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## **Conclusions**

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This case study has made three points: that the Boston Elbow is technologically distinctive; that it is only one way to compensate for the loss of an arm; and that public policy plays a substantial role in distributing the Boston Elbow and other compensatory measures.

Although this study has not had the benefit of a controlled evaluation of the Boston Elbow and its prosthetic alternatives, it is reasonable to conclude from the data at hand that for some, perhaps for many, above-elbow amputees, the Boston Elbow is an appropriate response to the loss of an arm. The study also indicates that the Boston Elbow is not equally available to every amputee who might want or need it and that the government's role in distributing the device operates on several levels.

First, public policy sometimes works directly on the existence of a prosthetic device. The Boston Elbow is a product of workers' compensation insurance and has been designed to restore abilities valued in the workplace. Second, the government makes explicit decisions about what may be purchased with public funds. The Veterans Administration prosthesis approval process, for example, and Medicare and Medicaid reimbursement practices control the provision of specific prostheses to specific clientele.

A third government influence is less direct but equally potent. It is the extent to which prostheses are made part of large public programs. In the Vocational Rehabilitation Program, for example, physical restoration is one means to further the objective of increasing the employability of amputees. The Boston Elbow is or is not provided to Vocational Rehabilitation clients depending on whether the device contributes significantly to vocational potential. Finally, the government is influential in making society more accessible to people with disabilities. The Rehabilitation Act of 1973, for example, opened several routes into mainstream America and has made prosthetic compensation simultaneously more of a right and less of a necessity.

It remains to be seen whether the sum of the influences described above constitutes the most appropriate relationship between government and the amputee: What should public policy be with respect to the Boston Elbow? Given that disability is idiosyncratic and contextual, government might favor the match of individual amputees to whatever prostheses they and their physicians choose. Government might also increase the likelihood of such a match by making every device widely available to potential wearers and their agents. This, however, would be a rare show of universalist in a system where health and welfare policies painstakingly distinguish among clientele.

The programmatic boundaries that shape diffusion of compensatory technologies such as the Boston Elbow are firmly fixed. It is unrealistic to think that a single judgment on the merits of the device can influence the diverse mandates, histories, and resources of the several programs that impinge on it. Rather, the Boston Elbow is more or less appropriate to each of these programs, as it is more or less appropriate to individual amputees.

Public policy is not providing adequate compensation to the extent that individuals' needs diverge from the goals of the program(s) for which they are eligible. Ironically, it is the array of programs available to the amputee-citizen, which do not include provision of the Boston Elbow, that promises to advance the cause of matching amputees to suitable prosthetic technologies and other options. The independent living and disability rights movements encourage people with disabilities to become informed consumers of rehabilitation technologies and to view assistive devices as part of larger compensatory strategies. One result of this movement will be more self-aware and assertive participants in the design and development of compensatory technologies. Another result will be an awareness among disabled people that responses to functional loss derive from political as well as technical intentions.