PHYSIOTHERAPY

PhysioForum

Contents

MISSION STATEMENT OF THE SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY

The SASP affirms that:

1. It provides a structure within which the needs of its members are met.
2. It strives to ensure the quality of physiotherapy services to all peoples throughout South Africa.
3. It does not discriminate on grounds of race, colour, creed, national origins, social status or gender in the practice of physiotherapy or in the administration of its organisation.
4. It safeguards the welfare of its members and makes representation against any form of discrimination against its members.
5. It acts as a planning, development and information resource to its members, to other health professions, to health planners at all levels and to the general public.
6. It supports unequivocally the provision of unitary health service and encourages all progress made in the integration of health care services.

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Member of

And the Band Played On...

Recently I watched the extraordinary film which was made from Randy Shilts' extraordinary book, *And The Band Played On*, about the first years of the AIDS epidemic in the USA. I'd seen it before, when it first came out, but the impact then was different; if I recall correctly, the film appeared on circuit about a decade ago, when the epidemic in South Africa was not a matter for the media. Back then, our concerns were the Codesa talks and the violence in East Rand townships and was Inkatha going to take part in the election?

This time around, I was even more deeply moved than I'd been back then. The parallels between the USA and South Africa sprang out at me like a slap in the face: in both countries, AIDS was initially an epidemic of an 'underclass' (gay men and Haitian illegal immigrants in the USA; gay men and the poor in South Africa); in both countries, AIDS was for a long time not given the attention it deserved in high places (it was years after the onset of the epidemic, with the death-toll mounting into many thousands, before President Ronald Reagan actually said the word AIDS in public!); in both countries, and for similar reasons, there was resistance from the people at risk against changing their lifestyles to protect themselves.

There's a very interesting scene in the movie (all of which is drawn from the actual events) in which scientist Don Francis meets with public health officials and gay representatives in front of a turbulent crowd of gay men to tell them that the Centres for Disease Control have discovered that all the men who have the disease picked it up in one of San Francisco's famous bath houses. (The bath houses were famous pick-up joints, but also a symbol of gays' freedom to be who they are sexually in this one small corner of the world.)

The scientist's solution? "We must close the bath houses." (This was at a point where they had not isolated the virus and knew little about it - but the death toll was frightening.) The gay community responds with an uproar and impassioned speeches, followed by a vote to keep the bath houses open. A character leans across to the gay community representative, played by Lily Tomlin, and says, "I don't understand..."

She replies, "They're human... and they're scared."

It's that intersection between plain old humanity and the virus which makes for some of the stranger behaviour we've been witness to. Why would young people who learn that their HIV status is positive, wittingly go out and have unprotected sex? Why do so many in the most well-educated and wealthy sectors of our society practise unsafe sex? (Apparently there's a time-bomb quietly going off in some Afrikaans communities and among young, well-off urbanites.) Why do people latch on to the idea that there's no virus, despite all the evidence to the contrary?

Because they're human... and they're scared.

It's hard for health practitioners to understand the way people act: if you're told that certain behaviour risks your life, why on earth would you engage in that behaviour? Heavens, the denial of threats to life is obvious in far less clear-cut situations: lung cancer patients smoke, heart disease victims avoid exercise - none of us likes to accept our own mortality.

But when it comes to AIDS, things are complicated by the fact that it's the most life-affirming activity of all which is implicated in death. Sex is the one way in which all of us, rich or poor, can declare our joy in life, our mutual love, our gender identity, our faith in the future through our hope of children. To have that joy cabin'd, cribbed and confined, by fear and the pragmatism of condoms and the need to say No when your soul just wants to stand up to the skull-and-crossbones with a resounding Yes... this is very hard.

All of which is why I think one very important clause in the SASP's HIV Protocol (see page 8) is this one:

"Ensure our members are aware of the psychosocial impact and stigmatization of HIV/AIDS and are sensitive to the needs of their patients and caregivers."

Remember that each of you has HIV-positive patients in your practice (you can assume that between one in ten and one in four of your patients - at least - is positive). Each of those patients lives daily with 'the psychosocial impact and stigmatization of HIV/AIDS'. Each is facing bitter choices (to tell or not to

▶ Continued on p. 23

On the Record

The Medical and Dental Professions Board of the Health Professions Council of South Africa's guidelines for record-keeping

GUIDELINES WITH REGARD TO THE RECORDS OF PATIENTS

These guidelines are applicable to medical practitioners and dentists in private practice (including managed health care organisations), as well as to those in the employment of the public service.

1. Compulsory Keeping of Records

Medical practitioners and dentists shall enter and maintain at least the following information for each patient consulted:

a. Personal particulars of the patient.
b. Bio psychosocial history of the patient, including allergies and idiosyncrasies.
c. The time, dates and place of every consultation.
d. The assessment of the patient's condition.
e. The proposed clinical management of the patient.
f. The medication and dosage prescribed.
g. Referral to specialists, if any.
h. The patient's reaction to treatment or medication, including adverse effects.
i. Test results.
j. Imaging investigation results.
k. Information on the times that the patient was booked off from work and the relevant reasons.
l. Written proof of informed consent, where applicable.

Records shall be kept in indelible black ink and erasure fluid shall not be used.

2. Alteration of Records

a. No information or entry may be removed from a record.
b. An error or incorrect entry discovered in the record may be corrected by deleting it with black ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.
c. Additional entries added at a later date must be dated and signed in full.
d. The reason for the amendment and or error shall also be indicated on the record.

3. Retention of Records

a. Records shall be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they are informed of the Board's guidelines with regard to the retention of patient records on computer compact discs.
b. Records shall be stored for a period of not less than six (6) years as from the date they became dormant. In the case of minors and those patients who are non compos mentis, medical practitioners and dentists should use their own discretion whether the records concerned should be kept for a longer period.
c. Notwithstanding the provisions in paragraph b. above, the records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.

4. Ownership of Records

a. Where records are created as part of the functioning of a private practice, the records belong to the medical practitioner or dentist responsible for the care of the patient.
b. The records, including specialist reports, X-ray films and pathology reports prepared in connection with the treatment of any patients at a provincial hospital, are the property of the Health Department and are to be filed at such hospital.
c. As the ownership of records in a multi-disciplinary practice depends on the legal structure of the practice, the governing body of such multi-disciplinary practice should ensure that these guidelines relating to records are being adhered to.
d. Should a medical practitioner or dentist in private practice (both in solo practice and in partnership) pass away, his or her estate, which includes the records, would be administered by the executor of the estate.
e. Should the practice be taken over by another practitioner, the executor shall carry over the records to the new practitioner. The new practitioner is obliged to inform all the patients in writing regarding the change in ownership and that the patient could remain with the new practitioner or could request that his or her records be transferred to another practitioner of his or her choice.
f. Should the practice not be taken over by another practitioner, the executor should inform all the patients in writing accordingly and transfer those records to other practitioners as requested by individual patients. The remaining files shall be kept in safe keeping

by the executor for a period of at least twelve (12) months with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

g. It should be noted that certain partnership agreements may make specific provision for the management of a deceased partner's share in the partnership, which would include the records.

h. In the event of a medical practitioner or dentist in private practice who decides on closing his or her practice for whatever reason, the practitioner shall timeously inform in writing all his or her patients of the following, namely -
   i. that the practice is being closed as from a certain date;
   ii. that requests could be made that records be transferred to other practitioners of their choice;
   iii. that after the date concerned, the records would be kept in safe keeping for a period of at least twelve (12) months by an identified person or institution (an identified person or institution in this sense means a responsible person such as the practitioner's attorney, accountant or bank manager) with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

i. It should be noted that certain partnership agreements may make specific provision for the management of an ex-partner's share in the partnership, which would include the records.

5. Accessibility to Records

a. A medical practitioner or dentist shall provide any person of age 16 years or older with a copy or abstract or direct access to his or her own records on request in terms of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000).

b. Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records.

c. Information about the termination of pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient.

d. No medical practitioner or dentist shall make information available to a parent or legal guardian regarding a patient who is over the age of 14 years, but under the age of 16 years without written authorisation of that patient.

e. No medical practitioner or dentist shall make information available to any third party without the written authorisation of the patient or his or her legal representative.

f. A medical practitioner or dentist may make available the records to a third party without the written authorisation of the patient or his or her legal representative under the following circumstances:
   i. Where a medical practitioner or dentist is a witness in a trial between a patient and another party or where a patient has instituted action in court against a medical practitioner or dentist and is ordered to testify on the patient's medical condition or to produce the records and he or she should request that such testimony be given in camera in accordance with section 153(1) of the Criminal Procedure Act, 1977 (Act No. 51 of 1977).
   ii. Where a patient sues a medical practitioner or dentist and the latter testifies in his or her own defence.
   iii. Where the Medical and Dental Professions Board has instituted disciplinary proceedings and the medical practitioner or dentist has to answer to a charge or defends himself or herself.
   iv. Where the medical practitioner or dentist is under a statuary obligation to disclose certain medical facts, e.g. reporting a notifiable disease or in terms of the Child Care Act, 1983 (Act No. 74 of 1983), reporting any case of suspected child abuse.
   v. In the event where the ailment of a patient becomes known to a medical practitioner or de tist and the nature thereof is such that the medical practitioner or dentist concerned is of the opinion that the information ought to be divulged, in the interest of the public at large. Before the information is divulged the relevant information shall be given to the patient and voluntary author sation shall be sought from the patient.

g. In provincial hospitals the records shall be kept under the care and control of the superintendent. Access to such records shall be subject to compliance with such conditions as may be approved by the superintendent.

