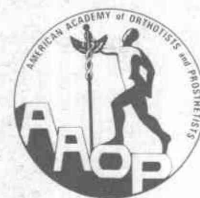
# Clinical Prosthetics & Orthotics




Vol. 6, No. 3 1982 Summer (Issued Quarterly)


# Continuing Education— Past, Present, and Future for AAOP


**Charles H. Dankmeyer, Jr., CPO***


In 1978 the American Board For Certification in Orthotics and Prosthetics, Inc. (ABC) and the American Academy of Orthotists and Prosthetists (AAOP) reached an agreement which provided that AAOP would administer the continuing education program begun by ABC. The program is very similar to its original format developed by ABC, and remains a voluntary program. The Academy is responsible for processing applications, developing the standards to be met by the participants, and developing a recognition system for successful participants. ABC continues to accredit appropriate educational programs submitted to it and to designate the number of continuing education credits awarded for each program.

The reason the organizations reached this agreement is two-fold. First, since the continuing education program that ABC was administering had no effect on certification outside of deciding the number of credit hours to be awarded for each program, ABC believed it should not be providing recognition to successful participants in a voluntary continuing education program. Second, AAOP believed that part of its responsibility was education. Since AAOP was directly involved in providing seminars, it seemed appropriate that AAOP should administer a continuing education program and provide recognition for successful participants.

It should be remembered that both groups agreed to the continuing education program being administered by AAOP only to the extent that it did not affect certification. It should also be borne in mind that AAOP has no influence on the number of credits awarded or the approval of programs for credit.

I stress that any continuing education program developed within the Academy does not affect an individual's certification by ABC. This emphasis is made because this is an area of grave misunderstanding by Academicians. Many members believe that if an individual does not participate in the continuing education program, he will lose his certification. Such is not the case. Any program developed by AAOP will affect only the membership within AAOP and not an individual's certification. The certification of an individual and the continuing certification of an individual remains the province of ABC.

At the 1981 AAOP annual meeting the membership voted to convert the existing voluntary continuing education program to a mandatory program. This move by the membership has caused AAOP to search for an acceptable system for mandatory continuing education. Many approaches to converting the existing voluntary program to a mandatory one have been examined. None have been deemed acceptable.

There are many problems within the continuing program which could lead to injustices for Academicians participating in a mandatory program. One of the things necessary, if we are to have a successful mandatory continuing education program, is the capability for an individual to plan ahead in meeting his continuing education requirements. Currently, there exists no publication which permits an Academician to sit down and look at all of the seminars and special programs being put on by other paramedical groups which may be acceptable for continuing education. Even if such a publication were available, there would be no listing of the number of credits allowed for each of these programs. Many programs which may well be suitable for credit are never even submitted to ABC to be approved. Program organizers are often not concerned about the need of orthotists or prosthetists to meet continuing education requirements and therefore never submit their programs for approval by ABC. Therefore, AAOP cannot recognize an Academician's attendance at many of the seminars and programs that are given locally by therapists and physicians groups. Additionally, there are extenuating circumstances which affect some Academicians' attendance at seminars.


*Chairman, Continuing Education Committee
President, Dankmeyer, Inc.
Baltimore, MD

For example, I received a letter from an individual who was concerned that his membership in the Academy would be in jeopardy because he was unable to attend seminars on Saturday. As you know, most seminars are held on Friday, Saturday, and Sunday. This particular individual is a practicing Orthodox Jew and is unable to attend any seminars held on the Sabbath. It seems to me that it is in the best interest of the Academy to attempt to develop a program which will accommodate all individuals and not require them to travel in order to participate in the continuing education program. Such a program would allow individuals several choices to meet continuing educational requirements.

I would suggest that reading of the AOPA Journal, *Orthotics and Prosthetics,* and clinical participation be the two mainstay requirements to maintain membership in the Academy. In fact under the current continuing education program, Journal reading is an acceptable means of obtaining credit. How does one know someone has really read the Journal? Journal reading could be verified by providing a group of questions at the end of a selected article within each issue. Academicians wishing to participate in a continuing education program would complete the questionnaire at the end of the selected article and return it to the National Office for approval. Although such a system appears to be a very minimal requirement, it would demonstrate that participants had at least read *Orthotics and Prosthetics.* There is currently such a system being used in a publication entitled *Contemporary Orthopedics.* This should satisfy the needs of those individuals who are unable to travel to seminars. Those individuals who decided to travel to seminars and meetings should be allowed to apply for credit for seminars attended. Therefore, they would not need the credits earned by responding to the questionnaires.

