



## Comings and goings

After six years service as Honorary President of the SOM, Richard Ellis has resigned. The society is very grateful for his help and advice over many years as a teacher, on the council, and as president. We are very pleased that Richard will be continuing to edit the journal and the more humble editor of this newsletter would like to particularly thank Richard for his injection training on my basic courses many years ago.

We are delighted that Keith Bush has agreed to take over the presidency from Richard. Keith qualified at the Royal Free in 1978 and was initially bent on a career in orthopaedic surgery but after attending a Cyriax course in 1979 and subsequently meeting James Cyriax and sitting in clinics with him Keith decided to become an orthopaedic physician. He has conducted a number of research studies and has papers published particularly on the subject of back pain and sciatica and has contributed to several textbooks. He has a long association with the SOM and was chairman between 1983 and 1988.

Another new face joining the SOM council is Paul Hattam, Paul is a physiotherapist who will be known to many of you as a member of the society's teaching team. Paul worked for many years in the NHS and from 1996 operated as an extended scope practitioner developing a triage service in Sheffield. Four years ago he left the NHS and completed an MSC. He enjoys teaching and has a growing private practice. There is no doubt that Paul will make a major contribution to the society's development over the next few years.



David Knott (right) thanks Richard Ellis at the AGM

## EDITORIAL

Welcome to the spring newsletter in which I hope you will all find something of interest.

The annual symposium which we put on in collaboration with BIMM is the biggest event in the society's year, and in this issue we report on the presentations delivered at the symposium. I hope those of you who attended found something useful to take away and use in your own practice or to stimulate further research. I am a believer in trying to draw something useful out of all our activities and would like to make room in future issues of this newsletter for brief reports or anecdotes that you feel other members of the SOM will find interesting and might learn from.

A few years ago in my hospital clinic I saw a young lady with a painful hip, examination suggested a possible psoas bursitis and with some doubts I injected this. I was delighted as was she with the result when the following week, her pain had gone and she felt so much better. It was only a couple of months later that her GP told me why - she had been diagnosed as having Addison's disease. The Kenalog I gave may or may not have soothed her bursitis but it certainly helped her steroid deficiency.

If you have something you would like to share with your fellow members please email me at [Nicholas.Shaw@gp-A82050.nhs.uk](mailto:Nicholas.Shaw@gp-A82050.nhs.uk).

NICK SHAW, EDITOR

## Membership handling

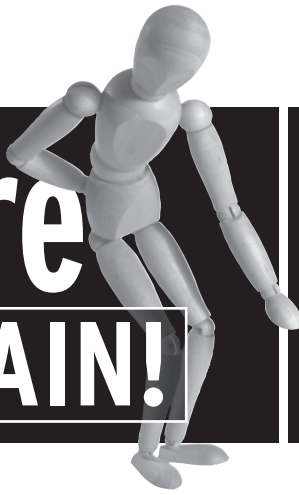
As a result of changes within the administration structure of SOM (*more details to follow in the next issue of SOM Times*), the SOM Council have decided to outsource the membership subscription handling to an outside company - Portland Customer Services.

Portland has a wealth of experience in managing membership subscription systems and this will improve the efficiency of running the SOM membership. All members will be asked to CANCEL their standing orders for payment of their subscription fees and set up a DIRECT DEBIT instruction. Further details will be sent with the membership renewals in September.

*(Farewell to Sue Cottrell - page 8)*



# Posture IT'S A PAIN!



Last year's annual joint symposium with BIMM was held in London on 2 December and we have received excellent feedback from delegates attending. Below is a brief synopsis of the lectures.



## HOW DO WE MATCH OUR TREATMENT TO OUR PATIENTS? - THE JOYS OF SUB-CLASSIFICATION

**Dr Christopher McCarthy (Warwick, UK) - MACP Guest lecture**

Dr Chris McCarthy presented a very interesting lecture on sub-classification of Non-Specific Low Back Pain, NSLBP. This was based on a study developed to evaluate the contribution of a typical physiotherapy examination to identify subgroups of NSLBP.

