

1: Office of Medical History

9 June > 44 men from MRTC, Camp Pickett, Blackstone, Virginia to rehabilitating and reconditioning convalescent patients. relating to the th Station.

These are familiar and compelling images of earlier urban and residential life in America. For two centuries, awnings not only played an important functional role, they helped define the visual character of our streetscapes. Storefront awnings over sidewalks and entrances were typical features of American streetscapes for much of the 19th and 20th centuries. Throughout their history, awnings have had great appeal. Along with drapes, curtains, shutters, and blinds they provided natural climate control in an age before air conditioning and tinted glass. Awnings permitted window-shopping on rainy days; they protected show window displays from fading due to sunlight. Manufacturers came up with attractive, attention-getting awnings featuring distinctive stripes, ornate valances, and painted lettering and logos. With a wide range of color and pattern choices, owners could select an awning that complemented the building and get both style and function in a relatively affordable package. In recent years, building owners and others interested in historic buildings have rediscovered awnings. Awnings were an easy way to dress up and distinguish homes of virtually any style. Continued concerns over energy efficiency have also persuaded building owners and developers to use awnings to reduce heat gain, glare, and cooling costs. Because awnings were so common until the mid-twentieth century, they are visually appropriate for many historic buildings, unlike some other means of energy conservation. This Preservation Brief provides historical background information about diverse awning applications in the United States; suggests ways that historic awnings can best be maintained, repaired, and preserved; and recommends the varying circumstances in which replacement in kind, or new awning design may be appropriate for historic buildings. Records dating back to ancient Egypt and Syria make note of woven mats that shaded market stalls and homes. In the Roman Empire, large retractable fabric awnings sheltered the seating areas of amphitheatres and stadiums, including the Coliseum. The Roman poet Lucretius, in 50 B. Early 19th century awnings featured canvas coverings stretched between the building facade and post-supported front bars. Projecting frameworks of extension bars were not common until later in the century. Awnings in the 19th Century When awnings began to commonly appear on American storefronts-during the first half of the 19th century-they were simple, often improvised and strictly utilitarian assemblies. The basic hardware consisted of timber or cast iron posts set along the sidewalk edge and linked by a front cross bar. To lend support to larger installations, angled rafters linked the front cross bar to the building facade. The upper end of the canvas was connected to the facade with nails, with grommets and hooks, or by lacing the canvas to a headrod bolted to the facade. The other projecting end of the canvas was draped over, or laced to, a front bar with the edge often hanging down to form a valance. On ornate examples, metal posts were adorned with filigree and the tops decorated with spear ends, balls or other embellishments. On overcast days or when rain did not threaten, the covering was often rolled up against the building facade; during the winter months proper maintenance called for the removal and storage of awnings. Photographs from the mids often show the bare framework, suggesting that the covering was extended only when necessary. Canvas duck was the predominant awning fabric. A strong, closely woven cotton cloth used for centuries to make tents and sails, canvas is a versatile material with a relatively short lifespan compensated for by its low cost. During the second half of the 19th century, iron plumbing pipe became a popular material for fixed awning frames. Here, a pipe frame without its canvas cover extends around the corner of a building in Washington, D. Awnings became a common feature in the years after the Civil War. Iron plumbing pipe, which was quickly adapted for awning frames, became widely available and affordable as a result of mid-century industrialization. It was a natural material for awning frames, easily bent and threaded together to make a range of different shapes and sizes. At the same time the advent of the steamship forced canvas mills and sail makers to search for new markets. An awning industry developed offering an array of frame and fabric options adaptable to both storefronts and windows. Operable Awnings In the second half of the 19th century, manufactured operable awnings grew in popularity. Previously, most awnings had fixed frames-the primary way to retract the

covering was to roll it up the rafters by hand. Operable systems for both storefront and window awnings had extension arms that were hinged where they joined the facade. The arms were lowered to project the awning or raised to retract the awning using simple rope and pulley arrangements. Because the canvas remained attached to the framework, retractable awnings allowed a more flexible approach to shading-shopkeepers and owners could incrementally adjust the amount of awning coverage depending upon the weather conditions. When the sun came out from behind clouds, the awning could be deployed with ease. In case of sudden storms, owners could quickly retract the awning against the building wall where it was protected from wind gusts. A 19th century shoe store in Richmond, Virginia had an operable awning retracted against the building facade. Hinged extension arms were raised and lowered allowing for an awning configuration easily changed in response to weather conditions. This photo shows how the fabric gathered and was exposed to the elements when retracted - part of the reason roller awnings later became prevalent. But the early operable awnings had their own drawbacks. When retracted, the coverings on early operable awnings bunched up against the building facade where it was still partially exposed to inclement weather. In fact, deterioration was often accelerated as moisture pooled in the fabric folds. Also, the retracted fabric often obscured a portion of the window or door opening and unless it was folded carefully, presented an unkempt appearance. Roller Awnings Addressing the drawbacks of the original hinged awning, new roller awnings featured a wood or metal cylinder around which the canvas was stored when the awning was retracted. When fully retracted, only the valance was visible. The roller was usually bolted to a backboard set against the building and protected beneath a wood or galvanized metal hood. In some cases it was installed in a recessed box built into the facade. A long detachable handle called a "winding brace" , or a gearbox and crankshaft attached to the building, was used to turn the roller. Some later models were operated by electric motor. Rollers, especially those on window awnings, often contained a spring that helped retract the awning and kept the canvas from sagging excessively. The roller bar at the top of a fixed-arm awning is cranked to release the fabric. As the canvas unfurls the vertical arms swing downward from their lower point. Because the pictured awning had a large projection, extending far from the building wall, the lower hinges were mounted on vertical slide rods affixed to the facade. When the awning is lowered, the bottom hinges of the arms travels up the slide rod to increase headroom beneath the fully extended awning. Most 19th century roller awnings had fixed arms that were similar to those found on the earlier operable awnings. The arms hinged flush to the building when the awning was retracted and, with the help of gravity, straightened out over the sidewalk when extended. Shapes and Stripes An expanded variety of available canvas colors, patterns, and valance shapes also appeared during this period. Some coverings were dyed a solid color; shades of slate, tan, and green were especially popular. Others had painted stripes on the upper surface of the canvas. A wide selection of striped patterns took the awning beyond its original, utilitarian function to serve as a decorative and appealing building feature. The broader choice of frame and canvas options encouraged the reassessment of awnings simply as a means to provide shelter from rain and sun. Homeowners found that the new generation of awnings could enhance exterior paint schemes and increase the visual appeal of their homes. Manufacturers developed new awning shapes, colors, patterns and hardware to fit different house, door, window and porch styles. They were an affordable, quick and simple improvement. They also proved to be an easy means of capturing outside space. Homeowners could use awning-covered balconies, porches and patios at any time of day; grocery stores were able to convert sidewalks to outdoor display areas protected from sunlight and quick changes in the weather. On Main Street, businesses used the expanded repertoire of awnings to draw attention to their buildings with bright colors, whimsical stripe patterns and exotic scallops. It was a trend that would culminate over a century later with awning installations in which shelter was secondary to advertisement. Awnings in the 20th Century Scissor arm awnings have a pair of vertical, hinged arms on either side of the assembly supporting the front bar. To unfurl the awning, the roller is cranked and the arms extend outward pulling the cover away from the roller. Awning development during the early twentieth century focused on improving operability. Variations in roller awnings addressed the need to provide an increasingly customized product that accomodated a wide range of storefront configurations and styles. New folding-arm awnings appeared that operated either vertically or horizontally supplementing the fixed-arm awnings developed in the latter 19th century. Vertical

folding arms were made up of smaller hinged arms that crossed like scissors. Operated by gravity the arms extended outward pulling the covering off the roller. Like a fixed-arm awning, the pitch of a scissors-type awning varied depending on whether it was fully or only partially extended. Somewhat different was the "lateral arm awning" a horizontally operating awning that worked like a human elbow with the spring action in the arms pushing outward toward the street, unfurling the cover from the roller and maintaining tension. Lateral arm awnings featured a shallow drop that remained relatively constant regardless of how far the arms were extended. Scissor arm awnings have a pair of vertical, hinged arms on either side of the assembly supporting the front bar. Operable awnings, whether fixed arm, scissors arm, or lateral arm, rapidly gained popularity as customers came to appreciate the flexibility, concealed appearance, and longer lifespan made possible by roller units. When lateral arm awnings were installed across a broad storefront or porch, manufacturers recommended spacing the arms at approximately eight foot intervals. New Coverings Slower to change was the fabric used to cover awnings. Canvas duck remained the common awning fabric during the first half of the twentieth century. However, its tendency to stretch and fade, and its susceptibility to mildew, and flammable materials like cigarettes and matches motivated the awning industry to search for alternatives. Shortly after World War II, a vinyl plastic coating that increased fade and water resistance was first applied to the canvas. By the s, vinyl resins, acrylic fibers and polyester materials were all being used to provide a longer-lasting awning cover. Ironically, just when these innovations promised more durable awnings, the fabric awning industry felt the debilitating impact of changing architectural fashion, the widespread adoption of air conditioning, and the increasing availability of aluminum awnings. Modernism dominated commercial architecture during the postwar era. Colorful awnings seemed old-fashioned, an unwanted distraction from the smooth lines of the machine aesthetic. The preference, instead, was for perforated structural screens or brises-soleil French: It was assumed that new buildings had no need for awnings. Widely available for the first time, mechanical air conditioning threatened to make the awning an unnecessary vestige of an earlier era. Awning companies fought back with arguments that traditional shading systems could reduce the required size and investment in air conditioning systems. Though canvas awnings continued to be used on contemporary buildings, new types were often selected to do the job, aluminum and fiberglass awnings.