An additional alternative could be a self-assessment examination. This could be required every three years of individuals who had not participated in a continuing education program designed around Journal reading or seminar attendance. Such a self-assessment examination could be structured in a manner which reported back to the individual his results without affecting his membership in the Academy. At the very least it would identify areas in which an Academician needed work. It is difficult to imagine that the Academy would be telling an Academician that he needed to bone up on a specific subject, because Academicians are currently practicing orthotics and prosthetics. To say that an Academician required additional work in a specific area is to say that orthotists and prosthetists are providing inadequate services. This is the same tack which therapists and physicians have taken with their mandatory continuing education programs. In essence, all of these programs state that practitioners who do not fulfill the requirements of the program are not maintaining competency.

I do not believe that this is the case for orthotists and prosthetists. I believe that most orthotists and prosthetists have met the challenge of modern day orthotics and prosthetics practice. I further believe that if we are attempting to require continuing competency, and not continuing education, we should change our goals.

The goal of all continuing education programs is to provide that practitioners maintain current standards which will benefit their patients. No continuing education program requires that a practitioner who attends a program utilize the material presented in that program. In other words, you can make someone sit down and listen to a different way of doing things, but you cannot make him practice it. This being the case, I do not believe that a mandatory continuing education program is in the best interest of the Academicians or the patients we serve. I suggest that continuing education not be a requirement for membership in the Academy. I further suggest that those practitioners who believe the ranks should be periodically reviewed for competency expend their efforts on obtaining a mandatory continued competency system.

Continuing education is indeed the route that all other medical professions have followed. Continued competency remains the burr in every medical profession's side.

To develop a continuing education program and to require that individuals participate in such a program appears to be the route that we must follow. I personally do not agree that this is the correct route. However, such a program has been requested by the membership. Academicians, I request that you submit to me your thoughts on such a mandatory continuing education program as a requirement for membership in the Academy.


**Clinical Prosthetics and Orthotics**



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**Spring Honorarium**

*William M. Brady, CPO has been awarded the $100 honorarium for his article,* "Post Operative Management of Lower Extremity Amputees Using Tubular Elastic Compression Bandaging."

# Questionnaire

Continuing education has sparked lively debate within the Academy membership. The structure of the program, its efficacy, and its viability are questions of concern to all Academicians. We want your opinion on this vital topic. Please complete the questionnaire below, and send it to Charles H. Pritham, CPO, Manager, Snell's of Louisville, 744 E. Broadway, Louisville, KY 40202.

1. Do you agree with Mr. Dankmeyer's contention that we should be establishing standards for continuing competency and not continuing education?

   Yes ________ No ________

2. Do you believe that such a program (competency or education) be mandatory?

   Yes ________ No ________

3. Do you participate in the current voluntary program?

   Yes ________ No ________

4. Do you consider the current program of educational offerings adequate?

   Yes ________ No ________

5. What do you believe the Academy should do to better enable you to meet your continuing education requirements?

   ________ More of the same (many different topics, little depth)

   ________ Narrower focus seminars (fewer topics, greater depth per lecture)

   ________ Review sessions

   ________ Exploratory seminars which extend your knowledge beyond the traditional borders encompassed by Prosthetic and Orthotic education

6. Additional comments:

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## Meetings and Events

**Please notify the National Office immediately concerning additional meeting dates. It is important to submit meeting notices as early as possible. In the case of Regional Meetings, check with the National Office prior to confirming date to avoid conflicts in scheduling.**

**1982, September 1–4,** International Skeletal Society, 9th Annual Refresher Course on Musculoskeletal Disorders, Hyatt Hotel, Union Square, San Francisco, California.

**1982, September 3–4,** Technical Aids for the Disabled, 1982, Daytona Hilton, Daytona Beach, Florida.

**1982, September 8–10,** Second Annual Advanced Course of Lower Extremity Prosthetics, Nassau County Medical Center, East Meadow, New York.

