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Dec. 9, 1960

Report

of the Committee

Relative to

Second Injury Fund

and

Vocational Rehabilitation

CYRIL M. JOLY
CHAIRMAN

HAROLD A. TOWLE

JOHN V. KEANEY

MISS ANNE E. ALLEN, CLERK

EX OFFICIO

MISS MARION E. MARTIN
COMMISSIONER OF LABOR AND INDUSTRY

GEORGE F. MAHONEY
INSURANCE COMMISSIONER

STATE OF MAINE
Industrial Accident Commission
STATE OFFICE BUILDING
AUGUSTA

WHEN REPLYING, PLEASE REFER TO FILE NO.

December 9, 1960

Honorable Harvey Pease
Clerk
House of Representatives
State House
Augusta, Maine

Dear Mr. Pease:

Pursuant to Joint Order S. P. 502 relative to An Act Relating to Report of the Committee Relative to Second Injury Fund and Vocational Rehabilitation Under Workmen's Compensation Act (S. P. 393) (L. D. 1137), the Committee has completed its study and submit herewith their report together with the proposed legislation and also report of the Secretary of the Committee covering his trip of inspection and interviews with Vocational Rehabilitation Departments of other states.

Yours very respectfully,

CYRIL M. JOLY
Chairman of Committee

H. P. 125

CMJ/aa
Enc.

House of Representatives
Refer to Com. on
Labor
Jan. 10, 1961
sent up for concurrence
HARVEY R. PEASE
Clerk

In Senate Chamber
Jan. 11, 1961
Refer to Committee on
Labor
in concurrence
CHESTER T. WINSLOW

TO THE 100th LEGISLATURE.

Report of Interim Committee on the subjects of the Second Injury Fund and revisions of Workmen's Compensation Coverage Rules.

Pursuant to S-502 herewith report on its study of the subject matters herewith referred to.

After holding meetings at Augusta, Maine on the following dates: November 20, 1959 — December 28, 1959 — January 29, 1960 — July 15, 1960 — August 13, 1960 — October 21, 1960 — November 18, 1960 and December 9, 1960 your committee respectfully submits proposed changes in the Workmen's Compensation Act to embrace the subject of Vocational Rehabilitation under the Workmen's Compensation Act.

At the August 13, 1960 meeting of the committee, it was voted to have the secretary of said committee, to wit: Harold A. Towle make a study of Vocational Rehabilitation at various points in Canada and United States. This study was made and a detailed report of Mr. Towle's study has been filed with all members of this committee, which report is hereto attached.

The sum of $1000 was alloted from the Legislative expense appropriation for the expenses of said committee. The only expense incurred by this committee was Mr. Towle's trip to Toronto, Canada, New York City and Boston, Mass. during the period from August 27, 1960 up to and including October 1, 1960 in the total sum of $362.89.

CYRIL M. JOLY
Chairman, Industrial Accident Commission

THOMAS N. WEEKS
Representing Insurance

ROGER A. PUTNAM
Representing Industry

B. J. DORSKY
Representing Labor

HAROLD A. TOWLE, Secretary
Commissioner, Industrial Accident Commission

REPORT OF REHABILITATION SURVEY

Pursuant to a vote of the Legislative Committee on August 13, 1960, your Secretary has made a survey on the matter of Rehabilitation in three areas, to wit: Toronto, Canada, New York City and Boston, Mass.

In New York advised by competent authority, that Rehabilitation methods in Connecticut and Rhode Island were not working too well and due to limited time for making this survey, those two states were not visited.

The survey was made on two different dates due to the fact the Labor Day holiday would have meant staying in Boston two days without accomplishing anything, so I left Bangor August 27, 1960 first visiting Toronto, then on to New York City, returning to Bangor on September 4th, 1960. The survey was continued in Boston on September 29th and 30th, 1960. In all of these places most kind and helpful cooperation was given.

In making the Toronto trip, I realized that in Ontario there are no insurance carriers, and the Government runs the compensation business, but I wanted to see what results might be obtained through their system, and the trip more than justified the time and travel involved. Prior to making the trip, Mr. Benjamin Dorsky, of our Committee, had strongly advised that I personally see and inspect the work being done there, also at the Bellevue-N. Y. University Center, Dr. Rusk, administrator, in New York City. This was a wise suggestion. In my opinion the work being done in Toronto is the ultimate on all phases of Rehabilitation. I will now break down the report into the specific areas covered.

The Compensation Board in Ontario consists of three board members, and it was my privilege to meet with and have long personal talks with Dr. Earl C. Steele, one of the Board members. He was familiar generally with compensation laws in the United States and appreciated it probably would be impossible for us in the States to follow their pattern, because of the differences in forms of Government. He said he had recently returned from the British Isles, where Workmen's Compensation originally started, stating a lot of our early compensation acts had been patterned after the English system. He said that now the old compensation system in England had broken down and had been absorbed in an entirely different system. He said he hoped that in our Rehabilitation work in Maine we would not follow too much on legalistic lines, suggesting we make the legal aspects, pleadings, practice, etc., very simple because he felt if we did so, we could work out Rehabilitation under our Act and still not break up the system which we already have in effect. There are no insurance

carriers in the Ontario set-up. The employers pay money into a fund which is administered entirely by the Workmen's Compensation Board.

Dr. Steele assigned Mr. Colin Shaw, Senior Executive Officer of the Board, to show me the facilities in and around Toronto explaining their functions. The Toronto Board's office is at 90 Harbour Street and occupies one entire building with, as I recall it over 1300 employees. In visiting many of the offices I found they had a most complete set-up on all phases of claim work including accounting and all phases of claim investigation, complete records of all accidents occurring in the Province and the payments made thereon. They have twenty-six full time doctors in Toronto and sixteen in the field. One entire floor is devoted to Safety and Accident Prevention. This division is supported entirely by the employers of labor and is very effective in its field. A very careful follow up system and daily check on patients at the Hospital and Rehabilitation Centre is kept. The doctors carefully screen all accident reports. The employee is allowed to select his own doctor, but a very careful check is made on these attending physicians to see if they are competent. If a case is very severe and not progressing satisfactorily the Board can order such cases into Toronto or other cities for care. All hospital facilities in the field are carefully checked to see that the injured man gets the very best of treatment from the very inception. This Board believes that prompt and efficient medical attention, care with careful follow-up, screening and cooperation of all parties, including the employee, employer, attending physician and hospital care all aids in the prompt rehabilitation of the injured.

