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Fat chance

Well, I never! Overweight people are uncomfortable in gyms!


Apparently researchers at The George Washington University Medical Center wondered why, if exercise is an antidote to obesity, the obese stay away from gyms and health clubs in droves. Only 30% of Americans trying to lose weight meet the National Institutes of Health exercise guidelines of 300 minutes a week.

So they asked themselves: is this because the obese are so thick (ha ha, pardon the pun) that they haven’t heard and understood the message that exercise helps you to lose weight and be healthy? Or are there some other barriers to regular exercise which don’t affect normal weight individuals – and what, they asked themselves, eyes wide in puzzlement, could those barriers possibly be?

The researchers followed and questioned 1 552 individuals, of whom 989 were classified as overweight. Contrary to what you might anticipate, the overweight did truly believe exercise improved appearance and self image – in fact, they believed this more strongly than normal weight individuals. But “overweight individuals felt more embarrassed and intimidated about exercising, exercising around young people, exercising around fit people, and about health club salespeople than individuals of normal weight”.

At this point I couldn’t help laughing out loud. This finding appeared to have surprised the researchers. It didn’t surprise me. I, like thousands of my tubby peers, have joined two gyms in my time. In both cases, I went about three times, then patiently paid the monthly fee until I could legally cancel the damn contract.

A plump person walking into a gym must run the gauntlet of critical eyes in the change room before taking her oversize T-shirt and tracksuit pants out among all the lycra and spandex. She (or he) may be subject to insulting comments, impatience or dismissive behaviour from staff, will likely struggle to keep up with aerobic classes and have a number of other negative experiences in the gym. Professor Tim Noakes once said to me, talking of hospitals: the one place that should have a gym never does. If exercise is intended to make you healthier and, hopefully, thinner, then gyms should be the one place fat people feel welcome – but the opposite is true.

Hey, fatty boom-boom

Do you think I’m exaggerating? There’s a huge pile of research that shows how deep and pervasive the bias against overweight people is. (Read your latest Journal of South African Physiotherapy, page 27-31, for a study which shows that physiotherapy students in our country have very negative attitudes to the obese.)

The Obesity Society, a major USA organisation, has this to say:

Overweight and obese individuals are often targets of bias and stigma, and they are vulnerable to negative attitudes in multiple domains of living including places of employment, educational institutions, medical facilities, the mass media, and interpersonal relationships… Other research shows that overweight employees are ascribed multiple negative stereotypes including being lazy, sloppy, less competent, lacking in self-discipline, disagreeable, less conscientious, and poor role models… they tend to be paid less for the same jobs, are more likely to have lower paying jobs, and are less likely to get promoted than thin people with the same qualifications.

And here’s something that may interest you:

In medical facilities, biased attitudes toward obese patients have been documented among physicians, nurses, psychologists, dieticians, and medical students, and include perceptions that obese patients are unintelligent, unsuccessful, weak-willed, unpleasant, overindulgent, and lazy. One alarming consequence of negative attitudes by health care professionals is that obese patients may avoid obtaining medical care because of these negative experiences. Research has demonstrated that heavier patients are more likely to cancel and delay appointments and preventive health
care services, particularly among women who are overweight or obese.

Kelly Brownell and Rebecca Puhl confirm this in their paper, *Stigma and Discrimination in Weight Management and Obesity*.

We have been studying bias and discrimination in obesity for four years and have found striking results... Numerous studies document explicit negative attitudes about obesity among physicians, nurses, dieticians, and medical students. These attitudes include: obese people lack self-control and are lazy, obesity is caused by character flaws, and failure to lose weight is due only to noncompliance... It is important to note that the stigma of obesity is somewhat unique from that of other marginalized groups, in that obese people internalize societal anti-fat and pro-thin biases. Obese people agree...

Numerous studies document explicit negative attitudes about obesity among physicians, nurses, dieticians, and medical students. These attitudes include: obese people lack self-control and are lazy, obesity is caused by character flaws, and failure to lose weight is due only to noncompliance... It is important to note that the stigma of obesity is somewhat unique from that of other marginalized groups, in that obese people internalize societal anti-fat and pro-thin biases. Obese people agree with society’s assessment that an imperfect body represents an imperfect person. (*Focus on Obesity, Part 2: Summer 2003/Vol. 7, No. 3, Permanente Journal*)

And finally, a recent paper, published in the November issue of the *Journal of General Internal Medicine* by researchers at Johns Hopkins Medical Institutions, showed that “Doctors have less respect for their obese patients than they do for patients of normal weight...”

“Mary Margaret Huizinga, M.D., M.P.H., an assistant professor of general internal medicine at the Johns Hopkins University School of Medicine, says the idea for the research came from her experiences working in a weight loss clinic. Patients would come in and ‘by the end of the visit would be in tears, saying no other physician talked with me like this before. No one listened to me,’ says Huizinga, the study’s leader and director of the Johns Hopkins Digestive Weight Loss Center. ‘Many patients felt like because they were overweight, they weren’t receiving the type of care other patients received,’ she says.”

**Imperfect body, imperfect person?**

It’s as if the overweight have inherited the mantle once worn by alcoholics: they’re the subject of contempt because of what is seen as their ‘moral failings’. Greater understanding of alcoholism has enabled us to see it as the result of a complex slew of genetic susceptibility, life experiences, psychological factors and more. We understand that alcoholics are in the grip of something incredibly hard to resist, we support them in their efforts to extract themselves, and we applaud their successes.

A very simple message has been hammered home in the last fifty years: fat people eat way too much, and they move too little. They have no willpower. (This, despite evidence that up to 98 percent of all diets fail – can so many dieters be so weak-willed?)

This permits society to make them the righteous targets of contempt. An article in Newsweek (26 August 2009), points out that “it’s hard for us to accept that weight could be not just a struggle of will, even when the bulk of the research—and often our own personal experience—shows that the factors leading to weight gain are much more than just simple gluttony. ‘There’s this general perception that weight can be controlled if you have enough willpower, that it’s just about calories in and calories out,’” says Dr Glen Gaesser, professor of exercise and wellness at Arizona State University and author of *Big Fat Lies: The Truth About Your Weight and Your Health*, and that perception leads the nonfat to believe that the overweight are not just unhealthy, but weak and lazy.”

Weight gain and loss is, as many professionals are slowly coming to realise, a pretty complex picture, perhaps even more complex than alcoholism. And willpower is not the magic bullet. Andrew Geier, a post-doctoral fellow in the psychology department at Yale University, points out in that Newsweek article that “weight loss is incredibly difficult to attain: Geier notes that even the most rigorous behavioral programmes result in at most about a 12.5 percent decrease in weight, which would take a 350-pound [160 kilos] man to a slimmer, but not svelte, 306 pounds [139 kilos].”

