Conference and course reports

Medico-Legal Expert's Certificate

Chartered Society of Physiotherapy, London, 25–27 July 2007

Have you ever wondered what it would be like to be an expert witness in court? I grew up in a legal environment and have always been interested in this aspect of practice. I have also been involved with physiotherapy regulation for many years, and have both taught on medicolegal issues and implemented these into clinical practice, so when I saw an advert for the Medico-legal Expert's Certificate course in *Frontline*, I signed up.

The course was organized by the Chartered Society of Physiotherapy, in association with InPractice Training, and all the students were physiotherapists. The aims of the course are for delegates to: gain a better understanding of the courts and their procedures; know what is expected of them as expert witnesses; and become more confident and competent in their role as an expert. The course consisted of 3 days of training in the classroom, including homework and a multiple-choice examination that had to be completed within 2 weeks of the course.

Our first day started with a discussion of the stark realities of being an expert witness, including the personal and professional risks. We were encouraged to consider these very carefully before undertaking the role because it can expose you to, amongst other things, a financial risk that may not be covered by your public liability insurance. For a moment, I thought that one or two participants might make their excuses and leave. Undaunted, however, we all stayed, continuing with sessions on topics such as the English legal system, civil litigation, accountability and the duties of an expert.

Remember hearing about Bolam and Bolitho? These were two of the key medicolegal cases that were explained at length. We had rules and procedures coming out of our ears, and then, just when we thought we could take no more, we started talking about report writing. We were given some witness statements and asked to write a medicolegal report during the evening that was to be handed in the next morning.

The second day covered issues such as consent, confidentiality and data protection. We also discussed practical issues like dealing with solicitors, establishing credentials and writing curricula vitae, developing terms and conditions, setting fees, and the process that follows report writing through to an appearance in court.

On the third day, we started with a barrister cross-examining us about our 'expert witness reports'. I felt that mine went fairly well considering how long it was since I had treated anyone with whiplash following an road traffic accident, although I was a bit 'stiff'. The solicitor who was facilitating the course was helpful in suggesting changes: in my case, to use my hands to express myself in the same way I do in other situations. We then spent a little time analysing the appearance of our peers from a 'court' perspective, which was interesting! Our facilitator also gave us tips on how to handle ourselves in court and how to control the situation as much as possible.

The multiple-choice exam was challenging. After about 3 weeks, an envelope dropped through the letterbox that contained a certificate from the Inns of Court School of Law, City University, London. Since then, I have been involved as a 'witness of fact' in a personal injury claim and have had the experience of giving evidence in court. I have also had the opportunity to observe expert witnesses in the same case – the style of experts varies widely, but I have seen how easy it is to get completely tied up in knots by an opposing barrister.

As clinicians, it is possible that some of you have already been a witness of fact. This is the most likely scenario that you will face as a clinician, and would involve you giving a statement and possibly evidence in a trial as a result of having direct knowledge relevant to a case (e.g. about the treatment you have given to a patient). The role of an expert is quite different: you have to be completely impartial, accurate, evidence-based as far as possible, and where an opinion is expressed, this has to be clearly stated. You have to expect to be challenged on everything that is written in a statement, and have to have the confidence and knowledge to

defend it in an adversarial court environment. If you were to consider working as an expert witness, I would thoroughly recommend this course – the role is challenging and risky, and is not to be undertaken lightly. As far as I am concerned, any opportunity to gain experience is to be grasped with both hands, so this training is essential in my opinion!

I would like to thank the ACPWH for supporting me with a contribution toward the course fees from the Dame Josephine Barnes Bursary. Prior to applying for this, I did some investigation amongst my peers and could not find any ACPWH members with this certificate. There is not much scope for personal injury expert witness work within the speciality of women's health, but there are other aspects of medicolegal work for which this qualification may be helpful. In fact, I have already been called on by the ACPWH with regard to medicolegal issues, and I am sure that I will be called on again. I am happy to share my knowledge and to support members with medicolegal issues in the future.

