PHYSIOTHERAPY IN THE COMMUNITY

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The population explosion, together with improved medical care, has led to an insidious increase in the numbers of geriatric, chronically ill and disabled patients. The number of hospital beds is ever in short supply. The population explosion however, does not seem to have radically influenced the number of practising physiotherapists. At the time of writing and with compulsory registration of physiotherapists with the South African Medical and Dental Council having been recently promulgated, there are 1 149 registered practising physiotherapists in South Africa. The results of which indicate the essential and judicious use of physiotherapy services, especially decentralised/dehospitalised physiotherapy within the community. The following questions must therefore be posed:

(1) Is physiotherapy of any value in the community?
(2) If so, in what way may physiotherapy services be efficiently and comprehensively utilised to the benefit of the community?

The physiotherapist today may no longer be regarded as "the kind lady who massages pain and paralysis away". The average physiotherapy training in South Africa today consists of a four year B.Sc. degree in Physiotherapy. "The traditional love of heat must be superseded by a more realistic approach to the pathological changes which have occurred in disability and which are irreversible. An acceptance of the fact that a gas or electric fire can give as much relief from pain as a radiant-heat lamp or shortwave diathermy machine must become a reality." (Patrick 1973)

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The official definition of physiotherapy in South Africa states that physiotherapy is the skilled use of physiologically based movement techniques supplemented where necessary by massage, electrotherapy and other physical means for the prevention and treatment of injury and disease. It is used to assist the processes of rehabilitation and restoration of function including the achievement of personal independence.

Clearly the aim of physiotherapy in the community should bias strongly towards a teaching and advisory capacity. The patients, their families and relatives, and the public in general must be educated to accept their responsibility in partaking of the rehabilitation and long term management of the chronically disabled and diseased. If the patient is incapable of accepting the responsibility for the continuation of his/her own self-treatment personally, this should be assumed by the family and relatives or become a public responsibility. The role of the general public in this regard is extremely important.

What then, is the role of the physiotherapist?

There are many avenues open to the physiotherapist within the community. It can only be of benefit to discuss some of these avenues. Firstly, consider the problems involving geriatric patients. The tendency today, is for the older person to gravitate towards institutions where nursing facilities are available if required. Many of the encroaching problems of old age could be staved off by adequate education of the elderly as to the importance of movement and the upright, active and alerted posture (Tucker, 1960). Participation in specially orientated exercise classes which maintain posture, joint mobility, vital capacity, physical fitness and general morale should be organised by physiotherapists for the healthy but elderly in such institutions.

The elderly patient who has been hospitalised for some time, e.g. for the treatment of the fracture of the neck of the femur or cerebro-vascular accident should have their home environment evaluated before their discharge. Their rehabilitation programme should ensure that they will be able to cope with the ordinary activities of daily life such as getting in and out of the bath, being able to get to the washline to hang out the daily wash and, if need, to manage stairs. It is also necessary to see that they can negotiate transport so as to ensure continued contact with the community; I do not mean the local bus or train service, but rather the use of a taxi or private car. Unless the elderly are rehabilitated to this extent, and their fears allayed by demonstrating their mobility they will tend to withdraw altogether.

When the elderly patient reaches the stage of becom ng a "nursing problem", the family should be instructed by the physiotherapist as to the optimum positioning in bed so as to prevent the development of pressure sores and contractures. The family should be taught how to turn the patient in bed, how to move the patient up and down in the bed, how to sit the patient forward and how to get the patient both on and off the bedpan. The correct mechanical use of the body by the family and relatives will not only prevent back injuries, but will conserve and give them energy for other activities so necessary when one is constantly involved in nursing the chronically bedridden.

Secondly, the role of the patient, family, relatives and friends becomes increasingly important when one surveys them in conjunction with the following groups of chronic diseases and disablements:

(a) disabled children — e.g. cerebral palsy, talipes equinus varus, poliomyelitis, acute infective polyneuritis and the blind;
(b) disabled adults — e.g. paraplegia, quadraplegia, head injuries, hemiplegia;
(c) the young chronically ill — e.g. mucoviscidosus, Still's disease, asthma, haemophilia;
(d) the chronically ill adult — e.g. chronic bronchitis, emphysema, rheumatoid arthritis, myocardial infraction, disseminated sclerosis.

Basically the physiotherapist should teach and train the above-mentioned patients to treat themselves as far as possible and when necessary the help of family and relatives should be enlisted. Patients should become acquainted with and accept the responsibility of doing and modifying their own exercise programmes in accordance with the dictates of their present condition. Application of splints, postural drainage, breathing exercises, specific positioning in relation to spasticity, passive movements and a host of other treatment activities are amongst those which patients can perform for themselves. They should, however, and this must not be forgotten, see the physiotherapist at regular intervals for evaluation, re-assessment and advice. The physiotherapist must at all times be available to these patients in an advisory capacity.

It is also essential that where possible these patients should be rehabilitated to the extent that they can make active contributions to the society and the community. They must be constantly aware of the aims borne in mind for them. The physiotherapist has a role to play in the team which rehabilitates or if need be, resettles these chronically disabled or diseased people in an alternative occupation.

Thirdly, let us look at the role of physiotherapy from the preventative point of view. Here again there are many possibilities. Backache is a very common occupational hazard. The physiotherapist should be employed by industrial concerns with a view to safety. Employees engaged in heavy lifting activities should be instructed and trained in the correct lifting procedures. Furthermore, work tasks involving the assumption of postures for indefinite time periods should be evaluated and the employee postured to the best mechanical advantage for that specific task. One needs only to think here of the "fibrositic" neck problems attributed to the postural attitudes of typists and all the other musculoskeletal problems that arise in conjunction with faulty posture.

Similarly, the physiotherapist could be of use in the school situation where adolescent postural problems arise. Remember also, the specific introverted postural problems of blind children. The physiotherapist's knowledge of functional anatomy, physiology, kinesiology, pathology and exercise therapy would enable her to advise the school gymnastic teacher as to suitable exercises to include in the general exercise programmes for these children.

Backache is also a common complaint amongst pregnant mothers. Here again physiotherapy has a place. The prospective mothers should be instructed as to the correct mechanical adaption to the ensuing posture of pregnancy. In addition to being taught exercises to prevent swelling of her legs and footstrain, she should be taught how to conduct her labour so that she will be able to relax both mentally and physically.

Continuing in a preventative vein — the hazard of the lack of exercise with regard to myocardial infarction is constantly being brought to our attention. Physiotherapists should be employed by companies who have large numbers of sedentary workers who are submitted to the severe pressure of the high-powered business life. These business executives could then be instructed and supervised in a purposeful lunch hour exercise programme expressly designed to keep them physically fit.

What about the prevention of sports injuries? The physiotherapist can be of help to trainers and coaches in the drawing up and execution of purposeful exercise programmes and schedules should be designed to facilitate maximum joint range, muscle length, strength and endurance and physical fitness. Thus the possibility of many specific injuries could possibly be eliminated. In the case of injuries occurring early, physiotherapy treatment would ensure an early and more speedy return to the game.

Finally, looking at rehabilitation in the community in its broadest sense, it is evident that the physiotherapist has a definite professional responsibility to serve on various committees in an advisory capacity: health education-, sports- (both for the healthy and the disabled), industrial- and architectural liaison-committees all seem to indicate this need.

From suggestions and ideas set by the dictates of our present times it seems that physiotherapy in the community, in the future, is infinitely important. Its successful implementation depends on enlightened physiotherapy prescription by medical practitioners and the foresighted demand of a community which has a developed insight.

REFERENCES

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