Subjective and psychological assessment had acceptable reliability. However, within the objective assessment, tests such as sacroiliac joint stress, repeated movements, combined movements, passive physiological intervertebral movements, prone knee bend, plantar response and Waddell signs all had a poor reliability. Postero anterior mobilisation over the spinous process was identified as a useful tool but not reliable.

The results of the study comparing items with acceptable reliability identified a subgroup, presenting with higher fear avoidance beliefs related to physical activity, sensory pain, anxiety and disability which he called hypervigilant. This group also was more likely to have positive pain provocative tests and central sensitisation. A highly predicted test for this group was the presence of allodynia, whilst a negative straight leg raise significantly reduced the probability of being in the hypervigilant group.

The identification of a specific subgroup of NSLBP should allow effective interventions. Clinical examination is a valid tool too but most of the tests and questions used do not reliably contribute to the identification of any subgroups.

**JOSÉ MARCELINO FSOM**



## SHOULDER GIRDLE MUSCLES IN PERSPECTIVE

**Ian Bayley (Stanmore, UK)**

Prof Ian Bayley gave a stimulating and engaging presentation concerning the shoulder girdle muscles and posture. He carefully explained the relative contributions of the spine, scapula and the five joints that comprise the shoulder. This was supplemented by reference to the long spinal and segmental muscles together with the contribution of trapezius, lat.dorsi and the rotator cuff.

This was followed by a systematic pathological analysis of posture dysfunction in terms of congenital disorders, nerve (paralysis), mechanical and postural. Congenital causes included absence of muscle fibres (e.g. trapezius lower fibres, rhomboids etc). The nerve pathologies were however further subdivided into myopathic, neuralgic, atrophy and injury to the long thoracic nerve. The mechanical list was more extensive

and included snapping scapula, clavicular fracture (malunion), scapular fracture (malunion), scoliosis and osteochondroma. Cortical inhibition and habitual muscle pathways (e.g. dyskinesia of old shoulder injury) were identified and explored with the postural component.

The role of pain in impaired shoulder and posture was described together with its role in dyskinesia. The contribution of traction at the cervical and brachial plexus was discussed and further supplemented by the role of proprioception (e.g. benign hypermobility, rotator cuff repairs) and cortical recruitment (e.g. poor core stability).

The talk was concluded with a review of treatments, primarily focussing on biofeedback and the role of botulinum injections.

An Active question and answer session then ensued with a productive discussion from the many clinical questions arising from the delegates.

In summary an enjoyable and engaging presentation of the complex relationship between the shoulder and posture.

**DR C MONELLA MSOM**



## LOW BACK DISORDERS- DISPELLING THE MYTHS

**Professor Stuart McGill (Waterloo, Canada)**

Prof McGill asked us to consider what really causes low back injury and to review our philosophy on which some may base exercise programmes for clients.

He highlighted some key issues: that often failure is due to inappropriately sub classifying the low back problem appropriately and as a consequence the focus of the rehabilitation is misdirected.

He had strong views on inappropriate focus on strength and instability, particularly in the literature when in his view one may be better focusing on endurance and control of torsion. His lecture was further enhanced by some slides of his native Canada which brightened a cold London day.

In overview he advocated:-

- Clear foundation (observation/history/provocation and functional tests. All with the purpose of testing a clinical hypothesis)
- Remove the cause of the trouble
- Design therapeutic exercises (correct motion pattern to stabilise, build endurance then work on strength & agility)
- Evaluate continually

These core principles were applied practically in the afternoon session. This was well received and sparked discussion about including practical workshops into future symposia. More food for thought!

**ANGELA CLOUGH FSOM**



## STABILISATION AND CORRECTIVE EXERCISE FOR THE LOW BACK

**Professor Stuart McGill (Waterloo, Canada)**

In the afternoon session Stuart McGill talked of his philosophy of treatment and challenged the tendency that has developed of concentrating on core stabilisers, he argued that EMG evidence showed much greater activity in long extensors during motion and described these as the guy ropes that support the spine. He then gave us some excellent practical demonstrations of stabilisation and corrective exercises with [as is traditional] the help of a volunteer from the audience.

