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Louis Gifford Editorial: Criticism – destructive or productive?

I hope that most of you will have read the current wave of articles, editorials and letters on back pain, evidence based medicine, gurus and changes in practice, in the last three Physiotherapy Journals (Banks & Banks 2001, Bartley 2001, Gifford 2001, Pinnington 2001, Rouse 2001, Stevens 2001, Ward 2001). I think the stance held and mounted by the PPA and its members has stood up quite well and that the work of many founder members of the PPA is starting to have an impact on our profession. I've had an unexpectedly large email bag – all with support, and including two from Australia! I hope the others involved have had a similar response. Criticism stirs the criticised to act! Is it productive though?

1. Resistance to change.

In their letter in the February Physiotherapy Journal, Kevin and Nancy Banks criticised evidence based practice, topical issues 'on' pain and academics who were 'hijacking' the profession, at the same time as promoting current practise as 'tried, tested and trusted (by our patients).' Sitting, paradoxically, at the front of the very same journal as the Banks' letter, Pinnington questioned Physiotherapist's ability to change their practices and take on current recommendations regarding management of non specific low back pain. He highlighted the need to identify the barriers to making changes in clinical practice. He also made the powerful statement... 'Let us not fool ourselves that what we currently do is best practice; it is contrary to a lot of the literature, it is contrary to clinical governance and is almost certainly not economical.' Powerful stuff. Perhaps a problem is that many find it difficult to contemplate any change following criticism. A natural reaction is to get angry and defensive and perhaps to then doubly resist change and doubly resist listening, creating even greater entrenchment. Patients often do the same if their perspective, or concept of their problem, is challenged in an unreasonable way or in an unreasonable atmosphere. Criticism is often destructive. Criticism drives a few to get involved in research that sets out to justify their stance, their hypotheses, beliefs and treatments. Laudable, but my understanding of good science has always been that it sets out to prove something is *not* 'true', then if it *is* found to be true, the results are that much more powerful. Do you know of anyone who is *truly* setting out to *disprove* the treatment or hypothesis they have chosen to investigate? (– in physiotherapy or anywhere else!). I guess that anyone who was adopting this stance might be considered a traitor to the cause! (I know that some authors of chapters in the Topical Issues in Pain series/PPA Yearbooks, have been called traitors to the profession, for example) A recommendation would be that it's sometimes wise to be wary of supportive research for therapies/approaches/findings which have been done by, or sponsored by, the therapy approach/organisation under scrutiny. Charismatic clinicians/researchers can be very seductive when presenting their findings. Another recommendation is to listen for those who present all perspectives of their findings with equal emphasis. The issues relating to making changes in clinical practice have been thoroughly reviewed. Please see Heather Muncey's chapter tucked away early on in Topical Issues in Pain 2 – 'The Challenge of change in Practice'.

2. Lack of proof

In the April Journal, Richard Bartley made some good points, for example, pressing us to practise clinical reasoning that enables us to critically review what we think and do; and hoist the flags for him pointing out that many of the clinical tests physiotherapists do and take as 'set in stone' lack sensitivity and specificity, yet are used unquestionably. They lack proof. It reminds me of the occasional patients who tell me that they have been diagnosed by the 'last physio' as having 'instability'. They have invariably been given (and given up), one, sometimes two, exercises that create tension and focus them on their bodies during movement. They often complain that the exercises are really quite hard to put in the context of normal life activities. These patients often move very cautiously and have given up a whole host of things that they could well be still doing. Carefully challenge and change their attributions via a little positive information and then progressively restore *thoughtless and fearless movement* at a comfortable pace, and life can often move into second, third then fourth gears again.

My simple criticism is - what right have therapists to designate somebody as having an 'instability' problem when there is no good proof for or against it. Anyway even if there was instability – is it such a big deal? This is just one example of what I called 'over-focused hype on minor physical impairments..' in my March Physiotherapy Journal letter as well as an example of how a label may promote incapacity for some patients.

But what evidence is there for *anything* that physio's find? Ah-ha! Point made, but the main thing should be that we view everything in an open minded way, think about its implications, and think about how our patients might interpret what we say or get them to do.

Its time to be honest. I think its healthy to say to patients (just like it says in 'The Back Book' (Roland 1996)) something along the lines of... "with all the current available knowledge on your sort of problem, surprisingly, while we recognise the presentation, we still do not know exactly what is causing it. What we do know very convincingly though, is that getting better movement, building strength, re-establishing confident function and getting gradually back to normal activities is the best way to get better."

3. The burden of proof – 'evidence based medicine is spoiling things....'

Many physiotherapists are voicing this sort of concern and are often angry and critical of what they perceive to be the overly science driven route that the profession is taking.

The following is a personal view of how I believe we might rationalise some of our passive therapies in a way that puts them into a bigger context at the same time as making us aware of some of the dangers attached to traditional approaches.

In our role with acute pain, prevention of chronic incapacity requires (in part) effective pain control (Linton 1997, Linton 1998). Recall that there is some proof that high levels of reported pain early on, combined with a high report of disability, are components in predicting poor outcome (Dworkin 1997, Katz 1997, Linton 1997, Watson 2000).

It stands to reason that effective pain control should be *part* of early management. This usually means 'doing something'. To Drs this means Drugs and to physios it often means passive treatment of some kind. (Although it's important to recognise that, for example, reassurance is a powerful pain killer too – once you see something as not mattering so much, you give it less attention – hence becoming less of a problem).