6. Retention of Patient Records on CD-ROM

a. Storage of clinical records on computer compact disc (CD-ROM) would be permissible, provided that protective measures are in place.

b. Protective measures referred to in paragraph a. would entail that -
   i. only CD-ROM technology is used, i.e. designed to record a CD once only so that old information cannot be overwritten but new information can be added;
   ii. all clinical records stored on computer compact disc and copies thereof are to be encrypted and protected by a password in order to prevent unauthorised persons to have access to such information;
   iii. a copy of the CD-ROM to be used in the practitioner's rooms will be in a read-only format;

iv. a back-up copy of the said compact disc must be kept and be stored in a physically different site in order that the two discs could be compared in the case of any suspicion of tampering;
v. effective safeguards against unauthorised use or retransmission of confidential patient information to be assured before such information was entered on the computer disc. The right of the patient to privacy, security and confidentiality should be protected at all times.

The Orthopaedic Manipulative Therapist Group

What do they do, how can they help you, should you join the group?

The Manipulative Therapists Group (MTG) was established on 2 March 1974 as a special interest group of the SASP. In 1988 the name was changed to Orthopaedic Manipulative Therapists Group.

According to the group's constitution, Orthopaedic Manipulative Therapists are defined as:

"Orthopaedic relating to disorders of neuro musculo-skeletal structures forming joints, together with associated muscle, connective tissue and neural tissue structures.

"Manual Therapy: the skilled and specialised use of manually and/or mechanically applied movement techniques, as part of comprehensive orthopaedic physiotherapy for the dysfunction of the moving parts of the body.

"The treatment strategy may incorporate any manual or mechanical modality to relieve pain, increase mobility, increase joint stabilisation, and may also incorporate training, counselling and instructing procedures."

The group's special objectives are:

- "To represent the interests of physiotherapists in South Africa with a special interest in Orthopaedic Manual Therapy (OMT) on the Executive Council, the National Executive Committee and on any other national or international organisation/s as may be approved by the National Council of the SASP.
- "To pursue and maintain the highest ethical standards in carrying out OMT.
- "To encourage the practice and improve the standards of OMT as an integral part of the science and practice of physiotherapy.
- "To work towards the acceptance of OMT as part of physiotherapy by the medical profession and by such authorities and/or institutions as may be necessary.
- "To work towards the incorporation of adequate training and examination in OMT as an integral part of the comprehensive service that physiotherapists provide as Supplementary Health professionals.
- "To promote contact and an exchange of scientific, professional and/or other information concerning OMT between members of the OMTG and Orthopaedic Manual Therapists in all parts of the world."

OMT 1

The OMTG has been presenting the OMT 1 course since 1978 in the (then) Southern Transvaal with Ms Freda de Bruin as the course leader. At that time it was a pure (Maitland) course of approximately 75 hours, run mainly by physiotherapists who did their training directly under Maitland himself (either in 1971 or 1979 when he presented courses in South Africa, or in Australia). Since then the course has been presented every year, alternatively the venue between Cape Town and Johannesburg. When there is enough interest, it is also presented in other centers, for example in Durban, Port-Elizabeth and Bloemfontein. In future the course will be run with CPD accreditation consisting of 6 modules worth approximately 20 points each.

OMRIF

The OMTG established a research investment fund to foster research in Orthopaedic Manipulative Therapy. This money is available for any person doing research in this field.

CPD COURSES

Courses of a wide variety and high academic quality are being presented

by the OMTG, all of which will be awarded CPD accreditation.

COURSES BY INTERNATIONAL LECTURERS

Acclaimed international lecturers are brought to South Africa to present courses on their specific field of interest. These courses will cost you much less if you attend them here, but you still have the wonderful opportunity to hear an international lecturer on your home ground.

FIRST CHOICE TO MEMBERS

The above mentioned courses are advertised, but members have the advantage of getting first choice when booking for courses.

NEWSLETTER

Members get a quarterly newsletter with all the latest OMTG news updates.

ARTICLES

Abstracts of relevant articles containing the latest research are published in the newsletter and copies of these articles can be obtained.

IFOMT

The OMTG was a founder member of the International Federation of Manual Therapists (IFOMT). Currently the OMTG is doing everything possible to make sure that the standard of physiotherapy in South Africa is sufficient to maintain membership of this international body. It is very important to have international exposure and IFOMT is the forum where we can achieve this.

IFOMT has a basic educational standard as entry level to be a full member. We have now streamlined our OMT 2 course to be in line with IFOMT's standards. This course will hopefully be run in 2004 as a professional masters degree and qualify you as a manual therapist.

IFOMT 2004

As you might know, Cape Town (South Africa) won the bid to present the IFOMT congress in 2004. We consider this a big honour and privilege, as well as an excellent opportunity to show the international physio world what we have achieved in sunny South Africa! Hope to see all of you there - watch the press for further details.

IFOMT 2004

8th IFOMT CONGRESS

(INTERNATIONAL FEDERATION OF MANIPULATIVE THERAPY)

Dates: 21 - 26 March 2004

Venue: International Convention Centre, Cape Town, South Africa.

Details: This promises to be one of the most exciting events in the history of physiotherapy in South Africa and you are encouraged to start your planning now.

Academic: The theme for the conference is "Balancing the Outcome of Manual Therapy." The programme will range from research based to clinical outcomes papers. Several speakers of international standing have indicated their willingness to participate. The programme will include sessions on Pain, Outcome Based Research, Community and Industrial Considerations, Musculo-Skeletal Spinal and Peripheral Dysfunctions.

Social: This promises to be an exciting programme and will include a banquet, wine tasting, and a theme evening at a typical South African venue.

Accommodation to suit all budgets will be available.

Cape Town: We are very proud of our superb Convention Centre and our beautiful surroundings and know that you will enjoy every aspect of your visit. *Richard Busch, Travel Editor, National Geographic Traveler* agrees with us and writes as follows:
"By any standard, the Cape Town region of South Africa is one of the most beautiful and compelling places to visit on the planet. Here, in addition to a city with fascinating historical sites, excellent museums, vibrant markets and a handsomely restored waterfront, I encountered mountain wilderness, rugged coastlines, sandy beaches, lush gardens, beautiful wine estates, superior hotels and some of the warmest, most welcoming people I've ever met"

Website: Our website will be continually updated as further information becomes available - please keep watching www.uct.ac.za/depgc/pgc/

Enquiries: If you would like further information, please send an expression of interest to:
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All the news that's fit to print!

We update you on recent significant meetings

The SASP's Annual General Meeting was held at Old Ed's in Houghton, Johannesburg, on Saturday 18 May 2002.

This was an important meeting, because it was the first to be held under the new constitution.

New office bearers reflecting the changes to the constitution were elected at the AGM. They are:

- *President-elect*
  Zola Dantile
- *Hospital & Schools Group*
  Regina Moswani
- *Lecturers*
  Tanya van Rooyen
- *PT Assistants*
  Peter Groepies, Nomondi Ngewu
- *New graduates*
  Ria Sanderberg
- *Black representatives*
  Veronica Mamabola
- *Male representatives*
  Hugh Everson, Robert Lelaka
- *Disabled rep*
  Herman Jordaan
- *Foreign qualified*
  Phillipa Jackson

Anna Bizos was thanked for all she had done during her years of presidency and she in turn wished Zola a successful term of office.

The AGM was followed immediately by the National Assembly, which took place from 18-19 May at the same venue.

The meeting began with an informative address by David Campbell of Glenrand about the extent and cover of the malpractice and public liability insurance. In question time, some important issues were addressed:

- Legal costs for members appearing before the HPCSA are covered.
- Members who give advice (for example, as a member of the Peer Review Committee), are covered if it is done in his / her capacity as an office bearer of the Society.
- The insurance will assist in civil liability cases where members are required to appear before the HPCSA.
- Physiotherapists involved in animal health are covered.
- Unethical conduct is not covered, for example, sexual harassment.
- Physiotherapists treating overseas patients are not covered.
- Public liability covers damage caused on physiotherapists' premises.
- Home insurance only covers activities as a home owner, not as a business.
- Category B members can take out public liability insurance.
- Physiotherapists employed by the State who do locums need to be covered by insurance.

Matters arising from previous minutes were then discussed and the President's report accepted.

The Finance Committee proposed honorary life membership for Rena Bernstein for her many years of service to the Society. Rena assisted the Society to purchase the present Head Office and has been involved with the Finance Committee since 1985. She has served on the National Executive Committee and more recently on the Integration Committee. The proposal was passed unanimously.

In her absence (Saira Kahn was in hospital at the time), the CEO's report was tabled and accepted, followed by the Finance report, Joyce Mothabeng's WCPT report, the Communications report and the Peer Review Committee report.

Jill Berridge tabled her Private Practitioner's report, and she was thanked for her leadership - Jill is leaving the country, and Wilma Erasmus will be taking on her responsibilities.

Other portfolios which reported included Quality Assurance, tabled by Ina Diener, Policy (it was agreed that henceforth this portfolio is to be chaired by the President or President-elect), Tariffs (Wilma Erasmus tendered her resignation as chairperson of the tariff committee; Melanie Skeen will take over), Education, the Professional Board, National Hospitals and Schools, the Provincial Reports, and reports from Special Interest Groups.

Community service as the main focus for students was discussed, and the Society was urged to give students appropriate assistance and support.

Herman Jordaan thanked the NA for allowing handicapped practitioners to have a voice in the Assembly (without having to resort to the Human Rights Bill!), and requested that as many accredited courses as possible be made available in Braille or audio taped. It was noted that the University of the Western Cape is doing an excellent job of training handicapped physio-

therapists. National Assembly congratulated Herman on what he has done as representative of this group of physiotherapists.