The first step of his clinical reasoning process leading to the exercises is represented by three pain reproduction tests:

- 1] a compression test performed by asking the sitting patient to flex his spine.
- 2] a shear test performed with the patient in prone lying on the plinth. The hips and legs are outside the plinth, he asks the volunteer to raise both his feet from the floor.
- 3] asking the patient to stand from a sitting position assessing the motor pattern.

The objective of this assessment is to identify and correct a motor pattern that is promoting pain or disability, the patient is asked to continue to use the corrected motor pattern after the treatment during his everyday activities. The first exercise proposed is a hip abduction with the patient in side lying. The aim of this is to activate and reinforce the gluteus medius while inhibiting contraction of the spinal muscles that can substitute the glutei adding to hip abduction a certain degree of lumbar rotation. The second exercise shown was a pelvic raise from the supine position. The aim of the exercise was to activate gluteus maximus and quadriceps - hip and knee extensors while keeping the lumbar spine in neutral. This exercise was developed to stand from a sitting position using the same muscles without lumbar flexion, and involving a particularly tight buttock clench.

In the second part of his practical demonstration Stuart McGill showed how to use his "Big Three" exercises - 'Curl up', 'Side bridge', and 'Bird dog' to develop & strengthen the quadriceps, glutei & long extensors as the basis of his postural approach. The demonstrations were clear and convincing, and I would recommend reference to Prof McGill's book to take his theories forward in clinical practice.

GIANPIERO CAPRA MSOM



## THE SURGICAL MANAGEMENT OF THE UNSTABLE FOOT AND ANKLE

**Professor Mark Tagoe (London, UK)**

Professor Mark Tagoe, a consultant Podiatrist from the Middlesex Hospital, London, presented his talk on surgical interventions in unstable foot and ankle lesions/problems.

About 12% of the cases seen in Accident & Emergency are acute lateral ankle sprains and the anterior talofibular (ATFL) and calcaneofibular (CFL) ligaments are the most commonly involved ligaments (Brostrom 1966) examined 105 ankles; 66% had ATFL injury, and none had an isolated CFL injury. ATFL may be repaired surgically if conservative treatment fails and the patient has residual pain, instability and reduced function.

Peroneal muscle weakness, ligamentous laxity, fixed calcaneal varus are some of the overlooked predisposing contributors to functional instability of the ankle.

Some of the associated pathologies seen on scanners/

MRIs/Arthroscopies are: Osteochondral defects; Pathology of Peroneii; Anterior calcaneal process fractures; Bony impingements; Fracture of 5th metatarsal; Meniscoid body; loose body.

Kanus and Renstrom (JBJS, 1991) believed that medial and lateral ligamentous tears and avulsion fractures were indicators of immediate surgery at the ankle.

Ankle instability has a direct effect on function and so needs surgical intervention (Brostrom, Gould is the technique often used). Ankle arthritis would be a contraindication for surgery. Surgical Repair of Peroneus Brevis may be necessary.

Discomfort, deformity and dysfunction are seen with flat foot (the weight bearing line falls medially). Navicular stress fracture, inflammation of long flexors, Tarsal tunnel syndrome are some of the pathologies to be kept in mind for differential diagnosis.

Pathology of Tibialis Posterior may be treated conservatively or surgically where flexor digitorum longus is used for tendon transfer.

RAMESH VASWANI, FSOM



## IMAGINING BETTER BODY USE - 25 YEARS OF TRAINING THE TRAINERS

**Dr Roderic MacDonald (London, UK)**

After lunch, Dr Roderick Macdonald from the London College of Osteopathic Medicine sought to answer the question 'How can the insights of FM Alexander, reconciled with contemporary understanding, be made accessible to busy people in the busier NHS?'

