Predict Other Successes

suggest that a rehabilitation regimen consisting of the palmar pulley system, a PIP joint block, and a 6-week program of early controlled motion is effective in inhibiting the formation of peritendinous scarring, joint contractures, and other complications that commonly occur secondary to flexor tendon grafts and repairs in zone 2 of the hand” (p. 463).

I feel that such a global statement is not supported by this isolated case study of a flexor tendon graft on an 8-year-old girl. It is well accepted that children have far superior surgical results than adults with flexor tendon repair or grafting. I am concerned that the inexperienced therapist treating patients with flexor tendon injuries will assume that this rehabilitation regimen will result in perfect results. Those of us who have been treating tendon injuries for some years believe that this is one of the most difficult areas of rehabilitation. Even with our best efforts we often are unable to obtain what we would consider optimal results. I would hope the authors would be less enthusiastic in assuming that their regimen works well with patients of all ages.

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Authors’ Response

It is always a learning experience to have someone with such extensive experience as Ms. Colditz provide suggestions and constructive critiques. This not only helps the authors but clarifies readers’ concerns or misinterpretations. We appreciate her interest.

Our enthusiasm stems from our clinical investigative experience in which the Washington Regimen of early controlled motion was used successfully with patients of varying ages. We cited these studies in other parts of the article, yet perhaps referring to them again in the cited conclusion statement would have been appropriate, and we apologize for excluding them. The following references do acknowledge positive rehabilitation results with the Washington Regimen of controlled motion for a varied age range:


We agree with Ms. Colditz that all therapists must approach the rehabilitation of flexor tendon repairs with respect and caution. Regardless of the tendon rehabilitation protocol being used, inexperienced therapists should always be under the proper supervision of the surgeon or a more experienced therapist. As clinicians, we must also realize that the use of a particular protocol does not guarantee perfect results. It is always important to note the other multiple factors such as the patient’s compliance, the therapist’s persistence, surgical technique, and other trauma associated with the tendon injury—all of which influence the rehabilitation outcome.

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Is Relief for Personnel Shortages in Sight?

The United States and Canada alike struggle with shortages of occupational therapists and contemplate the damage this “crunch” can, and does, cause to the occupational therapy profession (Kuretzky, 1987; Madill, 1987; Neeman & Neeman, 1983, 1988). Although the causes for these shortages may differ, approaches to solutions may be similar to a degree because the concerns about the consequences of personnel shortages in occupational therapy in our two countries are akin. For example, major concerns for President Helen Madill of the Canadian Association of Occupational Therapists (CAOT) are the high cost of training qualified occupational therapists within the overall rising costs of health care provision and the threat that, because of a chronic shortage of occupational therapists, “single modality therapies” with their narrow focus encroach on occupational therapy’s field. AOTA, too, is concerned that non-occupational therapists will fill the profession’s jobs (“Applications Decline,” 1987). We see falling enrollment in occupational therapy curricula as a cause of the developing personnel shortage (Neeman & Neeman, 1988); the Canadians’ plight is the chronic shortage of fieldwork placement for students, which creates a personnel bottleneck in spite of Canadian universities’ rising enrollment (e.g., at the Universities of Toronto, Alberta, and British Columbia). An additional hazard is that the shortage of fieldwork placement will get worse with the growing number of students (Kuretzky, 1987). One way CAOT rises to the challenge is by encouraging and guiding the many smaller clinical settings of occupational therapists (in smaller cities and nontraditional and community settings, which are seen as the settings of the future) to seek accreditation for student fieldwork placement. This approach is thought to generate respect for the occupational therapy profession. This is a poignant reminder of our major concerns with professional esteem and prestige (Bloom, 1987; Gilfoyle & Christiansen, 1987; Parker & Chan, 1986) for which I, together with M. Neeman, have outlined possible rem-
edies (Neeman & Neeman, 1983, 1988). For example, nontraditional work-study and particularly cooperative education graduate programs in occupational therapy would join a distinguished group of American Universities engaged in cooperative education (including the Universities of Cincinnati, Detroit, Iowa, Drake of Des Moines, Drexel of Philadelphia, and, most notably, Northeastern University). It is not reasonable to expect easy, short-range solutions for our profession’s long-standing problems of esteem, clinical substantiation and research, personnel shortages, and the attainment of a decisive advantage over encroaching competitors in the present-day cost-conscious health care environment, which depletes some of occupational therapists’ traditional areas of practice. The long-range, persistent quest for personnel solutions should go on until our profession’s standing, prestige, and self-esteem are secured.

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References


Metabolic Changes of Recovery

Much attention has been paid to the endocrine and metabolic responses to injury, illness, and surgery, the “ebb and flow” phases of which were originally described in the 1930s. When it became feasible to manipulate the harmful effects of the changes in the late 1960s and 1970s, interest in the subject expanded considerably, and practical developments meant that nutritional and metabolic support could be given with increasing safety to patients requiring it.

However, it is often forgotten that the total response has a third, “anabolic” or “recovery,” phase during which body mass is restored, muscles recover, and health is regained. There is little literature on the subject, and the concentration on hospital-based medical services in the last 25 years has meant that attention has been directed almost exclusively to the acute situation.

The metabolic changes of recovery are well described, but I can find remarkably little information on factors that modify the process as a whole. Specific areas of rehabilitation, such as rehabilitation after spinal injury and cardiac surgery, have been well developed, but little is known of the recovery of the many thousands of patients who are discharged from the hospital after acute medical illnesses or routine or emergency surgery. Depression is common, and return to productive activity often slow. The economic consequences of this are far reaching: millions of productive work days are being lost annually, with apparent acceptance that this is inevitable.

I believe it to be far from inevitable and am setting up an international working group to investigate aspects of recovery and rehabilitation and to plan a first international meeting and launch a journal toward the end of 1989. The group will be multidisciplinary, covering all medical, physical, and psychological perspectives on the problem. I would like to hear from anybody who wishes to be involved and would be grateful to receive names and addresses of people who might also be interested as well as any relevant articles or references from the literature.

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