**1982, September 11–12,** Florida Orthotic and Prosthetic Association Meeting and Seminar, Treasure Island Inn, Daytona Beach, Florida.

**1982, September 18,** New England Chapter of AAOP Seminar, Dunfey Hyannis Hotel, Hyannis, Massachusetts.

**1982, September 25,** Southern California Chapter of AAOP Seminar, Disneyland Hotel, Anaheim, California.

**1982, October 19–23,** AOPA National Assembly, Shamrock Hilton, Houston, Texas.

**1982, October 23–24,** Foot Management in C.N.S. Disorders, Lecture and Practicum, Blythedale Children's Hospital, Valhalla, New York.

**1982, October 28–30,** Houston Center for Amputee Services at the Institute for Rehabilitation and Research Seminar on "Successful Upper Extremity Prosthetic Function For The Child and Adult," Stouffers Greenway Plaza Hotel, Houston, Texas.

**1982, December 5–8,** American Medical Association's Interim Meeting of the House of Delegates, Fountainbleu Hilton, Miami, Florida.

**1983, January 26–30,** AAOP Annual Meeting, Hyatt Islandia, San Diego, California.

**1983, April 21–23,** AOPA Region IV Meeting, Jackson, Mississippi.

**1983, May 12–14,** AOPA Regions II and III Combined Meeting, Colonial Williamsburg, Williamsburg, Virginia.

**1983, May 25–28,** AOPA Regions VII, VIII, X and XI Combined Meeting, Hotel El Tropicano, San Antonio, Texas.

**1983, June 3–5,** AOPA Region IX, COPA, and the California Chapters of the AAOP Combined Annual Meeting, Harrah's, South Lake Tahoe, Nevada.

**1983, June 19–23,** American Medical Association's Annual Meeting of the House of Delegates, Chicago Marriott Hotel, Chicago, Illinois.

**1983, September 5–9,** The IV World Congress of the International Society for Prosthetics and Orthotics, Imperial College of Science and Technology, London, England.

**1983, October 25–30,** AOPA National Assembly, Hyatt Regency, Phoenix, Arizona.

**1984, June 1–3,** AOPA Region IX Meeting, Harrah's, South Lake Tahoe, Nevada.

*EDITORIAL*

# Organization Necessary For Continuing Ed

Continuing education is not an option if one plans to function using the best available information and techniques. With any career, the volume of new information and the changes this new information produces forces us to continue our education. Many people seek additional and new material all their life. This is done without a conscious effort of education. They like to learn and improve. At the other pole, some people avoid absorbing new information and resist change to the point that they are "outdated."

The question is: "Should there be required, organized continuing education?" This organization promotes the philosophy of education, competency and service. The members should expect to pursue education and training to maintain themselves at the highest level of functioning.

Some will achieve this without help. Some will need guidance. Some will resist efforts to continue the education process. All of these people need to be accommodated.

To become certified, one must follow a prescribed academic course (including shop work), participate in an apprenticeship program, and pass an examination. The first two are learning experiences. These same opportunities continue to be available. Formal programs and work shops are being presented frequently and at many places. Once again many people attend these educational opportunities "just to learn." Everyone should participate.

I feel continuing education is desirable. I feel that AAOP should have an organized program to continue the education process.

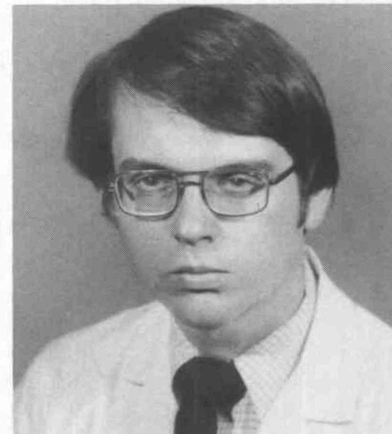

O. James Hurt, M.D.

Chief, Rehabilitative Medicine Service
Section Chief, Orthopedic
Clinic Chief, Amputee Clinic
Veteran's Administration Hospital
Louisville, KY

Clinic Chief, Juvenile Amputee Clinic
Dept. of Human Welfare, State of Kentucky
Louisville, KY

Vice President, American Board for
Certification in Orthotics
and Prosthetics, Inc.


