MANAGEMENT OF THE SEVERELY DISABLED

REPORT OF A SYMPOSIUM HELD IN APRIL 1981

A one-day simposium on the Management of the Disabled was arranged by the Department of Physiotherapy, University of Cape Town (U.C.T.) in conjunction with the Post Graduate Medical Centre, as part of the activities of the International Year for the Disabled. During the morning session several professionals gave an outline of their respective roles in handling the disabled and a patient also put his point of view. In the afternoon session specific problems of a selected number of disabilities/diseases were discussed. Abstracts or full papers were made available to all participants (over 80 of all disciplines), and adequate time was allowed for discussion.

Professor George Watermeyer of the Department of Community Health, U.C.T., set the scene by discussing the **Philosophy of Rehabilitation in 1981** and stated that rehabilitation is a concept whose meaning varies from the precise to the vague, according to individual taste, practice and experience. Quoting A. Mair, traditionally rehabilitation was restricted to physical methods applied to local parts of the organism, designed to improve function and alleviate symptoms. This had to be re-defined since the definition of the healthy state has become much wider and now encompasses a state of positive physical, psychological and social well-being. Many attempts, however, have become bound by the discipline they represent and end up with Mair's definition. More note should be taken of mental and social factors which may be more crippling than the obvious physical component, whilst cultural and environmental factors, totally amenable to correction, may compound a disability and enhance dependence. He cited the example of the amputee, "fully rehabilitated", that is discharged home and then becomes homebound, isolated and depressed because a sandy sidewalk prevents him from getting his wheel-chair out of the house; similarly, disrupted family relationships, cross-cultural constraints and other social issues may modify the outcome of an otherwise well-intentioned and carefully designed rehabilitation programme. The process of rehabilitation does not have a certain starting point and an end point in the course of disease/disability; however, periods of optimal intervention and times of maximum effect must be identified and utilised maximally for each individual circumstance. Rehabilitation goals should be realistic both for the patient and the therapist and sufficient time devoted to the assessment of progress. Evoking false hopes and expectations often result in a loss of confidence and compliance, thus it is important to state an acceptable goal and adhere to it. Assessment of the residual ability should not only be of physical and mental capability, but include the family, social, cultural and community resource potentials.

Active rehabilitation, be it complex and multifaceted, occupies a relatively short period and then the real problems start. Long-term support of the disabled in the community is essential. The concept of "alleviate care" put forward by Abel-Smith, namely that a community health care facility can care for the chronically ill within the community and that facilities can be mobilised in the community to help ease the burden of the care required by disabled at home, seems ideal. It would thus seem that the responsibility for rehabilitation and after-care of the chronically ill/disabled should be accepted by both health professionals and the community alike and we would be nearer to the ideal or broad definitation as stated by Mair. In South Africa the acceptance of the concept of rehabilitation by professional bodies has been slow, fragmented and unco-ordinated but the Health Act of 1977 has laid the ground rules for a total strategy which aims at a comprehensive, multidisciplinary approach to long-term care of persons with chronic disability.

Miss Ida Bromely, Superintendent Physiotherapist of the Royal Free Hospital and District Physiotherapist of Camden, as well as Chairman of the Council of the C.S.P., addressed herself to the role of the physiotherapist and titled her paper **"Observation + Action = Prevention"**. A trial document, *the International Classification of Impairment Disabilities and Handicaps,* published by the World Health Organization in 1980 with the sub-title A Manual of Classification Relating to the Consequences of Disease, attempts to give guidelines to assess and classify disablement so that information can be gathered on a sound basis and a better understanding of the problems can be obtained. In developed countries chronic illness and medical responses to it occupy a dominant position and more attention needs to be focussed on the disabling and handicapping consequences of disease rather than the pathology. She went on to define common terms; *impairment* is any loss or abnormality of psychological, physiological or anatomical structure or function; *disability* is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for human beings; *handicap* is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual. Handicap thus occurs when there is interference with the ability to sustain what might be described as "survival roles". Describing the consequences of disease more accurately and categorically will clarify the issues and give less offence through inadvertent stigmatising of people who have disabilities or handicaps. She cited the example from the Norwegian poet Bekke: "I used to be Mrs. Lind with a stiff hip. Now I am a stiff hip called Mrs. Lind." Handicap or disadvantage resulting from a patient's impairment may be increased through in-

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adequacies of health care, such as inappropriate or inexperienced care which often occurs when many patients already carry an intolerable load. Financial restrictions are present in all economies, but it was thought that resources are not marshalled to the best advantage to aid the severely disabled patient. Rehabilitation can be described as an attitude and the rehabilitation team as a team of "enablers" seeking to help the patient to help himself, teaching him ways of coping with his disabilities in order to reduce his handicap to a minimum. Successful rehabilitation depends on a high level dynamic, not custodial, care. The physiotherapist assists the patient to achieve maximum physical independence within the restrictions imposed by the impairment *and* in preventing further disability and handicap. All members of the team need to be realistic and honest with the patient about his potential *and* limitations, prepare him for what lies ahead and prevent complications if possible. Observation + action can mean prevention.

