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</table>

$\chi^2 = 15,28$ (acquired chi-square).
Degrees of freedom = 2.
Critical 5% level = 5,991.
1% level = 9,210.

Fig. 3

from unnecessary psychological and physical trauma during recurrent periods of hospitalisation and the family will be spared unnecessary expense. Every physiotherapist should therefore motivate the parent of such a child to become a member of the team.

References

TREATMENT NOTE:

SHORTWAVE DIATHERMY (S.W.D.) IN THE TREATMENT OF UNRESOLVED PNEUMONIA
S. H. M. BLACKWOOD, M.C.S.P., Dip. T.P.*

OPSOMMING
Dit is gevind dat pneumonie in die konsolidasie stadium effektief behandel kan word met kortgolfdiatermie om sodoende resolusie aan te help. Sommige chroniese borse, byvoorbeeld asma en enfisem, vind ook hierby baat. "n Deur-en-deur aanwending word gebruik en asemhalingsoefeninge moet altyd daarmee saam gedaan word.

How many physiotherapists know the frustration of treating a pneumonia which refuses to resolve. In spite of chemotherapy, postural drainage, percussion, shaking and vibrations, rib-springing, breathing exercises and the patient's own activity, back come the chest radiographs still showing that resolution has not occurred.

Many years ago, when all efforts to clear up a pneumonia in a patient who was herself a doctor had failed, it was decided to try shortwave diathermy. The patient was intermittently febrile and chronically unwell. The resistant patch of inflammation was situated in the anterior segment of the right lower lobe. Application was through-and-through this area with a large malleable electrode placed posteriorly and a medium glass electrode placed anteriorly with close spacing. Initially four mild thermic treatments of fifteen minutes duration were given twice a day for two days. The patient was sent for chest radiographs which showed a marked reduction in the size of the inflammatory patch. A further six treatments were given in exactly the same way for the next three days. At the completion of the course the chest radiographs were clear and the patient was feeling well.

As a consequence, over the years SWD has been used routinely by me and now in my practice for unresolved pneumonia. Application has always been as described, the electromagnetic field being directed as nearly as possible through the area of inflammation. It has been found, however, that one daily treatment of twenty minutes' duration is equally effective. A maximum of six to eight treatments should be given. If there is no change in the size of the pulmonary opacity, then some other lesion is present, possibly sinister, and the patient should be referred for further investigation. Check radiographs should be carried out after three or four treatments and if there is seen to be an increase in the size of the opacity then treatment should be stopped immediately.

As a further consequence SWD was tried for some other chronic respiratory disorders and found to be useful in the treatment of emphysema, asthma and chronic bronchitis. It is NOT used, however, in the treatment of bronchiolitis and bronchopneumonia in babies and young children.
The critical incident technique in physiotherapy education

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Report of a pilot study undertaken to determine the behaviour of an effective physiotherapist. The critical incident technique was used to collect data from 30 practising physiotherapists and 300 separate incidents of effective and ineffective behaviour were identified. On the basis of this study, the desirability of objectively identifying curriculum content in physiotherapy education has been established.

One of the problems facing physiotherapy educators today is what should be taught and what should be deleted from the rapidly expanding undergraduate curriculum. We must establish whether the present syllabus is meeting the needs of the society in which the physiotherapist will practice and ensure that the needs of the students are also being met.

Of the many studies that have been done by the various professions, one of the most promising methods of determining curriculum content appears to be the critical incident technique.

By incident is meant a unit of observable human activity which is sufficiently complete in itself to allow inferences to be made about the person performing the act. A critical incident is one which leaves the reader little doubt regarding its effectiveness or ineffectiveness.

The critical incident technique was evolved by Hanagan (1954) and he has used it as a basis for studies in many varied fields. Jensen (1960) and Barham (1963) have applied the technique to different aspects of nursing and a large study in Orthopaedic training was described by Miller (1968). In these studies, practitioners in the various professions were asked to describe a situation, record what action was taken by the person observed and what the result of the action was. Once the incidents had been collected, it was possible to identify the key actions of the profession being studied.

A pilot study was carried out by the Physiotherapy Department of the University of the Witwatersrand to determine whether the critical incident technique would be a practicable method of establishing what behaviours characterise an effective physiotherapist.

METHOD

Six physiotherapy colleagues were chosen to carry out the study and each was asked to approach five senior physiotherapists representing hospital and private practitioners, as well as those from special institutions.

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Opsumming

Verslag van 'n voorlopige studie wat onderneem is om die gedrag van 'n doeltreffende fisioterapeut vas te stel. Die kritiese incident tegniek is gebruik om data van 30 praktiserende fisioterapeute te versamel en 300 aparte insidente van doeltreffende en ondoeltreffende gedrag geïdentifiseer. Op grond van hierdie studie is die wensklikheid van objektiewe identifisering van kurruluminhoud in fisioterapie-onderwys vasgestel.

and training centres. There were eight physiotherapists from private practice, live from cerebral palsy schools and institutions, thirteen in hospital employ and four at training centres, who took part in the study. These 30 physiotherapists were given 10 forms each in which to report incidents which they considered to have had a positive or negative outcome, as regards effectiveness. To ensure the collection of a full spectrum of behaviours in the cognitive, psychomotor and affective domain, the areas suggested for collection of the incidents were:

- Interpersonal relationship with the patient, his family or other members of the health team.
- Intellectual — use of problem solving and other skills in the assessment of the patient or situation as well as the planning of a treatment programme.
- Technical — methods of carrying out the assessment or treatment programme.

Of the 300 forms given out, 180 were returned in time for the study which was limited to an initial six week period. As several of the forms had more than one reported incident, 300 examples were collected which fell under two or more of the main areas. Each incident was extracted from the form and recorded on a separate card.

The first analysis of the data was done in June, 1979, when 194 incidents were identified. In July, a further 106 incidents were categorised and of these only one was found to be a new behaviour (Table I).

Each main area was subdivided according to the incidents, and as new behaviours were received, new sub-areas were formed, e.g. A-1-Relationship with patient (a) Listens to patient, (b) Explains to patient, (c) Gains patient's co-operation etc.

ANALYSIS OF DATA

The validity of the interpretation and classification of the incidents was checked by submitting a random sample of the cards to two of the co-workers. These workers then sorted out the cards under the various areas and it was found that there was a ninety-five per cent agreement in their classification as compared