Mr. Shaw went with me to the Hospital and Rehabilitation Centre which is located 14 miles outside Toronto at 115 Tonbarrie Road, Downsview, Ontario. This is a wonderful place and I spent the whole day there being joined by Mr. William Kerr, Administrator, also Dr. B. H. G. Curry, medical director making the inspection very instructive and interesting in that I saw the premises and services being rendered. The aim here is to try and get the employee back to his regular job, if at all possible, because it is felt that such a man is happier in doing his regular job or something connected with it, and in this respect the cooperation of the employer becomes valuable. This centre can accommodate 500 patients, some hospital patients, the rest ambulatory patients. The physical property is wonderfully landscaped, it consists of over sixty acres and quite a bit of the maintenance is done by the walking patients who like to work out of doors. The program is planned so that something is going on all day long and no man is given the chance to think or worry about himself, which is an important factor in recovery. There is a staff of 300 including 16 full time doctors on hand,

including all of the specialities. In handling these cases under one roof, the daily cost comes to $13.75 per day, as compared to a cost of $24.00 per day in a general ward in the general hospital in Toronto, where no particular rehabilitation work is done. This price includes everything, meals included. While at the centre I had the privilege of talking with Thomas J. Mahar, Rehabilitation Officer, who advised me he felt Medical Rehabilitation and Vocational Rehabilitation had to be considered as one unit, and in some cases where it is obvious a man can never return to his former employment, for plans to be made immediately to get him ready for some other form of employment. In other words he feels it is never too early to plan for vocational rehabilitation. He said that much cooperation is had with employers in giving on the job training and not too many cases require special retraining. Common sense has to be employed in such matters and care must be taken in vocational rehabilitation to see that proper evaluation is made of a man's capabilities, and that an uneducated man ought not to be trained for a doctor, lawyer, etc., which makes good sense to me.

The work is so complete that I do not have time, in this report to comment on each and every factor, but I was impressed with the team work that goes into the handling of each case sent to this Centre. A team of psychiatrists, psychologists, social workers, prosthetic specialists, counselors and all types of specialists, where needed, work on these cases from start to finish. Daily conferences are held on troublesome cases, and I had the opportunity of seeing Dr. Curry preside at one such conference, where the problem was one of complaint of a sore stump from a leg amputation. Everyone connected with this case was present, giving their views on the subject, and as a final gesture Dr. Curry personally examined the man's leg, and a new form of stocking was suggested by the prosthetic specialist which will be tried for a time to see what results are obtained. A very careful daily card listing on the progress in each case is kept so that it is possible for one to learn, from this card index, just how things are going with a particular patient. The hospital and ambulatory facilities sparkle. Much stress is laid on physiotherapy, massage, heat and all kinds of baths and gymnastics under the leadership of trained gymnasts. It is felt that group participation, in many instances, is helpful from a physical and mental standpoint. The hospital has accommodations for 175 patients. The patient is cared for by a team comprising doctor, nurse, physical and occupational therapists, and rehabilitation officer. Weekly rounds, as a team permit review and discussion of the case as well as the plotting of a program for the patient's future care. Activity is the keynote of the hospital section. Active surgery is not performed in the hospital. Cases are

referred for admission following the post operation period. When the patient no longer needs nursing care, and is able to walk, he is transferred to the clinic section of the Centre where the tempo of his program is further increased. The Clinic is the treatment area for up-patients. The building contains the departments of physical and occupational therapy, remedial gymnastics, also a dormitory to accommodate 325 patients in rooms of eight beds each. In the occupational therapy field this is treatment of injury or disease by activity of a productive or diversional nature. The advantages of the activity are augmented by the distraction of the patient's mind from his physical and mental problems, turning his interest to the job he is performing. Often he does not realize he is still on treatment. The level of his activity is regulated by the medical prescription, and within its limits the therapist arranges activities to promote recovery. Activities may be in the fields of arts and crafts, weaving, et cetera, carpentry, painting, brick work, climbing, mechanical work, and stand-up occupations. Generally there is the desire to approximate as closely as possible the work situation using the tools of his trade. The occupational therapy department of the clinic comprises six main groups, one of which is associated with the hospital patients, four are concerned with clinic patients, the other with special responsibilities in relation to work tolerance job assessment. In the medical rehabilitation unit this one deals in the highly specialized field of complicated cases involving unusual psychological problems. The volume of this type of patient is small, resulting in closer individual supervision.

In addition to the active treatment facilities previously described, in the rehabilitation department a service is provided in counselling and job placement. In addition, the trained psychologist and vocational counsellor on this staff are available for aptitude testing and counselling when required. The work of the rehabilitation department, by providing liaison with employers of the province, rounds out the total rehabilitation service provided at the Centre. Recreational therapy also plays a good part at this Centre. It also includes classes in basic English sponsored by the Department of Education. It is felt that organized recreation improves morale and character also adds therapeutically in the reestablishment of the patient. The construction of the Centre was designed to allow ample space for these activities.

In the field of gymnastics the target is to improve function and mobility by active exercise and on a group basis. Also to improve general body condition.

I think the best way for me to sum up my impression of Toronto is to quote from a paper on Rehabilitation given by Dr. Steele and reprinted

from the Journal of the American Medical Association, January 9, 1960, Vol. 172, pp. 163-167. This outlines very clearly the Ontario Board's thoughts on rehabilitation and is exactly as I saw it from observation in Toronto.

"In Ontario the Workmen's Compensation Board is charged with the responsibility of the rehabilitation of the industrially injured. The Compensation Act was primarily designed 'to get rid of the nuisance of litigation,' and 'to have swift justice meted out to the great body of men,' who have been unfortunate enough to suffer industrial disease or injury arising out of, and in the course of, employment. The act is administered by a board of commissioners who have been given broad administrative powers by legislation to effectually interpret the spirit and intent of the act. The board is a body corporate of three members who are appointed by the Lieutenant-Governor in Council. They have power to make regulations within the meaning of the act - - -. The Board has exclusive jurisdiction in all matters pertaining to compensation, and there is no appeal to the courts. By statute the decisions of the Board are not bound to follow strict legal precedent, and the act states that 'the decisions of the Board shall be upon the real merits and justice of the case."

"Unimpeded by legal quarrels in the courts, divorced from political interference, and invulnerable to vested interests with the profit motive, the board can concentrate its efforts and focus its attention on what we have long considered to be the goal of the compensation process—successful rehabilitation. Our objective in every case is to assist the injured workman to return to his job as quickly as possible, with minimum impairment."

"The projection of this compensation philosophy has resulted in Ontario **adopting a biological or clinical approach to the compensation process rather than an adversary or forensic system. Rehabilitation in the broadest meaning of the term is an indivisible and integral part of the entire compensation system.** We, like other observers, have been unimpressed by the results of attempting to graft a rehabilitation program onto a purely forensic system, which inhibits the rehabilitee from accepting such service until court settlement is completed."

