

## Notes and news

### Chairman's update

These are unprecedented times, and as a charity, POGP – like its trustees, committees and members – has had to deal with new challenges during the COVID-19 pandemic lockdown.

#### Conference

As previously reported (POGP 2020a), it was with a heavy heart that we decided to postpone our annual conference until 2021. The plan is that Conference will now go ahead in the early autumn of next year. It will still be hosted in York, and the dates will be confirmed once we have firmed up our plans with the venues involved. I know that this comes as a great disappointment, but we have to be mindful of the health and safety of all involved. We look forward to meeting you all next year for a great reunion and learning experience.

#### Annual general meeting

A resolution to change the constitution to permit digital meetings to be held by the charity was passed on 9 June 2020 (POGP 2020b). The annual general meeting will now be held remotely on Friday 9 October 2020. More details will be provided closer to that date. You will not be invited to attend in person, but to be present virtually or vote by proxy.

#### Courses

The Education Subcommittee are working very hard to ensure that our courses follow the guidelines set out by the government. It is vital to maintain strict social distancing and infection control measures, not least because a number of these have significant practical elements. Some courses will now be online only, and others will have some practical parts that have yet to be agreed. If you have booked a course, the plan will be sent to you as soon as it has been approved. Other information about course delivery will be advertised on the website as it becomes available.

#### Facebook

Our members-only Facebook page provides an online community for us to exchange ideas and ask each other questions. However, those

who access Facebook for this purpose do not reflect the distribution of our members across the UK. Therefore, we actively encourage you all to join the page in order to support your colleagues' clinical work and research. It is also an important platform for the trustees, who use it to distribute information to the membership.

#### Pelvic floor dysfunction following COVID-19

The most common symptom of coronavirus infection is a continuous cough that can last for several weeks after the initial infection. Coughing is known to put pressure on the pelvic floor muscles (PFMs), and increase the risk of developing stress urinary incontinence (SUI) and vaginal prolapse. There has been much discussion of the need for rehabilitation for people recovering from coronavirus, but very little so far has specifically addressed PFM rehabilitation.

**Recovering from a chronic cough or COVID-19?**

Difficulty getting your bladder or bowel back to normal?

Are you experiencing embarrassing leaks?

You may have experienced new or worsening symptoms of:

- urinary leakage
- rushing to the toilet
- difficulty controlling wind
- vaginal heaviness or discomfort

Problems with your bladder or bowel can affect anyone.

Start with gentle pelvic floor muscle exercise.

Build up slowly, especially if you are feeling very weak and tired

Find out more on the POGP website  
[pogp.csp.org.uk](http://pogp.csp.org.uk)

Remember, you can seek advice from your local pelvic health specialist physiotherapist

POGP  
PELVIC OBSTETRIC  
GYNAECOLOGICAL  
PHYSIOTHERAPY

Figure 1. Pelvic, Obstetric and Gynaecological Physiotherapy COVID-19 poster.

Supervised PFM training is recommended as the first-line treatment for SUI and prolapse (NICE 2019), and specialist physiotherapists are trained to deliver this type of rehabilitation.

Pelvic, Obstetric and Gynaecological Physiotherapy have developed a free, downloadable information poster (POGP 2020c) that advises people who are suffering from the after-effects of coronavirus coughing to seek help from a specialist physiotherapist (Fig. 1). Although not a quick fix, patients who undergo a pelvic floor rehabilitation programme are eight times more likely to report a cure than those who do not do the exercises (Dumoulin *et al.* 2018).

The effects of incontinence and prolapse are distressing, but many people can improve their quality of life by adopting this relatively simple approach. We are encouraging people to seek help from a specialist physiotherapist in their area. Some clinics initially offer teleconsultations and/or phone call advice, and face-to-face appointments will be reinstated at a later stage when the government guidelines on travel and hospital attendance are reviewed.

If anyone has any comments or questions about these matters, please contact me (e-mail: k.mann@nhs.net).

**Katie Mann**  
*Chairman*

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## Touching from a distance: telehealth in the time of coronavirus

### Introduction

The COVID-19 pandemic has shocked and disrupted normal life as we knew it. In order to continue to practice, thousands of physiotherapists around the world have had to adapt to new ways of working, and diversify their skills. Therefore, we thought that it would be timely to report on the current state of telehealth, i.e. “the distribution of health-related services and information via electronic information and telecommunication technologies” (Wikipedia 2020). Here are the perspectives of three physiotherapists from different parts of the globe.

**Gillian Campbell**  
*Editor*

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### *Telehealth and safety: an interview with Jilly Bond*

A clinical specialist physiotherapist, researcher and educator based in Cardiff, Jilly Bond (Fig. 2) is internationally renowned for her work on pelvic pain. Rooted in evidence-based practice, her courses and online seminars are flourishing platforms for her teaching. As a clinical practitioner, Jilly has conducted telehealth consultations with patients from all over the world for more than 2 years.

**Biljana Kennaway**  
*Assistant Editor*



**Figure 2.** Jilly Bond.

**Biljana Kennaway:** *Can you share some tips about remote consultation?*

**Jilly Bond:** You need to have a good understanding of the technicalities and security issues. These are the essential things that you need to set up before you use telehealth:

- *Ensure that your laptop or desktop computer is secure.* You need to install ad blockers and antivirus software.
- *Do a General Data Protection Regulation (GDPR) check.* This is important because it is the back end of telehealth (PTAG 2020). You cannot set up a video call with someone without having their details, and when working electronically, you must have a robust data management procedure. I believe that this needs to be incorporated into the National Health Service Pathways triage software (NHS Digital, Leeds, UK) as standard so that paper notes are kept as these would be normally. Alternatively, these need to be incorporated into your practice guidelines if you work privately.
- *Use a secure program for telehealth.* Pick one that involves a generous amount of inbuilt security. At the beginning of April this year, 500 000 Zoom (Zoom Video Communications, San Jose, CA, USA) passwords were stolen by hackers and then put up for sale on the dark web (Winder 2020)! I use Cliniko practice management software (Cliniko, Melbourne, Australia) because it complies with GDPR, and has a large and safe storage capacity. Cliniko's telehealth software works well, and has also been shown to be safe. Other video conference programs like Microsoft Teams (Microsoft Corporation, Redmond, WA, USA) and Attend Anywhere (Attend Anywhere, Melbourne, Australia) are also reliable and secure.
- *Use a safe, secure and quiet space.* You must ensure that your patients can maintain their privacy and dignity whether you are working from your home or an office.
- *Ensure that you are conforming to the Chartered Society of Physiotherapy policy on chaperoning and consent.* Just because your patients are taking part in a video consultation, this doesn't mean that these guidelines (CSP 2013, 2016) are not applicable and appropriate.