# Editor's Message



On May 15th and 16th, I participated in a joint meeting of Working Group I and II of the International Standard Organization Technical Committee 168. My attendance at this meeting in London, England was supported in part by AAOP. Working Group I's responsibility is the international standardization of terminology and nomenclature in Prosthetics and Orthotics. In America, with its farflung borders and common language, the need for such harmonization may seem remote. However, the international community of prosthetics and orthotics is a relatively small one, and contemporary American prosthetics and orthotics practice has been enriched by many foreign influences. This trend can only be enriched by an increase in efficient communication. It should be remembered that the process is a long-drawn-out affair, where progress is marked in small increments, and if we wish to have any influence over the results, we must participate.

The most recent meeting resulted in a decision to adopt the system of naming amputation levels and prostheses (with a number of alternate terms judged acceptable) commonly used in the United States. This may seem like a minor accomplishment, but it should be borne in mind that it took some three years to arrive at it, and that many of the alternate terminology systems are radically different from current usage. With this decision made, the way is clear for consideration of a standardized technique for naming the component parts of prostheses.

Working Group II is concerned with developing standards for testing the physical strength of prostheses and orthoses. The task of Working Group II is the most interesting of all. This committee is attempting to develop objective standards for the results of amputation surgery and for assessing the results. This is a very exciting concept and the consequences of this long-range project could have the greatest impact for us and the patients we serve. I firmly believe that it is not only in our best interest as Academicians to participate in this process, but also, a part of our responsibility as professionals.


Charles H. Pritham, CPO

# A Seminar On Scenic Cape Cod
# Clambake — Free Beer

Saturday, September 18

presented by~

New England Chapter American Academy of Orthotists and Prosthetists

Dunfey Hyannis Hotel
West End Circle, Hyannis-Cape Cod, Massachusetts

## Program

**Muscle Disease Patient — Needs and Problems**
Ronald Altman, CPO; Mark Bondurant, B.S.

**Review of Current Designs for Knee Orthosis**
Robert Lin, CO

**Total Knee Joint Replacement**
Herbert S. Pasternak, M.D.

**Recent Developments in Lower Limb Prosthetics**
H. Richard Lehneis, Ph.D., CPO

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**Registration Form (please print)**

I wish to register ____________ (No.) persons for the Hyannis Seminar
Registration Fee ............. $60.00 for non-members of AAOP
$30.00 for members in good standing of AAOP (50% discount)

**Names and Titles of Registrants, check amounts**

| | | | |
|---|---|---|---|
| Last Name & First | $30.00 ☐ Academy Member | $60.00 ☐ other | $35.00 ☐ Clam bake |
| Last Name & First | $30.00 ☐ Academy Member | $60.00 ☐ other | $35.00 ☐ Clam bake |
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Enclosed find $ ________ Check must accompany registration.
Make check payable to: New England Chapter of AAOP.

Mail Check to: Michael Murphy, CPO
Prosthetic & Orthotic Labs of Worcester, Inc.
134 Lincoln Street
Worcester, MA 01605

# DISNEYLAND SCIENTIFIC SESSION

## September 25, 1982
## 9:30 a.m.

Presented by the Southern California Chapter AAOP

**TENATIVE TOPICS TO INCLUDE**

The future of Medicare and MediCal in California–
Tom Guth, CPO, President CODA

The "Lively Orthosis"–Reduction and Maintenance of
Plantar Flexion Contractures

Generation II Canadian Knee Orthosis

History of CAPP and the Pitfalls of Fitting the Child Amputee–
Yoshio Setoguchi, MD

State of the Schools–Tim Staats, CPO

Application of the Lerman Multiligamentus Knee Orthosis–
Max Lerman, CO

Postoperative Prosthetic Applications–
Timothy Bulgarelli, CPO

Clinical Evaluations of Inserts for the Diabetic Patient–
David Eckhous, OTR, CO

Technical Considerations and Clinical Management of the Halo Vest–
Tom Lunsford, M.S.E., CO

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**REGISTRATION FORM**

Last Name ______ First ______ Title ______ Organization ______

Address ______

City ______ State ______ Zip ______

**Meeting Registration fees:**

_____ $30.00 AAOP Members
_____ $40.00 Non Members
_____ $25.00 O/P Students
(with letter from institution)

Mail check to:
Bonnie Tokaruk, CP
1420 N. Waterman
San Bernardino, CA 92404

Luncheon will be provided but guaranteed only to those preregistering.