Patients with severe impairment and disability may gain independence only by mechanical means and yet these patients have married, written books and contributed to society. This life style depends on a high level of skill in the rehabilitation team, good motivation in the patient and a presupposed freedom from complications. There needs to be a system whereby the severely disabled patient can be screened regularly by the physiotherapist, as further disability can have small beginnings. The physiotherapist then needs to have an "at risk register" of patients who need close and constant *observation*. This may be easier if there is freedom to cross the boundary between hospital and home or working solely in the patients' homes or to have a general practitioner referral system to the hospital physiotherapy department. This will entail regular full examination and assessment of patients in all appropriate situations and activities. She then went on to cite some of the major contributing predisposing factors, such as bed sores, muscle imbalance, spasticity, contractures and increased reflex activity. The young patient, still growing, presents particular problems at times when there is a growth spurt. Reconfinement to bed could be dangerous for some patients. A total survey of the patient's daily activities, age and adaptations used, wheel-chair and calipers needs to be made. Discussion with the patient may be sufficient, as once he is aware of the consequences, he will follow advice given. Relatives or care attendants need instruction in appropriate measures for positioning in bed, adjustment to the wheel-chair or other equipment. An intensive short course of physiotherapy may be necessary if there are problems, the patient will move up the at risk scale and will need to be examined more frequently for a while.

Richard Brusser, a lecturer at U.C.T. and himself a paraplegic, spoke about the **Psychological Problems and Needs of the Paraplegic Patient.** He based his comments on his own personal experience and those of his friends and fellow patients with whom he spent several months in hospital. He felt that medical schools turned out a large number of persons trained extremely well in the various fields of medicine such as doctors and physiotherapists. They are superb technicians with an excellent knowledge of physical medicine but lacking in simple humanity. He discussed the patient's psychological problems and needs in two stages, namely when he first arrives in hospital after his accident and when he first gets out of bed and into his wheelchair. On arrival in hospital, particularly after an accident, the patient is overwhelmed by pain and total bewilderment. He realises something major has happened but does not understand the nature of it. He looks to the medical staff (doctors, nurses, physiotherapists) for psychological support and he strongly felt that they should explain the condition to the patient and give some sort of prognosis, although he realised that at this time an accurate prognosis was not possible. He felt that patients were considered morons, or incapable of handling the truth and that the uncertainty with which he was left, was the single most frustrating and depressing factor. He felt that there should be no standard policy on informing patients, but that each patient should be treated as an individual. He felt patients could be better prepared psychologically for the physical handicaps they are going to have to face. In discussion later on it was pointed out that patients often do not "hear" what the doctors or other health professionals tell them because they are not yet ready to receive the information.

Mr. Brusser then described the next stage, when the patient first gets out of bed and into his wheelchair. The patient is confronted with the enormous physical problems of movement with which he will have to contend for the rest of his life and at this stage these problems are more acute due to his extreme weakness from lying prone for three months. The major psychological problem at this stage is a general feeling of uselessness and fear of not being able to cope physically and socially under the new circumstances. The feeling of uselessness arises from the inability to move from one point to another, poor balance and incontinence, as well as re-evaluation of personal relationships in terms of what the patient can offer others and that he is only going to be a burden to all. This feeling of uselessness is compounded by the fear of the unknown outside the hospital where there are a myriad of physical and psychological obstacles. At this physical and psychological crisis stage the physiotherapist can act as the key to the future. He felt that the physiotherapist coped very well with the physical crisis but not so well with the psychological crisis. He once more appealed that all patients should be approached as individuals and that no "standard treatment technique" should be applied to all patients regardless. He felt that physiotherapists should receive more training in the psychological aspects of dealing with patients such as paraplegics. He felt this to be very important as the physiotherapist is such a key person in the treatment team.

Miss Christa Meyer of the Department of Occupational Therapy at U.C.T. dealt with **Sport and Recreation for the Severely Disabled.** She stated that it is important to differentiate between sport and recreation in order to understand that the disabled need both. U.N.E.S.C.O. defines *sport* as any activity which has the character of play which involves a struggle with oneself or others or a confrontation with natural elements, while Cantor and Wertham define *recreation* as all those things which man does and those artefacts he creates for their own sake, or that diverts the mind and body from the sad business of life . . . it is man in pursuit of pleasure, excitement, beauty and fulfillment. She then defined a severely disabled person as one who has suffered physical or psychological trauma of such a nature or extent that he is not capable of effectively carrying out activities related to daily living. In all cases a common problem is faced, namely, that of participation in life. Sport and recreation have numerous physical, psychological and social attributes that have overcome this problem and the occupational therapist uses them as special therapeutic tool to alleviate the results of pathology; to maintain physical, psychological and social aspects of function retained; to compensate or substitute for loss of function. Sport and recreational activities are graded in terms of time,

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endurance and effort/demands in order to meet the individual at his level of participation and to answer his specific needs.