"**We believe that the rehabilitation of the injured is a continuous process, influencing the patient from the time of injury to the point of gaining independence and returning to work. There can be no gaps. If rehabilitation is viewed merely as a salvage service, it immediately loses a great deal of its effectiveness. Expert medical and surgical care, in our opinion, is one of the most important features in a planned rehabilitation program.**"

"In Ontario the Compensation Board has been given the responsibility by statute to control and supervise medical care in cases coming with-

in its jurisdiction. The Board has delegated this responsibility to the medical profession and allows workmen the initial fee choice of medical attention. The physicians and surgeons throughout the province know what we want and demand the very best of medical care, regardless of cost. They know it is our policy to permit only those surgeons holding speciality certification from the Royal College of Surgeons to do major surgery. They know they can have unlimited consultation with their seniors. The physicians are aware that they can pick up the telephone, reverse the charges, and discuss their problems with a qualified surgeon or internist on the staff and they will receive courteous advice. In the small urban centers and rural districts in Ontario, physicians know that in serious cases, we either will send from our University Hospital whatever kind of specialist is required—plastic, orthopedic, or neurosurgeon, or will provide transportation to bring the patient to one of the larger centers where specialized help is available. Serious cases are discussed with our consultant radiologist and orthopedic surgeons. Problem patients coming from districts where specialized facilities are not available are transferred to the closest university center. We rent on a yearly basis a floor in our largest teaching hospital for the more serious and complicated surgical and orthopedic cases. Here we control admissions and discharges. We also maintain a block of beds and a specialized team for the care of paraplegics. **The cooperation and enthusiasm of the medical profession for our plan has contributed, to a large extent, to any success we may have gained in our attempt for early rehabilitation through a definite medical care program.**"

"**Supervised physical and occupational therapy have played a vital role in our rehabilitation program, inasmuch as restoration of function is one of the cardinal aims of treatment.** Our experience in this field dates back from 1932. Facilities have been gradually expanded and enlarged, culminating in a recently opened 550 bed hospital, with 65 acres of ground on the outskirts of Toronto, which was established as a rehabilitation center for patients receiving Workmen's Compensation. This building consists of a hospital section for the care of early convalescent traumatic patients received from general hospitals and a clinic section for ambulant patients. All our patients are referred through the board's medical department by physicians throughout the province. The staff at the hospital and rehabilitation center are 300 in number and include 12 full time doctors, 23 registered nurses and 20 assistant nurses, 22 physiotherapists, 21 occupational therapists, 9 remedial gymnasts, 3 psychologists, 2 consultant orthopedic surgeons, and a radiologist. **Planned and supervised activity is the keynote of treatment. On admission each patient is seen by a physician and rehabilitation officer, along with his complete record of previous treatment,** x-ray findings, work history and social background. **It is the duty of the rehabilitation officer to locate employment problems and to keep the employer informed regarding return to work and whatever job modifications may be required. When additional placement serv-**

ices are needed, referral is made to a field rehabilitation officer to follow up."

"After examination and diagnosis, a detailed prescription is planned for a seven-hour daily program, including physiotherapy, remedial gymnastics, occupational therapy, hydrotherapy and recreational activities. Cases are reviewed by staff physicians at weekly intervals and prescriptions are changed or modified according to the patient's progress. Monthly case-evaluation conferences are held regarding each patient, with all members of the team present. In both the hospital and clinic section, the patient follows a daily program of progressively graded individual and group activities designed for restoration of function, re-education of lost skills, regaining of confidence and preparation for return to independence, and useful community living. When the question arises regarding the ability of a patient to return to his former job, a work-assessment test is carried out in the occupational therapy department. Patients are assigned to tasks which simulate actual work conditions and when possible, with the tools of their own trade, such as bricklaying, carpentry, telephone linemen, laying railway ties, or pushing loaded ore carts. If change of job or retraining is necessary because of resulting disability, the rehabilitation counseling service evaluates intelligence, vocational aptitudes, background experience and personality traits. A small, self-contained unit within the center deals with those patients requiring specialized help to overcome emotional instability, hysteria, or neuroses."

"Like other observers, we believe that any organized plan for the restoration of the injured should be made on the basis of the following theories: rehabilitation always. Resettlement sometimes, and retraining as infrequently as possible. In our experience the vast majority of those injured in Ontario wish to return to their old or modified jobs with their former employer. Lack of education, inability to learn new skills, language barriers, middle age, and doubtful adjustment to new environment usually make retraining impractical, costly and wasteful. For actual retraining we use existing facilities in the province, e.g., business colleges, electronic and welding schools, barber colleges and institutions offering engineering courses. Our compensation law gives the board the right to spend up to $200,000 per annum toward this end. Last year about 80,000 men were injured in Ontario, necessitating a layoff from work of more than four calendar days. Retraining was carried out in 91 cases only."

"Our rehabilitation staff at the hospital and rehabilitation center and field men located in various cities throughout the province attempt to make early contact with the more seriously injured. Their rights are explained under the act, their doubts and anxieties are relieved, and their misgivings concerning the future are dispelled. The rehabilitation staff members offer reassurance and act on behalf of the board as friend and advisor. Early contact is also made with the local union representative and with the employer. A promise of reemployment

after severe injury often protects the patient against neurosis and hastens his return to work."

In summary the doctor had this to say:

"The Ontario plan of compensation based on a **clinical** rather than on an **adversary approach**, is, in effect, a large-scale rehabilitation effort. **The individual physician plays a vital role in a team effort to return injured employees to the job quickly with minimal disability. Our concept of rehabilitation includes skillful medical attention at the outset, along with all the skills, modalities and techniques available to restore the patients to their pre-accident state. From our experience over the years, we are convinced that this approach is more humane to the injured workman and less costly to the employer. Those groups of the community most vitally interested—organized labor, employers and the medical profession—endorse our rehabilitation-compensation system.**"

Dr. Steele in the above report presented a detailed breakdown of 341 patients in a year under the Rehabilitation Officers' work and under the head of re-employment of all types of injuries treated, it is interesting to note that 153 of these cases returned to their former employer. 114 to other employers, 21 retired and 53 were pending and under treatment. From all of the above we gained certain facts about rehabilitation which impressed me personally as follows: First: **The legalistic approach should be as simple as possible under our Act.** Second: **All cases are not proper subjects for vocational rehabilitation or retraining and every effort should be made to get the employee back to his original job, or something connected with his former employment to avoid as much retraining expense as possible. If retraining is necessary, it should only be done after very careful evaluation of many factors as explained by Dr. Steele.** Third: **Cooperation is vital on the part of employee, doctor, employer and insurance carrier to attain effective rehabilitation. The very best of medical and surgical care should be instituted from the start, and a careful follow up made in each serious case.** In some instances it may be necessary to send patients out of the state for specialized care, particularly in serious spinal and paraplegic cases.

I have much additional data on Toronto's procedure, which can be shown and discussed verbally, but time does not permit me to go further in this report.

In New York City, I first contacted Mr .Andrew Kalmykow, Manager of the Association of Casualty and Surety Companies as Mr. Thomas Weeks of our committee had suggested. Mr. Kalmykow very kindly set up appointments for me to see Col. S. E. Senior, Chairman of the Work-

men's Compensation Board located in downtown New York City, with Dr. Donald A. Covalt at the Institute of Physical Medicine and Rehabilitation-New York University Medical Center at 400 E. 34th Street, New York City, also with Mr. Donald Weiss, at the Institute for the Crippled and Disabled, at 400 1st Ave., N. Y. City.

