An Orthopaedic Surgeon Looks at Certification

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When I missed last year's meeting I thought I would not have to give a talk this year but I soon found out the invitation was easily carried forward another year and hence my appearance here today.

Prior to World War II my interest in prosthetics was practically nil. I am sure that I did what most doctors still do today, namely, told the patient to go to a limb shop and have a limb made and that was the end as far as I was concerned. The companies selected were frequently on a basis of which gave the lowest price or had the best glib talking salesman, or both. I knew nothing of check-out, fit, alignment, etc. To me aluminum was better than wood—perhaps I should have pursued this further. I often wondered how the limb maker happened to be at the patient's bedside when the patient returned from surgery following amputation of an extremity. While in this groggy post-anaesthetic state an attempt was made to quick sell a prosthesis. I found out that the clerk at the admissions desk, for a specified fee, was the informer to the prosthetist and the prosthetist was putting out payola. Unfortunately this still continues to some extent but I do not think it is as rampant as it once was.

I recall very vividly a child with an upper extremity amputation. We had heard of a new type of arm being made in the East, specifically at Kessler Institute, and we obtained one. The chief difficulty was that I, myself, nor no one at the University had the remotest idea how it was supposed to work. The parts of the arm were apparently too delicate for an active child. The arm was soon in a state of dis-repair, so extensive that further use could not be obtained, and we almost joyfully gave up on this one and were very happy in the fact that we would not again prescribe an upper extremity prosthesis.

During World War II I had many acute amputee patients, but under the direction of the Surgeon General I was not allowed to keep these patients for definitive care and prosthetic restoration, but, rather these patients were transferred to Amputee Centers. This was one good result of the Armed Services Medical Care and the real beginning of better prosthetic service.

On my return to civilian practice I'm afraid I again reverted somewhat to my previous status of not being very knowledgeable in regards to prostheses and it was only after my initial baptism in the pilot Upper-Extremity Course at U.C.L.A. in 1952 that I really became, in my own mind, prosthetically oriented.

Since 1952 there has been a considerable change in my own knowledge and feelings. As you know, I have been fairly active in the field of education by helping to conduct the course at Northwestern University Medical School and, in addition, have established Amputee Clinics at both the Uni-

versity of Illinois and Presbyterian-St. Luke's Hospital. With my further interest and knowledge of prosthetics I have become acquainted with the two organizations represented here today, that is, the American Board for Certification and the American Orthotics and Prosthetics Association.

Let us go back a few years in the history of your two organizations. Some of the older men in this audience know the story and I trust will bear with me for a few minutes. I am sure that many of the younger men do not know this history and I hope my remarks, however brief, will be interesting.

The original trade organization was called the Artificial Limb Manufacturers Association (ALMA). This had its beginnings in 1917 after the Surgeon General of the Army had invited the then limb makers of the country to Washington, D. C. to discuss the problem of supplying artificial limbs to World War I veterans. The membership of this association was made up of owners of "Artificial Limb Shops," some of whom also engaged in the manufacture of orthopedic appliances.

In 1946 the Artificial Limb Manufacturers Association increased its membership by opening its doors to those who manufactured orthopedic appliances and the name was changed to the Orthopedic Appliance and Limb Manufacturers Association (OALMA). This organization has continued ever since but with perhaps a final change in name in 1959 to AOPA. It was felt that the fields of orthotics and prosthetics were becoming more of a paramedical service group rather than manufacturing, per se., but the manufacturing companies were not to be deleted from membership.

As a means of up-grading the industry and patterned somewhat after the American Board of Orthopaedic Surgery, the American Board for Certification of the Prosthetic and Orthotic Appliance Industry was founded in 1946 through the joint efforts of the Orthopedic Appliance and Limb Manufacturers Association and the American Academy of Orthopaedic Surgeons.

Since the American Academy of Orthopaedic Surgeons was one of the co-sponsors, the Board in its by-laws has honored the Academy by having at all times three members of the Academy on its Board, each man serving a three-year term.

In 1959 this certifying Board changed its name to its present title of American Board for Certification in Orthotics and Prosthetics or the more familiar ABC. Thus, we have two separate and distinct groups, AOPA which is primarily a trade organization and must abide by trade practice rules as set up by the United States Government, and a certifying group which certifies as to the competency of both facilities and individuals to assure that the patient will receive the best possible appliance.

