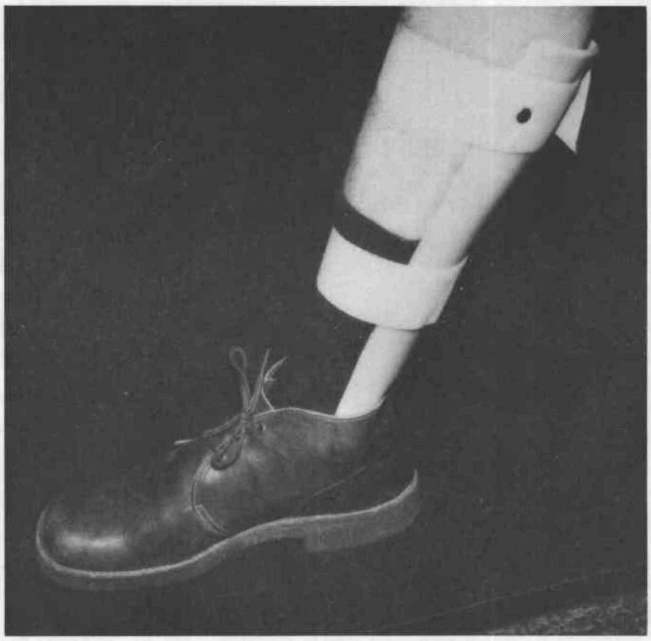

Figure 6

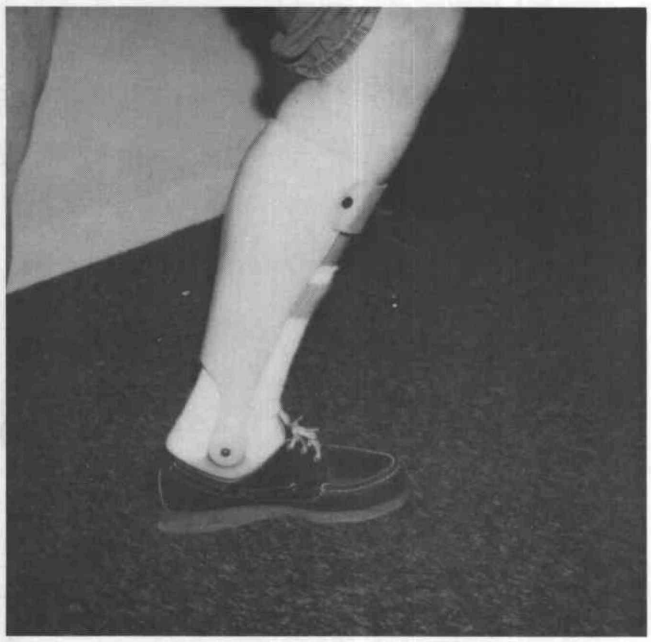

Figure 7

A third patient (P. B.) with a similar problem of ankle instability was fitted with the same type of orthosis made for R. R., but eliminating the anterior portion. This patient, too, was happy with the freedom of motion it allowed (Figure 7).

In these three cases, free plantar and dorsiflexion were allowed while mediolateral ankle stability was achieved. Though it involves extra work and time during fabrication of this type of ankle joint on a posterior solid ankle foot orthosis, the security of the ankle on weight bearing, the freedom of movement while walking, and the satisfaction of the patients wearing the orthosis are achievements justifying the extra effort and expense.

An Editorial

The Driving Force in Rehabilitation

William M. Susman, M.A., R.P.T.[1]

By design, and in daily clinical practice, rehabilitation is a multidisciplinary effort. The patient is best served by professionals addressing the psychosocial and vocational aspects of disability as well as the various aspects of physical impairment in a specialized manner. The driving force behind the effective functioning of this approach is communication among the professionals comprising the rehabilitation team. This communication may occur within the structured format of professional publications, the formal yet often spontaneous settings of team clinics and rounds, or the many informal daily contacts between colleagues involved in the treatment of any one patient.

Such communication enhances patient management in numerous ways. Consistent definitions and coordination of treatment approaches and goals can be achieved. Different perspectives regarding the same clinical situation can be shared, perspectives tempered by the different relationship each team member has with the patient, the expertise each member brings to the clinical problem, and the priority of concerns each establishes according to his or her functional role. Perhaps most importantly, the team is able to bring its collective clinical experience to bear upon the problem at hand. No one clinician, regardless of depth or breadth of experience, should fail to search out and use this collective experience for it can only serve to

broaden the range of possible solutions.

An excellent example of such an opportunity is provided in the lead article by Dr. Alexander in this issue of the Newsletter. This is not to say that executive decisions should not be made in the rehabilitation setting, but that if they are based upon the communicated experience and viewpoints of all team members, such decisions will not be autocratic.

It should not be forgotten that the clinician also benefits from such communication. The most stimulating workplace is one in which a free exchange of ideas can take place without the fear that image or role is being threatened. In an imperfect world with personality differences and professional pressures, this can be hard to achieve, but must be actively sought. The stimulation of thought through this collective process also leads to clinical innovation and new research ideas and, ultimately, improvement in the professional's level of expertise and advancement of the state of the art of rehabilitation as a whole.

Clinical professions involved in rehabilitation are currently undergoing rapid growth in knowledge base, upgrading of standards for entry into practice, and increasing professional responsibility. The fields of orthotics and prosthetics and physical therapy may be the best examples of these trends. It is imperative that no one clinical field, regardless of increased training, authority, or specialization becomes more isolated in clinical practice. Obviously, a given level of clinical skill cannot be replaced by input from another discipline, but the effective use of that skill can be channeled by communication within the clinic team towards better patient treatment, our foremost concern.

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