CLINIC TEAM PROCEDURES

By HOWARD V. MOONEY, C.P.

The Clinic-team concept for the management of amputees is for the most part well received by the prosthetists. This is shown by a recent survey conducted by the American Orthotics and Prosthetics Association (formerly OALMA), published as Report No. 1 of the Committee on Advances in Prosthetics.* However, the report revealed a number of problems and criticisms in some parts of the country.

These criticisms do not occur in the New England area, which stands firm in the resolve that the rehabilitation of the amputee shall be the most important single purpose in the entire rehabilitation program. Apparently in some other sections of the country clinic team procedure results in such problems as "domineering" clinic chiefs, whose decisions are not influenced by other responsible members of teams; petty jealousies that result in bickering among the prosthetist members of the team; lack of referrals by general practitioners, who, though not qualified to prescribe prostheses, do so rather than refer amputees to qualified clinic personnel, for fear they will lose these patients; and finally, unequal distribution of prosthetic appliance orders to these prosthetic consultants who attend amputee clinic teams regularly.

Howard V. Mooney, C.P., is a native of Lowell, Massachusetts, where he graduated from Burdette Business College. He has been on the staff of the Boston Artificial Limb Company since 1937, and is now manager and a member of the firm. Mr. Mooney received his certification in March of 1949. He has long had an interest in the development of improved prosthetic procedures and is a graduate of the three courses in prosthetics offered by New York University. His colleagues in New England elected him to serve as treasurer, secretary and later President of their New England Society of Orthotists and Prosthetists. Mr. Mooney is a member of the Editorial Committee of the *Journal,* representing the New England States.

---

*Copies of this report are available from The American Orthotics and Prosthetics Association, 919—18th St. N. W., Washington 6, D. C.

In view of the above I feel that the general procedures used in our area should be made public with the hope that they may serve as a pattern in areas where the present set-up is not attaining the best possible results. To begin with, it is first necessary for an amputee to be referred to the group who will be responsible for his or her rehabilitation—namely, the amputee team clinic. This clinic should consist of at least the orthopedist, as chief, one or more certified prosthetists, a physical and occupational therapist, a medical social worker, and a medical secretary. A rehabilitation counselor would be a very valuable addition to the foregoing when available.

In the New England area it is fortunate that we have doctors who are realistic. They realize that since prosthetics is a specialty, amputees should be referred to those specializing in the rehabilitation of people who have had amputations. I would estimate that at least 75% of all new amputees in New England are referred to an amputee clinic. This of course places a responsibility on the clinic to keep the referring doctor informed of its relations with and recommendations for his patient. The following is a typical letter from an amputee team clinic to the referring doctor:

L.S.D., M.D.
First Street
Haskins, Mass.

Re: A. L., Second Street, Haskins, Mass.

Dear Dr. D:

Your patient, A.L., age 48, with a diagnosis of right below-the-knee amputation, was seen for rehabilitation evaluation on May 1, 1959. R.C.H,. M.D., our Medical Director, made the following report of that evaluation:

This patient has not been seen since August of 1958. At the present time, he is in need of a permanent type prosthesis which will be made by the XYC Company. The present preparatory limb is also in need of repair before the permanent limb is obtained. He is to go to Boston to have this repaired and to be measured.

No treatment is considered necessary until he has obtained his limb and seen by the group.

It is our opinion that at the present time Mr. L. needs only prosthetic help, but after the permanent prosthesis has been constructed and delivered he may need some help with his gait.

We will keep you informed of his progress. If you have any questions, please get in touch with us.

Sincerely,
W. E. H., Director

This procedure keeps the referring doctor aware of what is going on and sets his mind at rest, so that he is more than willing to refer future prosthetic cases to the amputee clinic.

In order to operate any type of effective service it is of course necessary to have a set of rules. The following is an outline of the policy adopted by one New England Amputee Clinic. This policy was arrived at as a result of a discussion held at a meeting attended by the Director of the Rehabilitation Center, the Medical Director of the Center and four certified prosthetists representing four different facilities:

1. The Amputee Clinic will be held on the first Thursday of the month unless otherwise specified. Additional Amputee Clinics may be held at the discretion of the director of the Center.

2. At this time the four limb companies represented at this meeting will be the ones who are authorized to make limbs as prescribed at the Rehabilitation Center.

3. If a patient has no choice of the limb company he wishes to make his

limb, he may delegate that selection to the Rehabilitation Center. The Center will select the limb company which in its opinion is best equipped from every standpoint to meet the particular needs of this patient. In the event that there is no basis of selection of one company over another, the selection will be made on a rotating basis to be most equitable to all the limb companies participating in the Amputee Clinics.

4. A patient known previously by a limb company and desiring to continue with the limb company shall continue with that limb company for future prostheses. If the patient is seen at the Rehabilitation Center, he will be checked out on the same basis as any other patient.

5. Permanent prostheses will be used for the most part, and in the case of the prescription of a preparatory prosthesis followed by a permanent prosthesis where the Rehabilitation Center has been delegated to make the selection of the limb company, the permanent prosthesis will be considered in reaching an equitable distribution of prostheses.

6. All costs considered will be the net cost of the prosthesis to the patient or agency.

7. Each limb company will inform the Center Director in writing when the limb is delivered, and the cost as charged.

8. The limb companies authorized to participate in the Amputee Clinic must have a certified and qualified representative in attendance at all Amputee Clinics. Substitutes of lesser qualifications are permissable due to illness or other emergencies, but should not continue for more than three consecutive Amputee Clinics.

9. The limb companies will release the prosthesis to the patient or the Center, depending upon the individual situation and the knowledge of the patient by the Center and prosthetist.

10. If additional certified prosthetists wish to be represented in the Amputee Clinics and meet the qualifications, they may be invited to attend the Amputee Clinics on a regular basis, provided they meet all the requirements as may be prescribed from time to time.

11. Representatives of limb companies are expected to enter into the discussion of the prescription of the limbs made at this Center, giving their opinions of that prosthesis or accessory which is best for the patient.

12. All limbs prescribed at the Amputee Clinic are subject to the approval of the Clinic and must follow the prescription as recommended, except in cases where, in the opinion of the designated prosthetist, specific changes in the condition of the patient's stump have necessitated changes. Such changes should be discussed with the Director or Medical Director.

13. Questions or suggestions for additions to this policy should be directed to the Director of the Rehabilitation Center.

This policy is essentially similar to those under which other Amputee Clinics operate in the New England area with the exception of the Veterans Administration. Our V.A. Clinics are excellent but it is well known that the veteran has his own choice as to who will make his prosthesis.

It would seem to me that if all amputee clinics in every section of the country were to adopt the policies of New England clinics, the only remaining problem would be the possibility of a "domineering" clinic chief. The solution of this problem may not be an easy one. However, it may very well be that if all prosthetists pull together for the sole purpose of the successful rehabilitation of the amputee they may impress the clinic chief with their new attitude so that he may be more inclined to rely on their judgment. He may be only too happy to relinquish the "domineering" role if convinced that the prosthetist members of the clinic are truly a professional group.