [Work] is a medically prescribed activity under the supervision of a physician." This is further validated by a statement by Dr. Francis B. Carroll, who said, "It is important that in outlining therapy, the physician be the Captain of the team, and that there be complete understanding and cooperation of all other disciplines. ..."

In an effort to achieve understanding, and thus more meaningful cooperation, in a teamwork relationship, it will be necessary to look at some concepts regarding teams, including roles of team members and factors which prevent, as well as those which contribute to, good teamwork.

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1U. S. Veterans Administration Hospital, Bedford, Massachusetts.

2Ibid., p. 19.

3Ibid., p. 7.
The Rehabilitation Team

There have been a great many changes during the years subsequent to World War II in rehabilitation as has been mentioned. There will be more in the field as it comes out of its growing pains and trudges toward maturity. Much of the evolving terminology is nebulous and connotations vary in great measure among individuals. For purposes of this study, some concepts of "role" and "team" are discussed to lend clarity to the presentation and analysis of the data.

With regard to role, Jessie Bernard has said, "The essential thing about a role . . . is that it cannot be performed alone. It must always have a counterpart."¹ In applying this to the team under consideration in this study, it follows then that each of the professional people comprising the team holds a complementary position with respect to each other. Along with this, he also has a responsibility to his colleagues to utilize himself to the best of his ability as a team member. "Teamwork is not a collection of opinions from professional consultants, each considering the client from his own viewpoint in a static fashion with a master arranger combining these viewpoints into a decision,"² but


² Frederick A. Whitehouse, "Teamwork—a Democracy of Professions," Exceptional Children, XVIII, No. 2 (November, 1951), 46.
should employ every principle of democracy. A team should function as a close union devoted to a common purpose—that of the best treatment for each patient.

Administration in a team should be democratic to allow interplay among the disciplines toward developing treatment. Kessler points out that a team "is chiefly a working method for hospitals willing to pool a variety of skills instead of applying them sketchily, competitively, or parochially."\(^1\) In order for the skills to be pooled effectively, freedom within the setting is essential.

Whitehouse refers to administration in a team, and the team itself, as "an organismic group distinct in its parts, yet acting as a unit, i.e., no important action is taken by members of one profession without the consent of the group."\(^2\)

In a multi-disciplinary teamwork setting, the need is outstanding for each profession to recognize and understand its own scope, including its limitations. Certainly there will be some overlapping of roles, but some definitive structure should be developed to insure the utmost efficacy in function. Once these boundaries are set up, respect for them can, and should, be maintained intra-professionally as well as inter-professionally. "Cooperation lies as much in respecting the boundaries of one's own profession as in

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integrating action with the total plan and the plans of
coworkers.\textsuperscript{1} It is enough to expect one professional
person to know his own field and to practice it successfully.
He need not endeavor to partake of the dubious merits of
knowing and practicing another profession as well.

Some of the characteristics of a good team have
been summed up by Whitehouse\textsuperscript{2} as:

- freedom of discussion
- consensuality of its decisions
- good personal relations between members
- respect for opinions and sufficient accommodation
  for minor differences
- flexible and dynamic planning
- careful selection and stability in its membership
- the life term architecture of its projection\textsuperscript{3}

When a team cannot function as a unit, when it
resembles a dictatorship rather than a democracy, then it
is not operating to the best interests of the patient. In
all new teams, there is bound to be a certain element of
malfunctioning; this can be due to many causal factors.
One such reason can be attributed to role confusion.

\textsuperscript{1}Ibid., p. 51.

\textsuperscript{2}Frederick A. Whitehouse, "Teamwork: Some Questions
  and Problems," Paper read before the National Conference on

\textsuperscript{3}Ibid.
Bernard states, concerning this, that it is safe to assume that the people involved in the team are competent, willing, and able to perform roles adequately, and that the problem arises when there is confusion in the role structure of society. ¹ It is understandable that young teams, especially, are susceptible to this malady. From this point of view, such a team can be likened to a young child in that there is, hopefully, a constant struggle toward self-identification and find a place in the imbrolio of the world.

In addition to the problem mentioned above, there are other factors which prevent good teamwork. Some of these are:

1. Professional people are not necessarily cooperative people.

2. Previous experience may have been professionally isolated.

3. Theorists in all professions who have not had the responsibility of dealing with a real case in years tend to chase unreal goals, or to solve problems intellectually.

4. Long education in a profession breeds a conscious or unconscious assumption that treatment is centered about that profession. ²

There are many problems yet to be solved in order for teamwork to materialize in the way that it can be of most value to rehabilitation patients. Whitehouse has

¹Bernard, p. 47.

²Whitehouse, *Exceptional Children*, XVIII, No. 2, 47.
enumerated four significant changes which he believes must take place in the general outlook of professional disciplines in order for the concept of teamwork to become a working reality:

1. A more enlightened approach to all professional education to synthesize our knowledge rather than to create new specialties, a combination of training to eliminate the repetitions and less necessary materials, substitution of more integrating principles, the re-thinking of fundamental aims and purposes, and clearer philosophy and refocusing of objectives.

2. Actual teaching of methods and provision of opportunity for students to practice inter-professional as well as intra-professional cooperation, and understanding of the importance of other disciplines.

3. Exploration and research on the process of multi-professional dealings.

4. Emphasis on working cooperatively with others from grade school on.¹

It is well known and accepted in rehabilitation circles that to rehabilitate a person necessitates viewing the individual as a whole. It cannot be done successfully by treating only one aspect; it must comprise the whole man--his physical, social, psychological, and economic situations.