MOTIONS

Nominations for CPD Committee were carried unanimously - nominees were:
- Cielie Eales
- Helen David
- Judy Hahn *(OMTG/Ethics/Courses)*
- Mary Riley *(NRG + Public Services)*
- Tanya Bell *(Sports)*
- Hester van Aswegen *(Women's Health)*
- Eloise Boshoff *(Animal Health)*

A motion to invite Dr Rob Herbert, one of the instigators of PEDRO, the RCT website to South Africa utilising the PPK Fund for a series of workshops, was also carried unanimously.

The College of Physiotherapy clearly is no longer necessary, and it was moved that it be dissolved by due legal process - this motion was carried, although the minutes of the meeting record that votes in favour were made with regret!

The Executive Committee wanted to investigate the possibility of the Society employing two disabled physiotherapists who can take on some day to day duties of some of the Portfolios and provide capacity and support to the Office and CEO. This was carried unanimously, as was the motion that the SASP convene a meeting with the Professional Board as a matter of urgency to establish and discuss policy to deal with complaints regarding transgressions of ethical professional practice and to deliberate the roles of the Professional Board and the Peer Review Committee.

Face to face with HIV

The SASP has developed a policy on HIV/AIDS which we are publishing for your information

SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY Position Statement on the HIV/ AIDS Pandemic.

The South African Society of Physiotherapy recognises that South Africa, along with the rest of southern Africa, is experiencing a major devastating HIV/AIDS epidemic. This is having a huge impact not only on health but also on every aspect of our society. We are committed to playing a positive role in the management of the pandemic.

Fundamental to this role are the following beliefs:
- That primary infection with the HIV virus leads to progressive impairment of the immune system which then leaves the person vulnerable to opportunistic infections eventually resulting in death.
- HIV is transmitted through unprotected sexual activity, vertical transmission in utero or during birth, breast milk and through contact with blood.
- HIV spreads more rapidly in circumstances of poverty.

We will therefore endeavour to:
- Keep abreast of policy developments and legislation at both central and local Government level.
- Ensure that our members are appropriately trained in prevention of HIV/AIDS through the HIV/AIDS protocol we have adopted. This is available on the SASP website and through Head Office.
- Educate our members regarding aspects of HIV/Aids management including testing protocols, HIV/AIDS counselling, opportunistic infections, mother to child transmission, nutrition, health promotion and exercise prescription.
- Ensure our members are aware of the psychosocial impact and stigmatization of HIV/Aids and are sensitive to the needs of their patients and caregivers. Ensure that confidentiality of patients health status is respected.
- Encourage our members to become involved in community education programmes regarding prevention of HIV transmission and care of people with HIV/AIDS.
- Ensure our members are informed regarding the latest National and Regional Department of Health policy on the management of HIV/AIDS.

We will establish an HIV/AIDS support committee that will provide relevant resources for physiotherapists. We recognise that our members both as healthcare workers and members of society will be subject to severe stress as a result of the high levels of disability and mortality associated with Aids.

SASP Health Policy Portfolio
March 2002

Comrades: the students' experience

Christine Egenrieder, Wits PSC Chairperson and NPSC Secretary, reports for the Wits students who helped out on the day

Wow! Fun and games, lack of sleep, frozen hands, getting lost, bus drives, making fools of ourselves, touch rugby, food, Joe Kools, belly rings, shifts, 30 seconds and electricity cuts - a summarized version of Comrades for Witsies.

It all started on Thursday the 13th of June. For most, it was a rude awakening, as we had to be at Wits Medical School by 6:30am in the morning. As expected, no-one was early. The bus eventually left at 7:15am. The poor bus driver didn't have a clue what he was getting himself into. After an eight-hour drive we arrived in Durban. None of us had seen the accommodation, so naturally we were all a bit apprehensive. But to our surprise it turned out to be better than expected. Then again it didn't take much to beat our expectations of a huge barn-like room with beds lining the walls, sort of like the American army base dormitories.

WOW! Fun and games

ON THE BEACH

Our trip to Comrades was almost not possible due to financial constraints and lack of accommodation availability, but somehow a few hard-working students managed to find us this spot. It was literally on the beach. The pamphlet had said 100m from the beach, which we all glanced at thinking " Whatever..." but true as nuts we were, indeed, 100m from the beach. The typical vaalies that we are, we all dumped our bags and ran to the shore. Some more adventurous people even swam. Later we found out that the shark nets had been taken out due to the sardine run. The swimming expeditions suddenly came to a halt; helped by the fact that the weather was not really in their favour.

Our first dinner together was at the Spur. Booking tables was quite funny. We had passed by in the late afternoon to give them a little warning. When they asked us how many people we were booking for, their jaws suddenly dropped to the floor, as if to say, "Seriously?". We confirmed a booking for 50 people. We didn't say that they were all students. As planned the bus stopped outside Spur at 7:00pm, and 50 students piled into Spur. After lots of laughs and with full tummies, two of our classmates felt the urge to further entertain the whole restaurant and join in on the Spur birthday dance or "sokkie".

Not just once but three or four times. Understandably most of us were rolling on the floor with laughter. Nature's best medicine!

EXPO DAY

Friday morning we all woke up and had a wonderful breakfast. Most of us had collapsed into our beds for the night, and we were all well rested by the morning. For some of us it was Expo day. The first group of students left at 8:30am for their shift at the EXPO. Using trial and error navigation skills, they found the ICC centre and their location in the expo. Each student received a T-shirt and then proceeded to be used and abused by the athletes. Round One for our hands, although nothing compared to Race Day. The shifts were not too long, but long enough for some to curse any athlete wanting a rub or even some TLC.

At expo we worked with other physiotherapy students from TUKS, UDW, UWC, Bloem, Stellenbosch, and Medunsa. This was the first time that we had the opportunity to interact with students from other physiotherapy universities. Little did we know that another side of each university would come out at the Cocktail evening!

Friday night we were all treated to a sponsored dinner at McDonalds. Approximately 80 starving students filled the kiddies birthday party section in an unsuspecting McDonalds near the ICC centre. Dinner was mainly building up an energy reserve for the night ahead. Some of the universities met up at Joe Kools shortly after dinner. We danced the night away and even managed to get a song dedicated to all of us. The visit to Milky Lane at 1:00am went down extremely well. The poor bus driver got roped into waiting for all of us.

LET THE GAMES BEGIN

Saturday was yet again EXPO day. In the evening we put our trial and error navigation skills to the test yet again. Wits almost didn't arrive at the Cocktail evening (a very misleading term for the evening that lay ahead). Rather late than never though. On arrival we were offered some free food and drinks, which was very much appreciated and enjoyed. (We're talking about students, after all!) Chris and Michelle, the organisers of the physiotherapeutic services for comrades, explained the proceedings of Race Day to us, gave us our race day packs and then the games began. Each university was split into teams. Each team would play another university in Action Cricket, Netball and Soccer. Most of us were utterly exhausted after this evening, some from taking the games a tad too seriously and others from laughing again and again and again. It was a brilliant icebreaker for all of us.

Sunday evening the Wits physiotherapy students were treated to dinner subsidized by their Student Council. An early night was definitely good advice. Some took it, others regretted not taking it.

WE WILL SURVIVE

If Thursday morning was bad for some, then Monday morning was just awful. The bus left in the dark (5:00am) and returned in the dark (9:00pm). Wits was posted at two stations along the route, Ashburton and Top of Polly Shorts. All the students were dropped off at their stations by 6:30am. Throughout the day, the station leaders organized food and drinks for all the workers at each station. Each station had students from numerous Universities working towards a common goal, to survive Comrades 2002. For most of the day, our hands were numb, not from massaging but from icing many, many sore and tired legs. It was a once in a lifetime experience to be part of this massive race. For some athletes it is an achievement that they have been dreaming of, and for others a moment of frustration when they see the cut-off or finish line, knowing that they would not be getting the medal at the end. These emotions became very real for students working at critical stations en route.

Students at the end had a very different day. Some enjoyed their moments of fame, as they nabbed the TV crews. At the End it was very apparent how crucial it is to be

fit enough to complete Comrades and how dangerous it is running with a niggling injury.

After a long hard day, we headed back home. It would have been quicker to walk back. The N3 was at a standstill on and off for a good hour or so. For the first time in a long time, the bus was quiet.

PARTY, PARTY, PARTY

Back at our digs, instead of sleeping as normal human beings do when they are tired, the Wits physiotherapy students partied the night away. To most of us sleeping for three hours was a waste. We had a whole bus trip home to sleep through. The bus left promptly at 2:30am. A quick stop for munchies, and then straight on to Johannesburg.

Comrades 2002, was a wonderful experience, an experience we recommend for every physiotherapy student. The Wits Physiotherapy Class of 2002 will never look at each other in the same light again. The friendships built and strengthened, class spirit, tears of laughter and the professional exposure are priceless, when looking at the greater picture of life. Comrades 2002 will be a special memory for all of us.

A big thank you must go out to Chris and Michelle from Kwa-Zulu Natal for all their hard work and dedication. Organizing seven institutions is a hard enough task, but add to the equation the fact that they're all students, and it makes it seemingly impossible. Your hard work and time were very much appreciated. Thank you from all the physiotherapy students at Comrades and the NPSC (National Physiotherapy Student Council) 2001/2002.

Who you gonna call?

Information about the Peer Review Committee

The Peer Review Committee was established as a means for the profession to regulate itself and ensure quality service to patients/clients. The peer review process is conciliatory in nature. All physiotherapists are therefore encouraged to co-operate fully with the Peer Review Committee (PRC). In this way complaints may be satisfactorily resolved between complainants and respondents without referral to the Professional Board for Physiotherapy, Biokinetics and Podiatry (Professional Board) and the Health Professions Council of South Africa (HPCSA) or recourse to the law. The PRC also acts as a screening mechanism prior to referral to the Professional Board. However, anyone may refer disciplinary matters directly to the Professional Board. Serious disciplinary matters will be referred directly to the Professional Board by the PRC.

