

Physiotherapy in general practice

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SUMMARY. Approximately nine per cent of all episodes and of all consultations in this practice during a two-year period were for musculo-skeletal disorders. Absence of ready access to hospital physiotherapy departments stimulated us to explore the possibilities of organising a private physiotherapy service.

A scheme has now been in operation for over two years in which a physiotherapist treats patients on the practice premises. In this way it has been possible to provide prompt effective treatment at about one third of normal private physiotherapy charges. The scheme has succeeded from the points of view of therapeutic efficacy, of convenience to patients, to doctors and to physiotherapist, and of economy. The range of conditions treated and the results of treatment are described.

Introduction

Some of the conditions which confront a general practitioner tend to produce in him feelings of frustration at his inability to manage them effectively. This paper is about the treatment of musculo-skeletal disorders, a diffuse collection of illnesses which certainly comes into a category which dishearten the doctor and make him yearn for a more positive course of action.

People with musculo-skeletal problems constitute a substantial proportion of patients seen in general practice. Figures from our suburban practice of four partners in North-east England during a 12-month period show that 1,591 episodes of conditions in this group were dealt with requiring 2,827 consultations. As shown in table 1 this number represents about nine per cent of all episodes and of all consultations during the year.

The treatment available to patients in this group is often unsatisfactory, and we felt that many who might have benefited from physiotherapy were being deprived of this, either by the long delays involved in getting hospital treatment through the National Health Service, or by the prohibitive cost of private treatment. The practice has about 9,000 National Health Service patients.

In this area there is no open-access to hospital physiotherapy departments, and therefore patients must be referred to a consultant orthopaedic surgeon (with a waiting list of 8-12 weeks), who will then put them on to the waiting list for physiotherapy, involving a further delay of 2-6 weeks. Because of this long interval there is often a

TABLE 1
PROPORTION OF CONSULTATIONS AND EPISODES FOR MUSCULO-SKELETAL CONDITIONS

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Total episodes	6,965	11,047	18,012
Episodes of musculo-skeletal disorders	674	917	1591
Per cent of total episodes due to musculo-skeletal disorders	9.7%	8.3%	8.8%
Total consultations	11,888	18,770	30,658
Consultations for musculo-skeletal disorders	1,199	1,628	2,827
Per cent of total consultations for musculo-skeletal disorders	10.1%	8.7%	9.2%

prolongation of the patient's disability which may become relatively intractable. (Pennefather and Tanner, 1968.)

With these considerations in mind the partners in this practice held discussions with a local physiotherapist to determine whether it would be feasible to provide some form of physiotherapy at the group-practice premises. Matters that had to be resolved were:

- (1) Would it be worth while from the patients' point of view?
- (2) Could a scheme be devised which was financially acceptable to both patients and physiotherapist?
- (3) Would the premises be suitable and could such adaptations as were necessary be readily undertaken?
- (4) Could time be found to accommodate the scheme within the schedule of the practice?

Having decided on a system which it was hoped would satisfy each of these criteria it was decided to start it in July 1971.

The scheme

The physiotherapist decided what equipment could usefully be installed in each of three examination rooms which adjoined three of the consulting rooms. Two of these rooms are 5½ ft by 11 ft and the third 6½ ft by 8 ft. He provided the equipment and arranged for some minor modifications in the rooms, such as permanently fitting a lumbar traction unit to one examination couch which is pivotted over the couch when in use. A bell is in each room for the patient's use. One of the examination rooms contains a short-wave diathermy machine and a cervical traction apparatus. The third examination room contains an infra-red lamp and apparatus for resisted exercises.

The physiotherapist costed the service on the assumption that in using each room three patients would be treated simultaneously, and decided on a sessional fee of 50p per patient. With rising prices this has been increased and is at present fixed at 70p (about one third of his normal charge).

The sessions are held from 11.30 hours on three days a week and last 1½–2 hours depending upon the number of patients to be seen. Morning surgeries have usually finished by this time, which is convenient for the physiotherapist and for most patients. Individual patients are treated for 15–45 minutes, and 9–12 patients per session are seen. One session per week is primarily for the assessment of new patients.

The initial selection of patients is made by the doctors. When a patient is deemed likely to benefit from physiotherapy he is told of the service and given the option of being referred to hospital outpatients.

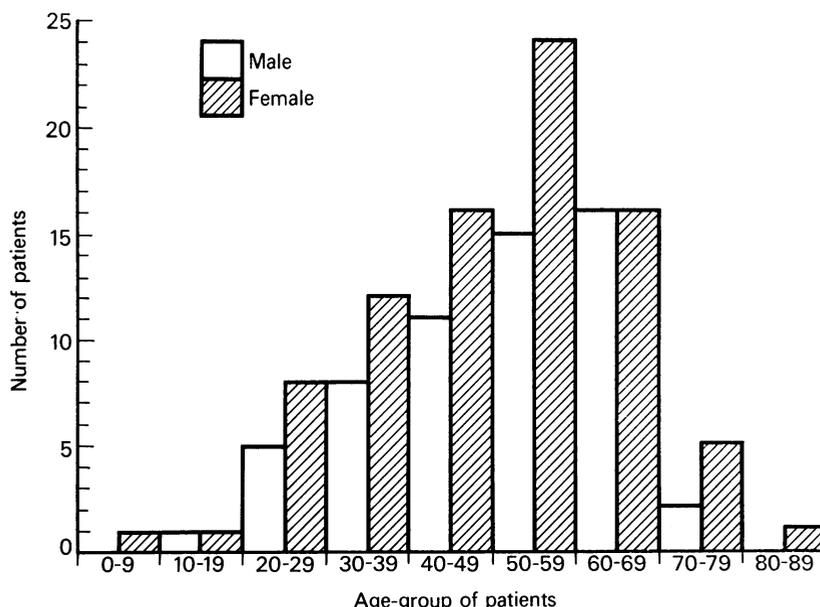
If he selects to have treatment under the scheme he makes an appointment to see the physiotherapist. The group-practice reception staff control the appointments and collect the fees for the physiotherapist; naturally no charge is made by the practice. In all cases the relevant information regarding diagnosis, investigations, and suggested therapy is available to the physiotherapist. The first session is for assessment of the patient's condition and it can then be decided how to arrange future sessions to make the maximum use of the equipment in each room.

