PRACTICE OBSERVED

Solving Problems

Access to physiotherapy services

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The mortality and morbidity from all sorts of conditions vary widely among the regions in Britain, which is a matter for both study and concern. Furthermore, the National Health Service contains within it big regional differences in the methods of organising and delivering health care. With the present Department of Health and Social Security policy of devolving power to regional and district health authorities, these differences may become more exaggerated. Studying and comparing the differences should help local health authorities—be they regional or district health authorities, family practitioner committees, or even individual practices—to arrive at better ways of organising and delivering health care, which is the aim behind this article and others that we hope will follow.

We have started with the problem of how best to provide general practitioners' patients with physiotherapy. In Bradford

How can physiotherapy best be provided for the patients of general practitioners?

the district medical liaison committee has decided that a consultant and a general practitioner representative will assess each case referred for physiotherapy. Not far away in Rotherham general practitioners have been able to refer their patients directly to physiotherapists for some time, while in Collingham, Nottinghamshire, the local health centre has a regular physiotherapy clinic. The authorities in north-east Scotland have recently conducted a pilot study of open access and will probably read of the experiences of the other areas with interest because they are now considering introducing direct access to physiotherapy services for all the general practitioners. Each authority will, of course, make its own decisions and each has special local conditions with which it must contend, but a look at what other authorities are doing may yield valuable insights and may avoid the repetition of mistakes.

Bradford

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At the first meeting of our district medical liaison committee the main item on the agenda was "direct access to physiotherapy by general practitioners." To many this may sound like an outdated issue, hardly worthy of consideration at the first meeting of this august committee. After all, it is common knowledge that 76% of districts provide community physiotherapy and 66% allow general practitioners direct access to physiotherapy. Even in our in some ways retarded region 76%

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of districts have provided for direct access. Yet in Bradford, once known for its many progressive medical and social ideas, this has remained an insoluble problem. Indirect access means a patient with a simple complaint waiting up to 20 weeks to see a specialist to approve the need for physiotherapy. This often results in months of physical and psychological pain, with the inevitable threat to the patient's employment and finances.

There were grave predictions of a sudden explosion in the number of patients referred to the physiotherapy department, experience to the contrary in the districts with a policy of direct access. Our specialist colleagues believed that this would further delay the all important treatment of their "own" patients, although it was difficult to understand the distinction made between "their" patients and "our" patients. Furthermore, there was a totally unsubstantiated claim that direct access would lead to more medicolegal cases owing to inappropriate referral by less than competent general practitioners. Such a harsh and biased assumption is at least in need of some reliable evidence, if nothing else. Some of us, however, could recall that similar fears were expressed when general practitioners were for the first time allowed direct access to laboratory and radiology services, which has been proved to be cost effective and of immense value to both the patient and the doctor.

In the face of all the evidence in favour of direct access it was not to encounter such resistance. The historical chain separating the two main branches of the profession seemed to be as wide as ever, and the welfare of the patient, which should be the guiding light for all our decisions, was barely considered. After a month of negotiations, however, it was agreed to start an experimental scheme of direct access for a limited period. The cases referred for physiotherapy will now have to be vetted by a consultant and general practitioner representatives before acceptance. We have welcomed this new development and hope that the results of this experiment will justify implementing a policy of direct access in Bradford.

Rotherham

M HAMID HUSAIN, SUE CLIFTON

The attempts made by the Rotherham Health Authority to improve physiotherapy access for the community by giving general practitioners open access to the hospital physiotherapy department have not only greatly reduced the time that patients have to wait for treatment but has appreciably increased their chances of recovery, curtailed the duration of incapacity, and reduced the number of hours lost from work. The physiotherapy department at the district general hospital welcomes direct referral from general practitioners of all patients who live or work in the district. We hope that satellite departments will be set up at the periphery, which will be more accessible for patients.

The physiotherapy department provides rehabilitation, exercises, mobilisation of spinal and peripheral joints, cervical and lumbar traction, ultrasounds, hot and cold therapies, paraffin wax baths, and splintage. Advice and help are given on the treatment of patients with general aches and disabilities, and on postural drainage, breathing exercises, and relaxation techniques. The staff have been trained in the use of acupuncture for pain relief and in the technique of transcutaneous nerve stimulation. A pool is used for hydrotherapy for arthritic children to improve breathing techniques, and for improving the mobility of disabled people.

