Physiotherapy *is* Handling

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Summary: This paper argues that the physiotherapy profession has its core of professional expertise in manual therapy, movement and mobility and must say so out loud in order to prevent the encroachment of others and to give physiotherapy a coherent and central public image.

Biography: At present District physiotherapist at Doncaster, Mrs Williams trained at the Sheffield School of Physiotherapy and worked at Oldchurch Hospital and St John's Hospital, Romford, before leaving for posts in Chicago; Greenwich, Connecticut; and Palo Alto, California. She returned to work in Rotherham and then held teaching posts in Sheffield before joining Doncaster Health Authority. She has held many posts on CSP and other committees and has served on the CPSM Physiotherapists Board.

THE Founders' Lecture is intended to remind us of our Society's beginnings, yet at the same time take us into the future. It should also be philosophical and reflective, and yet a challenge. The three themes of this lecture are to my mind interlinked. I hope to draw them to a conclusion about the profession which we must all consider. These three themes are first: the image of our profession, and how we describe ourselves; second, the historic base of our profession and the reason for its existence given in the Charter, and third, our professional growth and our future.

The Image of Our Profession

It worries me that the profession does not yet have the image that it ought to have. It worries me very much indeed that newly qualified physiotherapists cannot define physiotherapy. It worries me even more that when I ask superintendents and seniors that question, neither can they. The public and our professional colleagues find it difficult too. It is not a word that has been easy to define for anyone. We had an image that was simple once, but our current image is not at all clear.

Defining physiotherapy matters a great deal, and it is going to matter far more in the future. *The Australian Journal of Physiotherapy* in January, 1985, published an article called 'The marketing of physiotherapy services', which discussed the problems of professions which traditionally have not advertised. In our profession, indeed in all health professions, there is more competition nowadays. The public is growing more health-conscious and will turn to all sorts of people for help. If there is no clear image of physiotherapy, they will not know why they should come to us and they will not do so.

I was talking recently to a Chartered surveyor who had just given a lecture on how Chartered surveyors define their image and how they sell themselves to the public. I really mean marketing, ie the strategic planning before you actually sell. It is the kind of image and concept and model that you develop before you plan your sales strategy. Our founders knew that this was necessary and they went to a lot of trouble to think about the image that they wanted to present for massage — because it mattered.

The Australian article says: 'Marketing is a total approach. It places the customer in the centre of things. This really means that instead of approaching physiotherapy as a set of skills, one must look at the exchange from the patients' point of view because it is the customers who buy a bundle of benefits from you rather than the product of the service. A manufacturer of drill bits may think that the customer is buying a drill bit, but what the customer is really buying is a quarter-inch hole'. In the physiotherapy service what we must do is ask what needs we are meeting and what really is the bundle of benefits that we are providing to patients and to the NHS. Why should they want it? But if we cannot define it, they will never know the answers to these questions.

A story which appeared recently in the *Sunday Times* described the research for the new Guinness advertising campaign. They were asking: 'What is it about this product that is the distinguishing factor, that separates it from all other products in the same field — what makes our particular product different?'. Once you know this then you can decide how to sell. There are very clear dangers in not having an image. If we do not have one of ourselves, a very clear one, we do not know what we are doing. We do not know where to say our expertise lies. And the public do not know how to say whether they need us or not.

It was fairly clear to our founders in 1894 what they were selling. They knew what it was. It was trained, respectable masseuses. But if we look at today's physiotherapy, it is not clear. The table shows a list of headings in recent issues of *Physiotherapy* and some Congress themes. They do not fit the Society of Trained Masseuses, or appear to be related at all to the origins and foundations of the Society.

The term 'physiotherapy' was first used on July 15, 1905, in a letter in the *British Medical Journal* which referred to the abuses caused by healers who pretended to treat by therapeutic procedures. Nothing actually changes in this world! It went on to advertise the first international congress of physiotherapy which was held in Liège, August 13 – 15, 1905.

Subjects of articles in recent issues of *Physiotherapy*

Stress incontinence
Behaviour modification in rehabilitation
EMG biofeedback
Sports injuries
Mental handicap
Preventive exercises
Speech and swallowing
Paediatric development
Hyperventilation

Physiotherapy was described there as involving the treatment of chronic disorders not helped by drugs, and including hydrotherapy, light, movement, electrical therapy, X-rays and massage. Quite interesting!

