PHYSIOTHERAPY IN RELATIONSHIP TO DISEASES OF THE CHEST

(International Congress Lecture)

By Sir Clement Price Thomas, K.C.V.O., F.R.C.S:

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IT IS a privilege to me to be asked to address this International Congress, and especially so on this particular aspect of its work. We, here in London, are pleased to think that here is the birthplace of this particular form of therapy in relationship to thoracic disease, for, as far as my knowledge of the problem extends, it was in London that the first school of physiotherapy in chest diseases was founded in Brompton Hospital in 1936. The credit for this must go to Miss Winifred Linton and my late colleague, Mr. J. E. H. Roberts, for in 1934 Miss Linton commenced work in St. Bartholomew's Hospital, and consequent upon the beneficial effects seen by Mr. Roberts on his cases he subsequently persuaded the staff of the Brompton Hospital to invite Miss Linton to go to that hospital and continue her work there. This was the commencement, and since that time the school so founded has spread its influence far and wide, and I believe it is fair to say that from it the gospel has spread throughout our whole country, if not to the rest of the world, with the result that the physiotherapy units in the chest units here have become the envy of all who visit them. I do not know whether all here present know that Miss Linton passed away on Monday last. She had retired and gone to live at Deal in Kent and was very happy, but there came on Monday a recrudescence of a previous illness and, mercifully, it was only a matter of hours before she passed away. Those who were privileged to know Miss Linton will agree with me that she was nothing short of a remarkable woman.

In the early 1930's the large proportion of surgery was confined to the chest wall, and comprised such operations as thoracoplasty, the drainage of acute and chronic empyemas, intrathoracic interventions being relatively uncommon. In consequence of this, physiotherapy was demanded chiefly in order to increase the mobility of the chest wall and to correct deformities. These modest demands of the surgeon were more than amply filled, the whole general tone of the patient and not least his morale was improved out of recognition.

As the scope of surgery increased, the demands on the physiotherapist likewise became larger, both as to time and energy, and in this respect both these therapeutic arms grew together in their potentialities and in the results they achieved. The position today is such that we feel very strongly that the patient has not the same opportunity of a smooth and uneventful recovery if he is deprived of the advantage of good physiotherapy, both pre-operatively and post-operatively.

Physiotherapy, to be fully effective, should commence before operation and, within reason, for as long a time as possible. It is my practice to have the patient in hos'pital for a full week before operation. This serves two functions. Firstly, time is given for the observation of the patient and for him to get to know and have confidence in those who will take care of him, both nursing and medical personnel, and, secondly, this also gives time for pre-operative treatment, not the least of which is physiotherapy. During this pre-operative stage bad respiratory habits can be eliminated and respiratory efficiency can be increased enormously, and at the same time the patient can be instructed in the exercises he will have to carry out during the post-operative period. It is no time to get used to the bed, nurses and respiratory and postural exercises in the painful immediate post-operative stage; these things are better dealt with before the operation. I am sure both the patient's and the surgeon's outlook can be completely changed, if the patient is assisted by careful pre-operative preparation. It follows, of course, that the post-operative treatment is equally important, if not more so, and it is in this phase that the resources of both physiotherapist and patient are tested to the full; on this period of treatment its efficacy in the main will be judged.

We have learned—and chiefly from physiotherapy—that movement after operation is beneficial. Although painful to begin with, movement decreases the length of time during which pain persists. Encourage the patient to move as soon as possible after operation and he will in a matter of days get rid of the pain arising from the injury inflicted by surgery. There is also the important aspect of the confidence the patient himself will get as a result of his recovery. Patients may be ill when we operate, but we now consider that they are no more ill after operation than before a properly conducted operation.

One of the happenings against which we often have to fight is the practice of nursing sisters who make invalids of the patients after operation, so that their movements are restricted. I tell my patients that the bed belongs to them and I insist on them moving necks, legs, arms, &c., every day; also they can do five-finger exercises and even cycling in bed. All this gives a patient confidence to work rapidly towards recovery.

Anyone who has had a severe operation, especially if ill for some time beforehand, finds the thought of getting well too distasteful for words! This question presents itself as a steep hill up which the patient has not the energy to climb. I tell patients that that hill is somewhat unusual; that when they get a quarter-way up it is not half as steep as it seemed, and when they are half-way up it is no hill at all. Very important aids to recovery are the restoration of confidence and the urge to get well which you physiotherapists inject into your patients not only because of your cheerful presence but as a result of the enthusiasm you communicate to them in the carrying out of the exercises, so that they really are glad to undergo them.