Col. Senior took me through the New York Offices of the Commission and explained the mechanics of the Board. He put me in touch with Mr. Albert Agram, Rehabilitation assistant in the New York Office. The New York system of rehabilitation is handled in the main with cooperation of the State-Federal agency handling rehabilitation, the same set-up that we already have in Maine. There the injured employee has the choice of physician and reasonably good cooperation is had with them on the matter of rehabilitation. In discussing our proposed bill with him, he felt our approach was all right. He suggested, however, that I consult with representatives of the Mass. Ind. Board as they had some good ideas in that State. **It was Mr. Agram's idea we ought not to make our revision too involved or legalistic or we would defeat its purpose. I asked what he would suggest, if a person needed rehabilitation, after proper investigation and report by the State-Federal system and refused it, he suggested that we simply amend our Section 22, the last paragraph, to include Vocational Rehabilitation.** Copies of the New York Workmen's Compensation Act, with its amendments to date, were secured. Mr. Senior pointed out to me Sec. 9, Page 77 of the Act, as amended, which is the only reference to rehabilitation. This is quoted in full.

"EXPENSES FOR REHABILITATING INJURED EMPLOYEES:

An employee, who as a result of injury is or may be expected to be totally or partially incapacitated for a remunerative occupation and who, under the direction of the state education department is being rendered fit to engage in a remunerative occupation, may receive additional compensation necessary for his rehabilitation, not more than thirty dollars per week of which may be expended for maintenance. Such expense and such of the administrative expenses of the state education department as are properly assignable to the expenses of rehabilitating employees entitled to compensation as a result of injuries under this chapter, shall be paid out of a special fund created in the following manner: The employer, or if insured, his insurance carrier, shall pay in the vocational rehabilitation fund for every case of injury causing death, in which there are no persons entitled to compensation, the sum of five hundred dollars. The commissioner of taxation and finance shall be the custodian of this special fund and may invest any surplus moneys thereof in securities which constitute legal investments for savings banks under the laws of this state. He may also sell any

of the securities in which such fund is invested if necessary for the proper administration or in the best interests of such fund.

Disbursements from the vocational rehabilitation fund for the additional compensation provided for by this section shall be paid by the commissioner of taxation and finance upon vouchers signed by the commissioner of education or the deputy commissioner of education, provided that the compensation claim number of an injured employee, undergoing vocational rehabilitation has been verified by the chairman.

Disbursements from the vocational rehabilitation fund for administrative expenses of the state education department shall be paid by the commissioner of taxation and finance upon vouchers signed by the commissioner of education or the deputy commissioner of education."

Col. Senior emphasized that in order to make rehabilitation work, common sense must be exercised in evaluation of cases, before any rehabilitation orders are made, and wherever possible to get a man back onto his original job and not try to make college professors out of ditch diggers, or things of that nature. Also it requires the active cooperation of insurance carriers to make this work effectively. Steps should be taken to see that the matter of rehabilitation does not get out of hand, and cause companies and carriers unnecessary expense. **Without cooperation of doctors, hospitals, employees, employers and insurance carriers, such programs are doomed to failure.** This is what Col. Senior has been trying to do in New York to get effective and prompt rehabilitation services where needed at as reasonable a figure as possible. **There is no elaborate system of pleading and practice on rehabilitation under the New York Act, and Col. Senior feels we should keep as far away from that as possible in our proposed amendment to our Act.** The Colonel gave a paper at the 46th Annual Convention of the International Association of Industrial Accident Boards and Commissions held at Edmonton, Canada on August 23, 1960. It was entitled "Rehabilitation of the Industrially Injured as Administered in New York and a Report on the Findings of The New York University Study on Rehabilitation." I have read this carefully and will give some quotes from it which seem pertinent to our problem.

"While we do not have a state-operated facility, we do have in operation a system geared to achieving the long sought-for results on a broad and comprehensive basis. I say this because we now have the beginnings of what appears to be a truly realistic, workable and effective procedure actually under way—one which is calculated to bring for claimants early restoral to the labor market, a plan which commends itself especially for the simplicity of its approach. I would not, at this point, be so dogmatic as to assert that we have evolved a panacea for

all the ills in workmen's compensation medicine. What I am sanguine about is the fact that we've got the program out of the blueprint stage, off the lecture platform, beyond the 'believe it or not,' dramatic, single case demonstration phase. It now has become an integral factor for consideration and determination in each and every claim made under the New York Workmen's Compensation Law wherein disability or medical care continues for a specified period."

"First: **May I point out that to us 'rehabilitation' is an all-encompassing word which means doing everything necessary to restore a disabled man to work at his optimum capacity and with a minimum of residual disability. We consider rehabilitative care a part of medical care and inextricably interwoven therein. Generally speaking, it is not a special, separate type of care. Every aspect of medical attention, in some respect, constitutes a rehabilitative measure. It actually starts with the type of first aid rendered at the scene of the accident, and continues during handling of the patient as he is transported to the place of treatment. Equally important to the rehabilitation process is the correct diagnosis, the competency of surgical handling, if involved, and the care during ensuing periods of acute disability and subsequent convalescence.**

"What we are attempting to do may be considered a deviation from the concept that limits rehabilitation to the very crippling injuries,—the paraplegic, the amputee and victims of such other devastating disabilities. **Sad and unquestionably needful of special attention as the paraplegic may be, we must assail with equal gravity the thousands of other severe or potentially severe disabilities, relatively mundane, that render so many of our people incapable of earning a living.** I realize that the word 'severe' is a relative term subject to varied interpretation. We can readily categorize the paraplegic or quadriplegic in that class. But, **is not a fractured hip or arm or leg severe to the man who sustained it? Is not his incapacity to earn a living severely damaging to him? What we try to do is to make rehabilitation available to him also,—and in the appropriate intensive degree."**

"**We now make it the direct responsibility of the insurance carrier to look to the need for rehabilitation for everyone, and I emphasize every injured person who has received compensation and or treatment for more than three months."** This is how the plan works.

"By agreement the employer or carrier, in connection with every case in which (1) rehabilitation care has been initiated: or (2) in which it deems rehabilitative care is indicated; or (3) in any event, in every case in which compensation and or treatment has been paid or rendered for three months and is being continued, promptly files with us our 'R' form. R is for Rehabilitation.

"As may be appropriate in the individual case, the carrier advises us on the 'R' form whether it has given consideration to the question of advisability of instituting rehabilitative care; whether the claimant

has been referred to a specialist for a rehabilitation evaluation; whether a rehabilitation program is indicated and, if so, an outline of the plan; as appropriate, the reasons such care is or is not deemed indicated, and finally, whether a rehabilitation program actually has been instituted and, if not, why not.

If the carrier agrees with the attending physician that rehabilitation is indicated, the program is started and we are promptly advised of it. If it deems such care indicated, but the attending physician or the claimant disagrees, we are promptly advised and we can take necessary steps to resolve the issue. If (1) three months have elapsed since the accident and (2) if rehabilitative care has not been started and (3) if neither the attending physician nor the carrier has already informed us that there is disagreement on the question and (4) compensation or treatment still continues, then and in such case, the carrier promptly files an 'R' Form advising us therein of the steps it has taken with respect to rehabilitation evaluation."