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International Continence Society 37th Annual Meeting

De Doelen Congress Centre, Rotterdam, the Netherlands, 20–24 August 2007

Having attended several International Urogynecological Association conferences, I was very much looking forward to my first International Continence Society (ICS) meeting. I travelled out on the Saturday afternoon and couldn't believe how smoothly the journey went: the transition from the airport at Amsterdam to the rail link to Rotterdam was so easy!

Rotterdam is the second largest city in the Netherlands and the largest sea port in the world. It is a modern place with a mixture of architectural styles – most dating from after the Second World War, when it suffered devastating bombing. The meeting was held in the De Doelen Congress Centre, which was a 15-min walk from my hotel. This provided a very relaxing start and end to the day since I was able to stroll through a wonderful shopping district!

On the Sunday, my journey to the centre was made even more interesting because the centre of Rotterdam had been taken over by a Formula One racing event. The Physiotherapy Round Table provided four very thought-provoking presentations and then a choice of interactive sessions on a variety of topics – I would liked to have attended them all!

The Monday and Tuesday were taken up with workshops. I chose ones on 'Incontinence in Children', 'Pelvic Floor Function and Dysfunction in Men', 'Update on Management of Overactive Bladder Syndrome' and 'Strategies to Implement Pelvic Floor Muscle Training During Pregnancy and After Childbirth'. This last session included an exercise class led by Kari Bø that I found very challenging to the pelvic floor because it involved a maximum pull-up with fast flicks superimposed!

The lectures were all very stimulating and varied: there was something for everyone. This type of conference is a wonderful chance to hear lively debate, discussion and disagreement between those whose names have previously only been known through papers.

One of the most memorable lectures was by Andrew Browning, who discussed 'Obstetric Fistula – Past, Present and Future'. He told us about his work in Bahr Dar Hospital, which is linked to the Fistula Hospital in Addis Ababa. I have never seen a presentation receive such a standing ovation as this one did – truly inspiring work!

The social events were great fun and very entertaining. The gala dinner was held in St Laurens' Church, one of the few buildings to escape the blitzkrieg during the war. We were welcomed by a group of singing monks and then treated to a feast of delights for all the senses.

This was a very intensive week, but it was a wonderful chance to meet up with old friends, make new ones and exchange ideas for changing and improving practice.

You can watch the lectures from ICS 2007 by logging on to <www.webcast.prous.com/ics2007>, then following the webcasts programme. Andrew Browning is found under SOA (state of the art). Alternatively, use <www.icsoffice.org>, then go into the abstracts on the left-hand menu and follow as above.

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Postgraduate Certificate: Continence for Physiotherapists

University of Bradford, Bradford, 2007–2008

'It will be good for your professional development.' These were the words I heard whilst being gently persuaded to apply for a place on the Postgraduate Certificate: Continence for Physiotherapists. Some might think that working with Teresa Cook, the clinical manager and course lecturer on the University of Bradford course, meant that I had no option but to apply. I am happy to say that this was not the case, and the decision to apply for the course was entirely my own.

The 'Bradford Course', as it is affectionately known, offered me the opportunity to extend and develop my knowledge of physiotherapy in women's health, more specifically in continence care, by studying pelvic floor, bladder and bowel dysfunction. Achieving the postgraduate certificate involves the completion of two core modules and another optional one. The two core modules are 'Continence Theory' and 'Continence Practice' for physiotherapists.

I have just completed the theory module, which included giving a presentation to small groups of fellow students and two assessors on an area of practice, and the submission of a literature review and critical appraisal, similarly on an area of practice. These two forms of assessment have certainly allowed me to reflect upon and develop my communication skills, and my ability to appraise literature critically and effectively at Master's level.

The teaching on the theory module involved some excellent lectures on both familiar and unfamiliar topics, including male and female assessment, neurophysiology (related to the lower urinary and anorectal tracts), psychosexual therapy, anorectal examination and dysfunction, and management of paediatric bowel dysfunction. The practical workshops included vaginal and anorectal examination sessions, and the use of adjuncts to physiotherapy pelvic floor muscle rehabilitation, such as biofeedback, electrical stimulation and dynamic ultrasound. The seminars also provided a platform to discuss both clinical and non-clinical issues that all students were able to contribute to and learn from. This teaching took place over three residential blocks in Bradford.