# Academicians Volunteer To Help

*Earlier this year, Academy President H. Richard Lehneis, Ph.D., CPO, in an effort to involve more members in the affairs of the Academy, invited members to volunteer to serve. Shown below are those who responded.*

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## Survey Results

Below are the summarized results of two questionnaires that appeared in recent issues of this publication. These results are important tools for observing, recording, and predicting trends within the Academy and the profession. Your responses are greatly appreciated, and we ask that you encourage your colleagues to send us their thoughts by answering the questionnaire in this issue (see p. 3), and those in future issues.

# Scoliosis Orthoses

*From the Summer, 1981 Issue, Vol. 5, No. 3*

A total of six responses have been received. Two respondents were institutional facilities and the rest were private. The six reported fitting a total of about 757 patients last year, an average of about 126 per facility. The maximum was 400 patients and the minimum was 8. Not too surprisingly, the maximum was an institutional facility (Newington Children's Hospital). The most commonly prescribed orthosis was the Boston System, and among four of the respondents it accounted for the majority of orthoses fit. One individual reported that the Boston System accounted for 100% of orthoses he fit for scoliosis (actual number, 13); however, two of these orthoses had been modified by the addition of a super structure, and 3 with anterior uprights. Only one respondent reported using more than 50% conventional Milwaukees (60%) and this individual, practicing in the Southwest, stated that all had leather girdles as plastic girdles were too hot. He also reported using 35% Orthomedics SOS Systems, the only mention of this style orthosis in the survey.

Interestingly enough, one respondent reported that 36% of his scoliosis practice was comprised of Raney Flexion Jackets prescribed by a neurosurgeon for treatment of scoliosis and as positioning devices.

Only one respondent, Richard D. Koch, CO of University Hospital, Ann Arbor, Michigan, reported using a preponderance (90–95%) of custom molded TLSO Body Jackets and Low Profile Orthoses combined (actual numbers fit 120–125). The rest of his scoliosis practice was comprised of conventional Milwaukee braces. Mr. Koch comments:

"Through school clinics and early screening for scoliosis the range of curves have reduced in degree of their severity. Consequently, we find that TLSO Body Jackets and Low Profiles are in wider use than CTLSO's."

Newington Children's Hospital, mentioned earlier, reported using 75% Boston Systems and 25% custom molded TLSO's primarily for treatment of non-idiopathic scoliosis secondarily to paralytic diseases.

# Results of the Survey Concerning Endoskeletal Prostheses

*From the Winter, 1982 Issue, Vol. 6, No. 1*

As of March 25, 1982: 27 responses

1. How many definitive endoskeletal prostheses does your facility fit a year?

   Total of 1,814 fit, an average of 67 per respondee
   Maximum of 380
   Minimum of 0, second lowest 5

2. Indicate the percentages of the type fit.

   While it is difficult to give precise figures, roughly speaking the same trend prevailed for all respondees. About 95–100% of Below-Knee prostheses fit were exoskeletal and 95–100% of Hip Disarticulation/Hemipelvectomy prostheses were endoskeletal. Above-Knee prostheses occupied some middle ground with many respondents reporting fitting more than 50% endoskeletal Above-Knee prostheses. Only four respondents reported fitting as many as 50% endoskeletal Below-Knee prostheses. These four tended to be among the most frequent users of endoskeletal prostheses reporting 380, 170, 75, and 50 respectively.

3. Which Endoskeletal Prosthetic System was used most frequently?

   Otto Bock 20
   AFP 2
   Both Otto Bock and AFP 2
   Both Otto Bock and USMC 2
   IPOS 1

4. Do you consider endoskeletal prosthetic systems light enough?

   11 said yes
   14 said no
   1 said yes to AK's and no to BK's
   1 said yes to AFP andUSMC and no to Otto Bock

