Vigorous prohibition of deliberately dangerous play is needed to reduce the very high rate of injury in this sport.

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Hospital Topics

Doctors, physiotherapists, and placebo pharmacology

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Summary and conclusions

A seminar of physiotherapists studied the psychological aspects of their work. Difficulty with doctors rather than patients was unexpectedly prominent. The following factors were identified as contributing to their dissatisfaction: doctors misused physiotherapy as a placebo in cases of incurable and untreatable disease and mental problems; because they faced questions about diagnosis and prognosis that doctors escaped they learnt to avoid knowing the facts about their patients; using quasi-scientific apparatus had tended to replace physical contact; they saw their psychological skill as illicit and unprofessional; and they were uncertain about their role as social workers.

Nevertheless, they tended to idealise doctors, which sharpened gratification in collaborative work and helped to alleviate anxiety about death and disease, but tended to reinforce sexual stereotyping and the image of physiotherapy as "unscientific," empirical, and intuitive ("feminine").

Introduction

A seminar of 16 experienced female physiotherapists met weekly for two years to study the psychological problems in physiotherapy. They aimed at combining education with research¹ by discussing relevant case histories.² I led the discussions, having done similar work with seminars for general practitioners.³⁻⁵

General practitioners complain that they are subject to "non-medical" demands. Balint⁶ described "the drug doctor"—

the illness and the treatment are often merely a convention that allows doctor and patient to spend time together. Doctors may prescribe the placebo physiotherapist as a way out.

Chronic problems

In chronic incurable conditions and obscure functional disorders physiotherapy is used as a placebo. Many of the treatments are rituals known frankly not to work, and this increases the contempt with which physiotherapists vaguely feel surrounded, even though colleagues are personally friendly. Apparatus and gadgets intensify feelings of quackery and the undercurrent of scorn.

Clinical example 1—After a road accident a boy had no physical injury but refused to walk. The family was disrupted because of his father's alcoholism. No one felt like tackling the problem, and referral for physiotherapy was a cynical "supportive" measure, mainly evasive.

Hopeless cases

Doctors rarely think of how much despair physiotherapists shoulder in treating patients with hopeless conditions for which "there is no treatment but physiotherapy." Doctors sense the burden of crippled patients that physiotherapists carry, but know little about the other side of their work that annihilates optimism—for example, sustaining the semblance of treatment in a patient with an inoperable tumour. In many units the physiotherapist confronts every patient who has undergone a mastectomy, as she also confronts the amputee with bone sarcoma. All incurable cases (malignant, degenerative, neurological, arthritic, and geriatric) converge on the physiotherapy department. The roles of doctors and nurses who treat incurable or dying patients are hard, but can still be performed without recourse to misplaced therapeutic zeal; they must offer comfort and care to the end. By contrast, the physiotherapist's job is to promote an illusion of "treatment," implying improvement or even "rehabilitation." The doctor may fall into the same trap but need not—for physiotherapy the unrealistic aim is built in.

Clinical example 2—Amputee aged 80 with arteriosclerosis. While trying to teach him to walk, "... we had to give up for the day (my italics) when he was just dripping faeces."

Working in intensive care units now brings physiotherapists into direct touch with death, a useful antidote to the unreality which has

hitherto been confusing and disabling. Otherwise, they toil with the maimed and stricken but, unlike doctors and nurses, are denied the grim satisfaction of seeing their patients through to the end.

Clinical example 3—A member of the seminar found that she could comfort a boy dying of polycystic disease by staying still instead of trying to chat (he could hardly breathe) or bustle about. But is this physiotherapy?

Avoiding awkward information

The physiotherapist often spends time alone with her patients and gets asked many questions. She may not know what the doctor has said or what is best to say. There are few practical guidelines and little training or theory for dealing with such thorny problems; but the doctor, unlike the physiotherapist, has authority to make his own rules. She soon learns, however, that it may be better to know as little as possible about her patients. This collides with the accepted precepts for good treatment and the teamwork that is emphasised nowadays; but the physiotherapist works empirically, keeps her conflicts inside herself, and adopts practical solutions when she can. She may hide behind the doctor who did not tell her anything, but pays the price in irritation and humiliation. "Teamwork" may exist only in name if the members of the team never actually get in close touch with one another, and awkward questions and answers may be kept apart as a form of defence.

Clinical example 4—Girl aged 3 with astrocytoma. The nuisance of finding out too much was dramatically shown by this girl, who had an inoperable tumour but was improving with radiotherapy. The physiotherapist was puzzled by curious outbursts of shouting during treatment, with sudden collapses into "feeling poorly", and the seminar pushed her to sound out the family. The discovery that two siblings had died (of gastroenteritis and spina bifida) depressed everyone and confirmed that it is better never to inquire. The physiotherapist still evaded finding out the prognosis for this child.