2: Utah Department of Transportation

Convalescent reconditioning applies to all specialties but it is of vital importance to psychiatry not only because of its specific value in functional disabilities but also owing to the large number of such disabilities.

Brigadier General Paul R. Aaron, Chief Nursing Division 6 Introduction: The overall scope of the Program was to hasten the return of patients to active duty. Rehabilitation activities in the Office of the Chief Surgeon had already begun on the initiative of Lt. Each convalescent patient was graded periodically by his Medical Officer. His activities were prescribed in accordance with his rate of recovery and his MOS. The overall program was adapted to Theater requirements and proportioned among physical and military reconditioning and recreational diversion. The program was a success because it furnished those disabled patients with such hospitalization facilities as would speedily restore them to good health and fighting efficiency. It was not sufficient to cure the patient of his disease or injury; it was necessary that the proper treatment cover the entire period until he was physically and mentally fit to return to his unit. The Rehabilitation Program effectively covered that phase, from the time the soldier became a convalescent patient and could leave the hospital until he had completely recovered and could return to his unit!

Training in Rehabilitation Exercises: The CO, 8th Convalescent Hospital, had recently discussed this program with all interested parties and indicated a series of exercises for muscle re-education. Physical rehabilitation, to a large extent, was to be conducted by Medical Department Enlisted personnel at each hospital under the direction of a specially trained Non-Commissioned Officer. A total of eight 8 Non-Commissioned Officers was to be trained at each course, and courses were to be continued until one 1 NCO from each Hospital had been trained! Commanding Officers were instructed to make a careful selection of the NCO to conduct the program and give special attention to the development of a cogent program. The selected Non-Commissioned Officer was instructed to train sufficient Enlisted Ward Attendants to insure that Rehabilitation exercises be conducted on each Hospital Ward. Trained War Attendants, in turn, were supposed to instruct selected ambulatory patients in conducting these exercises. The initial course for NCO instruction was to start 18 October Each Hospital Commander was therefore instructed to submit to his Base Section Surgeon, the name rank and serial number of the NCO designated to attend. Orders were to be published and distributed by the respective Base Sections.

Convalescent Rehabilitation in Hospitals: The general purpose of the Rehabilitation Program was the return to duty of service personnel, recovering from disease or injury, in the best possible physical and mental condition through the use of planned physical conditioning and the constructive use of leisure time in educational pursuits designed to effect a greater realization of personal importance and produce a more informed soldier. There was also the need to restore physical health and vigor and to foster the mental toughness so essential for effective military duty. The Officer was expected to create the desire to get well and the expectancy of further service. Hospitals that had already carried out intensive Rehabilitation programs found out that: Pictures illustrating aspects of general rehabilitation activities, military training, and occupational therapy conducted at the Convalescent Centers. They were divided into groups for medically supervised exercises according to anatomical limitations such as upper and lower extremity, abdominal, and special cases. Frequent rest periods were essential. As convalescence progressed; it became higher in physical training and proportionately lower in educational subjects. This program was designed to produce gradual progress and improvement in strength and resistance to the point where the patient could be discharged from the hospital and assume full military duty without physical injury to himself. It was important to begin Rehabilitation while the patients were still in the hospital ward. It was equally underlined to introduce the Rehabilitation Program as soon as the convalescence was begun. As convalescence progressed, the soldier was able to consult his physician and follow his advice. It was important for morale that wholehearted effort and optimistic enthusiasm be directed by hospital personnel toward the success of this Program. The physical training during the hospital ward phase consisted of the following: Stinchfield, during a demonstration held for student Officers at the Rehabilitation Center No. The Chief Surgeon, ETOUSA, as part of the general Hospital Rehabilitation Program in operation, instituted and conducted a program of military training based on the physical capability of the patients. The

program for patients in the early phase of Rehabilitation emphasized individual training in Physical Conditioning and Basic Military Training. Interesting, helpful, informative, and educational talks and discussions were to be brought to the bedside in the wards. Later, a central point could serve for lectures and demonstrations. About two hours daily were to be reserved for classes in military instruction, training films, and in general education. The Medical Department Officer chosen for this work was to be capable of enthusiastic and dynamic direction. General Hospitals caring for patients returned from combat found it desirable to employ in the Rehabilitation Program, Officers and EM who had had previous combat experience overseas or long service with tactical units. It was recommended to make use of the Chaplain, the American Red Cross staff, the Instructors on the post, air base, camp, or station. Guest speakers were to be invited from the community and from adjacent educational and cultural institutions. It was highly recommended to combat idleness and boredom in the hospital with interesting directed activity. It was underlined that any patients capable of a prompt return to full duty after a short illness were NOT to be retained in the hospital for the rehabilitation training. The Rehabilitation activities to be conducted by General and Station Hospitals were not meant to replace the need for or the use of rehabilitation activities in Convalescent Hospitals as per instructions dated 19 Oct 43, selected patients who could not be returned to duty within fourteen 14 days were to be transferred to the 8th Conv Hosp " those patients who could return to duty within fourteen 14 days were logical candidates for General and Station Hospital Rehabilitation Programs "ed. It was important to maintain medical supervision at all times over all aspects of the training program to prevent any harmful overdoing and to encourage advancement. It was recommended that once a week a representative specialist in the field of the original disability examine the patient to insure satisfactory progress. The Medical Officer in charge of the Rehabilitation Program was to accept responsibility for the indoctrination of all other Medical Officers, Nurses, and other personnel in the General or Station Hospital, in the principles of rehabilitation for duty. The dearth of scientific medical information concerning convalescence gave an unparalleled opportunity for accumulation of valuable data and findings for future use to medicine. Also foreign language kits French, German, Italian were considered, accompanied with linguaphone language classes. Also included were orientation films, Army-Navy movies, and GI movies.

3: Building Repair and Rehabilitation Consulting Services | CTLGroup

When convalescent reconditioning was established as an Army program, hospital commanders placed that activity in a variety of locations in their organizational structures; but by February the Surgeon General's Office concluded that reconditioning should be considered as a professional service on a par with medical and surgical services.

