A Single Success May Not Predict Other Successes

In the Case Report “Early Controlled Motion Following Flexor Tendon Graft” (July 1988), the authors gave an excellent overview of the physiological rationale for early controlled motion. I must express my concern, however, at their conclusion as stated: “The good functional results achieved 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 contractions, 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 are often 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...
The quest for truth and the key to excel·
sions.

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gram enrollments down.


and, most notably, Northeastern Uni­
versities engaged in cooperative educa­
tion (including the Universities of Cinncinati, 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' tradi­
tional areas of practice. The long­
range, persistent quest for personnel
solutions should go on until our pro­
fession's standing, prestige, and self­
estee are secured.

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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 origi­
nally 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 dur­
ing which body mass is restored, mus­
cles recover, and health is regained.
There is little literature on the sub­
ject, and the concentration on hospi­
tal-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 recov­
ery are well described, but I can find
remarkably little information on fac­
tors that modify the process as a
whole. Specific areas of rehabilitation,
such as rehabilitation after spinal in­
jury 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. De­
pression 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 inevita­
able 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 multidisci­
plinary, covering all medical, physi­
al, and psychological perspectives
on the problem. I would like to hear
from anybody who wishes to be in­
volved and would be grateful to re­
ceive 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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