Members are encouraged to contact the member of the PRC closest to them, but if they wish to contact another member they are free to do so. Consultation by telephone or email is welcome, but formal complaints have to be submitted in writing. This will be sent to the person against whom the complaint is, for comment. After this further consultation may be necessary before a decision can be made. If a matter has already been referred to the Professional Board or lawyers, the case is out of the jurisdiction of the PRC.

Members of PRC and contact details:

Dalene Booysen	North Gauteng	(012) 341 2525 (w/f)
Marion Butler	Eastern Cape	(041) 585 6161 (w)
		(041) 585 7629 (h/f)
Wilma Erasmus	Mphumalanga	(013) 697 0410 (h)
		(013) 656 4176 (w/f)
Narina Gilder	Westren Cape	(021) 531 1820 (h/f)
		082 395 1989
Judy Hahn	South Gauteng	(011) 646 0797 (h/w)
		(011) 486 2797 (f)
Janice Hall	Northern Cape	083 448 9266
Debbie Hill	KwaZulu Natal	(031) 201 4652 (w/f)
Hester Huysamen	Tariffs	(012) 807 0601 (h/f)
		(012) 8074305
Dirk Malan	Free State	(051) 448 8555 (w/f)
Katie Schoeman	Western Cape	(021) 447 8644 (w/f)
		(021) 531 5924
Lieske Stewart	Limpopo	(015) 296 2269 (w/f)
		(015) 296 1622 (h)

Africa Unite!

WCPT Africa meets for a special regional seminar; WCPT Delegate for South Africa, Joyce Mothabeng, reports.

WCPT Executive members and delegates at the WCPT Africa Regional Meeting

WCPT Africa held a special regional seminar in Kenya from 17 - 21 April 2002. The primary aim was to foster professional development in the region through 'Training-the-trainers'. Seven African countries sent delegates to the seminar. The Kenyan Society of Physiotherapists worked very hard to make sure this was an occasion to remember.

The seminar was a major achievement and a measure of success towards achieving regional development objectives that include amongst others:

- Meeting annually as a region in CPD workshops / seminars
- Encouraging MOs (member organisations) to organise CPD activities
- Embarking on skills development for individuals within MOs.

The Kenya meeting was special in that it was held at the same time that the WCPT Executive was having its own meeting. This created opportunities for the regional and international WCPT ECs (Executive Committees) to meet. The following high profile visits were arranged for the international WCPT EC:

- A visit to Moi University (where a degree programme is being planned).

At the Jomo Kenya Airport, departing to visit Moi University.

- The Kenya Health ministry was also visited

The programme of the regional seminar was:

Thursday: 18.04.2002

- Ina Diener conducted a full-day workshop on Evidence Based Practice.

Friday 19.04.2002

- Ina Diener presented a morning workshop on the physiotherapeutic management of cervical headaches.

- Joyce Mothabeng presented an afternoon workshop on Applied Research - building on to the previous day's EBP.

Saturday 20.04.2002

- A whole-day special meeting was held to discuss regional affairs. The highlight of the meeting was the launch of the region's first regional newsletter - the AFRICAN VOICE, with Tyson Simuzingili from Zambia (WCPT Africa vice chairman) as the editor. It was decided at the meeting to change the name to the AFRICAN PHYSIO TODAY. The newsletter will appear twice a year, and the next issue is October 2002. The meeting also agreed to support Kenya in bidding to host WCPT 2007.

Sunday 21.04.2002

- A short WCPT Africa EC meeting was held to immediately look at plans for issues that the previous day's regional meeting raised.

GENERAL

The Regional seminar in Kenya was more of a professional development than financial success. Delegates were happy that Professional development activities are being arranged at regional level and requested that more of these be arranged by the regional EC - hence the Swaziland seminar in October.

NEWS FROM MEMBERS

Zimbabwe

The Zimbabwe Physiotherapy Association (ZPA) reported that the regional treasurer who was also an official of the ZPA had left their country and was working in the United Kingdom on a 3-year scholarship. The ZPA is prepared to provide a 'replacement' if the region so desires. The regional meeting decided to leave it up to the Regional EC to co-opt a treasurer, and Mr. Willard Mutungwazi was co-opted as the 'replacement'.

Zambia

The Zambia Society of Physiotherapy held their Annual General Meeting on the 30th and 31st of March 2002. This was a memorable occasion for two reasons. Firstly, a new executive committee was ushered into office. Secondly, the theme of the WCPT-Africa 2004 congress was formulated.

The Theme of the congress is 'PHYSIOTHERAPY: FACING THE CHALLENGE'.

Dates for Congress are 26th April to 3rd May 2004.

Ethiopia

We have received disturbing news that due to some political problems the running of the Ethiopian Physiotherapy Association (EPTA) has virtually been brought to a standstill. The situation is so severe that the EPTA President and Vice President (Desalegn and Fasiel) had to seek political asylum outside the country. The EC is looking into the matter and you will be kept updated.

Swaziland

Ergonomics workshop

The Association of Physiotherapists of Swaziland has planned two major events later this year. On the 29th and 30th of June, there was an ergonomics workshop on Workplace Rehabilitation, focusing on Musculoskeletal problems of Manual Handlers. The workshop was facilitated by Joyce Mothabeng, and attended by delegates from Swaziland, South Africa and Botswana.

Regional conference

As agreed in Kenya, Swaziland is hosting the next WCPT Africa regional conference for 2002. The conference will focus on musculoskeletal problems (in line with the Bone and Joint decade!) and the physiotherapeutic management thereof. Topics will be covered in practical hands-on type workshops in the following three categories:

- Mobilisation with movement (neck and shoulder)
- Headaches (back by popular demand!)
- Mechanical back pain

The conference will take place in the heart of Mbabane from the 11th to the 13th of October 2002. Leading specialists in the above three topics have been invited. You will agree with me that this is not a conference to miss!

I am appealing to you, my fellow South Africans: let us be there in great numbers to show our support for the region. October is the perfect time to visit Swaziland, with so many of their cultural events taking place. The conference is also so cheap!

For more information, contact Lungile at lungilev@yahoo.com
Tel: +268 404-7601(W)
Fax: +268 404-7751
or the conference organiser
nomceboallice@yahoo.com

Executive members from WCPT and the Kenya Society of Physiotherapy at Moi University.

WCPT INTERNATIONAL

International calendar of events

- Pan-Pacific Rehabilitation Conference, 23rd to 25th August, Hong Kong
  Contact: rsppcr@polyu.edu.hk
- International Congress Of Manual Therapy, 18th to 20th October - Estoril, Portugal. Contact: mundiconven@mail.telepac.pt
- Kuwait International Conference, 19th to 21st October - Safat, Kuwait
  Web: www.kpto.org
- General Assembly of Asian Confederation, 17th to 20th November - Bangkok, Thailand.
  Web: www.physicalthai.or.th
- Austrian Disease Symposium, 27th to 30th November - Vienna, Austria.
  Web: www.physio.at/congress.2002.htm

Around the world in thirty days

Zola Dantile has been representing your Society in far-flung places!

At the Yomo Kenya Airport, departing to visit Moi University.

"On our first day, we went to Eldorat, where top Kenyan athletes train, to visit Moi University and see how their physios are taught. The Acting Dean of the faculty was our host - he was a bit taken aback by the size of our delegation. He couldn't get over the fact that the President of the WCPT was there, all the way from Australia; and when we all introduced ourselves one by one and told where we came from, he said, 'You mean the whole world is here?'"

Zola Dantile is talking about her trip to Kenya from 17-21 April this year to attend the WCPT meeting which was held there to coincide with the WCPT-Africa meeting attended by Joyce Mothabeng.

She was very interested to see that Kenya, which has hitherto only trained its physios to diploma level through the University of Nairobi, and is in the process of implementing a degree course, uses 'problem-based learning' as its teaching method. "The Kenya Society of Physiotherapy (KSP) got funding from WCPT to do curriculum development, and they've been working on it for two years now, so we went to see what they've done. We were met by the Dean of the Faculty, who had come in even though he was on leave and had left the department in the hands of the Acting Dean, and the co-ordinator of the programme, who is an orthopaed who studied in the Cape."

The delegation shared their experiences of physio around the world with the faculty and students - and in turn received a heartfelt plea. "They are very enthusiastic, but under-resourced," says Zola. "They have just enough equipment to get by. They need gym equipment - balls and things like that - and the help of qualified physios. Of course, they pointed out that they can't pay much in the way of salary, but it would be an exciting opportunity for retired physios or physios on sabbatical who want to contribute something to the profession in Africa."

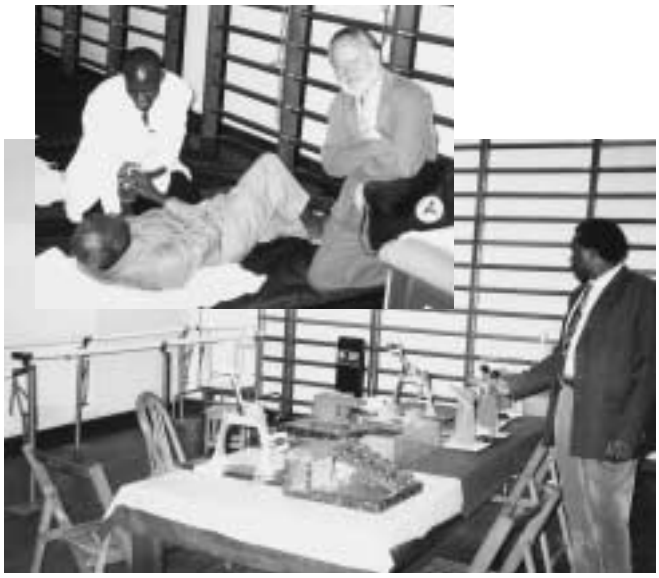
The wards, says Zola, reminded her very much of wards in rural hospitals in South Africa. She was impressed by the set up in ICU. "It's done in such a way that the physios are actually in the ICU, an integral part of the unit."

