Whither Cardiac Work Evaluation Units?

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Editorial

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CARDIAC WORK evaluation units, after 27 years of operation, face problems both internal and external, which make it imperative to reconsider and resolve their future. Heart disease is a continuing and growing concern to society; barriers to employment of cardiac patients exist and are worsening. Despite the success of some work evaluation units (WEUs) and the opening of new ones, others are closing or having difficulty with economic support or with the number of referrals. Neither industry nor the community is sufficiently aware of the function and potential of cardiac evaluation units, nor is the physician.[1] What has the WEU achieved and where is it going?

Goldwater established the first WEU in 1941 using a team skilled in multiple disciplines to assess the employment potential of cardiac patients.[2] Some 50 similar units have since been organized; most of them have consisted of an internist-cardiologist as medical director, a psychiatrist or psychologist, a social worker, and a vocational counselor. Thirty-three units, partially or totally supported by the American Heart Association (AHA) and its affiliates, processed 1,900 patients in 1964-1965.

The purposes of the WEU include service, education, and research. The principal accomplishment of most units has been vocational rehabilitation. Thirteen of the units have conducted some research, and half of all units have carried on educational programs for physicians and medical students.[3]

The WEU has effectively demonstrated that the great majority of cardiac patients are capable of returning to productive work. This has tremendous social and economic import in a nation where so many men and women have manifest cardiovascular disease, and so many more in the prime middle years of life have latent disease or are at excess risk. WEU contributions to the evaluation and prediction of cardiovascular function and to job placement have been variable. However, the simple demonstration of capacity for physical work among cardiac patients has had a profound and positive impact on attitudes toward heart disease—in industry, among the medical profession, and on the patients themselves. The enormity of the cardiovascular disease burden in this country is such that the function of existing units should be strengthened and expanded in the community and their influence made greater upon the medical profession and industry. A hard look at the goals and organization of the WEU seems required. We emphasize too that the function of the WEU along all lines, service, education, and research, needs shoring up.

How can this be accomplished?

A set of general standards for performance in all functions of the WEU was called for by an important conference in 1966, the Third National Conference on Work Evaluation Units, sponsored by the American Heart Association, the U. S. Public Health Service, and the Vocational Rehabilitation Administration: "Be it resolved that the American Heart Association . . . aid in the preparation of criteria of quality with certification by the Work Evaluation Committee of the AHA of those units which meet these voluntary standards."[1]

The critical problem is to find the optimal balance of service, education, and research. Without such balance each WEU becomes isolated, eventually ineffective in all of its functions, and as often now, a holding operation without vigor. This can come about when the service function is the sole emphasis. It must now be recognized that the service function will deteriorate, and the WEU retrogress, when its educational and research functions are

inadequate. The enthusiasm of neither the medical profession nor the public can be enlisted in what they regard as commonplace activity confined to community service. Evaluating and rehabilitating cardiac patients become effective and exciting when the WEU program is based on solid research which includes studies of physiological response to exercise, psychosocial determinants of work performance, and the effect of intervening to mitigate risk factors in the cardiac patient. There is still much to be learned about physical reconditioning, psychosocial readjustment, and maximum rehabilitation of the cardiac patient which can be pursued in an active WEU research program. Not only do such programs provide a base of information for more effective service, they are more likely to be supported by the practicing referring physician than programs which provide no new information on his patient.

A balanced program with multi-disciplined staff requires work under the aegis of a modern medical center. A firm research program, now the weakest aspect of most WEUs, can help to insure an integration of the WEU into the new medical and rehabilitation structure which is becoming aware of its responsibilities to patients with long-term disease, to medical care after acute illness, to community service, and to continuing professional and public education. A research and teaching program can help to insure direct participation of the various related departments of medicine in the medical center, with the WEU becoming an integral part of physician education in comprehensive family care. Capable professionals seek out or gravitate to centers of intellectual activity; their interest rarely is enlisted in the routine or the unimaginative, even if it should be remunerative. The integration of modern concepts of preventive medicine and the WEU educational and research programs with traditional medical training in diagnosis and management of the acutely ill patient can have a salubrious effect on the education of young physicians, preparing and challenging them for the broader responsibilities of medical care now required.

The medical orientation of the units must be maintained through coordinated use of the expertise of personnel from many disciplines. The existing primary social service orientation of some WEUs results in deterioration of the very social service that WEU strives to provide, allowing the function to be taken over by agencies outside medical control.

The problem of economic support of the WEU is demanding. Several sources have been inadequately exploited. Some continued AHA and affiliate heart association support is required until more viable and integrated WEU function can be realized, at least in a few successful demonstration models. Government research support has hardly been touched. Yet in study councils and in the Congress there is great interest in supporting well-designed studies which intervene on factors of risk in the cardiac patient. State and Federal public health departments, social security, and rehabilitation agencies are alert to new possibilities for effective application of the public resources when there is evidence of sound concept and program. Consideration can be given also to joining the WEU with the voluntary groups involved in evaluation and rehabilitation of the patient with chronic pulmonary disease.

The future of the WEU is now in doubt. The attention of all physicians, especially those active in the work of the American Heart Association is directed to the recently published *Proceedings of the Third National Conference on Work Evaluation Units*[1] available through the Heart Association. Informed opinion on the future role and structure of the WEU should be made known to the Heart Association and active interest channeled through the local WEU and the AHA Committee on Rehabilitation.

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2. GOLDWATER, L. J., AND BRONSTEIN, L. H.: Fifteen years of cardiac work classification. J Occup Med **1:** 145, 1959.
3. REHABILITATION PROGRAM ACTIVITIES: Annual program reports. American Heart Association, 1964-65.

Planning a Curriculum

The most important stimulus in planning the new curricula comes from the desire 'to instruct less and educate more': this is at the same time the most important and the most difficult objective to translate into effective terms. It certainly means that we must be prepared to omit. We all know that this is easy to say and difficult to achieve; we are prepared to sacrifice the other man's field but seldom our own. Yet it must be done, for the worst enemy of education is to attempt to cover the elements of everything. Too often now the medical student is in the position of learning the rudimentary facts only, proceeding through his 6 years always at the beginning of new subjects, always memorizing and never with the opportunity to go deep enough into anything to learn to think. We have to accept the paradox that we must take risks of omission and at the same time we must allow the student to go deeper into at least one or two disciplines, not in any sense to make him a specialist, but in order that he may learn something of scientific method and thought which he can carry into all of his work.—J. H. F. BROTHERSTON: *The new curricula.* Scot Med J, **7:** 293, 1962.