We now realize that the way to solve human problems is comprehensively. The moment of contact with any professional treatment must spark an attempt to solve the problem as fully, and as fundamentally as possible, with a life-time dimension. The individual who requires attention must not be left to prolong and aggravate his condition as he wanders through his community in the wilderness of uncorrelated treatment paths. It is only by a definitive and fundamental method that this situation may be remedied. We need a comprehensive effort because pennies spent early will avoid dollars spent

¹Ibid., p. 51.
later: We need a comprehensive approach because every human being in a democracy has the right to achieve his fulfillment regardless of his level of contribution. We may approach this ideal through as high a level of team operation as we can bring to bear.

"The rehabilitation team is a device for aiding the patient to find a safer way of life than he had previously discovered."² By viewing and treating a patient as a whole, this can be accomplished. In order for a patient to be viewed and treated as a complete person, a team must function as a unit in which friendly relations and professional respect are paramount.

This Chapter has been directed toward prefacing Chapter IV which presents the primary data:² It has pointed out the need for a program of activity for patients at the Veterans Administration Hospital, Coral Gables, Florida, and briefly discussed the beginning phases of the Program on which this study is focused. Reference was made to a report which was compiled regarding the first five months of the Program's operation. In addition, a memorandum was mentioned which officially established the Rehabilitation and Hospital Industries Program as an activity of the hospital.

The subsequent section dealt with some concepts of role as applied within a teamwork setting and teams in general. The latter concerned itself with characteristics

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¹Whitehouse, Paper read before the National Conference on Social Welfare, p. 5.

²Kessler, p. 399.
of a good team, some factors which preclude teams from operating most effectively, and some suggestions for changes in attitude which might serve to alleviate problems.

Chapter IV will present the primary data, i.e., interviews with the five members comprising the team which is being studied. This is done primarily by using excerpts from these interviews and discussing them. Some impressions noted during the interviews are expressed, along with some illustrative tables and an index derived from each.
CHAPTER IV

PRESENTATION OF DATA

Chapter III brought the focus of the previous material from a wide, general discussion of work as a method of therapy to the narrower view of a team endeavoring to utilize this method. It also encompassed a minimal discussion of characteristics of good teamwork and factors which serve to negate the effectiveness of a good team.

The data to be presented in this Chapter will consist of interviews with five members of a team which is trying to mobilize itself into a good working unit. The members of this team consist of five professional people. These people are as follow, listed in the order that their individual interview appears: Physician, Coordinator, Social Worker, Clinical Psychologist, and Counselling Psychologist. As was pointed out earlier, there is no social worker for the Program at this time. Therefore, the Chief of the Hospital Social Work Service was interviewed for the purposes of this study.

1Appendix A.
The interviews were held during a three month period from September to December, 1958. These interviews are used in excerpt form along with the inclusion of impressions noted during the course of each interview. The focal concern of these interviews was perceptions of role in the team, both self-perception and perceptions of the other team members. This was chosen in an effort to determine whether there is role confusion in the team. Each of the five tables presented in this Chapter are used to illustrate graphically these perceptions. Each one has as a title a particular professional figure. The tabular description shows both self-perceptions and perceptions of others of a single discipline. An index to indicate agreement and disagreement in role perceptions is derived from each table.

**Physician**

This section of Chapter IV deals with the role of the Physician. It first points out how he sees himself as a functioning member of the team, then the way his role is perceived by each of his colleagues.

As was mentioned in Chapter III, the Physician, by policy prescription, is Chief of the Physical Medicine and Rehabilitation Service. Thus, this role in the team is filled by an occupant whose other role qualifications specify a notable degree of training and experience in rehabilitation. However, his experience in a teamwork relationship of this kind is limited. It will be remembered that he was officially
named to head the Program in October of 1958, seven months after the inception of the Program.

In explaining his role as he perceives it relative to the team, the Physician said:

I will be responsible for the medical segment of patient care and general supervision of the patients and of the Program as a whole. With a full-time Counselling Psychologist and the Coordinator, I feel that I need only be consulted when medical problems arise. I intend to make rounds on the rehabilitation ward every morning and keep check on the patients on that ward. The patients who participate in the Program but are not on the rehabilitation ward are the responsibility of their respective ward physicians, except for the time they are on their prescribed job. This definitely applies to psychiatric patients: I will not accept the responsibility for the patients from the locked ward except while they are working. I am not a psychiatrist and am not qualified to treat psychotic patients. However, I do have responsibility for all patients who are transferred to the rehabilitation ward. This includes the psychiatric as well as the medical and surgical patients.

In addition to these duties, I conduct the Evaluation Board, which is a board made up of various people who have had contact with a particular patient. The purpose of this board is to decide if a patient is eligible for transfer to the rehabilitation ward.

During the interview with the Physician, he demonstrated a very positive attitude toward the Program itself and toward its goals. He apparently feels that the ultimate result will be of great benefit to the veteran participating in the Program; and with this in mind, will go to great lengths in an effort to perfect it.

He was most emphatic in stating that he would not accept responsibility for those participating patients from the locked ward. He evidenced a great deal of feeling in this area.
The Coordinator expressed his perception of the role of the Physician in the following statement.

The Physician is the supervisor of the Program. He handles overall administration, makes major decisions, makes general Program plans with me, and conducts the Evaluation Board. He has responsibility for the Program.

The attitude of the Coordinator toward the role of the Physician seemed to be very good. He evidenced much respect and warmth while discussing this role.