Physiotherapist as psychologist

Physiotherapists complain of being "used as dustbins for psychological problems," yet their work remains essentially psychological. They teach, encourage, and goad to get people to do things they could not otherwise do. Many doctors and most patients see physiotherapists as women with machines, powerful lamps, and strong, gentle hands who are experienced in massage (with the exasperating and persistent bawdy connotations that this implies). Yet physiotherapists seem to do less and less massage, and at times I almost sensed a taboo on physical contact, which is at extreme variance with everyone's fantasy. Physiotherapists often come to life as inspired teachers, developing striking gifts for mimicry that are probably connected with the essential gift of getting inside their patients' skins. They acquire a kind of physical empathy but the psychological empathy simultaneously generated has only uncertain outlets, such as in the "social-worker" role (see below). Their acquired psychological talents seem, in open use, like a betrayal of their elaborate physical and anatomical training. Many doctors feel the same, but are helped by the traditional expectation that a doctor should be wise and understanding; whereas the physiotherapist is expected to emanate youth and bodily vitality despite her attunement to anxiety and decrepitude.

Clinical example 5—A woman aged 23 who had had an operation on her knee awoke to find that her patella had been removed unexpectedly. She was angry and panicky, refusing to move her leg unless the physiotherapist supported it. This was an impasse until the physiotherapist encouraged her to chat, whereupon it emerged that "finding herself with bits chopped off" had awakened raw feelings about the death of her mother a year earlier and the yearning to be held by her. This simple insight, sensed but not formulated, may have helped rehabilitation to proceed.

But physiotherapists are not trained to understand or feel at ease working in that way. Sometimes the brief is openly psychotherapeutic.

Clinical example 6—A docker aged 48 developed rheumatoid arthritis of sudden, severe onset, and the doctor explicitly wanted the physiotherapist to get the patient to face his bad prognosis as he was unrealistically optimistic.

Physiotherapist as social worker

The physiotherapist sometimes has a more intimate practical knowledge of the patient's physical capacities and of his home conditions than other members of staff. She may know best whether the

patient can manage the lavatory or cope with the stairs or the cooking (territory shared uneasily with the occupational therapist). Some social services departments now have posts for physiotherapists as "disabled living advisers," but the physiotherapist often remains an unofficial social worker whose role is half recognised, semi-illicit, and slightly bewildering to all concerned.

Clinical example 7—A woman aged 81 with a fractured femur and conjunctivitis was still in hospital six weeks after the physiotherapist had been landed with arranging her discharge. When the seminar had disentangled the physiotherapist from some inappropriate tasks it emerged that a seemingly simple problem masked extreme family tensions. Actually, a meeting with the family left the medical social worker in tears and the physiotherapist providing cups of tea. Nevertheless, some facts having been faced, a trial visit home was then followed by discharge a few days later.

The physiotherapist may often be the best person to co-ordinate progress in treatment, the provision of home facilities, and discharge arrangements; but she seems to have stumbled into the role. She is not sure whether to feel flattered or put upon, or to accept that she is just doing her normal job. Lines of authority and responsibility become even less clear than usual, and the consultant may seem unsure whether he is behaving appropriately; deputing and shirking can easily overlap. On the other hand, few doctors realise how enraged the physiotherapist may be when other patients are sent home without her approval.

Discussion

THE PARAMEDICAL ROLE

The patient is under the doctor's authority, but no one is sure whether paramedical people, the "professions supplementary to medicine," are also under his authority, though much is asserted. The Tunbridge Report⁶ on rehabilitation was prepared without a physiotherapist on the committee. After complaint, some balance was restored by the subsequent McMillan Report⁷ on the remedial professions.

Physiotherapists seem sometimes to have more trouble from difficult doctors than difficult patients. The troubles with patients are not central to this paper; the troubles with doctors are. The following factors are relevant. (a) The physiotherapist is overtrained and her skills are underused, but the patchiness of her knowledge makes it uncertain where her autonomy begins and ends. (b) Most doctors know little about physiotherapy but they "prescribe" it.⁸ Their prescriptions are often misconceived and scrappy ("Backache—try traction") but they have little basis for knowing whether they may leave the physiotherapist to decide about treatment (which is often but not always best). Mutual knowledge and trust is an excellent basis for co-operation, when attainable.⁹ (c) Since so much of the physiotherapist's work is with the incurable and untreatable she needs much faith and optimism, which tend to be based on idealisation. She colludes in the universal tendency of patients and ancillary staff to idealise the doctor, which leads to a backlash of anxiety at the falseness of this attitude and to resentment of the inevitable diminution of status for everyone else. The doctor may not want to play god but is pitched into doing so.