"**We recognize that all cases may not be amenable to or feasible for rehabilitation.** In such instances the employer or carrier states reasons for any negative decisions. The case is then carefully evaluated by the Board and its trained representatives which may entail a medical examination by the Board's doctor solely for the purpose of rehabilitation and case work development, if assertions on the 'R' form are subject to question."

"**Generally speaking, we have authority under our statute to inject ourselves into a case at any time, to ascertain and investigate, and to direct changes which we deem indicated and desirable in the medical care being rendered or in the indemnity benefits being paid. Unless the parties requested a hearing and determination by our Board, however, we have seldom done so on our own initiative.**"

"**We subscribe to the belief that governmental participation should be held to a minimum and exercised only if and when the parties with direct interest are unable to effectuate the full purposes of the program.**"

"**In conjunction with the Division of Vocational Rehabilitation of the New York Department of Education, which assigns its vocational counselors to the claim areas of the Workmen's Compensation Board's offices, we have developed a joint screening process and evaluation system whereunder there is, on a very much broader and speedier basis than obtained in former years, early identification of cases which might benefit from vocational rehabilitation.**

Part 2 of Col. Senior's paper was devoted to the New York University Report on Rehabilitation, and I make some quotes from his comments on this.

"The Study team offered a definition of Rehabilitation, based on objectives as follows: 1. To eliminate the disability if that is possible. 2. To reduce or alleviate the disability to the greatest degree possible. 3. To retrain the person with a residual physical disability. This team reported and recommended that the prompt and effective rehabilitation of injured workmen's compensation claimants, under the Workmen's Compensation Law, can be achieved through maintaining free choice of physician but introducing a system which provides for the early identification of claimants with severe disability or potentially severe disability and some supervision over the referral for rehabilitation evaluation and the rendering of rehabilitation services to such claimants."

Some significant observations contained in the report include the following:

"1. **A majority of the medical rehabilitation procedures can and should be done by the practitioner or specialist responsible for the patient's primary medical care and such procedures should be an integral part of such medical care.**

2. **A minority of the claimants with severe or potentially severe disabilities have needs which cannot be met without concentrated effort, including the skill of certain ancillary medical personnel and specialized rehabilitation techniques and apparatus. These cases will require referral, principally to psychiatrists or specialists in physical medicine and rehabilitation.** This is still medical care.

3. **The Study Team was unfavorably impressed by the undue emphasis upon the litigious aspects of the compensation system at the expense of the medical care and rehabilitation aspects. Litigation depresses the quality of medical care because it affects the workman's right to obtain care, it affects his choice of physician, and it affects his receptiveness toward proposals for rehabilitation.**

5. **They recommend a system which provides for early identification of the severe cases and some supervision over the referral for rehabilitation evaluation and the rendering of rehabilitation services to such claimants.**

8. **The recommendation for a state-operated rehabilitation center under the jurisdiction of the Workmen's Compensation Board is not considered desirable."**

In his concluding remarks the Colonel made some comments, excerpts which we now quote.

"It is my fixed opinion that if Workmen's Compensation is to continue its existence as a separate benefit system, then it must first justify its right to so continue. If it is to limit its reasons for perpetuation solely to (1) assuring the industrially injured worker periodic cash pay-

ments as partial replacement for his loss of earning capacity and (2) assuring him the payment of the bills for his necessary medical, hospital and other related care, then it seems to me that as other public benefits expand their scope, the warrant for the preservation of Workmen's Compensation as an independent system will wither and atrophy. If Workmen's Compensation remains a system which is merely to provide for the payment of disability benefits and medical and hospital bills, then it might very effectively be contended that it would be more practical, economical and efficient to arrange for its appropriate absorption by some other program. However, Workmen's Compensation can now carve for itself another indestructible, justified and highly respected niche in our social order if it accepts as its primary and dedicated purpose the mission of promptly ascertaining whether the industrially injured worker is receiving necessary, proper and adequate medical care, including rehabilitation; if not, make the necessary directions to assure that he does get this care; equip him as may be appropriate through vocational rehabilitation with the highest possible degree of employability, with a minimum of disability, and then assist him in every reasonably possible way to obtain employment compatible with his capabilities. Let us have a Workmen's Rehabilitation Law; let us administer Workmen's Rehabilitation Laws."

I had a long and very pleasant chat with Mr. Kalmykow, explaining our proposed amendment, or thinking, about changes in our Maine Compensation Act. He thought our approach was good. He was opposed to any general fund to be paid by each carrier but felt in individual cases where vocational rehabilitation was definitely indicated, after proper evaluation, to be sure it is one for rehabilitation, that a definite order on each case be made limiting the amount to be paid weekly for board and maintenance, as is mentioned in the New York Act. Generally speaking he felt rehabilitation was a good thing if handled within reason, he felt most if not all of the companies represented by his association were of the same mind. I asked about the states that already had vocational rehabilitation in New England, he said that in Rhode Island where the state maintains a Center, that this was not working too well, because in that state the workman can select his own physician under the Act, and the attending physicians were not sending in many cases.

In Connecticut, under the Act, their plan has not yet been brought to a point where it is working too good. As was suggested by Col. Senior, he felt I should contact the Massachusetts Board stating they had some good ideas which we might be able to use to some extent. I therefore took his advice and did not go to Rhode Island and Connecticut.

It was my impression, in talking with Col. Senior, that the insurance carriers did consider vocational rehabilitation to be a good measure and prob-

ably in the long run would be beneficial to all concerned, he emphasized, as had the other gentlemen, I had talked with, that every effort should be made to get the man back to his original job, if possible, not try to teach common laborers, with no education and language difficulties, to become doctors, lawyers, engineers or professions of that nature. In other words, very careful evaluation as to capabilities before any attempts were made in any case, to institute vocational rehabilitation causing unnecessary expense to the carriers who have to pay the bills.

Due to the fact that a nation-wide conference on rehabilitation was being held in New York City, when I was there, I was unable to meet Dr. Rusk at the New York University Medical Center. I did talk with Dr. Donald A. Covalt and learned this center is devoted primarily to physical rehabilitation, well equipped in every way to handle all such problems. Inasmuch as it would be repetitious for me to explain all of the features of this place, I will comment about an excellent place devoted to vocational rehabilitation in New York City, known as the Institute for the Crippled and Disabled located at 400 1st Avenue, New York City. This place was so interesting and directly in the field in which we are interested; namely vocational rehabilitation. The director of this Institute is Mr. W. C. Gorthy. Unfortunately he too was busily engaged in the world conference so I could not talk with him personally. However, after I returned home he wrote me a letter, under date of September 6, 1960, portions of which I now quote.

