Rehabilitation Centers and the Prosthetic-Orthopedic Facility: How to Develop Effective Cooperation for the Mutual Benefit

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The W. E. Isle Company

Questions concerning the relationship between local prosthetic, orthopedic facilities and local rehabilitation centers have arisen in the minds of orthotists and prosthetists since the inception of the team concept and our inclusion in it. Reservations, at least mental, regarding the feasibility and desirability of close cooperation between the two persist even now. Our experience in Kansas City with these institutions has been such that for us the questions are answered and the reservations resolved. I am happy that it is my privilege to pass on to you our thinking on this subject and tell you of the mutual benefits to be derived from close cooperation. I shall also try to outline means we have employed to develop this attitude and make it effective. I intend to do this by posing a number of questions and giving such answers as we have learned and such conclusions as we have drawn from our experience.

To begin with, I would state unequivocally that effective cooperation between any two separate institutions, however closely related, does not occur spontaneously. *It must be built.* Building in these days and times, even building something as intangible as cooperation, seems full of complexities and by instinct we shy away from it. Which brings me to the first of the questions I want to ask about building cooperation:

Why Should We?

Why extend ourselves in an effort to cooperate with a Rehabilitation Center? Or why strain to get such a center to cooperate with us? From our experience with such institutions in Kansas City, and from my own personal experience, I think I can give several sound and valid reasons. First of all, because it is to the best interest of our clientele. Regardless of the manner in which these clients come to our facility, whether they drop in as customers, or are sent to us for our service as the patients of a medical practitioner, they are invariably the victims of a physical handicap. The best, most completely rounded program for the physically handicapped is available through the facilities of the Rehabilitation Center or the Rehabilitation Service of a fully organized Medical Center. I know of no other place where all the personnel who may be needed are readily available. Physician, physical therapist, occupational therapist, clinical psychologist, vocational counselor, and medical social worker, all are here and all their services and therapies are on call. If genuine cooperation exists between the center and the local limb and brace facility, then you, too, are there and *prosthetist* and *orthotist* can be added to the list of available personnel.

The rehabilitation center provides a central location to coordinate the total program for each handicapped person. When a cooperative spirit exists between the center and your facility, your service will be called for when it is needed and when the person needing it is ready for it, not sooner, not later. Speaking from my own experience, I can tell you that it is a wonderfully helpful thing to be certain that when an amputee comes

* Delivered at the National Assembly of the Limb and Brace Profession (OALMA) New Orleans, Oct. 19, 1955.

to your shop for a prosthesis he has been psychologically prepared for the experience. Physiologically, all has been done for him that can be done. Stump shrinkage has been brought to the optimum level. Contractures have been eliminated. Debilitated and atrophied muscle structures have been strengthened, and the range of stump motion has been brought to maximum, all under the watchful eye of the physician who is clinic chief. I have called this wonderfully helpful. Actually, it is much more than this. Looked at from the standpoint of the prosthetist, it is wonderfully helpful to have so many of our fitting problems solved for us before fitting is even begun. Looked at from the angle of the physically handicapped, it is even more wonderful to realize that here is one more step, a very tangible one, in the process of rehabilitation. Getting the appliance, limb, brace or whatever, is not an end in itself, but is part of a process which will continue through training and vocational guidance to the goal of rehabilitation, which Dr. Kessler defined on Television as "Relief of symptoms, restoration of function, and restoration to home, job, and family."

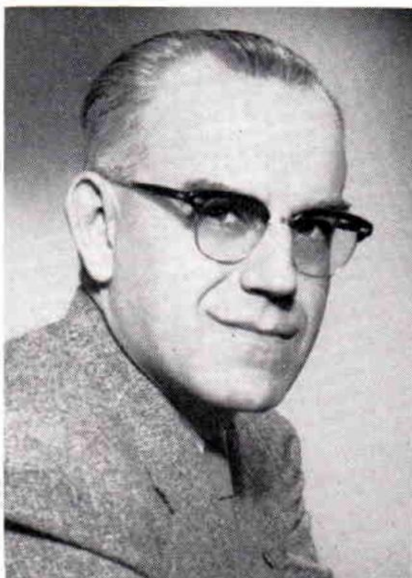
Why try to cooperate with the Rehabilitation Center? Second, because it is to our own best interest to do so. I realize that there are some, perhaps many, who will not agree with this opinion. They will say that working in a Rehabilitation Center is too time-consuming. The pace of the Rehabilitation Center is too slow, and each patient who is served requires too many hours. They will say that working in a Rehabilitation Center is too expensive, that, in addition to the time involved, the cost of traveling back and forth time after time between the center and the shop makes it prohibitive. Too, they will sometimes say, and this is unfortunate, that the personnel of the Rehabilitation Center makes cooperation impossible. Mostly these arguments sound reasonable. They seem sound. I believe, however, that they only seem so.

