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How did we get here? The development of women's health physiotherapy special interest groups in the UK

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Abstract
This paper describes the development of UK women's health physiotherapy special interest groups from 1912 to the present. Thought to have been introduced by Minnie Randell at St Thomas' Hospital, London, in 1912, special exercises for pregnant women were further developed by Helen Heardman, who founded the Obstetric Physiotherapists' Association in 1948. In 1961, this organization became known as the Obstetric Association of Chartered Physiotherapists, and in 1978, it was renamed the Association of Chartered Physiotherapists in Obstetrics and Gynaecology (ACPOG). The physiotherapy treatment of bladder and bowel disorders further developed in the 1980s, and Chartered Physiotherapists Promoting Continence (CPPC) was formed in 1991. In 1994, ACPOG became the Association of Chartered Physiotherapist in Women's Health (ACPWH). As a result of further developments in the teaching and practice of physiotherapy treatment for pelvic, obstetric and gynaecological disorders, the organization has now moved forward again as Pelvic, Obstetric and Gynaecological Physiotherapy, which combines ACPWH and CPPC. The authors' personal recollections of the period from 1960 are discussed.

Keywords: continence, gynaecology, history, obstetrics, women's health.

Introduction

History

As physiotherapy developed before and after World War I, various special interest groups were established to further knowledge and practice of a particular topic.

By 1912, Minnie Randell had qualified as a nursing sister/midwife and teacher, and joined what was then called the Chartered Society of Massage and Medical Gymnastics (Greenhill & Montgomery 1988). She devised a system of exercises for women in the maternity ward at St Thomas' Hospital, London, UK, prior to the formation of any specific women's health physiotherapy organization. She later collaborated with one of her former pupils, Margaret Morris, who was an ex-ballet dancer, to develop an exercise programme for pregnant women (Haslam 2004). Minnie Randell had quite a following: the first three editions of *Training for Childbirth, from the Mother's Point of View* (Randell 1939, 1941, 1943) had sold out by the end of 1943 (Greenhill & Montgomery 1988).

July 1948 saw the birth of the UK National Health Service (NHS), and a special physiotherapy group dedicated to women's health must have seemed to reflect the spirit of the new era when it was formed 2 months later in September. Helen Heardman was a chartered physiotherapist with both a teacher's certificate and a diploma in physical education who had initiated classes for pregnant women in Birmingham, Manchester, Leeds and London. The Obstetric Physiotherapists' Association (OPA) was conceived by Helen, who later became its chairman, in order that postgraduate students could meet and share experiences. The Chartered Society of Physiotherapy (CSP) conference was held in London in 1948, and a paper entitled "The role of physiotherapy in the training of the expectant mother" was presented (Nixon 1949, cited in Greenhill & Montgomery 1988). The first com-

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Table 1. Development of women's health organizations in the UK

Year	Establishment
1912	Minnie Randell introduced exercises for childbirth
1948	Obstetric Physiotherapists' Association
1961	Obstetric Association of Chartered Physiotherapists
1978	Association of Chartered Physiotherapists in Obstetrics and Gynaecology
1991	Chartered Physiotherapists Promoting Continence
1994	Association of Chartered Physiotherapists in Women's Health
2014	Pelvic, Obstetric and Gynaecological Physiotherapy*

*Formed with the unification of the Association of Chartered Physiotherapists in Women's Health and Chartered Physiotherapists Promoting Continence.

mittee of the OPA had members from Bristol, Glasgow, Leeds and London. Sadly, Helen Heardman was killed in a road accident in 1949. At that time, the majority of births still took place at home, as recently shown on television in the BBC drama *Call the Midwife.*

In a 1951 OPA newsletter, it was stated that, ''There is a continuous demand for more physiotherapists to be trained in order to extend facilities for antenatal preparations to more mothers'' (Jill Mantle, personal communication, 20 August 2014). Courses had been held in Leeds for the previous 7 years. Maria Ebner and Betty Barlow were both physiotherapy teachers and members of OAP at the time, and they developed a reputation for both high standards and good organization. Evidence of the regular training courses developed by them and other members of the organization following its inception is contained in the archives of the Association, which are held by the Wellcome Trust in London.