Personal involvement on the part of the therapist and a suitable method of presentation will capture the patient's interest and co-operation and elicit maximum participation and attention. Normality of the activity and treatment situation is enhanced by the correct therapeutic atmosphere, wearing suitable clothing, having the necessary equipment available, a sound knowledge of instruction methods, rules and regulations, as well as good planning and preparation to prevent confusion and resultant loss of enthusiasm. Modification/adaption of rules, materials or tools may be necessary to enhance fun and enjoyment to give satisfaction from participating and to accomplish the activity more easily. Accurate physical, psychological, social and functional assessment of the disabled will determine the method employed by the occupational therapist for grading, presentation, structure, modification and adaptation of the activity as well as the handling of the person. The *disabled should* be involved in planning the sports/recreation programme so as to allow him the privilege of making his own decisions and feeling part of the programme. In this way the occupational therapist uses the pleasurable activity of sport and recreation and function derived from them to reintegrate the patient into his total life pattern, namely work, social and personal life scales.

Miss Elsabe Burger highlighted some interesting aspects of the **Role of the Social Worker** in the management of the severely disabled, aimed at returning the disabled to the community, functioning to their full potential. This requires liaison between welfare based services and the rehabilitation team in order to assess, mobilise and develop resources within the community to support the disabled to achieve active participation within the community. She focussed on accommodation as the living environment which will determine the level of independence that can be achieved. Very few are in a position to build a home to their specification and most frequently alteration and adjustment of existing homes would be more realistic. The disabled person and his family should be aware of literature giving information about, and be encouraged to bring about these changes. The emphasis recently has been on returning the disabled to the community, but it is felt that various options of living arrangements should be open to disabled persons. Cheshire Homes offer a form of communal accommodation where assistance with daily care is available, as well as participation in the daily affairs and socialisation and yet affording a degree of privacy. Smaller houses, accommodating 8 or 9 persons, run and managed by the residents themselves, have also been started. Focus Flats in Sweden contain a certain percentage of individual flats, in a large block, reserved for the disabled and specially adapted with extensive support systems such as care attendants, communication systems, communal rooms and transport facilities enabling the severely disabled to live amongst non-disabled persons, thus running their own homes with adequate aid and support. Ten Ten Sinclair, a scheme developed in Canada, assists young adults in gaining residential living experience, developing maximum physical independence, acquiring personal and home-making management skills, experiencing confidence in total community integration and developing meaningful vocational and leisure time activities. The possibility of a similar scheme, in Cape Town, of individual living units attached to the support system of the Cheshire Homes is being explored. The availability of regular, sympathetic and adequate attendant care is a major requirement for secure and independent integration into the community. This often falls to close relatives, placing inevitable and considerable strain on the disabled and his family, often ending with institutionalisation where care is guaranteed. There is a pressing need to develop attendant care services and support in the community. Linked with providing attendant care should be a facility enabling both the family/carers and the disabled to have holidays which can be of enormous value to the disabled and at the same time bring relief and respite to the carer/family. Mechanical aids can be of great value and assistance, but there is a lack of information and a permanent display of a comprehensive range of aids is essential. The community needs to develop support systems which will enable the the disabled to move outside the home and family and develop new interests and activities. To establish meaningful employment opportunities, extensive back-up services are required; effective approach by professionals well versed in the abilities and limitations of the person needing employment, and employers' previous experience in employing the disabled all play an important part. Where full-time employment is not possible, home industries have provided the satisfaction, stimulation, sense of achievement and socialisation which are all aspects of "work". This type of activity can be introduced during hospitalisation/rehabilitation and continue on return to the community. Finally, the problem with architectural barriers were mentioned and the formation of an Access Committee, comprising several severely disabled persons, to look at this problem. A disability register is being compiled in order to assess the extent of the problem.

Mrs. Joy Miles gave her personal views on **Rehabilitative Aspects of Community Nursing** and felt the structure of existing services need not change, but that a closer liaison between hospital, local authority and welfare services was necessary. Understanding of goals, roles and procedures of each between members of the multidisciplinary team will improve inter-personal relationships and effectiveness. She gave the W.H.O. definition of "organised community nursing usually outside the hospital, providing *comprehensive* nursing care to individuals, *families* or groups, with the major emphasis on the promotion of *health,* prevention of disease and rehabilitation". The community nurse has knowledge of the various National Councils and voluntary organisations, skill in assessment (physical, social and emotional) and her approach is family centred, assisting the family to meet health needs by using their own resources and available health services. The first intensive phase of rehabilitation begins in hospital at the time of diagnosis and with the trend towards early return to the home/community, the community nurse can act as liaison between the hospital-based rehabilitation team and home/community, by assessing the physical and psychosocial environment the patient will be returning to and suggesting/implementing aids/adaptations. She can provide continuity of care and support, monitor progress and problems, ensure maximum and balanced function of patient and family, and liaise between hospital, other services, community and patient. She could reinforce and encourage commitment to long term therapy, supervise drug regime and educate the patient and family in therapy routine. All this should ensure lessening of the stress on the patient and his family, enabling him to integrate and function in the family and community to his maximum capability.

