

Psycho-Social Implications of the Geriatric Amputee*

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Modern surgical methods coupled with modern chemotherapy and the ready availability of whole blood have greatly reduced the number of casualties that formerly resulted from amputations, particularly among the so-called geriatric group. Today, with good nursing care and modern chemotherapy, even the most debilitated patient with severe infection or vascular problems usually responds to treatment making it possible to carry out safely an amputation at almost any level. Unfortunately, the same degree of progress has not been made in the psycho-social-economic problems of the amputee, particularly the geriatric amputee whose problems are usually much more severe in this area and whose ability to solve these problems is greatly impaired because of age, and social and economic factors.

It is estimated that there are 16,000,000 persons in the United States who are 65 years of age or older. While this figure comprises only a small percentage of the total population, older persons (over 65) suffer more than 25% of the chronic illnesses. Most of our geriatric amputees come from this group. It is admitted by all who have had wide clinical or research experience with this group that the geriatric amputee without psycho-social and economic problems is rare indeed. It is interesting to note that of 15,000 Old Age Pensioners hospitalized in Colorado in 1960 under the Blue Cross-Blue Shield Medical Care Plan, 4,000 were suffering from peripheral vascular diseases of the lower extremities. Victor D. Sanua, in a socio-cultural study⁶ of 45 aged amputees undergoing rehabilitation in New York hospitals, found that the cultural backgrounds of this group, unless understood and appreciated, would make rehabilitation unlikely. All the subjects in the study entered the hospital suffering from peripheral vascular diseases. The majority had developed gangrene which necessitated amputation. They represented four cultural groups and included 18 Jews, ten white "Old Americans," ten Negroes, and seven people of Irish extraction. The average age was 67. At the time of the study all were destitute, yet there were such marked differences in the psycho-social attitudes of the various ethnic and religious groups as to make the findings of the study most significant.

The majority of physicians are raised with middle-class values which have, in general, been influenced strongly by Protestant traditions. The emphasis of their training has been to handle the specific illness of the patient. However, if the physician does not familiarize himself with the social and cultural environment of his patient, no matter how capable he is in his field of specialization he will fall far short of his responsibilities. This problem becomes even more critical when the patient happens to need psychological help or guidance.

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Reusch" has this to say about the doctor-patient relationship:

"In the United States, doctors are generally middle-class persons who view the world with the distortions characteristic of middle-class societies . . . Ultimately, then, the doctor has a composite view which is made up of his life experiences as an individual and of his collective experience as a member of a certain social class, religion, ethnic group, geographical locality, age group, sex, and professional group . . . When the therapist (doctor) meets his patient, who exhibits another set of values and tries to live up to the stereotype of 'a good patient,' the difficulty begins."

This exclusive concern with the physical aspects of illness is not confined to the doctor alone. Indeed, it is even more apparent in the attitude of the prosthetist, the occupational therapist, the physical therapist, and even the social worker and the rehabilitation counselor. All have the tendency to look upon the amputee only as one whose problems can be solved easily by giving him a prosthesis and some gait training, when it is entirely possible that the amputation is the least of the patient's problems. When he does not progress as expected, altogether too often the blame is placed on a "poorly fitted prosthesis," "lack of cooperation on the part of the amputee," or, more commonly, on "lack of motivation." At the hundreds of "Amputee Clinics" which I have attended personally, I cannot recall ever hearing the "Clinic Team" ask themselves "Wherein have we failed?"

It is entirely possible that prostheses are now being furnished many geriatric amputees who would be better off and live longer and happier lives without them. Gillis² states: "The ultimate decision as to whether or not an artificial limb is going to benefit the patient will depend on the physical powers and the mental make-up of the individual. A good artificial limb will not succeed, even in the presence of good physique, if the patient's psychological make-up sets up some latent aggravating focus as a barrier."