Dr Macdonald emphasized that he was not introducing the Alexander technique (as practiced world wide) but rather showing how the principles laid down by Alexander could be adapted for use in NHS practice on their own or as an adjunct to other treatment modalities. He emphasized and demonstrated the need for visualization of good postural patterns by the patient to bring about change. We were told that functional brain imagining has revealed that the majority of cortical activity during the generation of an action was indistinguishable whether the action was simply visualized or whether it was actually being performed. He argued that this overlap between process of volition and visualization encouraged an approach whereby it is the imagination of the patient rather than the practitioner's hands that moulds and guides the actions of the self; and here refers back to Alexander's concept of the 'self' and his refusal to split it into separate functions of the body and mind. Dr Macdonald then demonstrated very convincingly a way of teaching good movement patterns to encourage proprioceptive recognition that an optimum posture had been reached. He asked us to visualize our cervical posture and correct it by head flexion and muscular release to lengthen the neck followed by a return of the head to neutrality and relaxation of the shoulders to what I certainly found to be more comfortable resting position and what he described as an easy neutral stability. A similar demonstration of methods involving the lumbar spine and pelvic tilt were also shown on screen.

The presentation's final message was that poor posture is the cause of much pain and discomfort. Many of us, no doubt, tell patients that their posture is dreadful but having done so it is then up to us to do something about it, for in Dr Macdonald's words "persons made aware of deficiencies in their self but not offered help to correct them have been harmed rather than empowered".

NICHOLAS SHAW MSOM

# Evidence for the concept of capsular pattern

**V**ery little has been published regarding evidence for the existence of a capsular pattern and its value as a diagnostic and management tool. As much of SOM practice is based upon this concept it would be a valuable area in which to conduct further research.

SOM define the capsular pattern as a limitation of movement in a specific pattern which is peculiar to each joint and indicates the presence of an arthritis (Kesson and Atkins 1998). Further definitions of capsular pattern can be found in the literature.

- A joint specific pattern of restriction that indicates involvement of the entire joint capsule (Hayes et al 1994)
- A proportional motion restriction unique to each joint that indicates irritation of the entire synovial membrane occurring with an active inflammatory process or degenerative change. (Fritz et al 1998)

Some articles define capsular pattern in terms of a proportional movement loss.

Where this is the case very few patients demonstrate a capsular pattern suggesting a proportional definition is not particularly useful in clinical practice. More patients are identified as having a capsular pattern if it is defined in terms of a pattern of movement loss rather than a proportional movement loss (Hayes et al 1994, Fritz et al 1998)

The majority of the literature refers to capsulitis at the shoulder. Palmer et al (2000) highlight the fact that standardised criteria do not exist for the diagnosis of shoulder capsulitis and attempt validation of an upper limb examination schedule as a means of standardising diagnoses.

Rundquist et al (2003) were able to demonstrate substantial range of movement deficits in subjects with frozen shoulder. However the pattern of movement loss can vary according to whether it is tested in an adducted or abducted position (Rundquist & Ludewig 2004, Rundquist et al 2003). This may contribute to lack of agreement between SOM described capsular pattern and patterns of movement loss described in the literature.

Some studies assess movement loss at the shoulder using scapular to humerus movement and some use trunk to humerus. It has been demonstrated that these 2 measurement methods produce different patterns of movement loss. Future studies need to clearly define which measurement method is being used and there may be value investigating the differing movement loss patterns using both methods (Rundquist & Ludewig 2004)

Internal rotation was found to be the most limited motion in shoulders particularly with the arm abducted by Rundquist & Ludewig (2004) which does not support SOM capsular pattern.

According to Rundquist & Ludewig (2004) and Rundquist et al (2003) there may be a relationship between shoulder

movement loss and anatomical structures at fault that is consistent with cadaveric studies. Loss of external rotation suggests coracohumeral ligament restriction. Loss of internal rotation is consistent with capsular tightness in the posterior band of the inferior glenohumeral ligament complex.