It is felt by the Social Worker that the chief function of the Physician lies within administrative lines. His primary responsibility is the overall supervision of the Program. She sees his part in the Evaluation Board as an important facet of his duties. With regard to his medical responsibility:

He has full medical jurisdiction over the patients on the rehabilitation ward. This responsibility also carries over to the participating patients while they are carrying out the job prescription; He also acts as an interpreter of the Program to the other doctors.

The Clinical Psychologist has stated his views concerning the Physician's role as:

... primarily a medical position. He answers responsibility for the patients on the rehabilitation ward, makes rounds, prescribes medication, etc. He conducts the Evaluation Board to select patients who are eligible for transfer to the rehabilitation ward. He has recently been assigned total responsibility for the Program.

The Clinical Psychologist tends to minimize the role of the Physician as a member of the Hospital Industries team, but at the same time seems to recognize the need for a medical role in the administration of the Program.
The Counselling Psychologist was much more verbal in expressing her feelings and views concerning the role of the Physician.

The Program is technically under the jurisdiction of the Physician. However, his assistance is limited to giving medical coverage on the rehabilitation ward. He in no way helps in identifying, evaluating, or securing jobs for patients on other wards. He apparently gives no services to patients other than those on the "rehab" ward. He provides little help in determining work tolerance of the patients; this continues to be done by the ward physicians.

It was obvious during the interview that the Counselling Psychologist has strong negative feelings regarding the role of the Physician in the Program. She seemed to feel that he had accepted the authority that goes with his new position, but not the added responsibilities.

Table 1 illustrates a summation of the perceptions as presented in this section. Various facets of the Physician's perceived role were taken from the interviews and listed. These are checked according to the ideas held by the various professional people. From this, an index was derived which indicates the agreement and disagreement in role perceptions as applied to the role of the Physician.
TABLE 1

PERCEPTIONS OF THE ROLE OF THE PHYSICIAN

<table>
<thead>
<tr>
<th>Role Prescriptions</th>
<th>Self</th>
<th>Coord.*</th>
<th>S.W.*</th>
<th>Cl.P*</th>
<th>G.P*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Supervision of Program</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Medical care of rehabilitation</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility for rehabilitation</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision of rehabilitation</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program planning</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Conduct Evaluation Board</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Interpreter of Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>27</td>
</tr>
</tbody>
</table>

*The following abbreviations will be used throughout this Chapter in presentation of the tables: Phy., Physician; Coord., Coordinator; S.W., Social Worker; Cl.P., Clinical Psychologist; C.P., Counselling Psychologist.

Table 1 shows that the Physician sees his role as active in all areas except that of interpreter. It is interesting to note that only the Social Worker saw him in
this role. Further, the opinion of the Coordinator almost parallels that of the Physician himself. This would tend to indicate that there is a good measure of understanding between the two. Another near parallel is shown in the concepts evidenced by the two Psychologists. It is notable that both of them see the Physician in an almost exclusively medical role. Both of them stated that he held the position of administrator, yet neither allowed themselves to go further in this statement. The Social Worker seems to be taking the middle ground between these two opposing fronts.

The total shown in Table 1 indicates that, out of a possible 40 areas of agreement, 27 are marked. This gives an index of .675. As was previously noted, the Social Worker was the only interviewee who saw the Physician in the role of interpreter. If this impression is eliminated, then the agreement is 26 out of a possible 35, or approximately .743.

Coordinator

The Physical Medicine and Rehabilitation Coordinator is an assistant to the Chief of that service. It was stated in the aforementioned hospital memorandum that:

The Coordinator, PM&R, will assist the Chief, PM&R, by coordinating the efforts of the Hospital Industry team and by providing administrative supervision of the Program.

1Appendix B.
When interviewed, the Coordinator stated that his role is rather difficult to define inasmuch as his duties are diversified and constantly change from day to day. He sees himself primarily as an assistant to the Physician.

I handle the action phase of the Program. The Physician and I make plans, I execute them. I feel it is my responsibility to see that the Program runs smoothly and efficiently. As an example, I have ordered lockers for the use of the patients on the rehabilitation ward. All participating patients are soon to have uniforms. Another example is that I have had card racks made to hold a card on each patient in the Program. These cards will show at a glance such things as the patient's name, his diagnosis, the date he entered the Program, the kind of work he is doing, and his time schedule. In short, the cards will carry an overall picture of each patient. There is a set of these cards in my office and in the office of the Counselling Psychologist. I also assist with the Evaluation Board.

The position of the Coordinator is a unique one. The policy statement that formally articulates the role of the position does not specify that the Coordinator will represent a defined discipline as in the case for other team members. The central element in this role is responsibility for the effective operation of the team itself. Thus this position is defined so that the Coordinator carries responsibility for an enabling function in relation to the team. An example of this is indicated above in his statement concerning the card racks. Such an innovation will enable any member of the team to know the whereabouts of a patient at any given time. As such, it represents administrative control.

1 Appendix A.
The Physician stated that he sees the Coordinator as an executor of the Program plans. He feels that the Coordinator relieves him of much of the administrative details of the Program. He stated that "I have utmost confidence in his ability and feel that I can depend on his carrying out any and all of my administrative decisions. He carries responsibility for many of the details of the Evaluation Board." He also indicated that the role of the Coordinator is an essential one in a Program of this kind.

The Social Worker views the Coordinator in much the same way as the Physician does. She sees him as primarily an assistant to the Physician, whose duties are widely diversified and therefore difficult to define. She feels the most notable characteristic of his function is in carrying out the details which contribute to the smooth operation of the Evaluation Board.