Consider the matter of time involved. Certainly the spending of time in the center is required. But if one goes there determined to be of help, the time is well spent. As an educational experience it is incalculably valuable. Once you have qualified yourself as a member in good standing of the Rehabilitation Center's clinic team, dedicated to achieving their goals, you will have the happy experience of working professionally with professional people, and their professional secrets will be secrets no longer but part of the technic of the team. This technic belongs to you as much as to any other team member, and it is amazing how many things one can learn that are helpful in his work if the time he spends in the Rehabilitation Center is spent with open eyes and ears and more especially an open mind.

Leaving the matter of time, let's talk a little about expense. Here we are dealing with something concrete and measurable. Of course, the amount of money involved will vary widely from place to place, but again, on the basis of our experience I can assure you that the expense is self liquidating. To show you what I mean, I'm going to be very personal now and speak in terms of my own work. For some years my work has been limited largely to upper extremity prosthetics. During the past two years I have been a member of the Upper Extremity Clinic Team in two Rehabilitation Centers in Kansas City. In these two years the average number of upper extremity amputees served per month through our facility has increased 156.6%, while the dollar volume per month has increased 193.4% over our average prior to participation in the clinic programs. These averages were calculated from the total number and price of all new upper extremity appliances furnished by our shop in two

Ivan A. Dillee's position as head of the Upper Extremity Prosthetics department of the W. E. Isle Artificial Limb Company, Kansas City, Mo., has been a vast change in experience from that of foreman of a porcelain enameling plant where he was working in 1943 when he entered Army service. Assigned to the Medical Department, he was stationed for 16 months in the orthopedic shop at Bushnell General Hospital, Brigham City, Utah. He immediately liked his new work with amputees and upon discharge in May, 1946, he completed his apprenticeship under the G. I. training bill at the Isle Company and was certified as a prosthetist.

Mr. Dillee is a graduate of Graceland College at Lamoni, Iowa. He has completed extension courses in anatomy and kinesiology at University of Kansas Medical Center. In September-October, 1953, he attended the Upper Extremity Prosthetics School at UCLA and since that time has been a member of the upper extremity clinic teams at Rehabilitation Institute and the Veterans Administration Hospital in Kansas City. A native of Independence, Mo., he is 44 years old.



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twelve-month periods. The earlier one, prior to the establishment of the clinics was 1 August 1952 to 31 July 1953. The later one, subsequent to the establishment of the clinic service, included the dates 1 September 1954 to 31 August 1955, which is the latest twelve-month period for which complete figures are available.

We reason that the numerical increase comes from two sources. One of these is the inexplicable but highly efficient "grapevine" which operates among amputees. "The Word" about this new and improved service is getting around, and increasingly we find amputees desiring to avail themselves of it. Second, and probably more important, up to this time, we, the staff members of the Rehabilitation Center, the participating doctors, and other interested persons, circulated the news of this newly available service among insurance carriers and the various state, federal and charitable agencies which purchase services of the type the clinic team can offer. The result was this —instead of being the slowly accelerating thing we at the shop had anticipated, the work load jumped. In the first three months subsequent to the opening of the clinics the number of amputees increased 156% above our former monthly average and the dollar volume increased 229%. This has led us to the belief that we are serving a real need. It must be true that the cases were there all the time, but they were not being reached. They were not being served, and we believe it was only because there was no service available which adequately met their needs.

We have not been operating long enough in the Rehabilitation Centers to establish any trends by mathematical evidence. However, we feel confident that our experience in recent months of a fractional increase from time to time is an indication of an upward trend which will continue. Our confidence is based on a high percentage of successful prosthesis

wearers. There have been only two known non-wearers among all the cases processed through the clinics in Kansas City. You all are aware that this was not always the situation, especially among above elbow amputees. AE appliances in the past were too often hung in the clothes closet and hanging there they were eternal. Now these appliances are being worn, and being worn, they will eventually be worn out and will need replacement.