Treatment options can be broadly divided into nonsurgical and surgical, with the majority of patients initially placed on a trial of conservative therapy. For those with irreparable RCT, low functional demand, or interest in nonoperative management, there are a number of nonsurgical treatments to consider, including rehabilitation and injections of corticosteroids, hyaluronate, and platelet-rich plasma. Surgical treatment is increasingly common, as geriatric patients remain active with high functional demands. Studies in elderly populations have demonstrated satisfactory healing and clinical results following surgical repair. Predictors of poor outcome after repair are large tear size as well as higher stages of fatty infiltration. Decompression is a less invasive surgical option that has been shown to provide short-term pain relief, though the lasting effects may deteriorate over time. A number of factors must be weighed when considering which patients are likely to benefit from surgical intervention. Management can be broadly divided into nonsurgical and surgical treatment. The majority of patients are initially placed on a trial of nonsurgical management, since symptoms may resolve or become tolerable to a point of satisfaction. A common feature shared among nonsurgical protocols is a rehabilitation program to strengthen and support the affected shoulder. Various injections into the subacromial space and glenohumeral joint have been used, including, but not limited to, corticosteroids, hyaluronic acid, and, in recent years, platelet-rich plasma PRP. These interventions have provided mixed results. In cases of failed conservative treatment in appropriate surgical candidates, options for further management include repair of the RCT or decompression and debridement. A major concern with RCT repairs in older patients is decreased vascularity and healing potential of the tendons. The challenge, therefore, becomes identifying patients with the greatest chance for a successful repair and optimizing timing such that the tear does not progress to a point of irreparability. Nonsurgical Management Exercise and Rehabilitation Exercise and rehabilitation, often conducted under the guidance of a physical therapist, are an important part of managing RCT in the elderly patients. In their multicenter, prospective cohort study of full-thickness RCT in patients with an average age of 62, Kuhn et al 15 tracked long-term outcomes following a week physical therapy protocol. Similar satisfaction rates were found by Merolla et al 16 in their study of 40 patients older than 60 who underwent 6 months of nonoperative treatment for RCT, which included pain control, stretching, and strengthening. Moosmayer et al 17 conducted a randomized controlled study comparing nonoperative treatment to repair in small- and medium-sized RCT. Patients randomized to physiotherapy average age 61 underwent a twice-weekly rehabilitation protocol for a minimum of 18 weeks. These results suggest that exercise protocols are effective at providing pain relief and satisfaction in the majority of elderly patients with RCT. However, functional outcomes may be superior following surgical repair in those with smaller tears that are amenable to surgery. Corticosteroid Injections Corticosteroid injections CSI are often used to treat tendon pathology due to their powerful anti-inflammatory effects. Supraspinatus biopsies from patients receiving subacromial injections of methylprednisolone have demonstrated potentially harmful effects of steroids on tendons, including decreased cell proliferation and vascularity. In their study of 78 patients with RCT average age 62, Shibata et al 26 randomized patients to 5-weekly injections of either dexamethasone or hyaluronate into the glenohumeral joint. Four weeks after the final injection, Taken together, the current evidence does not categorically support the use of CSI for definitive nonsurgical management of RCT. Hyaluronate Injections Hyaluronate is a component of synovial fluid that contributes to joint lubrication, 27 and it is has been used to treat patients with rotator cuff injury. Chou et al 28 conducted a randomized, double-blind, placebo-controlled trial of hyaluronate injections for patients with rotator cuff lesions and partial RCT, however, none had complete tears. Patients were given weekly injections of 25 mg sodium hyaluronate SH for 5 consecutive weeks, and after unblinding, patients randomized to placebo were given the option to undergo SH injections. It should be noted that the published minimal clinically important difference for Constant scores in patients with

RCT is estimated to be The previous studies on hyaluronate for RCT included patients with average age less than 60 years, and as such, no definitive conclusions can be made regarding its efficacy for geriatric RCT. The results in younger patients are mixed, and further studies should be conducted to determine the utility of hyaluronate injections in managing RCT. Platelet-Rich Plasma Injections Platelet-rich plasma is an autologous blood product containing supraphysiological concentrations of platelets that can activate various growth factors involved into the tissue repair process. No such study has clearly shown definitive clinical benefit. At 1-year follow-up, the authors found that PRP was no better than placebo at improving quality of life, pain, disability, and shoulder range of motion. In contrast, positive results were reported by Rha et al 39 in their study of 39 patients average age 45 with tendinosis or partial RCT. Patients were randomized to either 2 injections of PRP or dry needling spaced 4 weeks apart. At the 6-month follow-up, those treated with PRP had superior results in terms of pain, function, and range of motion. Clinical results are mixed and do not currently demonstrate its efficacy in nonoperative management. Further, none of the current literature evaluates the use of PRP in the elderly population, and as such, the evidence does not suggest any benefit. Surgical Management Surgical Repair A number of recent studies have investigated the rates of healing and satisfaction in elderly patients undergoing surgical repair of full-thickness RCT. In a prospective trial by Flurin et al 40 in patients older than 70 years, RCT were randomized to either repair or decompression. The authors reported improved Constant 19 and ASES 18 scores in both groups at 1-year follow-up, however, the repair group scored significantly better than those with decompression alone. Complete healing was found in However, higher retear rates have also been reported, 46 , 47 in particular when stratifying results for large and massive RCT. Decompression and Debridement Without Repair Subacromial decompression, acromioplasty, and debridement of RCT without repair are reasonable alternatives in those patients for whom repair is unlikely to succeed or in patients with low functional demands seeking pain relief. Kempf et al 53 retrospectively reviewed cases of RCT treated with acromioplasty average age 61 , and, at a minimum 1-year follow-up, The authors advocate acromioplasty, especially for elderly patients with less functional demand. Other studies report less favorable results from debridement and decompression as definitive treatment for RCT. A recurrent concern with this management option is that the initial pain relief and satisfaction may deteriorate over time. Zvijac et al 59 performed a longitudinal study of 25 patients with full-thickness RCT who underwent arthroscopic subacromial decompression. The current literature suggests that decompression and debridement can provide relief and satisfaction, a result found in a majority of patients, however, there may be concern regarding its long-term satisfaction. Conclusion Rotator cuff tears are common among the aging population and can be managed through either nonoperative or surgical therapy. Conservative management is an important first-line approach for those with irreparable tears, low functional demand, or interest in pursuing nonsurgical treatment. The results of rehabilitation programs to strengthen and support the shoulder have been positive and provide satisfaction to the majority of patients. Often rehabilitation is supplemented by injections of corticosteroids, hyaluronate, or PRP. The current literature raises concerns over the possible detrimental effects of CSI on tendon and muscle tissue, and the clinical evidence does not currently support the use of hyaluronate or PRP as definitive therapy for nonsurgical management of RCT in the elderly patients. As geriatric patients are increasingly active with higher functional demands, more patients are being considered for surgical management of RCT. The current evidence has shown that satisfactory healing and functional results can be achieved through repair, especially when selecting those patients and tear characteristics that are most amenable to surgery. Caution should be used when considering repair of large and massive tears or tears with a high degree of fatty infiltration. Further, patient comorbidities must be considered when determining who can safely undergo surgery. Decompression with debridement is able to provide pain relief and satisfaction in those with irreparable tears, though concern may exist regarding deterioration over time. Footnotes Declaration of Conflicting Interests: Rotator-cuff changes in asymptomatic adults. The effect of age, hand dominance and gender. J Bone Joint Surg Br. Abnormal findings on magnetic resonance images of asymptomatic shoulders. J Bone Joint Surg Am. The demographic and morphological features of rotator cuff disease. A comparison of asymptomatic and symptomatic shoulders. The impact of aging on rotator cuff tear size. Pathology of the torn rotator cuff tendon. Reduction in potential for repair as tear size increases. In vivo

measurement of tissue metabolism in tendons of the rotator cuff: In vivo visualization of vascular patterns of rotator cuff tears using contrast-enhanced ultrasound. *Am J Sports Med.* Contrast-enhanced ultrasound characterization of the vascularity of the rotator cuff tendon: *J Shoulder Elbow Surg.* Prospective analysis of arthroscopic rotator cuff repair: Factors affecting healing rates after arthroscopic double-row rotator cuff repair. Arthroscopic repair of full-thickness tears of the supraspinatus: The factors affecting the clinical outcome and integrity of arthroscopically repaired rotator cuff tears of the shoulder. Outcome of nonoperative treatment of symptomatic rotator cuff tears monitored by magnetic resonance imaging. Clinical and structural outcomes of nonoperative management of massive rotator cuff tears. Effectiveness of physical therapy in treating atraumatic full-thickness rotator cuff tears: Conservative management of rotator cuff tears: *Muscles Ligaments Tendons J.* Comparison between surgery and physiotherapy in the treatment of small and medium-sized tears of the rotator cuff: Reliability, validity, and responsiveness of the American Shoulder and Elbow Surgeons subjective shoulder scale in patients with shoulder instability, rotator cuff disease, and glenohumeral arthritis. A clinical method of functional assessment of the shoulder. *Clin Orthop Relat Res.* Treatment of tendon disorders. Is there a role for corticosteroid injection? Intra-articular steroids in the treatment of rotator cuff tear: *Arch Phys Med Rehabil.* Results of nonoperative management of full-thickness tears of the rotator cuff. Glucocorticoids induce specific ion-channel-mediated toxicity in human rotator cuff tendon: *Br J Sports Med.*

4: Medline: Manufacturer, Distributor of Healthcare Products and Solutions

The third biannual International Extreme Sports Medicine Congress, which will be held at the St. Julien Hotel in Boulder, Colorado June , will include presentations on extended topics in the.

