PHYSIOTHERAPY in a MISSION HOSPITAL

A DOCTOR'S VIEWPOINT

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THE DOCTOR

It used to be a commonplace saying that a mission hospital doctor tried to be almost all things to all men. Happily this multi-potential role is being reduced to more human proportions as the staffing of these country hospitals fills out. However, he does continue to have important leadership functions in the more strictly medical sphere and in relation to his nursing and para-medical colleagues. Let us hope for everyone's sake and his own that the days of his god-like pre-eminence have passed; but the teamwork, which is today's ideal contribution to patient care, still requires leadership, especially in developing countries.

I will first admit that very often the doctor himself has to be an object for motivation by his expectant team. And the thoughts I shall be expressing are directed as much to my medical colleagues as to our "Physios" who read this journal. I write as a specimen of doctor from a hospital without a physiotherapist — an object of interest to your readers and, I hope, sympathy. There are many of us.

And in such situations, untrained as we ourselves are in many of the para-medical responsibilities, we must assume we are likely to be the best endowed to discern, to arrange and to lead. The mission hospital doctor must be willing to initiate and sustain new endeavours — such as simple physiotherapy. In day-to-day case work he may have to be the driving force in maintaining and rehabilitating function. Is not this driving force, this vicarious enthusiasm for recovery, the characteristic attribute of the physiotherapist?

THE PATIENT

My hospital is in the Transkei and my patients are Xhosa-speaking Tembus. Let me just make a few sweeping remarks about them as patients! They do lie inert in bed. They have been thrust into this strange thing called a hospital bed with sheets laid flatly above and below, instead of being swaddled in a blanket. Every few hours nurses come to make sure this arrangement is unchanged. Sometimes a Very Important Nurse comes and scrutinises the arrangement very severely. Perhaps this is why they wonder whether they should move in it. Or, perhaps, it is that to a people to whom "daily exercise" is inevitable, there is none of this exercise-anxiety that white people have, which leads to daily dozens, turns round the block with the dog and other evidences that our bodies are slack. So that, even in bed, white people think to bestir themselves.

But, on the other hand, our patients have one paramount thought in their minds. "When can I go home?" This get-up-and-go outlook does fit in very well with the overcrowded hospital conditions, in which beds are commandeered and patients hit the road at five minutes' notice. So, if physiotherapy can get into this situation, there must be a wonderful motivation to work from. Here will be one of your problems: to persuade bed-conscious doctors to delay a patient's discharge long enough to practise a little fundamental restoration. You will have to demonstrate, if possible, that you can work within rather low patient-stay averages. I believe you can.

There's another thing. The Tembu seems to be a clumsy character; at least his protective instincts seem dangerously reduced. Their first exit from bed may be an amazing, but nerve-stretching, exhibition of the power of mind over matter. Crutches seem to be treated as incidentals. Thus they are a danger to themselves, around the ward, in the sluices, on steps and amongst the various hazards that old hospitals excel in. What a lot of skilled help is needed in this important, if condensed, period between Up and Home.

Nosingile Holi — a double tuberculous lesion of the spine has been surgically decompressed at another Mission Hospital. Although paraplegic for several months, she can now walk unaided.

Yet so many well-intentioned efforts on the part of staff to get patients to move, to breathe, to exercise limbs, to posture, are regarded with unbelieving indifference! This idea that the doctor is attempting the impossible (as usual) is often shared by nurses as well as patients. The Umlungu is at his usual game — attempting the impossible, to which the African must respond — but really, surely in sickness there is a limit? Here then is where the physio must enter the scene. How useless, I am well aware, are my three-minute exhortations. How vital are the 20 minutes of gentle persuasion.

A SURVEY

In 1969 our hospital was fortunate to have a physiotherapist from England working with us for two months. During this time she recorded her work and considered whether there was sufficient to occupy a trained physiotherapist. The answer was an unqualified yes, although her potential would be limited unless better facilities were provided.

At that time the patient-day-average of the hospital was about 240 but, under the circumstances, she decided to omit some groups from her work, such as antenatal admissions,

pulmonary tuberculotics. The Table shows wards covered, those for whom physiotherapy was desirable and those for whom it was essential.