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**TREAT THE PERSON**

There’s no room here to go into all the interesting research of recent years which indicates that factors like prolonged stress, inflammation, insomnia, gut bacteria and more can hobble those trying to lose weight. (If you’re interested, I can do that in another issue of *Hands On*.) What I’d like you to think about is your own attitude to your overweight patients. Physios are not immune to societal trends in thinking, and it could be affecting how you treat people.

The Obesity Society has some useful questions to ask yourself:  
- Do I make assumptions based only on weight regarding a person’s character, intelligence, professional success, health status, or lifestyle behaviours?
- Am I comfortable working with people of all shapes and sizes?
- Do I give appropriate feedback to encourage healthful behaviour change?
- Am I sensitive to the needs and concerns of obese individuals?
- Do I treat the individual or only the condition?

And some specific strategies for health professionals:  
- Consider that patients may have had negative experiences with other health professionals regarding their weight, and approach patients with sensitivity.
- Recognize the complex aetiology of obesity and communicate this to colleagues and patients to avoid stereotypes that obesity is attributable to personal willpower.
- Explore all causes of presenting problems, not just weight.
- Recognize that many patients have tried to lose weight repeatedly.
- Emphasize behaviour changes rather than just the number on the scale.
- Offer concrete advice, e.g., start an exercise programme, eat at home, etc., rather than simply saying, “You need to lose weight”.
- Acknowledge the difficulty of lifestyle changes.
- Recognize that small weight losses can result in significant health gains.
- Create a supportive health care environment with large, armless chairs in waiting rooms, appropriately-sized medical equipment and patient gowns, and friendly patient reading material.
- And if any of you know of a gym where overweight people can exercise in an atmosphere of acceptance – tell us about it!

Let me know if you’d like more on this subject (mandiwrite@icon.co.za).
From the President’s Desk

KE NAKO!

President Magda Fourie tells us what it’s time for, in the amazing year ahead of us

The official South African World cup slogan, KE NAKO means “It’s time’. 2010 will be an exciting year in more than one way.

The soccer 2010 FIFA World Cup and the changes to the SASP structure will be two of the major highlights.

Before we look at the pros and cons of the World Cup and if physios in South Africa could benefit from it, I would like to give you feedback from the members on the EXCO proposals on the SASP structure review.

On structure

Between other EXCO members and I, we managed to meet with more than 200 members (the average attendance at a SASP AGM is between 40-60 members). Overall most of the members appreciated the way that the SASP EXCO went about interacting with them, and that they were consulted on these matters. Some do not feel they have the capacity to make informed decisions, but still value the fact that their opinions were heard. Although the presentation was met with mixed feelings and concerns not to re-invent the wheel, most of the members agree that it is good to revisit the SASP structures regularly. It was felt that our model should be similar to world trends wherever a National Health System has been implemented, and to ensure the new SASP structure will be pro-active in preparation for the National Health Insurance (NHI) in South Africa.

THE FOLLOWING HAS BEEN AGREED TO BY MEMBERS IN PRINCIPLE:

1. National Assembly is to be discontinued and be replaced by the SASP Annual General Meeting (AGM).

2. The Society should be managed in a more business-like manner, ensuring a profitable, growing and respected profession within South Africa, even if that means a higher membership fee.

3. EXCO:

Should be decreased to eight members as suggested with the proposed combined portfolios which should ensure good communication and better management.

Needs more transparency, e.g. who is currently on EXCO, what do they stand for, do they make decisions for the better of the profession, what drives EXCO?

Should have representation of all spheres within the SASP, namely public and private sectors, Special Interest Groups (SIG), students etc.

4. Leadership:

The President should be a position upheld as a prestigious honour and be a physiotherapist by profession. If permanently employed, concerns were raised about Basic Conditions of Employment Act (BCEA) implications if the President does not perform according to members’ satisfaction.

The President should still be the leader of the SASP and the person bearing the highest responsibility and accountability.

The President should be the WCPT representative for the SASP.

The proposals were that the term of office for the President should be longer than two years (at least four), members to have the option of re-electing the President if the President is available for a second term of office. This way the Presidency will be open to physios in all provinces and there should be no pressure to relocate to Johannesburg to work from Head Office.

A business leader, not necessarily a physiotherapist, should be appointed and be fully responsible for the finances, external marketing, administrative and human resource departments of the SASP.

The Deputy President does not automatically become President (following the example of the World Confederation of Physical Therapists – WCPT) and will have specific tasks to fulfil, e.g. looking after provinces, SIGs, students and newly graduates.

More emphasis should be placed on the utilisation of the employed provincial secretaries directly from Head Office, with regular interaction between Head Office, the provincial secretaries and their members.

The members agreed that expertise should be contracted for effective marketing, legal responsibility, health environmental scanning, health economy, and so on.

The SASP Journal editor should also be on a contract-basis instead of an honorarium.

5. Funding:

The honoraria for the President, EXCO members, Provincial and SIG chairs and committees should be increased to compensate for the effort and time they spent on behalf of our profession.

Suggestions were to use large accumulated funds in some provinces and SIGs instead of increasing the membership fees annually.


National SASP AGM would set the strategy of the SASP and agree on motions and tasks for EXCO to execute within certain timeframes.

The suggestion is that the National SASP AGM should be the main forum for inputs from members and motions from EXCO to be passed. Each Province would send their representative/chairman to the National AGM with a mandate to vote (or per proxy) on motions.

Sub-branches could continue as normal, discussing motions and raising issues, but only one provincial or SIG AGM can make the final decision and nominate a representative to the National SASP AGM.

All SASP members should attend the National SASP AGM.
It's time!
Can you remember when you were a child, and you couldn’t wait to open your Christmas or birthday presents? As an adult, have you felt you couldn’t wait for that long-awaited holiday or the new car you always dreamt of? Most South Africans have tolerated road works, construction of the new Gautrain and building activities at all the airports and more, all in anticipation of the FIFA 2010 World Cup!
At last: KE NAKO! “It’s time”.

The 2010 FIFA World Cup™ will be held from 11 June to 11 July 2010 and will consist of 64 matches played in 10 venues in nine Host Cities. Thirty two Member Associations will participate and there will be approximately three million tickets available for purchase for all matches.