On 15 December , Changes No. Liberally interpreted, this meant that psychiatric patients, if treated and rehabilitated within a reasonable period of time, could be returned to duty. However, many psychiatric patients, regulations notwithstanding, had, before this time, received some sort of treatment. Occupational therapy and recreational diversional activities, used in civil hospitals for many years, had been introduced into the Army hospitals with the civilian psychiatrists and the American Red Cross arts and crafts and recreational workers. In the Army, these civilian psychiatrists, now military officers, soon discovered that disposition procedures were frequently long drawn out affairs, especially for psychotic patients recommended for transfer to State hospital care. They, therefore, attempted some measure of treatment so that these patients as well as those with severe neurotic tendencies could be sufficiently improved to be discharged to their own custody or to that of immediate relatives, thus materially speeding up the process and freeing much needed beds. There were no official directives or standards to insure uniform methods of treatment so that any treatment given varied not only from post to post but also from psychiatrist to psychiatrist. Born of necessity to conserve manpower from an administrative 1Menninger, William C.: Psychiatry in a Troubled World: Convalescent Programs Authorized Late in , military and civilian opinions were being expressed relative to the development of special accommodations for convalescent patients. W, which authorized convalescence and reconditioning in hospitals. Although the convalescence program actually proceeded faster than the reconditioning program, there had been and there followed some effort in reconditioning and rehabilitating patients, including those with psychiatric problems. Occupational therapy was in prior use, especially for psychiatric patients. It was officially authorized for general hospitals on 12 August , with the issuance of Circular Letter No. Reconditioning Programs Authorized More than a month after occupational therapy had been officially recognized, and 3 months after the convalescent program had been approved, The Surgeon General, in Circular Letter No. The prime objective of this program was to return recovered medical and surgical patients to duty in the best possible condition. At this time, however, there were no provisions to include psychiatric patients in the program. Apparently, the program did not develop as rapidly as was desired because, on 10 December , The Surgeon General issued Circular Letter No. Psychiatric patients in general hospitals were mentioned, but they were to be placed in specific centers or on special wards; they were not to be intermixed with other patients. Hospitalization and Evacuation, Zone of Interior. Government Printing Office, , p. This presented, in detail, various treatment procedures but did not officially include psychiatric patients in the reconditioning program. Except for those patients capable of returning to duty, neuropsychiatric patients are not to be included in the reconditioning program but are to be handled separately and provided with the program outlined above. There should be cooperative efforts between the two programs in the utilization of special instructors and physical facilities. Psychoneurotic patients, as a group, cannot maintain competition in the physical training of the reconditioning program, and their failure not only affects them adversely but grossly interferes with the effectiveness of the program for the individuals for whom it is designed. Thus, as a modification of the directive, the psychiatric patients were included but with definite limitations. Barton, MC,4 a psychiatrist and the assistant director of the Reconditioning Division later the Reconditioning Consultants Division , with the support of the Neuropsychiatry Consultants Division, directed his influence and efforts to improving the psychiatric reconditioning program. Regard every case as salvageable. Start treatment as early as possible. Avoid the hospitalization of psychoneurotics. Remove situational factors if possible. An individual or group approach as indicated. On 19 August , he was assigned to the Reconditioning Division as Director. On 3 February , Col. Current Trends in Military Neuropsychiatry. Planned activities can serve as a trial at duty. Proper job assignments are most important. Smith⁶ commented on the convalescent reconditioning program as follows: Convalescent reconditioning applies to all specialities but it is of vital importance to psychiatry not only because of its specific value in functional disabilities but also owing to the

large number of such disabilities. Psychiatrists are fully aware of the value of a reconditioning program, and probably are better informed than most medical officers as to how it may specifically function. At some military installations a psychiatric medical officer has been appointed as reconditioning officer. In civilian life every physician who successfully treated psychoneuroses learned that treatment must be based on carefully planned purposive constructive scheduled activities. Psychotherapy was necessary, but in many cases failed to achieve results unless the work, play, rest, and exercise of the patient were organized constructively along principles of good mental and physical hygiene. Barton,⁷ in summarizing the reconditioning program, stated: Out of the renewed interest in the convalescent patient brought about by the necessities of war, it may be anticipated that increased attention will be given in civilian practice after the war to reconditioning. The reconditioning program begins while the patient is still in bed. A planned program of physical fitness training of educational reconditioning and of recreation has been instituted in all Army hospitals. An occupational therapy program stressing masculine interests, new activities, and useful work has been developed and coordinated with physical therapy and remedial exercise under medical supervision. Patients are removed from the over-protecting sympathy and sick-bed atmosphere of the hospital as soon as possible and segregated in a Reconditioning Unit to continue their convalescence. Progressive physical training, education and recreation are planned to direct attention from disability and illness to healthy activities that promote physical and mental fitness. Rehabilitation, which has as its objective the retraining of individuals to overcome the handicaps of disabilities, the development of self-reliance and social adjustment and placement in useful work assignment, is largely the responsibility of other government agencies. The medical department of the Army can undertake the beginnings of such rehabilitation simultaneously with medical and surgical treatments. Rehabilitation programs of the blind, the deafened and the amputee were briefly presented. The overall reconditioning program, however, was authorized for all hospitals of sufficient bed capacity to make the program worthwhile. The specially designated centers in were: Treatment Activities in War Psychiatry.

5: Preservation Brief The Use of Awnings on Historic Buildings, Repair, Replacement and New Design

Rate Running Contract for repair maintenance of split type/window type Air conditioners and water coolers installed at various offices of CDA Islamabad (for the year) etc download November 14,

Today, only the building at the end of the "circle" and the Swimming Pool extreme top left survive. By early summer of , Atterbury was an efficient army training camp with growing medical needs. Because of its immense growing size, the army soon realized that Atterbury needed its own hospital. The original hospital plans included completion of the buildings by the end of June, However due to weather-oriented delays, only a temporary dispensary was set up by this deadline. This primitive makeshift medical center was set up in a large building near Schoolhouse Road and Division Street. It was established by Major Carlos Fish in June, During June and July the 43 concrete buildings were nearing completion. The hospital was put into use on August 1, although the buildings were not entirely completed until mid-October. In July of , news came of an expansion program to start in effect at Atterbury. These plans included the erection of buildings for the training of field hospital units. This was only the beginning. During the first two years of its service, it was called "Attebury Station Hospital", but in the Army decided that the it could become a better hospital with the addition of a few buildings, some special equipment, and some new doctors who specialized in different fields of medicine. In addition, three new buildings were constructed, some former barracks were converted into hospital buildings for use as clinics and wards. Air conditioning was installed in X-ray labs, and a ventilation system installed in all wards. This air cleaning system could change the air in a room in one minute. The name of Atterbury General was soon changed upon the death of a dedicated medical officer. On May 8th, , Lt. Conner dedicated the hospital in honor of the late Colonel Frank B. In he was commissioned a Lieutenant in the U. Wakeman died in the summer of Wakeman Hospital was located in Block 10 and was bordered by the following roads: Hospital Road ran along the south side of the hospital and provided easy access to the hospital from the Atterbury medical field units stationed nearby. Riley Street bordered the hospital on the west. Edinburgh Street followed the north side of the hospital formation. Quinney Street bordered the hospital on the east. Wakeman Hospital was even more impressive on the inside. Thousands of disabled and disfigured men regained their limbs, faces, looks and pride in the five plastic surgery wards. At one time patients occupied the well-staffed plastic surgery wards. Some soldiers were brought to Wakeman with badly injured or destroyed eyes. The optical technicians at Wakeman could repair or replace damaged eyes to the best of surgical knowledge. Neuro-surgery and orthopedic surgery were also practiced at Wakeman. Soldiers experiencing convalescence for an extended period of time lived in barracks on Clark Street, just 2 miles from the hospital. The swimming pool was located in building The hospital had its own radio station, WAKE that made regular broadcasts. A publication of the hospital was the "Splint and Litter". After land acquisitions were made, the awarding of contracts began. The various jobs were divided into different sections. The main section, Section A, involved most of the buildings. Because this was such a large section, it was divided into the following parts: Section A-2 temporary buildings for troops or auxiliary units attached to the division; including 8 barracks, 78 mess halls, 22 administration buildings, infirmaries and post offices. Section A-3 Utility buildings, warehouses, workshops, quartermaster offices, bakery, laundry, fire stations, incinerators, cold storage buildings, steel igloos for ammunition, salvage yards, prisoner barracks and 14 guardhouses. Section A-4 Temporary buildings for the hospital complex constructed of cement blocks. The new hospital is semi-permanent in construction, ultra-modern in design and completely equipped. Its cement block exterior makes it the only unit in the Camp designed for permanent operations after the war. It is located in Block 10, between Edinburg Road and State Road and covers nearly 75 acres of ground. Thirty-one of the 43 buildings are connected by corridor, the longest one being over one-third of a mile long. Each of its connected ward buildings contain four wards in two-story buildings. This new improved arrangement, enjoyed only by Station Hospital at Camp Atterbury, gives it compactness in spite of its size and spaciousness. Charles Lonero, in charge of Medical Supply Department, was the first medical officer to arrive at camp. By the end of June, a temporary dispensary, under the direction of Maj. There were several officers assigned to report on July 1.