Bertelsen¹ says that "Limb fitting in geriatrics is quite another problem than in the younger groups, partly because of the special psychology of the old patients. Here it is very important to know the senile confusion which frequently follows an accident, an acute illness, or the knowledge of the necessity of an amputation. This confusion may often be a severe complication and may resemble the senile dementia, the patients being quite unreasonable, not fully aware of time and place, and not realizing the actual problems."

McKenzie⁴ says "In dealing with amputation cases we must always remember that the stump is only part of a human being and that the remainder of that organism is subject to all the ailments, weaknesses and defects to which the human subject is heir. It is therefore not sufficient to confine one's attention solely to the stump but we must consider the total patient." McKenzie goes on to say that some of the psychological factors that should be considered are "Firstly there is the patient's personality. The personal reaction to amputation varies enormously and is dependent on many factors of which probably the basic personality is the most important, but other factors such as compensation litigation, clinic team or physician approach etc. may have considerable impact." He goes on to say that adverse psychological reactions can form an important additional handicap.

It is my opinion that the conditions, or combinations of them, referred to by McKenzie and others may well result in a disability of much greater

magnitude than the amputation itself and one much more difficult to solve.

The "Clinic Team" as originally conceived by Bechtol was designed to help prevent, or at least minimize, the psychological problems of the amputee. But, in many sections of the country, the reverse has been true. I am sure we need to take a new look at the "Clinic Team" concept. To do this I believe we need to begin with ourselves and get clear in our own minds what we mean by "Clinic Team." For example, does a prosthetist think of rehabilitation in the same manner as a physical therapist? Does a nurse working on an orthopedic ward view her role with the same concept as the social worker? Is the wife of the amputee any less important in his program of rehabilitation than the physician, the prosthetist, the physical therapist, the vocational counselor or the Veterans Administration Prosthetics Chief? And what about the amputee himself? Altogether too often his views receive no consideration at all.

Tell me, if you can, how one can reconcile the "teamwork" concept on the one hand with the almost pathological possessiveness of each professional group when they have their "turn at bat" with the amputee. For a long time, it has seemed to me, and perhaps you have had similar feelings, that this constant talking about "teamwork" is but a psychological "crutch" for our many failures to deal with the amputee in a manner that reveals the carefully coordinated and intermeshed planning that would occur if we were really working as a team.

To work as a team requires mutual understanding, mutual respect, and acceptance of the fact that each professional person has a contributing part, but only a part, to give in the attainment of the amputee's ultimate rehabilitation. But each and every part is truly fundamental. This "team" will never be more than fiction in my opinion so long as the physical therapist, for example, resents giving "her time" or any portion of it to the prosthetist, or when the physician resents the invasion of the psychologist; nor will it be effective as long as members of each discipline consider themselves equally expert in the several fields of knowledge represented by the other "teammates."

Training the amputee in the use of the prosthesis, as well as pre-prosthetic training, is admitted by all authorities to be all-important. Thomas and Haddan⁸ say "it is the duty and responsibility of the surgeon and the prosthesis maker, and of all persons and agencies having anything to do with the rehabilitation of the amputee, to make sure that no effort is spared in training the amputee so that he may obtain the greatest possible amount of function from his prosthesis."

R. Langdale Kelham³ makes the comment "... no matter how efficient be the artificial limb the best results cannot be obtained from its use without training on proper systematical lines; training is an integral part of the treatment."

Deaver, Kessler, Rusk and many, many other authorities in the field of rehabilitation, have written and spoken repeatedly on the necessity of training the amputee in the use of his prosthesis, but there appears to be no general agreement as to the amount and kind of training. I am sure it cannot be denied that many geriatric amputees in this country are literally being "trained to death."

Dr. Arne Bertelsen¹, Chief Surgeon at the Orthopaedic Hospital in Copenhagen, advises that a psychological evaluation of the geriatric amputee be attempted before prescribing the prosthesis and before planning the rehabilitation of the patient. Dr. Bertelsen quotes from documented clinical studies conducted at Roehampton, Copenhagen and other European

centers, and makes the conclusion that "You have to reckon with a 'hard core' of about 50% of unsuccessful prosthetic rehabilitation in geriatric patients." He goes on to observe: "The stump is by no means the most important problem. An extensive examination must be made of the patient's entire mental and physical make-up. These two basic requirements for satisfactory limb fitting are more important than an adequate stump in the aged patient."