Will life be better, healthier and safer during and after the Soccer world cup? You decide!
- R 11.7 billion has been invested in the transport infrastructure.
- The satellite teleport and telecommunications infrastructure will support transmission capacities of 40 gigabytes per second.
- 80 000 beds of accommodation are currently available in South Africa. Visitor numbers to South Africa, which is already a major tourist destination, should be boosted significantly during and after 2010. Small businesses in the hospitality sector stands to benefit widely.
- The spectacular new stadiums seat more than 570 000 people collectively.
- There’ll be free primary healthcare at official venues, 24-hour emergency medical services and international and local surveillance measures for disease outbreaks.
- R8 million will be invested to upgrade South Africa’s emergency medical services, including two well-equipped communications centres per province for real-time co-ordination of emergency vehicles to the nearest available emergency centre as well as a medical helicopter services and 450 new vehicle ambulances.
- R665 million will be spent on procuring state-of-the-art equipment to ensure security, including crowd-control equipment, unmanned aircraft, helicopters, 10 water cannons, 100 BMWs for highway patrol and mobile body armour, four high-tech mobile command centres and a dedicated force of 41 000 officers will be deployed.
- Immigration procedures at ports of entry will be speeded up through ‘fast-track’ lanes, with event-specific visas that will enable ticket holders to enter the country with ease.
- All the airports in SA have been upgraded, but the most spectacular one is the King Shaka International situated north of Durban at La Mercy with an opening passenger capacity of eight million per year.

In light of these very important decisions, please look out for the notification of the date of the National SASP AGM, diarise the date and be part of history in the making for the best of the physiotherapy profession and the Society! WE NEED YOUR OPINION AND VOTE!
Hands On February 2010

**From the President’s Desk**

**Challenges facing our population, municipalities and government:**

- It is expected that each tourist will generate between 1.7 to 2kg of waste per day, meaning a massive 3 410 000 kg of waste over a period of a month if only 55 000 people visit SA.
- Entrepreneurs need to be realistic about the opportunities the World Cup will bring - and should get help before opening a new business or expanding an existing one. Please contact the Department of Trade and Industry before you embark on a new business.
- Prices for soccer tickets will range from R 490 to R 3150 for an individual ticket for the opening match, R 140 to R 1120 for normal group matches, R700 to R 4200 for semi-final matches and R 1050 to R 6300 for the final match.
- Return flights during 21-23 December 2009, from Johannesburg to Cape Town were priced between R 1655 and R 2014; return flights from Johannesburg to Bloemfontein were priced at R 1913; and return flights from Johannesburg to Durban were priced between R 1192 and R 1565. The same return flights during mid-soccer world cup (21-23 June 2010), from Johannesburg to Cape Town will cost between R 4678 and R 5350; Johannesburg to Bloemfontein will cost R 4438; and Johannesburg to Durban will cost between R 2478 to R 4210.
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**Will there be economic opportunities for us as physios?**

The short answer is, “Not directly”. Commercial activity is limited to FIFA and its sponsors and there will be strict restrictions on sales, marketing and advertising in designated areas such as stadiums – advertising your business in and around the stadiums is not legal.

At one stage the Society suggested having physios on call and available when games are played in your area, not for the soccer teams but more for the fans and spectators. Think about all the injuries that could occur in the fan parks alone when people have been watching, celebrating (and drinking!) for a full day? According to our Hippocratic oath we promised to “treat without exception all who seek my ministrations…”

If you are consulted by a foreign patient, it’s probably a good idea to charge cash for treatments, BUT what about your malpractice insurance if something goes wrong? Consider the following:

SASP members are covered for treatment of overseas visitors in RSA. However, we are not covered if treating a USA/Canadian who tries to sue us in a jurisdiction that applies their law and a judgement is obtained and is sought to be enforced in RSA. Depending on international law, the usual position is that other countries do not have jurisdiction over our citizens. In any event a judgement obtained against an SA citizen in a foreign country will not have any teeth if our citizen has no property in that country to attach to enforce the judgement. The only time a judgement will work is if there is some kind of reciprocal treaty in place between our two countries which allows a foreign judgment to be enforced here. So normally, if a foreign national wishes to sue one of our citizens they would have to do so here in RSA.

The problem is that their damages will be the equivalent of what it would cost them to obtain treatment in their own country. Where their country has a stronger currency than our own, would the R2.5 million limit that SASP members enjoy be enough? Bear in mind that you as a SASP member have an aggregate limit: if there is one claim during the year that exhausts your limit, you will then effectively be uninsured for the rest of that year.

Therefore you as the private practice owner need to make a decision about your risk. If you consider the risk to be significant and feel you want to be one of the physios on call during this time, you should purchase individual top-up cover of an additional R2.5 million (cost: R1064 per annum) or additional R7.5 million top-up cover (cost: R2017 per annum). If you want top-up cover, first pay your SASP membership fees for the underlying cover, then contact Kristy Carr at Glenrand to arrange the top-up. It might seem expensive, but in fact members are getting excellent rates which they would not be able to access outside of the SASP scheme. It’s also inexpensive when compared to the potential exposure physiotherapists face if they will be treating a lot of foreign patients.

Unfortunately, members cannot share the top-up insurance nor take out cover for one month only. So if you do not wish to purchase top-up cover, you should strongly consider identifying the nearest colleague with top-up cover and perhaps refer all foreign patients to that practice.

Again just a reminder: it is vital to inform Glenrand immediately should anything go wrong - even if the patient doesn’t complain or say anything about suing you.

According to Kristy Carr from Glenrand, in over 10 years of experience she has never seen a foreign claim of this kind so the chances are pretty remote.

**Opportunities**

But direct engagement with foreigners aside, there may well be excellent opportunities to market our profession.

Every host city will be flooded with visitors around the time of the games – and in the nature of things, probably the bulk of them will be South Africans. They’ll come for a few days and will need to stay somewhere, eat, shop and entertain themselves. Then there are the towns which are offering base camps to teams – I know that at least three teams will be based in the Garden Route, for instance. These teams will bring a large entourage and will attract swarms of fans into the region (including locals who are passionate about famous soccer personalities).

This offers us an ideal – in fact, unbeatable – opportunity to market physiotherapy. We will not be breaking FIFA rules if we set up stalls in local malls or entertainment venues.

It might be worth our while to give a little less energy to National Physiotherapy BackWeek this year, and put more energy into a push around the World Cup. If you practise in an affected region, put your thinking caps on and let’s come up with some bright ideas!

Enjoy the pros and cons of a ‘soccer-full’ 2010!
Imagine this: you’re a 53-year-old soccer fan who’s come all the way from Germany to watch your team play in the 2010 World Cup. You’re at Ellis Park, wearing all Germany’s colours and waving your scarf madly when suddenly, a terrible crushing pain envelopes your chest. You’re right in the middle of one of the stands, surrounded by close on 70 000 excited people. How do you get help?

The 2010 World Cup Unit in the National Department of Health have put their minds to this and other health dilemmas the World Cup might pose. One of the team, Dr Liz Luenberger, showed Skyways the medical rooms underneath Ellis Park, and told us about the country’s plans for 2010.

Which is good news for our putative German heart attack victim. There’ll be medical personnel all over the stadium, on foot patrols, on bicycles and on all-terrain vehicles outside. It’s likely that it will be paramedics on one of the golf carts stationed in the tiers, and equipped with everything necessary to cope with a Priority One patient, who will see his friend’s madly waving hand and will be with the unfortunate pair within four minutes, stabilising him and ensuring he is rapidly moved to an Accident and Emergency Unit close by.