However, due to delay in construction, many received temporary assignments in other Army camps. Hendricks, Surgeon, did not arrive until the middle of July. During the next week about enlisted men arrived from Ft. These men were first assigned to cleaning everything in Block The new barracks soon became home, trash was burned, hospital windows were washed by scrub squads with gallons of suds. By August 1, Col. Carr was organizing the Dental Department and Lt. Grossman was aiding the Surgeon in organizing the many new hospital units. Aleshire under the supervision of Capt. It was September before nurses were seen in numbers. Similar to large corporations, the station hospital is departmentalized to conduct its work swiftly and efficiently. The medical service includes general, medicine, contagious, heart, respiratory, neurological, psychiatric, dermatological and gastro-intestinal sections. Veterinary service includes food inspection of animal origin both at processing plants and kitchens. Sanitary service includes public health, sewage disposal, mosquito control and checking on drinking water supplies. Dental service includes X-ray, extracting, plate work and general practice. The best and most advanced equipment has been installed in the pharmacy, X-ray department and general laboratory. The more than forty buildings in the hospital group are of the permanent type of construction. Constructed of concrete blocks, the buildings are two stories in height and connected with more than three miles of corridors. The hospital boasts the finest laboratory equipment designed and embodies the most modern type of construction.

Deliverable - Window Repair, Rehabilitation and Replacement: Draft Measure Guideline Prepared for: Building America 44 Figure Example sill detail of.

For most of the last century, people were discouraged from being active after a stroke. Around the s, this attitude changed, and health professionals began prescription of therapeutic exercises for stroke patient with good results. At that point, a good outcome was considered to be achieving a level of independence in which patients are able to transfer from the bed to the wheelchair without assistance. In the early s, Twitchell began studying the pattern of recovery in stroke patients. He reported on patients whom he had observed. He reported that most recovery happens in the first three months, and only minor recovery occurs after six months. Around the same time, Brunnstrom also described the process of recovery, and divided the process into seven stages. As knowledge of the science of brain recovery improved, intervention strategies have evolved. Knowledge of strokes and the process of recovery after strokes has developed significantly in the late 20th century and early 21st century. Current perspectives and therapeutic avenues[edit] Motor re-learning[edit] " Neurocognitive Rehabilitation by Carlo Perfetti concept", widespread in many countries, is an original motor re-learning theories application. Constraint-induced movement therapy The idea for constraint-induced therapy is at least years old. Significant research was carried out by Robert Oden. After two weeks of this therapy, the monkeys were able to use their once hemiplegic arms again. This is due to neuroplasticity. He did the same experiment without binding the arms, and waited six months past their injury. The monkeys without the intervention were not able to use the affected arm even six months later. In , this study was published, but it received little attention. Notably, the initial studies focused on chronic stroke patients who were more than 12 months past their stroke. This challenged the belief held at that time that no recovery would occur after one year. The patients undergo intense one-on-one therapy for six to eight hours per day for two weeks. The greatest gains are seen among persons with stroke who exhibit some wrist and finger extension in the effected limb. These changes accompany the gains in motor function of the paretic upper limb. The same general principals apply, however in this case, the client is constricted from using compensatory strategies to communicate such as gestures, writing, drawing, and pointing, and are encouraged to use verbal communication. Therapy is typically carried out in groups and barriers are used so hands, and any compensatory strategies are not seen. Mental Movement Therapy is one product available for assisting patients with guided mental imagery. Bobath concept In patients undergoing rehabilitation with a stroke population or other central nervous system disorders cerebral palsy, etc. Clinical studies that have combined mirror therapy with conventional rehabilitation have achieved the most positive outcomes. In a recent survey of the published research, Rothgangel concluded that In stroke patients, we found a moderate quality of evidence that MT as an additional therapy improves recovery of arm function after stroke. The quality of evidence regarding the effects of MT on the recovery of lower limb functions is still low, with only one study reporting effects. These findings have led to MSCs being considered for treatment of ischemic stroke, [36] specifically in directly enhancing neuroprotection and the neurorestorative processes of neurogenesis , angiogenesis and synaptic plasticity. Possible mechanisms of neurorestoration and neuroprotection by MSCs after stroke[edit] Transdifferentiation of MSCs into excitable neuron-like cells has been shown to be possible in vitro [32] [34] and these cells respond to common central nervous system neurotransmitters. Induction of neurogenesis development of new neurons is another possible mechanism of neurorestoration; however its correlation with functional improvement after stroke is not well established. MSC treatment also has shown to have various neuroprotective effects, [33] including reductions in apoptosis, [40] inflammation and demyelination, as well as increased astrocyte survival rates. However, for MSC treatment to be used effectively and safely in a clinical setting, more research needs to be conducted, specifically in the areas of determining the relative influences of key variables especially patient variables on patient outcomes as well quantifying potential risks, e. Although ethical concerns are mostly limited to the use of embryonic stem cells , [53] it may also be important to address any possible ethical concerns however unlikely over the use of somatic stem cells.

Training of muscles affected by the upper motor neuron syndrome[edit] Muscles affected by the upper motor neuron syndrome have many potential features of altered performance including: The term "spasticity" is often erroneously used interchangeably with upper motor neuron syndrome, and it is not unusual to see patients labeled as spastic who demonstrate an array of UMN findings. Various means are available for the treatment of the effects of the upper motor neuron syndrome. For muscles with mild-to-moderate impairment, exercise should be the mainstay of management, and is likely to need to be prescribed by a physiotherapist. Muscles with severe impairment are likely to be more limited in their ability to exercise and may require help to do this. They may require additional interventions, to manage the greater neurological impairment and also the greater secondary complications. These interventions may include serial casting, flexibility exercise such as sustained positioning programs, and patients may require equipment, such as using a standing frame to sustain a standing position. Applying specially made Lycra garments may also be beneficial. As previously described, the role of spasticity in stroke rehabilitation is controversial. However, physiotherapy can help to improve motor performance, in part, through the management of spasticity. In order to help manage spasticity, physiotherapy interventions should focus on modifying or reducing muscle tone. The problem with these medications is their potential side effects and the fact that, other than lessening painful or disruptive spasms and dystonic postures, drugs in general have not been shown to decrease impairments or lessen disabilities. The most commonly used medication for this is baclofen but morphine sulfate and Fentanyl have been used as well, mainly for severe pain as a result of the spasticity. Injections[edit] Injections are focal treatments administered directly into the spastic muscle. Botulinum toxin BTX , phenol , alcohol, and lidocaine. Botulinum toxin is a neurotoxin and it relaxes the muscle by preventing the release of a neurotransmitter acetylcholine. Many studies have shown the benefits of BTX [55] and it has also been demonstrated that repeat injections of BTX show unchanged effectiveness. Hemiplegic Shoulder Pain Following Stroke[edit] Cause[edit] Hemiplegic shoulder pain shoulder pain on the stroke-affected side of the body is a common source of pain and dysfunction following stroke. These include proper positioning, range of motion exercises, motor retraining, and adjuvant therapies like neuromuscular electric stimulation NMES e. Subluxation is a common problem with hemiplegia , or weakness of the musculature of the upper limb. Traditionally this has been thought to be a significant cause of post-stroke shoulder pain, although a few recent studies have failed to show a direct correlation between shoulder subluxation and pain. The exact cause of subluxation in post-stroke patients is unclear but appears to be caused by weakness of the musculature supporting the shoulder joint. The shoulder is one of the most mobile joints in the body. To provide a high level of mobility the shoulder sacrifices ligamentous stability and as a result relies on the surrounding musculature i. This is in contrast to other less mobile joints such as the knee and hip, which have a significant amount of support from the joint capsule and surrounding ligaments. If a stroke damages the upper motor neurons controlling muscles of the upper limb, weakness and paralysis, followed by spasticity occurs in a somewhat predictable pattern. The muscles supporting the shoulder joint, particularly the supraspinatus and posterior deltoid become flaccid and can no longer offer adequate support leading to a downward and outward movement of arm at the shoulder joint causing tension on the relatively weak joint capsule. Other factors have also been cited as contributing to subluxation such as pulling on the hemiplegic arm and improper positioning. Diagnosis can usually be made by palpation or by feeling the joint and surrounding tissues, although there is controversy as to whether or not the degree of subluxation can be measured clinically. If shoulder subluxation occurs, it can become a barrier to the rehabilitation process. Treatment involves measures to support the subluxed joint such as taping the joint, using a lapboard or armboard. A shoulder sling may be used, but is controversial and a few studies have shown no appreciable difference in range-of-motion, degree of subluxation, or pain when using a sling. A sling may also contribute to contractures and increased flexor tone if used for extended periods of time as it places the arm close to the body in adduction , internal rotation and elbow flexion. Use of a sling can also contribute to learned nonuse by preventing the functional and spontaneous use of the affected upper extremity. That said, a sling may be necessary for some therapy activities. Slings may be considered appropriate during therapy for initial transfer and gait training , but overall use should be limited. As the patient begins to recover, spasticity and voluntary movement of the shoulder will occur as well as reduction in the shoulder subluxation.