The Clinical Psychologist sees the Coordinator as an assistant to the Chief, Physical Medicine and Rehabilitation, whose primary contributions to date have been in this capacity. Included in this is responsibility for staff services to the Evaluation Board. The Counselling Psychologist indicated the same viewpoint and went on to say that she feels his work has been focused on procedural implementation rather than substantive contributions to the Program. Here, there may be some confusion as to role. Clarification of administrative implementation which may be a prescribed role
responsibility and substantive program development which is the responsibility of leadership and the responsibility of the team itself may be an implicit question in the response.

Table 2 illustrates the general perceptions concerning the Coordinator's role as derived from the five interviews, including an index to the areas of agreement and disagreement.

### TABLE 2

**PERCEPTIONS OF THE ROLE OF THE COORDINATOR**

<table>
<thead>
<tr>
<th>Role Prescriptions</th>
<th>Self</th>
<th>Phy.</th>
<th>S.W.</th>
<th>Cl.P.</th>
<th>O.P.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Execute plans of Physician</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Assistant to Physician</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Assists with Evaluation Board</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Undefinable duties</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
</tbody>
</table>

As indicated in Table 2, there are not as many discrepancies in the perceptions of the role of the Coordinator as there were of the Physician. It is notable that in the first row entitled "execute plans of Physician," the two team members who did not register this role element also do not feel that the Physician makes any plans with regard to the Program. It is seen that the Social Worker sees the Coordinator in the same way that the Physician does and that the Coordinator
Table 2 shows that there are 20 potential points of agreement in the perceptions of this role. Agreement is expressed in 16 of these. This gives a measure of agreement of .800, which is higher than was shown in Table 1 regarding the role of the Physician.

**Social Worker**

In discussing the role of the Social Worker, if one could be assigned solely to the Program, the interviewee stated that it would include all phases of social work. This would consist of casework with the patient and his family, investigating economic and home situations, securing social histories, and working closely with other team members in planning for the patient. A Social Worker would also contribute her knowledge of community resources. She would maintain close contact with the hospital Social Workers in an effort to help identify patients in all areas of the hospital who would be candidates for the Program.

At the present time, all the hospital Social Workers are endeavoring to work with the team by discussing possible referrals with the ward Physicians and compiling social histories on the patients who are accepted into the Program.

With regard to the Social Worker's function in connection with the Evaluation Board, the interviewee stated:

If a case is being presented to the Evaluation Board which is not known in Social Work Service, then the Chief, Social Work Service, would assign the case to a worker on the
staff or handle it herself, in accordance with the predetermined work loads of individual workers. The worker would then work up a complete social history for presentation at the Board. If it is decided by the team that the patient needs follow-up casework services, the worker continues with the case until it is closed. If the Board decides the patient is not feasible for rehabilitation but is medically ready for discharge, Social Work Service is then assigned the task of making discharge plans for the patient.

With regard to the Social Worker, the Physician made the following statement.

We have not had a full time Social Worker, but we have an extremely capable staff and an interested one. I suppose the Social Worker is the most important cog in the wheel of Hospital Industries as a rehabilitation effort because the family counselling and looking into the economic factors make all the difference in the world as to the ultimate outcome of setting a rehabilitation goal and making it work. She would help us in identifying patients on the hospital wards who would be eligible for the Program, make up social histories, and help with both Program planning and discharge planning.

He appeared to have a very positive feeling toward a Social Worker's contribution and apparently would like to have one assigned to the Program.

The Coordinator, too, expressed a positive attitude toward social work and feels that a Social Worker is an invaluable member of a rehabilitation team. He said:

A Social Worker should help in overcoming obstacles that form a barrier in this office toward rehabilitating patients. They should help pick out candidates for the Program and help with discharge planning. They would also help to iron out home setting, economic problems and other things we [Physical Medicine and Rehabilitation office] might not know about which keep the Program from being effective.

The Clinical Psychologist also presented a perception of the role of the Social Worker as a significant member of
the team. He pointed out that Social Workers are an invaluable aid in a rehabilitation program with their knowledge of human behavior, relationships, and community resources.

Social Workers are oriented toward seeing a person as a whole. This would apply doubly to a patient in a hospital inasmuch as he is often viewed in a hospital as "the schizophrenic, or the broken leg" rather than as "the patient who is schizophrenic" and the "patient who has a broken leg." A Social Worker in a teamwork relationship can help the rest of us in focusing on the total person in planning rehabilitation treatment.

In addition to this, a Social Worker helps locate candidates for the Program, compiles social histories, works with the patient and his family, and assists in discharge planning. They know to which agencies a patient or his family should be referred for any need this hospital cannot meet.

The following excerpt was taken from the recording of the interview with the Counselling Psychologist and points out the perception she has of the role of the Social Worker.

I see this Program as a joint enterprise for psychology and social work. I think the Social Worker is valuable in making the Psychologists aware of outside factors to determine handling of a case, such as the patient's previous work history, social history and whether he will be a long- or short-term case. She also helps identify patients for the Program and does casework with the patient and his family. The Social Worker is also very important in discharging patients and in planning for this, which includes her knowledge of community resources.