By 1961, the organization had grown, and it became the Obstetric Association of Chartered Physiotherapists (OACP). Minnie Randell survived until 1975, and during her lifetime, she saw the ascendency of physiotherapy in women's health. She was honoured by being made an Officer of the Most Excellent Order of the British Empire (OBE) in the 1940s and the CSP awarded her an Honorary Fellowship in 1948.

In the 1970s, great changes were taking place with regard to the position of women in society. The ''Swinging Sixties'' were but a memory, but with the freedom provided by the contraceptive pill, women were able to plan their families and felt more able to play a larger part in society. The 1973 OACP conference took place in Manchester and Ann Bird was one of the delegates. A member of our organization is now awarded the Ann Bird Prize each year. Physiotherapists were beginning to treat incontinence and other gynaecological problems, and therefore, the title of the Association became an issue. The prime movers for the change of name were Dorothy Mandelstam and Sheila Harrison, and in 1978, the Association of Chartered Physiotherapists in Obstetrics and Gynaecology (ACPOG) came into being. At this time, there was very little, if any, research evidence to support many physiotherapy practices, but all that was to change in the 1990s.

During this decade, there was a movement to be clearer and to use less jargon. Did the public understand what ''obstetrics'' and ''gynaecology'' meant? Also, CSP-validated continence courses were developed by Jo Laycock in the late 1980s and 1990s in Bradford, and Chartered Physiotherapist Promoting Continence (CPPC) was formed. Would it be simpler and more holistic to say ''women's health''? Both the USA and Australia were also making similar moves. At the 1994 ACPOG conference in Manchester, the annual general meeting (AGM) agreed to a name change once more, this time to the Association of Chartered Physiotherapists in Women's Health (ACPWH). At that time, Jill Mantle was chairman, and it was agreed at the AGM that those who had successfully completed the Bradford continence course could become full members of ACPOG/ACPWH.

The last conference in Manchester was held in 2003, so it seemed timely for the city to again host one in 2014. The title of the organization has changed again to Pelvic, Obstetric and Gynaecological Physiotherapy (POGP). This new name encompasses all women's health issues, as well as the treatment of men with pelvic disorders, including urinary and faecal incontinence, pelvic pain and prostatitis, and erectile dysfunction.

Table 1 outlines the development of the various women's health associations. Over the years, the logo/badge of the organization has altered in

Figure 1. Logo of the Association of Chartered Physiotherapists in Obstetrics and Gynaecology.

line with the changes in the scope of the medical conditions treated by its members. The ACPOG logo (Fig. 1) was originally designed to commemorate Minnie Randell. It contained the lotus, the Egyptian symbol representing childbirth, and the CSP "helping hands". With the advent of ACPWH, the primrose, the Chinese symbol for women's health, was added (Fig. 2). The CSP and others from outside the profession were asked to help design the new POGP logo, which needed to be clear and flexible for a number of media applications. The new badge (Fig. 3) retains the flower motif, but now has gender balance in its colour scheme (Lough 2014).

Jo Laycock's memories

Training

I trained under Margaret Hollis, the principal of Bradford Hospital's School of Physiotherapy, from 1959 to 1962. I don't remember learning much about women's health, but postnatal exercises were taught and students took postnatal ward classes. Patients generally stayed in hospital for 10 days, and were on bed rest in the early days post-partum. There was no mention of vaginal examinations (VEs) in the training. Furthermore, there was no research evidence to support what we were doing, and doctors dismissed our efforts as unproven "but not doing any harm". This was infuriating!

The physiotherapy school was run along the lines of a *school*, not a further education college. Uniform had to be worn at all times, even for lectures; we all wore grey skirts and maroon jumpers. For hospital work in the wards and the department, we wore a white coat, and the colour of the belt signified who was a student and who was qualified. The length of the coat had to be well below the knees. We had a maroon cloak for outside wear. When shorter skirts and dresses became fashionable, we felt very old fashioned, and protested in vain about the length of our dresses! "Butterfly" hats were worn during our 3 weeks of nursing experience.

Figure 2. Logo of the Association of Chartered Physiotherapists in Women's Health.

