Letters to the Editor

Studies used similar number of treatment sessions

First I thank the Journal for publishing a critically appraised paper on our study (Stuge et al 2004a). I would also like to provide a clarifying remark on Ferreira’s commentary (Ferreira 2004) concerning the exercise dose used in our trial.

Ferreira’s commentary compared our trial to the trial by O’Sullivan et al (1997) and noted that ‘…while patients in the Stuge et al trial received an average of 60 treatment sessions, O’Sullivan et al applied only 10 treatment sessions.’ Unfortunately this comment is incorrect. It appears that the commentator has confused the number of in-room treatment sessions with the number of independent exercise sessions. In our study the patients attended 11 physiotherapist-supervised treatment sessions and completed 60 independent exercise sessions (3 times a week in 20 weeks). In the study by O’Sullivan et al (1997) the patients attended 10 physiotherapist-supervised treatment sessions and 70 independent exercise sessions (7 times a week in 10 weeks). This means that a similar number of supervised treatment sessions and independent exercise sessions were provided in the two studies. Two differences in treatment dose, however, were the duration of the treatment program (20 weeks in our trial; 10 weeks in the O’Sullivan et al (1997) trial) and the length of the treatment sessions (30–60 minutes in our study; 10–15 minutes in the 1997 study by O’Sullivan et al).

When considering the costs and benefits of exercise treatment it is important to be precise about the number of treatment sessions in the treatment program. Eleven treatment sessions is significantly less than 60 and that is why I have taken the time to correct this misconception about our trial. In my view 11 treatment sessions over a period of 20 weeks is a small investment considering the significantly positive long-lasting effects of exercise that were evident two years postpartum (Stuge et al 2004b). Finally, I agree with Ferreira that future trials should examine the effect of exercise dose in the treatment outcome of low back and pelvic pain patients.

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References


Evidence-based practice is not the whole answer

I found the AJP Editorial ‘Outcome measures measure outcomes, not effects of interventions’ (Herbert et al 2005) thought-provoking. The message was that clinical outcomes are not necessarily a reflection of practice, and so therapeutic interventions are best selected according to an evidence base rather than outcomes—unless the outcomes are either very poor or very good.

Physiotherapists have embraced the call to evidence-based practice with clear respect for the science of physical medicine. We now have abundant high quality research in the form of randomised controlled trials raising our profile in both the scientific and public arenas.

I attempt to modify my clinical practice in response to research findings and evidence-based guidelines. Nevertheless, I have some concerns that unless we are careful, the drive to an evidence base may be at some cost. Over time I have learnt about reading the persona of the patient, gaining insight into patients’ perceptions of their conditions, realising their expectations—in other words ‘being part of their story’. Clinical research is a science, but people are not pure science. No randomised double-blind controlled trial can account for the range of patient sensitivities, perceptions, and expectations. The University of Queensland whiplash team has conducted pivotal research to identify a subgroup of whiplash injury patients likely to develop a chronic condition. Not surprisingly the key is the heightened sensitivities of these patients’ nervous systems, detected in the immediate post injury stage (Jull 2004). Such sensitivities may have myriad aetiologies aside from the injury itself.

It is not possible to control for all such factors and it never will be. This is where an experienced and intuitive clinician can work with the patient and offer interventions based on evidence but with respect for that patient’s story. It would be a shame if the profession were to lose this attribute. As David Butler and Lorimer Moseley advocate in their fascinating text Explain Pain (2003), in chronic pain states changes occurring in the patient’s belief system through education may help the brain to ‘stop playing the pain tune’.

In the same issue of AJP I note the Dutch research by Swinkels et al (2005) ‘Physiotherapy management of low back pain: Does practice match the Dutch guidelines?’ Their study of 90 therapists in 40 practices found substantial variation in guideline adherence. The investigators conclude that ‘…the quality of Dutch physiotherapy care shows distinct room for improvement’. I wonder if the 90 clinicians are comfortable with these conclusions.

Unless clinicians use their intuition and imagination in practice, how will the questions that need to be answered by research be discovered? Surely it is through a team approach between researchers and clinicians that our profession will move forward.

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