**B.K.:** *What is your experience of this innovative mode of delivery?*

**J.B.:** In telehealth, the biggest challenge is to develop a relationship with someone as you would in a clinical setting. You can immediately

establish the same sense of security if the patient can see and hear you clearly. People don't react well to poor-quality images and sound. There are some important practicalities to consider in order to achieve this in a remote consultation:

- *Lighting.* A window or another source of light either needs to be to one side of you, or in front of you. There must be some form of lighting, and you need to check that you are not backlit, which will cause you to appear dark and brooding onscreen. Patients need to be able to see your facial expressions in order to form a connection.
- *Sound quality.* Having a good microphone is important because people won't understand what you're saying if they can't hear you well, and you could lose their respect. There's nothing worse than a bad line! Identify where the microphone is on your laptop, computer, iPad or mobile phone, and then position your device to optimize the sound of your voice. Laptops are usually not a particularly good option because these generally have poor-quality microphones. In my experience, it is sometimes better to use a simple, cheap headphone microphone, or a proper one that you can plug into the side of your device.
- *Professionalism.* It is expected that you will bring the same level of professionalism to telehealth consultations that you bring to your practice. People worry about using technology, but I would say that we should focus instead on establishing virtual relationships by providing clear sound, projecting a good image and always behaving in a professional manner.

The way your camera is positioned creates a power dynamic between you and your patient, and it is important to consider this when building a therapeutic relationship. I believe that we get the best out of patients when they feel that you are collaborating with them on equal terms. Position yourself in a collaborative zone by making sure that your camera is in front of the middle of your head, which will allow you to look forwards, and not up at or down on them. In the same way that you wouldn't tower over your patients or sit too close to them in the clinic, you shouldn't place yourself on their screen in a way that could be intimidating. Position your head in the centre of the screen, and allow some space around it so that it's easy to show patients pelvic models and charts. It's all about not being a "bear", or in other words, disempowering the patient with your unconscious body language.

- *Eye contact.* It requires skill to maintain eye contact during telehealth consultations, and it's important to acknowledge that watching an image feels very different to looking at a camera. When you look at patients on a screen, they see you glancing down instead of maintaining eye contact. You need to look at the tiny camera on your device to do this. Be careful if the camera is below your screen because this will again look like you're looking down on them, which is a powerful position to assume. When someone tells me their story, I simply listen for the first 10 min. I do glance down at the image a lot so as to judge their emotions during this period, but I keep looking up in order to maintain the eye contact. When I do podcasts, I never look down and maintain eye contact throughout the recording. This is where a lot of people currently struggle with telehealth because it doesn't allow them to use their hands, which is where they may feel that their skills are focussed. I use manual therapy every day in my clinic, but in telehealth, we use eye contact to create that connection instead.
- *Be flexible.* If your device stops working, don't get frazzled, just use another one to continue (e.g. your mobile phone). For example, I use two devices at the same time. I record my notes on my main laptop, and use the camera on top of my tablet. If my tablet fails, I revert to using my laptop's built-in camera. If the sound is poor quality or patients can't make their microphone work, I call them on their mobile and put them on speaker. We can still see each other while we talk, of course.

**B.K.:** *How do you manage to take notes during consultations?*

**J.B.:** I have two screens, the one in front of me is for interacting with my patient, and I also have another at my side for other administrative tasks. When I need to make a few notes, I ask my patient if it is okay to do so for a second, and I just turn myself sideways to write a few lines. I only write headlines, not the whole story, and even when I do that, I often turn back to the camera to maintain eye contact. If you use only one device and need to make notes, then you should open two windows side by side, one for the telehealth session and one for your observations. Lots of programs have a screen sharing option, and when I ask questions about bowel health, for example, I can use this facility to show my patients the Bristol Stool Chart (RMNHSFT 2016).

**B.K.:** *How do you go about completing your objective assessment in pelvic health?*

**J.B.:** Telehealth is not perfect, and it will certainly not replace assessing patients in person. But when this is impossible, the only thing that we can do is to trust them. You can still make a lot of observations online. For example, I perform some simple lumbar and neural assessments, and ask my patients, "How does it feel when you move your body forward?"

I have also been asking patients to self-examine their pelvic floor between sessions. I explain what we may find on assessment, and then get them to give me an assessment of their tone, movement, any pain and whether they achieve urethral overpressure. Given their symptoms and findings, you can then make an informed guess about how to progress treatment. This shouldn't replace a live objective assessment, of course, but needs must and this is good enough until that can be achieved safely.

A lot of patients contact me about the TheraWand therapeutic device (TheraWand, Carlsbad, CA, USA) because they want to know how to use it. In my clinic, I would never recommend that my patients buy a wand without assessing them first, and therefore, I would get them to assess themselves in a much gentler way before introducing a wand. You can guide them online and ask them to report back. I also tend to shy away from live observations of the perineum unless I'm directly asked to do so by my patients. Currently, I feel that this is not socially appropriate – society isn't used to this degree of invasiveness in remote healthcare, and it has pornographic connotations. I'm also aware of the potential for misuse of such images should a telehealth session be hacked.

**B.K.:** *How do you screen for red flags online?*

**J.B.:** You can detect quite a lot via your subjective questioning, and although you can't make an objective assessment, you can trust your patients to tell you how they feel. You should be fine if you start from a position of paranoia regarding red flags!

**B.K.:** *How do you go about conducting practical treatment sessions online?*

**J.B.:** The most important parts of this are explaining clearly what the treatment is, and outlining your reasoning for why you would like your patient to trial it. We do this in the clinic too, but in telehealth, it is important to have the ability to talk patients through each step clearly. When prescribing exercise, patients can record themselves while I describe the movement and give



feedback in real time. If you are using Zoom, you can enable the option for your patient to record it, or they can use their mobile phone. I also send every patient a short e-mail after their session that summarizes what we discussed, and clarifies how they can complete their treatment.

**B.K.:** *What do you think are the most essential skills for a telehealth provider?*

**J.B.:** The ability to communicate, being able to understand unconscious body language and the capacity to build a therapeutic relationship quickly through a screen are all essential. You should be able to apply your physiotherapy skills in different ways. Be flexible with regard your technological options, and know what these are so that you won't be frazzled when issues arise, which they certainly will!