Table 3 is a summation of the perceptions of the Social Worker's role as taken from the individual interviews. The total points of agreement are included in this table, from which the index is derived.
TABLE 3
PERCEPTIONS OF THE ROLE OF THE SOCIAL WORKER

<table>
<thead>
<tr>
<th>Role Prescriptions</th>
<th>Self</th>
<th>Phy.</th>
<th>Coord.</th>
<th>Cl.P.</th>
<th>O.P.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casework with patient and his family</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Social history</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Community resources information</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Identifying candidates for the Program</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Information on home and economic conditions</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Patient planning for Program</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>33</td>
</tr>
</tbody>
</table>

Judging from the results of these interviews as shown in this table, there is a greater degree of agreement among the team members concerning the role of the Social Worker than in the previous roles. All of those interviewed evidenced very positive attitudes toward social work and it seemed that they feel a Social Worker should be assigned to the Program. It is recognized that, since the interviewer was a student in social work, the reactions might be colored. However, in view of the remarkably helpful and candid manner
in which the interviewees responded about themselves and their colleagues, it is felt that these stated attitudes toward the Social Worker could be accepted.

The number of possible agreements concerning this role is 35. The Physician and Coordinator were the only two who did not mention the Social Worker as adding knowledge of community resources. Thus, there was agreement on 33 points out of a possible 35, or approximately .943.

**Clinical Psychologist**

In describing how he sees his role in the Program, the Clinical Psychologist stated that he feels he has some recognition of the complications of developing such a Program and that he has some responsibility in helping to work out the conflicts between team members. He feels that with the new organization, he operates primarily on a consultive basis and as supervisor for the Counselling Psychologist.

He stated further:

The Clinical Psychologist is of help in resolving technical and administrative problems that occur in the operation of the Program. Another function is the follow-up of patients who are disrupting problems on the ward. I feel the Psychologist should communicate with other individuals either directly concerned with the Program or in the hospital in an attempt to give them more understanding of the goals of the Program and of the value it can provide to their service as well as to the individual patient. I also think the Psychologist can lend interpretation and assistance to the general hospital staff in learning to better understand and accept the rehabilitation patient from the psychiatric service, and also the general psychological significance of the Program to the patient, regardless of the ward he comes from.
It will be remembered that the Clinical Psychologist was director of the Program during the first seven months of its existence. He apparently has some feeling about no longer being in that position, although he seemed very pleased that the beginning efforts toward the Program had been sufficiently successful to warrant official action.

The Physician pointed out in his interview that the Clinical Psychologist had instituted the Program and has a good concept of the scope of the Program. The Physician perceives the present role of the Clinical Psychologist as that of acting as a liason with various other people concerned and primarily as a supervisor for the Counselling Psychologist.

The Coordinator expressed himself as follows:

No rehabilitation will be effective without psychological help, for either physical or psychiatric patients. The Psychologist is of most help with the psychiatric patients and long-term patients. The Psychologists are "big guns" in the armamentarium of the Program and give us ammunition in planning the Program. The Clinical Psychologist also serves as supervisor to the Counselling Psychologist.

This statement is rather sparse and generalized, although it is felt that it indicates respect for the profession as a whole.

The Social Worker sees the Clinical Psychologist in somewhat of a consultive capacity. Since he initiated the Program, he would have a good idea as to some of the pitfalls and obstacles; therefore, he can lend valuable assistance in resolving working problems. He performs a valuable function in interpreting the goals as well as the Program itself to
hospital administration and staff in a public relations capacity. He also acts as supervisor to the Counselling Psychologist.

The Social Worker seemed to have a very positive attitude toward the role of the Clinical Psychologist and recognizes the value of such a role to the Program.

The Counselling Psychologist sees the Clinical Psychologist in much the same manner as evidenced by the Social Worker:

I feel that the Clinical Psychologist has more of a consultive status. He takes no part in placement or other details of the Program. He does a great deal in the way of public relations in the hospital for job opportunities for the patients, and is invaluable in administrative decisions and policy making in which he has been in a supervisory capacity.

The attitude of the Counselling Psychologist toward the role of the Clinical Psychologist is a positive one. She evidenced a great deal of respect in discussing the role and seems to feel it is an invaluable one to the Program.

The following table, Table 4, shows the role perceptions concerning the role of the Clinical Psychologist. The total agreement areas are shown and an index is derived.

It is interesting to note that the Counselling Psychologist and the Social Worker registered the same perceptions of the Clinical Psychologist that he did.

Judging from the results of the interviews as illustrated in Table 4, the Physician and Coordinator feel that the role of the Clinical Psychologist is limited to the provision of
supervision to the Counselling Psychologist, and the Physician sees public relations in this also. The only area of full agreement was with regard to supervising the Counselling Psychologist.

The totals shown in Table 4 indicate that, out of a potential 25 areas of agreement, there were 18 expressed agreement points. From this, the index .720 was derived.

**Counselling Psychologist**

The Counselling Psychologist described her role in the Program as falling into three major categories.
My first obligation is to become aware of patients (identifying) who will profit from the Program. I do this in various ways, such as direct conversations with patients, consultation with ward physicians, and contacts with nurses. My second major responsibility is in actually deciding if the Program has some activity which will be helpful to the patient and in planning the type of work activity patients should do. The third major area concerns locating and getting activities for patients. This is done by contacting various chiefs and supervisors of divisions in an effort to discover if they need and want to participate by having patients assist in their departments, and if their work will meet the needs of these patients. If needed, I also help with discharge planning. In all of these functions, the Clinical Psychologist is my supervisor.

The Physician expressed his perception of the role of the Counselling Psychologist in these words:

She and the Clinical Psychologist have been rather effective in selling the Program to other people in the hospital. When we [Physical Medicine and Rehabilitation] get better control of the Program, she will be of more value since she needs someone, preferably a physician, to guide her and control her activities so that her energies are channeled constructively. By this I mean she tends to make a fair analysis of most patients but it takes her too long to do it and too long to tell me about it. She needs to make every word count in her relationships with other people. The patients, in general, seem to be favorably impressed with her part in the Program.