Professor Kay de Villiers opened the afternoon session by expanding on the **Meaning of Neurological Illness.** Patients consult a neurologist or neurosurgeon for the same reasons which take them to any other doctor, namely pain, fear and anxiety; often they have no choice as they have already been rendered unconscious by a catastrophe. The patient expects, and re-

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ceives, a diagnosis and treatment. The diagnosis will unintentionally accentuate his defects rather than his abilities and can hold disastrous implications, since labels, such as paraplegia, hemiplegia or epilepsy will require painful physical, psychological and social adjustment. Diagnosis can bring relief with the realisation that the disease is organic and self-esteem can be restored despite the fact that it may impose a sentence such as a restricted life or a limited lifespan. For a small group it may even be a way out and rejection of the realities of life. Implications for the relative of the neurologically affected patient may vary from a change in life style, altered financial circumstances, and guilt, which can be particularly devastating in the case of parents whose child has a hereditary neurological condition. Reaction to the diagnosis can vary from rejection, with the patient consulting different doctors/institutions in the hope of a cure, to depression or anger against those closest to him. Euphoria or negativism may be a feature of the disease itself and not necessarily the patient's reaction. The unconscious patient awakes to a new reality, often confused and with impaired memory, being cared for by strangers in a strange environment, whilst realisation of his situation may (or may not) slowly dawn on him, all of which increase the psychological pain for himself and his family. He is faced with the loss of independence, of working and earning capacity, and of mobility, leading to loss of self-esteem and confidence. An awkward gait, for instance, makes him the object of unwelcome attention and horizons are narrowed whilst pleasure comes from small things such as the ability to walk unaided. He becomes aware of the proximity of death and a new look at life may be necessary. In order to rehabilitate the patient, the despair and depression must be understood, and attainable goals must be set to help him overcome this. Clinical defect should not be equated with disability since a minor stroke can be totally disabling for one and a major stroke cannot hold back another person. With a sound personality, correct environment and an intact intellectual capacity, many people can become new and greater individuals than before, and therapists must give each person the chance to attain this.

Dr. Pat Klemp (Department of Rheumatology, U.C.T.) in dealing with the **Problems and the Patient with Rheumatoid Arthritis,** underlined the despair of most of these patients by stating that although rheumatoid arthritis (R.A.) does not kill, it may make the patient wish he was dead; during the productive years the patient's body will disintegrate into uselessness and he will suffer great frustration. He quoted statistics for the U.S.A. and U.K., to demonstrate the major socio-economic implications of R.A. He dealt with the specific problems facing the patient under a number of headings. Physical problems during the acute phase will be that inflammation of synovial joints leads to pain and stiffness, as well as constitutional symptoms such as fatigue and weight loss all of which often confines the patient to bed at home or in hospital, interrupting normal activities and work regularly over a period of many years. In the chronic stage the patient usually has a number of joint deformities, often imposing severe limitation on his life style. There will be interference with activities of daily living and mobility, whilst sport and recreation is curtailed by problems of access to public buildings, leading to isolation of the patient. Extra-articular manifestations can lead to progressive respiratory impairment or blindness, whilst the rare "malignant" R.A. is associated with a high mortality. Sexual dysfunction due to pain and limited mobility, as well as depression, the feeling of being sexually undesirable and constitutional symptoms, may be a major problem. Treatment itself may cause problems, in that the patient is usually on life-long medication and polypharmacy has side effects that vary from trivial to lethal. Orthopaedic rheumatology has made great strides but often necessitates multiple procedures and the subsequent rehabilitation taxes the patient physically as well as mentally. Employment is a very real problem as flare-ups interrupt work, and progressive disability limit the possibilities. Most patients are forced to resort to a disability grant which increases their financial and psychological dependence. Depression can be a primary feature of the disease but often is secondary to the numerous problems already mentioned. The cause of R.A. is unknown, but early aggressive medical therapy and appropriate surgical intervention can reduce or even prevent disability and both the medical profession and the public need to be educated to this effect. An effective multi-disciplinary rehabilitation team go a long way to alleviate the patient's problems but a great deal still needs to be done in this respect.