We should not try to provide a normal service – we need to be able to provide one from afar. Be a collaborative coach during the course of treatment. This is something I feel that we should be all striving to achieve anyway, and telehealth demands these skills.

I think this experience will vastly improve our practice, and challenge what we think physiotherapy is. We achieve so much more with our words and minds than we realize.

In telehealth treatment, patients are not relying on physiotherapists to make them better physically, they're relying on our knowledge and skills to do this. I truly believe that physiotherapy should be a collaborative process, not just us a matter of *us* doing things to *them*. This period of lockdown is highlighting this, and making our patients true partners in the treatment process.

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## Lockdown down under

Here in New Zealand, we moved very quickly from total freedom to total shutdown. Within 2 days, I had lost 50% of my income because my private clinic work evaporated, and my sessions in the adjacent birthing centre were stopped after being classed as non-essential. Even though I was still able to continue my public health triage work from home, things did not look very positive or even financially manageable.

The private clinic where I am employed ([www.nzpelvicphysio.com](http://www.nzpelvicphysio.com)) is also under contract to provide postnatal physiotherapy services to Birthcare, Auckland's main birthing centre, for three mornings a week all year round. This involves seeing individual referrals in their rooms, and running a postnatal class that anyone staying in Birthcare can attend.

In order to keep me afloat, my team kindly offered me all of the Birthcare physiotherapy work once full lockdown began, as long as I could find a way to continue this remotely. We designed a presentation to deliver as an online class, which allowed us to honour the contract. We repeatedly scanned the PNZ (Physiotherapy New Zealand) website (<https://pnz.org.nz/>) to keep up to date with the ever-evolving guidelines on delivering telehealth services.

At the same time, my husband had to adapt to working remotely full time, and both of us were fumbling our way through home schooling our children. We quickly set up a makeshift workstation in the garage so that I could sit in front of a camera and deliver the postnatal class (Fig. 3). The laptop faced a table covered in a fluffy blanket with a pillow at one end so that it looked like a bed. In order to demonstrate off-loading the perineum, I placed a model pelvis in some rolled-up towels behind me on the bed. The laptop sat on top of a shelf so that I could store and reach for things offscreen (e.g. the model baby, Tubigrip bandages and towels) while talking to camera. We sorted the lighting with extra inspection lamps hung from the garage door runner. Everything I needed was within arm's reach. The garage bricks behind me made it look rather like I was in a bunker. However, we had no time to paint any walls, and no shops selling relevant posters were open anyway.

Practising sitting to one side of the screen on an old high chair, I found that I could easily move straight from my perch onto a toddler step in order to climb on the table. From there, I could demonstrate moving from sitting to standing, turning in bed, cat stretches for the thoracic



**Figure 3.** Romy Tudor in her lockdown workstation.

spine and how to check your own diastasis, all within good range of the camera. Then I put on my physiotherapist's uniform and smiled for the camera.

I delivered the classes via Zoom. Mothers at Birthcare were given a flyer on their breakfast tray. This gave them details of the class, and instructed them to e-mail me before 09:45 h on a Monday, Wednesday or Friday. This was so that I could send everyone who was interested a link to the session, which started at 10:00 h on these days. Before and after each class, I would respond to any other requests entered in our physiotherapy referral book at the centre. I would arrange a phone call, or a FaceTime or Zoom chat to address individual referrals/problems.

The condensing of a 1-h, face-to-face class into a 35-min session actually proved easier than I would have thought. Because I was not gauging the "emotional" atmosphere in the room, I found it easier to deliver the important messages – and there was less chance of getting involved in chit-chat. . . Indeed, the whole process was more time-efficient since there were no interruptions! At the beginning of the class, I would explain that I was going to present a series of slides and images that would be interspersed with live demonstrations – and that there would be some time for questions at the end. I enjoy lecturing, so I felt fairly confident about delivering my presentation to an audience by video link. This is a much easier way to explain things than the telephone – like many physios I use my hands a lot!

I felt that the PNZ telehealth guidelines were very clear, and regular e-mails and updates throughout the lockdown made me feel supported while using a very new method of delivering a service.

Encouragingly, once I returned to the face-to-face setting a few weeks ago, I received some very positive feedback from new mothers who had attended the Zoom class, and they subsequently booked a clinic appointment with me. Some of them classed it as an essential service for all new mothers. A couple of mums said that they preferred the remote setting – they were able to turn off their video, relax and breast-feed while they just listened to the information being delivered succinctly, and had a chance to ask questions at the end. One said that she found the remote setting to be far more sensitive in those first few days when some women don't want to feel "exposed". Another commented that hunkering down in lockdown led to mums feeling more protective of their little ones, and hence, the remote setting was perfect for them.

I have only a couple of less-positive observations. Remote delivery leaves little room for humour, and I find that my face-to-face classes are very much eased with a bit of comedy about the early days of motherhood. Perhaps remote equals a more-precise and effective clinical message, but the downside could be that there is less empathy? Another issue was that, once mothers had my e-mail, they could essentially contact

me anytime they wanted. However, I must admit that I didn't mind this during lockdown. Some of them were grateful to get any kind of help at all, and a couple with serious problems [i.e. worsening postnatal pelvic girdle pain (PGP) and third-degree tears] could easily have slipped through the net had it not been for our service and subsequent onward referral.

There was one occasion when my camera failed and I had to improvise, and I also worried constantly about falling off the "bed" in front of the camera! However, this was generally a really positive and progressive experience that provided me with a lot of ideas. Platforms such as Zoom could facilitate further exciting developments in the delivery of postnatal physiotherapy care. For example, new mothers who cannot attend a face-to-face appointment in the very early days after giving birth can now be reached.

**Romy Tudor**  
*Reviews Editor*

### *Back to the future*

Just 2 weeks before lockdown in Switzerland, some independent healthcare practitioners took the initiative to protect the at-risk population. Many of us reduced our clinical appointments, and in some cases, even completely stopped working. Shutting my clinic before the expected lockdown was a financial hit that I believed I needed to take to protect my patients, my family and myself.

Once full lockdown was introduced, it became obvious that we would continue to provide some form of virtual care. Immediately before this, I had begun to offer my patients telephone support in addition to communication via e-mail, which had already been established. I knew that I needed to move things online fast, and so I trialled several different video conferencing programs, including Microsoft Teams, Zoom, Physiotec (Physiotec, Montreal, Canada) and Skype (Skype Technologies S.A.R.L., Luxembourg City, Luxembourg).