You will have noted that in all instances cited the dollar volume showed a greater increase than the numerical volume. The seeming disparity is not accounted for by a price increase as one might suspect. We credit the upper extremity clinic team with this phenomenon. The sole concern of the team is service, consequently, prescriptions which come from this source call for equipment the team members have deemed most suitable. Insurance carriers, federal, state, and charitable agencies, as well as individual purchasers, defer to the opinion of the team where they might not to the opinion of one prosthetist against the opinion of another. Thus we no longer need cut corners by dispensing equipment not well suited to the needs of the amputee.

One more item in this general connection I would like to mention: all this increase in volume of business has been handled by our arm department with the addition of only one part time employee. As the prosthetist involved, I know how to account for this. New techniques in fabrication and fitting account for some of it, true. More important however, by making full use of the services and therapies of my fellow team members, physician, clinical psychologist and physical therapist, to assure that the amputee is ready before he comes to me for fitting and the occupational therapist to assure that adequate training is carried out after the fitting is made, the team gains for me very nearly as much time as it takes from me.

From this you will see that we do speak advisedly when we say that the time is well spent, the expense is self liquidating, and it is advantageous to become a participant.

And now to deal briefly with this question of personalities. Of course we all realize it is a question, which should not arise but the fact remains that it does. Before you permit yourself to say, "I simply cannot work with So and So," stand aside and take a long slow look at yourself and see if perhaps you may not be looking at the source of the difficulty. See that you are exhibiting to those with whom you are working the best of your personality and hiding as best you are able those facets which might be objectionable to them. If, after doing this, you still want to say, "I simply cannot work with So and So," still do not permit it. Make yourself work with them and force yourself to be congenial. The self discipline involved will make you a better prosthetist or orthotist, one more nearly able to cope with the problems which are part and parcel of our work.

Should there be those who remain unconvinced that we, as an industry, should strive diligently to perfect cooperation between ourselves and the Rehabilitation Centers, I would like to point out that there is a third strong argument in favor of doing so. We have *no choice;* we must cooperate with them. The type of clinical service I have been talking about is not a dream of the distant future, it is a present reality. The clinical techniques I have been describing are not a thing with which we may align ourselves or not as we see fit. They are broadly recognized now and as the concept and program of Rehabilitation expand, their recognition will broaden still further. The opportunity is here and now. We have the chance to "get on the team." Failure to make the most of our opportunity

would constitute a long step backward from our avowed goal of establishing and constantly raising the professional standards within our industry.

I seriously doubt that these few paragraphs have served to convince anyone not previously convinced of the wisdom of and necessity for cooperation between the Rehabilitation Center and the Prosthetic, Orthopedic Facility. Nevertheless, let's get on with the second of these questions I want to pose for your consideration, which is:

Where Shall We?

Where shall we begin and where end in our efforts to build cooperation? A very good question—and it has no one answer. One begins wherever he can and there must never be an end. All I can do is make available to you our experience, tell you some of the things we have done, and are doing in the hope that they may serve as guide posts indicating direction.

Invite the Rehabilitation Center's staff to your facility and when they respond to your invitation, treat them as guests. Really show them your place and explain your service and the qualifications of your personnel. Encourage them to ask questions and answer all questions asked honestly, candidly, and fully.

Visit the center's facility, and encourage your staff to visit it too. You don't need to wait for a special invitation. Take advantage of annual meetings or open houses, and when you are "in" make yourself known. Exhibit a sincere and friendly interest in the place, the people, and the service.

Make yourself, your facility, your equipment and your staff available to teaching hospitals. Invite students to come to you, or if asked, go to them. In Kansas City we have had interns and student nurses as guests in our shop and we have been guest speakers in their class rooms. We have addressed hospital staff meetings. Each class in occupational therapy and physical therapy visits our facility as a class for a lecture and demonstration on bracing and lower and upper extremity prosthetics delivered by three of our people, which serves as indoctrination and familiarization. We have lent our equipment for instructional purposes, and have built special equipment for the same purpose. In short, we have tried to make ourselves useful, and I can only recommend that you try it too. Some of these activities may seem to you to be pretty far-fetched, quite far removed from serious efforts to establish cooperation between your facility and the local Rehabilitation Center. In answer, I can only say that in our case they have worked. Perhaps doing such things is like "casting bread upon the waters,"—if so, you have scriptural assurance that, "after many days it will return," and for whatever it is worth, my assurance that generally it comes back "buttered."