Dr. Brookes Heywood of the Department of Orthopaedic Surgery, U.C.T. said that **The Major Orthopaedic Disabilities** will interfere with man's ability to stand up straight, to walk, and to use his hands, and could be due to many genetic and environmental diseases. The impact varies with the age of the patient and the nature of the pathology. The very young child stricken with paralytic poliomyelitis will never know independence nor achieve it, despite rehabilitation, aids, or surgery; at some stage he will realise how poorly endowed he is. An intelligent vigorous young man may be rendered paraplegic in an accident and lose all that has been. Fortunately man's spirit enables him to find a new meaning in life within the confines of a narrowed existence, guided by a rehabilitation team. Different again is the experiences of the average middle-aged arthritis patient who may have had a normal childhood, adolescence and young adult-hood; early on he can compensate for the pain and stiffness, but sooner or later function is lost, jobs have to be given up and dependence increases. However, man has an astonishing capacity to adapt and the patient combines with the rehabilitation team to fight the disease. There has been great surgical advance in this field and for instance total joint replacement is extremely cost-effective, particularly when it enables the patient to continue working. In orthopaedics the accent is not on the preservation of life, nor on making death more bearable, but on improving the quality of life. Dr. Heywood also touched on the lack of employment opportunities, architectural barriers, poor community support and lack of planning to provide facilities for the severely disabled. He feels the disabled often overcome their physical disabilities by a sense of dedication and resolution which enables them to excell in their callings and become superior citizens. A full social responsibility for these individuals is long overdue in South Africa.

The Problems Facing the Handicapped Child usually stem from two sources, namely the fact that they normally progress rapidly through a series of developmental stages and the tremendous dependence the child has on his physical and social environment. Dr. Chris Molteno of Red Cross Children's Hospital went on to explain that development can be defined as a progressive series of changes in an orderly coherent pattern, each new skill depending on preceding changes. As all changes fit into a global pattern, interference with one set of changes influences the total developmental picture. Thus handicap in one area could interfere with other developing skills, leaving one to distinguish between primary and secondary or reversible handicap. He cited the example of a cerebral palsied child with a reversible perceptual disability which related to body image. His drawings of a man rapidly improved when he received therapy incorporating tactile, kinesthetic,

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visual and verbal cues. Early diagnosis and intensive and comprehensive therapy will reduce the frequency of perceptual and conceptual disabilities in children from lower socio-economic backgrounds. A more obvious example of a secondary handicap is the motor delay experienced by a blind child, due to inadequate visual cues and feed-back despite normal motor ability. The influence of the mother-child or caregiver-child interaction on early development is significant. Piaget describes the way the child elicits responses from the mother and vice versa, very well in the development of imitation in infancy. If the child cannot respond adequately because of his handicap or the mother because of the lack of motivation due to a failure of bonding, the child's development will suffer. The attitudes of fathers is also important as was demonstrated by a comparison between marasmic children and their well-nourished younger siblings. A father whose handicapped child does not live up to his expectations, may lose interest in the child and not supply the much needed paternal stimulation. Parents of handicapped children react by demonstrating shock, guilt, revulsion, inadequacy and embarrassment which could cause withdrawal from social contacts, as well as going through the stages of bereavement at the loss of the normal child they expected. They can show anger, expressed in aggressive behaviour; grief, giving rise to depression and finally adjustment. Unfortunately health professionals often also have negative feelings and show negative behaviour which only add to the problems of the handicapped child. All children need a stable and loving social-affective environment, but handicapped children will require this more as their parents are usually expected to carry out a complicated neurodevelopmental programme under the guidance of a therapist. Only those parents in the final stage of adjustment will be able to do this adequately. Adverse parental attitudes could include rejection, abuse or over-protection. In addition discipline may be lacking so that social development will also suffer. He stressed the need for assessment of strength and weakness, being aware of potential problems and that the aim should be to allow each child to achieve his optimal developmental level, even though this may be compromised.

Dr. Harold Hecht concluded the afternoon by explaining that **Geriatrics is an Exercise in Multiple Pathology.** Since old age is frequently characterised by the presence of multiple pathologies, disability often reflects a combination and interaction of several minor and major handicaps. Thus management of the elderly disabled needs to be based on a thorough evaluation of the physical, psychiatric and social factors involved. Intervention requires a problem-orientated approach as it is usually impracticable, impossible or unnecessary to tackle all the presenting problems. Disabilities should be weighted according to their severity, importance to the individual and their potential for correction. Once a full assessment has been made, management can be planned and tailored according to individual needs. Intervention at one particular level can affect other levels of functioning both positively and adversely; for instance the treatment of hypertension can aggravate depression, whereas improvement in eyesight can reduce confusion. Iatrogenic illness is common in the elderly, mainly due to altered pharmacokinetics and often due to polypharmacy practised by different specialist disciplines. A co-ordinated and multi-disciplinary approach is the key to optimum health care for the aged and the most important role of a geriatrician would be that of assessor and co-ordinator of a treatment plan.

REPORT OF THE NINTH MEETING OF THE NATIONAL COMMITTEE OF REPRESENTATIVES WHICH WAS HELD ON SATURDAY 26 SEPTEMBER 1981 IN JOHANNESBURG

NATIONAL EXECUTIVE COMMITTEE

The Chairman, Mrs. Mathias, welcomed the delegates and convened the meeting. She reported on the activities of the new National Executive Committee elected in March, which has had four meetings to date. The standing committees as well as sub-committees and ad hoc committees have been convened and chairmen appointed. The industrial, investigating and medical referral subcommittees have been disbanded.