During our first week of lockdown – which also meant home schooling! – I set up a Zoom account, and linked a few apps, videos and forms to it. Zoom proved to be the most useful platform of the four, and it provided me with a range of options for interaction – from single-patient consultations all the way through to large Pilates group classes. I was also able to schedule calls and meetings, and record sessions. Later on, we also integrated it into the booking system on my website ([www.bkennaway.net](http://www.bkennaway.net)).

I also continued to use the Hudl Technique app (Agile Sports Technologies, Inc., Lincoln, NE, USA) because this is an easy way for patients to record and share a movement with me. Physiotec provides great exercise programmes, and enables me to track a patient's compliance and progression. The SqueezyCX app (Propagator Ltd, London, UK) is one of the online support links that I use with many of my patients. It enables me to share evidence-based information, document outcome measures and supervise patients online. I also purchased the Living With Pelvic Health app (Living With Ltd, London, UK) in order to extend the clinical features on my online platform. Investing in the above apps and accounts was my initial expense, and after few a hitches, I knew that I needed to update my hardware too with a new, large-screen laptop.

My work is normally divided between two clinics. One is in my home in Zollikon, and the other is on the other side of Lake Zurich at the excellent Praxiszentrum Arcus in Thalwil (<https://arcus.ch>), where I work as part of a multidisciplinary team. I serve a large multicultural and multilingual expatriate and Swiss community in Zurich, and having lived and worked in Geneva, speak both English and French professionally.

During lockdown, I worked on both patient caseloads from my home clinic. The change of approach meant that I could remove my treatment table in order to give me more space. This also allowed me to capture the whole picture during my Pilates classes. There is a large mirror in my clinic room, and in my view, this is an essential tool of our trade. It continued to provide a great many benefits throughout this period of virtual teaching – not least the provision of additional perspectives on particular movements and techniques.

Surprisingly, lockdown didn't decrease the rate of new referrals that I received from midwives and gynaecologists. Therefore, my online experiences began with assessing new patients, and then providing an initial consultation, support and initiating rehabilitation. Each virtual appointment lasted more than the hour that I would normally devote, but after a few weeks, it became easier to stick to the allotted time.

However, I found follow-up sessions to be more challenging. I had to be close to the screen for the initial greeting and conversation, but it took me some time to figure out where to position my laptop for an optimal and non-obstructive view during any subsequent demonstration of movement.



Like many of you, I found it difficult to sit in front of a screen instead of a person while I demonstrated different pelvic models and therapeutic materials, explained how to perform a self-assessment, and in some cases, even prescribed treatment. When my hands are tied and my view is limited, my vocabulary expands and sometimes flourishes in new ways in order to respond to an individual's verbal learning preferences (e.g. visualization, practical orders or comparisons). This wasn't easy to do in French and there was no thought of making any suggestions in German, but it forced me to learn more and to start studying German formally at last.

I have also been meaning to record lectures for the ante- and postnatal Pilates course run by the Australian Physiotherapy and Pilates Institute (<https://appihealthgroup.com>) for quite some time, but I never managed to get around to it before. Lockdown was the opportunity that I had been waiting for, and I was happy to learn about video messaging using the Loom screen recording app (Loom, Inc., Costa Mesa, CA, USA).

This hasn't been a smooth transition for anyone. My fear of the unknown and the disturbing news coming from Italy, and also the sudden overload of social media posts about how to advance our profession online, resulted in my short withdrawal from work during the first week of lockdown. I felt emotionally exhausted by the new way of working and home schooling, but I was lucky to have colleagues and contemporaries who shared the same experience. Reading Amanda Savage's Facebook post on the POGP members-only page (Savage 2020) made me realize that I wasn't alone, and that this ambiguously scary time would pass.

Weather was on our side here in Switzerland, and I was able to run and exercise alone or with my children on a daily basis. We live near a wood where many locals go to run, cycle or walk. As part of my job, I often go to my patients' outdoor exercise sessions to evaluate, assess and modify their training. I visit gyms, parks, woods, lakes or swimming pools, so I'm used to passing my patients during my workouts. However, an elderly patient whom I was looking after gave me the idea of continuing to treat her outdoors. I would find her sitting on a bench in the woods, and while maintaining a good distance from each other, we were able to continue our physiotherapy sessions outdoors. These involved many balance exercises, hip and trunk strengthening, and integrative pelvic floor contractions in sit-to-stand manoeuvres. My patient welcomed the sessions

because she lives alone, and she treasured the much-needed human contact. On my part, this formed a bridge between the traditional way of delivering physiotherapy, and perhaps, a new al-fresco approach to treatment.

During the first phase of easing the lockdown, many patients preferred to continue our sessions on Zoom, and I took this as an opportunity to offer more outdoor sessions to those I rehabilitated and coached in order to return to sport. Like me, many other physiotherapists in Switzerland offered telehealth consultations. However, it took a few weeks for the medical insurance companies to agree to the provision of online care, and they stopped it as soon as we could return to work and see urgent cases. Unfortunately, this isn't every practitioner or patient's preference – there are many individuals that we could begin seeing online, and if necessary, then progress treatment in the clinic. It will take a little longer for the insurance system to recognize this and make the necessary changes. Until then, we need to keep innovating while still being mindful of the risks that COVID-19 poses.

Lockdown created some opportunities for me by extending my clinical practice from video consultations to outdoor appointments, and allowing me to make a good start in learning German. As an independent practitioner, I need to take a financial loss on the 10–15 min spent airing and disinfecting my clinic between patients. On the other hand, I now offer more private video consultations and online Pilates classes, which almost balances this out. "Mixtury" is a new word that my daughter made up, and I now practise it by mixing skills, languages and abilities so that I can deliver the best possible physiotherapy support for my patients and students during these challenging times.

**Biljana Kennaway**  
*Assistant Editor*

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## Load management and the pelvic floor muscles: an interview with Dr Tim Gabbett

Just before the lockdown came into force in Switzerland, I was lucky enough to meet Dr Tim Gabbett (Fig. 4) when I attended his course on load management. I was the only pelvic health physiotherapist who attended this very informative and practical session, and our subsequent discussions identified research gaps in the pelvic health field.

Tim is a sports scientist who has worked with athletes and coaches from a wide range of sports worldwide for over 25 years. He has two doctoral qualifications: one in human physiology, and another in applied sports science. His research sprang from his work in high-performance sports, and he has now published more than 250 peer-reviewed articles. Tim is a leading scientist whose work addresses: progressive overloading rehabilitation and training programmes; maintenance of competitors' skills while under pressure and during periods of fatigue; and preparing athletes for the most demanding aspects of their sport. Although he is not a pelvic health practitioner, Tim is interested in understanding more about the pelvic floor and exercise, and his interest was piqued by my case study of the management of load in a female runner with pelvic floor dysfunction (Fig. 5).

