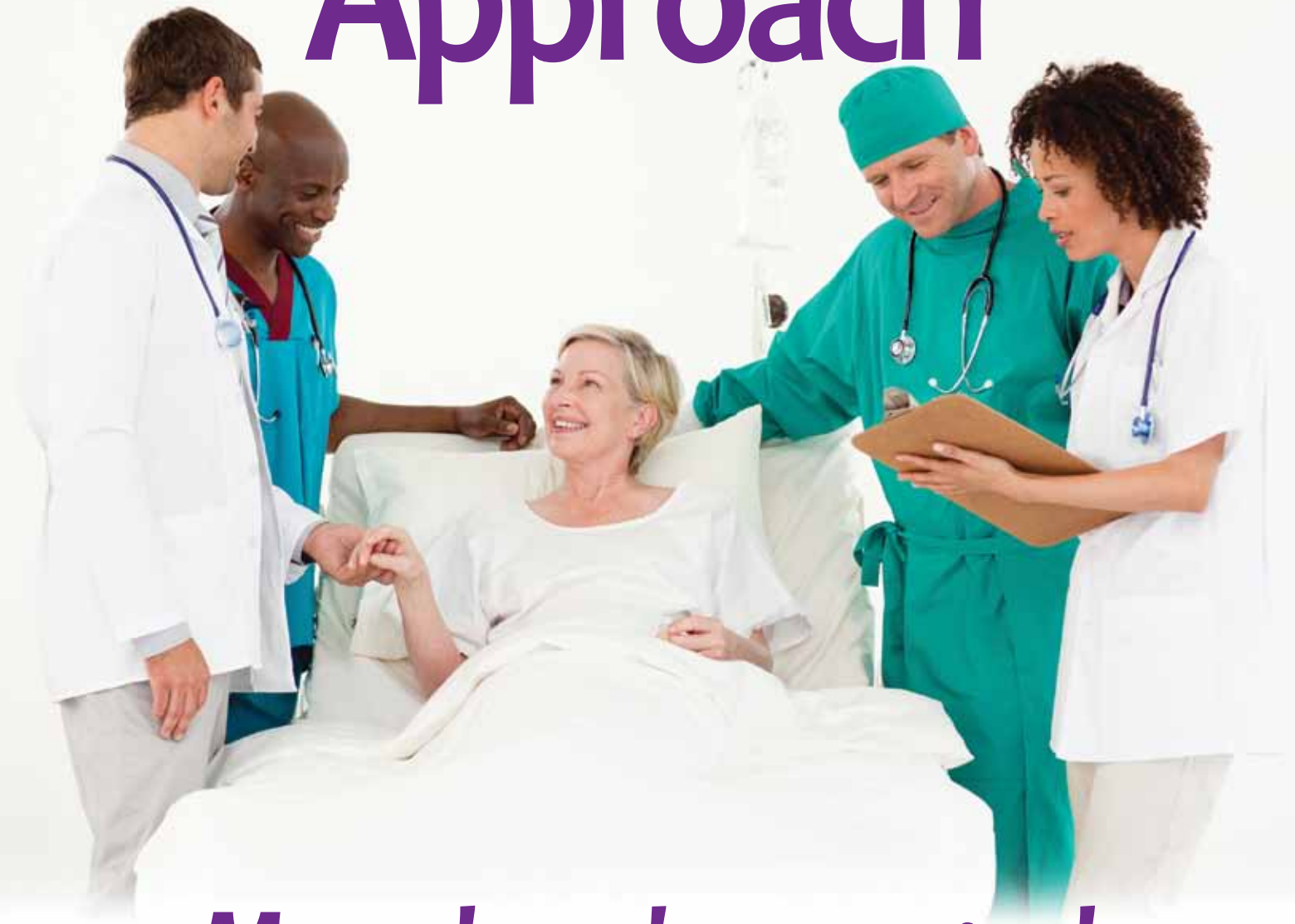
The Team Approach



Many hands, one goal

by Terrence P. Sheehan, MD

The care offered to those with limb loss, especially early in their recovery, needs to be given by many people. Whether it is the love of a significant other, the compassion of a nurse, or the optimism of a therapist, help and healing needs to come from many. The person new to limb loss needs to accomplish a lot of work and timely success depends upon a cohesive group of professionals coming together to provide the tools to accomplish that success. This team cannot do the work of the person with limb loss, but they can ease the burden, quicken the pace and shine the light on the path ahead.