There is a clearly defined protocol that everyone is advised to follow. The referring doctors are expected to complete a card requiring physiotherapy with relevant clinical details and the results of investigations undertaken. Precise diagnoses are not required, but it is assumed that the sinister pathologies have been excluded and that the patients who need specialist treatment are not referred. General practitioners are not

required to indicate specific treatment, but it is always hoped that limitations and possible contraindications will be clearly noted.

New patients are interviewed and assessed by a senior therapist on Tuesday and Thursday mornings and appropriate treatment prescribed. Monday evenings are reserved for a sports clinic to that people who have been injured during the weekend may be treated with little delay. The referring doctor is always informed about treatment by a form letter and is sent a detailed report at the end of treatment, indicating the outcome and suggesting further action. The senior physiotherapist may decide if the treatment should be continued or terminated early and informs the doctor. Patients remain under the clinical care of their general practitioners and are not normally seen by a consultant unless referred. Physiotherapists may decline to treat a patient if in their opinion treatment is either contraindicated or unlikely to be helpful in the light of the information given. They may also delay treatment if insufficient information is given to assess the patient properly.

An open access service has reduced the pressure on consultant orthopaedic surgeons and enabled patients to receive treatment quickly. Those who suffer from back and neck pains and musculoskeletal disorders, including trauma, and those with chronic chest conditions have found the service especially valuable.

Community physiotherapy

Services are also provided in patients' homes and at special schools for those who find it impossible or difficult to travel to the hospital. Requests for domiciliary services are usually made by general practitioners, but community nurses are encouraged to initiate referrals for patients who are likely to benefit, with the general practitioner's approval. Treating patients at home prevents further deterioration, maintains mobility, and avoids admission to hospital. The physiotherapist can also see the conditions at home and advise relatives, nurses, or health visitors on appropriate exercises to be done in a familiar environment to retain as full a range of activities as possible. Equipment such as nebulisers, heat pads, and nursing aids are sometimes loaned to patients who are trained to use them. But patients and their relatives are mainly taught exercises and about rehabilitation, thus avoiding the need for frequent visits to initiate passive treatment. Domiciliary treatment has been valuable, not only for chronically disabled people and those who have had a stroke and cannot go to hospital, but also for recently discharged patients who have had fractured hips or cerebrovascular accidents and need to exercise continuously to remain active.

We commend open access to physiotherapy services, believing that it has done much to reduce unnecessary suffering to patients.

Collingham, Nottinghamshire

MIKE PRINGLE, F E HILL

In May 1981 three partners and a trainee moved into a purpose built district health authority health centre. The district physiotherapist had helped in the planning, which led to reinforcement of a wall and ceiling in the treatment room. Because of the enthusiasm of both the superintendent of the local physiotherapy department in Newark Hospital (six miles away) and the district administrator a physiotherapy clinic for patient referrals was started in the health centre within one week of opening. With a special allocation of £2000 and some existing funds, a continental Akron couch, wall handrails, mirrors, and the equipment for ice, short wave diathermy, all forms of heat, ultrasound, electrical stimulation, cervical traction, and exercises requiring weights, pulleys, slings, and

spring were bought. The main problem before the health centre clinic started for the 5300 patients of the Collingham practice was to ensure 15 minute physiotherapy treatment sometimes taking four hours or more out of the patient's day. At the beginning of 1982 there were two sessions a week totalling six hours, and in June this increased to three sessions, totalling seven hours. Thus a total of 322 hours of physiotherapy was given for the year and in December 1982 we added a physiotherapy helper to the staff. The table analyses all discharges of patients from the clinic in 1982. (There were 163

Analysis of discharges in 1982 from the Collingham physiotherapy clinic

Diagnostic group assigned by doctor	Total referred	Not from practitioner	Maximum	Total	Average
	No.	No.	No.	No.	No.
Chronic spinal problems	40 (24.2)	2	18	340	8.5
Orthopaedic	29 (17.6)	0	15	191	6.6
Orthopaedic	29 (17.6)	0	15	191	6.6
Upper limb problems	10 (6.1)	0	18	68	6.8
Acute spinal problems	10 (6.1)	0	18	68	6.8
Neurological	10 (6.1)	0	18	68	6.8
Neurological	10 (6.1)	0	18	68	6.8
Service colour spine, etc	4 (2.4)	0	1	4	1.0
Ill defined referrals	4 (2.4)	0	1	4	1.0
Non-attenders	1 (0.6)	0	0	0	0
Total No	165	16 (9.7)	126	7.7	

new referrals, but discharges allow a better measurement of duration of treatment.) The number of new referrals varied from nine to 24 a month, the busiest month being July with 169 treatments. The new referrals from Collingham represented 73% of the total for the department of physiotherapy at Newark Hospital which employs 5.4 whole time equivalents of physiotherapy time. All referrals but one were from the Collingham general practitioners or local orthopaedic consultants and conformed to the advice in circular HC(77)35 (from the standing medical committee on the relationship between the medical profession and the remedial profession, 1977).

