

Questionnaire

Professionalism

The Clinical Prosthetics and Orthotics—C.P.O. editorial board believes that two-way communication will aid the growth of the profession. The Academy provides a forum, within this publication, through which practitioners can let their voices be heard on significant issues. Please take the time to complete the questionnaire on professionalism and return to: Charles H. Pritham, CPO, Editor, Clinical Prosthetics and Orthotics, c/o Durr-Fillauer Medical, Inc., Orthopedic Division, 2710 Amnicola Highway, Chattanooga, TN 37406.

1. Do you believe the profession's Canons of Ethical Conduct benefit the public?

Yes _____ No _____

2. Do you believe they are adequately enforced?

Yes _____ No _____

3. Do you believe that society has benefited from the presence of various governmental bodies in the area of self-regulation (of all professions)?

Yes _____ No _____

4. How do you define professionalism?

5. Other Comments:

Analysis of the Results From the Questionnaire on Metal vs. Plastic Orthoses

By May 1st, fifty-four (54) responses had been received, considerably more than usual. Fifty-two (52) respondees were certified personnel, one was a physician, and one was an unspecified "other." Interestingly enough, the individual listing himself as other was by far the most negative in his comments.

The results were as follow:

1. Percentage of plastic vs. metal orthoses prescribed:

100% plastic—17%
75% plastic, 25% metal—61% of the time
25% plastic, 75% metal—13%
100% metal—2%

2. Percentage of staff trained in plastic:

100%—74% of respondees
75%—9%
50%—9%
25%—7%

3. Most significant advantages:

lightweight—43%
cosmesis—28%
versatility—26%
correction increased—17%
other—11%
total contact—9%
Many individuals checked more than one.

4. Most significant disadvantage, most commonly indicated factors (actual numbers):

1. Inability to adjust dorsiflexion/plantarflexion—20
2. Fluctuating edema—7
3. Fitting a proper shoe and heel height—5

5. Durability of plastic and hybrid orthoses vs. metal orthoses:

more durable, less maintenance—40%
equal—30%
less durable, more maintenance—22%

6. Do you agree with Mr. Shurr's arguments for the use of traditional metal upright orthoses?

yes—69%
no—30%

7. Do you share Mr. Shurr's skepticism regarding prefabricated plastic AFO's?

Yes—83%
No—13%

This seems to be one issue about which considerable unanimity exists within the profession. Questions one and two seem to indicate that plastic plays a major role in the practice of many orthotists and that most of them are versed in its usage. The re-

sponse to question 5 indicates that most practitioners are not experiencing significant problems with durability, probably as good an indication of good fabricating technique as any. In looking at questions 3, 4, 6 and 7, it appears that most respondents understand the role of plastic in orthotics and its advantages and disadvantages.

In light of this unanimity of opinion it is interesting that the question of plastic vs. metal should excite enough interest to spark so large a response, particularly as plastic orthoses have now been in use for over ten years. It may be that orthotists still confront the need to defend plastic orthoses and justify their use. Contrarily it may be that enough individuals have enough experience with plastic that they feel comfortable responding to the issue.

Additional responses: The following samples are chosen somewhat at random as examples of differing opinions:

Comments on question 4:

1. It is my firm belief that the fixation of any joint will have the result of severe atrophy and eventual fusing of the joint. The long term results of the use of the (non-jointed) plastic AFO are not known. Putting it simply:

What's the use of working toward recovery of use of an extremity (and that return gradually takes place) when the 'treatment' by an orthotic device has created other problems that the degree of recovery is not able to overcome?

2. I feel there has been an overemphasis on plastic AFO/prefab AFO used by R.P.T.'s which have a limited application, and may be used with some success on geriatric patients in convalescent areas. They do make damned good night splints and that's about all. If used on hilly terrain or streets the patient usually ends up on his butt or smashes his face.

3. How anyone could argue the cause for plastic AFO's is unreal. Any amount of comparisons with the traditional AFO reveals less durability and limited function. Seven out of 10 patients have disabilities necessitating metal over plastic, numerous modifications [to plastic] are a *must*, and medial lateral support is nil. In my experience, I have found that very mild cases necessitate the use of a plastic AFO when drop-foot (only) is the reason for bracing. Instability in the M-L plane is often accompanied by drop-foot, thus ruling out the plastic AFO.

4. I feel that the plastic AFO is definitely a more desirable type of orthosis for all the reasons mentioned in question #3. However, not every patient is a candidate for a plastic AFO, especially if the patient has edema or needs adjustability at the ankle.

5. Most students coming out of schools at this time *only* know how to make plastic AFO's and are not proficient or comfortable in making conventional orthoses. These "students" who usually possess degrees never spend sufficient time working in the lab to

become bench technicians and most, when handed a pair of bending irons, are in jeopardy of hurting themselves.

6. I agree with Mr. Shurr, but only from the standpoint of a therapist. Adjustment of plastic AFO's requires more than just a general knowledge of thermoplastics. During patient rehabilitation, minor changes in the degree of dorsi or plantar flexions that the orthosis is set in can make a drastic change in patient function. In clinical settings, this should always be done by the orthotist. However, physical therapists working with patients wearing AFO's may not have accessibility to an orthotist whenever they want to "experiment" with different ankle settings. I can therefore understand Mr. Shurr's intermference. This is, however, no comparison between the superiority of plastic systems over metal. Orthotists should be involved with any change made to their patients orthotic system.

In response to question 6:

Therapist adjustment syndrome (TAS) is not a valid RX criterion.

General Comments:

Far more important than durability is the ability to provide superior fit alignment and function. Improperly fitting plastic orthoses, by their very nature, are far more obvious and as a result more nearly considered unacceptable than the traditional Brace—which by *its* very nature masks improper fit and alignment and of course results in improper braces being worn. In 1980, we introduced a policy of providing all necessary repairs and adjustments without additional cost for the life of any plastic orthosis. This policy specifically excludes traditional metal/leather braces.

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