The practice module includes observational clinical visits, some of which were compulsory and others optional. The compulsory visits include observation of surgery for stress incontinence, male surgery and urodynamic studies. Observation of anorectal physiology studies, a cystoscopy clinic and urology nurse specialists formed part of my list of optional visits. A reflective statement on each visit encourages students to consider individual learning outcomes and to reflect on if, and how, these were achieved at the end of each visit. I am looking forward to using these clinical visits to substantiate my current clinical practice and to discover more about interventions that are not currently included in my practice.

To complete the practice module successfully, students are assessed on their ability to deliver a patient education class on either the prevention of continence problems, or pelvic floor, bladder or bowel rehabilitation, and provide evidence to support this intervention. In addition, each course member is assessed whilst performing an examination and assessment of a new patient. Every student is assigned a clinical mentor for the duration of the practice module and the assessments can take place at the workplace of either. As well as the practical element, the final part of the module assessment comes in the form of a critical reflective case study based on clinical experience throughout an episode of patient care.

To achieve the postgraduate certificate, a third module has to be completed from the MSc rehabilitation studies programme at the University of Bradford. Suggestions for this module include the development of an evidence-based guideline, independent study and exercise rehabilitation.

Distance learning may not be for everybody, but support is available via e-mail, telephone and in the tutorials that take place during the residential blocks. Students also have access to the university's 'Blackboard', which stores documents and information related to the course. Blackboard is also an effective communication tool, providing regular announcements from the course leaders. My fellow students are also a valuable resource, and questions and queries can be discussed by e-mail. The clinical mentors, some of whom have previously completed the course, are able to provide support during the practice module.

One of many things that I have learned during this course is the absolute necessity of good time management skills. It is not easy balancing the coursework with full-time employment and

other commitments, but it is well worth the hard work. The residential blocks are good fun, and there are some valuable opportunities to network with fellow clinicians on a more informal basis after dinner!

My attendance on the course was made possible after seeking funding from a variety of sources, and I was fortunate enough to receive an award from the Dame Josephine Barnes Bursary. I would like to express my gratitude to the executive and education subcommittee for their support in considering my application and awarding the bursary. The funds were put to good use and contributed to the overall cost of the course. In the current climate, Trusts have limited funds to contribute to courses and continuing professional development, so the opportunity to apply for financial support is most welcome.

After completing the postgraduate certificate, I hope to be able to become a more active member of the ACPWH.

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United Kingdom Continence Society 15th Annual Scientific Meeting

The Anvil, Basingstoke, 9–11 April 2008

Kay Crotty was awarded the United Kingdom Continence Society (UKCS) best oral presentation prize for her paper, 'An investigation of optimal instruction for pelvic floor muscle contraction using ultrasound imaging: a pilot study'. She is working towards her PhD and this study forms part of her research. The ACPWH congratulates Kay on her success.

Figure 1 shows the presentation of the award by Mr Tim Sayer, consultant obstetrician and gynaecologist at the North Hampshire Hospitals NHS Trust, Basingstoke, and chairman of the UKCS 2008 conference organizing committee.

Ann Mayne

Figure 1. Mr Tim Sayer, chairman of the United Kingdom Continence Society 2008 conference organizing committee, presenting Kay Crotty with her award for best oral presentation.

Sexual Difficulties Study Day

St George's Hospital, London, 23 May 2008

There was an excellent turnout from across the country for this value-for-money event, which covered topics ranging from teenage sexuality to the role of mechanical devices in male sexual difficulties.

Highlights included 'Sex after Childbirth', during which Ms Polly Hughes, locum consultant, obstetrics and gynaecology, St George's Hospital, gave us a comprehensive overview of postpartum sexual difficulties, and discussed treatment options including perineal injection and the benefits of topical oestrogen. She also addressed the important role of the Perineal Clinic, which is run by a multidisciplinary team, in the management of women who have experienced perineal trauma during childbirth.