Slings are of no value at this point. More recent research has failed to show any reduction of pain with the use of FES. Aggressive exercises such as overhead pulleys should be avoided with this population. Now known as CPSP, it is characterized by perceived pain from non-painful stimuli, such as temperature and light touch. This altered perception of stimuli, or allodynia, can be difficult to assess due to the fact that the pain can change daily in description and location, and can appear anywhere from months to years after the stroke. CPSP can also lead to a heightened central response to painful sensations, or hyperpathia. Affected persons may describe the pain as cramping, burning, crushing, shooting, pins and needles, and even bloating or urinary urgency. Higher rates of successful pain control in persons with CPSP can be achieved by treating other sequelae of stroke, such as depression and spasticity. As the age of the population increases, the diagnosis and management of CPSP will become increasingly important to improve the quality of life of an increasing number of stroke survivors.

Apraxia An uncommon, less understood result of stroke is a condition called apraxia. This condition was initially recognized as: Conceptual apraxia is similar to ideomotor apraxia, but infers a more profound malfunctioning in which the function of tools or objects is no longer understood. Ideational apraxia is the inability to create a plan for a specific movement. Buccofacial apraxia, or facial-oral apraxia, is the inability to coordinate and carry out facial and lip movements such as whistling, winking, coughing, etc. Many believe that the most common form of apraxia is ideomotor apraxia, in which a disconnection between the area of the brain containing plans for a movement and the area of the brain that is responsible for executing that movement occurs. A common theory is that the part of the brain that contains information for previously learned skilled motor activities has been either lost or cannot be accessed. The condition is usually due to an insult to the dominant hemisphere of the brain. More often this is located in the frontal lobe of the left hemisphere of the brain. Treatment of acquired apraxia due to stroke usually consists of physical, occupational, and speech therapy. Oral apraxia was related with an increase in age at the time of the stroke. There was no difference in incidence among gender. It was also found that the finding of apraxia has no negative influence on ability to function after rehabilitation is completed. The National Institute of Neurological Disorders and Stroke NINDS is currently sponsoring a clinical trial to gain an understanding of how the brain operates while carrying out and controlling voluntary motor movements in normal subjects. The objective is to determine what goes wrong with these processes in the course of acquired apraxia due to stroke or brain injury. Treatment in the acute setting is mostly focused on symptomatic management. After initial treatment in the hospital, some patients will need short-term placement in a nursing home or rehabilitation facility before going home. In hospital settings the doctors work with speech pathologists in issues like these.

7: Rotator Cuff Tears in the Elderly Patients

CSCS Ch. 20 Rehabilitation and Reconditioning study guide by bryan_jones16 includes 43 questions covering vocabulary, terms and more. Quizlet flashcards, activities and games help you improve your grades.

The organization was created by the inactivation of the 4th General Hospital, stationed at Camp Lee, which was accomplished on 14 April under the same directive mentioned above. Medical trainees began a 3-day march over the 42 miles separating the two camps, while training aids, supplies, and equipment were transferred by truck. Requisitions were immediately submitted for the total allowed strength of Officers " Nurses " Warrant Officers " and Enlisted Men, but it took some time before these were received. It is important to note that neither the Nurses nor the 3 ARC workers were permitted to join the unit before the 4th moved to its Staging Area! Picture taken in The base was also home to the Quartermaster Motor Transport School. During this period the following offices were filled by the staff, resulting in many members holding at least two or more positions. By 23 December , the unit consisted of the following 40 Officers: The above Officers had received special training for the positions they filled in the organization. By 3 November , 1 Warrant Officer was present for duty. He was trained as Assistant Registrar. Starting with the original 52 EM on 15 April , requisitions were filled and underwent fluctuations. All of the men received had finished the regular week Basic Military Training prior to join the 4th. The original cadre 52 EM as well as several trained key personnel obtained from various local sources conducted both Technical and Tactical Training. The organization had the following vehicles all turned in to the Quartermaster Motor Pool, Camp Lee, 5 October "ed: In addition to the special training each Officer had received prior to joining, all of them received practical Training in Administration and Recruit Training of a tactical numbered hospital in the Zone of Interior by being assigned to 2 or more positions, before being transferred from one position to another so that each became proficient in the duties required in several positions. On 3 October a single Company was formed of Officer personnel only and given a 4-week period of intensive Basic Military Training additional training away from the unit was further organized between 15 April and 31 December "ed. However, it was found that all had already received some basic instruction, especially in military drill, discipline, and march formations prior to this time. Between 15 April and 19 May , the cadre were given intensive training as Instructors. In addition to the men who were assigned to the various administrative departments and clinics, the 4th Sta Hosp took over 8 medical wards and 2 convalescent surgical wards. Training films, calisthenics, physical training, and infantry drill, in addition to Technical medical Training were also included. Great improvements were made in military courtesy, physical fitness, and pride in the wearing of the uniform. During the initial phase it was discovered that some Enlisted Men displayed no aptitude for their original assignment and others showed latent abilities which were not evidenced on their classification cards. Furthermore, a select group displayed intelligence, understanding, cooperation, and leadership, which marked them as NCO material. Based on these findings several re-distributions of assignments were effected. By mid- July , another 10 surgical wards were taken over for operation by the 4th Station Hospital. Inspections were held daily to check the efficiency of the personnel and improvements were introduced as need for them was discovered. Much of the training at the time was devoted to Field Training. Various echelons of the Medical Department were studied and examples set up in the field. Assimilated patients were collected and evacuated through all of the respective echelons. Ward, medical supply, and administration tents were set up and duly camouflaged in order to reproduce a vivid picture of the way the Medical Department functioned in the field. Night hikes and forced marches were given in addition to those held during daytime. Lectures and field exercises were also devoted to defense against chemical attacks, defense against aerial warfare, field sanitation, and instructions in the treatment of gas casualties. From this date until 28 October when the unit left Camp Lee for its Staging Area , an intensive training program in Preparation for Overseas Movement was conducted. While at the Staging Area, personnel were instructed to settle all financial matters and make all allotments desired. While at Camp Kilmer training was continued including: Complete exchange of gas mask with inspection and test in the gas chamber Hikes and road marches Infantry drill and athletics Inspection of clothing and equipment Life saving drill by