The alteration of examination results at the Pretoria College was discussed at the Council meeting held in April and an Emergency Council Meeting held in June, 1981. A round table discussion with representatives of the involved institutions was requested and this request has gone both to the Professional Board and the S.A.M.D.C.

It has been suggested that post-registration courses in Industrial/Occupational Physiotherapy, the Rehabilitation of Adult Hemiplegia and Exercise Therapy be investigated and various overseas lecturers have been approached in this regard.

The N.E.C. has been actively involved in various aspects of the career and salary structure of the profession. A comprehensive memorandum on all aspects of the profession was submitted to the Commission of Enquiry into health service under the chairmanship of Mr. Browne; the evaluation of the profession of physiotherapy by the Commission of the Administration was in progress and comments from the representatives in the various provinces will be collated by Mrs. van der Watt; a sub-committee had been appointed to investigate the situation of physiotherapists working in special schools; a memorandum was submitted to the Human Sciences Research Council dealing with the role of the physiotherapist in education and as an educator in general. When it became known that a proposed bill to provide for the practice of the professions of chiropractor, homeopathy, neuropathy and herbalist was once again before Parliament, a memorandum was compiled and an interview sought with the Minister of Health; the support of the M.A.S.A. and the S.A. Orthopaedic Association was requested and received, but the N.E.C. was informed by the Minister that the bill would no longer be discussed during the present session and an interview at this stage would be unnecessary. The draft constitutions of the S.A. Association of Sports Medicine was approved and a memorandum on the role of physiotherapy in the rehabilitation of physical disorders, in relation to the role of the physical educationalist in rehabilitation of physical disorders, was submitted to Col. E. Hugo. Australia, the USA, Canada, Israel, Britain, Germany, Holland and New Zealand were approached about the possibility of instituting an exchange system for physiotherapists and thus far only the USA had answered (see notices elsewhere in the Journal). The Department of Health had been approached to make posts of District Physiotherapy worthwhile to the incumbent expected to deliver the service in the community. The N.E.C. considered a suggestions put forward at Council as to the role the Society would play in co-ordinating and encouraging research in the profession and as a result a sub-com-

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mittee has been convened under the chairmanship of Mrs. J. Beenhakker (see notice elsewhere in Journal). Several members of the Society have had their papers for the Congress of the World Confederation for Physical Therapy provisionally accepted and Mrs. K. M. Levy and Mr. J. J. Craig have been proposed as honorary members of the 1982 Congress.

In discussing matters arising from the chairman's report it appeared that the S.O.F.S. Branch had considered asking Miss P. Davies to direct a course on Hemiplegia at the congress in 1983 and that Miss McPhee (industrial/occupational physiotherapist in Australia) had accepted an invitation to visit South Africa but that her dates were still uncertain. It was also suggested that the Joint Services Rehabilitation Medical Unit in the U.K. be approached for suggestions of courses/speakers on exercise therapy as the physical educationalists are becoming more and more involved in this field. The outcome of the Commission of Enquiry into the Health Services is awaited. Members reported on the evaluation of the profession of physiotherapy by the Commission of the Administration from various centres. It appeared that they were sympathetic, had worked from a comprehensive questionnaire and had interviewed staff particularly as regards provincial conditions of service and salary scales. It was reported that there would be parity of all salary scales from April 1982. New information could be submitted until December 4th and N.E.C. would ensure that all memoranda be submitted. It was suggested that salary scales be linked to the inflation rate, that a reasonable starting salary be established and that physiotherapists working in hospitals that are short of staff, as well as those in private practice and in training centres, be interviewed.

PROFESSIONAL BOARD

Mrs. Levy, Chairman of the Professional Board for Physiotherapy, reported on the two meetings that have been held since the last meeting of the N.C.R. At 30th June 1981 there were only 1 881 registered physiotherapists, as many have been erased through failure to pay their fees or to notify their change of address. Guidelines for the acceptance of qualifications in physiotherapy for registration purposes had not yet been finalised by the Lecturers Group and the Registration Committee, and it is proving a very difficult task as certain registerable qualifications at the present time may well be affected. Inspections of the final year examinations of the University of the Orange Free State and the University of Durban-Westville will take place at the end of 1981. It is hoped that the training at the Pretoria College for Physiotherapy will be changed to the University of Pretoria by 1982 (this has since been confirmed). The request by the Society to investigate the circumstances surrounding the granting of a diploma by the Department of National Education to a student alleged to have failed the final year examination had been forwarded to the Medical Council for consideration.

Applications for registration received from Austria, Belgium, France, India and the U.S.A. have been forwarded to the registration committee The final examination to register persons practising physiotherapy, but not holding a registerable qualification, was held on the 7th September 1981.