**South African first**

Dr Luenberger has worked as the stadium doctor at Ellis Park for a number of years, so she was a natural choice when it came to planning for medical care during this massive event. She and her colleagues immediately did the natural thing: turned to her peers in Germany and Korea, who had recently dealt with soccer world cups themselves, and asked for assistance.

Fortunately, Dr Luenberger has statistics from all events at Ellis Park for about twelve years, including major soccer and rugby events as well as the kind of event that doesn’t spring to mind immediately: church rallies, musical performances and the like.

The result is a tool which, once you’ve inputted some detail about the event, will tell you how many ambulances, golf carts, all-terrain vehicles, beds, paramedics, doctors and more you need, right down to small items of equipment.

This tool has been honed in the course of recent events like the Confed Cup, and has been applied to all the stadia across South Africa which are hosting 2010 events.

It’s not only useful for planning medical care, but it’s also proven effective in sourcing equipment. Because the tool enables them to draw up a complete list of equipment needed (such as defibrillators or suction units), the team has been able to shorten the lengthy tendering process. They’ve done a tender at national level, so provinces don’t have to do their own piecemeal tendering, but can simply call on the national resource. Obviously, this has also reduced costs a bit, due to economies of scale.

**Working together**

The Department’s team has been working closely with NGOs like the Red Cross, St John’s Ambulance Service and the SA First Aid League, as well as with the private sector, to ensure that the right level of personnel is available, not only at the stadia, but also beyond, in the hosting cities.

What happens if, heaven forbid, there is a major traffic accident involving, say, two buses transporting fans to the stadium? What happens if there’s another awful disaster inside a stadium? An instant response is called for, from the dedicated staff working at the event, but also from all the health care resources available in the immediate vicinity. “We have planned a Casualty Clearing Station for mass disasters which can handle up to 1 400 patients, and we will have staff held in reserve for such an eventuality,” says Dr Luenberger. There will be a core of reserve vehicles for each city, and each hosting province will have separate holding areas to provide for things like traffic accidents.

“The SA Military Health Service has been very helpful,” says Dr Luenberger. “They deployed during the Confed Cup and will be helping out in each province during 2010. They have very good logistics officers.”

Volunteers and permanent staff have been doing a range of courses to prepare for the event, such as the British Major Incident Medical Management Course. Some have even done clinical forensic courses to be ready for the dark side of such a huge event – rape and assault cases are likely to arise wherever you have rowdy crowds, lots of emotion and plenty of booze.

Staff will be on duty long before and long after each event, says Dr Luenberger. ‘We are planning for 12-hour shifts.

All of this will leave a very valuable legacy. We will have staff who are highly trained in all kinds of mass management; Dr Leunberger and Peter Fuhri have been working on regulations for mass events, which are likely to be promulgated before 2010, and will create certainty for events managers afterwards as well; and, of course, South African work drawing up effective manuals for this kind of planning will assist others around the world in the future.

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(This article first appeared in Skyways, the inflight magazine for Airlink, November 2009, and is reproduced with kind permission.)
Duffy Sweatman sadly passed away on 29 November 2009 after bravely battling an illness for four years.

Her kindness and generosity will be sorely missed; her professionalism, thirst for knowledge, and her willingness to share this knowledge will always be remembered by all of us who had contact with her.

Duffy trained as a physiotherapist in London during the 1950’s. Shortly thereafter she married, and after living in Kenya for a few years, came to live in Tokai in Cape Town, where her husband’s parents had a small-holding. She opened a private practice at her home, which in those days was well off the beaten track.

I met her shortly after I moved to Cape Town from Johannesburg in 1979 when I was asked to start up a Western Province branch of the OMTG. Duffy was about the only physiotherapist I knew, and she was very enthusiastic. Initially we set up meetings at different practices, discussing the treatment of difficult cases requiring our expertise. We provided the patients, and together we all discussed the treatment. I was always nervous about what we would do if the patient failed to turn up – which lo and behold occurred, and we were stranded for a subject. Now I knew that Duffy had been reading up about the treatment of elbow conditions, so I asked her to give us an impromptu lecture on the elbow.

After a little blustering, our self-effacing colleague stood up and did just that. For many years afterwards, Duffy always maintained that I had pushed her into the lecturing aspect of her career.

In the beginning

During the 1980s, there were great changes taking place regarding the physiotherapy treatment of orthopaedic patients. As an undergraduate, Duffy had been greatly influenced by Dr James Cyriax and his methods, so one of the earliest lecturers we brought out from the UK was Stephanie Saunders, and Dr Ellis, an orthopaedic physician. Not only were the courses over-subscribed, but we attracted a number of doctors, including orthopaedic surgeons, who were interested in the work that Dr Ellis was doing. We held several modules over the following couple of years, during which Duffy was initiated into giving lectures under the guidance of the course leader. During one of the acupuncture modules which Charles Liggins was presenting, we came upon the work of Janet Travell on myofascial pain and dysfunction. Duffy immediately pounced on the importance of myofascial trigger points, and set out to purchase and devour any literature she found on the subject. She was making regular trips to England to visit her mother and twin sister, and always returned with an armful of the latest literature which she read like novels. Her greatest excitement was seeing the work of Bob Elvey, whose research led us to mobilisation of the neural tissue.

It was largely through Duffy’s urging that we, the W.P.O.M.T.G. as it was then called, brought to Cape Town and other parts of the country that wanted to participate, lecturers from Australia and the UK such as Bob Elvey, Peter Gifford, David Butler, Gwen Jull and Peter Baldrey, who all added a dimension to the treatment of pain.

Duffy did a huge amount of reading on the treatment of chronic pain, and having the insight to meld together all the aspects of pain which had been presented to us by the international lecturers, started giving courses both here and in England.

The course with which her name is most synonymous is The Amazing Nervous System, where she highlighted the role the autonomic nervous system plays in the relief of chronic pain. The course incorporated joint mobilisation according to Maitland, neural mobilisation, the explanation of chronic pain according to David Butler, the role of acupuncture, Trigger Point Therapy by Travell, and Cranio-Sacral Therapy, but never forgetting the importance of the psycho-biology of mind-body healing, thus creating a unique, holistic approach to the treatment of pain.

Duffy touched many people with her refreshing personality, and her generosity in sharing her knowledge with others. Her contribution was enormous.

On a personal level, Duffy and I spent many wonderful hours going on all manner of courses from Shiatsu at the Sufi Temple to Body Alignment Therapy, as well as anguished hours looking for premises for the courses, and wondering whether we would ever be able to meet our commitments in paying our overseas lecturers!

The world has lost a wonderful lady and a beautiful person.