jumping in deep water wearing life preserver or by catching a barracks bag full of air before striking water The th Sta Hosp was to remain at its Staging Area from 29 October to 4 November , on which day it boarded a troop transport for an overseas destination. It eventually departed from Camp Lee, Virginia, 24 September The party was in charge of much of the organic unit equipment when the main body arrived. The hospital was not complete on arrival as the contractors were still building floors and installing doors and windows. The first patient was formally admitted to the th Station Hospital on 18 December and from that date until the end of only 26 patients were admitted to this organization, and all were from command! Buildings and grounds were satisfactory and a water system was already installed and functioning in the area, having its source from deep wells and being pumped to elevated water reservoirs. Bathing was not so adequate as all ranks had to use detached bath houses at uncomfortable distances from quarters. Laundry was taken care of in London by contract which required 7 days delivery; dry cleaning required 3 weeks between delivery and return. A prophylactic station was available in the hospital area and in almost all of the surrounding cities and towns. Food was on no occasion purchased from civilian sources but remained adequate and well-balanced. Storage facilities were good resulting in less waste of foodstuffs. Immediately after the unit arrived at its overseas destination, an orientation course was initiated to instruct the men and women in the functions and the channels of the European Theater of Operations. A general defense plan was also worked out for the protection of the unit and its patients against any chemical attack, air raids, and fire. Personnel were given adequate training in their duties in case any of these emergencies should arise. The delivery point was Depot O During the continuous buildup in the United Kingdom, Hospital Commanders were encouraged to adopt any measures for pooling hospital resources and designate units to specialize in particular types of cases. The medical service specialized institutions included a growing number of units dedicated to rehabilitating and reconditioning convalescent patients. Moreover such training would reduce the high rate of hospital re-admissions among casualties newly returned to duty. In fall of , Lt. His proposal included the establishment of a center where sick and wounded military personnel could be sent as soon as they reached the convalescent stage and were no longer in need of active surgical and medical attention in the hospital where they were treated. The intended program was to include supervised physical, educational, military, and recreational activities which could help restore a patient to his former physical and mental capacity. Portrait of Lieutenant Colonel Rex L. Diveley was instrumental in organizing and opening the first Rehabilitation Center in the United Kingdom essentially based on gradually intensified physical and mental training of convalescent patients. Rehabilitation Center The aim of the Rehabilitation Center was to prepare convalescing military personnel for further military service or for discharge depending on the nature of his wounds and disability. The patient was accepted from the hospital where he was being treated as soon as possible after he had reached the convalescent stage. He was then subjected to a specific physical therapy or remedial exercises as well as general reconditioning and hardening, which reduced the convalescence period to a minimum and preparing the soldier to return to duty as soon as possible in a strong and able physical condition. The Rehabilitation Center tried hard to avoid any mental or physical deterioration of the patient that occurred while he was in the hospital. The theory was that the longer he was hospitalized, the more permanent his deterioration became. A first unit and site were selected, leading to the establishment of Rehabilitation Center No. On 7 April , the unit with a final staff consisting of 9 Officers and 37 EM, augmented by specially trained personnel, opened Rehabilitation Center No. Hixson, MC, as Commanding Officer. This was the FIRST organization of its type in the US Army and a true experiment for the United States Army Medical Corps in the reconditioning of soldiers discharged from other hospitals before returning them to their military duties. Hall, MAC â€” Director Military Training The facilities at Bromsgrove soon proved insufficient to handle the Theater convalescent patient load patients admitted by 1 Sep 43 â€”ed and it was therefore judged that additional units had to be set up. The new center opened 5 October under command of Major Frank E. Portrait of Major Frank E. By December of , the census of patients had already reached 1, and in the meantime orders had been received to release the 8th Convalescent Hospital for assignment to a field Army it was sent to France 9 Feb 45 â€”ed. The unit was henceforth gradually replaced by the bed th Station Hospital with key personnel from the 8th being retained and Major Frank E. Stinchfield, MC, O, still in command. The complete

exchange was finalized on 24 December. By June-July, the patient load had increased tremendously and following the D-Day assault on the continent, a further expansion was deemed necessary. On 19 June, an extra piece of land was released by the British Ministry of Works which allowed for an expansion of patient beds, increasing overall capacity of Rehabilitation Center No.

8: Tender Notices & EOI

On the continent, the 7th Convalescent Hospital with a capacity for handling 1, patients/trainees and the 8th Convalescent Hospital with a capacity for treating 2, convalescent patients, were operating under the Advance Section, Communications Zone.

Now has 9, patients. Army hospital Wakeman capacity expanded by more beds. The arrival of casualties here is marked by efficient and clock-work organization. Recently a three-car train was unloaded in 17 minutes, with the first man entering Wakeman before the last man was unloaded from the hospital car. Commenting on the handling of new arrivals, Col. They are getting it, too. They are entitled to it, and it should reassure the families of servicemen to know that everything that medicine and science can do will be done at Wakeman. This includes the establishment of a convalescent reconditioning center for patients in the latter stages of convalescence. The hospital itself has undergone extensive alterations since Col. Conner assumed command and now can accommodate over 2, bed patients. Several new ward buildings have been added and other units converted in order to provide specialized treatment. A well balanced staff, consisting of specialists in neuro, plastic, orthopedic and ophthalmologic surgery, has arrived at Wakeman from other sections of the country and are now treating the casualties. Casualties here are of the type requiring orthopedic surgery, surgery of the bones and joints; neuro-surgery, surgery of the brain, surgery to rebuild parts of the body and ophthalmologic surgery, eye surgery. The principal course of the treatment in the center includes occupational therapy and physical and mental reconditioning. The program also embodies all types of recreational activities, both indoor and outdoor. Wakeman is now capable of caring for 3, men in its convalescent reconditioning service. Patients from other general hospitals in the Fifth Service Command are sent here for the Army program designed to bring every soldier up to maximum physical fitness. Severenski from the "air ambulance" Lt. Ann Kopcsp, flight nurse, directs the bearers. Harold Lipshutz, receiving medical officer from Wakeman extreme right watches the procedure. The next step is the loading of the patient in a waiting ambulance. James Westmoreland is shown being carried into the vehicle and soon will be placed on the litter holders inside. At Wakeman General Hospital, less than a hour later, Pvt. With cigarette in mouth, Cook is shown. The "cut" came at according to the clock at the Atterbury Army Air Field and 21 seconds later litter bearers from Wakeman General Hospital were inside the "air ambulance" aiding the flight nurse prepare her 17 patients for unloading. Next in the plane was Capt. Harold Lipshutz, receiving medical officer from Wakeman. The captain worked fast. As soon as he formally received a battle casualty, the doctor "tagged" the soldier, assigning him to a hospital ward. Then the litter bearers took over. The bearers worked fast but gently. One quartet operated within the transport while the other foursome took over from plane to waiting ambulance. It took less than five minutes after the Captain checked a soldier before he was being placed into the vehicle. Ann Kopcso, flight nurse, stated that the trip from Mitchell Field, N. She reported that all her wards were "resting well", with no ill effects resulting from the takeoff or landing - the only bumps usually experienced in the "air ambulance". Before leaving the air field, Capt. He made sure that the litter cases were resting comfortably, head first in the ambulance. Specially trained ambulance drivers wheeled their vehicles the 12 miles to the hospital at a steady speed of 35 miles per hour. Wheeled litter stands were waiting and as soon as a patient was unloaded from the ambulance, he was whisked straight to his ward for a complete medical examination. Of the 17 patients received by air transport, 9 of them were fighting in France and Italy just a week previously. They were flown to the States almost immediately - with one casualty leaving France less than two hours after being wounded by machine gun fire, Most of the men were flown to Mitchell Field from England, but two came direct from the invasion coast. The same type plane, C, which landed the paratroopers on D-Day is flying the wounded from the battlefronts. A flight nurse is in attendance to furnish any attention required during the journey. The Caduceus - Weekly newspaper published for the patients and staff at the U. Army Hospital during the Korean War era was founded April Wakeman General Hospital was referred to simply as U. Army Hospital after WW2. Last year Grant County veterans were buried with military honors. We do one some days or sometimes up to four and five a day. We go all over the county. The families

compliment us all the time. During WWII Holt was in an x-ray technician training class led by Harvard doctors at Camp Atterbury and her skills were so exceptional that her films were chosen for publication in a medical book. He sat down at the end of the hall and waited. They danced with us at the NCO non commissioned officers club. They were my age. Her only grandson, who is 19, has served in Baghdad, Iraq since the start of the war. Holt is an inspiration to her daughter, Gilda Cordell. We all do what we have to do to satisfy ourselves.

9: Repair & Rehabilitation: Capital Projects: Capital Planning & Facilities: Indiana University

We talk to him about topics on the rehabilitation, restoration, and reconditioning of athletes, including the military's influence on sports training, the integration of medicine and performance, pain science, postural restoration, and the role of medical imaging.