5. Do you consider them reliable enough?
   19 said yes, one of whom qualified his response by saying for adults and geriatrics only
   7 said no
   1 said yes and no
6. Are cosmetic covers and skins adequate?
   23 said no
   3 said yes, one qualified his answer by saying only the AFP system
   1 said yes and no
7. Do you consider it necessary to have full capability to modify alignment in definitive endoskeletal prostheses?
   11 said yes, one stating that the need for making changes in alignment as the patient's condition changed was an indication for prescribing an endoskeletal prostheses. One specified the use in temporary prostheses.
   1 stated that he considered it desirable early in the patient's progress and unnecessary late
   14 said no, one of whom indicated that he used the AFP system exclusively and revised 380 of them
   1 ambiguous
8. How often do you make changes in alignment?
   7 said never
   17 said occasionally, one of whom stated that he occasionally made changes early in the patient's progress and never in more advanced instances.
   3 said frequently. One was the individual in #7 who identified the need for alignment changes as an indication for prescribing an endoskeletal prosthesis.
9. Would you consider it satisfactory to trade alignment modification capability for lightness and durability?
   22 said yes, one of whom qualified his position by saying not at the expense of the ability to interchange components.
   5 said no
10. What changes would you like to see made?
   a. 11 specified improved cosmetic covers
   b. 4 specifically recommended a more durable cover at the knee, or a way to reinforce or prevent impingement at the knee.
   c. 3 recommended more work on hydraulic and pneumatic knee control units, one of whom mentioned a hydraulic foot.
   d. 2 mentioned a more secure system of maintaining alignment.
   e. 2 mentioned waterproof skin for covers
   One each:
   f. lighter safety knee
   g. improved strengh
   h. easier to operate and more cosmetic knee lock
   i. interchangeability of knee units without necessity of altering pylon tube length.
   j. easier and better attachment of cover to foot and socket for improved cosmesis, yet allowing removal for adjustment of alignment.
   k. reduction in weight of single-axis feet and ankles
   l. modular, removable, hip joint and pelvic belt
   m. more versatile socket for geriatrics to accommodate weight fluctuation and vascular problems
   n. incorporation of cable systems in upper extremity prostheses.
   o. durable covers easily donned by the layman
   p. easier access to the adjustment screws on top of the foot of the Otto Bock system.
   q. "Covers such as those used on Hydra-Cadence, but they must look better and last longer. Preferably in assorted sizes."
   r. noise reduction (spring squeaks)
   s. system for small girls
11. Additional comments:
   a. "The Otto Bock System was the best of both worlds (lightweight and adjustable) until the alloys and tubing were changed for increased strength. A main selling point of the endoskeletal systems has always been improved cosmesis. This may be true for standing and during the first few months post-delivery. However, the common foam cover system deteriorates relatively rapidly—cuts, tears, folds, and compression of the foam remain common problems. Therefore, I feel the foam covers need refinement."
   b. "I want full adjustability while aligning. After alignment on definitive prostheses the adjustability doesn't have much value."
   c. "In regard to question #7. Depending on patient indications two systems would be desirable; one fully adjustable in terms of alignment, the other lighter and more reliable."
   d. "Most endoskeletal prostheses are for AK female amputees."
   e. "In reference to question #4 and #5 above, of course they could be more reliable and lighterweight if they could redesign the system (Otto Bock, Ed's note). As it is, they are doing the best they can with what they have to work with (design)."
   f. "It is a good unit but needs improvement."
   g. "Endoskeletal is a poor excuse to charge more money. Shell replacement is too costly too soon. I'm afraid the dollar sign prevails and not the patient's welfare."
   h. "For below-knee amputees, I do not feel an endoskeletal system is any advantage. For the young, active above-knee amputee, the foam cover is not durable enough. For the hip disarticulation of any age, it is usually preferred, except in special cases."
   i. "The endoskeletal system should only be used in those cases where lightness is desired and where changes in alignment are anticipated."

## Questionnaire Summary Comments

The article on endoskeletal prostheses provoked an astonishing and gratifying response, something of a record in size, in the recent history of this publication. A surprising total number of prostheses are reported fit, and endoskeletal prostheses occupy a significant total in many individuals' overall practice. In assessing the results of this survey, it would do well to bear in mind, however, that according to the statistics, we are primarily talking about prostheses for the higher levels (Above-Knee, Hip Disarticulation, and Hemipelvectomy) fabricated with Otto Bock components. This fact is particularly interesting when considered in light of the fact that below-knee amputees are undoubtedly far more common in most practices.