> "In response to your question" (something I had requested of Mr. Weiss) "be advised that 58% of the compensation cases treated here at the Institute receive vocational rehabilitation services of one form or another, As you know, this category of our service is all inclusive in that we are fully staffed and have on-going programs of vocational counseling, evaluation, training and placement."
>
> "Your work in drafting legislation for the State of Maine, which will provide, among other things, for the rehabilitation of the industrially injured, is a matter of considerable importance and one to which I have given much of my thought and time. **The laying of a proper basis for the utilization of rehabilitation services in Workmen's Compensation so that all concerned, including carriers, insureds, and claimants is, to my mind, fundamental to the establishment of a worthwhile program.** In my work with groups throughout the country, my concern is the improvement of Workmen's Compensation legislation. **I have sought to emphasize the need for a mutually satisfactory basis which will engender enthusiastic support from the interested parties."**

In talking with Mr. Weiss, who was my guide on this inspection trip at the Institute, he pointed out to me that early this year in New York a meeting was held in which representatives of industry, labor and insurance car-

riers were invited, at which time actual large size moving pictures were shown of the work actually being done at this place. This was received with much enthusiasm by the carriers, and I understand that shortly Mr. Gorthy will conduct a similar gathering in California. He is now working on a plan under the United Nations for Turkey, he sent me some data on this.

This statement from Mr. Gorthy about **mutual cooperation in any program of Vocational Rehabilitation is one that I too would like to emphasize in this report. Without it all laws passed, in this respect, would be difficult to handle from a practical standpoint at least.**

Mr. Weiss briefed me on the work of the Institute, the oldest rehabilitation center in the United States, started in 1917 to assist injured World War I disabled veterans. It specializes in Vocational Rehabilitation, working in conjunction with Dr. Rusk's University-Bellevue Medical Center, the institute previously mentioned, which is engaged primarily in physical rehabilitation. It also cooperates with the New York State Division of Vocational Rehabilitation, which would correspond to our own Federal-State Rehabilitation setup under the Department of Education. 44% of their cases last year were referred to them by the Department of Education. 28% referred by Casualty Insurance Companies. They will accept cases from other States for a full evaluation, job studies and report. They will also handle rehabilitation work from start to finish on a scheduled fee basis. They evaluate each subject very carefully including physical and mental, using the so called Tower System, to see what if anything the patient can do in particular trades. They evaluate for office practice, stenography, typing, filing, etc. They have a complete book bindery setup, leather goods manufacturing, instruct in making of fine jewelry, business machines, precision machine shop work (no art work). In the book bindery and leather goods setup 90% trained in that category found good employment. In optical mechanics, which they train, 96% were made employable. **They also train welding. This Institute does not think much of on the job training.** They make their own prosthetic and orthopedic supplies, braces, shoes, etc. These are not made by the patients, but in a few instances they help make them. They have the very latest things in this field. For instance ladies with leg amputations, in the past were bothered a great deal because of the hindrance with their clothes in having to use so many straps, etc. to hold the leg in place, but today they have evolved an artificial leg which can be attached simply by a clever use of the person's stocking worked in conjunction with the leg itself. Also the best artificial hand today, the most efficient one, is the hook. If a lady wishes to discard the

hook to dress up, said hook can be detached and an artificial hand, which is colored to the exact shade of the patient's good hand, can be inserted, this hand even shows the veins in it, and if there should be traces of hair on the back of the other good hand, hair is implanted on the artificial hand to simulate the looks of the good hand. They also use the very latest thing in amputees, with arms off at the shoulder, which is operated by controlled gas cartridges on the inside of each arm, the valve of which can be opened by the patient by a simple motion of the shoulder, this gives motion of rotation at the wrist, upward bending of the arm, at the elbow and many other things that formerly were impossible to accomplish. This institute has the most complete library on all phases of rehabilitation in the United States. 23% of the cases referred to them are back injuries, 47% diseases and damage to the bones and joints. The number of back cases is on the rise, whereas they now only see 11% of cerebral palsy cases and 3% of polio cases. Just a few years ago the trend was the other way.

This Institute stresses evaluation first, both in the physical and mental field, next treatment, then vocational rehabilitation. They are equipped to give full evaluations in the psychiatric and psychological field.

This Institute also has a complete teaching staff to help people with limited educations to obtain better educations. They can also handle the language problem. If, for instance, after a Tower System test, it definitely shows a patient has a sufficient aptitude to become, say an electrician, but because of language and educational limitations, is presently unable to become an electrician, they will teach him English and give him the equivalent of a High School education so that he may be able to pass the necessary tests to become an electrician. However, this will not be done, in any case, unless the patient is able to pass the requirements laid down in the Tower test on evaluation and aptitude. This is a comprehensive rehabilitation facility which functions as a patient's service, research and training center. It functions entirely on an out patient basis for handicapped persons of all ages with physical and psychiatric disabilities. Its five major services are social adjustment, medical and vocational rehabilitation, industrial rehabilitation and prosthetic and orthopedic laboratories. On the matter of evaluation careful check is made to see what the individual patient needs. Physical and occupational therapy is given, also counseling, training and placement. Also sheltered workshop employment and prosthetic and orthopedic appliance services. It operates in an eleven story brick building with a staff of nearly 200 presons. It services more than 5,000 handicapped people each year. These services are not limited to insurance or workmen's compensation cases but to all handicapped people.

It would be impossible for me to accurately picture the marvelous work being done at this institute. Just a few examples. In the cerebral palsy section I saw two girls terribly twisted throughout their entire bodies, one of whom was operating some sort of a large press which I personally would not want to attempt to operate. Another girl was assembling fountain pens. I saw men, who had previously been engaged in heavy laborious work, who are no longer able to stand for any length of time, making the most intricate and delicate types of jewelry. Others engaged in repairing delicate machines and doing all types of fine work in the book bindery, leather manufacturing and other fields taught at this place. Here is a place where real difficult cases might be sent that cannot be handled elsewhere. In fact they welcome just such cases and have had remarkable success in many so called impossible cases. To recapitulate, this institute in its evaluation services covers the following:

Social intake study.
Rehabilitation medical examination
Psychological screening
Consultations in internal medicine, orthopedics, neurology, opthalmology
Speech and hearing evaluation
Psychological test battery
Psychiatric review
Comprehensive vocational evaluation by work sample technique

Treatment services consist of the following:

Physical medicine and Rehabilitation
Occupational therapy
Physical therapy
Licensed Medical Dispensary
Mental Hygiene Clinic
Clinical Psychology
Psychological retraining
Social case work
Speech and hearing therapy
Group and Individual Psychotherapy
Group work
Vocational training

Vocational counseling
Job placement
Prescription, manufacture and training in the use of Prosthetic and Orthetic devices
Integrated industrial workshop.

I have much more data pictorially and otherwise which I can present if desired. This report will not permit further detail.

In Massachusetts I had very fine cooperation through the efforts of Chairman Michael DeMarco of the Division of Industrial Accidents, which corresponds to our Industrial Accident Commission. Mr. Edward J. O'Leary, Director of Rehabilitation for the division was delegated to assist and explain the Mass. Act, and to explain his duties. We spent one and one-half days together, and through his cooperation I inspected the spinal and paraplegic section at the Mass. Memorial Hospital, also the Rehabilitation Institute of the Boston Dispensary, which is a part of the New England Medical Center. This combination of the New England Center and Institute of the Boston Dispensary follow very closely, but not to such an extensive degree as the New York setup I have previously described. Dr. John J. Lorentz, doctor in charge of the Institute told me he was entirely familiar with the setup for physical and vocational rehabilitation in New York, stating they were attempting to follow exactly the same setup as best they could. The physical setup at the Dispensary is located at 185 Harrison Avenue, Boston, Mass. This place serves the physician and the local hospital as they initiate a rehabilitation process for the patient. The physician carries the medical responsibility as the rehabilitation team develops an individual training plan.