Pat Swilling
9 December 2009
Brun Winter

Brunhilde (Brun) Winter died recently after a short illness, a few weeks before her 78th birthday. She was a member of the first group of physiotherapists to be trained at the old Pretoria School of Physiotherapy, qualifying in 1952. She was also the first South African physiotherapist to be trained as a physiotherapy teacher. She qualified as a chartered physiotherapist at St Thomas’ Hospital, London, and then went on to achieve the CSP teaching qualification. It was during her years at St Thomas’ Hospital that she became aware of the work of Dr James Cyriax, the pioneer of orthopaedic medicine. Whilst in England she also worked at the Rowley Bristow Orthopaedic Hospital, working in the field of rehabilitation of adults and children with neurological and orthopaedic disabilities.

She returned to South Africa at the end of 1959 and started her teaching career at what was by then the Pretoria College of Physiotherapy, which trained students for the National Diploma in Physiotherapy. She was innovative in her use of interactive teaching in which the students participated. She later took up a lecturer’s post at the University of the Witwatersrand. In 1967 she moved to the Cape, first as a lecturer at the University of Cape Town, and later at the University of Stellenbosch. She was regarded by the students as an excellent and stimulating lecturer, and as a strict but fair examiner.

Brun Winter is best known for her work in orthopaedic manipulative therapy. She was instrumental in bringing Jennifer Hickling to South Africa in 1963, to introduce South African physiotherapists to the work of James Cyriax and Gregory Grieve. In the early nineteen-seventies she was the first South African physiotherapist to travel to Australia to complete the three-month diploma course given by Geoff Maitland, and the first physiotherapist to qualify with distinction in the diploma. She also brought Maitland to South Africa to introduce his concept here. She was a pioneer in developing the OMT courses in South Africa and was an important force in the development of manual therapy in this country to the level at which it is internationally recognized. During these years she taught OMT to hundreds of therapists, and was their inspiration and a role model for clinical excellence. It was her interest in manual therapy and her desire to work more closely with patients that were instrumental in her choice to leave the academic field and go into private practice.

Brun was awarded Honorary Life Membership of the SASP, as well as of the OMTG and the Western Cape Branch of the SASP. She was a member of the first Professional Board for Physiotherapy and was a member of the National Executive Committee of the SASP. She also holds the distinction of having organized, as the then Chairman of the Northern Transvaal Branch, the first national SASP meeting which incorporated a scientific programme.

Her friends and former colleagues will remember her as a person who would always give her full attention to their queries or needs. She had a variety of interests and a quiet sense of humour that was never far below the surface.

We shall remember her with love and with gratitude for all that she did for our profession.

Sheena Irwin-Carruthers
November 2009

Summer salad

Try this delish recipe –
Mandi Smallhorne loves it!

One of my favourites online finds is Heidi Swanson’s www.101cookbooks.com. Heidi is an inspired cook who creates the most delectable dishes – they’re so tasty, you probably won’t even notice they’re all vegetarian.

I go back to the site again and again for inspiration – one of my winter dinner party standards is her Cauliflower and Gorgonzola Cheese Soup, which you can adapt to suit your own taste, but which always, without fail, has guests umming and aahing as they smack their lips.

This salad gives a new twist to coleslaw, perfect for summer meals that have a fusion theme.

**Lime and Peanut Coleslaw Recipe**

(Heidi suggests, by the way, that you can substitute chopped avocado and red onion for the tomato, or shredded apple. And you can leave out the jalapeno if you like it milder – that’s what I did, as I don’t like food that’s too hot.).

- 1 1/2 cups unsalted raw peanuts
- 1/2 of a medium-large cabbage
- 1 basket of tiny cherry tomatoes, washed and quartered
- 1 jalapeno chile, seeded and diced
- 3/4 cup cilantro, chopped (that’s coriander to us South Africans)
- 1/4 cup freshly squeezed lime juice
- 2 tablespoons olive oil
- 1/4 teaspoon fine-grain sea salt

In a skillet or oven (180 C) roast the peanuts for 5 to 10 minutes, shaking the pan once or twice along the way, until golden and toasted.

Cut the cabbage into two quarters and cut out the core. Using a knife shred each quarter into whisper thin slices. The key here is bite-sized and thin. If any pieces look like they might be awkwardly long, cut those in half. Combine the cabbage, tomatoes, jalapeno (optional), and cilantro in a bowl.

In a separate bowl combine the lime juice, olive oil, salt. Add to the cabbage mixture and gently stir to combine. Just before serving fold in the peanuts (add them too early and they lose some of their crunch). Taste and adjust the flavour with more salt if needed.

Serves 6 as a side
What makes a WCPT Congress special? The International Scientific Committee organising the programme for the 2011 Congress in Amsterdam, Holland, is building on past experience and surveys of physical therapists to create an invaluable professional event – whichever part of the world you happen to come from. Simon Crompton, editor of WCPT News, talks to Ann Moore, Chair of the Committee, about the planning to date, and what’s in store.

It may sound a way off, but to WCPT’s International Scientific Committee, 2011 has been looming large for a while now. The group of physical therapists from around the world who are responsible for putting together the scientific programme of World Physical Therapy 2011 have been considering its shape and aims since their appointment in summer 2008 – and they are taking some fascinating changes of direction.

Chair of the committee is UK physiotherapist Ann Moore, Professor of Physiotherapy and Head of the Clinical Research Centre for Health Professions at the University of Brighton. She says that what really enthuses her about the task is that congresses make a difference. She speaks from personal knowledge. She’s attended four of them.

“I think it’s the sense of conviviality, the ease of networking, that makes them so special. I love the way that, during congresses, you can’t help but be exposed to different ways of thinking, new ideas, big issues that other countries are facing and which put a new perspective on your own. There’s that sense of the profession standing shoulder to shoulder.”

That’s why it’s been a priority for the next Congress to be as inclusive as possible. Central to the programme will be focused symposia, where a convenor will lead a group of presenters through a series of linked presentations on a topic of international appeal. At least three of WCPT’s regions have to be represented by the speakers contributing to each symposium – ensuring that sessions embrace the interests and practice of delegates whatever part of the world they come from.

The programme will start to be put together from February, once the focused symposia have been announced. But there are definitely structural changes on the way. One is to integrate the programme far more closely thematically.

In particular, the committee is looking to cater for clinicians and educators who want to hone their practical skills. At previous congresses, there have been pre- and post-congress courses focusing on applied skills, but these are now being integrated alongside the main programme. Delegates will be able to “pick and mix” sessions according to their professional interests. For example, they will be able to participate in a specialist course on one day, a clinical visit on another, and scientific programming on another.

Highly-regarded keynote speakers will also now be integrated into symposium sessions, so that they can answer questions and join in debates.

“We want a programme that will attract practising physical therapists as well as researchers and educators,” says Ann Moore. “They’ll be able to attend workshops, courses and discussions which complement the scientific programme, and will allow them to take away new skills.”