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This reminds me of a story in which a World War II soldier came upon a church in a European town that had been bombed. The church still stood but was badly damaged. A statue of Jesus Christ caught the eye of the soldier. Unlike many of the other statues that were shattered beyond recognition, this statue was quite well-preserved. Except for the missing hands. This statue had meaning to the soldier. He was determined to make things right – he would find the missing hands. After an exhausting search through the rubble, however, he was forced to give up – it was time for his troop to move on. He posted a sign on the statue and continued on his journey. The sign simply read, "Please Be My Hands." The coincidence of the lost limbs struck me, but more importantly, it helped me visualize what occurs when someone new to limb loss presents for services. It takes many gifted hands to join with the person being served to reach the "back to life" goal.

The team successfully leads the person with limb loss through the process of adjusting and getting back to life. It is the many hands of caregivers and supports that make this happen. The process, as we all know, usually begins with a crisis, whether it is an infection, trauma or tumor. The ball starts rolling and the next scene is a person lying in a hospital bed with the medication-fogged, surreal post-operative experience of knowing that they have just lost their limb. Most patients have not, up until this point, had any education on what lies beyond the operating room. Nobody has even indicated there is a map of how to get back to life. In most cases, the folks who can lead the way to, and give the vision of, recovery have not been contacted yet. The expectation is that all doctors and nurses know what is to happen after limb loss. Unfortunately, this is not true. Most aren't really equipped to provide the vision of what happens after the surgical phase. A specialized team is needed. Hopefully, they will call the rehabilitation team.

I recall a 55-year-old primary care physician who developed a sore on his foot from an ingrown toenail. This is a person who worked 12 hours a day taking care of others, including family – that's what caregivers do. Having much knowledge of the body and healing, this doctor believed that it would heal as expected. Within a short time, however, the sore became infected and tracked deep into the foot and the crisis point occurred, resulting in a rush to the emergency room. I was surprised to see that this physician exhibited

the same sense of denial that many of my other patients, of all backgrounds, have expressed. That is, that this sore was "not so bad" – it didn't hurt too much and they were still able to get around, so the threat of limb loss never crossed their minds. This crisis and resulting hospitalization was the point at which this physician learned that he had diabetes.

Adult onset diabetes doesn't knock when it arrives. It is usually found during routine annual surveillance or when doing an examination associated with a medical event such as infection, heart attack, stroke, limb loss, etc. I have had many patients find out they have diabetes at the time of limb loss. It is at this point the amazement of the limb loss finally makes some medical sense. The diabetes causes the nerves in the feet to stop working, so all alarms are off and no pain is felt from the sore. The diabetes causes the blood supply to the legs and feet to be sluggish, so the sore heals slowly and fighting off infection is difficult. The physician/caregiver was now lying in a hospital bed in a drug-induced stupor no different from any of my other patients after a limb loss surgery from most any cause inclusive of trauma and cancer. He was in need of care, needing a map to get back to his

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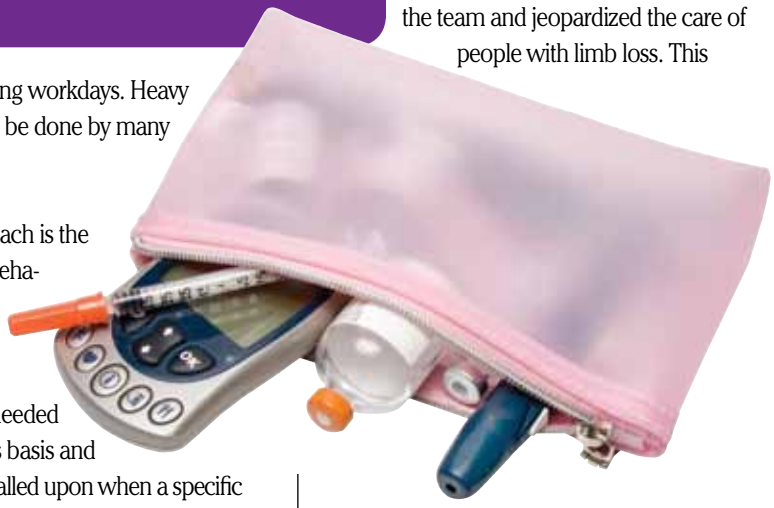
12-hour caregiving workdays. Heavy lifting needed to be done by many hands.