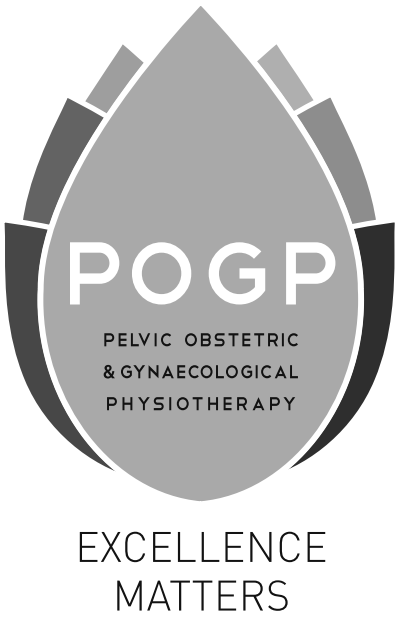

Figure 3. Logo and strapline of Pelvic, Obstetric and Gynaecological Physiotherapy.

Early work

I learned about antenatal classes (on the job, from a leaflet) at Leeds Maternity Hospital, following the scheme devised by Maria Ebner. At this time, a physiotherapist was available 24 h a day and could be called to the labour ward when an antenatal class patient was admitted. This was soon stopped because of economies in staffing levels. Postnatal patients had to wear huge white shorts over their nightdresses for the daily exercise class. Many women hid in the toilets to avoid these sessions. Pelvic floor muscle (PFM) contractions were taught by ''crossing the legs and squeezing the ankles, knees and thighs together, tightening the bottom and tummy, and pulling up between the legs, as if stopping spending a penny''.

In the late 1970s, after my own childbirth experiences, I returned to full-time work at St Luke's Hospital, Bradford, being responsible for obstetric and gynaecology patients. I attended a 5-day ACPOG course at St James's University Hospital, Leeds, only to find that there was still no research evidence to support our work. Vaginal examinations were mentioned, but the only instruction given was during a morning in a gynaecology clinic, where the PFMs were bypassed on the way to identifying the position of the cervix! My first VE was a disaster because I was embarrassed and didn't know what I was looking for, and my second wasn't much better. In those days, PFM contractions were taught in isolation; doctors were still dismissive.

I started to treat women with urinary incontinence using faradism and PFM exercises (PFMEs), and later interferential therapy and vaginal cones. I was directed to the department's equipment cupboard, where I found: a rectal electrode, which I wrongly assumed was a vaginal electrode; a large, triangular, ''indifferent'' sacral electrode with a lint pad that was secured with a ''many-tailed bandage''; and a battery-operated, hand-surged Smart–Bristow faradic coil. Then I was expected to ''get on with it''; nobody else wanted to treat incontinence. Instruments were washed in soap and water, and returned to a paper bag. There was no infection control or chaperone policy, and no private cubicle for assessment and treatment. My first patient for faradism was slightly deaf, and with no privacy, the whole department could hear what I was saying. Everything went quiet when I said where I was putting the electrode, but I muddled through. A Bourne pressure perineometer provided biofeedback, but it was too large and coloured dark green. Not surprisingly, some patients refused to use it.

Despite my lack of training, but thanks to the frequency–volume chart produced by a pad company that I acquired from a nurse continence advisor, I started to get good results and some satisfied patients. During this time, I was promoted to Superintendent Physiotherapist at Bradford Royal Infirmary, and later decided to specialize in the treatment of urinary incontinence and research the various treatment options. I registered for an MPhil at the University of Bradford, and subsequently upgraded to a PhD. I was encouraged to resign from my post as superintendent and concentrate wholly on research. This meant raising enough money for my salary for the next 5 years, which I managed to do. I attended a urodynamics course in Bristol, and held a urodynamics session each week for patients who agreed to enter the clinical trials. A randomized controlled trial confirmed the value of electrical stimulation in activating the PFMs in the treatment of urinary incontinence (Laycock & Green 1988), and vaginal cones and PFMEs (Laycock *et al.* 1999) were later proven to reduce symptoms. The PERFECT assessment scheme was developed and tested, and individual home exercise programmes were established (Laycock & Jerwood 2001). My supervisors at the University of Bradford were Dr Roger Green, an electrical engineer, and Dr David Jerwood, a statistician. I was greatly helped by staff in the Medical Physics Department at Bradford Royal Infirmary.