The views of physical therapists themselves have been fundamental in shaping the new plans. In 2008, more than a thousand physical therapists around the world responded to a WCPT survey asking them about the issues that interested them the most. It found that the challenges of an aging society, new roles for physical therapists, physical inactivity and health promotion were common concerns around the world.

“What I found fascinating was how many common issues affect people globally,” says Ann Moore. “This means there are some obvious issues we intend to address at the next Congress.”

“This time, with all the progress made in previous years on technicalities like an on-line abstract management system, we feel we can really focus on getting a lively programme together, moulding it to the needs of as many people as possible.”

The act of shaping World Physical Therapy 2011 is well and truly underway. Ann Moore is confident that her fifth Congress could well be her best.

For full details of the Congress, including deadlines for satellite programme sessions, poster abstracts and platform abstracts are available at http://www.wcpt.org/congress.
Adios from the chairman

Outgoing chair Wilma Erasmus reflects on the past two years

At the AGM held on 15 January 2010 I handed the chairmanship of PhysioFocus over to Wilna-Mari van Staden. I can’t believe that two years have gone past so quickly, but they did. Maybe it is because we were so busy at PhysioFocus and also because I had such an awesome committee with me. It is not often that members volunteer to be on a committee.

The other day I read in a very good book on leadership: “Leadership; the care and growth model, by Etsko Schuitema (Ampersand Press),” that a good leader must not ask, “What have we done?” but “What have we changed?” This made me think, what about PhysioFocus has changed in the last two years that was not just part of our normal duties and roles? Will these changes affect our current members, future members, the profession and maybe even South Africa and Earth positively, now and in the future?

Environmental Changes:
PhysioFocus proposed a motion at the 2008 National Assembly that the SASP must go green and cut down on unnecessary paper usage. This resulted in the electronic version of the PhysioFocus Directory and Blue Book and also the SASP changing the constitution to enable the minutes and reports of meetings to be made available electronically to members and not posted. PhysioFocus is proud to be associated with this environmental responsibility project of the SASP that will help, maybe in a very small way, to decrease the carbon footprint of physiotherapists in South Africa. This is, however, a project that must be carried on and extended into the daily running of every private physiotherapy practice. E-mail accounts and exercise programmes to patients if you can, don’t print e-mails unnecessarily, recycle usage paper and use recycled paper to print your referral pads and business cards.

Professional Changes
PhysioFocus was instrumental in and part of the delegation that drafted some SASP position papers. All these position papers have been approved by the HPCSA. You may ask so what? How is that changing the way I practice? The SASP Position paper on the interpretations of: Advertising and Making your Professional Service Known gives clear guidelines to our members and the SASP Peer review committee on what is seen as acceptable professional advertising.

The position paper on employment gave us for the first time clarity on what is acceptable practice on paying commission to employees and locums.

The First Line Practitioners position paper also gives clear guidelines on the responsibilities of a physiotherapist as a first line practitioner and has already been used in negotiations with funders and where funders refused to pay for some physiotherapy service, such as counseling and evaluations.

The position paper on ceding of accounts is a valuable tool that can and will be used to improve the practice management of private practitioners. We now have a document that stipulates what can be done and how. In the past we had to rely on hearsay and individual opinions that gave rise to confusion for us all.

I urge you all to get hold of a copy of all these documents (all available on the blue book CD and on the SASP website) and use it to enhance your practice.

Membership Changes
- From the beginning of 2009 all SASP members working/practising in private practice are members of PhysioFocus. We changed the PhysioFocus constitution to reflect these changes and also changed the wording of the previous A1 and A2 membership to: A1 = PPO, private practice owners and A2 = PEP Physiotherapist employed in private practice.
- The inclusion of both groups in one association has been challenged at the 2009 PhysioFocus AGM. Legal and expert opinion has been optioned and the conclusion was that it is a good change, especially in the current medical climate with NHI facing us. It was said that we must stand together as one unit and use our membership numbers to lobby for changes in the interest of private practice.
- I still get the impression at times that there is mistrust among our members, and different committees within the SASP. We are one team and everyone serving on any committee and all our members surely only want what is best for the profession and for private practice. I want to challenge you all to remember that and to respect other people’s opinions, their style of leadership and knowledge, even if it is not the same as yours. Remember the PhysioFocus slogan: Together we are the difference.
- During this last year I realised that even if you have done some things many times over, it does not guarantee you won’t make mistakes. This resulted in a SASP guideline for running and organising an AGM that will be used by all SASP committees. We should accept fallibility, not only from ourselves but also from colleagues and other health care professionals, and not be so quick to judge.

So you may ask, now that I am stepping down as chairman from PhysioFocus, what will I do with all my time?

My motto in life is: If live gives you lemons... make lemonade, marmalade, lemon pie... sommer start a lemon industry. I am going to start my lemon industry!

Thanks to all the members, committee members, SASP EXCO and Head Office staff for your support, friendship, criticism and love in the last two years. I am so proud to be a physiotherapist in South Africa and a SASP member. Please keep on supporting the new PhysioFocus chairman in the same manner.

Practice Physiotherapy Perfectly!
I am writing this in December for you to read in February! In this fluid and fast-changing health environment, what information do I have to impart that will still be pertinent and current two months hence?

The Reference Pricing List (RPL)
Will there or will there not be an RPL for 2010? On what will the 2010 RPL be based? Will it merely be a percentage increase on the 2009 RPL or will it be based on our submitted rates? These are all questions we know need answering. As I write this, all I can say is that, unless a settlement agreement is made, no RPL may legally be published before the end of February. Already we are receiving anguished requests from you, the members, for definitive tariffs. The Competition Commission does not allow the SASP to suggest tariffs. It is against the law. Even the RPL is only a guideline (set by the Department of Health).

So what does one charge?
The RPL was supposed to be based on the costs of running a practice, a reasonable salary and a reasonable return of investment. Unfortunately this useful guideline has not come to fruition. So, taking these factors into account, it is necessary for you, the practitioner, to decide what you think a physiotherapist in private practice should be earning? Should it be more or less than a lawyer (R1500.00 per hour), a plumber (R500.00 per hour), an IT person, a hairdresser? The SASP cannot decide for its members. Each member needs to calculate the costs and needs of their own particular practice and their patients. We should not undersell our profession. Look at our submission on the DOH website to get an idea of our consultants’ calculations regarding the average cost of running a practice which was based on the information that the members sent in. Also take into account inflation.

However, when and if we receive definitive information about a 2010 RPL, this will be relayed to you immediately by email.

Compensation for Occupational Injuries and Diseases (COID)
We have communicated all our issues to COID and hopefully by the time you read this we will have met with COID and will have information on the rates for 2010 that will come into effect in April. We are continuing to confront COID on the issue of slow inaccurate payments.

2010 Courses
Our Tomorrow in Private Practice – Survivor 2010 courses will be held around the country later than usual so as to bring the most up-to-date information possible to you.