The current *Oxford English Dictionary* describes physiotherapy as 'the treatment of diseases by natural remedies: massage, electricity, light, heat, fresh air, and so on'. You will note that we have lost movement and appear to have lost X-rays; and we are no longer treating chronic disorders and we are into diseases. But it is interesting to consider the actual words in this one. Do physiotherapists actually treat disease? Do we treat pathology? I suggest to you that today we do not or at least only rarely. If not, then what do we do? Let us try our own professional documents.

For us in the UK, of course, the most important definition is contained in our Royal Charter, which was granted in 1920 by George V. It says that the Chartered Society was established and incorporated 'to improve the practice and training and education of the persons engaged in the practice of massage, medical gymnastics and electrotherapy or kindred methods of treatment'. When I show students that, they groan. It is not physiotherapy as they perceive it, they dislike the old-fashioned sound to it, they dislike the technique-oriented concepts implied in it and they seem somewhat ashamed of it. It does not sound scientific.

However, when one asks them or for that matter any experienced physiotherapist for a definition that they do like, and with which they feel happy, on the whole people are at a loss. The type of phrases that one hears are usually about rehabilitation, or mobility. Physiotherapists are concerned that there is no easy explanation. They are very often faced with a public which does not understand what they do and they frequently feel that their medical colleagues do not always understand, either.

Of more concern is the lack of a model of physiotherapy on which to base our practice. When a junior physiotherapist is asked which patient it would be most important for a physiotherapist to treat, a chronic bronchitic with retention of sputum or a person with broncho-pneumonia and a temperature of 103°, they find it difficult. The reason is that they are operating on a medical illness model. They have not developed a physiotherapeutic model. In the medical model one does deal with pathology; one labels it and looks for treatment and cure. It is a model which puts a high priority on saving life. But physiotherapy is not about pathological diagnosis. It is about disorder and about problems of function and ability.

Inexperienced physiotherapists who believe themselves to be operating on a medical model of physiotherapy will assume that the urgent and problem patient must be the one who is most ill. They will tend to judge that by pathological symptoms like temperature. On the other hand a physiotherapist who can see her role using a model of physiotherapy which encompasses problems of function such as inability to clear sputum will see that it is her job to assess that problem and deal with that and not the temperature.

The temperature is *not* a physiotherapeutic problem. Is the model we should have of physiotherapy one of assessing and dealing with problems of function? This does not get us much further, however, if we look at our third example, which is the definition of physiotherapy from the CSP curriculum for 1976, ie that physiotherapy is the treatment of disease and injury by physical means. At least we extended into the field of injuries, but it still talked about disease and treatment, which was very limiting. I suggest that we have no option but to go back to the early definitions, those in the Charter. We must ask if these definitions remain the base of the profession, or have we (as the table seems to suggest) grown so far away as to be unrecognisable in those terms? — which is how our juniors feel.

The Historic Base of Our Profession

Let us therefore begin by taking the three components of physiotherapy as given in the Royal Charter — massage, medical gymnastics and medical electricity — and look at current practice in relation to them. Massage is our oldest element by a long way. It is defined, if we go back to the Oxford English Dictionary, as *'the application with the hands of pressure and strain upon the muscles and joints of the body in order to stimulate their action and increase their suppleness'*. There is nothing there which has changed. We are less happy calling it massage now, but it *is* what we do every day. This use of hands is basic to physiotherapy.

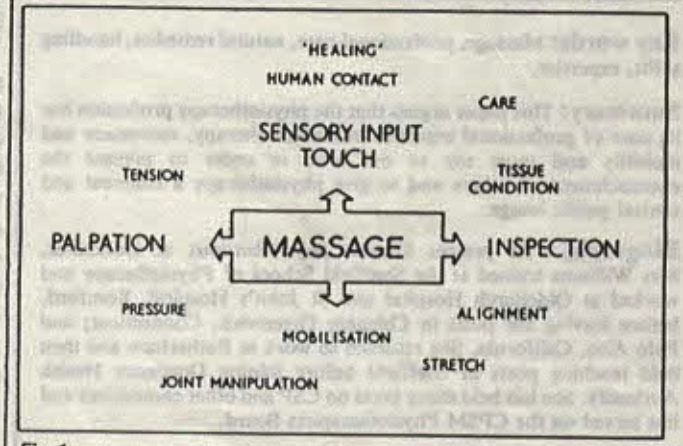

Fig 1

Massage is our central core (fig 1). In this profession we use our hands, for palpation, to explore tissue condition, to feel for alignment, to feel pressure, to feel tension. We have another way too of using our hands: we use them in a therapeutic healing way, we touch people, we stroke people, we have a healing sensory touch that expresses care and human contact. We do not say this aloud very often, but all physiotherapists know that it is part of what we do, and with virtually every patient we meet. Other professions do not do it, and the difference is quite marked.