The Coordinator again was not inclined to be verbal in discussing his perception of the role of the Counselling Psychologist. He said he sees her as "a subsidiary to the Clinical Psychologist and is supposed to do counselling psychology."

The Social Worker feels that the Counselling Psychologist's major responsibility lies in locating patients who might be eligible for the Program and in finding constructive and beneficial work activities for them: "She carries out
the major aspect of the Program in that she locates patients for the Program, locates work activities, and has the responsibility for placing the right patient in the right job."

She also presents psychological findings on patients for the Evaluation Board, supervised by the Clinical Psychologist.

The Clinical Psychologist sees the role of the Counselling Psychologist as:

She does the most work with the patients in that she locates patients for work, plans for, tests, and places them. In addition, she contacts various chiefs and supervisors in an effort to locate jobs for the patients. She helps patients who are being discharged from the Program to plan for and prepare for an occupation outside the hospital.

Table 5 presents a summation of the role perceptions related to the Counselling Psychologist. From this table, an index relating to the potential areas of agreement versus the expressed areas of agreement is derived.

In view of the information shown in Table 5, it is obvious that the Physician and Coordinator feel that the Counselling Psychologist fulfills very few of the role tasks that the other team members attribute to her. Again, the Social Worker seems to be in agreement with the role as seen by the subject. Notable, too, is the fact that the Clinical Psychologist and the Counselling Psychologist expressed complete agreement as to role performance.
TABLE 5

PERCEPTIONS OF THE ROLE OF THE COUNSELLING PSYCHOLOGIST

<table>
<thead>
<tr>
<th>Role descriptions</th>
<th>Self</th>
<th>Phy.</th>
<th>Coord.</th>
<th>S.W.</th>
<th>Cl.P.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients for the Program</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Plans work activity</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Locates work activity</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Assists in discharge planning</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Places patient in work activity</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>Tests patients for evaluation</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>4</td>
</tr>
<tr>
<td>Assistant to Clinical Psychologist</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>24</td>
</tr>
</tbody>
</table>

It will be noted that in Table 5 there are 35 possible areas of agreement. Of these, the team members agreed on 24. This gives an index of approximately .686.

Table 6 summarizes the results shown in the previous five tables. These are listed by individual role perceptions indicating the possible areas of agreement, the expressed areas of agreement, and the index derived from these.
It is noted that the team members were in almost complete accord in their perceptions of the role of the Social Worker. The role of the Coordinator, as perceived by himself and his colleagues, was second with 16 out of a possible 20 areas of agreement expressed. The role of the Clinical Psychologist followed with an index of .720. The table indicates that the roles of the Counselling Psychologist and the Physician showed a lower degree of agreement than any of the others. The index describes these as .686 and .675 respectively. However, it is interesting to see that, with the elimination of the Social Worker's perception of the Physician as an interpreter of the Program, the role then moves into third place in agreement with an index of .743.

This Chapter has presented the primary data consisting of interviews with the five professional people who comprise...
his colleagues. Although the idea of work as a curative agent in the psychiatric hospital is widely accepted, this Program is a new one at the Veterans Administration Hospital, Coral Gables, Florida. In this setting, the operating roles in the Program have not been defined and the most effective use of these roles have not been spelled out.

The knowledge of general laws enables one to predict that to achieve a desired objective in a situation of a given sort it is necessary to take certain actions rather than others. To choose the correct course of action, knowledge of the specific character of the situation at hand is also required.¹

It is hoped that this study will present specific knowledge concerning the professional roles of the people involved in administering the Rehabilitation and Hospital Industries Program² in order that they will be able to choose a correct course of action.

Problem

The growth of the multi-disciplined unit grew out of the need of individual disciplines for assistance as programs broadened and patient loads increased. However, the growth of the unit did not insure the growth of mutual understanding among the disciplines. In working together


²The Rehabilitation and Hospital Industries Program will be referred to as the Program throughout the remainder of this study.
the Rehabilitation and Hospital Industries Program team. Each of these represented the perceptions the team members have concerning their individual roles as well as their perceptions of their colleagues. In addition, tables were used at the end of each section to provide a graphic summary of the data presented. These tables included totals from which an index was derived showing the number of possible areas of agreement and the expressed areas of agreement.

Table 1 showed that the Physician was seen mainly in a medical and administrative role. Conducting the Evaluation Board can be considered as a part of his administrative duties. It will be remembered, though, that the opinions of the two Psychologists are that the administrative role is only a technical one. Only the Social Worker saw him in the role of interpreter of the Program. It is interesting that only the Physician brought out the fact of his supervising the patients participating in the Program. All except the Counselling Psychologist agreed that he assumed responsibility for the patients on the rehabilitation ward.

It was shown that there were 27 points of agreement expressed out of a possible 40, or .675. With the removal of one point, the index read .743.

In Table 2, which represents the role perceptions of the Coordinator, the general consensus of opinion is that he serves primarily as assistant to the Physician. His assistance with the Evaluation Board can be considered a continuation of
this role. Here, it is interesting that the Physician and the Social Worker see the Coordinator in the same role as the Coordinator sees himself.

It was shown that, with regard to the role of the Coordinator, there were 20 possible areas of agreement. Of these 20, the team members expressed 16, or .800, in accord.