Other inspiring topics included 'Sex and the Older Person' and 'Female Genital Circumcision', which appears to be practised in an alarming number of countries. There were also a number of fascinating case studies that demonstrated the importance of psychosexual awareness.

Although attended by an impressive number of women's health physiotherapists, it was disappointing to note that there was no physiotherapist amongst the speakers, something that we hope will be addressed in future study days!

Overall, this study day was dynamic and informative, and helped to raise the awareness of certain issues that we encounter daily in our clinical practice. It also highlighted the often complex nature of sexual difficulties, which necessitates a unified approach by the multidisciplinary team.

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The Pelvic Floor and All Your Patients – Exploring the Role of the Pelvic Floor in Lumbo-Pelvic Pain and Continence

Imperial College, London, 18 June 2008

Diane Lee is well known internationally for her clinical work on lumbar and pelvic dysfunction, and she has integrated scientific research on lumbopelvic function into a clinical model for assessment and treatment.

Her interest in the relationship between load transfer through the musculoskeletal components of the pelvis and the organs it contains began at the 4th World Congress on Low Back and Pelvic Girdle Pain, when she heard a presentation by O'Sullivan *et al.* (2002). They demonstrated the impact of the active straight leg raise (ASLR) (Mens *et al.* 1999) on the position of the bladder in pelvic girdle pain patients using real-time ultrasound (RTU) imaging. O'Sullivan *et al.* (2002) noticed that the bladder tended to descend during ASLR and that this descent decreased when compression was applied to the pelvis. Diane and her colleague Linda-Joy Lee asked themselves: 'How much should the bladder move when you lift your leg?' This led to a search of the literature on stress urinary incontinence, and low back and pelvic pain. They came to the conclusion that the factors that must be optimal for effective force closure and stability of the pelvic girdle, and those that must be present for optimal force closure of the urethra, are the same (Lee & Lee 2004).

This informative and inspiring lecture was well attended by a mixture of women's health and musculoskeletal physiotherapists, as well as osteopaths, raising the game for women's health physiotherapists treating musculoskeletal and pelvic floor dysfunction.

Diane demonstrated an excellent understanding and awareness of current research, with regard to musculoskeletal and, more surprisingly, urogynaecological dysfunction. While much of the content reinforced and supported our current practice, mention was made of using digitation of the rectum to empty a rectocele, which, from a women's health point of view, is incongruent with current thinking about treating bowel dysfunction.

It was an assumption on Diane's part that pelvic floor muscles are routinely assessed by using RTU, which is not realistic within every department. The ultrasound images and videos included in the lecture were excellent, and along with Diane's engaging presentation style, this ensured our sustained interest throughout the full 3 h presentation. We can corroborate the value of RTU from our own clinical experience since we regularly use abdominal ultrasound imaging within our own department.

The pertinent use of perineal ultrasound provided Diane with illuminating visual material that supplemented the topic beautifully and provided strong evidence for the use of this tool with our patients.

Diane included articulate and clear explanations of basic concepts, and the in-depth and advanced discussions were stimulating for even the most experienced clinicians. We cannot recommend this lecture highly enough to anyone with an interest in musculoskeletal or urogynaecological dysfunction.

Lucy Williams & Paula Igualada-Martinez
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References

Lee D. G. & Lee L. J. (2004) *An Integrated Approach to the Assessment and Treatment of the Lumbopelvic–Hip Region.* [DVD.] Diane Lee & Associates, White Rock.

Mens J. M. A., Vleeming A., Snijders C. J., Stam H. J. & Ginai A. Z. (1999) The active straight leg raising test and mobility of the pelvic joints. *European Spine Journal* **8** (6), 468–473.

O'Sullivan P. B., Beales D. J., Beetham J. A., *et al.* (2002) Altered motor control strategies in subjects with sacroiliac joint pain during the active straight leg raise test. *Spine* **27** (1), E1–E8.