Editorial Note

As the new editor of Newsletter. Prosthetics and Orthotics Clinics, *it is my primary aim to continue the quality and editorial excellence of the previous editor, A. Bennett Wilson, Jr.*

This and future issues of the Newsletter *will feature lead articles of a non-technical nature by prominent clinicians in the field of Orthotics and Prosthetics.*

Another section will be devoted to technical, therapeutic, and medico-surgical matters. Any technical innovations should be sent to the attention of Gary Fields; therapeutic and training procedures to William Susman; and medico-surgical issues to Charles Epps, all members of the editorial board.

Editorials will be concerned with current and progressive issues in the field, and will include frequent guest editors. Of course, reader response is highly encouraged and a special section will be devoted to this.

The present issue features two invited articles by two prominent clinicians. Dr. Epps reviews the traditional clinic-team approach initiated well over two decades ago and still practiced and taught throughout the country. Dr. Sarno describes a somewhat different approach for selected cases, where the team members relate to the patient on a one-to-one basis. We thought that a review of the traditional and newer clinic-team approaches was timely in view of the social and economic changes that have occurred since the institution of the first clinic-team concept.

H. R. Lehners

Clinic Team Concept— Reassessment 1979

Charles H. Epps, Jr., M.D.

In recent years, the interdisciplinary team concept as it is applied to the care of amputees has become very popular and the practice has been utilized for both adults and children. During the 1960's over 30 child amputee clinics were organized under auspices of the Subcommittee on Child Prosthetic Problems (CPRD) and included certain organizational requirements. Foremost among these was the clinic team, which consisted of a physician, usually an orthopaedic surgeon, physical therapist, occupational therapist, prosthetist and a social worker. Pediatric and other services were available on a consultation basis. In 1961 a clinic was organized at the Handicapped and Crippled Children's Service at D.C. General Hospital in Washington, D.C. and has continued to function under the original guidelines. We have found the team concept to be a most effective means of providing optimum care for our patients.

The changes in patient and public attitudes regarding clinic services have prompted some to drop the team concept in favor of an arrangement in which each member of the team sees the patient individually. Such an arrangement may be beneficial for certain individuals. However, the team concept as practiced in our clinic has been most satisfactory, and my purpose for writing at this time is to enumerate the advantages of this system.

Clinic Operation

The modus operandi for our clinic has changed little through the years and follows a simple format. At the clinic session, a brief synopsis of the patient's history is given including diagnosis, previous treatment and present status. Knowledge about interval problems since the last visit (usually three months) is contributed by team members who may have seen or had contact with the patient. The patient enters the examination area and the current problem is identified if one exists. The problem is discussed by the team members and a solution recommended. This is an excellent opportunity to demonstrate teaching points to students and visitors. The patient is scheduled for a visit to the appropriate team member for correction of the problem, for example, a visit to the prosthetic shop for repairs or to the therapist for additional training. A return appointment is scheduled. After the patient leaves the examination area, detailed teaching points or questions can be elaborated upon. Student questions may be entertained at this time. We have found it useful to see new patients alone for the initial visit (without students or visitors). The clinic format is explained at that time and patients and parents feel comfortable about this arrangement at subsequent clinic sessions.

Patient Benefits

The visit to the clinic has certain benefits for the patient and parents. There is an opportunity to see other patients with similar or

often the identical problem. In instances where conversion surgery is under consideration, seeing a patient ambulate who has the procedure is helpful to all concerned including the surgeon. In fact, we find it convenient to arrange such simultaneous visits, and old parents and patients have been cooperative in demonstrating postoperative results and prosthetic fittings to new families and patients. It has been interesting and educational to watch the spontaneous "psychotherapy" that takes place in the waiting room of our clinic. Parents freely discuss problems relating to dress, toileting, school, prosthetic wear and care and many aspects of patient life. Another advantage is the fact that the patient sees all team members simultaneously, which is time saving. If individual consultation is necessary with an individual team member this can be arranged at another time. The team members can study mutually a problem involving prosthetic prescription, prosthetic malfunction or harnessing—an obvious advantage to team members, with benefits occurring to the patient. The old adage that two heads are better than one is no less true in this instance.

Team Benefits

There are additional advantages to the team members, who educate each other under these circumstances that allow valuable exchanges of information. In a free discussion the physician and prosthetist may learn from the occupational therapist who has studied a harnessing problem in detail. Similarly, all will profit from a discussion and analysis of an amputee who demonstrates a gait problem during the clinic session. Later the prosthetist will correct the defect in the prosthesis and the physical therapist will correct a gait idiosyncracy by further training. When the patient is seen at the next visit all can see the improvement. Considerable time is saved by the clinic team meeting together as opposed to the time that would be required if each member were visited individually.

Opportunity for Teaching

In this setting there is an unparalleled opportunity for teaching students who may visit the clinic session as observers. In our clinic routinely there are in attendance students from many disciplines: Medicine, physical therapy, occupational therapy, prosthetics-orthotics, and nursing. Postgraduate educational experience is afforded to pediatric and physical medicine residents, who attend as observers. Orthopaedic residents attend the clinics regularly over a six months period as a part of their pediatric orthopaedic rotation. These residents participate more actively as they are involved intimately in the care of patients who become inpatients for surgical procedures.

Precautions

If certain safeguards are taken, the clinic team can avoid the circumstances of clinics that many patients have found objectionable in the past, two of which are lack of privacy and "dignity". Care should be exercised to respect the modesty of teenagers and any patients who are sensitive about being seen by a number of individuals. We try to overcome this by seeing all new patients as a team without visitors or students present during the initial visit (intake). The parents and patients are more relaxed and comfortable under these circumstances and the next clinic visit with the presence of visitors is not traumatic. Most patients do not object to demonstrating their prostheses to students and other patients.

Team Concept—Another Application

The method has been equally applicable to another group of complicated patients (cerebral palsy, myelomeningocele, muscular dystrophy and arthrogryposis, etc.) who wear orthotic devices and require physical therapy at our local health school. At clinic sessions the following individuals are present: orthopaedic surgeon, physical therapist, occupational therapist, orthotist, school administrator or teacher, school nurse, and social worker. This arrangement permits free exchange of information among many of the individuals concerned with the patients' problems. Orders for treatment and repairs to equipment can be coordinated with the involved individuals including parent and teacher. On the morning the clinic meets, the parent brings the child to the clinic and after clinic the school bus, which normally transports the children to and from school, takes all of the students to school in time for lunch and the afternoon session.

Although public attitudes have changed since the introduction of the clinic team approach, this is still an appropriate method of management that can effectively accomplish two worthwhile objectives simultaneously—service and teaching.