Our discussion addressed the general approach to load management and clarified the terminology used in the field, and we considered how similar principles could – and should! – be applied in pelvic health rehabilitation.

**Biljana Kennaway**  
*Assistant Editor*

**Biljana Kennaway:** *How would you define an athlete?*

**Tim Gabbett:** Everyone is an athlete! All our clients have their own unique daily forms of activity



**Figure 4.** Dr Tim Gabbett.



**Figure 5.** Biljana Kennaway presenting a case study.

that can be challenged in a number of ways simply by changing their load. Even an elderly lady who climbs one flight of stairs a day is an athlete: her load could be challenged by climbing the stairs twice a day or carrying a heavier shopping bag, or simply by having a bad night's sleep.

**B.K.:** *How would you define load?*

**T.G.:** You can look at load in several ways. First, it can be defined in terms of external load, which refers to the training stimulus – essentially, the work you do. For example, this could be the distance you run, the weight you lift, the number of jumps, the number of times you throw a ball – anything like that. However, we also need to consider the internal load for that external load – this reflects an athlete's ability to tolerate load. Two different athletes, for example, could produce very different internal loads in a 4-mile run: one may have a higher heart rate or rate of perceived exertion in response to that distance, and the other's could be lower. So, internal load is about the athlete's response to that specific external load (Gabbett 2016, 2020; Gabbett & Whiteley 2017).

The ability to tolerate load is dependent on many factors that are easily missed when talking about it. It's not just physical load, and parameters such as frequency, volume and intensity that we manage when thinking about this, it's the

matrix of physiological, psychological and other factors outside of training that can have an impact on the ability to tolerate load (Gabbett *et al.* 2017; Verhagen & Gabbett 2019).

I suspect that internal load plays a large part in the management of load in the population with pelvic health issues, particularly as it addresses sensitive symptoms such as incontinence and perineal pain.

**B.K.:** *Could we apply the same understanding of the impact of internal and external load on the pelvic floor when treating individuals with PFM dysfunction?*

**T.G.:** In my view, we should look at the pelvic floor complex as a structure or a tissue, and as with any structure or tissue, we have structure- or tissue-specific capacity. In other words, to improve the capacity for tissues to adapt, you should gradually increase the load. In pelvic health rehabilitation, you could evaluate this subjectively by asking a client, “How hard was your session today in relation to your perineum?” This would be instead of a general quantification such as, “How hard was your session today?” In rehabilitation, we’re focused on increasing local tissue capacity in order to reduce symptoms, increase strength and improve function, but eventually, all athletes (and remember, everyone is an athlete) will move towards increasing their capacity for activity-specific performance. As an example, this could refer to a postpartum athlete going through PFM-specific rehabilitation (i.e. loading through a specific number of repetitions and sets in a specific position), and then applying sports-specific loading in order to return to running or CrossFit. My view is that the pelvic floor is like any other tissue or structure that can be loaded, and capacity can be increased with an individual approach.

**B.K.:** *We often hear the terms “load” and “force” being used interchangeably, but you clearly separate them. How would you define force?*

**T.G.:** When we talk about force, we are essentially referring to how quickly you can accelerate a mass through space. Injuries can occur when a large amount of force is generated – or absorbed – in a short amount of time. In this respect, an injury may be caused by the acute force(s) going through a joint or a tissue, as opposed to the accumulation of load over a period of time.

On the other hand, “load” can be described in terms of either “external load”, which may include a measurement of force, or “internal load” (e.g. an athlete’s perception of effort or heart rate in response to an external load). Our ability to tolerate load is influenced by many external factors, including sleep, psychological and academic stress, lifestyle factors, and also physical qualities such as strength and aerobic fitness.

*[To put this in terms of the pelvic floor, loading the PFMs is not just about muscle tissue load, but also considering how the multiple forces across the pelvis and pelvic floor could have an impact on the training load and the performance in a simple functional task (e.g. a single-leg hop). Tim and I discussed the biomechanical and psychological changes that female athletes go through before and after birth that would influence load. At the same time, we agreed that the forces going through the pelvis and pelvic floor could be increased or decreased, depending on the strength of the hips or trunk muscles. Therefore, in terms of individual repetitions and sets of PFM contractions in one static position, the load applied is probably not enough to sustain the forces in repetitive high-impact tasks, such as hitting a tennis ball with a racket.]*

**B.K.:** *How do we know that an athlete can progress further? How do we identify the absolute limit?*

**T.G.:** That’s a tough question and I’d argue that there are two key things you need to know:

- What is the starting point, i.e. how much load is already tolerable?
- What is the goal or end point, i.e. how do you know the load is too much?

One doesn’t know when it’s too much until it’s too much! We don’t know that someone is going to break until they break. However, there are some signs that can help us to recognize that point. In order to load, we look at chronic load, which is our indicator of tolerance to subsequent load, and local-tissue- or sport-specific capacity (Gabbett 2016; Gabbett & Whiteley 2017). For example, consider the hamstring. We can use objective tests like eccentric hamstring strength or isometric bridge exercise to judge different levels of tissue capacity. If progress is made in the test, then capacity is improving.

I imagine that it’s the same thing with pelvic health. There is a certain amount of chronic load that one develops, although I must say

that I never considered capturing chronic load for PFMs, and it would be interesting to look at that. For example, if someone does PFM exercises on a regular basis, i.e. a certain number of sets and repetitions every day, then you can capture the chronic load of that exercise in one specific position.

*[We agreed that load can change in different positions.]*

Local-tissue- or structure-specific capacity is another question to be considered. Is there a way to estimate the capacity of a structure like the pelvic floor? We talked about how it could be possible to capture it, perhaps with ultrasound, internal examination or through evaluation of an exercise/function. Depending on the test, we can identify the starting point and examine the response to load. If the load is gradually increased without increasing the number of repetitions too quickly, one might find that there are no symptoms at all. That may make you think you could push your athletes a little harder, and part of that comes down to them believing that they can trust you. It is also important that you believe in them, and know that you can push them a little harder. Equally, if the progression is sensible and you get a negative response (e.g. incontinence), that indicates that they are not tolerating the load and it needs to be adjusted. This could be done through regressing the load a little bit, or perhaps maintaining rather than progressing it (Bourdon *et al.* 2017).