CHAPTER XV Improvements in the Internal Organization and Administration of Hospitals in the United States In the latter half of the war, reductions in the staffs of hospitals and changes in their make-up made more imperative than formerly the improvement of hospital organization and administration. It will be recalled that the Wadhams Committee had recommended such action as early as November and as a result The Surgeon General had brought into his Office in the spring of an experienced hospital administrator, Lt. In his opinion preliminary studies confirmed the need for improvement. Extending to all technical and supply services, including the Medical Department, it comprehended the standardization of organization, the elimination of nonessential activities and records, the simplification of work methods, and the improvement of administrative procedures. About a month later, at a service command conference in Dallas, Tex. Bliss thru Col A[lbert] H. Schwichtenberg, 6 Nov 43, sub: Observations Based on Recent Visits. The latter Division called for assistance upon the ASF Control Division, which had had experience and which had personnel qualified in such matters. Studies were to be made to simplify hospital organization, hospital admissions, ward administration, fiscal procedures, mess management, hospital statistics, nursing administration procedures, personnel office procedures, information office procedures, and hospital dispositions. To avoid unnecessary delays in their use, procedures were to be studied separately and, when revised and tested, were to be issued as parts of a loose-leaf manual on hospital administration. The Division also lacked personnel qualified by training and experience to make procedural studies and to draft procedural manuals in the form desired by ASF headquarters. Furthermore, its director was absent on special overseas missions during much of and work on the program suffered from his absence. Even so, the ASF Control Division considered progress on the program unsatisfactory and threatened, early in , to take over its completion. Improvement of Hosp Admin Procedures. Problems on Hosp Manual. Improvement in Hosp Admin Procedures. Erpf for Col O. Gottschalk, 17 Mar Status of Hosp Admin Procedures. Other revised procedures-those for linen control, disability discharges, and disability retirements-were published in separate manuals or circulars before that date. The hospital admissions procedure can be used to illustrate both the manner in which new procedures were developed and the methods used to simplify hospital paper work. Two basic forms were prepared for the admission of patients to hospitals: Archibald, SGO, 30 Jun 44, sub: Progress of Hosp Procedures Simplification Project. Improvement in Hosp Admission Procedures. Under the revised procedure, all forms containing common information were blocked off alike and a mimeograph duplicator was used to transfer that information to as many copies as needed throughout the hospital. Thus one typing replaced fifteen or twenty under the old system. The chapter on the new admissions procedure illustrated each of these forms and gave detailed instructions for their preparation and distribution. One of the procedures developed during , that for the control and distribution of hospital linens, was designed for this purpose. Developed in a manner similar to the hospital admissions procedure, the linen control procedure was published in December in an ASF circular rather than as a chapter of the hospital-administration manual. In order to avoid being "caught short," they required ward personnel to count soiled linen as it left the ward and clean linen as it was returned. Furthermore, they required periodic inventories and some tended to hoard linen unnecessarily. Additional linen-counts were made at intermediate storage points and at hospital laundries. Under the new procedure each hospital had a linen officer who was responsible for all linen used. All counts of linen in wards and intermediate stations were eliminated; and linen officers, rather than ward officers, made periodic inventories. According to some hospitals, a disadvantage of this procedure was an excessive loss of linens. It was also reported that the new procedure decreased the hoarding of linen and speeded up its distribution to places where needed. Lack of enough medical stenographers in hospitals, as a result of the civilian labor shortage and of hospital personnel ceilings, made it necessary during for doctors themselves to prepare clinical records,

sometimes in longhand. To relieve them of such a time-consuming process, hospitals began early in to acquire dictaphones. At convenient times doctors recorded on these machines consultation reports, progress notes, case histories, and final summaries. Clerks organized in central pools then transcribed the information recorded. This system of preparing clinical records permitted doctors to keep more complete and more legible records and to devote more attention to care of patients. It also contributed to the more efficient use of clerical personnel. Finally, by enabling doctors to keep clinical records up to date it helped to speed the disposition of patients and to shorten their period of hospitalization. Beginning in July chapters in the hospital-administration manual were published on the following subjects: As part of its program for efficient personnel utilization, early in ASF headquarters began to require subordinate installations to set up programs of "work simplification" and "work measurement. Work measurement was the determination by various standards of the number of employees required for certain jobs or operations. To correct that situation a delivery service staffed with twenty people was set up, and forty ward attendants were released. Seventeen work-measurement and work-simplification studies made at Newton D. Baker General Hospital during resulted in the saving of 2, man-hours per month. Other hospitals reported similar savings from local changes. Gradually hospitals began to list nursing as a professional rather than an administrative service and to show neuropsychiatry as an independent service rather than as a section of the medical service. Revision of the ASF organization manual in December caused addition of control officers to serve as staff advisers on administrative, procedural, and management problems. These new activities-special services, information and education, personal affairs, and classification and counseling-were to be known later as "welfare services" or as "individual services. Furthermore, the seven functional divisions which previously comprised all post activities were replaced by seven administrative and seven technical staff units. To make this change, the erstwhile Administrative Division, a functional division which had included the adjutant, judge advocate, and fiscal officer, was abolished and its officials were listed among the seven administrative staff units. Certain technical services-quartermaster, ordnance, chemical warfare, signal, and transportation-were relieved from their former subordination to the Supply Division and were established as independent technical staff units. Medical and engineer activities, considered as functional divisions under the old plan, now became technical staff units. All welfare activities continued, under the new post plan, to be grouped under the Personnel Division. In the administrative field, hospitals made adjustments in various ways. Also see above, Chart Although it had most of the officers which that plan called for, it placed many who were supposed to be grouped under an intermediate supervisor, such as special services and personal affairs officers, in a direct relationship with the commanding officer. After it had been tested for about six months, The Surgeon General submitted it for comment in February to other service commands. On the basis of their suggestions, he made minor changes in the Third Service Command plan and adopted it as standard for general, regional, and station hospitals. Tentative plans were published in and The final plan for convalescent hospitals was published in December , but that for hospital centers remained unpublished because they began to close before it was completed. Hospital commanders generally and service command surgeons in some instances raised arguments against inflexible standardization. One feared that it would crystallize hospital organization, increasing efficiency in the operation of some installations but prohibiting imaginative and capable commanders from making valuable innovations in others. For example, hospitals giving little outpatient care might not need to establish separate outpatient services. Others believed that commanders needed freedom to fit their organizations to the personalities of officers assigned to them. An eye, ear, nose, and throat specialist of intense individualism and higher rank than a chief of surgical service, for instance, could hardly be successfully subordinated, in an EENT section, to the latter. The most telling arguments in favor of standardization were that it was the first step toward the simplification and standardization of administrative procedures, that it facilitated the measurement of work and of personnel require- 37 1 Rad, SG to CG 4th SvC attn SvC Surg, 3 Mar Morgan and Donald O. Press, 9 Oct Identical letters were sent to all service commands; these letters, with their replies, are on file in HD: I, Hosp Orgn, 1 Jul That they did not insist on inflexibility was demonstrated by a proviso that hospital commanders might deviate from the standard plan if their respective service commanders approved. General hospitals, according to the standard plan, were to have six of the seven administrative staff

divisions of posts. The seventh, training, was to be subordinated to the personnel division. In addition, they were to have four administrative staff units not called for in the post organization plan. The plan for hospitals had no technical staff divisions as such. Some, such as ordnance and chemical warfare, were eliminated completely; others, such as quartermaster and transportation, were subordinated to the supply division; and another, the engineer, was placed on the administrative staff. The welfare services, despite the wishes of hospital commanders, were left subordinated to the personnel division. The plan for hospital organization naturally included professional services. There were nine in general hospitals, including the reconditioning service, the neuropsychiatric service, and the nursing service. In this field hospital commanders were left with more latitude than in the administrative because, the manual stated, the professional services "function solely in a professional manner and are subject to constant variation by reason of changes in types of patients treated. The chief differences were that administrative and technical units which existed as parts of post and general hospital organizations were eliminated and the neuropsychiatric service was subordinated, as a section, to the medical service. I, Sec I, 1 Jul I, 1 Jul Having only limited amounts of personnel and no guides for organization, ASF convalescent hospitals were organized by their commanding officers to fit individual circumstances. Consequently they differed from one another in many respects. Convalescent hospitals that were separate installations attempted generally to organize administrative activities according to the standard ASF post plan. The result was that, as they received more patients and operating personnel, some set up administrative offices that duplicated, or at least paralleled, those of the general hospitals located near by. They were to be grouped in three divisions: The infirmary division was not to be established in convalescent hospitals located near general hospitals. The reconditioning division was to have a twofold function: This program was to include occupational therapy, physical reconditioning, educational reconditioning, and classification and counseling. The plan served as a guide to convalescent hospitals that remained separate installations during , and it was used to some extent, particularly for the organization of convalescent activities, by those that became parts of hospital centers in the spring of that year.

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