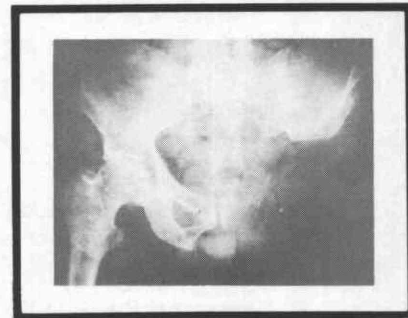
Despite the numbers fit, it is apparent that the respondees were less than totally satisfied with the components available. While somewhat ambivalent about weight, and in general satisfied as to reliability, they were almost unanimous in judging cosmetic covers inadequate.

Taking questions 7, 8, and 9 together, it would seem that most of the prosthetists replying would feel comfortable using an endoskeletal system that did not have full indwelling alignment capability if it were clearly superior in other aspects. This is noted in light of the proponderent use of Otto Bock endoskeletal components.

The written comments and suggestions for change are presented, with few exceptions, in toto to provide more than simple statistics, and some inkling of the thoughts of the respondees. Taken in conjunction with the rest of the survey, they should provide food for thought to all and stimulus to action for designers and manufacturers.

## AAOP Brochure

### *Introduces Orthotics, Prosthetics To The General Public*



What are orthotics and prosthetics? Surprisingly or not so surprisingly many people do not know what these words mean or what is involved in the orthotic/prosthetic profession. To help inform the general public, the American Academy of Orthotists and Prosthetists has published a brochure which defines the terms and offers a description of the profession. The description includes a discussion of professional responsibilities of orthotists and prosthetists; educational and professional standards; and research in orthotics and prosthetics. The Brochure is available from the National Office for $1.25 plus 75¢ handling for a total of $2.00. Canada add an additional 75¢ and Foreign add an additional $1.75. Please make your checks payable to AAOP.

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## LETTER TO THE EDITOR

Dear Editor:

I like the new format for *Clinical Prosthetics and Orthotics—C.P.O.* (Spring, 1982, Vol. 6, No. 2). Dr. Murphy's article brought back many events that I experienced personally. Dr. Epps and Ben Wilson point out very clearly the challenge we all face for the near future.

The education and R & D programs in prosthetics and orthotics in the last 30 years have improved the patient care and products fitted by members of our profession. I was proud to come into this profession in 1947, but I'm more proud today.

I volunteer our Winkley facility in Golden Valley for a private R & D project if the private funding can be found. Our facility is 12,600 sq. ft., has 19 patient treatment rooms (3 large walking rooms), and unused lab area.

Let me know.

Robert C. Gruman, CP
President, Winkley Orthopedic Laboratories
Golden Valley, MN

## Academy President Lehneis Makes TV, Lecture Appearances

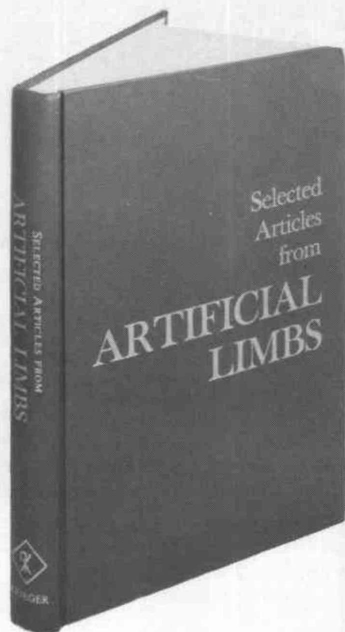
Academy President Dr. H. Richard Lehneis, CPO added to his already busy schedule earlier this summer when he appeared on a nationally televised news program, and lectured as a visiting professor.

Aired on July 7, "The Freeman Report," an interview show on the Cable News Network, featured Dr. Lehneis as a guest. He spoke on prosthetics and bionics.

In May, Dr. Lehneis was honored by an appointment as a visiting professor at the Mayo Clinic in Rochester, Minnesota. His lecture topics included Advanced Lower Limb Orthotics, Prosthetics Management of the High Level Amputee, and Orthotics Management of Scoliosis, highlighting Biofeedback.

# Announcement . . . . . .

The American Academy of Orthotists and Prosthetists is pleased to announce the SALE of a limited supply of a most valuable book for your professional library.

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