The Certification Board - Views of a Surgeon

Address at the 1954 Certification Meeting

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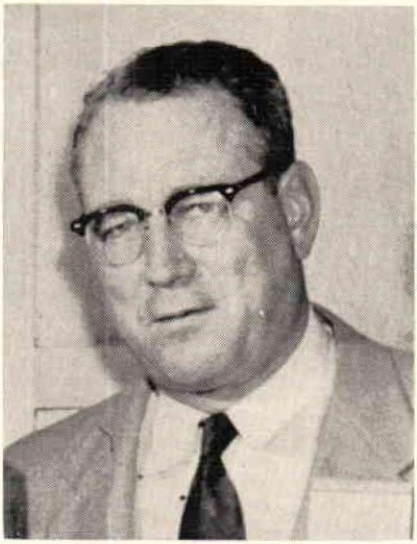
Mr. President, Mr. Executive Director and friends. I hesitate to address you as Orthotists and Prosthetists for several reasons. First, I never know how that one word will come out and secondly because I shall always think of you as my friends, the limbfitters and bracemakers. There is something good about words ending in "er." They represent action rather than just belief—"rider," "driver," "plumber," "wood chopper," "bricklayer," or an "engineer" is a man who does things. Everyone knows that a "tool maker" is superior to a machinist. Whether you like it or not, you will continue to be limbfitters and bracemakers and you have every reason to be proud of your craftsmanship as it requires topnotch work in a number of different lines. I know of no skilled worker who needs proficiency in so many diverse trades.

The only reason for having this American Board for Certification of the Prosthetic and Appliance Industry, Inc., is to insure in every way possible that the individuals and facilities engaged in this trade or profession will not only have the required proficiency but will use it. The ABC (and if you must use New Deal initials these are simple enough for even a child to remember) in its short existence of only six years has made a valiant attempt not only to insure but also to improve the caliber of work and ethical business-conduct in this field. Whether all of the actions or policies of this Board meet with your approval is not a question for me to debate today. I can however as one of the medical officers assure you that any actions taken or decisions made by the Board are done with due consideration and for the good of industry as a whole. I have never been associated with a more conscientious and hard working group than the officers and directors of your ABC.



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I have not come here to eulogize the Board as I am sure that some mistakes have been made and there is always room for improvement. The only people who make no mistakes are the ones who do nothing. I wish to talk to you briefly about the relationship between your profession and the medical profession. Whether you like it or not we are inextricably (how do you like that word?) inextricably bound together. Your "satisfied customer" is our "happy patient." Mr. Flick, for many years the director of the old Ruptured and

Crippled Hospital used to say with his Belgian accent — "Da patient komes first." This must be the never forgotten motto of both our professions. I am sure that like doctors many, if not most of you gentlemen, are in this field not because of the great fortunes that you expect to make but because there is an inner satisfaction in improving in any way possible the lot of our fellow human beings. I am not a religious person and I don't mean to claim that we are dedicated disciples who are giving our lives for the good of mankind, but you must admit that you get a kick out of seeing an amputee with a well-made leg or a polio patient with a real well-fitted brace stride out of your shop. I am sure that the great majority of you could make much more money if you had invested your brain, training, and money in some other line.

Because we are working on the same material (the patient) and toward the same end, the contacts between your profession and the medical one should be close, friendly, and mutually helpful. Unfortunately, this has not always been the case and a large part of the fault I am sure lies with the medical profession. Many of them feel that an amputation represents a failure of medical treatment and like many laymen avoid amputees like they were lepers. Even the surgeon who performs the amputation often thinks his duty toward the patient is finished and takes no further interest. As you know, an amputee can be the best (or the worst) possible patient with whom to deal. It depends upon what he has *left* (not what he has lost). This applies not only to the stump but to his mental and physical equipment, and most of all to his attitude toward life. If these are all right he will be easy to fit (or satisfy). But *remember*—this type who does not complain *deserves* the best and should not be allowed to go out with a second-rate job. We all know that "the squeaking wheel gets the grease" and I'm afraid that this applies to some of us.

The Orthotist (or may I say bracemaker) often has an even tougher job for he may have a subject who is trying to get some use out of an extremity that cannot be made to function even with the best possible bracing. You hear a lot about "rehabilitation," O! magic word, but who does the most rehabilitation for the amputees and the cripples? There is *no* question about it — the Prosthetists and the Orthotists. They have done a good job in the past, and I think are steadily doing a better one. The medical profession should help in every way possible. Unfortunately, not many doctors have the knowledge or interest to be of any help. Gradually more of them are getting into this field, and I would like briefly to introduce a few of them to you.

Since the organization of the ABC there have been eight doctors among your officers and directors. These, except for myself, have fortunately been well qualified Orthopedic surgeons with considerable experience and much interest in the entire amputee problem. They have been especially sympathetic with the idea of improving the limb-fitting and brace making throughout the country.

In England they have a very special specialist called a "limb-fitting surgeon." He is not a limb fitter as he does not make or fit limbs. He is not a surgeon as he does not operate. He has gained a good deal of experience with what constitutes a good fit of a satisfactory prosthesis but in my opinion this dictation to the surgeon as to what amputation he should perform and to the limb fitter exactly what type of prosthesis he should apply is not the ideal solution.