Most of you will realize that so far the greater interest seems to have been spent on prosthetics and this was very probably justified by the fact that prosthetics needed more up-grading. At the present time, and in the immediate future, you can all see that the trend is toward improving orthotics such as the new study of spine braces, the Milwaukee Brace and the new University of California ankle brace, etc.

One might now ask what is the advantage of belonging to AOPA and/or being certified. Similar questions were asked when the American Board of Orthopaedic Surgery was organized. Doctors had their M.D. degrees, their license to practice and it seemed in the early days that all Board Certification did was to make one eligible to work in a charity clinic since it was easy to state that only Certified Board men would be accepted. During the years, however, Board Certification has become mandatory for appointment and promotion on hospital staffs, universities, etc.

Some of the older Orthopaedic men expressed the belief that we were training and certifying too many orthopaedic surgeons and if the trend continued the older men would soon be out of business. This has proved to be exactly untrue. Each year more and more young men are certified by the Board, more and more cities are represented by certified men and the older man has not been put out of business. Competition has improved the quality of Orthopaedic Surgery.

A similar situation probably exists in prosthetics and orthotics. Some may have resisted the increase in certified facilities for fear that this would make more competition and/or less income. Americans as a whole are a gregarious lot and wish to be with their own "kinfolk" and hence this togetherness is one reason for becoming certified. One does not like to be on the outside looking in but prefers to be an active participant.

In this country today it is estimated there are approximately 1200 facilities dealing in prosthetic and orthotic services. Of these slightly more than 400 or approximately one-third are certified by ABC. About 200 facilities are certification eligible. By this is meant they are owned or managed by a certifee or they employ a certifee who would thus make them eligible. It would seem to me that this group of 200 facilities should be the next group to become certified. Why, since they are eligible, have they not joined? What can AOPA and ABC do to convince these facilities of the desirability and probably the necessity of becoming certified. At my own clinic at the University of Illinois, only certified prosthetic facilities are utilized. Similarly in the Veterans Administration, only certified facilities are recognized. My private cases are referred only to certified facilities because I am properly oriented. Under a provision of the Medicare Bill, those of 65 and over who are eligible for Medicare benefits, also become eligible for prosthetic restoration. I am sure that restrictions will be made to the extent that only certified facilities may participate in this plan as is now in effect with the Veterans Administration. As a result there should be a rush for certification requests.

Of the remaining 600 facilities, about 100 are institutional facilities which in a great many instances, should be certified. Here again, the stimulus for certification is going to have to come from the doctors on that staff insisting upon certified personnel and then facility certification. I can speak quite freely on this subject since at the two institutions where I work we do not have certified personnel in orthotics. All of our prosthetic work is referred to certified facilities. At the University we have available a faculty appointment for a research engineer in Orthotics and/or Prosthetics but so far we have been unable to fill this position. I am sure that when this position can be filled there will go with it a request for a certified orthotist or one who is eligible for certification. At the private hospital it is now a matter of replacement when the present incumbent retires in the near future. This incumbent is an old style orthotist, having been making braces for forty years but who was never stimulated to become a certifee and now it is too late. I am sure similar situations are present at many institutions and the stimulus for certification again, I believe must come from the attending staff doctors.

This is similar to several instances when the American Board for Orthopaedic Surgery was formed. At that time certification was granted all of those of professorial rank if they would only apply. This one man did not apply, stating that he felt the Board would never amount to anything. Some ten years later when the Board had proved itself, he then applied and was informed that despite his academic title he would have to take

the examination. He was sure he could not pass and did not take the examination and never did become certified. There may be other orthotists in a similar situation and to my mind the ruling on these men becoming certified must be an individual matter.

There are about 100 additional facilities which could and probably should be certified except for the lack of having certified personnel and thus openings are present for newly trained men. In addition approximately 70% of the eligible facilities of AOPA are certified by ABC. What about the other 30%? The arguments as stated above very definitely apply here.

Certification must be considered, first of all, an honor, secondly, as a badge of achievement of having passed the Board examination, and, thirdly, a necessity for membership.

A great deal of this stimulation to this group must come from within the membership of your two organizations, from personal contact, and also from doctors who are prescribing the prosthetic and orthotic appliances.

I have just received the Report of the Committee on Facilities. I quote from that report, "During the year, the Committee certified nineteen (19) new facilities; eight (8) in prosthetics, seven (7) in orthotics and four (4) in prosthetics and orthotics. In addition, one (1) facility was reinstated, four (4) facilities were granted extension of title. During the same period, two (2) facilities were rejected by the Committee. At the time of this report, thirteen (13) applications for facility certification are in process; two of which were in process at the time the 1964 Report was prepared."