GLOBAL MATTERS

The following day was devoted to the executive meeting of the WCPT. "We got down to some strategy planning for the Barcelona Congress next year, and touched on the issues which will be dealt with. We also looked at policy matters; for example, the USA is moving towards making a Masters the entry level for physiotherapy - how will that impact on the rest of the world, especially as America has the biggest organisation in the world? We looked at the application form for membership in WCPT and ensured that it was still relevant and made sense, especially in the light of the fact that in the USA, most accreditation bodies - and there are many of them - want to join the world body.

The WCPT requires that all member organisations show financial sustainability by paying their fees.

WCPT Executive Committee Members



Physiotherapy Department at the Nairobi hospital, where physiotherapists are trained.

"Once you've joined the organisation and paid your subs, we do make sure that you are able to attend the meetings," says Zola. One of the issues under discussion was the fact that so much of the WCPT's funds are being dispensed to cover airfares, while rather less is being spent on developmental work. Not that the airfares aren't important, Zola hastens to add, but the WCPT is looking at ways to promote developmental work effectively. "We're looking to give more info to people which will enable them to put together their own continuing professional development courses and seminars, for instance, and to get skilled people to visit other countries and 'train the trainers' as well as give courses."

Important issues like Evidence-based practice and Community-based rehabilitation came under the spotlight, too.

Feedback from last year's 50th anniversary was given, and the links with other important organisations like the World Health Organisation were discussed - it is part of the WCPT's mandate to forge these links and maintain them.

It is also part of the world body's mandate to raise the profile of the host country's organisation, so the delegates devoted some time to visiting significant government and other role players, including the Minister of Health. Zola was very impressed with the KSP's relationship with the government. "They have a very good working relationship, and are highly regarded. Did you know the KSP performs the same functions in Kenya as our HPSCA, as well as acting like a union, negotiating salaries and conditions?"

In the course of their visits, the delegates popped in on an AIDS course attended by about 50 physios. Once again, course attendees and lecturers were overwhelmed that the world had come to visit them. "It was a moving moment," recalls Zola. "The sort of moment which makes you realise that, after all, you are doing an important and meaningful job."

DOWN UNDER

Hardly had Zola unpacked her toiletry bag than she was packing up again to fly to Australia, where she attended the 5th Wonca Rural health Conference from 30 April - 3 May. (No, don't ask what Wonca means - Zola never did find out, except that it's not an acronym!) The last of these conferences was held in Durban in 1997, and resulted in the Durban Declaration.

For the first time, the World Organisation of Family Doctors opened its doors to physiotherapists and other ancillary health professions, and there were more than 800 delegates from 26 countries present. Zola was sponsored by the WHO via our own Department of Health - "Otherwise," she laughs, "I would never have been able to go! I think the registration alone worked out to about R5000!" She presented a paper on 'The Provision of Physiotherapy Services in the Rural Areas'.

Delegates from South Africa at Monca Conference in Australia.

"It was certainly the busiest conference I've ever attended," says Zola. Fortunately, all the South Africans - there were 22 of them present - got together in advance and agreed to split things up so that between them, they would cover as much as possible.

Official Monca Conference Dinner. Delegates in traditional dress.

Zola with the delegates from the Aboriginal community attending the Monca Conference.

The highlight of the opening night, for Zola, was a cleansing ceremony held at the conference venue, the Carlton Crest in Melbourne. "Apparently the ground on which the hotel is built previously belonged to one Aboriginal tribe, and was taken away from them. Only very recently have they been included and recognised in this way."

It was interesting, says Zola, to discover that rural health is the same the world over, whether it's in the tightly-packed island of Britain or the outback of Australia. "There are never enough health personnel, resources are limited and transport is always a problem!" What becomes apparent, though, is that the poverty-related diseases differ - in England it's coronary heart disease, in Africa it's TB.

WCPT had developed a document preparatory to the Wonca meeting, which looked at case studies in Switzerland, Nepal and South Africa as typifying rural health. The South African case study involved an innovative project in KZN, the Mosveld Bursary scheme, which sponsors local students to enable them to gain qualifications. They are required to work at local hospitals during their holidays, and once they're working, must contribute R10 of their salary to assist the next student to benefit.

South African delegates who attended the Monca Conference.

"The conference was real eye-opener, and reassuring also - I came away with a sense that we are doing the right things in South Africa," says Zola. "The Australian government's involvement in rural matters was heart-warming - they train rural students on-site, at satellite universities developed at the places where they will work, for example. And that's working very well. Like much else that I heard and saw at the conference, it's something we can learn from."

The Melbourne Manifesto

A Code of Practice for the International Recruitment of Health Care Professionals:

Adopted at 5th Wonca
World Rural Health Conference
Melbourne, Australia. 3 May 2002

PREAMBLE

Many countries in both the developing and developed world are experiencing shortages of skilled Health Care Professionals (HCPs), particularly in rural and socially deprived areas.

One of the responses of wealthier countries is to recruit HCPs from poorer countries, rather than training sufficient numbers of their own.

This leads to a flow of highly trained professionals away from the countries that can least afford to lose them. The effect is to impact negatively on already seriously under-resourced health systems and therefore on the health status of developing countries.

Development of an ethical code should balance the rights of individuals to travel against the needs of communities.

Principles

We assert that:

1. It is the responsibility of each country to ensure that it is producing sufficient HCPs for its own current and future needs; is retaining them; and is planning for both rural and urban areas.
2. International recruitment is related to an inability on the part of individual countries to satisfy their own workforce needs.
3. The principles of social justice and global equity, the autonomy and freedom of the individual, and the rights of nation states, all need to be balanced.
4. Integrity, transparency and collaboration should characterise any recruitment of HCPs.
5. International exchanges of HCPs are an important part of international health care development.

6. Countries that produce more HCPs than they need, may continue this contribution to global health care.

Purpose

This code of practice aims to:

! promote the best possible standards of health care around the world;
! encourage rational workforce planning by all countries in order to meet their own needs;
! discourage activities which could harm any country's health care system.

The code

1) Countries considering and benefiting from recruitment from other countries must:

a) examine their own national circumstances and
i) consider the effect that their existing recruitment policies and practices are having on lesser developed countries
ii) develop and implement their own ethical recruitment policies
iii) ensure that the number and distribution of undergraduate and postgraduate training posts available within the country are adequate to meet their own workforce needs
iv) ensure that the working conditions and educational opportunities in their own countries are sufficient to encourage HCPs to work in areas of need
v) develop and resource active educational links with universities and medical schools in lesser developed countries that contribute to the education and training of their HCPs
vi) consider alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams and intersectoral collaboration..
vii) explore using the skills of HCPs who have migrated for personal reasons living in these countries but unable to work.

b) review their recruitment strategies to ensure that they:
i) acknowledge the principles outlined in the 1997 Wonca Durban Declaration, "Health for all Rural People", together with the principles outlined above.
ii) develop a Memorandum of Understanding (MOU) with countries from which they wish to recruit. This MOU should outline issues such as:
- how this recruitment will be done
- the benefits to each country
- the nature and degree of compensation that should be paid to contribute to the support and training of HCPs in their country of origin
- the steps required to ensure that any recruitment by agencies or government is conducted and monitored according to this Code of Practice
- the inclusion of HCPs recruited from abroad under the receiving country's employment laws
- the provision of full and accurate information to potential recruits regarding the nature of the job, selection procedures and their contractual rights and obligations
- the support, further education, training and continuing professional development available to recruited HCPs that is equivalent to that provided to other HCPs
- the support and encouragement of nationals to return to work in their country of origin.
iii) only recruit and advertise (including national journals) from another country when a MOU exists.

2) Countries experiencing damaging loss of HCPs should explore the reasons why HCPs are leaving and address these by:

a) evaluating their own training programs to ensure that they equip their graduates with the knowledge, skills and attitudes that are most appropriate for their national needs
b) ensuring that the working conditions, incentives and educational opportunities in their own countries are sufficient to encourage HCPs to work in areas of need
c) considering alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams and intersectoral collaboration

3) Developing countries should be supported to recruit from developed countries, given that they will not be able to compete in terms of financial incentive packages. Such recruitment would focus on providing short-term opportunities for HCPs with clinical, educational, management, research and other skills to assist in the development of health care services in these countries.

4) Countries should develop transparent processes for the limited registration or licensing of HCPs trained abroad which allows for

a) short term exchanges, fellowships, and sabbaticals, which can:
i) offer opportunities for enhanced practice and experience over a specified period of time
ii) allow trained staff from the recruiting countries to benefit from exchange experience abroad.
b) further training of HCPs from developing countries in more developed countries. This can make a positive contribution if it is structured in a way that ensures that HCPs return to their home countries after training for at least the equivalent period of the duration of such training.
c) international mobility of HCPs prepared to work in areas of great need.

We believe there should be an international process to ensure the evaluation and monitoring of international migration of HCPs to inform this code.

Participants at this 5th World Conference on Rural Health in Melbourne hereby call on all countries to adopt this Code of Practice for the International Recruitment of Health Care Professionals.

