The Editorial Board of *Australian Journal of Physiotherapy* strives to publish an informative and interesting journal featuring high quality research that has implications for the practice of physiotherapy. One research design that has particular importance as a guide to clinical practice is the randomised trial, because it provides the least biased estimate of the effect of intervention.

In order to publish the highest quality randomised trials, *Australian Journal of Physiotherapy* employs several complementary processes. The first is to actively seek high quality trials. We search clinical trial registers and conference proceedings to identify well conducted trials and invite the investigators to publish with *AJP*. Next, the *AJP* Author Guidelines require the submission of information, such as trial registration and declaration of conflicts of interest, which can improve the believability of the results. In the final manuscript, we ensure that authors report on the use of features in the design, conduct, and analysis of the trial that affect trial quality, whether favourable or not. For example, *Australian Journal of Physiotherapy* works closely with submitting authors to ensure they have clearly reported whether features such as concealed allocation and intention-to-treat analysis were carried out. To assist with standardisation of this process, we use the Consolidated Standards of Reporting Trials (CONSORT) checklist of recommended standards for reporting randomised trials, including its various extensions (Vaarbakken et al 2008). We also work with authors to ensure their data are presented to maximise ease of interpretation. We use a consistent format for tables of results to ensure CONSORT recommendations for reporting are met and to facilitate comprehension of the data by our readers. We require authors to report the between-group difference with 95% CIs instead of *p* values. This is because the 95% CI provides equivalent information about statistical significance and greater information about the magnitude of the effect of intervention (Gardner and Altman 1986). We also encourage authors to make their data freely accessible via our eAddenda (Herbert 2008). This provision of individual data allows it to be scrutinised and re-analysed, not only as power calculations for future trials but also for inclusion in meta-analyses of individual participant data (Higgins and Green 2009).

Given all these efforts, it is worth examining the current quality of physiotherapy trials in *Australian Journal of Physiotherapy*. In order to do this, we used the Physiotherapy Evidence Database (PEDro) scale as a measure of methodological quality of the trials (Maher et al 2003). This scale has good reproducibility and inter-rater reliability (Sherrington et al 2000, Maher et al 2003). Furthermore, de Morton (2009) has recently shown that the summed score out of 10 can be treated as an interval level measurement.

We downloaded the PEDro scores of trials published in *Australian Journal of Physiotherapy* between 2005 and 2009. For comparison, we also downloaded the PEDro scores for any trials published between 2005 and 2009 that were indexed on PEDro. These downloads were performed on 4 October, 2009. The distribution of these scores is summarised in Figure 1a for all trials and Figure 1b for those published in *Australian Journal of Physiotherapy*. Scores for trials published in *Australian Journal of Physiotherapy* were 1.9 points (95% CI 1.4 to 2.3) higher.

Despite the combined efforts of the authors, the reviewers and the Scientific Editor, none of the *AJP* PEDro scores exceeds 8 out of 10. The two criteria that were met the least often in both sets of trials were ‘blinding of participants’ and ‘blinding of therapists who administered the intervention’. Given the difficulties inherent in blinding physical interventions, these scores will not be easy to improve. Nevertheless, we encourage researchers to seek novel ways to blind their interventions to eliminate this important source of bias. Furthermore, where criteria such as blinding have not been met, we encourage authors to report this

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**Figure 1.** Distribution of total PEDro scores of randomised trials published between 2005 and 2009. (a) All trials (*n* = 3508). (b) Trials published in *Australian Journal of Physiotherapy* (*n* = 47).
unambiguously so that readers can judge the presence of potential sources of bias as accurately as possible.

In summary, while we are very pleased with the quality of the trials in *Australian Journal of Physiotherapy*, we strive to improve these standards. We think that checklists for reporting research can help do this. We therefore encourage researchers to maximise the quality and the reporting of their trials and reviews by using the CONSORT checklist.

We hope this Editorial will help readers judge the believability of the results of trials as they consider applying them in clinical practice.

References


 Websites

Cochrane Collaboration: www.cochrane-handbook.org
CONSORT: www.consort-statement.org
PEDro: www.pedro.org.au

Erratum

In Vol 55 No 3 there was an error in the results reported in the paper by Stevens et al (2009). The error occurred in the final page make up. The last two paragraphs of Column 1 p. 188 should be corrected as follows (corrected text in bold type):

‘Linear regression analysis was also performed to determine whether total amount of physical activity was predicted by revision hip arthroplasty. The regression coefficient for being in the revision group was –394.3 (95% CI –701.1 to –87.5). The regression coefficient for being in the revision group of –121.2 (95% CI –408.0 to –165.7) was no longer significant when age, gender, and Charnley group were added to the prediction equation, suggesting that these additional predictors did confound the relation between group and total amount of physical activity (Box 2). Revision group, age, gender, and Charnley group accounted for 18% of the variance in total amount of physical activity.

Finally, linear regression analysis was performed to determine whether total intensity of physical activity was predicted by revision hip arthroplasty. The regression coefficient for being in the revision group was –1153.7 (95% CI –2241.1 to –66.3). The regression coefficient for being in the revision group of –912.8 (95% CI –1989.1 to 163.6) was no longer significant when age, gender, and Charnley group were added to the prediction equation, suggesting that these additional predictors did confound the relation between group and total intensity of physical activity (Box 3). Revision group, age, gender, and Charnley group accounted for 9% of the variance in total intensity of physical activity.’

AJP apologises to the authors and to our readers.

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