It is my own personal observation that, for the most part, we in this country have avoided this question in the past, and have treated the geriatric patient in about the same manner as any other adult.

It is known that all locomotion requires energy and that locomotion on a prosthesis requires more energy than normal locomotion on two good legs. Saunders and Inman⁷ stated as early as 1953: "So great is the cost that, as our experience has shown, the loss of two joints in the elderly subject will inevitably shorten life from the demands upon his cardiovascular system which must supply his requirements at the usurious rate of 300%." This being true, it behooves the "Clinic Team," before prescribing a prosthesis for the geriatric amputee, to be sure there is adequate exercise tolerance available.

Unfortunately, our knowledge of the geriatric amputee's psycho-social, economic, and energy problems has not kept pace with our prosthetic knowledge. We are faced with the problem of not knowing whether he should have a prosthesis at all, and, if he should have, what kind. There are at least three schools of thought as to the type of prosthesis the geriatric amputee should be furnished. These range from the simple pylon, to a temporary socket attached to an adjustable leg, to the most elaborate permanent prosthesis, the followers of each philosophy being equally vigorous in defending their particular viewpoint.

In summary, I strongly urge that the "Clinic Team" concept be re-evaluated with the thought of adding disciplines who can evaluate better the psycho-social problems of the amputee, at the same time keeping in mind the practical approach of having only those present who have something to contribute.

My final plea is that all those working with amputees should never lose sight of the fact that the stump is only a part of the amputee's problems—and quite often may be a minor part; that every amputee should be treated as an individual, and that we should learn as much about this individual as is possible before attempting any prosthetic restoration.

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Three Fellowships Granted By World Rehabilitation Fund

Dr. Howard A. Rusk, President of the World Rehabilitation Fund, Inc., has announced that three physicians, from India, Greece, and Colombia, S.A., have recently been awarded fellowships for post-graduate study in rehabilitation in the United States.

Dr. Wiesner Duran, staff member of the Colombian Institute of Rehabilitation for Crippled Children "Franklin D. Roosevelt," Bogota, has received a Continental Can Company International Fellowship in Rehabilitation, which will provide a minimum of one year of study in the United States. Dr. Duran began his Fellowship on January 1, 1962, at the New York University Medical Center Department of Physical Medicine and Rehabilitation.

Two women physicians are the recipients of Memorial Fellowships. Dr. Sarot Gokarn, of Bombay, India, who received the Mary Dingham Memorial Fellowship, has just completed six months in the Newcastle General Hospital, Newcastle Upon Tyne, England. Dr. Gokarn entered on her studies at New York University Medical Center in January. The late Miss Dingman was a leading member of the International Staff of the YWCA and was associated with the International Union for Child Welfare.

The Rebecca B. Rose Memorial Fellowship, named in honor of the late Mrs. David Rose who was interested in many philanthropic causes, was awarded to Dr. Yvonne Loukides-Dhrymiotis of Athens, Greece. Dr. Loukides-Dhrymiotis began her training in the Department of Physical Medicine and Rehabilitation in November 1961.

The World Rehabilitation Fund is a non-profit organization supported by American industry, foundations and individuals to assist in the international development of rehabilitation services for the physically handicapped.

During the 1960-1961 academic year the World Rehabilitation Fund provided full or partial fellowship assistance to 55 trainees (39 physicians and 16 non-physicians) from 31 different nations who received advanced training in the United States.

Its Honorary Chairmen include former Presidents of the United States, Mr. Herbert Hoover and Mr. Harry S. Truman. Mr. Bernard M. Baruch, world-famous financier and philanthropist, is also Honorary Chairman.