These authors go on to suggest that different areas of the capsule may tighten in different subgroups of frozen-shoulder patients resulting in no consistent capsular pattern across subjects. This questions the validity of a theorized single capsular pattern of motion loss at the shoulder.

In an article regarding the capsular pattern at the hip Klassbo et al (2003) highlight the discrepancies between examination and radiological findings. A capsular pattern being demonstrated in some but not all hips with a radiological diagnosis of OA and there being no correlation between radiological findings and pattern of movement loss at the hip.

The concepts of end feel and pain/resistance sequence are central to SOM assessment and treatment principles but there is little evidence regarding the reliability of them as assessment tools. Hayes et al (1994) recommend more investigation of the reliability and validity of the selective tissue tensioning system if it is to be used to guide management decisions.

DEBBIE COX, SOM RESEARCH FELLOW

## References

- Fritz, Delitto, Erhard, Roman. *Physical Therapy* 1998 Dec 78 (12) p1339 'An examination of the selective tissue tension scheme with evidence for the concept of a capsular pattern of the knee.'
- Hayes Falconer Peterson *Physical Therapy* 1994 74 (8) p697-707 'An examination of Cyriax's passive motion tests with patients having osteoarthritis of the knee.'
- Kesson, M & Atkins, E 1998. *Orthopaedic Medicine a Practical Approach*. Oxford: Butterworth Heinemann. p386-440.
- Klassbo, Harms-Rhingdal, Larsson 2003. *Physiotherapy Research International* 8 (1) p1-12 'Examination of passive range of movement and capsular patterns in the hip'
- Palmer, Walker, Linaker, Reading, Kellingray, Coggon, Cooper 2000 *Annals of Rheumatic Diseases* Jan 59 (1) 5-11 'The Southampton examination schedule for the diagnosis of musculoskeletal disorders of the upper limb.'
- Rundquist Ludewig 2004 *Clinical Biomechanics* 19 (8) p810-8 'Patterns of motion loss in subjects with idiopathic loss of shoulder range of motion.'
- Rundquist, Anderson, Guanche, Ludewig 2003 *Archives Physical Medicine and Rehabilitation*. Oct 84 (10) p1473-9 'Shoulder kinematics in subjects with frozen shoulder.'

# Prescribing for Physios – an update

Since the publication of the NHS plan in 2000, NHS policy has been focussed on increasing access and choice of services for patients. Traditional professional boundaries have become blurred and perhaps the most conspicuous example of this has been the extension of prescribing rights to a range of health professionals, so called ‘non-medical prescribers’. The pace of change has been rapid and significant, not only for nurses and pharmacists but also allied health professionals (AHP's) such as physiotherapists, all of whom are now eligible to undertake prescribing training.

There are two categories of prescribers - ‘independent’ and ‘supplementary’.

## Independent Prescribing

An Independent prescriber is a practitioner responsible for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about their clinical management - including prescribing. Up until last year, independent prescribing was limited to doctors and dentists but in November 2005, Patricia Hewitt, Health Secretary, announced the extension of independent prescribing rights to appropriately trained nurses and pharmacists giving them access to the full drug formulary to use within their scope of practice. Independent prescribing for AHP's is likely to follow at some stage in the future although this does not appear to be a Department of Health priority at present. Until then, supply and administration of drugs such as Triamcinalone acetone and lidocaine for musculoskeletal injections for example, can still only be done within the framework of a ‘Patient Group Direction’.

The issue of mixing steroid and local anaesthetic continues to cause problems for many physios endeavouring to formulate PGD's within their Trusts. This has been brought to the attention of the National Prescribing Centre by the SOM and we are hoping that clarification will follow in the near future.

## Supplementary Prescribing

Supplementary prescribing is a voluntary partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient specific, clinical management plan with the patient's agreement.

