Amputee Clinic or Clinic Team

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For a number of years the process of developing a prescription for upper-limb amputees at the Institute of Rehabilitation Medicine has involved an interdisciplinary rehabilitation team headed by the physiatrist and including representatives of the departments of physical therapy, occupational therapy, psychology, social service, vocational services, and of course, prosthetics. Customarily, the patient is first seen and examined by a physician. The following day the other team members meet with the patient on an individual basis. The physician then acts as chairman of a meeting at which the various reports are given and discussed and a prescription decision is reached.

As with many innovations this one was prompted by a painful experience with one of the first patients for whom a myoelectric prosthesis was prescribed. After having gone through the lengthy and costly procedure of supplying the prosthesis it was discovered that the young man was awaiting sentence in a federal court, a fact which may not have changed the prescription but would surely bear on how the prosthesis would be used.

It has since been learned that there are more compelling reasons for a thorough initial evaluation for amputees since experience has made it increasingly clear that success in the use of a prosthetic device depends upon more than fitting a good prosthesis to a suitable stump and that outright failure is often due to psychological, social or vocational factors rather than prosthetic ones.

Although the procedure appears to be of greater importance to the upper limb amputee, we have recently instituted a similar one for lower limb patients in recognition of the fact that they, too, often have extra-prosthetic problems. Beyond the avoidance of problems, the team approach seems to offer the best means of arriving at a good prescription, and in some cases no prescription at all, based upon an in-depth knowledge of both physical and psychosocial factors.

A moments reflection will point to the shortcomings of the traditional clinic approach to prosthetic prescription. The sole focus of the procedure is to determine the condition of the amputated limb and try to decide on the observed physical condition of the patient, his or her age, perhaps something of the history, what the best prescription might be. The setting is uncomfortable for the patient at best and there is no possibility of eliciting relevant information at a personal level. The evaluation must, therefore, be gross and possibly incomplete.

By contrast the clinic team method elicits a wealth of information. As each staff member determines whatever technical or demographic data is pertinent to his field (e.g., the PT gets stump data, the OT, functional information, the vocational counselor, work or school data), each team member picks up valuable impressions about the patient, enhanced by the private, comfortable setting, which are often very important in arriving at a prosthetic prescription. It is commonplace for the so-called technical specialists, like the prosthetist or the occupational therapist, to contribute valuable bits of psychosocial information gleaned in the course of their interaction with the patient. The process is not overly time-consuming, each team member spending about one half hour with the patient.

The team clinic approach has proven to be of great value both to determine the reason for past prosthetic failures and to assure a high rate of success in new patients. This has been our experience with the myoelectrically-controlled upper limb prosthesis in particular and suggests that increasing sophistication in prosthetic technology will require even greater attention to the multiplicity of factors which may contribute to success or failure in prosthetic use.

From the standpoint of the physician, I have found the procedure to be most rewarding, for it results in the accumulation of more pertinent data than the physician could ever elicit alone and creates healthy cooperation among a variety of disciplines, all of whom have something of value to contribute.

In the interest of balance it should be noted that there are situations in which the traditional clinic approach is entirely adequate. One should avoid organizational rigidity and be able to prescribe a prosthesis in a very straightforward manner when it is indicated. In general, this will apply to lower limb prostheses primarily, almost never to the upper limb amputee.

Perhaps it should be emphasized, in conclusion, that psychosocial-vocational services should not be grafted onto the process of providing a prosthesis but should be an integral part of that process for optimal results. The acceptance and efficient use of a prosthesis goes beyond technical factors. If the patient is depressed or fearful, ashamed or discouraged, overwhelmed by circumstance or unconsciously tired of trying, the very best prosthetic prescription will be a failure. Herein lies the strength of the clinic team approach.

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Editor's Note: See Vol. 2, No. 3 1978 of the *Newsletter* for additional description and information on the clinic team procedure discussed by Dr. Sarno.