In the 1980s, I joined the International Continence Society (ICS) and the Association for Continence Advice (ACA). The ICS is a multidisciplinary society that hosts an annual conference in different countries. Its membership mainly includes urologists and gynaecologists, although a number of physiotherapists, nurses, engineers and neurologists are also involved. At my first meeting in 1985, there were only two physiotherapists; by the time of the Glasgow meeting in 2011, there were 453. The United Kingdom Continence Society (UKCS) is run along similar lines to the ICS, and hosts an annual conference in the UK. I later presented my research findings at the ICS and ACA conferences, and thanks to other physiotherapists around the world, particularly Kari Bø from Norway, physiotherapy began to be acknowledged as the appropriate first-line treatment for stress urinary incontinence (SUI) by

the US and UK governments. Invitations to teach enabled me to travel the world and talk about my research.

The ACA attracts mainly nurse continence advisors, but also small numbers of physiotherapists and occupational therapists, and I needed to learn how these other professions were managing incontinence. In the early days, the continence role of district nurses and continence advisors was generally, but not entirely, to supply the appropriate incontinence pads and manage patients with catheters. Some enlightened nurses were also advocating PFMEs, and I was asked to teach them PFM assessment and re-education, and how to use biofeedback. I was criticized by some physiotherapists for this, but my response was that we couldn't see all the patients in the country and it was better that nurses were trained. I later established the Department of Urotherapy at Bradford Royal Infirmary, and was joined by Stephanie Knight and then Diane Naylor.

Later career

In 1989, I ran the first CSP-validated continence course in Bradford. Since I was still learning, I invited many experts in this field of medicine to lecture. However, the CSP would not allow us to practice VEs on each other. For the second course, 2 years later, this decision was overturned, and thanks to the support of Jeanette Haslam, who was a course participant, and Dr Angela Shepherd, a urogynaecologist from Bristol, 18 women on the course agreed to examine each other and record their findings using the PERFECT assessment scheme. After training and practice using a modified Oxford scale, inter-rater analysis validated this subjective method of recording PFM contractility. Vaginal palpation and assessment of the PFMs has since become standard practice on most continence modules. The early courses also introduced the importance of assessing bowel function (and treating faecal incontinence and constipation), and reading the medical literature and referencing written work. In addition, an introduction to literature analysis and basic statistics was included. We now take all these things for granted on a women's health course.

The use of surface electromyographic biofeedback, a technique developed in the 1980s and 1990s, highlighted the need for a light-weight vaginal electrode that could be used for both electrical stimulation and biofeedback, so Roy Sherlock of Neen HealthCare and I developed the Periform Probe. Working with companies selling incontinence equipment helped to develop an understanding of the devices required for treatment.

On retiring from the NHS in 1996 to live in the Lake District, I established a private practice and ran residential continence courses for 10 years. During this time, Jeanette Haslam and I co-edited two editions of *Therapeutic Management of Incontinence and Pelvic Pain: Pelvic Organ Disorders* (Laycock & Haslam 2004; Haslam & Laycock 2007). As with my validated courses, experts were invited to contribute to this textbook.

Jeanette Haslam and some of her experiences in women's health

Student life, 1968–1971

So what was life like on the "shop floor" during my working life? I began my training at Manchester Royal Infirmary (MRI) in September 1968 without knowing very much about physiotherapy. However, I thought that anything would be better than the teacher training that my school advised me to do. Little was I to know at that time that, although clinical physiotherapy work was a wonderful way to be employed, teaching was the icing on the cake. Women's health, by whatever name it was known, was part of life from my student days. It seemed like every alternate rotation saw me returning to St Mary's Hospital (Manchester's hospital for women), and becoming involved in obstetrics and gynaecology. The "old" St Mary's housed the gynaecology wards. It may now seem odd to younger physiotherapists that we spent so much time on pre- and post-operative care. However, it has to be remembered that pelvic floor repairs and hysterectomies meant that women stayed in hospital for about 10 days, doing very little other than resting and eating.

The antenatal class participants attended eight weekly 1-h classes. These were the days of using a knitted uterus to explain labour, and mats on the floor for exercise and relaxation. No fathers attended the classes, although some, but far from all, attended their wives during labour – there was no mention of partners in those days. Mrs Audrey Kelbrick was the superintendent physiotherapist at St Mary's, and she was a woman who had to be listened to; we had to do everything "the correct way". We all did as we were told and learned a great deal since we

had had no formal education in any aspect of obstetrics and gynaecology before placement. The *Birth Atlas* (Dickinson & Belskie 1968) was a prominent feature of our education during antenatal classes. I will be forever grateful to Mrs Kelbrick for the delightful and very easy deliveries of my four children: I did what I had been told to do.

