"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-

thetist, physician and therapist. Additionally, innovative techniques in prosthetic management not infrequently result from discussions involving the prosthetist and physician and the presence of all team members in clinic greatly enhances this aspect of the amputee program.

In conclusion, I now feel that the multidisciplinary clinic team approach is sound and has no equal in the educational sphere. Spinoffs from the dialogue created may enhance prosthetic research and thus ultimately patient care. Efficiency in this sytem is less than ideal, but the benefits are greater in the long run. Suitable precautions must be taken to avoid "depersonalization" of the amputee in the multi-disciplinary environment and it is encumbent upon each team member **to insure that the clinic experience is a rewarding one for the patient.**

Meetings and Seminars

January 30-February 3, 1980
AAOP Round Up Seminar, Newporter Inn, Newport Beach, California

April 10-15, 1980
"Third International Congress On Physically Handicapped Individuals Who Use Assistive Devices." Hotel Galleria Plaza, Houston, Texas, USA

June 16-20, 1980
Interagency Conference on Rehabilitation Engineering, Sheraton Center, Toronto, Canada.

June 22-27, 1980
World Congress of Rehabilitation, International Winnipeg Convention Center, Winnipeg, Canada.

September 14-20, 1979
AOPA National Assembly, New Orleans Marriott, New Orleans, Louisiana.

September 28-October 4, 1980
Third World Congress (ISPO), Bologna, Italy.

COMMENT

Dear Sir:

I have just been reading Volume II, Number 4, 1978 of the NEWSLETTER. While I have a lot to say on immediate postsurgical fittings, whose major problem I fear is the inaccurate name since very few people really fit a prosthesis immediately post-surgically, I think that the part of the NEWSLETTER that deserves the most comment is the reprint of the article "Prostheses, Pain and Sequelae of Amputation as Seen by the Amputee" from Prosthetics and Orthotics International.

There appears to me to be little doubt that the complaints of the amputees are accurate. There is not only poor fitting and poor fabrication, but a tremendous absence of knowledge on what is correct on the part of the medical profession, the amputees, and, unfortunately, sometimes even the prosthetists. We must recognize the fact that many doctors "prescribe" an artificial limb with instructions to the prosthetist to "give the patient a prosthesis" or, if they want to be very accurate, "give the patient an above-knee prosthesis". This leaves the entire prescription, fabrication and sometimes training of the amputee on the prosthesis to the prosthetist, who does the best he can, but is not adequately trained to take over the entire responsibility for the care of the patient. It is the exact equivalent of a doctor "prescribing" a medication for a patient and saying "give heart medicine".

Most of the doctors doing amputation have little or no interest in the aftercare of the amputee once the wound is healed. For that reason, the amputee is required to be responsible for his own care and must seek out amputee clinics in which adequate prescription, checkout and training can be given to assure that adequate prosthetic fabrication has been achieved. The average general or vascular surgeon cannot be