

Use of Community Resources In The Continuing Prosthetic Care of the Child Amputee

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More than 70 per cent of all children receiving prosthetic care at the Child Amputee Prosthetics Project have their continued training with occupational or physical therapists near their homes. Nearly all the children in the Los Angeles area receive their initial training as well as their continued training near their homes. Approximately 50 per cent of all prostheses are made and maintained in private limb shops located within reasonable traveling distance of the patients' homes.

The use of these community resources did not come about quickly and was not motivated exclusively by the expediency of saving project staff time. As the needs of patients and their families became more clarified and working relationships with the resource personnel in the communities better established, the benefits of stimulating and supporting continued treatment on a decentralized basis became apparent. It was also recognized that the community itself, with all of its activities and demands on the patient, provided a real laboratory for the testing of equipment and the evaluating of treatment methods.

Prosthesis Training

In 1955 only a very few children who were active in CAPP received training on a local basis. These children were severely involved, necessitating attendance in special schools. These schools were set up primarily for children with cerebral palsy. The therapists responsible for these children made direct requests to the CAPP occupational therapists for assistance in prosthetic training methods.

During this time the other children in the CAPP program received their initial training from the project therapist and were scheduled for periodic follow-up at CAPP. The initial training consisted of approximately five to fifteen sessions over a one to three week period. The number of sessions was determined by the severity of the problem and the complexity of the device. Parent and child stayed in a nearby motel when the distance from home was too great for daily commuting. Frequently the follow-up training proved impractical because the distance to be travelled from their homes to the project precluded sessions on a weekly or in some instances, even a monthly basis. For some children a loss of skill occurred during the interim between sessions. This resulted in questions from parents, child, and staff about the feasibility of fitting children when motivation to use prostheses could diminish so easily. Other children retained their initial skill but did not improve their skill in keeping with their developmental level. With the prosthesis they remained at the developmental level at which they were trained while the rest of the body and mind had moved on to more complex tasks.

The CAPP therapist believed that with consistent training a child develops and maintains skills that would make the prosthesis a useful device for him. Those few local therapists who were training children continued to express interest in knowing more about working with child amputees. With the CAPP therapists' belief in the benefits of consistent training, with the interest expressed by the local therapists, and with the investment (in money and energy) of the State Bureau of Crippled Children Services, a plan was worked out for all CAPP patients to receive prosthetic training on an outpatient basis in the special schools.

As first each therapist received detailed instructions of training methods whenever a referral was made. A form was prepared so that each therapist could report progress and difficulties at periodic intervals. Despite the efforts of the project therapist to provide detailed instructions, the local therapists expressed considerable apprehension about their work with CAPP patients. They saw an upper extremity prosthesis as extremely complicated, requiring a skill and understanding they did not have. It was necessary for the CAPP therapist to explain terminology, principles of bio-mechanics, and step-by-step training methods to each therapist. Therapists coming individually to the project, or the project therapist going to the special schools, proved impractical because of the heavy time involvement. For a period of time the local therapists were invited to attend the clinic when their patient's program was reviewed. Although these therapists contributed information valuable in a better understanding of the patient's progress or difficulties and they took with them additional information about the patient's potentials and limitations, the time involvement raised questions about the practicality of continuing with this individualized type of procedure. In addition only those therapists who were within reasonable travelling distance of the Project could participate in this way.

Early in 1957, after a year's experience of referring children for their continued training, plans for conducting workshops for participating therapists were worked out with the Los Angeles County therapists and the Project. Since that time, 16 workshops have been conducted. These workshops have been extended to include geographical areas other than Los Angeles County. Workshops have been conducted for those who have not had previous experience with prosthesis training and for those with considerable experience. Some of the advanced workshops have had separate sessions for physical therapists working with children having lower extremity problems.

Presently more workshops are in preparation. New therapists are coming into the field constantly and the previously prosthetically trained therapists see their need for additional knowledge more acutely. Almost all children below the teenage group are receiving their continuing training in their communities and this group is enlarging as referrals in the pre-school aged group have increased during the past few years. The therapists continue to prepare reports that are sent to the project prior to the patient's clinic visit at UCLA.

Prosthesis Manufacture

In 1955 during the first year of the Project's operation, a question was raised about having the standard types of prostheses fabricated in the private limb shops in order to free the project prosthetists to concentrate on more difficult problems. The Southern California Orthotists and Prosthetists Association appointed a special committee, known as the Prosthetics Industry Participation Program, to work out agreements with the project. Some of these agreements were that the prosthetist would be selected on the basis

of his certification, proximity to the patient, and graduation from an approved Upper Extremity Prosthetics School. All prostheses would be sent to the project after completion, with the check-out taking place there. During the first two years the project did all upper extremity harnessing, but the present practice is to have the local prosthetist complete the entire prosthesis with the project providing only the terminal device. The private industry participation program has been in effect since the middle of 1956. Many of the prosthetists in the Los Angeles area attend the check-out and some have done the harnessing at the project in order to benefit from the experience of the project prosthetist's years of experience in fitting children. The local prosthetist has a card which he mails to the project whenever he completes any adjustment or repair on the prosthesis. The nature of the work and the date it was accomplished is recorded on the card which is then transferred to a master record kept by the Project prosthetist. A study is in progress to determine the average life of prostheses for various age groups, as well as the nature and extent of repairs and adjustments.

Medical Care and Social-Psychological Services

The increased use of community resources has given the Project staff a more realistic view of the patient's needs. At the same time the community has gained a better understanding of the complexity of problems inherent in children with amputations or malformed extremities. Through the medical director's consistent communication with the family physician, working relationships have been developed that are of benefit to individual patients and have led to earlier referrals of patients with acquired and congenital amputations. Parents and their children, who present social-emotional problems requiring treatment on a continuing basis, are helped to accept referral to appropriate resources within their communities. Although many of these problems are not solely related to the child with the disability, it is apparent such a disability heightens already existing disturbances making family adjustments difficult.

Conclusion

The goal of any prosthetic program of this kind is to assist children to grow up into responsible adults who can make a contribution to the community. The more closely the community can be involved during a child's growing years the more likely the community is to have a place for him during his productive years. At the same time all of these community services that meet or supplement training, prosthetic, medical and social-emotional needs are feeding back to the project information about the realistic requirements for these patients so that in the future more effective ways of treating these children with amputations or malformed extremities will be achieved.