PLEASE DIARISE THE DATES FOR THE BIG CENTRES NOW -
Johannesburg 17 April,
Cape Town 8 May and
Durban 25 May.
There will be loads of information on RPL and NHI, basic and advanced coding tips and ethical issues.

Rule 008
There are physiotherapists who do not seem to be aware of rule 008 or are interpreting it incorrectly.

The rule states (both in the RPL guide to fees and the SASP structure) that:

The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code number to indicate that this rule is applicable.

In essence this means that one may charge any of the above mentioned codes at full price – taking into account the rules and descriptors that govern these particular codes. Then one may only charge for three other codes, of which the fee for the second and third codes must be reduced by 50%.

For instance a treatment for low back pain may consist of Rehab (501), myofascial release (303), spinal mobs (401), massage (302), ultra sound (203) and hot packs (001) but one would only be able to charge for 501 (provided the requirements of the descriptor are met) at full price, 303 at full price, 401 at half price (modifier 0008 to be quoted) and any one of the other three codes at half price (modifier 0008 to be quoted). No charge may be levied for the remaining two codes.
Western Cape Rocks Back Week!

By: Jessica Stander

The Western Cape Physios went all out to promote our profession over the entire area. A wide variety of schools were visited in the Cape Town area, including private and government schools. At Parkhurst Primary School in Mitchells Plain, nearly half of the 200 children present reported that they had had backache before! Children were rewarded with Slouch=Ouch stickers, SASP pens and a home-made marshmallow spine for asking and answering questions.

The 4th year US students performed a skit to classes at Bishop Lavis Primary School on back-care while sitting at desks and carrying school bags. It was a great learning experience for everyone!

Other activities included talks given to nursing homes and corporate groups, where PR items were given out. Back classes were given at gyms and other physios emailed the press release to all the companies in their office blocks. Physiotherapists teamed up with biokineticists to give talks and practical sessions on kinetic handling and positioning of patients to nursing assistants, cleaners and porters in hospitals.

In the Southern Cape a ‘Boere Sport’ day was held in George with 72 children participating. A few of the SWD Eagles rugby team members were also present to give a talk on the importance of physiotherapy for them.

Our profession was promoted to the public by placing press releases in local newspapers, including the Tygerberger and the Constantia bulletin. The Constantia bulletin also placed an article on back care every week in September. Jessica Stander did an interview with Eye Witness News on KFM radio and other radio stations were also targeted.

As a province, we decided to celebrate National Physiotherapy BackWeek with our third annual 5 km and 10 km fun run on Saturday, 12 September. We worked in conjunction with Run Walk For Life who helped us organise the venue, route and permits.

We had a total of 176 entries and each participant and all the volunteers received a goodie bag. Coca Cola provided us with a banner and refreshment stations and numerous other sponsors were generous with prizes for our lucky draw. Our Women’s Health SIG hosted a stand and our Sports SIG had a massage tent to relieve the tired legs.

We made R3 710, which was donated to the Chris Burger/Petro Jackson Rugby Players Fund, who do brilliant work for rugby players with spinal cord injuries.

Thanks to each physio who took the time to improve the health of their community!
Keryn de Bruyn, senior physiotherapist at Madwaleni Hospital, wrote to the SASP:

Thank you for your sponsorship of the Madwaleni Hospital Rolling Hills Wheelchair race. We would like to thank you for your kind and generous contribution of T-shirts, caps, water bottles, pens, stress balls, paper, Bar-Ones, strapping, bandages, cotton wool, Dettol, massage oil and anti-inflammatory gel, towards our wheelchair race. The race would not have been as successful without your donation. And you can see from the pictures what a success it was!

Plans for sport
What’s ahead for the Sports SIG? The group is planning a sports physio conference in November 2010. The inaugural SA Sports Physio Conference – From Plinth to Podium will be held in Joburg from 5-6 November.

Sam Nupen is organising the SPT1 course to be run in Joburg in 2010. The SPG will be offering a bursary to successful applications doing the SPT1 course; the bursary will be linked to presenting their research project at the national SPG conference and writing it up and publishing it in an international sports physio journal.

The SPG will set up a national sports physio accreditation system whereby physios working in sports can be accredited and recognised as sports physios by this system.

The SA SPG to set up links and relationships with other international sports physio groups and the international federation of sports physiotherapy (IFSP).

A new national executive has been elected:
Chair: Craig Smith (who represents the group on SASMA)
Vice chair: Ria Sandenbergh
Treasurer: Brent Grimsley
Secretary: To be appointed

DO YOU WANT TO BE A MEMBER OF THE SPORTS PHYSIOTHERAPY GROUP?
Please tick the appropriate box on your membership form. The group will keep you up to date with activities through a website and quarterly newsletter in 2010. They also intend to open an office with an admin staff member to help with the many projects they have planned, including their usual involvement in major events like Comrades and Two Oceans.
Fun on wheels

Jose Cox reports on the Momentum 94.7 Cycle Challenge

The Momentum 94.7 Cycle Challenge, on Sunday 15 November 2009, was a well-organised Event, as always. This year the number of entries was approximately 30 000 cyclists of all fitness levels and abilities. I was stationed at water point nine with three second-year students from the University of Pretoria who were well-presented, hard-working, enthusiastic and great to work with.

After arriving at the water point at around 6:00 am and setting up the physio tables, there was time to sit and relax while watching the elite athletes zoom past and not even bat an eyelid at the waterpoint. Our first patient stopped for a massage due to cramping quads at around 10:00 am and thereafter the floodgates opened and we were pretty much busy non-stop until the cutoff at 15:00 pm. The majority of cyclists were cramping in their quadriceps, hamstrings and gastrocs but there were also a few painful backs and arms with the usual ITBs. With the day being so incredibly hot, the water point was buzzing and the cyclists really benefitted from some ice massage until the water point ran out of ice at around 13:00 pm. Perhaps the only two suggestions that would improve the experience next year is to ensure enough ice is available for the entire day and to perhaps have an additional two students at water point nine as at times there was a very long line of cyclists waiting. All in all the day was really enjoyable with a great vibe and tons of hard work.

Tracy Taljaard was at the first water point

With the number of participants in mind, I think that the race went relatively smoothly. Although, with the amount of accidents, heart attacks and the like, I don’t think that the 94.7 can be referred to as Jo’burg’s safest race anymore.

I was based at the first water point and would just like to comment that the spirit and enthusiasm of the water point volunteers from Momentum, the physio students, paramedics and Netcare staff was remarkable. Nobody hesitated to lend a hand when needed and the camaraderie was spectacular.

I feel the Netcare staff need special mention in that they did a phenomenal job dealing with everything from a broken arm, a sprained ankle, an asthma attack, numerous cases of dehydration and exhaustion with the upmost professionalism. For some reason, our physio tent was left without any massage gel or paper towels and the Netcare staff kept us supplied with enough Voltaren gel to keep cyclists’ cramps at bay.