Physiotherapists, chiropractors/podiatrists, optometrists and radiographers joined the nurse and pharmacy professions in 2005 in being able to train as supplementary prescribers. Clinicians working in a multidisciplinary setting with patients who have long-term conditions will be able to see advantages in being able to become supplementary prescribers. For example, an appropriately trained physiotherapist working in a multidisciplinary rheumatology clinic would be able to adjust patients medication provided this has been agreed and documented within the patients' management plan.

## Training

Supplementary or independent prescribers are expected to:

- Be working within a multidisciplinary team.
- Have access to the patient record.
- Be working in a specialist role with an identified need for prescribing which benefits patients.
- Have a minimum of 3 years relevant postgraduate experience.
- Prescribe only within their scope of practice.
- Have their employers support.
- Have an approved medical practitioner mentor.
- AHP's will need to be HPC registered.

A curriculum framework for AHP prescribing training has been devised by the Department of Health. This framework describes a generic and multi-professional programme similar to the shared pharmacist and nurse training already in place which comprises a minimum of 27 days theory and 12 days in practice mentored by a doctor.

For more information go to [www.doh.gov.uk](http://www.doh.gov.uk) and type ‘prescribing medicines’.

ALISON SMEATHAM FSOM



The following universities have indicated that they are planning AHP prescribing courses:

Derby	Edge Hill
Nottingham	Manchester Metropolitan
Lincoln	Huddersfield
London Metropolitan	Leeds
Homerton	Bradford
Chester	Plymouth
Hertfordshire	Leicester De Montfort
Bolton	Birmingham and Black Country
Northumbria	SE London
Oxford Brookes	South Yorkshire
Liverpool	Essex
John Moores	

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**British Institute of Musculoskeletal Medicine  
Society of Orthopaedic Medicine**



# Challenging Our Practice

**Saturday 1 December 2007  
LONDON HILTON METROPOLE**

This year we have another eclectic line-up of speakers including Professor Nicola Maffulli, our Keynote Speaker, who will be speaking about recent trends in the treatment of tendonopathies, Roger Kerry speaking about Cervical Arterial Dysfunction, and Keith Bush who will talk on the pros and cons of injection therapy. This year our speakers are prepared for debate and discussion and there will be plenty of time factored in for this. Registration and full programme details available soon.

Email: [admin@somed.org](mailto:admin@somed.org) or [info@bimm.org.uk](mailto:info@bimm.org.uk)

Further details from:

**[www.somed.org](http://www.somed.org) or [www.bimm.org.uk](http://www.bimm.org.uk)**

# RESERVES

After the annual general meeting in December some members questioned why the SOM as a charity should have such an apparently large financial reserve.

The SOM council have considered this frequently most recently at the meeting last October. It is the councils feeling that reserves should be kept at a level roughly equal to a year's turnover; the reason for this is that we live in uncertain times. The society's principal source of revenue is the National Health Service through course fees funded to physiotherapists and doctors undertaking training and as the NHS lurches from financial crisis to crisis the council is very aware that training budgets may be cut and income flow reduced and that such a change might happen quite suddenly. If this was the case the council believe that it is right to maintain a reserve to draw on to maintain the society's activities during harder times.

NICHOLAS SHAW, EDITOR SOM TIMES

## Journal of Orthopaedic Medicine

You will be receiving your copy of *The Journal of Orthopaedic Medicine* with this newsletter. The editorial board have agreed some changes which will interest members of the society.

For many years the society in association with BIMM have published the journal privately. However times are moving on and it has been agreed to transfer this task to Maney Publishing, a company that publishes a large number of special interest journals. A major advantage of this move will be that the journal will become available worldwide on line, a change which will surely raise its profile. The name of the journal is also to change. Orthopaedic Medicine means different things in different countries and it is felt that 'International Musculoskeletal Medicine' will be more widely understood. Do please be reassured though that the SOM will remain the SOM!



### Men in Tights!

Never mind Johnny Depp in *Pirates of the Caribbean* you should have seen Bob Smith in *Pirates of Penzance* recently performed in Melrose in the Scottish Borders. Bob was the Pirate King and Bob, you were fantastic, your singing amazing, your acting superb and the make-up, long hair, earring and high heels suited you.