Dr. Lorentz is interested in Maine, having a place at Kennebunkport. He is familiar with rehabilitation services at Bath, Maine also at Waterville, having seen cases in both places. Mr. O'Leary said he uses this medical-rehabilitation setup at the New England Medical Center and the Institute with fine results. **Dr. Lorentz said evaluation both physical, medical and psychological is very important before any attempts to rehabilitate are made and they do this.**

This Institute differs a bit from the Institute for the handicapped in New York in that they have a few bed patients there who are able to help themselves to some extent. This Institute will take referrals from any state, and I have a schedule of the charges in my file for reference. Inasmuch as the services at this Center so closely resemble those in New York, with

the exception they are on a more limited scale, I will not comment in detail, except to say I feel this is a place well conducted and very helpful on the vocational setup, and might well be used in some cases out of Maine.

I was particularly interested in the work at the Mass. Memorial Hospital in the spinal and paraplegic section, and had the pleasure of meeting with and talking to Dr. Spaatz, the resident neuro-surgeon. While there I found a severe back injury case that had come before our Maine Industrial Accident Commission in the southern part of the state, the Dan McCollum case, with whom I talked. I also talked with Mr. David Barrie, Chief Examiner of rehabilitation for Liberty Mutual Insurance Company, whose work covers all rehabilitation, for his company, throughout the United States. He was interested in the McCollum case, from a rehabilitation standpoint, as his company had voluntarily entered into some sort of an agreement, even though liability was very doubtful, to pay up to $10,500 for rehabilitation of this man. This case had been mentioned to me the day before by Mr. O'Leary. Mr Barrie said he was able to make this sort of an arrangement principally due to the fact that in Mass. the act covers for unlimited medical and hospital expense, which is not the case in Maine. Both Mr. Barrie and Mr. O'Leary said that it would be helpful to us in Maine, particularly in paraplegic and very serious paralytic spinal cases, if we were thinking about rehabilitation, to have something added to our Act to give unlimited medical and hospital care in such cases, if not as a general matter. It was plain to see Mr. Barrie was sold on rehabilitation in all of its phases, provided cases were properly evaluated and supervised both medically and vocationally. The Liberty Mutual has its own rehabilitation facilities but in special cases, like McCollum's case, they use other facilities for treatment such as the Mass. Memorial Hospital and other places. Evidently the Liberty feels that rehabilitation, both physical and vocational, is a good investment, if properly conducted, evaluated and followed up.

In discussing the Mass. setup, Mr. O'Leary told me that up until 1955 the Board had used the then existing State-Federal system administered by the Department of Education, but not being satisfied with results, a special Act establishing the Mass. Rehabilitation Commission was set up which administers Rehabilitation in the State. This fits into the Compensation Act, so that liaison has to be effected between this Commission and the Accident Board. Mr. O'Leary is the liaison man between the Mass. Rehabilitation Commission and the Board. The provisions in the Mass. Act covering Rehabilitation are found in Sections 30, 30A, 30B, 30C and 30D of the Act, and I have up to date copy of the law and all amendments to same on file. While somewhat lengthy, and probably not a system that we can

adopt at first in our proposed Vocational setup. The following are quotes from these sections for whatever they may be worth:

"Sec. 30. The insurer shall furnish to an injured employee adequate and reasonable medical and hospital services, and medicines if needed, together with the expenses necessarily incidental to such services. The employee may select a physician other than the one provided by the insurer; and in case he shall be treated by a physician of his own selection, or where in case of emergency or for other justifiable cause a physician other than the one provided by the insurer is called in to treat the injured employee, the reasonable cost of the physician's services shall be paid by the insurer, subject to the approval of the division. Such approval shall be granted only if the division finds that the employee was so treated by such physician, or that there was such emergency or justifiable cause, and in all cases that the services were adequate and reasonable and the charges reasonable. In any case where the division is of opinion that the fitting of the employee with an artificial eye or limb, or other mechanical appliance, will promote his restoration to or continue him in industry, it may order that he be provided with such an artificial eye, limb or appliance, at the expense of the insurer. **The provisions of ths section shall be applicable so long as such services are necessary, notwithstanding the fact that maximum compensation, under other sections of this chapter, may have been received by injured employee.**"

"Sec. 30A. The rehabilitation board established under section twenty-four of chapter twenty-three shall continuously study the problems of rehabilitation and shall examine such rehabilitation facilities, both private and public, and establish a list of such physicians as are available to render competent rehabilitation services for seriously injured industrial workers. Rehabilitation facilities shall include medical, surgical, hospital, prosthesis and physical restoration services. No facility shall be considered as qualified unless it is established to provide rehabilitation services for persons suffering from some specialized or general type of disablement within the field of industrial injury and unless such facility is operated under the supervision of physician qualified to render rehabilitation services, is staffed with trained and qualified technicians and has received a certificate of qualification from the said commission. No physician shall be considered as qualified unless he has had experience for a reasonable term of years in a qualified rehabilitation facility or is qualified for a special rehabilitation procedure because he holds a certification by an American Board of Specialty."

"Sec. 30B. The rehabilitation board shall designate to act as impartial rehabilitation examiners physicians who are specially qualified and experienced in special means and methods of rehabilitation. The chairman of the Industrial Accident Board shall appoint such physicians as are so designated by the rehabilitation board to serve as impartial rehabilitation examiners and to assist the division and the

board in cases which may require rehabilitation services. A reasonable fee shall be allowed to the impartial rehabilitation examiner by the division, and the insurer shall reimburse the division for the amount so paid.

The division and the rehabilitation board or any member thereof may refer to an impartial rehabilitation examiner any employee entitled to compensation under the provision of this chapter for recommendation of the need and kind of rehabilitation treatment or services required by him. The report of the impartial rehabilitation examiner shall be admissible as evidence in any proceeding before the division or member thereof; provided that the employee and the insurer have seasonably been furnished with copies thereof.

An insurer or self-insurer shall furnish rehabilitation services by a rehabilitation facility or a physician who, in the opinion of the board, is qualified to render rehabilitation services, and shall also furnish vocational rehabilitation services to any injured worker eligible for or receiving compensation under the provisions of this chapter who is determined to be fit and eligible for vocational rehabilitation by the Mass. rehabilitation commission, established by section seventy-four of chapter six; provided, **that any dispute concerning payments for such vocational rehabilitation by said insurer or self-insurer shall be decided by the Industrial Accident Board. Fees for rehabilitation services shall be the reasonable and necessary cost of such services; expenses for the rehabilitation of the injured employee shall include travel, board and room when necessary, subject to the approval of the division, and shall be paid for by the insurer."**

"Sec. 30C. Nothing in sections thirty A or thirty B shall be construed as requiring any injured employee to accept rehabilitation services."