The role of the Social Worker, as illustrated in Table 3, indicates that all five team members agree, for the most part, in their perceptions. The only deviation from this is that neither the Physician nor the Coordinator saw her as contributing knowledge of community resources. All members of the team demonstrated strong positive feelings about social work, which, as has been pointed out, could be due to the fact that the interviewer was a social work student. However, it is felt that this is comparatively irrelevant.

There is a marked degree of agreement in the perceptions of the Social Worker, as indicated by Table 3. Out of a possible 35, the team members expressed agreement on 33 points. The index derived from this was .943, the highest indicated.

In Table 4, the perceptions regarding the Clinical Psychologist are shown. It appears that the Social Worker is in agreement with the two Psychologists. The only unanimous perception is that the Clinical Psychologist supervises the Counselling Psychologist. The table would
indicate that the Physician and Coordinator seem to feel that the Clinical Psychologist has, in reality, little function in the Program.

The expressed agreement, 18 points, was notably less in the table regarding the Clinical Psychologist than was shown in Table 3. The index for this role is .720, with agreement in 18 out of a possible 25 role prescriptions.

It is noted in Table 5 that the Clinical Psychologist sees the Counselling Psychologist performing the same role in which she sees herself. The Social Worker agrees with their perceptions except for the point concerning discharge planning. It is interesting to note that the Physician sees her as testing patients for evaluation and assistant to the Clinical Psychologist, while the Coordinator sees her only as assistant to the Clinical Psychologist.

The index derived from Table 5 pertaining to the Counselling Psychologist is .686. The expressed agreement was on 24 points out of a possible 35.

A summation of the role perceptions was done in Table 6. This showed that, by index figures, the role with greatest expressed agreement was that of the Social Worker, .943, while the role with least expressed agreement was that of the Physician. The index for that role was .675.

Chapter V presents the findings and interpretations. These are based on the data which has appeared in this Chapter.
CHAPTER V

FINDINGS AND INTERPRETATIONS

The purpose of this study was to describe the present roles of the professional people involved in administering the Program and the perception each of these people has regarding the role of his colleagues. The Program has been in effect only a short time; the operating roles have not yet been defined and the most effective use of these roles have not been spelled out. This study represents an effort to present the perceptions of various professional roles as seen by each team member.

It was assumed that:

1. There is a system in the functioning of the Program.
2. Each professional person involved in administering the Program has a perception of his role as it relates to the Program.
3. Each of these people can communicate a perception of the roles played by their colleagues.

Each of these assumptions appears to have been supported by the data. It was shown in Chapter III that the Program originated early in 1958 and that it was sufficiently successful to warrant official action in October of that year. Therefore, it can be assumed that there was a system,
disorganized though it was, in the functioning of the Program.

It was shown in Chapter IV that each of the professional people involved could relate a perception of his own role with regard to the Program. These perceptions were expressed in individual interviews and recordings of these were utilized in this study. In addition to the interviews, responses were cast into tabular form for the purpose of summarized presentation of role prescriptions. An index was drawn from each of the tables which showed the expressed agreement in relation to potential areas of agreement. The results of the interviews and tables show that each of these people can communicate a perception of the roles played by their colleagues.

The basic questions, as postulated in Chapter I, were:

1. How does each of the professional people involved in the administration of the Program see his role in the clinical team?

2. How do each of these people see the roles of the other team members?

The answers to these questions are found in Chapter IV. The role perceptions were demonstrated both in narrative form and in tabular form. The results of these tables indicated that there is a relatively high degree of disagreement in the perceptions of each role, except that of the Social Worker. The index taken from Table 3 regarding this role was .943. The next highest index was .800, which applied to the role of the Coordinator. The Clinical Psychologist occupied the third rating, which was .720.
The role of the Counselling Psychologist showed an index of .686, with the role of the Physician showing the lowest index, which was .675.

It appears, from the data, that the Physician and the Coordinator are in accord with one another in their thinking about their individual roles as well as the roles of the other team members. It might be pointed out here that while the Coordinator expressed little regard for the roles of the two Psychologists, he indicated a respect for the profession in general. The Physician's contribution was a little more verbal, but had an element of hostility as well as respect in it.

Looking at this from another aspect, the two Psychologists seem to be, for the most part, in agreement in their perceptions. The interviews and tables indicate that these two people apparently have little positive feeling about the cooperation they receive from the Physician and the Coordinator.

Apparently the role of the Social Worker is much less controversial than those of the other team members. Along the same line, the Social Worker's perceptions of her colleagues occupied somewhat of a middle ground. There is not so much discord in the conception of this role as was evidenced regarding other roles, as shown in the index, .943. It must be remembered, however, that there is no Social Worker assigned to this Program. Therefore, the other four
team members can relate only what they think a Social Worker would ideally do as judged by their previous knowledge of and experience with that profession. The possibility of a personality conflict or present role conflict is completely overruled in this case. It would be interesting, in the event that a Social Worker were assigned to this team, to re-conduct this study after she had been there a year. One would wonder whether such a person would be able to aid in establishing better working relationships among the team, or perhaps serve to clarify some of the present conflicts.

There are many theories which may be drawn from the data. One of these is that the reason for the lack of role definition is caused by poor lines of communication. Due possibly to their varied backgrounds and orientations, there seems to be a lack of understanding, and indeed even acceptance in some instances, of the respective roles of the team members. It would seem that semantics, too, pose a problem in this lack of understanding.