Massage has led us into the whole area of tissue manipulation, mobilisation, stretching and joint manipulations. From our original basis of massage we are spreading out into these quite legitimate fields; they are the areas of physiotherapy which have come from that original base, from our central core. And from massage we have developed very specialist skills, such as chest clearance, manipulation, neuromuscular feedback and sensory input techniques.

Indeed from massage I suggest we have evolved two key strands of modern physiotherapy. First, we are the profession which uses touch for sensory therapeutic input and healing; second, we are the profession which uses manual skills for manipulation of joints and tissue. *We use our hands, we are manual therapists.*

Medical gymnastics (fig 2) was another of our core elements, with its origins in Swedish remedial gymnastics. It has led us to become experts in normal and abnormal human movement. We have developed skills of observation and analysis, in which we use our hands. One does not work in this field without touching patients. We deal with biomechanics. We align people for posture. We deal with strength, weakness, neuromuscular control and balance, in all cases using manual feedback. We deal with stiffness, mobility,

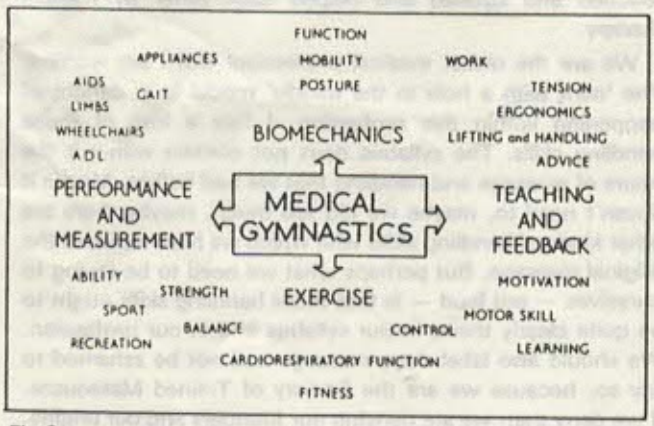

Fig 2

function, activities of daily living, fitness, cardiac rehabilitation, recreation, sport, injury prevention and health education. They all form other strands from our original theme of dealing with human movement and the teaching skills related to human movement. The underlying academic base of medical gymnastics means that we have a thorough understanding of biomechanics, of physiology, of performance, of teaching and of exercise theory. Those areas are still within the compass of hands. One rarely uses an enormous amount of machinery.

From medical gymnastics, then, come two further key themes. First, we are the profession which within orthodox medicine contains the experts in problems of function and mobility and in the physical and physiological basis of dealing with and preventing injury, by natural methods based on active movement. Second, we are expert in teaching and in dealing with the motivational basis of problems of disability and function. We handle patients physically and we handle them mentally.

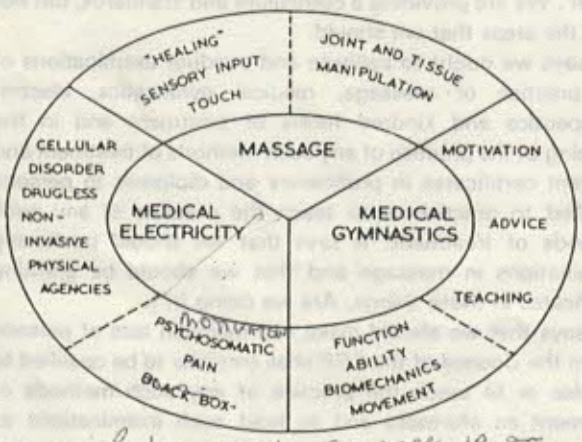

Fig 3

Behavioural Science is an important element in context

The final element of our core is that of medical electricity and kindred treatments (fig 3). From this we deal with cellular, neuromuscular and circulatory disorders. We also have a psychosomatic element, a 'black box' component which is important in the psychological way in which we handle our patients. The placebo effect and the endorphin consequences are important in physiotherapy.