It appears that physiotherapy assistants will be placed on a supplementary register under the jurisdiction of the Medical Council and under the umbrella of the Professional Board. The Department of Health, Welfare and Pensions wishes to discuss the role of physiotherapy in the field of psychiatry with an ad hoc committee of the Medical Council and the Society, and this will be put to the Council in October. The comments of the Professional Board for Occupational Therapy on the overlap between the professions of physiotherapy and occupational therapy is awaited, but it appears that it may well be a question of semantics. All physiotherapists were requested to study the letter sent with the account for the annual fee asking them to ensure that they are employed by an approved organisation or institution. If they are in doubt they could write themselves or ask their employer to write to the Registrar, S.A.M.D.C. P.O. Box 205, Pretoria, 0001. The acceptance of introductory circulars distributed by physiotherapists, will necessitate an amendment to Rule 1 (b) of the rules by which registered physiotherapists are governed. When the suggested amendment is accepted by the Medical Council and promulgated, the society should give consideration to the amendment of its own ethical rules. A delegation from the Professional Board discussed the administration of drugs by physiotherapists with the Medicines Control Council but no comment had been received as yet. The Minister of Health has referred the report submitted to him by the Medical Council, concerning the increase in physiotherapy fees back to the Tariffs Committee for reconsideration and clarification of certain points (a raise of 33½% has since been agreed).

The formation of new Branches, such as for instance, East and West Rand was discussed, but it was pointed out that more information and statistics were required and that smaller branches had several problems. It was agreed that the matter should be discussed at the Southern Transvaal Branch A.G.M. and that a suggestion should come from the Branch and be brought to the next Council meeting.

STANDING COMMITTEES

Finance Committee

Mrs. Victor, Treasurer, presented the financial report. The Finance Committee has met three times since Council. The auditors will, in future, charge for time spent on the books. The financial statements were not ready for the meeting but will be tabled at the next N.E.C. meeting. Students' subscriptions were clarified, namely all students paid R4 capitation up to the 30th June, 1980, whilst final year students paid R2 for the period July/December, 1980. Negotiations are in process with two firms of insurance brokers and a recommendation will be made to the N.E.C. after a further meeting of the financial committee. It is expected that expenses for the IXth International Congress in Sweden will be high and it is hoped to receive sponsorship for this. Donations from post-registration courses were received from Southern Transvaal and Natal Coastal (two courses) Branches. Thus far there has been a poor response to the advertisement for a paid general secretary (on a sessional basis). In discussion branches were reminded that they are responsible for journal subscriptions for honorary life members of the Branch. Branches were also requested to submit a list of members *with their categories* in duplicate so that one copy could go to the N.E.C. and one copy to the Journal Circulation Manager.

Editorial Board

Miss Chatterton, reading the Editorial Board report, explained that advertising rates and non-member subscription rates had been increased in view of the escalating costs of paper and printing. An appeal was made for a representative to make contact with potential advertisers in the Reef area. Free advertising on an exchange basis had been agreed to with Physiotherapy Canada and Physiotherapy (C.S.P.). In discussion Branch Secretaries were requested to print or type changes of address in duplicate and to add postal codes. The

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Obstetric Association questioned being charged R24 for an advertisement and it was explained that this was Journal practice where a Branch/Group/Association charged for the course being run.

Registration Committee

In reporting on the Registration Committee Miss de Bruin said that an application form had been drawn up and sent to the Professional Board for comment; it is hoped that this will assist S.A.M.D.C. and speed up the procedure of registration. Limited registration was recommended for applications from Austria and Belgium and those from France and India were not recommended. Canada and Zimbabwe enquired about evaluation of credentials of "foreign physiotherapists" and the importance of interaction with overseas physiotherapists was stressed.

APPOINTMENTS INFORMATION SECRETARY

The Appointments Information Secretary, Miss Blake, stated that there had been an increase in enquiries. It was agreed that N.E.C. request the exact requirements for registration with the S.A.M.D.C. Applicants should be warned that limited registration could last for up to a year and a certificate or a certified copy of registration should be sent to facilitate the granting of a work permit.

SUBCOMMITTEES

Actions Committee

Mrs. Glauber reported on the activities of the Actions Committee which intends to employ a professional public relations firm to improve the image of physiotherapy in the eyes of the public and the medical and allied professions. To defray the cost of this it was suggested that a voluntary levy be placed on each member or that Branches raise a set amount. Mrs. Keays will continue with the slide-tapes programme and other channels of publicising physiotherapy, such as articles in Medical Association newsletters, Microphone In, Audio-Mix and the Star are being investigated. In discussion the meeting agreed in favour of the project but it was felt that sponsors could be found to help pay for this venture. The mechanism of Branch payment was referred to N.E.C. for decision.

Constitution Committee

The Constitution Committee report was read by Miss Irwin-Carruthers. Mrs. Levy had agreed to act on this committee in an advisory capacity. The most economical method of printing amendments will be investigated as it is not feasible to reprint the constitution as a whole.

AD HOC COMMITTEES

Mrs. Beenakker reported on the Committee to investigate services for the aged (taken together with the S.A. National Council for the Aged) and said that S.A.N.C.A. had discussed the role it will play in organising the year of the aged. Posters and pamphlets on various topics were being prepared, a co-ordinating committee had been formed and Branch Secretaries had been asked to consider various proposals and supply suggestions to the committee. It was felt that people who care for the aged should be educated on correct handling, and that the role of the physiotherapist in the care of geriatrics should be emphasised by the media. Mrs. Hack reported on the various interesting activities in which Branches had participated during the International Year of Disabled Persons and made a final appeal to sell car stickers.