There are many conceptual tools which one could use in a study of this kind. While the concept of role was chosen by this writer, the concept of status could also be of value. Status has been defined as "the ranking of a role by a group."¹ Since there are wide differences in the

importance ascribed to roles in various groups, it would be of interest to conduct a study of the subject team with their ranking, in terms of role value, their own roles and the roles of the other team members.

It must be pointed out that this study is limited to the team involved in the administration of the Rehabilitation and Hospital Industries Program in effect at the Veterans Administration Hospital, Coral Gables, Florida, and probably could not be applied to any other team. However, it is possible that role conflict, lack of communication, and semantics could be considered as bases for any team which is not operating to its maximum efficiency.

In setting up a structure for the Program, conflict has arisen. The people who are building structure are aware of their own needs and are jealously guarding them. Nobody wants to give up any part of the role he considers his. In view of the existing conflict of roles, there is danger that unless these conflicts can be resolved, the Program will lose its effectiveness.
APPENDIX A

PHYSICAL MEDICINE AND REHABILITATION SERVICE COORDINATOR

For many years we have stressed the importance of coordination and have noted the response to the sound principle of hospital operation. One reflection of progress in this matter is the greater number of Executive Assistants in field stations, who might well be termed Medical Rehabilitation Coordinators, and the entirely different light in which these personnel are regarded today as compared with a decade ago. Then, the Executive Assistant was considered primarily as an Administrative Assistant, to help the physician and all FM&R sections with purely administrative and paperwork problems. Today, we pay tribute to the vision and leadership of those Executive Assistants who have demonstrated the ability of layment-trained and qualified in rehabilitation to work so closely with physicians in charge that they have been accorded the status of professional lay leaders or operating assistants. They have been conscious of their non-medical limitations, but devoted and loyal to their chiefs of service and the medical profession in general.¹

APPENDIX B

REHABILITATION AND HOSPITAL INDUSTRIES PROGRAM

I. **The Purpose:** The goal is the psychological rehabilitation of patients through constructive work activities which are valued by and essential to the operation of the hospital.

II. **The Patients:** The majority of the patients come from the Neurological and Psychiatric Service, but with lesser numbers from Orthopedic Service, tuberculosis, and medical wards. They are referred to Psychology by the ward physician who delineates physical factors governing the type of work activity desirable for each individual. Each patient is then seen by the Psychologist who determines what sort of activities would be of greatest psychological benefit for him.

III. **The Work Activities:** Almost every type of work activity from unskilled labor to technical skills, from clerical to the trades, is done by the "rehab" patients. Almost every division or service of the hospital has participated and has found the work done of real value.

IV. **Summary of the Program for a Five Month Period Ending August 15, 1958:** Approximately fifteen patients per day and about 100 different patients for the total five month period have been in the Program. Usually ten will be working four hours per day each and five will be on the job eight hours, making a total of 400 hours per week or 8,000 hours of volunteer time for the five month period.

V. **Results:** The hospital has profited tremendously through the high caliber work provided by patients through this Program, but what about the patients? While a serious research study is in progress to delineate values, the positive effects in terms of psychological adjustment are apparent from the behavior of the patients, both within the hospital and after they leave. The patients appear in better shape psychologically and they verbalize such feelings, attributing much of this to the Program. One positive "by-product"
has been the growing understanding and acceptance of mental patients by those services where they have worked. In a sense, then, this Program has been "good" for the patient, "good" for the hospital, and "good" for the Veterans Administration employees. In only five months, significant changes have occurred in the hospital structure that point to improved, more lasting rehabilitation efforts with mental patients and those limited by their physical condition.  

1Report compiled by Charles A. Stenger, Ph.D., Chief, Clinical Psychology, Veterans Administration Hospital, Coral Gables, Florida, August 15, 1958.
APPENDIX C

HOSPITAL INDUSTRY

1. **Purpose:** To establish Hospital Industry as an activity of this hospital.

2. **General:**
   a. The basic aim of Hospital Industry is to help the patient disabled by physical or emotional disease to make the transition from bed to vocational placement in an atmosphere of sincere interest in his progressive rehabilitation.
   
   b. During the past year this hospital has successfully operated a pilot program under the supervision of the Chief Clinical Psychologist. This Program has amply demonstrated the vast benefit Hospital Industry can offer our patients. In view of its success and requests that this service be expanded, the specific organizational outline if effective immediately?

3. **Program Responsibility:**
   a. The Chief, Physical Medicine and Rehabilitation will be responsible for conducting the Hospital Industry Program.
   
   b. The Coordinator, PM&R, will assist the Chief by coordinating the efforts of the Hospital Industry team and by providing administrative supervision of the Program.

4. **Referrals and Opportunities:**
   a. . . .
   
   b. Services and division chiefs with opportunities for Hospital Industry patients can make their position opportunities known to the Chief Clinical Psychologist. In this instance an elaborate job study is not necessary but a general description of the duties will be helpful.
5. **Assignments:**

   The physical limitations and work tolerance of the patient will be determined by the Chief, MMAR, or referring ward physician. The Counselling Psychologist under the Chief Psychologist determines the ultimate assignment for the individual patient, taking into consideration the psychological value, the existing capacities, skills, and available work opportunities.

6. **Responsibility of Using Service:**

   a. Cooperating services and divisions will be expected to keep the Counselling Psychologist informed as to significant information regarding the patient's adjustment to his work situation.

   b. The successful operation of this therapy Program depends upon the genuine interest and cooperation of everyone who has contact with the patient in his work.¹

¹Memorandum from Dr. Earl C. Gluckman, Manager, Veterans Administration Hospital, Coral Gables, Florida, October 7, 1958.
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