The physiotherapists assess all referrals, and the decision to stop, curtail, or prolong treatment is taken on their advice. They have access to the medical records of the practice, although they do not write in them. Consumables, such as collars, wrist braces, epicondylitis claps, and walking sticks, are supplied from the physiotherapy department at Newark Hospital, and some patients need to have their treatment transferred there, or indeed to be seen in their own homes. Patients who have problems in getting to the health centre have used the voluntary transport scheme operated by the health authority's GP, and patient referral to the clinic has been universally favourable.

The physiotherapists (Mrs Pat Shepherd and Mrs Anne Burns) enjoy working outside their usual environment and are pleased with the easy access to the general practitioners. This has also helped the doctors to learn about physiotherapy, and the quality of their referrals has improved. Moreover, patients, physiotherapists, and doctors have benefited from the ability to get earlier treatment for acute injuries. The clinic maintains its popularity, and we all hope that it is a permanent feature of Collingham health care.

North east Scotland

DAVID W L RICHARDS

Open access to physiotherapy services has long been considered in north east Scotland, and a pilot study has been carried out among 20 doctors. The results of the pilot study suggest that there would be no inappropriate demand for physiotherapy time and that the service might be able to be provided on a buy some peace, which could create a "bottomless pit" of

chronic complainers who, having already been for osteopathy and chiropractors, would clog up physiotherapy facilities. They also suggest that general practitioners understand the changing role of physiotherapy and most allow for natural recovery. Those who refer patients early do so for immediate advice and instruction in self help.

In a recent paper by the Department of Health and Social Security it was suggested that community physiotherapists would be employed in health centres and group practices. They would be paid by the local authority but work on an attached or peripatetic basis. The superintendent physiotherapist in north east Scotland would welcome this addition to the main open access facilities that would be based at Woolmanhill and serve the city of Aberdeen. Preferably, patients should place as little burden as possible on the ambulance service and we should have to use our domiciliary physiotherapists more efficiently. But availability of trained staff does not permit the early start of a system of open access to physiotherapy, and we are not at the top of the priority list.

In 1979 there were 2552 new referrals to the physiotherapy department from all the hospital clinics; in 1980 there were 2576; and in 1981 there were 2647. Of these, 46% were orthopaedic referrals, 34.7% were from rheumatology clinics, and 19.3% from mainly medical, neurology, and dermatology clinics. In the pilot study we considered the patient, the appropriate consultants, the superintendent physiotherapist, the availability of qualified staff and staff in training for such a service, the general practitioner, and the primary care team.

Several schemes of open access operate successfully in Scotland, in particular at the Western and Eastern General hospitals in Edinburgh since July 1976 and at Leith Hospital since July 1981. The results of the pilot study suggest that open access would be used more for back, neck, and shoulder lesions, and also for some soft tissue lesions and cerebrovascular accidents. Our main worry is developing an administrative system for referral and, thereafter, satisfactory record keeping. It is striking that so few doctors have any knowledge of physiotherapy techniques, and it is important to remedy this.

The feeling in north east Scotland is that with the help and experience of others and the tremendous amount of local good will progress is being made towards open access to physiotherapy, and a more extensive study is being carried out.