Better skills, better practice

Mandi Smallhorne talks to Dimitrios Kostopoulos, PT, PhD, who will be presenting two workshops here in November.

Dimitrios Kostopoulos is the co-founder of Hands-On Physical Therapy. He earned his Doctorate and Master's degrees at New York University and is actively pursuing his second Doctorate of Science degree at Rocky Mountain University (Clinical Electrophysiology). Dr Kostopoulos has extensive training and teaching experience in different areas of manual therapy with emphasis in Trigger Point, MyoFascial, Neuro-Fascial Therapy and Manipulation. He is a past faculty member at Mercy College, a Diplomate of the American Academy of Pain Management and an active member of the American Physical Therapy Association.

Dr Kostopoulos has taught students both in the US and in Europe and has published numerous articles. He is also the co-developer of a comprehensive therapeutic approach that integrates trigger point, myofascial, neurofascial, proprioceptive and manipulative therapy techniques.

What makes your course and your training concept different from others? What is unique about it?

Clinical application is the most important component of teaching a physical therapy concept or technique. Many continuing education courses may offer scientific knowledge without providing the ability of duplication of knowledge and further application. In our courses, we make absolutely sure that there are immediate clinical applications for all the concepts and techniques that we teach. It is very important for the clinician who is taking our course to be able to apply each one of the techniques he or she learned immediately after the end of the course. The format of the course is very unique with the use of highly effective multimedia presentations and ample demonstrations of each one of the techniques and procedures. Lab sessions cover a significant component of the courses and allow the participant to learn and feel certain about each of the techniques.

What will physios come out of the course knowing which will make a real difference to their practices?

Immediately after the end of each of these courses the course participants and clinicians will be able to:

- Discuss the diagnosis and treatment of Myofascial Dysfunction and identify principles of Differential Diagnosis.
- Demonstrate how to diagnostically choose the proper muscle systems to work with.
- Demonstrate how to create their own Myofascial Treatment Protocols which include Trigger Point Therapy, Muscle Strengthening Programs, Myofascial Stretching Exercises, and Proprioceptive Training.
- Demonstrate how to effectively treat acute and chronic pain problems.
- Demonstrate the techniques immediately after the seminar

How have other students responded to your courses?

Here is just a sample of things students have said:

"I wonder how many of my patients could have received better, quicker results from therapy if only I could have applied the techniques I learned in this course."
Donna Fardellone, MA, PT

"This was the most informative and fun course I have attended in years!"
Susan Schor, PTA

"The combination of great information and the entertaining way of delivering the information made the course a lot of fun."
Amy Smoot, ACSM

"This course has given me incredible insight into treating patients with any diagnosis with a completely different and effective approach."
Gaby V Chorny, PT

Where did you grow up, why did you get involved in physical therapy, what do you enjoy about it?

I was born and grew up in Tripolis, Greece. At the age of five

▶ Continued on p. 19

For further details on Dr D Kostopoulos' workshops in Johannesburg see course notes on page 24.

News from PhysioFocus

Information about the Peer Review Committee

Contracts of Employment and amendments to the BCEA

Information from Johann Le Roux, Regional Director of Express Personnel Services, for private practitioners.

With the implementation of the latest changes to the Basic Conditions of Employment Act (BCEA), now scheduled for 1 August 2002, employers need to review how the amendments will impact on current and future contracts of employment.

CURRENT CONTRACTS

The first principle that applies in this regard is contained in Section 4 of the BCEA (or an amendment), and is automatically a term of any contract of employment. The only exceptions are if another law (or amendment) or the contract itself, provides terms that are more favourable for the employee.

Employers need to review how the amendments will impact on current and future contracts of employment.

The second principle to be noted states in Section 5 that the BCEA 'takes precedence over any agreement, whether entered into before or after the commencement of the Act'. This in effect means that contracts of employment (agreements) in which employees agree or agreed to lesser terms and conditions are invalid.

Your current contracts of employment should be written as outlined in section 29 of the current BCEA. Should this be the case, some employers may be locked into terms and conditions agreed to, to comply with the current law. This means they may not be able to take immediate advantage of amendments, which are now more favourable to the employer. Whether or not this is the case depends on the wording of certain clauses.

FUTURE CONTRACTS

Employers will be advised to phrase all new contracts of employment, taking into account proposed amendments that allow a more favourable arrangement for the employer. One such area is definitely in respect of notice periods. The amendments in this regard, allow for the shorter notice periods than contained in the current BCEA. The minimum notice periods will be a week's notice; employees who have been employed for more than 6 months but less than a year's service (currently 4 weeks service), must receive 2 weeks notice. Employees who have been employed for more than one year, and domestic and farm workers, who have been employed for more than 6 months, qualify for 4 weeks' notice.

Employers need to check their wording on notice periods in contracts of employment. If your current contract states a set period, which is longer than that stipulated in the amendments, you will be bound by that period, since this is more favourable than the minimum required by law. If your contract reads 'a notice period as stipulated by the BCEA or amendments', you may apply the new lesser periods to existing contracts. This is in any event the recommended wording to be employed in respect of any new contracts of employment entered into.

It should be noted that, as is the case with the current BCEA, all amendments will apply to indefinite term contracts of employment and limited duration contracts of employment. This means that so-called contract employees must receive all benefits stipulated in the BCEA. Employers who have concluded independent contractors are likely to find that most of those are now defined as employment relationships, irrespective of the content of their agreements.

▶ Better Skills, Better Practice (Continued from p. 18)

I suffered from a serious illness that made me want to help people and made me fall in love with the health professions. Later on Physical Therapy became an important choice for me. In 1987, after finishing the Physiotherapy School in Athens-Greece, I traveled to New York, USA, for graduate studies. I completed my Master's degree and later on my Doctorate degree at New York University. I am currently finishing my second Doctorate at Rocky Mountain University of Health Professions.

I like variety in my life. Treating patients, teaching seminars, doing research, writing books and articles and always studying further keeps me busy enough and provides my life with variety. I am looking forward to the courses in South Africa and meeting and sharing new ideas with my physiotherapy colleagues.

ZOOM into PhysioFocus

When I started in private practice in 1987, many physiotherapists were females who worked for a couple of hours per day.

- Many worked because they wanted to and not because they had to.
- It was a convenient career where you could choose your hours, location and the type of patient you wanted to see.
- You could raise children and have a career.
- Patients were under informed about the medical field, so you could tell them anything and convince them it was true.
- There were few rules and nobody knew anything about individual rights.
- We were even called a cottage industry amongst the funders.
- Payments were guaranteed and the competition was weak.
- The majority of physiotherapists worked for the luxuries in life.
- Words like **outcome based treatment, clinical guidelines** and **treatment plans** were hardly ever used or didn't even exist.

In the past couple of years I have noticed a trend that is becoming increasingly obvious.

- More and more physiotherapists are the breadwinner or a 50/50 breadwinner.
- The luxuries have been replaced by necessities for the family.
- You might not be able to choose who you want to see, when and were.
- You must be available when the patient, hospital or doctors need you.
- The patients, now your clients, are well informed about the medical field and know their rights.
- Competition amongst fellow therapist and other medical professions is strong.
- Funders are demanding and payments are no longer guaranteed.
- Great emphasis is placed on evidence based treatment outcomes and clinical guidelines.

It might seem that the past was better. It is my opinion that NOW is better.

- Competition amongst providers is good; it keeps you on your toes.
- Informed patients are good, they keep you alert and thinking.
- Generally, change is good, it helps our profession to grow and develop.

Your competitors will catch up with you if you rest on your laurels, while managing your practice.

My focus as PhysioFocus Chairman is to:

- keep the relationships within the whole of SASP and PhysioFocus strong and healthy
- keep PhysioFocus alive and kicking in the SASP, South Africa and within the International Private Practitioner's Association (IPPA)
- aid all members of PhysioFocus to manage the changing health scenario
- keep members informed about national and international trends in the medical field
- keep members informed about best practice management tools

Snippets from the Health Industry:

"Mediese skemas, dekking duurder, voordele minder. Lede van mediese skemas moet sorg dat hulle weet presies waarvoor hul mediese skema betaal. Mediese koste.....heelwat pyn kom nog.
"Deur te verseker dat kostes in bedwang gehou word, verseker ons dat gesondheidsorg op lang termyn bekostigbaar bly vir ons lede" sê Mr Matisonn van Discovery Health"
Finansies en Tegniek
5 Julie 2002. Pg. 15

"Patients do have the right to refuse treatment"
Patients Rights Charter, PhysioForum June 2002

Implications: You cannot inflict your treatment on an unwilling patient, even if the doctor referred the patient and insist on treatment. The correct procedure is to explain the benefits of the treatment and the consequences of refusal and communicate the patient's decision to the doctor. Report every detail in the patient's clinical records.

Wilma Erasmus
PhysioFocus Chairman
Caring with Quality.

HIV under the microscope

Denial, denial everywhere

Associated Press reports (8 July, 2002) that a study of young gay and bisexual men in major US cities found that more than three-quarters of those infected with HIV were unaware they had the AIDS virus.

Ignorance of infection among HIV-positive gay and bisexual men was twice as common as previous estimates.

Researchers surveyed 5,719 men aged 15 to 29 at dance clubs, bars, health clubs and street locations in Baltimore, Dallas, Los Angeles, Miami, New York and Seattle from 1994 to 2000.

Of the 573 who tested HIV positive, 440, or 77 percent, had not known they were infected with the virus.

The stigma of being positive - and the fear that comes with the knowledge - are leading men into denial, and researchers fear this could lead to a surge in infection rates once again in the USA.