BRANCHES

Branch representatives reported on various activities as a contribution to the International Year of Disabled Persons, annual general meetings and Branch lectures covering interesting subjects such as Perthes hip, training the visually disabled, rheumatic conditions, sports injuries, diagnostic ultrasound, chronic obstructive airways disease and cerebral palsy, the use of electricity in the control of pain and to treat non-union of fractures, psychiatry, scoliosis and adult hemiplegia, to name but a few. Mrs. Shrock conducted ante-natal courses at several of the Branches. Maitland courses were held, as well as symposia on a variety of subjects. Northern Transvaal reported that the congress proceedings should be in the post in the near future (these have since been sent out). Southern Orange Free State reported that they were busy organising the National Congress to be hosted by their Branch in 1983. The theme will be "The Seven Ages of Physiotherapy". This will be followed by the council meeting.

SPECIAL INTEREST GROUPS/ASSOCIATIONS

Mrs. Beenhakker reported that the Lecturers' Group had elected Miss J. Blair an honorary life member and that new registerable qualifications approved by the Senate of the University of Stellenbosch and the Department of National Education were: a one year B.Sc. (Hons) course in Mobilisation and Manipulation; Intensive Care; Paediatric Neurology (Neuro-Developmental Therapy); Adult Neurology; Obstetric Physiotherapy. A workshop on implementation of clinical examinations rather than examinations on models is being planned and quarterly production of the newsletter is to be resumed. Mrs. Edeling reported that the Manipulative Therapists Group will be holding a shoulder course in November, that a 72 hour course will be held in 1982 in conjunction with the University of Stellenbosch, and that an article is being prepared for the S.A.M.J. Miss Ferguson reported that the National Hospital Group held discussions on all aspects of national administration and that Mr. A. Rothberg had been made an honorary life member. The Natal and Cape branches were well established and the new Intensive Care sub-group hoped to initiate a country-wide trial on an aspect of intensive care. In reading the Obstetric Association report Mrs. Pretorius stated that the library service is proving popular, and that an information leaflet on starting an obstetric practice and a new 1982 register were being compiled. A day course by Mrs. Shrock was held in Johannesburg. Inclusion of an item for obstetric physiotherapy in the medical aid tariff fees is being investigated. Attention was drawn to the interest shown by sports researchers, gymnasium owners and the lay public in fitness in pregnancy and training centres, and members were asked to stimulate research in this field. Mrs. Edeling reported on the Private Practitioners general meeting and the election of Mrs. Pilkington as honorary life member, a matter which had to be referred to N.E.C. Negotiations continued for an increased professional liability insurance, attention was drawn to the proposed Associated Health Professions Bill (this has been withdrawn at present), the availability of physiotherapists to treat patients referred by the district surgeons at adequate remuneration was pointed out and many members in private practice were considering contracting out of the medical aid schemes due to escalation in costs of running a private practice.

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REPRESENTATIVES ON NATIONAL AND INTERNATIONAL ORGANISATIONS

Mrs. Mathias, in reporting on the National Council for the Care of Cripples in South Africa, said that there had been much interaction between physiotherapists and the committees of Cripple Care, but there had been some discussion on the motivation of the patient by the physiotherapist and it was felt that more could be done in this regard. Mrs. Utermöhlen reported that the National Council of Women in South Africa had had various lecturers on the I.Y.D.P. themes and were at present investigating the shortage in nursing and para-medical staff. Miss Irwin-Carruthers said that the present chairman of the South African Neurodevelopmental Therapy Association was Mrs. R. Battison (a physiotherapist). Updating the existing standards for certification of instructors and for design of courses, is being considered. The 1982 course to be held in Natal is greatly over-subscribed and there is a demand for a further course in the Transvaal.

W.C.P.T.

There were no motions from the S.A.S.P. to the general meeting of the World Confederation for Physical Therapy. Two alternate delegates are allowed (two votes) and these will be appointed by N.E.C. The agenda for the general meeting will be sent out in January 1982 and a special N.E.C. meeting will be held to discuss this and brief the delegates. Miss Bowerbank reported that she was investigating the possibility of cheaper accommodation in Stockholm and interested persons should contact her. Two papers had been withdrawn and members were reminded that all papers had to be recommended by the Society.

GENERAL

In discussion it was agreed that a general practitioner may carry out ultra-sound therapy provided he does the treatment himself. It was felt that elderly patients who wished to attend Keep Fit prophylactic classes need not be referred by a doctor, provided that they are reasonably healthy. Concern was expressed at the degree to which physiotherapy is being taken over by other professions.

NEXT MEETING

The next N.C.R. meeting will be held in Johannesburg on 20 March 1982.