**B.K.:** *Is it possible to progress the load capacity of a postpartum female runner who has already recovered, and returned to their previous level?*

**T.G.:** It depends on her history and individual story, and what more she wants to achieve. If she intends to go from a traumatic childbirth to being able to run for 30 min, that will require a different approach to that needed to rehabilitate a woman with a similar history who wants to return to marathon running! Just recently, I took on a client who is a female athlete. Her goal is not just to compete, but to win, so she – and I! – must be prepared to be pushed and experience uncomfortable places. And I have to be sensible and mindful about both her physical and psychosocial factors.

*[This is an interesting area. Sports scientists, coaches, pelvic health physiotherapists and*

*athletes are all working together in an attempt to understand what spikes in load do to a structure and athletic performance. The achievement of optimal loading involves many factors, and an integrative approach is required in order to be able to interpret findings and apply the relevant science in such scenarios (Gabbett et al. 2017).]*

**B.K.:** *Can you tell us more about the psychosocial model and its relevance to athletes?*

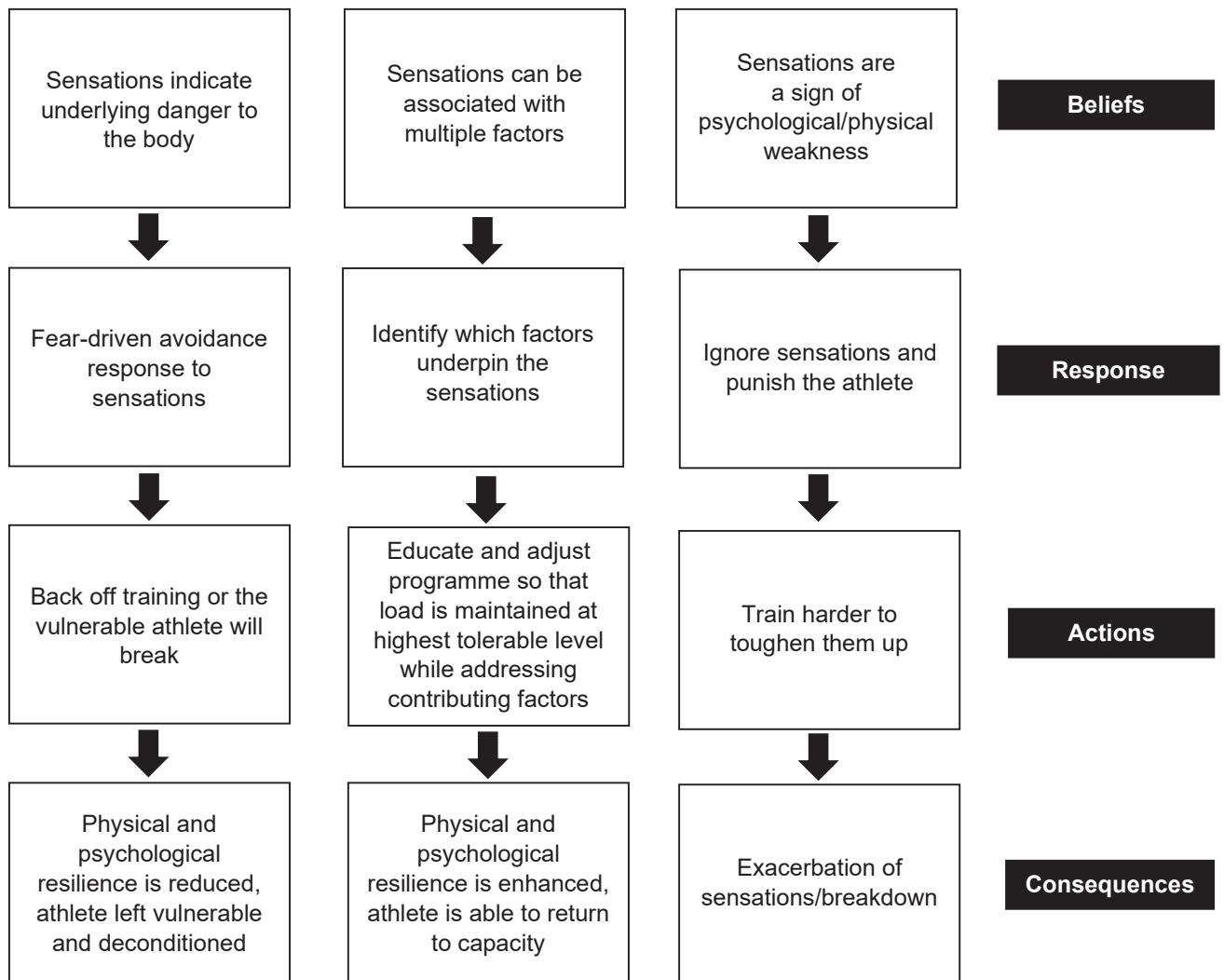
**T.G.:** I think the first thing to do when working with athletes who are experiencing pain is to rule out tissue damage as a cause of their symptoms (O’Sullivan *et al.* 2018). The psychosocial component is often overlooked or underestimated. The female athlete whom I work with is really intriguing, and there are probably some doubts in her mind about what she is capable of now. Most people would not recover from some of the injuries that she has had, but she bounces back each time. She feels and says that she is frail, but she forgets that she always recovers. From these past experiences, it’s clear that she has a degree of resilience.

We need to look at all our athletes individually, and find where the sensation is coming from by listening to their stories. The problem could be driven by multiple factors. As practitioners, the key is for us to ask the right questions and to listen carefully to their answers (O’Sullivan *et al.* 2018). Once we identify and understand what their sensations are, we can help them to return to full capacity, and of course, beyond tissue damage, there are plenty of reasons why someone could be in pain or discomfort. For example, if an athlete experiences incontinence, then we need to identify whether this is a result of tissue damage, or psychological or even sociological reasons? It is often difficult to identify the triggering sensations (Fig. 6).

The questions I ask are:

- Is it loading? Let’s say we get to the point of 15 min of running, and symptoms only happen at 7–8 min of running – what is the difference between 7–8 and 15 min? Is it fatigue, which may indicate a capacity issue, or is it something else? What if the run is asymptomatic for 15 min and the sensation comes at 16 min?
- Is it a psychological issue? Stress and fear of experiencing incontinence when running may trigger this sensation. In that case, there are other ways to increase load and capacity, and you can minimize the risk of experiencing the symptoms. If the athlete thinks that it comes at 16 min, and s/he can’t pass that





**Figure 6.** Parallels between the interpretation of pain and fatigue. Adapted with permission from O’Sullivan *et al.* (2018, p. 555, Fig. 1).

point without experiencing it, then you can play with time. For example, three or four, 14-min blocks with a recovery period in between could suddenly achieve a total of 56 min. That can be powerful enough to change the psychological message – the stress that’s bringing on the incontinence. Just as with all muscles, it’s about constantly making progress, little by little. And with that extra training comes confidence too.