All in all, it was a good experience. Well done to all who lent a hand in making the 2009 94.7 cycle challenge a race to remember.

Original Article:  
**THE ASSOCIATION BETWEEN DEGENERATIVE HIP JOINT PATHOLOGY AND SIZE OF THE GLUTEUS MEDUS, GLUTEUS MINIMUMS AND PIRIFORMIS MUSCLES.**  
Alison Grimaldi, Carolyn Richardson, Warren Stanton, Gail Durbridge, William Donnelly, Julie Hides.

**Abstract:**  
This study aimed to investigate changes in the deep abductor muscles, gluteus medius (GMED), piriformis (PIRI), and gluteus minimus (GMIN), occurring in association with differing stages of unilateral degenerative hip joint pathology (mild: n¼ 6, and advanced: n ¼ 6). Muscle volume assessed via magnetic resonance imaging was compared for each muscle between sides, and between groups (mild, advanced, control (n ¼ 12)). GMED and PIRI muscle volume was smaller around the affected hip in subjects with advanced pathology (p < 0.01, p < 0.05) while no significant asymmetry was present in the mild and control groups. GMIN showed a trend towards asymmetry in the advanced group (p ¼ 0.1) and the control group (p ¼ 0.076) which appears to have been associated with leg dominance. Between group differences revealed a significant difference for the GMED muscle reflecting larger muscle volumes on the affected side in subjects with mild pathology, compared to matched control hips. This information suggests that while GMED appears to atrophy in subjects with advanced hip joint pathology, it may be predisposed to hypertrophy in early stages of pathology. Assessment and exercise prescription methods should consider that the response of muscles of the abductor synergy to joint pathology is not homogenous between muscles or across stages of pathology.


Original Article:  
**THE ASSOCIATION BETWEEN DEGENERATIVE HIP JOINT PATHOLOGY AND SIZE OF THE GLUTEUS MAXIMUS AND TENSOR FASCIA LATA MUSCLES.**  
Alison Grimaldi, Carolyn Richardson, Gail Durbridge, William Donnelly, Ross Darnell, Julie Hides.

**Abstract:**  
The aim of this study was to obtain, using Magnetic Resonance Imaging (MRI), muscle volume measurements for the gluteus maximus (upper: UGM and lower: LGM portions) and tensor fascia lata (TFL) muscles in both healthy subjects (n ¼ 12) and those with unilateral osteoarthritis (OA) of the hip (mild: n ¼ 6, and advanced: n ¼ 6). While control group subjects were symmetrical between sides for the muscles measured, subjects with hip joint pathology showed asymmetry in GM muscle volume dependent on stage of pathology. The LGM demonstrated atrophy around the affected hip in subjects with advanced pathology (p < 0.05), however asymmetry of the UGM (p < 0.01) could be attributed largely to hypertrophy on the unaffected side, based on between group comparisons of muscle volume. TFL showed no significant asymmetry, or difference compared to the normal control group. This study highlights the functional separation of UGM and LGM, and the similarities of the UGM and TFL, both superficial abductors appearing to maintain their size around the affected hip. Further research is required to determine the specific changes occurring in the deeper abductor muscles. This information may assist in the development of more targeted and effective exercise programmes in the management of OA of the hip.

**MANUAL THERAPY 14 (2009) 623–629**

Original Article:  
**RELIABILITY, VALIDITY AND DIAGNOSTIC ACCURACY OF PALPATION OF THE SCIATIC, TIBIAL AND COMMON PERONEAL NERVES IN THE EXAMINATION OF LOW BACK RELATED LEG PAIN.**  
Jeremy Walsh, Toby Hall

**Abstract:**  
This study investigated the reliability, validity and diagnostic accuracy of manual palpation of the sciatic, tibial and common peroneal nerves in the examination of 45 subjects with low-back related leg pain. The nerves were palpated manually and with an algometer, to determine pressure pain thresholds (PPTs). A second examiner performed the straight leg raise (SLR) and slump tests to determine nerve trunk mechanosensitivity. The procedure was repeated by another examiner to determine inter-rater reliability (n ¼ 20). Scores for agreement between raters for manual palpation were 0.80, 0.70 and 0.79 for the sciatic, tibial and common peroneal nerves respectively, demonstrating excellent reliability. PPTs were significantly lower on the symptomatic side, for each of the three nerves, in subjects who were positive on manual palpation. In subjects who were negative on manual palpation, PPTs were not significantly different between sides, demonstrating criterion-based validity, using PPT as the criterion. Highest scores of diagnostic accuracy were obtained when two or more of the three nerves were positive on palpation (sensitivity ¼ 0.83; specificity ¼ 0.73).
The application of a single session of manual therapy program produces an immediate increase of index HRV (F = 4.5, P = .04), but not for standard deviation of the normal-to-normal interval (F = 1.1, P = .3), square root of mean squared differences of successive NN intervals, index HRV, low-frequency component, and high-frequency component, PPT over both temporalis muscles, and Profile of Mood States questionnaire (tension-anxiety, depression-dejection, anger, hostility, vigour, fatigue, confusion) were obtained pre-intervention, immediately after intervention, and 24 hours post-intervention. Self-reported head pain was also collected pre-intervention and 24 hours post-intervention. Separate analyses of covariance (ANCOVAs) were performed with each dependent variable. The hypothesis of interest was group × time interaction. Results: The ANCOVA showed a significant group × time interaction for index HRV (F = 4.5, P = .04), but not for standard deviation of the normal-to-normal interval (F = 1.1, P = .3), square root of mean squared differences of successive NN intervals (F = 0.9, P = .3), low-frequency component (F = 0.03, P = .8), or high-frequency component (F = 0.4, P = .5) domains. Pairwise comparisons found that after the manual therapy intervention, patients showed an increase in the index HRV (P = .01) domain, whereas no changes were found after the placebo intervention (P = .7). The ANCOVA also found a significant group × time interaction for tension-anxiety (F = 5.3, P = .03) and anger-hostility (F = 4.6, P = .04) subscales. Pairwise comparisons found that after the manual therapy intervention, patients showed a decrease in tension-anxiety (P = .002) and anger-hostility (P = .04) subscales, whereas no changes were found after the placebo intervention (P = .58 and both subscales). No significant changes were found in PPT levels (right F = 0.3, P = .6, left F = 0.4, P = .5). A significant group × time interaction for pain (F = 4.8, P = .04) was identified. No influence of sex was found (F = 1.5, P = .3). Pairwise comparisons showed that head pain (numerical pain rating scale) decreased 24 hours after manual therapy (P < .05) but not after the placebo intervention (P = .9).

Conclusions: The application of a single session of manual therapy program produces an immediate increase of index HRV and a decrease in tension, anger status, and perceived pain in patients with CTTH. (JManipulative Physiol Ther 2009;32:527-535)