More and more while lecturing I'm getting questions about Evidence based Medicine – stopping us doing our thing. You can't give traction, you can't give a collar, you can't say go to bed, you can't give electrotherapy, you can't do TENS, you can't do acupuncture, you cant give an exercise or ergonomic advice – because its 'not got the evidence....' Is the message that I'm hearing all too often. I get the 'what the bloody hell *can* we do?' question attached to 'pissed off with EBM' anger statement. This needs addressing urgently.

Considering the placebo may help.

At the recent PPA study day on the placebo and nocebo these two responses were put on a firm and rational physiological footing located in, but coming out of and going into, the CNS. Quite obvious really, and made easier if you are comfortable with the notion that all events have a rational explanation – then the placebo has to too. The placebo isn't a hocus-pocus thing, it's real, it does something and its good for you – even though it's a word that's used as an insult and always taken as one. Cancel the term 'placebo' and change it into some kind of biological response that hinders pain and enhances recovery, and emotions simmer down. Look at your patient and see the need to set 'their system' up for best physiological response to the situation. Turn the right biological switches by creating a professionally friendly, open, comfortable and believable atmosphere, give some reassuring and reasonable explanation, do a well structured and highly skilled examination (in the patients eyes); give a plan of action, a prognosis and perhaps do some passive thing too – and its already running and warming up.

The thing you 'do', needs the other things too. Also, the thing you 'do' has to be viewed as feasible by the patient. Belief is an important factor. Think what you say to the patient before doing something.

Do you do a technique without explaining what it does or what its for? If you do then you're loosing a large part of its potential. Do you get a bit over technical? Making it easy and logical for the patient to follow your reasoning is likely to improve a technique or specific exercise's potential.

If all this is the case for the placebo, then doesn't the burden of proof issue weaken a bit? Clinical trials try to avoid the placebo, they try to cut out the bit that 'sets the system', they do the same thing to different individuals with supposedly the same condition. But, everyone's system, especially the CNS and all the sensing, thinking responding, reacting bits, is different.... and hence requires, different

words, different reactions, different responses, different activation methods, different kinds of touch/no touch and different kinds of input. So long as the end goals are the same and we all agree on them – does it matter what the passive treatment bit really is? Perhaps not, so long as we are acutely aware in our clinical reasoning of contraindications and precautions – to any passive input! Considering passive therapy like this may be a bit novel, but in the light of what we now know about chronic incapacity and disability being promoted by passive therapy and so called ‘traditional approaches’, this is a major consideration in every patient. Patients really must not perceive that we are doing something that will fix them and that they just need to sit back and wait. If we are not encouraging patients to take responsibility then we may be promoting passivity and its disabling consequences.

Would I be near the mark in saying that if what you do or give to an acute pain patient helps reduce their pain and distress and promotes function, self-care, reactivation and responsibility – then do it, but all the time being aware that overemphasised passive therapy can be dangerous to some patients and needs to have a programmed withdrawal component?

Its easy to criticise passive therapy, but in its place as a modest tool to be used early on in acute management for secondary prevention of chronicity it seems to have a role. But it must be used modestly in a positive and activating context. Passive therapy, can help with pain control and can help with restoration of confident movement, but it has, and as far as I can see still is, being terribly over-used.

Evidence based medicine is science in action, it evaluates things in the context of the trial. We embrace it when it suits us, we reject it when it doesn't – we can't have it both ways. Best to always keep an open mind, and always think about the context in which a given finding is determined. What evidence based medicine is doing though, is showing us the most important and most efficient components of therapy. In his book, Alf Nachemson states (page 1) :

‘Now, however, there is enough evidence from good scientific studies to state clearly that a whole new treatment paradigm has emerged, resulting from randomized controlled studies (RCTs), metaanalytic reviews, and guidelines, all published since 1991. As stated by Frank et al., “New evidence gives new hope – if we can just get all the players on side”...’

4. In favour of science - Carl Sagan

We live in a scientific age, we like science and go along with it when it suits us, but the human condition is such that we respond to ideas, approaches and hypotheses that weigh heavy with emotional content and are largely founded on untrustworthy and irresponsible story telling, anecdote and questionable reasoning. Humans tend to reject unpleasant evidence that fails to fit with his/her way of thinking (see Sutherland 1992).

The late Carl Sagan (1997) wrote very powerfully in favour of rationality:

On science:

‘Plainly there is no way back. Like it or not, we are stuck with science. We had better make the best of it. When we finally come to terms with it and fully recognise its beauty and its power, we will find, in spiritual as well as in practical matters, that we have made a bargain strongly in our favour. But superstition and pseudoscience keep getting in the way,.....’

‘The scientific way of thinking is at once imaginative and disciplined. This is central to its success. Science invites us to let the facts in, even when they don't conform to our preconceptions,. It counsels us to carry alternative hypotheses in our heads and see which best fit the facts. It urges on us a delicate balance between the most rigorous sceptical scrutiny of everything – new ideas and established wisdom. This kind of thinking is also an essential tool for a democracy in an age of change. One of the reasons for its success is that science has built-in error-correcting machinery at its very heart. Some may consider this an overbroad characterisation, but to me every time we exercise self-criticism, every time we test our ideas against the outside world, we are doing science. When we are self-indulgent and uncritical, when we confuse hopes and facts, we slide into pseudoscience and superstition.’

On instants of pseudoscience:

‘They purport to use the methods and findings of science, while in fact they are faithless to its nature – often because they are based on insufficient evidence or because they ignore clues that point the other way. They ripple with gullibility..’

Keep criticising – its good science, but try to be non-confrontational with colleagues and your patients – its more productive!

With best wishes
Louis Gifford.
Editor.

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