**B.K.:** *How can we move research forward in pelvic and sports science?*

**T.G.:** In sports science, I experience a disconnect between the people working in universities and those operating in the field. The latter ask questions, and they are the ones who drive the research forward, but the academics are usually at least 5 years behind them. My suggestion is to bring the two groups together so that they can share their experiences.

To push the research forward, we need to ask clinically relevant questions, and all of us, including pelvic health clinicians, have to work together to apply the lessons of load management. There are many things that we still don’t know about the endurance and resilience of the PFM complex in athletes. Equally, elite athletes experience symptoms that are often not discussed, and certainly not reported. This is a pity and something that we should try to change.

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### East Anglia area representative

I have enjoyed a career in pelvic health physiotherapy since 2008, and completed my postgraduate certificate in continence at the University of Bradford in 2012 (Fig. 7). I have been the POGP area representative for East Anglia since 2014, and now lead the Pelvic Health and Obstetric Physiotherapy team at Addenbrooke’s Hospital, Cambridge. I am a tutor on the POGP pelvic organ prolapse course, and run a pessary self-management service at the hospital.

The East Anglia area includes the counties of Norfolk, Suffolk, Cambridgeshire, Essex and Hertfordshire. We aim to hold meetings twice a year, and last did so in March, when a local



**Figure 7.** Claire Brown, POGP area representative for East Anglia.

gynaecology consultant and a specialist nurse talked to us about endometriosis (Fig. 8). This was a wonderful opportunity to discuss our shared practice. The meeting was well attended by 22 of the 55 members in the area.



**Figure 8.** Members of the East Anglia POGP group.

Other meetings have included a lecture on reducing obstetric anal sphincter injuries by using Episissors-60 (Medinvent Ltd, Gosport, Hampshire, UK), a discussion of new and revised continence products, presentations from psychosexual counsellors and a wonderful talk on managing PGP in pregnancy by Clair Jones. To help improve attendance at our meetings, a local survey of members was conducted to establish the best location, time of day and topics. This has helped us enormously with the planning of future events. During lockdown, regular video conference meetings are being held within the group in order to provide mutual support and share ideas.

The COVID-19 pandemic has created many challenges for us all. Our main concerns include the change from face-to-face appointments to telephone consultations, although some members are able to use video conferencing apps. Many of us have been asked to return to general physiotherapy work on the wards, and others have been asked to reintroduce face-to-face appointments. The opportunity to discuss not just the challenges that we are facing, but also the opportunities with which we have been presented, has been hugely rewarding.

We are a very friendly group. If you are new to East Anglia, please feel free to get in touch in order to find out more about our meetings (e-mail: [claire.brown32@nhs.net](mailto:claire.brown32@nhs.net)).

**Claire Brown**  
*Area Representative*

### **Anne Bird Award 2020**

The POGP Trustees are very pleased to announce the presentation of the annual Anne Bird Award to Dr Ruth Jones for her role in advancing knowledge and practice within the world of pelvic health (Fig. 9).

Anne Bird was chairman of the Association of Chartered Physiotherapists in Obstetrics and Gynaecology (now POGP) from 1985 to 1988. As superintendent of the Bristol Royal Infirmary physiotherapy department, she created a centre of excellence for obstetric and gynaecological physiotherapy. The Anne Bird Award (Fig. 10) commemorates her life by encouraging and recognizing in others those qualities that she valued.

This prize is normally presented annually to an individual, or individuals, who have shown overall excellence, professionalism and empathy in their educational development within POGP. The successful nominee will also have made a



**Figure 9.** Dr Ruth Jones.



**Figure 10.** The 2020 Anne Bird Award.

special contribution to a POGP post-registration course, or to the field of pelvic, obstetric and gynaecological physiotherapy.

Nominations are confidential, and the recipient is not informed of the presentation in advance of receiving the award.

Below are some of the statements made by the POGP members who made this nomination:

“Ruth Jones has made a major impact on the personal and professional lives of many, many people over the years. She is one of the rare physiotherapists who has excelled in many aspects of our profession [...] as a highly specialist clinician, researcher, lecturer, tutor and mentor. Her PhD research and subsequent



publications increased our understanding of the association between [PFM] function and urinary incontinence with an inevitable impact on our teachings and professional practice.”

“She pioneered [...] musculoskeletal management of both female and male chronic pelvic pain. She taught courses nationally and internationally, published on her subject and edited a book where she drew physiotherapists and other [allied healthcare professionals] worldwide together.”

The POGP Trustees felt that the sentiments expressed in these statements reflected the qualities valued by Anne Bird, and have great pleasure in presenting the 2020 Anne Bird Award to Dr Ruth Jones.

**Ruth Hawkes FCSP**  
*Education Subcommittee Chair*

## Clinical guidelines and good practice statements

### *Clinical guidelines*

A clinical guideline (also called a medical guideline or clinical practice line) is a statement that is intended to help practitioners make decisions about appropriate healthcare in specific clinical circumstances. These systematically developed declarations define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. Most clinical guidelines are based on a consensus of expert opinion, or rigorous systematic review and synthesis of the published medical literature within the paradigm of evidence-based medicine (NCCIH 2017; SIGN 2019; Wikipedia 2020). These recommendations are developed by multidisciplinary working groups, and involve “healthcare and other professionals, technical experts, and patients and carers who have relevant expertise and experience” (NICE 2012, p. 12). More information can be found in publications by the ADAPTE Collaboration (2009) and Attia (2013).

### *Good practice statements*

In contrast, to paraphrase Tugwell (2015), a good practice statement is a declaration about an area of practice where there is high level of certainty that the recommendation will do more good than harm, but little direct evidence (e.g. the evidence for parachutes saving lives is not based upon studies of individuals jumping out of aircraft with and without parachutes).

In light of the above, I have drafted the following qualification to be appended to POGP good practice statements:

“DISCLAIMER: While POGP good practice statements are written by experienced clinicians and informed by evidence-based research, anyone referring to this resource must use independent judgement with regard to applying the suggestions made herein.”

**Andrew J. Wilson**  
*Managing Editor*

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## Using QR codes

### *Do you have a smartphone or tablet?*

If you have a smartphone or a tablet, then you will be able to make use of a new feature for the journal that is included this edition’s opinion article (see pp. 5–11). Quick Response codes, which are more commonly known as “QR codes”, originated in Japan. These matrix barcodes act as hyperlinks within printed or digital articles, and allow us to showcase supplementary content such as videos, external websites and digital images.