To take two strands from this: first, we are the profession which within orthodox medicine uses natural physical agencies which affect cellular activity, pain and function; and second, we are a profession which uses natural physical agencies for their recognised effect in changing patients' perception of pain and for the way in which they themselves can handle pain. By putting these three historic bases at the centre of the model that is physiotherapy, we begin to see a network developing. If we take the six components which are derived from our three core areas, we can see a series of rings evolving which lead us very clearly to the academic basis of the profession. One can also regroup these six strands. By putting joint manipulation, exercise and the physical effects together we have a basis for the science side of our profession, with its academic bases in physiology, physics and anatomy and biomechanics. In the other three components we have the touch and healing, we have our behaviour and social sciences and our holistic view of patients as people — the arts and human side of our profession. We rely on both science and art. We have a manual art that is our core and very important. We have been in danger of forgetting it in the past few years. Because we were told that we were not evaluating our work and that we were not doing research, we thought only scientific things counted. We were in danger of forgetting the other half, perhaps the most important part of the way in which a profession like ours works; at risk of allowing other people to define our profession for us. This serious threat has now been overcome.

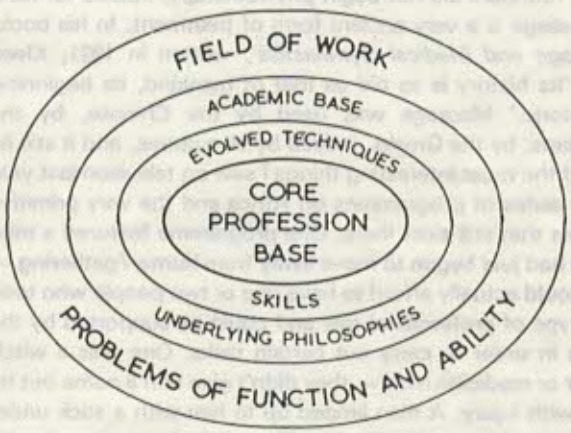

Fig 4

So we have a model of a profession (fig 4) — and one could use this type of model for any profession. The model shows a profession as having a central core, a professional historical base. From that core evolve the techniques and skills which the modern profession uses, leading to an understanding of its academic base and underlying philosophies. From there one can define the field of work. We deal with problems of function and ability, so we can put in our central core and say this model is physiotherapy and physiotherapy only. Another profession would have to put a different core in the middle.

This concept of a profession having grown from its professional core which is unique to that profession is important. If one loses that professional core one develops the model of a profession that is like a mint with a hole in the middle. And some professions are in grave danger of losing or abandoning their core, and thus of moving out into related techniques and losing their reason for existence, because inevitably these rings will continue to open out and begin to overlap with other professions. Our profession would be very unwise to let that happen. We have a very strong central core, we have held on to it, and we must ensure that we continue to do so.

We also need to try to find a concise phrase to sum it up. I tried to sum up physiotherapy in one sentence, but it became 40 words long. We do need to say that we deal with problems of function, and to indicate not only that we deal with them, but that we identify them. I do not think that other people tell

us what those problems are. Our profession makes its own therapeutic diagnosis; we identify the problem. We are presented with a patient who has some kind of a difficulty, then we look at it and find the underlying problems of function. We assess that and work out how to deal with it and how to prevent it from recurring. Junior staff are probably right when they groan at old terms like medical gymnastics — they do not convey much today and they are not very helpful. But I do like the Oxford English Dictionary definition of physiotherapy as being the use of natural remedies; that is an appropriate model for today. It distinguishes the way we work and makes our approach distinct from drugs and from surgery. We will also need to define what kind of problems and disorders we deal with, indicating that they are not necessarily diseases.

This is my definition: 'Physiotherapy is the identification and assessment of musculoskeletal and neuromuscular disorders of function including pain and those of psychosomatic origin and of dealing with or preventing those problems by natural methods based essentially on movement and manual therapy and on other physical agencies.'

There is no other profession which could define itself quite like that. It is a definition based on our core skills. It defines what we deal with and by what methods.