What is of more importance to me is the fact that during that same period 26 facilities had their certification terminated in 1964 and 40 since 1961. Of the group 7 have been re-instated. It is interesting to note the reasons for the termination of certification. Of the 40 facilities since 1961 48% lost certification because they lost certified personnel. This really means an opening for newly trained and certified personnel and such facilities should be encouraged to obtain new certified personnel, and thus regain certification. 30% of this group lost certification because the facility was dissolved. 18% or 7 facilities expressed either disinterest or dissatisfaction and withdrew. I feel this is a group that should be very carefully studied by your Board. What are the disinterests and why the dissatisfactions? If we can obtain these answers we can perhaps prevent such termination of certification in the future.

This brings us back to the role of the relationship between the American Academy of Orthopaedic Surgeons and the American Board of Orthopaedic Surgery and your two organizations. Since its inception you have had at least sixteen Orthopaedic Surgeons serve on your Board. This group of sixteen, I am sure, is definitely orthotically and prosthetically oriented as to the necessity of both facility and individual certification. But what about the remaining almost 3000 members of the Academy? It is to this group that I think our communications have broken down. There is not a sufficiently large number of Academy members who are prosthetically and orthotically oriented. I would venture to guess that not over 50% know of AOPA and ABC and are still prescribing a prosthesis in the old fashioned way of telling the patient to go to a limb shop and obtain a leg.

In addition there is a group of general surgeons who do a large percentage of the amputee work who are definitely not prosthetically or orthotically oriented. This would include the vascular surgeons. At the private hospital where I work I established an Amputee Clinic knowing that the majority of the amputations done on the general surgery service were being referred to limb shops without a prescription and no means established

for check-out, training, etc. Slowly this is being changed by personal contact with the general surgery group and by inviting them to attend Amputee Clinics (which they do not do) but the fact that there is an Amputee Clinic has begun to make an impression on them.

This local situation I am sure is repeated many times over throughout the country. It is this group of both Academy members and general surgeons that we must educate to the fact that there are certified facilities and referrals should be made only to certified facilities. To do otherwise would be foolhardy and could be likened unto an orthopaedic surgeon referring a patient to a chiropractor for consultation.

Since the advent of the prosthetic schools at New York University, Northwestern University and U.C.L.A. many of our younger orthopaedic surgeons are being exposed to orthotics and prosthetics and thus should be much better oriented. It is this group that I look forward to in the future of being in command of orthopaedic programs and I am sure will stress the necessity of cooperation with certified facilities.

In turn however, the certified facilities by precept as well as example must prove to the orthopaedic surgeon that they warrant his referrals. This is done by providing adequate, clean, convenient facilities. They request and follow a definite prescription. Their conduct is on a professional level at all times. In the facilities adequate consideration must be given to children and female patients, in that female attendance and help is mandatory. This not only makes good sense but may prevent a law suit. Patients must not be left unattended since a fall may again provoke medical-legal problems.

The remaining group comprising about 400 facilities are chiefly in fringe areas, such as drug stores, corset shops, and surgical supply houses and mail order brace shops. In one respect these drug stores and corset shops cannot be eliminated. I am sure that if a manufacturing company of corsets, say for example, would sell to only certified facilities, they might be held in restraint of trade and this is why you can see these same corsets made by "X" company on sale at certified facilities but also in dry goods stores, corset shops, etc. wherein there is no supervision as far as the manufacturing company is concerned and certainly not as far as AOPA is concerned. This becomes a very touchy subject. Considerable question has been raised about a certain exhibit that was shown at our last Academy meeting wherein a non-certified facility demonstrated a line of corsets, this in direct competition to a similar display of corsets from certified facilities. One question here; which certified facility or AOPA member made these corsets for this company? These were probably under a private brand name.

We might sum up this brief discussion by stating that there are two areas that must be further investigated and improved and/or educated. The first is the approximately 200 facilities that could very rapidly and easily be certified. The stimulus for such certification must come from within the present certified group. In other words, you men here must be further dedicated to the task of convincing these facilities and men of the value of certification. This will probably be most effectively done on a personal appeal basis.