ONE HUNDRED YEARS AGO Between the years AD 806 and 810, an Emperor of Japan commanded his court physicians, Ahenanus and Idanuma Kinoshita, to collect in one volume all extant records of native medicine and surgery. A manuscript copy of this work, for centuries forgotten, although the facts of its origin were recorded in Japanese history, was found in 1827 by a priest, in a provincial Buddhist temple. Dr Scheube, of Leipzig, has recently examined this work, and in an article published in a recent number of *Virchow's Archiv*, has shown its undoubted authenticity and its high value from a purely scientific point of view. It was written long before Chinese ideas had penetrated into Japan and influenced native practitioners. The most interesting passages are descriptions of local and general affections, which clearly prove that syphilis, and several allied disorders, were well known to the ancient Japanese. Chancroid and phagedenic chancre are clearly described, as well as a "swelling on the penis, of the size of a millet-seed," followed by eruptions, feverishness, pains in the bones and head, blindness, swelling of the testicles, and other very familiar symptoms. These were observed to continue for many years. The passages of this work, called the *Daidouro Tsui-ho*, which relate to the treatment of these symptoms, have not yet been translated into English. Herbs alone appear to have been used, and without much success; mercurial treatment was introduced at a comparatively recent date, from Europe. The ancient Japanese surgeons do not appear to have recognised the venereal origin of the disease which they describe, although the *Daidouro* distinctly traces all the secondary symptoms to "the poison from the affected organ." (*British Medical Journal* 1883; 374.)

Practice Research

Out of hours calls in general practice: does the doctor's attitude alter patient demands?

TERENCE CUBITT, GABRIELA TOBIAS

We studied out of hours calls in two practices in the same health centre in London. At the time both practices had six partners and two trainees, and one partner in each took little part in out of hours calls. Both practices have roughly 12 000 patients on their lists and are similar demographically—that is, for age, sex, and social class. Both practices have few private patients. Out of hours calls are normally received by an answering service that passes on all calls to the doctor on duty. A deputising service is not used.

We were trainees in 1978 in the two practices, and it was apparent to us that demand for out of hours calls differed between the two practices. We therefore decided to carry out a prospective study of out of hours calls during four weeks in June and July 1978.

The study was set up to:

- (1) Describe the pattern of demand in two north London practices.
- (2) Document the number of calls received by both practices in a defined period.
- (3) Compare the response of the two practices to out of hours calls.
- (4) Investigate factors influencing the response of the doctors.
- (5) Document the rating that doctors gave for the necessity of individual out of hours calls.

Method

Out of hours calls were monitored for four consecutive weeks in June and July 1978. An out of hours call was defined as one occurring between 1900 and 0830 on weekdays and between 1200 on Saturday and 0830 on Monday.

We requested that for each out of hours call the doctor fill in an encounter form (figure). The results of the questionnaire were recorded, using a modification of the Royal College of General Practitioners diagnostic classification for items (7) and (11) and a group of broad categories for other items. The data were then put on computer at Bedford College, London, using the Defend program of the Statistics for Social Sciences Package (Vogelberg Computing Center, Northwestern University).

We also obtained data for the number of out of hours calls in the six months up to and including the study period, and we asked local

hospitals to tell us how many patients of the two practices referred themselves to the accident and emergency departments without a general practitioner's letter.

Results

In the four weeks studied in June and July 1978 practice A received 100 out of hours calls and practice B 91. In the period January to July 1978 practice A received 156 out of hours calls. Table gives the time that the calls were made in the four weeks in June and July.

TABLE 1—Time of call

Time (h)	Practice A	Practice B	Total No.
1901-2300	42	39	81
2301-0100	20	18	38
0101-0900	38	36	74
(not in weekend or "on" calls)			

AGE AND SEX OF PATIENTS

There were 64 calls about children aged up to 10 years: 10 children were under one year, 26 were aged 1 to 5, and 28 were aged 5 to 10. There were 12 patients aged 10 to 20, and 35 were aged 20 to 35, of whom 23 were men. This is in line with the population profile of the district. Twenty six patients were aged 35 to 50 years, 15 were 50 to 65, and 31 were 65 and over, of whom 22 were men. In other age groups there was no difference in sex distribution. There were 42 unrecorded observations. In all, there were 103 (57.6%) male patients and 74 (41.8%) female patients.

KNOWLEDGE OF PATIENT

There was no important difference between the practices with regard to prior knowledge of patients, and prior knowledge did not noticeably affect the decision to visit.

STATED REASON FOR THE CALL

In 56 out of hours calls the stated reason for the call was fever, with or without a rash, or respiratory or ear symptoms. Twenty patients had chest pain, 14 patients abdominal pain, and 11 diarrhoea and vomiting and a similar number neurological symptoms. Ten "reasons" could only be described as malaise or collapse. Ten calls were for accidents; eight were related to psychological symptoms; eight were for skin ailments; 10 were classed as social problems or miscellaneous queries—about drug dosage or side effects; six were for musculoskeletal symptoms; five were about asthma; three were about urinary tract symptoms; two were about symptoms of pregnancy; and one concerned a gastro-intestinal bleed.

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