Newsletter

Prosthetics and Orthotics Clinic

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To Check Out Or Not To?

That Is The Question

By Kurt Marschall, C.P.

It is now over twenty-five years since the introduction of intensive short-term courses in prosthetics and orthotics at New York University, Northwestern, and the University of California at Los Angeles. These condensed courses have benefitted every practitioner, not only in his practical approach to patient management, but also in his inter-relationship with his peers through a unified and common language that we call "nomenclature." In countless cases, these formal educational courses have served as a springboard to successful completion of the certification examination.

It was the Veterans Administration which at that time took the primary responsibility of disseminating and funding prosthetic research programs. Their Clinic Team approach became very popular, leading to the simultaneous education of physicians, therapists and prosthetists/orthotists. Undoubtedly, this close relationship of the three disciplines, working together for one common goal, namely, the rehabilitation of the disabled, has narrowed a gap that formerly was all too visible. I feel it has also helped to lift the field of prosthetics and orthotics out of the dark age, out of its sole "craftsmanship concept" into the more comprehensive classification of "professionalism"—all in all, an appropriate tribute that was long overdue.

Every prosthetist/orthotist, having successfully completed these short-term courses, came out a better person, a better clinician. The physician and therapist, by the same token, gained insight into our field as never before. Now all three disciplines in their deliberations at clinic meetings spoke at the same level through a unified language, and intelligent solutions were arrived at by understanding the underlying problems.

A by-product of this progressive and noteworthy approach was the respect the prosthetic/orthotic practitioner gained from the medical and paramedical professions, once his continued striving for excellence in performance and elevation of standards was realized by them. This respect, however, was not attained very easily. In our quest for sharing the knowledge and insight into our field with the physician and therapist, we also committed a monumental mistake—making them experts in the fitting, alignment and fabrication of every prosthetic/orthotic device there is. Without realizing it at the time, we gave into their hands a powerful tool, even further, a most powerful weapon —*the check-out sheet!!!*

There, in black and white, we developed a questionnaire telling them exactly how to pick a device apart, piece by piece, making them the sole, omnipotent judge of whether to pass or fail it. By setting up this systematic method of examining our devices we have admitted that one cannot trust our professional judgment or technical expertise. I know of no other group in the health care profession that has so mindlessly relinquished its professional prerogatives and intricate understanding of a subject to another discipline, with certainly less knowledge of the particular subject, for its scrutiny. Even today, after 25 years of continuous upgrading, we sheepishly subject ourselves to this procedure. This permits even a therapist fresh out of school, but equipped with a check-out sheet, to suddenly become powerful and to be feared for his or her "judgment" when check-out day rolls around. Countless man-hours and precious components and materials have been wasted when physician and therapist could not see eye-to-eye with the prosthetist/orthotist on alignment, fitting and finishing procedures. A device often had to be altered, sometimes even done over entirely, for rather trivial reasons, not to mention the immense damage inflicted on the patient-prosthetist/orthotist relationship when these so-called "problems" were hashed out in the open, for everyone to hear, rather than in a more private setting.

There is no doubt in my mind that the level of education and the competence of every prosthetist/orthotist has risen tremendously in the last two and one-half decades, especially for one who takes advantage of the continued education process. He is a better person than he was 25 years ago, and his knowledge of the subject, "Prosthetics and Orthotics," is vastly greater than that of a physician or therapist. He is a professional who will, without complaint, work his way

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"Nobody denies the need for a check-out after prosthetic-orthotic device has been completed. But yesterday's check-out sheet should be scrapped in its entirety—the sooner the better."

around a poorly-amputated limb that may not be to his liking for fitting purposes and come up with a functional prosthetic device without asking the surgeon for a revision. He will produce an adequate prosthetic device despite flexion contractures and edema, due to insufficient exercise and lack of proper stump-wrapping.

Nobody denies the need for a check-out after a prosthetic/orthotic device has been completed. But yesterday's check-out sheet should be scrapped in its entirety —the sooner the better—and replaced with one consisting of only three questions:

1. Is the prosthesis/orthosis as prescribed?
2. Is the patient comfortable?
3. Is the prosthesis/orthosis functional?

The above criteria should more than satisfy any physician or therapist.

The decision as to pleasing cosmetic appearance, insofar as possible, should be left to the patient.

The decision on whether or not accepted standards and principles have been met in the fitting, alignment and fabrication of the device, should be entirely that of the prosthetist/orthotist.

The field of prosthetics and orthotics has come of age; so have its practitioners. The check-out sheet has not kept pace with changing times and should be abolished in its present form. ■

Guest Editorial

THOUGHTS ON THE AMPUTEE CLINIC TEAM

by Newton C. McCollough, III, M.D.

The Amputee Clinic team as we know it today, evolved during World War II when the Surgeon General of the Army established a number of Amputee Centers within Army Hospitals to upgrade the management of these patients. Impetus to this multidisciplinary approach was given by the Veterans Administration in 1948 when suction suspension was introduced for the above knee amputee and a protocol was developed establishing the Amputee Clinic Team which initially comprised the physician, the prosthetist and the therapist.

Since that time as a more holistic approach to disability developed the team has been enlarged in most clinics to include the occupational therapist, social worker and vocational specialists among other disciplines.

The clinic team approach is comprehensive and unquestionably has resulted in superior management of patients with limb loss over the past thirty years. However, recently questions have been raised regarding the efficiency of such a clinic and whether or not a more streamlined approach is desirable from the standpoint of the logistical management of relatively large numbers of patients. The impersonal nature of such a clinic has also been impugned in recent years, and some have felt that the patient may actually be intimidated by such a host of professional personnel.

Several years ago, at the University of Miami, a compromise approach to amputee management was undertaken. All new patients and patients with identifiable medical problems (including skin breakdown) were seen in the traditional setting with the physician as the amputee team leader in clinic. Routine follow-up visits and problems which were purely prosthetic in nature were seen in "prosthetic clinic" by the prosthetist and therapist with a prosthetist as the team leader or clinic chief. Other clinic personnel including physicians were available for these clinics but were not necessarily in attendance. This approach was far more efficient in terms of man hours and in many ways more practical than imposing the traditional approach upon all patients at every clinic visit.

Two major drawbacks to this system of care slowly became apparent and currently we have resumed the traditional approach to all patients. The first difficulty encountered was that many routine prosthetic visits were also accompanied by concurrent medical problems which could not be identified before the patient was actually seen. Of course, the patient could be referred to the next "full team clinic" but this resulted in undue delay of treatment. Psychological or vocational problems though less frequent were also concurrent in some patients. Secondly, in a major teaching hospital, the education of residents, interns and students suffered from this approach. The critical analysis of prosthetic problems in relation to alignment, gait, suspension, etc. was lost upon students in the absence of interchange between pros-