Each patient is usually treated twice a week and when the therapist considers that the patient has achieved as much improvement as possible, or that no improvement is being obtained, he is referred back to the doctor. The physiotherapist makes a report which is entered on the patient's medical record card and the doctor makes a final assessment of the condition.

Results

The figures represent the results of the first two years of the scheme (1 July 1971-30 June 1973).

In the first year 60 patients were referred for treatment and in the second year the figure was 82, a total of 142. Of these 84 (59 per cent) were female and 58 (41 per cent) were male. The age and sex distributions of the patients who used the scheme are shown in figure 1.



The variety of conditions treated is shown in table 2.

The results in table 3 represent the combined assessments of the physiotherapist and the doctor at the end of treatment.

During a total of 1,568 treatment sessions, 142 patients were treated representing

TABLE 2
CONDITIONS TREATED

	<i>1st year</i>	<i>2nd year</i>	<i>Total</i>
Cervical spondylosis (including cervical disc lesions)	22	17	39
Lumbar spondylosis (including lumbar disc lesions)	14	16	30
Frozen shoulder, capsulitis	6	8	14
Non-articular rheumatism	4	10	14
Injuries	5	8	13
Postural defects	2	8	10
Osteoarthrosis—knee and hip	1	8	9
Others	5	4	9
Tennis elbow	1	3	4
Totals	60	82	142

TABLE 3
ASSESSMENT OF TREATMENT

	<i>Number</i>	<i>Per cent</i>
Complete or substantial relief of symptoms	105	73·9
Slight improvement or no change	9	6·3
Ceased to attend	13	9·2
Still receiving treatment	15	10·6

an average of approximately 11 sessions per patient. The principal forms of therapy employed were:

- (a) short wave diathermy,
- (b) infra-red heat,
- (c) exercises,
- (d) traction,
- (e) passive mobilisation.

In most cases a combination of two or more of these techniques was used, and the final decision as to what was the appropriate treatment for each individual was made by the physiotherapist.

Discussion

The types of condition referred for treatment tended to reflect the doctors' views as to what they regarded as being amenable to physiotherapy. However, other factors have also influenced this selection, such as the degree of distress of the patient, his willingness to make a financial contribution towards the alleviation of his discomfort, and the lack of satisfactory alternative forms of treatment within a reasonable time.

The latter consideration is undoubtedly part of the explanation for the predominance of cervical and lumbar conditions among the disabilities treated.

As more experience was gained a wider selection of cases was referred, but at times the physiotherapist reminded the doctors of some branches of his skills which they seemed to be ignoring. Co-operating in this way we have often found that together we have been able to obtain results that neither of us would have achieved in the same period of time working independently.

As doctors we find it a considerable asset when recommending physiotherapy to a patient to be able to offer a service of this kind. It enables those who are not rich or covered by private insurance schemes to have prompt treatment at a time when their conditions are most amenable to physiotherapy.

The physiotherapist has indicated that he feels an improvement in his professional status by being a valued member of the general-practice team, and that this attachment, which is quite obvious to the patient, has resulted in a markedly improved relationship between patient and therapist. He is also assured of a regular flow of patients during the hours he devotes to the scheme.

To the patient the fact that treatment takes place in his doctor's surgery, and with his doctor's recommendation, endorses confidence in the physiotherapist; and in addition the surgery is likely to be more conveniently placed than the hospital. Furthermore, in dealing with a reception staff whom he probably knows fairly well and, having treatment from a single physiotherapist, many of the anxieties and uncertainties of attending a large impersonal hospital department are removed.

The scheme has been growing steadily and very few patients seem to request hospital treatment when offered the choice. Many who have been treated have expressed their appreciation of the scheme, and several have returned with some other condition at a later date requesting further therapy under the same system. It is significant that with few exceptions they attend promptly and conscientiously.

It seems probable that by early treatment in this way many conditions can be remedied much more quickly than would otherwise be the case, resulting in the patient's earlier return to work and to a full life.

Application of the scheme to other practices

We feel that we have established a definite place for a physiotherapist as a member of the team providing primary medical care.

Given the physiotherapist's enthusiasm it should be possible for similar schemes to work in most practices. As a result of our experience during the past two years it seems to us desirable that free physiotherapy should eventually be provided by the National Health Service in the same way as medical and nursing care.

Because in our case the physiotherapist had a supply of spare portable equipment, the expense to the practice was negligible, amounting only to the purchase of a number of pillows for use on the couches. Laundry and electricity are the only running expenses.

There is a small increase in the workload of the reception staff in arranging the appointments, and collecting the fees on behalf of the physiotherapist. There need, however, be no interference in the normal practice routine if the sessions are carefully timed.

Minor adaptations to rooms or furniture may be necessary, and the therapist is the best person to decide upon these. Folding or portable equipment and storage boxes can be kept under the examination couches between treatment sessions.

In considering the design of health centres and surgeries of the future perhaps more thought should be given to the incorporation of suitable accommodation and facilities for physiotherapy.

REFERENCE

Pennefather, M. E. & Tanner, E. R. (1968). *Practitioner*, **201**, 933-937.