This brings me to the third and last of the questions I have to ask about building effective cooperation. We have asked, and to some extent answered the questions, "Why Should We?" and "Where Shall We?" Now we come to the question of:

How Can We?

There is an old and honored saying that goes, "Would you have friends, be friendly." I don't believe I will do any violence to its meaning if I paraphrase it into "Would you receive cooperation, be cooperative." Let me reiterate, see to it that all you have, your personnel, your facilities, your time, are made available to the Rehabilitation Center, *when they need them.*

There is another aspect to this being cooperative that may have escaped your attention, and I want to take a minute here to discuss it. I wonder if you who are owners or

managers of prosthetic, orthopedic facilities have given sufficient thought to the position of your employee working in a Rehabilitation Center. Here, if ever there was one, is a man squarely in the middle. He is your employee, but he is working in the Rehabilitation Center and is under the necessity of looking two ways for cooperation: Toward the center, where he must earn it; toward his employer, where he has every right to expect it. The man is in the middle, and there he has to stay, but don't make it the middle of the two horns of a dilemma. Don't let him down. In defense of my own employers, and I'm happy to fly to their defense, I must say that this has never happened to me, but I know that it has happened. Don't let it happen to you. See to it that the policies of your company are compatible with the policies and goals of the Rehabilitation Center. See that the policies are firm and are clearly understood by your employee working in the center. Let him know that when he speaks there he represents you and he involves the business and professional integrity of your firm. If you do this—the middle isn't a half-bad place to be.

Back now to our third question, we have said "Be Cooperative," next I would say: "*Be Critical*"—of yourself, your facility, and your service. Check often and carefully to see that standards are maintained. Accept the criticism of others graciously. As prosthetists or orthotists, we are peculiarly susceptible to criticism because we bring to the Rehabilitation Center an appliance. It is a tangible device whose performance is readily measurable against established standards, and any deviation from these standards is very apparent. Consqeuently, it is often necessary to remind ourselves that our critic is our friend—he is on our side. If he were not, he would not criticize—he would merely reject. Listen to your critics and learn from them. Because we have brought to the team a workable appliance, it does not necessarily follow that the solution we have evolved to the problem is the best that can be evolved, so invite criticism and welcome it.

Wisdom dictates that we, as the junior member of the Rehabilitation Center's Clinic Team, be chary of offering criticism. Certainly, it should not be done until we, as individuals, have earned a place on the team and been recognized as a member in good standing. Even then the criticism should be of the work, never of the worker. Remember, too, that criticism is far more than fault finding. In fact, criticism can be favorable, and when unfavorable, it should be positive. In its first definition "criticism" is "the act of making judgments; analysis of qualities, and evaluation of comparative worth." Do criticize when you know that you should, but bear in mind all its components, judgment, analysis, and evaluation. When you offer your criticism, think of the words of the popular song of some years ago and, "Accentuate the Positive and Eliminate the Negative."

Be Diplomatic—In the Rehabilitation Center you will be dealing with professional people who are professionally trained. Keep on the professional level. Respect the professional prerogatives of your colleagues. Within the limits of your own prerogatives, which we are in process of professionalizing, stand firmly, but not inflexibly, for what you conceive to be the best interest of the patient. In doing so, you may be sure that all you say and do will contribute toward the professional standing of our industry.

Doctor Leonard Mayo has said, "Rehabilitation is first a philosophy, second an objective, and finally a method." The existence of our organization and the nature of the work we do is *ipso facto* evidence of our acceptance of the philosophy. A careful study, even a cursory examination,

of the proceedings of OALMA will convince the most skeptical of our sincere desire to achieve the objective.

This presentation of our best thinking about the relationship between the local limb and brace facility and the local Rehabilitation Center is intended to show that we are—and of right possess—and desire to become increasingly, a part of the method.

MARCH, 1956

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