causes vasodilation which modifies the kpc value for each tissue. Thus the tissue does not display the same heating pattern as would be expected in a similar system, without blood flow.

Temperature increases stimulate an increase in blood flow and this has a cooling effect on the tissue (Stoll, 1960). It was observed that the lateral subcutaneous tissue cooled down most rapidly, followed by the muscle and medial subcutaneous tissue, bone having the lowest cooling rate. In those cases where blood flow changes appear to have been minimal, cooling occurred more rapidly after the 1,5 MHz application than the 3 MHz applications. However, once blood flow changes had been induced, this pattern changed. The cooling rate was variable, probably due to inconsistencies in blood flow changes.

CONCLUSION
The results of the trials conducted led us to conclude that an increase in temperature can be induced with continuous ultrasound at therapeutic frequencies, intensities and times. The amount of heat produced at different depths changed with intensity and time.

We feel that this study highlights the need for further research to determine the point at which high intensities produce dangerous temperature increases.

References
QUESTION 2

Is the physiotherapy you prescribe mainly prophylactic or curative?

(a) Prophylactic only ...................................................... 8% (4)
(b) Curative only ......................................................... 16% (8)
(c) Both ................................................................. 75% (36)

Self-explanatory answers.

QUESTION 3

Do you think your knowledge of physiotherapy is sufficient? If not, how could it be improved? (A comment was asked for).

Yes ........................................................... 14% (7)
Without comment .............................................. 4% (2)
With comment .................................................... 32% (16)
No .............................................................. 4% (2)
Without comment .............................................. 86% (41)
With comment .................................................... 8% (4)

Some of the comments were that there was a need for: better liaison between Medical Officer and Physiotherapist (12); lecture/demonstrations (18); individual hospital staff talks by the Physiotherapist (7); more physiotherapy lectures at undergraduate level (3); visits/demonstrations in Physiotherapy Departments (11). One improved his knowledge by reading. From the Medical Officers' comments there was an obvious awareness of their lack of knowledge and a marked willingness to learn more.

QUESTION 4

When you prescribe Physiotherapy, are you aware of what physiotherapy modalities will be used?

Yes ........................................................... 56% (27)
No .............................................................. 4% (2)
Unsure .......................................................... 40% (20)

This was an interesting result. It is our general experience that though most Medical Officers are aware of some modalities physiotherapists use, they do not seem to know their specific applications, nor the full range.

QUESTION 5

Are you aware of the Day Hospital's Domiciliary Physiotherapy Service?

Yes ........................................................... 50% (24)
No .............................................................. 50% (24)

A self-explanatory analysis. One presumes it is our fault that half of the Medical Officers had no knowledge of the service.
AIMS:

- Physical fitness and the development of agility, flexibility, strength and stamina.
- Movement development, i.e. the learning of new movement skills or patterns.
- Emotional and social well-being through self-achievement, competition and team spirit.
- Intellectual development — by way of physical education.

CONCLUSIONS

This survey highlighted areas where we as physiotherapists had fallen down in communication. It gave us guidelines for methods in which we can improve the doctors’ knowledge of physiotherapy. It also boosted our morale in that we realised that the majority of the medical officers appreciated us even if they were not all too sure exactly what we did!

Although the survey was conducted amongst the Day Hospital Medical Officers, we feel that it probably reflects the attitudes of Medical Officers in general. A similar survey conducted in a general teaching hospital may produce slightly different results.

Finally, the lack of knowledge of physiotherapy was obvious to all involved in this survey. Where does the fault lie? In the Medical Officers’ under-graduate training or in our poor physiotherapy public relations? Would effective physiotherapy treatment, good results and active communication of these results not be one of the best public relations methods we could use?

Reference


THE ROLE OF PHYSICAL EDUCATION AND SPORT IN A CEREBRAL PALSY SCHOOL AND THE INTERACTION OF THERAPISTS AND PHYSICAL EDUCATIONISTS


OPSOMMING

Die junksies van terapeute en liggaamlike opvoedkundiges in skole vir serebraalverlamdes word omskryf. Samewerking tussen terapeute en liggaamlike opvoedkundiges in die seleksie van sportaktiwiteite en posisiering van elke serebraalverlamde kind word beklemtoon. Die adolessente en volwasse serebraalverlamde het die reg om te besluit aan watter aktiwiteite hy wil deelneem, maar moet op die nadelige gevolge en fisiese agteruitgang wat verkeerde aktiwiteite tot gevolg mag he, gewys word. Die voor- en nadele van verskeie sportaktiwiteite word bespreek.

In order to clarify some misconception about the role of sport and physical education in a cerebral palsy school, it is necessary to define the aims of physical education and sport, and decide whether the methods of applying these aims are suitable for the physically handicapped, cerebral palsied child.

AIMS:

- Physical fitness and the development of agility, flexibility, strength and stamina.
- Movement development, i.e. the learning of new movement skills or patterns.
- Emotional and social well-being through self-achievement, competition and team spirit.
- Intellectual development — by way of physical education.

SUMMARY

The roles of therapists and physical educationists in cerebral palsy schools are described. Cooperation between therapists and physical educationists in selecting sporting activities and positioning of each individual cerebral palsied child is emphasised. The adolescent and adult cerebral palsied have the right to decide in which activities he wishes to participate, but the adverse effects and physical deterioration that can result from incorrect activities, should be pointed out. The advantages and disadvantages of different sporting activities are discussed.

One can see that there should be no difficulty in applying these aims to the psycho-neurologically disturbed (P.N.D.) or minimal cerebral dysfunction (M.C.D.) child, or to the child who is really minimally cerebral palsied (M.C.P.). This is said with certain qualifications, which we shall enlarge on later. It is also possible to apply them to the child with physical handicaps resulting from spinal or peripheral neurone damage such as paraplegia, poliomyelitis and even spina bifida in the absence of cerebral involvement.

To some extent the problem which we are about to discuss has arisen because of the exciting development of sport for the disabled which has taken place over the years, originating at the famous Stoke Mandeville Hospital, where one had the type of patient to whom the above aims would apply, with modifications. However, most of the children with physical handicaps in our South African cerebral palsy schools are there because of brain damage. They are referred directly, or indirectly, by the doctor who diagnosed the condition; to a special school where he expects that the child will receive the necessary remedial therapy.

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