Click on [www.melroseopera.com](http://www.melroseopera.com) to see more pictures. Pirate costumes could be the new tutor uniform!



Meg Gilbert, retiring SOMTimes Editor, receives a token of thanks from the SOM Secretary, Fiona Ottewell

# SUE COTTRELL: WITH THE SOM FROM 1982 TO 2007

*Has anyone survived as long as this in an organisation?*

## **Sue's been with us forever!**

She has been a longstanding and devoted supporter of the SOM as Administrative Assistant. This meant that she was involved in many different roles through the years, though the most time-consuming was as Membership Secretary and the associated task of renewing the membership directory. SOM members have benefited a great deal from her involvement with the SOM - time spent in answering questions and encouraging them to pay their subscriptions promptly!

## **Who hasn't been chased for a standing order!**

Sue also spent a huge amount of time on the thankless task of packaging and posting the journals all over the world. The Symposium was another area of involvement where she was partially responsible for the smooth running of registration and attendance - memories of Sue at Church House directing traffic....!

Of course, there were many other demands on Sue's time and skills, and changes have had to be made as the Society continues to grow. Sue is currently working with Amanda to ensure a smooth handover with outsourcing the membership handling systems.

Once again, THANK YOU SUE for all that you have done for the Society over the years. You are a STAR and we shall all miss you!

FLORA PEDLER, SOM COUNCIL MEMBER



## **COUNCIL MEMBERS AND STAFF**

Dr Elaine Atkins  
*(Education Committee Representative)*  
Mrs Angela Clough *(Research Committee Chair)*  
Mr Jonathan Flynn  
Ms Emily Goodlad  
Mr Paul Hattam  
Dr David Knott *(Chair)*  
Dr Christopher Monella  
Mrs Fiona Ottewell *(Secretary)*  
Mrs Flora Pedler  
Dr Duncan Reid  
Dr Nicholas Shaw *(SOMTimes Editor)*

## **Ex Officio Members**

Ms Anne-Marie Ainscough-Potts  
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## **PGDIP/MSC in Orthopaedic Medicine**

### **NEXT INTAKE – SEPTEMBER 2007**

This exciting programme has been developed as a collaborative venture between Middlesex University and the Society of Orthopaedic. It is the first of its kind in Europe. Recognising the importance of continuing professional development (CPD), we provide the opportunity for experienced physiotherapists and medical practitioners to develop clinical, research and other relevant skills to extend their qualifications in orthopaedic medicine. You will explore injection therapy, advanced practice, project development and research methods.

Applications are now being received for the September 2007 intake. Full details from the web site at [www.somed.org](http://www.somed.org)

## **Theory and Practice of Injection Therapy**

The injection module comprises two separate units that are separated by an inter-unit period to allow for practice, consolidation and evaluation of the material presented in unit 1.

The module is designed to develop cognitive and psychomotor skills essential to the advancement of the chartered physiotherapist specialising in injection treatments for musculoskeletal lesions. It further aims to enhance constant critical reasoning and evaluation in the application of injection skills.

VENUE: Sheffield COST: £590.00 DATES: Unit 1 28-30 June 2007; Unit 2 4-5 March 2008  
Unit 1 8-10 Nov 2007; Unit 2 27-28 June 2008

## **Advanced Clinical Practice in Orthopaedic Medicine**

This module intends to extend the manual skills of chartered physiotherapists, or those with an equivalent overseas qualification, as applied in clinical practice in orthopaedic medicine. It is targeted at those students who have completed the Society of Orthopaedic Medicine Membership (SOM) course and who wish to develop those manual skills further based on their continuing clinical experience.

The module requires a total of five days attendance (including the assessment day), split over two weekends, with a period of guided study in between.

VENUE: Sheffield DATES: Unit 1 21-23 June 2007; Unit 2 7-8 September 2007