We also had an outpatient PFME class, of which all I can remember is women sitting on stools performing pelvic rocking, and also posture correction in sitting and standing. Was this an early primitive form of core stability exercise? There were also the elusive PFMEs, which took a lot of concentration. Some women, but not all, were also seen separately in another room. It was with these patients that I was introduced to the VE. Although I had scanty anatomical knowledge, I donned a polythene glove and palpated the vagina to detect a squeeze – a few seconds later, the deed was done and a tick could be put in the appropriate box. What did I learn? Not to be afraid, and also the need for more education.

Each morning, the student physiotherapists were assigned to the postnatal wards. We would ascend to the wards and try to ''capture'' the women. I remember travelling the four-bed wards and repeating the same things many times over. Occasional relief was provided by having a patient's perineum to ultrasound: you felt far more important when you had a machine in tow. Another, less-favoured task was that of treating the engorged breast by massage.

Meanwhile, other women's health treatments were also being carried out back at MRI. We were taught spectacularly vigorous exercises to take with any unfortunate soul who had been referred with dysmenorrhoea, but thankfully, this did not happen very often. In the women's electrical department, there were two main women's health treatments. One involved crossfire short-wave diathermy to the pelvis for pelvic infections and dysmenorrhoea, and was performed with the patient sitting in a deckchair. This treatment was abandoned at a later date; however, this was not because of the obvious lack of a research base, but as a result of the health and safety issues raised by the deckchairs collapsing! The other major therapy was ''faradism to the pelvic floor''. I believe that the hand-surged Smart–Bristow faradic coils we used can now be seen in medical museums. The basic treatment involved a lint-covered button electrode being placed on the perineal body and another, larger electrode, also wrapped in lint, being placed on the sacrum. Patients were encouraged to undergo maximum stimulation. They were also told to practise PFMEs, but not in any structured way.

Unusually for the time, MRI had pioneered the treatment of SUI with maximal perineal stimulation. This involved a qualified physiotherapist accompanying the surgeon into theatre and administering maximal faradic stimulation to the anaesthetized patient. I remember being very impressed that a physiotherapist was allowed to perform a treatment in the operating theatre.

First employment and onwards

After the statutory 3 years and 3 months of the physiotherapy course, I married and found my first employment on the Isle of Wight. In those days, it was in at the deep end with a full patient list from the beginning.

I joined another physiotherapist who was providing a service at the island's psychiatric hospital. Every morning, we visited this institution, which was deep in the countryside, and then made a bus journey to St Mary's Hospital in Newport. The afternoon's work began in the maternity unit with a class on the antenatal ward. This was for the many pregnant women who were often admitted and remained for many weeks after being stranded following a holiday. I had to think of more to say each day, and what I had learned in Mrs Kelbrick's antenatal classes in Manchester proved to be more than useful. Then, after visiting the labour wards, there were exercises on the postnatal wards. Following this, it was hotfoot from the main hospital buildings down to the physiotherapy department and an afternoon list of outpatients.

My first afternoon as a qualified member of staff consisted of seeing many new patients. These included two women with urinary incontinence, another two referred for mobilization following Colles' fractures, a paraplegic who needed help to walk with her new leg braces and several women with leg problems. Newly qualified physiotherapists would never be expected to multitask in so many ways on their first placement nowadays, but we and the patients somehow survived the ordeal. After a few weeks, I was also asked to give a talk to a Royal College of Midwives meeting on the Isle of Wight because I was now responsible for all such allied treatments. Full of confidence, I taught the midwives and learned much from them; it is easy to

be confident when not understanding the huge amount that there is to know!

In this rosy glow of achievement, I approached one of the consultants regarding maximal faradic stimulation: could I enter the sisterhood of ''operating'' in theatre? The consultant's first words were, ''Show me the evidence. What research has been done?'' Goodness gracious, what had I got myself into? Research and evidence had never been touched upon during my training. Therefore, I dispatched a letter asking for more information to Miss E. H. Eaton, the principal of the MRI School of Physiotherapy. Her brisk response gave me the authors and title of a relevant paper (Moore & Schofield 1967). Using initiative and with great aplomb, I sauntered into the doctor's library, a place where physiotherapists were not normally seen, and found the article. However, on reading it, I thought: *Do I really want to put women through this*? Performing treatment in theatre had seemed glamorous to me, but now I had second thoughts. Little was I to know then that research studies would become such a large part of my life many years later.