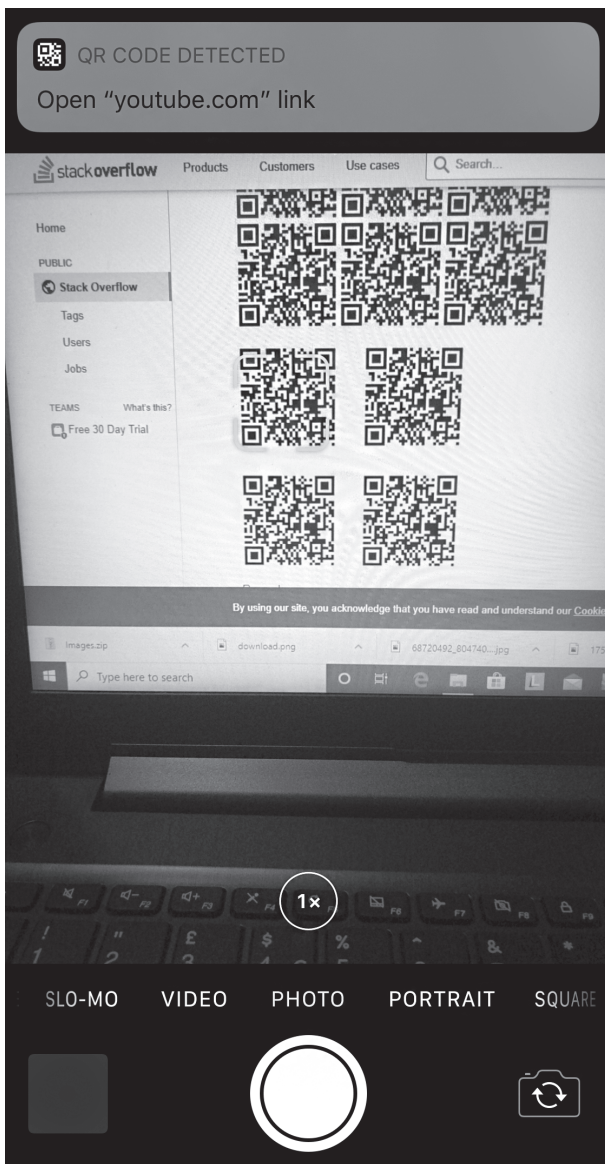


Figure 11. The QR code focus zone.

### How do these work?

Most modern camera phones already possess the ability to read a QR code. Simply open your camera app, frame the QR code within the preview screen and you should receive the following notification: “QR code detected, open link.” Simply click the link to be directed to the appropriate resource. If this is not the case, there are third-party apps that can be downloaded to allow your device to read the QR code.

### What if there are multiple QR codes?

If more than one QR code is displayed (e.g. see Fig. 3 on p. 7), you may need to ensure that the relevant QR code is fully visible on screen. You should experiment until you see the autofocus surround the image that you intend to scan (see Fig. 11).

### What do you think?

We would like to hear your views on the use of QR codes within the journal. To give us feedback, please complete this online survey: <https://www.surveymonkey.co.uk/r/GLBMBD3>

**Bianca Broadbent**  
Social Media Officer

### Members in the media

It's a pleasure to report that members continue to spread the word about pelvic, obstetric and gynaecological physiotherapy. An interview with POGP Trustee and Communications Subcommittee Chair Lucia Berry about her role as a women's health physiotherapist was published by the Patient.info website in November last year (Turner 2019). Kelly Steed was interviewed with Katina James on BBC Radio Bristol to promote the Women's Health Fair in Portishead that they organized in March (BBC 2020). Outgoing JPOGP news editor Rosie Conway, a long-serving member of the Journal Subcommittee, has published an article in *Menopause Matters* (Conway 2020). Last but not least, Gráinne Donnelly and Emma Brockwell are among the authors of an infographic providing guidance for women who are returning to running in the postnatal period (Donnelly *et al.* 2020), and this has been published online ahead of print by the *British Journal of Sports Medicine*.

**Andrew J. Wilson**  
Managing Editor

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### New brand and website for World Physiotherapy

World Physiotherapy, the global body for national physiotherapy associations, has launched a new brand and website after changing its name from the World Confederation for Physical Therapy.



Emma Stokes, World Physiotherapy president, said:

“Earlier this year we announced we would be changing our name and it’s exciting to now share our new brand. This is an opportunity for us to clearly explain who we are and how we support the global physiotherapy profession. The new brand is fresh, vibrant, sharp, and concise.

“We’ve been through a lot of change and progress in the past five years and the launch of the new brand and website is the next step.”

The website (<https://world.physio>) showcases the member organizations that make up the organization, and highlights areas of its work in different parts of the world. New sections focusing on World Physiotherapy’s advocacy and project work have been added, resources have been reorganised to make it easier for people to find policy, guidelines and information, and content about World Physiotherapy Day has been refreshed.

**Shirley Bustard**

*IOPTPWH Newsletter Editor*

## **New dates for ICS 2020**

Following the latest developments in the COVID-19 outbreak, the fiftieth annual meeting of the International Continence Society (ICS), has been moved to 18–21 November 2020 (ICS 2020a). However, ICS 2020 will still take place at the same venue, the Rio Convention Centre in Las Vegas, NV, USA.

Even in the face of an unprecedented pandemic, we strongly believe that it is important to

host the ICS annual meeting, and bring together everyone involved in the research and treatment of continence-related issues.

We hope that you will be able to join us for this one-of-a-kind multidisciplinary meeting. Urology, gynaecology, colorectal surgery, physiotherapy, nursing, and medical and basic science disciplines will all be covered.

For more information, please visit our website (ICS 2020b).

Thank you in advance for your support!

**Yuliana Angelova**

*ICS 2020 Marketing Coordinator*

## **Reference**

International Continence Society (ICS) (2020a) *The 50<sup>th</sup> ICS Annual Meeting*. [WWW document.] URL <https://www.ics.org/2020>

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## **Communications Subcommittee vacancies**

The POGP Communications Subcommittee now has two vacancies. If you are interested in joining this friendly and active group, please contact its chair, Lucia Berry (e-mail: [lucia\\_physio@hotmail.co.uk](mailto:lucia_physio@hotmail.co.uk)).

**Andrew J. Wilson**

*Managing Editor*