The team approach is the cornerstone of rehabilitation medicine. The team is composed of those who are needed on a continuous basis and those who are called upon when a specific need arises. It is usually the person with limb loss and supports: the physician (primary care, physiatrist and surgeon), nurses, therapists (physical and occupational), and the prosthetist. This group is the core, usually involved early after surgery with the initial phase of starting the education and moving around again. There are other important members, including the peer visitor, social worker, podiatrist and nutrition specialist.

Like a living organism, it is important that the team expands and contracts as the need arises and resources allow. By resources, I mean not only insurance but also the availability of specially trained professionals and peers who know their role and when other team members are needed. For example, our physical and occupational therapists have been trained and have worked with many people with limb loss. This is not always the case, whether in rural Tennessee or that well-known medical center in your city. Not all therapists, nurses or primary care doctors have had experience with limb loss. They need to advise the person with limb loss on what they know and then contact other resources, such as the peer visitor or vocational counselor, when needed. A prosthetist and a person with limb loss alone is not enough of a team – this type of "isolated care" has the poorest outcomes.

Getting a team of professionals together is not only difficult but costly. Over the last 15 years, insurers have insisted on less costly care. Unfortunately this has fragmented the team and jeopardized the care of people with limb loss. This



was never more frustrating than a case in which a private insurer would not authorize the admission of a 71-year-old woman with diabetes and cardiac disease into acute rehabilitation to learn how to use a prosthesis. In a tense, hour-long teleconference, I lost my battle. I explained multiple ways that this person would need the full, comprehensive team to learn how to use the prosthesis safely and functionally in her home and community.

Standards developed by a group of experts through the Commission on Accreditation of Rehabilitation Facilities (CARF) guide the process, and they are filled with critical education points that the team must impart to the amputee early and clearly in the process – or else. The "or else" is a list of all possible complications, such as contractures, skin

breakdown, pain and loss of the other limb. Each therapist, doctor, nurse, counselor, etc., plays a critical role. When it happens, excellent functional quality outcomes occur. The criteria used by the insurance company's physician to grant admission were so severe, the woman would have needed to be critically ill to gain admittance and be served by a comprehensive team. The alternative was to try to do this from the woman's home. I explained that what could be done by the comprehensive team in a week at the hospital would take months to do from home as an outpatient and still would not hit all the standards the experts say need to be addressed. It has now been months and this woman is still not functionally independent with the prosthesis.

A team needs to have a leader and good communication. This is a dynamic process that can be compared to an orchestra. Each team member brings an important component to the process of recovery after limb loss. They need to communicate well with each other and with the person being served. The leadership often rotates, depending on the rehabilitation phase or the need of the person at that time. The outcome is very clear, as it is when the correct notes are played and the "piece" is translated into beautiful music. This doesn't just happen in a single day – the members need to practice, learning how to best work with each other and play off of each other's talents. Bottom line, they have to "know their stuff." The person being served needs to be active in this team process, communicating well, asking questions and advocating for himself or herself so he or she too can take a bow when the goals are achieved. Passive behavior just doesn't work on a team.

This team concept is very important early in the rehabilitation process, but the team needs to stay together through the continuum. Last time I looked, limb loss doesn't go away – neither should the team. There should be few hands waving goodbye. There is the phase before surgery, after surgery, and of returning home and becoming increasingly mobile. This follows right through the first year and subsequent years after the loss occurs. The physician I talked about earlier is now back to 12-hour days (not my recommendation), monitoring his skin and blood sugars, as well as his patients. He follows up for routine care and when conditions change, such as the fit of his prosthesis.

The team, especially the core, stays together and is ready to help the person with limb loss keep the music of his or her life playing. The many hands involved earlier with the heavy lifting now applaud repeatedly as the "getting back to life" goals are achieved again and again throughout life after limb loss.

About the Author

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