"Sec. 30D. Every insurer or self-insurer shall furnish to the Industrial Accident Rehabilitation Board, established by section twenty-four of chapter twenty-three the name and address of every person who has been receiving from such insurer or self-insurer compensation under the provisions of chapter one hundred and fifty-two for a period of six months. Such information shall be confidential and for the exclusive use of said board in the discharge of its duties, and shall not be open to the public, notwithstanding the provisions of section ten of chapter sixty-six or other provisions of law; provided, that nothing herein shall be construed to prevent the board from publishing such information in statistical form without disclosing the identity of the applicant involved."

In both New York and Massachusetts the respective Boards rely upon the insurer to report to them whether or not rehabilitation services are indicated after a certain period of disability has been in effect. I have sample report forms from each jurisdiction which may be perused by our committee or other interested parties.

The Mass. Rehabilitation Commission setup became effective on November 4, 1956 and is contained in Chapter 602. I have a complete copy of this Act. This is too lengthy to comment on in full, but briefly it consists of a Commissioner of Rehabilitation and an Advisory Council of eleven members. It shall cooperate with the United States Department of Health, Education and Welfare or its successors in the administration of Public Law 565 (83rd Congress, 2nd Session 1954) and amendments thereto, relating to the vocational rehabilitation of handicapped persons, and may expend such state, federal or other funds as are available for the vocational rehabilitation of handicapped persons.

In this Act but not under its supervision or control, an Industrial Accident Rehabilitation Board is established, consisting of the Chairman of the Industrial Accident Board and the Commissioner of Rehabilitation and five members to be appointed by the Governor. **If further study or perusal of this setup is indicated I have the Act to refer to.**

Mr. O'Leary tells me this setup functions very well and there are very few cases that go to the Industrial Board for action.

In the Mass. setup, it will be noted there no special funds are set up to be contributed to by the insurers.

After inspecting rehabilitation procedures and facilities in Toronto, New York City and Boston, Mass., and in talking with representatives of compensation boards and insurance carriers, also doctors engaged in rehabilitation work, it is my feeling that Vocational Rehabilitation is necessary and should be made an integral part of our Maine Compensation Act but that evaluations, as to rehabilitation, should be made in the majority of cases by the Federal-State setup under our Department of Education. It is my definite conclusion that the Industrial Accident Commission should never make any orders for such rehabilitation, without its first being fully demonstrated that such rehabilitation is necessary. Some method should be devised whereby the insurer reports to the Industrial Accident Commission, whether or not it considers an employee requires the services of Vocational Rehabilitation, with a brief explanation as to why or why not. If Vocational Rehabilitation is suggested this patient should be referred fairly early, or after a reasonable convalescence period has expired, not to exceed six months, preferably four months, to the State Rehabilitation Service. This to be done after all available medical and surgical work has been performed. Some cases obviously will be so severe that this time limitation will have to be extended, but in the great majority of cases the time above suggested does not seem out of line. In the report to the Commission the insurer should include the nature of the injury, whether or not amputation

has been performed and the number of weeks compensation has been paid. If the facts warrant an investigation the matter should be referred to the Department of Education for a full evaluation and report to the Commission. If this employee needs special treatment and training, and vocational rehabilitation is advised by the Department of Education stating what is needed and required, the Commission will then make its order concerning vocational rehabilitation, setting a figure as to how much per week shall be allowed in addition to the regular compensation as is suggested in the New York Act. We will have to determine in our bill the weekly amount to be allowed for travel, board and room. Progress reports should be made to the Commission at proper intervals so that rehabilitation can be followed up properly. In some cases it will be found that an employee under compensation may have some work ability and yet some phases of rehabilitation may have to continue, and in those cases the Commission will have to work out some equitable system to cover that contingency. Common sense should prevail in rehabilitation matters and impossible goals not sought for. All parties agree that the best plan is to attempt to get the man back to his regular job or in the same general area, because in the majority of cases he will be happier that way. In this connection it will be seen that the cooperation of employee, employer, labor representatives and the carriers can be most effective to get the man back to his old job. As will be seen it is vital that the earliest and best possible medical and surgical attention is very important in the scheme of rehabilitation. It is difficult to disassociate physical and vocational rehabilitation but it is very important that there be no extended time lags between the end of physical rehabilitation and the evaluation for vocational rehabilitation. If too much time elapses in many cases neuroses, pathological and psychological and psychiatric blocks set in which are difficult to overcome. In some cases by careful planning vocational rehabilitation can be contemplated even before physical rehabilitation is complete, and that should be done early and especially in cases where it is obvious that the injured man will never be able to engage in his former employment. In some involved and difficult spinal and paraplegic cases it may be necessary early to refer such cases to other states for more thorough evaluation and special care and treatment. In this connection the attending physician's advice and cooperation is vital. In such cases time is of the essence as prompt specialized treatment by men who do nothing but this type of work and who have special hospital facilities, nurses and equipment to work with may prove to be very effective and economical in the long run. Cooperation between patients, doctors and carriers is vitally necessary if rehabilitation is to be real effective. I feel that if Sec. 9 of the Act, with the suggestion made about extra time for certain spinal and para-

plegic cases, is sufficient to cover the physical rehabilitation feature of such cases. It seems to me that the carriers have a vital reason for wanting the employee to have the very best of medical and surgical care and that this responsibility should rest with the employers and carriers. At the moment I would prefer to continue on with Sec. 9 with the responsibility for treatment resting on the employer and carrier rather than the selection of the doctor by the man himself. In the beginning at least I think we can better handle rehabilitation with Sec. 9 practically the same as it now is.

I recommend a very simple amendment to our Act and something along the line of New York as it refers to vocational rehabilitation. It is my feeling that no assessment fund be established but that each case requiring vocational rehabilitation be charged to the individual carrier responsible for the particular case and that no case be ordered for vocational rehabilitation until it is first determined whether vocational rehabilitation is necessary and some idea obtained as to how long a period may be required for this rehabilitation and its approximate cost if possible. I feel it would be helpful in order to handle some vocational rehabilitation matters if Sec. 9 of the Act could be amended in some way to give unlimited medical, hospital and other services to certain types of cases such as paraplegic and paralytic cases beyond the five hundred week period because it seems unrealistic for a man to become permanently injured so that he will require certain treatment for the balance of his life and at the end of five hundred weeks have to assume this expense. This also applies to prosthetic appliances which such a party will have to buy at the end of five hundred weeks and after his compensation has terminated. It would be extremely helpful in such cases by way of handling a case on a lump sum basis if such a provision were in our Act. This was emphasized to me by Mr. O'Leary of the Massachusetts Board. Mr. Barrie of the Liberty Mutual also mentioned the same thing.

This subject is so interesting in all of its phases that one might go on indefinitely but for the purpose of this report I stop here but will be glad to elaborate on any part of the subject with which I am now familiar to the Committee.

In closing I wish to thank the members of the Committee for allowing me to make this trip and study and trust this report may be of some slight interest and value. It was pleasant, instructive and rewarding.

Respectfully submitted,

HAROLD A. TOWLE
Secretary, Legislative Committee on
Vocational Rehabilitation.