This idea of doctors and bracemakers working together is not new. Hugh Owen Thomas, the real father of Orthopaedics in Great Britain, was an expert bracemaker and made all his own braces. You all are familiar

with his ischial weight bearing ring. In this country about 1850 there was a small but successful brace shop on Lexington Avenue in New York City which made trusses for hernias and braces for cripples. The bracemakers called in some doctors to help advise them in some difficult problems (mostly severe tuberculosis) and the Hospital for Ruptured and Crippled was born. It still is centered around an active brace shop even though the name has been changed to Special Surgery. It is an interesting story about this change of name. About 10 or 15 years ago a group of doctors decided that they were losing a lot of fine Park Avenue patients because they did not want to tell their friends they were going to the Hospital for Ruptured and Crippled so now it is called "Special" Surgery. We don't know just what that means but some of us think it means a type you don't dare talk out loud about. Perhaps that is the way I feel about prosthetist and orthotist.

Whether a hospital, a rehabilitation center, or a Veterans Clinic should have its own brace shop or artificial limb factory, or both, are problems that I do not care to discuss today, but the fact remains that there is no question that the doctors and the limbfitters and bracemakers must work together and the more they cooperate and pull together the better chance we have of having a well-treated patient and a satisfied customer.

I cannot begin to give you the history of each of these Orthopedists who have or are serving on your Board.

Dr. Atha Thomas of Denver has been actively associated with amputee work for more years than I can remember. His books should be read by all of you.

Dr. Rufus Alldredge of New Orleans I have known since 1935 when he was a resident at the Ruptured and Crippled Hospital. When Walter Reed Hospital was made the first Army Amputee Center in 1943 I applied to Procurement and Assignment to get Dr. Alldredge released for duty in the Amputee Service. He had been in the Tulane unit as a Major but the University had declared him essential. By the time we got him released the order came out that any medical officer under thirty-five years of age had to come in as a first lieutenant.

Being three months under thirty-five, he had to be a first lieutenant. However, I was able to make him Assistant Chief of the Amputation Service where he supervised quite a number of Captains and Majors until he was stolen away to head up the 1100 bed amputation service at England General Hospital. This was, as you may know, housed right here in this hotel. He did a marvelous job and after the war toured Europe with a Committee from the National Research Council. As you may, or may not know, it was this Committee who was largely responsible for bringing the suction socket back into popularity in this country. Dr. Alldredge was also largely responsible for the Atlas on braces.

Dr. Henry Kessler has for many years been interested in cineplastic amputations and has written extensively on this subject. During the last World War he was responsible for the building up of the fine Navy Amputation Center at Mare Island. He now is Chief of the Kessler Rehabilitation Institute in New Jersey.

Dr. Robert Mazet, Jr., who is here today was also a member of the staff of Ruptured and Crippled until he entered the Navy in 1941. He became interested in amputees at Oak Knoll and since 1946 he has continued to have an amputee clinic at the Veterans Hospital in Los Angeles. Recently, he has organized a children's amputee clinic in the Pediatrics Department of UCLA.

Dr. Charles Bechtol became interested in amputee work in the service and participated in a lot of the experimental lower extremity research

work in the San Francisco Bay area. Many of you will remember him best for his fine work as an instructor in the Upper Extremity courses in Los Angeles. I am happy to report that he has recently moved to New Haven, Conn., as Assistant Professor of Orthopedics at Yale University. We in the East will gain what the West has lost.

Dr. Clinton Compere, who has just finished three years service on this Board, worked at the Amputation center at McClosky Hospital in Texas during the war and continues his interest in amputees by supervising several clinics in the Chicago district.

Dr. Edward Holscher of St. Louis, the new member of this Board, was Chief of the Army Amputation Center at Lawson General Hospital in Atlanta during the war. He will be a big help to you as you can't put anything over on him. While I was at Walter Reed I had a very good limbfitter (I mean Prosthetist) whose home was in Atlanta. There was a good boy in the shop at Lawson General from Washington. I had a very hard time arranging a transfer as Ed thought I was trying to send him a lemon. Incidentally, this man that he got has turned out to be one of the leaders in your profession.

As for myself, I can only say that at Walter Reed I had 700 amputees on the service at all times and could not help but learn a little about them. I had a few simple things to do—like submit complete plans for a limb shop on twelve hours notice with no specifications as to how many men were to work in it, nor how many limbs were to be made each month. I can say that we think we did a little better job than my partner Dr. Philip D. Wilson and General Norman Kirk (then Major) did in the 1st War. In 1946 with Dr. Jerome Lawrence, I started an amputee clinic for civilians at the Ruptured and Crippled and though it is not very fancy, our relations with your group are most cordial, and in spite of the fact that we get the toughest problems imaginable our failures are surprizingly few.

I have just returned from an Army Consultants' trip through Germany and France. I attended the International Orthopedic Association meeting in Berne, Switzerland and the International Polio Conference in Rome.

In Rome among many other things I saw a Danish long leg brace that had only a single inside bar from the knee down to the shoe. The slip lock was on the outer side and the band below the knee, which connected this inside and outside bar, was solid in front instead of behind. The absence of the side bar below the knee improved the cosmetic appearance greatly. This brace was only useful for holding a flail knee in full extension but apparently did this very well.

In Frankfurt I spent several hours in the Schede-Habermann limb factory and was greatly impressed. They claim great advantages for their special knee joints which are certainly ingenious. I was most impressed, however, by their method of taking the mould for the suction socket which they use almost entirely. I am sure, however, that you will get a first-hand report tomorrow of many more things in Europe than I could tell you.

In conclusion, let me tell you again what a pleasure it has been for us of the medical profession to work with you all for the advancement of your industry. Any improvement that has been or can be accomplished is primarily due to your own efforts. Those improvements will necessarily be reflected in improved care of our patients. Let me thank you primarily for them and express the deep appreciation of your numerous friends in the medical profession for the fine work you are doing.