The second group or the institutional facilities will only be changed when the attending doctors demand it and they will demand it only when they become better oriented and educated as to prosthetics and orthotics and the orthopaedic surgeons as a group become aware of the fact that AOPA and ABC do exist. This can be accomplished by direct personal contact of those orthopaedic surgeons who are knowledgeable imparting further information to their colleagues. The fundamental group to be such leaders in this field are those who have become adequately oriented by:

1. Serving on your Board.
2. Participating in activities of CPEI and CPRD and their sub-committees.
3. Clinic Chief of Juvenile Amputee Programs.
4. Presenting further information to the Academy members by papers presented at the Academy meetings and information notes in the Bulletin.
5. Stressing to those attending the Orthotic and Prosthetic Courses the relationship of AOPA and ABC to the specific problem.

A final look from my own personal viewpoint on certification: I do not feel that once a facility has been certified, that this means certification forever. I personally have inspected or visited may shops throughout this country, usually unannounced. Some have made a very excellent impression on me. Others I have found extremely dirty, the personnel unkempt and the whole atmosphere anything but attractive. I am sure that this is the usual appearance since many patients have substantiated the condition of these shops.

The residency training programs for orthopaedic surgeons are supervised by a joint committee called the Residency Review Committee and made up of men representing the Council on Medical Education of the American Medical Association and the American Board of Orthopaedic Surgery. Each and every training program is reviewed by this committee at least once in three years. This is not a paper review, but an on-the-spot inspection of physical plant, teaching program, library, operations, etc. Any deficiencies are listed, and the program has one year to make corrections. If corrections are not made the program may be and occasionally is completely disapproved and dropped. If this can be done in medical education, cannot further evaluaton be done at repeated intervals on existing facilities?

Similarly all hospitals are inspected on a routine basis by the accreditation committee of the American Medical Association and the American Hospital Association and if the hospital is found wanting, accredition can be denied. Even the Cook County Hospital of Chicago had to make specific changes in view of the criticism of this accreditation board, especially cleaning up the place and the overcrowding.

We all tend to become lazy and self assured and it might be a good idea to consider reappraisal of facilities. I can already hear some of you in this audience begin the discussion that such a suggestion for re-inspection should not come from a physician member of your Board. However, when I accepted a position on your Board it was with the idea that I would do as if I were an actual member and say what I felt would be the best for your organization.

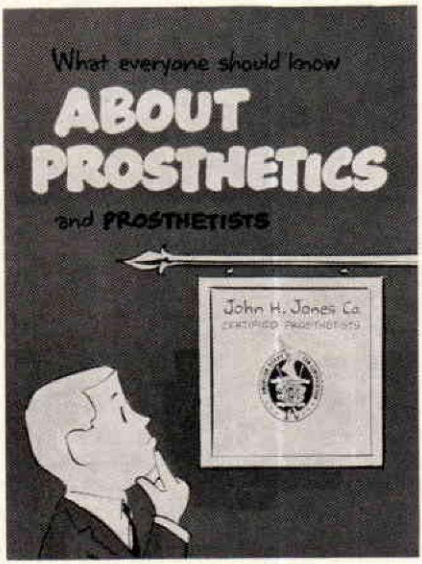
You will recall that I previously expressed myself in regards to a prosthetist being a part of a surgical team. In the two years since I discussed this matter there has come into being the immediate post-operative application of a prosthesis. In this experimental study the prosthetist does come to the operating room and begins his work in the operating room as soon as the wound is closed. He does not however, assist with the actual operative procedure and I think this is correct.

It has been my privilege for the last two years to be on the Committee on Facility Certification of your Board and as such have freely expressed my opinion, either approval or disapproval of certifying facilities. In this same spirit and from my personal observation of facilities I would like to

suggest that your Board consider the idea of routine re-inspection of facilities to make sure that the initial standards which gave them certification are maintained.

Also to be considered is the sometimes apparent confusion between facility and personnel certification. One additional item is the requirement for membership in AOPA. True, we cannot and should not go backwards. Our theme today is looking to the future. If so, then may not certification by ABC be a pre-requisite to membership in AOPA, similar to Board Certification being a requirement for membership in the American Academy of Orthopaedic Surgeons.

If we—ABC and AOPA are to be "merged" at the top level, should not some of the merging begin at membership level as well.



"WHAT EVERYONE SHOULD KNOW ABOUT PROSTHETICS AND PROSTHETISTS"

Illustrated booklet published by the American Orthotics and Prosthetics Association, Washington, D. C. 1965. 15¢ each.

Reviewed by Alvin L. Muilenburg, C.P., Houston, Texas.

This new scriptographic booklet is a companion to the well known "What Everyone Should Know About Orthotics and Orthotists," which appeared in 1964 under the sponsorship of the American Orthotics and Prosthetics Association.

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