In those days, physiotherapists on the Isle of Wight were not allowed to return to work after having a child, so I was able to enjoy being a full-time mother at home. I have no regrets because I had a lovely life, and four healthy babies within 7 years. We later moved back to Lancashire via Shropshire. When my youngest child started school 12 years later, I returned to work part-time to find a wholly different world in outpatients. My new superintendent was of the belief that ''old knowledge'' together with ''life experience'' would mean that I would be able to cope, even though I had not been involved with physiotherapy for 12 years. The one thing that hadn't changed was that no one wanted to treat patients referred with incontinence problems. In general, ''women's health'' was not highly regarded, and therefore, my ''old knowledge'' was still as good as anyone else's and better than some! I was allowed to set aside a session a week for the treatment of women with incontinence while I was on a basic grade rotation.

In the late 1980s, Jo Laycock came to teach as part of a general study day on electrotherapy at Chorley. A colleague working with elderly people was allowed to go on the first validated Promotion of Continence and Management of Incontinence course run by Jo in 1989. My rotation into the care of the elderly unit gave me more pause for thought. My colleague and I then found ourselves speaking on physiotherapy and the treatment of incontinence at a locally run study day, and met our new continence advisor. It seemed like destiny was calling regarding my future career: clinical work, teaching, and being involved with research and writing. Over the years, I was asked to speak on many more study days and courses, and as a result, I needed to think, read and question evermore. Attending the second validated continence course in 1990–1991 was a wonderful experience. The people whom I met there will forever be special to me. We worked very hard together, but also had some riotous evenings in the nurses' home at St Luke's Hospital, Bradford, where we were all in residence. We were not only women seeking knowledge, but ones who were prepared to share with and encourage each another.

Chartered Physiotherapists Promoting Continence

Chartered Physiotherapists Promoting Continence was formed on the final day of the 1991 Bradford continence course. It took over from the previous group, ''PISI'' (Physiotherapists Interested in Stopping Incontinence), which had been established by the first validated course members. We had a strong desire to continue meeting together to discuss any further research developments in treatment, and to continue to expand our knowledge by having study days with expert speakers. I was ''elected'' the secretary/treasurer for the now newly formed group CPPC; Julia Herbert, who had been on the first validated course, was chair of the group.

Our first meeting, which featured John Sutherst as our main speaker, was held on 30 November 1991. During the part of the meeting that we dedicated to business, the aims of CPPC were stated as being to:

- continue membership as before, i.e. the CPPC should be made up of those physiotherapists who had passed the validated continence course;
- have two meetings per year;
- charge members a fee of £5.00 per year; and
- conduct a multicentre trial to evaluate different pelvic floor regimes in the post-partum period (Jo Laycock, Julia Herbert, Jackie Highcock, Cathy Abbot and myself were entrusted to report to the members at the next meeting).

Julia Herbert and I met regularly to agree the minutes of meetings and arrange the next study

day. I was responsible for chatty newsletters and keeping members in touch. At first, CPPC membership was restricted to successful validated course participants. As we grew and had successful study days, it seemed appropriate to relax the restriction. Initially, this was to allow those who had participated in a recognized course to join, and later, anyone who was interested would be welcomed. The aims and objectives were stated as being to:

- encourage research in the treatment and management of incontinence;
- meet regularly for study days and to exchange of information; and
- update our knowledge regarding recent research into the management and treatment of incontinence.

As the years rolled by and the workload increased, it was decided to form a committee to run the organization. Ann Mayne was the next chairman, and she was followed by Jane Dixon, Sarah Murdoch and Annette Woodward.