Professional Growth

Our founders did not begin physiotherapy, indeed far from it. Massage is a very ancient form of treatment. In his book, *'Massage and Medical Gymnastics'*, written in 1921, Kleen says: 'Its history is as old as that of mankind, its beginning prehistoric.' Massage was used by the Chinese, by the Egyptians, by the Greeks, indeed by all cultures, and it still is. One of the most interesting things I saw on televison last year was a series of programmes on Africa and the very primitive cultures that still exist there. One programme featured a tribe which had just begun to move away from hunter/gathering — they could actually afford to have one or two people who took on a type of professional role and could be supported by the others in order to carry out certain tasks. One was a witch doctor or medicine man — they didn't give him a name but he dealt with injury. A man limped up to him with a stick under his arm, a clear sprained ankle. The witch doctor examined it and his handling was superb. He did an assessment of which any physiotherapist would have been proud. He had obviously been doing it for years. He did not have an academic base in the sense of anything formal, but with his hands he did know. Physiotherapists *know* with their hands. They learn through their hands and it is extremely difficult for them to express what it is that they know. This man quite clearly knew about ankles. He also did an excellent peripheral mobilisation, he got that foot straight, put the man to standing up, and made him do some balance reactions with it. Off walked the patient with no limp and I was utterly impressed. I felt in tune with that therapist. Throughout the world and throughout history there have always been people like us doing the same job as we do. We do it in our society, within our culture, he was doing it in his society and within his culture, but we were the same, we were using the same skills, we were the same ancient profession.

In ancient Greece the gymnasia were places where one went for help and advice with problems of pain and function. They had gymnasium directors who were experts in massage and exercise. We know of one — Proditus — who was written about before Hippocrates. We are carrying on a tradition thousands of years old — we are perhaps the second oldest profession. I would suggest that we are the first branch of medicine. There were others, apothecaries and barber surgeons, but they were the second and third branches of medicine. We were the prehistoric branch where people touched and stroked and helped each other by manual therapy.

We are the oldest medical profession! But I am worried. The 'mint with a hole in the middle' model is in danger of happening within this profession. I fear a loss of those handling skills. The syllabus does not contain within it the hours of massage and handling that we had before. Maybe it doesn't need to, maybe we did too much, maybe there are other kinds of handling skills with which we have replaced the original massage. But perhaps what we need to be saying to ourselves — out loud — is that those handling skills ought to be quite clearly there, in our syllabus and in our profession. We should also label them massage and not be ashamed to say so, because we *are* the Society of Trained Masseuses. If we deny that, we are denying our founders and our origins.

Beware of that mint model and of the vacuum. There are other groups who are beginning to fill in vacuums because they never last long. Other people, recognising that we have not lately said that we are the society of massage, have begun to claim that they are masseurs. They are running courses and providing certificates and they are becoming the massage profession in this country. If we are letting that happen, we are not fulfilling our Charter, which says: 'The objects for which the CSP was established and incorporated are: to improve the training, education and professional status of persons engaged in the practice of massage, medical gymnastics, electrotherapeutic or kindred methods of treatment and to foster and develop these.'

Are we doing that — fostering the use of these treatments and developing them and doing the research into touch and handling that a profession should if they are its core base? Or are we rather sliding off into other academic worlds that really belong to other professions, and ignoring our own?

The Charter also says that we should 'promote for such persons a curriculum and a standard or standards of qualification'. We are providing a curriculum and standards, but not in all the areas that we should.

It says we ought to institute and conduct examinations of the practice of massage, medical gymnastics, electrotherapeutics and kindred forms of treatment and in the teaching of the practice of any such methods of treatment and to grant certificates in proficiency and diplomas to persons qualified to practise or to teach the practice of any such methods of treatment. It says that we should be having examinations in massage and that we should be granting certificates in those things. Are we doing it?

It says that we should make and maintain lists of persons whom the Council of the CSP shall consider to be qualified to practise or to teach the practice of any such methods of treatment as aforesaid and to hold such examinations as aforesaid and to grant certificates. If other people are now awarding certificates in massage and we are not, then we have betrayed our founders. We were given the Charter so that we and no one else would be the approved qualifying body for massage in the UK.

The core of this profession is our hands, for we are the profession which uses hands and handling to assess. We are the NHS experts on manual therapy and movement and mobility, and we must say so. We are the profession in the NHS which carries the responsiblity for that. No one else does. We should reclaim our base. There is a whole public relations exercise to be developed over the next few years

based on the concept of physiotherapists who handle. There are some very valuable images one could develop using hands and handling.

The base of our profession was the Society of Trained Masseuses, validated and agreed by a Charter and by our examinations. That is what our founders gave us, expertise with our hands, and what they expected us to carry forward. It is that expertise we should be marketing, which makes us significantly different from other professions, and what we should make sure all our students have. We have an image that we can market. We should be using our badge — it has hands on it. We should have a logo which clearly shows those hands and we should say quite clearly and out loud that physiotherapy *is* handling.

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