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

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assumed to have been able to keep up with the latest in prosthetic components, fitting and training. While research is important, we are not, at the present, delivering the standard of care which we could have delivered twenty-five years ago had every amputee the access to an amputee clinic team.

It is obvious that the amputees questioned are suggesting checkout procedures, such as x-rays, to measure the accuracy of prosthetic fit which have been available to us and have been used for decades. Unfortunately, it is the "consumer" who determines what is produced in the market place. In my view, the amputees must band together and insist on getting adequate service. When they do so, the competitive market place will give them what they need.

In some areas, there is a problem because there are very few prosthetists and the amputee is, to some extent, at the mercy at that individual. With modern transportation however, any dissatisfied amputee should be able to get to a knowledgeable amputee team for adequate care. I know that there are many problems. In a neighboring state I know that the orthopedic surgeons have inhibited any competitor from coming into the state to challenge what everyone admits is an inadequate prosthetist-orthotist because they like that individual as a person, even though they know that the devices produced are grossly inadequate. While this is beneficial to the individual prosthetist-orthotist, it is to the detriment of his patients.

Part of the problem is that each amputee is concerned with his own welfare, and when his needs are satisfied to a tolerable level, he tends not to band together with his fellows for their common good. This decreases their effectiveness in demanding optimal care. Rehabilitation is a process in which a patient is made responsible for his own well-being. In this regard, we may have made amputees feel so independent that they have lost sight of the power of communal action.

Perhaps the NEWSLETTER format should be duplicated for the amputees as well as for those of us serving the amputees, so that the amputee himself could know what is going on and what devices and techniques are available to him should he need them. Certainly a list of the formal clinics and services would be of help.

While there is much discussion of the advantages and disadvantages of different socket designs and other prosthetic components, it appears to me that these are, to some extent, academic discussions, since even the plug fit socket can be made comfortable for the majority of above-knee amputees, provided it is properly fabricated for the individual. What is needed is to improve the state of prosthetic delivery, even more than the state of the prosthetic art. The situation in prosthetics is the same as the situaiton in general medicine, in which in many places in this country what has been known in the medical literature is not getting to the individual patient.

As far as upper extremity amputees go, the professor is much more satisfied with the appearance of the cosmetic hand cover than are the amputees themselves. I believe that I have the opportunity in this region to see some of the most cosmetic hand covers available. They are, despite all our efforts, still inadequate and rejected by the great majority of amputees. As far as myo-electric hands are concerned, all of my patients want them. Most of them use them for a period of a few months and then discard them, except for rare use as a cosmetic hand, since they are so poorly functional as well as delicate. I believe it is important to prescribe one, if the patient demands a myo-electric hand, because he will never be satisfied of its mediocre function, until he has the opportunity to try it. I think the professor needs to be aware of many of its limitations. We, perhaps, get carried away too often by our favoritism for our own development.

I believe further discussion on this point would be of help to the amputee community and also to the medical community in its broader sense, to give us a proper perspective of where our problems are.

Best wishes for a happy and productive year.

Lawrence W. Friedmann, M.D.

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