Bad news

Anso Thom of health-e news reports on 1 July 2002:

The scale of the worldwide AIDS crisis now outstrips even the worst-case scenarios of a decade ago with even worse yet to come.

According to the latest report released by the Joint United Nations Programme on AIDS (UNAIDS) the realisation is fast dawning that the epidemic is at an early stage of development while its long-term evolution is still unclear.

The Report on the Global HIV/AIDS epidemic said hopes of the epidemic reaching its natural limit, beyond which it would not grow, have been dashed particularly in southern Africa.

In Botswana for example, the average HIV prevalence among pregnant women in urban areas already stood at 38,5% in 1997. In 2001, it had risen to 44,9%.

Similar patterns are visible elsewhere in Zimbabwe, Namibia and Swaziland. In sub-Saharan Africa approximately 3,5-million new infections occurred in 2001, bringing to 28,5-million the total number of people in the region living with HIV/AIDS.

Fewer than 30 000 people were estimated to have been benefiting from anti-retroviral drugs at the end of 2001. The estimated number of children orphaned by AIDS living in the region is a staggering 11-million.

Drug-resistant HIV?

About one in seven people who have recently been infected with HIV have contracted a strain of the organism that is already resistant to drugs used to treat the disease, according to doctors in the USA (from a report in the Nando Times, 6 July 2002).

Dr Frederick Hecht, associate clinical professor of medicine at the University of California, San Francisco, analyzed the virus that infected 225 patients in San Francisco who showed signs of having been newly infected with HIV. He looked at the genetic makeup of the virus in three groups of patients - 80 percent of whom were men: those infected in 1996-1997; those infected in 1998-1999 and those infected in 2000-2001.

While just 1 or 2 percent of patients were infected with strains resistant to two classes of drugs in the early time periods, 13.2 percent of patients in the last group had resistant viruses, Hecht said. And one of his patients was resistant to all three major classes of antiretroviral medications.

Delegates decry health gap between rich, poor countries

Level the playing fields!

AP Online (12 July 2002) reports from Barcelona that emotions have been roused by the huge gap between rich and poor nations. To bring the epidemic under control through prevention programmes and anti-retrovirals for just 5% of the world's infected people, some $10 billion a year is needed - but who will foot the bill?

"More than 90 percent of the world's 37.1 million HIV infected people live in developing countries. Sub-Saharan Africa accounts for 26 million - or 70 percent of the total, according to the U.S. Agency for International Development.

"A study released at the conference predicts that in less than a decade, many southern African countries will have average life expectancies of around 30 years. In Botswana, life expectancy will be 26.7 years...

"AIDS activists insist that the United States and other industrialized countries have exacerbated the problem in the developing world through economic exploitation...

"According to a study by the British charity Oxfam, many of the hardest hit countries are spending more on foreign debt repayments than on health care.

"Kevin Watkins, author of the study, said $1.6 billion in debt relief would free up significant revenues that could be spent on AIDS programs. "That's less than two days" of the $350 billion in subsidies that rich countries give to their farmers each year, he said.

GO TELL IT ON THE MOUNTAINS!

On 25 May 2002, the PRs from all the provinces were invited to a workshop held at head office, at which Pro Tactic executive Glynnis Branthwaite gave a lecture about the role of PR and how it is measured. Most of the PRs were delighted to discover that clippings of all publicity are collated and kept by Pro Tactic every year. Glynnis discussed how PR works, how press releases are prepared and how to handle the media generally.

In the afternoon, PR activities in all the provinces came under discussion, and PRs asked if we could develop a standard promotional kit, with banners, balloons, posters and so, to ensure uniformity of quality and branding - this is being done. It was also agreed to do a survey to see how back pain stacks up in the average practice - this has been done, and the results make it clear that focusing on back pain is the right route to take - it accounts for between 52% and 58% of all cases at most practices. Next up, we'll be looking at the causes of that pain - is it primarily motor vehicle accidents, workplace factors, or what?

One of the striking things that came out of discussion was how little handover is done when one incumbent leaves office with the Society and another one steps in. "It was very useful to be able to help people with information they really need, and sit around a table together to discuss issues," says Zola Dantile who hosted the workshop from the Communications portfolio.

Since May, a number of teleconferences have been held to follow up on discussions at the workshop.

No to HRT?

Associated Press reports (9 July, 2002) that US "government scientists abruptly ended the nation's biggest study of a type of hormone replacement therapy, saying long-term use of oestrogen and progestin significantly increased the women's risk of breast cancer, strokes and heart attacks.

"Six million American women use this hormone combination, either for short-term relief of hot flashes and other menopausal symptoms or because of doctors' long-standing assumptions that long-term use would prevent heart disease and brittle bones and generally keep women healthier longer.

"Two of those assumptions are wrong, the National Institutes of Health announced ... In fact, years-long use of oestrogen and progestin increased otherwise healthy women's risk of a stroke by 41 percent, a heart attack by 29 percent and breast cancer by 24 percent.

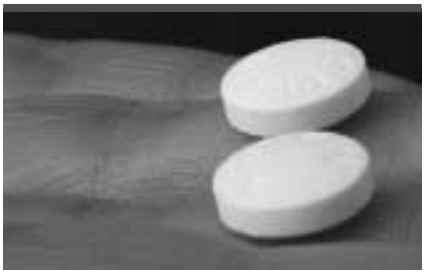
"On the good side, it cut by a third the risk of colon cancer and hip fractures - but there are other ways to fend off those illnesses, doctors noted.

"Concluding the hormones' risks outweighed those benefits, the NIH stopped the 16,600-woman study three years early - and is advising other women who use the oestrogen-progestin combination to ask their doctors if they, too, should quit."

Grow old gracefully

At the American Geriatrics Society 2002 Annual Scientific Meeting, Jerome Fleg, MD, Director of the Laboratory of Cardiovascular Science at the National Heart, Lung and Blood Institute, Maryland, presented a review of the research on what happens when older adults become sedentary. "We know that peak cardiovascular oxygen consumption declines in sedentary persons. Body composition changes with a sedentary lifestyle, increasing the fat in the abdominal area. We also see increases in blood pressure, insulin resistance, and cholesterol, specifically a decrease in HDL, the good cholesterol."

Fleg said that "increasing exercise may have more 'health' benefits than actual 'fitness' benefits. Fitness is related to a person's maximal capacity and has been linked to lower mortality rates. However, exercise, especially aerobic exercise, can improve health even if the person does not achieve maximal fitness. Some clear health benefits include improved cardiac function, better functional capacity, enhanced psychosocial well-being, improved mental status, and modification of coronary risk factors."



TAKE TWO ASPIRIN?

Scripps Howard News Service (8 July 2002) reports that guidelines published in Stroke: Journal of the American Heart Association, and Neurology, the journal of the American Academy of Neurology, indicate that giving patients 160 to 325 milligrams aspirin within 48 hours of a stroke brought on by a blood clot can reduce the severity of the stroke and the chance of death.

Such treatment offers a "small but statistically significant" decrease in death rates and disability from stroke. But the experts said there isn't enough data to justify giving other types of agents that prevent clot formation, or to give anticoagulants like heparin to reduce death or disability.

ULTRA HELPFUL!

The Loskop marathon, from Middelburg to Loskop dam, is a 50 km ultra marathon. Physiotherapists have been working at this ultra marathon for the past five or six years, and are a vital part of the marathon due to the hilly terrain.

"It is always great fun and a big PR drive for physiotherapy in Mpumalanga. Unfortunately we are always short of physiotherapists to help out on the day!" says Wilma Erasmus (physio), who was assisted by Dr Anne-Marie Herselman (anaesthetist and one-time physio), Sister Ann Taylor and Staff Nurse Marie De Wet.

▶ And the Band Played On...
(Continued from p. 2)

tell, for instance); some are facing down the daily evidence that their body is succumbing to the disease; all will be dealing with a level of stress that you can't even imagine. Which all has huge implications for their health and the outcomes of treatment, of course.

They need the best you can give: the best information, the best and most inspired treatment, and most of all, the best understanding you can offer. They need tenderness, they need acceptance, they need empathy - even when they behave in ways that frustrate and irritate you.

Because they're human... and they're scared.

Mandi Smallhorne

Physiotherapy

SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY

LIBERTY

PROPRIETY
Financial Planning (Pty) Ltd

The South African Society of Physiotherapy has enlisted the services of Propriety Financial Planning (Pty) Ltd, to provide Physiotherapists with a Provident / Pension Fund Scheme as well as a Medical Scheme, under the banner of the SASP. The insurance company that will undertake this for the SA Society of Physiotherapy is Liberty Group.

The reason for this decision, is due to requests being made at National Assembly in September 2001, for the Society to investigate the possibility of obtaining pension/provident/medical cover for it's members and their employees, as part of a group scheme. This would make the premiums more affordable for Physiotherapist.

Our various investigations has led us to Liberty Group, whom I feel are competent to undertake the administration of this fund and also have competitive pricing structures and benefits to suit a variety of needs. They are also a reputable company.

The SASP and Liberty Group will undertake a road show, in the larger provinces, to discuss these options with you. Please make sure you read your Provincial newsletters for further information, as we will be updating the provinces with the road show information.

Saira Khan

COURSE NOTES

CLINICAL SOLUTIONS COURSES SHOULD BE YOUR FIRST CHOICE. WHY?

*** Clinical Solutions courses are CPD approved for the year 2002.**

All 2002 CPD points earned will be accumulated for 2003.