It seems to me that there are two essentials to success in this particular field. Firstly, the quality of the personnel engaged in the task and, secondly, the formation of a school. To analyse the first pre-requisite, the quality of the personnel. It would be out of place for me to try to outline the requirements of the technical training which is necessary, or for me to stress its necessity; there is over and above this technical efficiency a further requirement, and that is enthusiasm for the work, and more than this, too, is the personality that so communicates this enthusiasm to the patient that the patient is, as it were, lit by it and glows in response. All the great physiotherapists have this quality, and to see them at work, as has been my privilege, is indeed an inspiration. It has been said that such qualities cannot be acquired, that they are inborn, and if they are not present nothing can communicate them. This I refuse to believe; example is the best preceptor, and I'm sure that to work with one who has this power to communicate

is in itself the means of transformation. This ability to treat your patients as human beings is difficult. Many people stand on a high perch and pontificate. That is all wrong. You never get anywhere with patients in that way Once you have the enthusiasm, the drive, and can communicate that enthusiasm to your patients you will succeed, always bearing in mind that you treat your patients as human beings.

Given a good personnel, then the foundation of a school is the next pre-requisite. Let me hasten to explain that there are two types of school: one desirable and the other essential. The desirable one is the training school where young physiotherapists are trained. As in other walks of life, the educational establishment depends for its elevated status not merely, or by any means, on the quality of its teaching staff but also on the critical quality of its students; be they of a sufficiently inquiring mind they will so keep their teachers on their toes that the latter must perforce keep themselves well informed if only not to lose face. Seriously, however, this critical faculty surrounding a school, and the opportunity to discuss problems with one's colleagues, form probably the greatest asset of any teaching institution. Obviously not every physiotherapy unit can have such a teaching school, but it can have a school for patients; this can be, and I know is, established even though there be only one physiotherapist. Therapy can be and is being carried out both as individual sessions and in the form of a class. Individual sessions are, of course, necessary when the patient is bedridden, and are invaluable. The class, however, has many advantages. Firstly, many patients can be instructed at the same time, and in this way there is a great saving of specialist-time. Secondly, it is a good thing for the patient that he can leave his ward, the almost cloistered atmosphere of his ward, and carry out this most essential part of his treatment away from it; added to this, he will often, in such a class, meet with patients who have come direct from their homes and will immediately be returning to their homes, and in this way he is made conscious of his relationship to his own home and the reality of his shortly returing there comes nearer. Thirdly, there is a certain competitive air about such a class, which tends to increase the enthusiasm of each individual. In this way the class has a distinct advantage over individual treatment; in the latter the patient is apt to consider himself as unique, whereas in the class he knows he is just one of many and, more important, he can see patients getting back to normal who have undergone the same procedure as himself. I emphasize that the establishment of a school is very helpful and valuable, even though there may be one solitary physiotherapist spending the morning taking classes and perhaps in the afternoon giving individual treatment.

All that has been said has unconsciously been related to the surgical aspects of diseases of the chest, but it applies with almost equal force to those diseases which are predominantly in the realm of the physician, and this, of course, must be so, as the whole aim and object of physiotherapy is to make the body as efficient as possible, in the particular connection we are considering, in order to enable the patient to use the full potentialities of his cardio-respiratory reserve, a factor which really is as necessary in diseases having a medical connotation as those involving surgery in their treatment, although it is right to say that the dramatic results occur, in the main, following surgery. I am often, however, struck by the thought that a large number of us in so-called health, and possibly not a few physiotherapists

themselves, could do with a large draught of this medicine.

Speaking as a thoracic surgeon, I feel that we cannot be grateful enough, first, to the pioneers who started physiotherapy and, secondly, to those who are now carrying on the good work. Incidentally, it would not be a bad plan if you as physiotherapists gave the medical personnel breathing exercises. It is really a horrible thought that we have been going on for 50 years not knowing the way to breathe properly. And it is also true that probably some of the physiotherapists—seeing that the bulk are of the fair sex—could do with a little of their own medicine. Women, generally speaking, are the worst breathers of all. They have an idea that it is impolite to push the diaphragm out when breathing.

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PERSONAL—continued from page 7.

New members on the Addington staff are Miss M. Gebers, Miss R. McMillan and Miss A. Caley.

Miss R. Lovely is leaving shortly on a visit of several months to England.

Mrs. Joan Cooper has gone to Canada with her husband.

Mrs. Thompson (Pat King) gave birth to a son in December 1953.

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Rhodesia Railways, P.O. Box 792, Bulawayo.

EDITORIAL—continued from page 1.

What a relief it would be to the Out-Patient Departments of General Hospitals to know that those patients could receive expert treatment in a centre of this kind, rather than dragging back and forth to the Department three times a week and not making much headway. Some progress very well as out-patients, but we are bound to admit that it is impossible in our overcrowded, inadequately equipped, and understaffed Departments really to give of our best to patients requiring lengthy and specialised care.

The problem of the arthritic is one of which the fringe has hardly been touched in South Africa, and it is well to remind ourselves of it, now that we are having so many discussions about rehabilitation. It is high time a little more publicity was given to this possibly unspectacular but most disabling disease.