Ward	Number of Patients	Desirable	Essential
Children (up to 5 years) General	37	13	8
Male: General	15	5	3
Female: General	16	5	4
Children (over 5 years)	14	3	3
Maternity: Post-natal	19	4 (Caesars)	4
Children: Pulmonary T.B.	42	6 (Spines)	6
Other Infectious Diseases	10	2	2
	153	38 (25%)	30 (19%)

During the two-month period the average number of patients attended per day, including weekends, was ten, with the maximum attendance 22.

With good care the prognosis for conservative treatment is good. Goinikaya Qege. Tuberculosis of Dorsal Spine with paraplegia.

IN-PATIENTS: THE BASICS

The following are the kinds of cases for whom "physiotherapy" must be provided somehow, by some of us, day in and day out.

Chest Infections. Lobar pneumonia is common and, amongst the elderly, particularly, lingering pneumonic infections frequent. One would expect miles of walking up hill and down dale to breed good chest-movers, but many are surprisingly bad. Children with advanced chest infection are admitted and the non-professional approaches sputum-raising postures with anxiety. There are post-operative chests, lung abscesses and asthmatics.

Orthopaedics. Acute admissions dominate the scene and include fractured legs, T.B. spines with paraplegia, and polios.

The Unconscious and the Seriously Ill. This applies to so many patients. Head injuries, meningitics, cardiacs, typhoids, typhus, cerebro-vascular accidents.

Hand Sepsis and Trauma. Although many are treated as outpatients, some are so severe or advanced that admission is essential, not only for cure of infection but to salvage function.

Burns. Burning, due to epilepsy and domestic accidents, is common and extensive burns involving joints need a lot of supervision.

"Cold Orthopaedics". Bed shortage is so severe that the physiotherapist is likely to be appalled at the neglect of orthopaedic problems. Much orthopaedics, including cases under specialist supervision at Provincial Hospital level, are managed, for this reason, in a passive, emplastered, contracture-preventing manner; rather than an active, supportively splintered, function-orientated manner. This is the common lot of many an outpatient for whom a bed cannot be spared and for whom no rehabilitative type of hostel may be available. But every hospital, nevertheless, has its spastics, hemiplegics and paralytics for whom only the scantiest of programmes can be sustained at present.

OUTPATIENTS

I have briefly summarised the inpatient challenge. But it is a fantastic fact that, even as we establish posts for physiotherapists for the care of inpatients, we are probably making little allowance in our thinking for the almost totally unattended outpatients. At least we can inspan the attention of nurses for inpatients. But most outpatients, relieved of their plasters, are given little more than a quick once-up-and-down and a friendly pat on the back. And whereas (beds dictating) the majority of inpatient orthopaedics centres on the lower limb, there are many upper limb problems amongst outpatients. Wrist and elbow fractures seem common and there is tremendous scope here for supervision.

ACCOMMODATION AND FACILITIES

Our hospital lacks designated physiotherapy accommodation; I don't think we are alone in this. The following seem to be the minium facilities which the physio may find it necessary to insist on having:

1. A covered, protected space — until buildings are available. In most mission hospitals the grass and the sun are close at hand and much can be done out of doors.
2. Adjustable parallel bars.
3. Walking aids — frames, tripods, crutches, sticks.
4. Faradism.

THE STAFF QUESTION

The mission hospital doctor, responsible for applying "physiotherapy" even if he has no physiotherapist, has a dilemma common to all para-medical initiatives. Should he temporise with unqualified assistance or not? The sad thing is that I have found little sympathy from the professionals for the idea of doing our best with unqualified workers. Nor are the profession at all keen, so it appears, to help out by providing basically trained assistants to fill the gaps until there are enough established posts, with appropriate salaries, the facilities that the professional requires and the trained people to fill them. The profession's argument that it is unfair to expose partly trained people to the demands of a situation which really requires fully trained skills, always seems to me particularly hard on the doctor — whom everyone seems to expect to perform just such tasks for which they too have had no training. Pathologists and radiologists (is it because of their medical alliance?) are more accommodating and allow for the need for partly trained personnel. So, physios, come down from your ivory towers and help us in this!

Footnote:

I acknowledge with thanks the insights and data given to me by Miss Marguerite Hinds-Howell, whose service to All Saints' Hospital I have referred to.