THE SEXUAL STEREOTYPE

Physiotherapists (like psychotherapists) are uncomfortably aware of the empirical and unproved basis of much of their work. It is "unscientific" despite their detailed study of anatomy and use of impressive apparatus. They tend to attribute the scientific "flabbiness" (together with their poor pay and lowly status) to being a women's profession. They deride much of the equally empirical and questionable male medical behaviour around them and yet, in a dissociated way, say, "Only a bunch of women would behave as we do." The assumption that the physiotherapist is usually a woman and the doctor is usually a man may not now be true, but it is still prevalent. It was certainly true when professional attitudes crystallised into patterns not

easily changed. The sexual polarisation of doctor-to-physiotherapist (like doctor-to-nurse) intensified the apparent subservience of one to the other, but it would be naive to accept this at its face value. Elements of excitement and satisfaction as well as rivalry and ensnarement complicate the collaboration. Sometimes physiotherapists seem like little girls worshipping their big brothers, locked in rivalry with the nurses, social workers, and occupational therapists for the position of favourite—be it favourite wife or favourite child—or even for some excitement as “the other woman” in a triangle. At other times they appear to indulge the vanity of their doctors, colluding with every kind of nonsense like doting mothers reluctant to interrupt the imaginative games of their little boys. To tell the great neurologist that his electrical treatment for Bell’s palsy is wasting everyone’s time might be like calling in the Duke of Wellington to clean his teeth before bedtime.

Nevertheless, an undercurrent of genuine satisfaction in legitimate professional sublimation of sexual roles may serve to make intolerable conditions tolerable, and the seminar could not afford to promote cheap debunking. We could sometimes see how seemingly stupid situations had become stuck, but we learnt to become cautious before scoffing at the anachronisms in which medical work is embedded. Other beds may prove worse. Describing the difficulties of physiotherapists and some tough lessons for doctors should not hide the professional and

personal satisfaction shared in struggling alongside one another. Throughout our ups and downs and many fraught periods of work I was astonished and captivated by the grit, humour, empathy, ingenuity, and feminine grace that pervaded this group.

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How should a consultant spend his time?

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Summary and conclusions

The activities of a whole-time consultant psychiatrist with clinical, teaching, and administrative responsibilities were analysed over six weeks. With the exclusion of time spent on call at night and weekends he worked an average of 57.4 hours a week. Altogether 42.3% of his time was spent on clinical work, 25.5% on general administration, and 24.0% on tutorial activities. Although he discharged his duties as well as might reasonably be expected, his clinical work was thought to have suffered.

Postgraduate activities and medical administration are important in the ultimate care of patients, but the structure of the National Health Service does not enable a consultant to meet all these demands adequately.

Introduction

Apart from figures based on personal estimates¹ little information is available on how consultants in the National Health Service use their time. With the growth of postgraduate education, particularly in “non-teaching” hospitals, and the increasing

participation in administration the demands on consultants often conflict with their primary function—namely, the care of patients. Two reports,^{2,3} however, have emphasised the importance of the doctor’s role in management.

This inquiry was designed to see how a whole-time consultant psychiatrist spent his time over six weeks. While patterns of work in different specialties vary, all embrace clinical, administrative, and teaching components. Psychiatrists, however, have also had to cope with changing concepts of practice, particularly over the past decade or so. These include providing services in the community, often some distance from the parent hospital, and the transition from inpatient services based in the old county mental hospitals to new psychiatric units in district general hospitals.

The clinical commitment of the consultant was similar to that of many psychiatrists and comprised responsibility for about two-thirds of a mixed urban and rural population of some 83 000 focused on Rugby as well as overall administrative responsibility for the area service as a whole. Outpatient care was provided at the Hospital of St Cross, Rugby; inpatient facilities were available at the local psychiatric hospital—Central Hospital, Warwick—20 miles (32 km) away, and a new district general hospital—Walsgrave Hospital, Coventry—some 15 miles (24 km) away. The consultant was also a University-appointed clinical tutor, for both the psychiatric and district general hospitals, and in April 1972 undertook chairmanship of the district general hospital’s psychiatric division—one of two Cogwheel divisions with which he was concerned.

In view of the large amount of time that he was spending on administration he asked the management services division of the then Birmingham Regional Board to analyse the pattern of his work to see whether his time could be used more efficiently. A management services officer was assigned.

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