Relationship with ACPOG/ACPWH

Meanwhile, the continence course had confirmed my desire to expand the service for the women (and also the men) of Chorley. In the following years, I was able to develop a women's health service encompassing participation from pregnancy through childbirth, as well as postnatal and gynaecological problems. Men with continence problems were also treated. This was made possible by my manager, who gave me freedom to develop, and help and advice from the wonderful women's health team in the neighbouring NHS trust in Preston. Pat Sutton was the superintendent there, and she taught me a great deal, always with a generous spirit and heart. She and her team also introduced me to ACPOG. My first ACPOG conference with them was brilliant. To meet all the famous physiotherapists of the day was such a treat. To find that they were kind, approachable and so very willing to share knowledge over breakfast, lunch, dinner and tea breaks was a revelation. Women's health was definitely my calling. I was invited to join the Education Committee of ACPOG, and later, to became its chairman for 2 years in 1998. By this time, the Association was now known as ACPWH. On my return from 3 years in Germany in 2004, I resumed that position and held it until my retirement.

Also in the 1990s, I had started to have rotational physiotherapists pass through my fledgling department, which was based in the Obstetrics and Gynaecology Unit at Chorley and South Ribble District General Hospital, Chorley, Lancashire. They had lovely, questioning young minds and they enjoyed the work. What more could I want? As the work increased, I managed to keep two of them (Clare Holden and Kirsty Moore) as permanent staff, and I also had one other rotational member of staff.

In 1995, Jill Mantle asked me to be a lecturer on the new ACPWH continence course. These were still the days of overhead projectors and acetates. Jill is one of the wisest women I have ever known, and she is always reliable, knowledgeable and approachable. I was most fortunate to become part of her ''team''. Many other organizations, including ACPOG/ACPWH and the University of East London (UEL), have also benefitted from her wisdom.

It was on the initial ACPOG continence course that I first met Grace Dorey and became reacquainted with Jane Dixon, who were both students on the programme. Since that time, Grace has carried the flag of male incontinence forwards, and Jane has done much to advance the use of real-time ultrasound in continence physiotherapy. The next continence course, which took place in 1996, was validated by the UEL, and as ''clinical manager'', I was privileged to be Jill Mantle's right-hand woman. This was to continue until the final UEL continence course was completed in 2004. At that time, we developed a Master's-level continence course with the University of Bradford. As course leader for the first cohort of students in 2005, I was extremely well supported by Teresa Cook and the staff at the University of Bradford School of Physiotherapy. To date, the continence course has continued over eight cohorts, and since my retirement, it has been very well led by Teresa Cook with the assistance of Julia Herbert.

Meanwhile, obstetrics and gynaecology courses had been further developed. The previous modules that had been required in order to achieve full membership of the Association were validated by the CSP in 1984, and then further validated at Level 3 by the University of Bradford in 1999. This programme was later developed into a Master's-level course. In 2005, it then became possible for a postgraduate physiotherapist to gain Master's-level points from both the continence and women's health courses at the University of Bradford that counted towards a Master's-level qualification.

A series of short 2- and 3-day courses on various aspects of women's health were also developed from 2000 onwards, some of which have been validated by the CSP.

As ACPWH, the Association was a founding member of the International Organization of Physical Therapists in Women's Health, which Gill Brook has played a large part in from its inception. Our members have participated in various National Institute for Health and Clinical Excellence (NICE, now the National Institute for Health and Care Excellence) committees with our medical and nursing colleagues. We have cooperated with the Royal College of Midwives and the then Health Visitors' Association (now the Community Practitioners' and Health Visitors' Association) on joint statements, and worked alongside our colleagues in nursing, with several of us taking the chair of the Association for Continence Advice. Members of ACPWH and CPPC have worked towards MSc, MPhil and PhD higher degrees. Honours such as CSP Fellowships and Distinguished Service Awards, and national awards including OBEs and MBEs have been bestowed upon our members. We have witnessed the International Continence Society (ICS) having greater input from physiotherapy, culminating in the very successful ICS conference in Glasgow in 2011, when the ICS Lifetime Achievement Award was presented to Jo Laycock. When I attended the first annual meeting of ICS (UK), later to become the UKCS, there were two physiotherapists in attendance. Oh, how we have been a part of the change in that organization!

There is no such thing as standing still. It has become apparent over the years that cooperation with colleagues, being open minded, and the sharing of knowledge and expertise benefits not only ourselves, but more importantly, those for whom we care. It is most fitting that we now have the coming together of two important organizations, ACPWH and CPPC, to form POGP. By moving forwards together, we will have a greater ability to achieve change.

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