*** More affordable course fees.**

PAIN MANAGEMENT - A SPECIALISED SKILL IN PHYSIOTHERAPY,
Phyllis Berger, **JHB, Sat - Sun, 19 - 20 October,**
11 CPD points approved, **R550**

THE AMAZING NERVOUS SYSTEM,
Duffy Sweatman, **JHB, Sat - Sun, 19 - 20 October,**
The only course for 2002!
13 CPD points approved, **R850**

PELVIC DYSFUNCTION AND ITS ROLE IN LOW BACK PAIN: ASSESSMENT AND MANAGEMENT,
Ina Diener, **JHB, Sat - Sun, 26 - 27 October,**
15 CPD points approved, **R850**

INTENSIVE TRAINING ON TRIGGER POINT, MYOFASCIAL AND PROPRIOCEPTIVE TRAINING - BASIC, Dr. Dimitrios Kostopoulos - International lecturer, **JHB, Fri - Sat, 1 - 2 November,**
14 CPD points approved, **R1150**

CLINICAL KINESIOLOGY, Adrian Stevens,
JHB, Sat - Sun, 2 - 3 November,
13 CPD points approved, **R850**

PILATES FOR PHYSIOTHERAPISTS,
Jacqueline Swart and Natasha Madel,
JHB, Sat - Sun, 2 - 3 November,
13 CPD points approved, **R850**

"GOING GLOBAL" - A NEW APPROACH TO EXERCISE IN SPORTS AND REHABILITATION,
Tanya Bell and Claire Bourne,
JHB, Fri - Sat, 8 - 9 November,
12 CPD points approved, **R800**

ADVANCED MYOFASCIAL SEMINAR,
Dr. Dimitrios Kostopoulos - International lecturer,
JHB, Sat - Sun, 16 - 17 November,
14 CPD points approved, **R1250**

Contact Michelle/Yolanda on
Tel: (011) 485-3447, 08 44 99 77 55,
Tel/Fax: (011) 640-3970
E-Mail: clinisol@mweb.co.za
Website: www.physiosa.org.za

NOTICE:

We are pleased to announce that South Gauteng OMTG will be running the OMT I Course in 2003 (late January - November). Physios interested must be registered with the Health Professions Council, SASP and OMTG. They must be working in the field of OMT.
The cost of the Course will be R6,500.00.
Please phone Jean Anderson at 485-3794 between 8.30am - 1.00pm for application forms.
Closing date for applications will be the end of September 2002 to allow for selection and those selected to do pre-course study.

OMT CLINICAL WORKSHOPS - OFFERED BY HELEN DAVID

1. OMT BASIC SKILLS WORKSHOPS

Suitable for:
- Physiotherapists who have recently qualified and wish to consolidate their training
- Physiotherapists who have not worked for some time and require an update in OMT
- Physiotherapists who have worked in other fields and are now moving into OMT ▶

▶ *Assessment and clinical reasoning skills as well as practical techniques related to the neuro-muscular-articular systems will be covered for the cervical, thoracic and lumbar spine and the extremities.*

Dates: Tuesday mornings 09h15 - 12h00
10th September and 22nd October
(lower quarter)
Venue: Physiotherapy Rooms, Senses Corner,
Corner Wessels & 8th Ave, Rivonia
Cost: R1000 for the 4 workshops,
payable in advance to secure a place.
(Maximum 10 participants)
CPD points have been approved.

2. OMT ADVANCED CLINICAL WORKSHOPS

Suitable for physiotherapists who have successfully completed the OMT Course and who wish to consolidate and further their clinical expertise.
Patient presentations by course participants will be welcome (by prior arrangement).

Dates: Tuesday mornings 09.15 - 12.00

17th September - Trauma to the Spine (MVA's sports injuries, violence) - acute and chronic management.
8th October - Degenerative syndromes of the Spine (including nerve/disc pathology and instability)
5th November - Holistic Management of Postural syndromes(including ergonomics and exercise therapy)

Venue: Physiotherapy Rooms, Senses Corner,
Corner Wessels and 8th Ave, Rivonia
Cost: R1000 for the 4 workshops,
payable in advance to secure a place.
(Maximum 10 participants)
CPD points have been approved.

Helen David is a Private Practitioner, an Honorary Lecturer at Wits University, has presented papers at local and international congresses and has been the S. Gauteng OMT Course Leader from 1983 to 2001.

ENQUIRIES AND BOOKINGS:
Riana or Virginia (011) 807-0760.

CPD Seminars

Enrol now to benefit from these excellent courses,
highly recommended speakers and affordable prices, presented in Pretoria.

		Early Bird	Normal
Sept 7-8	**Dry Needling: Module 3** *Steven Stavrou* (15 CPD points)	R700.00	R800.00
Sept 14	**Sports Injuries - Assessment and Treatment for Rapid Results** *Dr E Pelser; Dr C J v Rensburg; Thys Fourie* (accreditation in process)	R400.00	R450.00
Oct 5-6	**Clinically Applied Postural Analysis and Biomechanics** *Tania Bell-Jenje; Clare Bourne* (15 CPD points)	R900.00	R1000.00
Oct 19	**The Shoulder: Current Orthopaedic Concepts and Modern Rehabilitation** *Dr Thys de Beer; Cyntetia Liebenberg* (accreditation in process)	R420.00	R470.00
Nov 2-3	**The Sacro-Iliac Joint and Low Back Pain: Differentiation and Rehabilitation** Ina Diener (15 CPD points)	R800.00	R850.00
Nov 9	**Ethics Workshop for Physiotherapists (1/2 Day)** Hester Huysamen (accreditation in process)	R160.00	R230.00
Nov 16	**On the Ball with Pilates!** Jacqui Stewart (accreditation in process)	R500.00	R500.00
Nov 30	**Chronic and Acute Lung Conditions, Abscesses; Blood Gases; Current Concepts: Chest Physiotherapy; Intensive Care and Paediatric Patient** Dr G Ras; Dr G Irsigler; Dr L Marcus; Lucille Butow; Dalene Booysen; Annetjie Stander (accreditation in process)	R350.00	R400.00

ENQUIRIES Johan Talma
Tel & Fax: (012) 803-8711, Cell: 083 556-8711, Email: talma@mweb.co.za

Early bird fee for registrations received more than two months prior to the seminar

CLASSIFIEDS

ROOMS AVAILABLE

Consulting room available to sub let from Optometrist in Kyalami. (Shared reception). ±R2800. There is also a Doctor, Dentist and Pharmacist on the same level in the centre. Contact: Johan, Tel: (011) 466-3031 or 083 234-4012.

PRACTICE FOR SALE

Amberley, New Zealand South Island, 30 minutes North of Christchurch. Long-term locum or Sale; Rural general. Physiotherapy/ Hydrotherapy Practice in new Medical Centre. 6 x 3 meter hydrotherapy pool, well-equipped gym, 2 cubicles high/low beds. Further information e-mail dketal@xtra.co.nz

Western Cape: Well-equipped practice for sale in Somerset West. 082 804-2164.

LOCUMS NEEDED

Parktown: Locum required for 23 September to 11 October 2002. Tel: (011) 726-5466.

Cape Peninsula: Full-time locum for private practice needed immediately for approx 3 months. Please contact Rina, Tel: (021) 783-5533, Cell: 083 691-1518.

Umhlanga Rocks: Locum needed at private practice from September 2002 to February 2003. Tel/Fax: (031) 561-6411, e-mail: phin@iafrica.com, Cell: 083 262-6489 (Karen).

Johannesburg: Forest Town School. Locum needed for January to April 2003. Contact: Diane, Tel: (011) 646-0131 or 082 330-8127.

SITUATIONS VACANT

Bedfordview: Physiotherapist required to work in Sports Clinic in Bedfordview Virgin Active Gym. Contact: Mercia, Tel: (011) 450-3323.

Rosebank: Full-time and part-time posts available for general rooms and hospital practice. Contact: Fiona (o/h) (011) 447-1815 / 880-5365.

Springs: 2 Full-time physios required for hospital work in Springs to start a.s.a.p. Contact: Mrs. Malaka, Tel: (011) 815-5621.

Sandton: Part-time physio needed. Brilliant opportunity. Call: 083 600-1777.

Sandton: Pilates Ball and mat class instructor needed. Call: 083 600-1777.

Sunward Park / Boksburg: Physio required for mainly afternoons and weekends. Hospital and rooms. Good salary. Contact: (011) 913-3602/3.

Durban: Full-time physiotherapist required for busy private practice. Pleasant working environment. From January 2003. Tel: (031) 312-2308 or 082 260-0218.

Umhlanga Rocks: Full-time physiotherapist needed at private practice. Tel/Fax: (031) 561-6411, e-mail: phin@iafrica.com, Cell: 083 262-6489.

PHYSIO CONNECTIONS: For a permanent or locum employment connection. Please contact: (011) 678-5212 / 476-3810. Reasonable once off placement fee.

Sunninghill / Parktown West: Physiotherapist required for Dawn Hansen's private practice. Hospital and/or rooms work available, varied work, hours negotiable. Contact: (011) 803-2227 or (011) 726-1512 or (011) 442-8970.

Walvisbay Namibia: Full-time physiotherapist required for private practice. Work permit, accommodation and flight arranged. Tel: (092 64 64) 203099, Fax: (092 64 64) 209 099.

NOTICE:

OMT 1 COURSE - 2002/2003
PRETORIA

The NEC of the OMTG would like to advise you that the next OMT 1 course will commence in September 2002 in Pretoria.

If you are interested, you can contact Annelize at (012) 991-4499 from 08:00 to 13:00 on weekdays or e-mail: annalieb@intekom.co.za. The course will run in 6 modules of 3 1/2 days each, spread over a year. The cost will be R6500-00 and can be paid with post dated cheques.

CHECK OUT THE SASP'S WEBSITE AT www.physiosa.org.za

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