

CLINICAL CONSULT COLUMN

Dear Editor:

I recently finished my residency in physical medicine and rehabilitation and have accepted a position in a large medical center. Most of my residency training involved working in acute rehabilitation settings, but my new position will involve primarily outpatient work. My new employer explained that our outpatient program is closely affiliated with a sizable vocational rehabilitation program. I've had difficulty getting straight answers about my role as a physiatrist with such a program. Is there much work to do with patients who are long-term postinjury? How do I define my role? Is my role likely to be a minor or major one?

RL
Omaha, Nebraska

Dear RL:

Thanks for your question. First, I would like to say that you are not alone with regard to your relative level of confusion relating to the topic of the role of the physiatrist in vocational reentry. It is my opinion as a staunch advocate for physiatric involvement in postacute care that often the physiatrist is underutilized in this aspect of the clinical continuum. All too often, the lack of information from the physiatrist regarding functional impairments can impede vocational reentry efforts. A good interdisciplinary team approach should involve the physiatrist in several key ways. First, the physiatrist should provide information to the vocational rehabilitation specialists regarding identification of specific areas of impairment and more importantly, how these areas of impairment may impact functionally on the person's performance in the workplace and community at large. Second, as specific functional problems are addressed and identified by the vocational team, the physiatrist may serve to provide recommendations from a neuromedical and rehabilitative standpoint regarding these issues.¹ There should definitely be ongoing opportunities to follow up patients once they have left the acute care setting. Part of this follow-up should include interfacing with treating professionals including vocational specialists. This type of cross-communication only further augments vocational rehabilitation efforts. Some of

the areas that may be problematic in the work setting that can be addressed by the physiatrist to at least some extent include: cognitive issues including distractibility, speed of processing deficits, and memory impairment; behavioral problems including impulsivity, irritability, fatigue, and episodic dyscontrol; functional mobility deficits; and sensory impairment including diplopia, photophobia, hearing deficits, vestibular disorders, tinnitus, olfactory dysfunction, and balance problems. Obviously, other neuromedical disorders associated with traumatic brain injury (TBI) may present obstacles to vocational re-entry, particularly posttraumatic epilepsy which not infrequently (approximately 20% of the time) will present as temporolimbic epilepsy. Neurorehabilitationists must have a firm grasp on not only the rehabilitative interventions that they might offer patients at this stage of recovery but also the full complement of neuromedical interventions that may be appropriate to address issues germane to this class of post-TBI impairments. Of course not everyone requires physiatric intervention, but I do feel that follow-up is still indicated if nothing more than "follow along." A well-trained physiatrist who can interface and communicate with patient, family, and treatment team only augments the rehabilitation process, thereby optimizing vocational reentry success. If you are interested in further readings in this area, there are several good references available.²⁻⁴

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Editor

REFERENCES

1. Zasler ND. The role of the physiatrist. In: Wehman PH, Kreutzer JS, eds. *Vocational rehabilitation for persons with traumatic brain injury*. Rockville, MD: Aspen, 1990; 71-89.
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