Physiotherapy Exercises and Back Pain
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Published in
British Medical Journal
1991

DOI (link to publisher)
10.1136/bmj.303.6806.853

document version
Publisher's PDF, also known as Version of record

Link to publication in VU Research Portal

citation for published version (APA)

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preferences with regard to treatment. There is a shortage of studies of clinical effectiveness. Little attention has been given to patients' desires or perceptions of the effects of treatments. Limited importance has been placed on evaluating routine clinical practice.

Medical audit is about continuous improvement. To achieve its stated objectives audit must, of course, give valid, meaningful results, which must be interpreted to prompt revisions of practice, where necessary. Bogus results, based on ill thought out questions or derived from haphazardly collected information or inappropriate larger data, should convince no one, whether obtained through audit or research.

Medical audit is fostering a climate of review and evaluation: to measure quality of practice it is necessary to know the evidence on which clinical interventions are based. One of the objectives of audit is to get clinical staff to consider the justification for the interventions that make up their clinical practice. The link between medical audit and medical education and training is crucial for this and for the development of approaches to audit.

Considerable improvements have been achieved through national audits such as the confidential inquiry into perioperative deaths. But so much more can be achieved by applying these ideas locally through the development of local clinical audit, whether within departments in hospitals or in general practices or between specialists from different hospitals.

Locally organised audit projects concerned with specific issues, using small datasets, over limited periods of time have the potential radically to influence approaches to practice. Where standards have been set audit can rely on quite small samples, particularly where improvement is needed. The finding that a single patient with acute severe asthma has not received oral or parenteral corticosteroids should prompt action.

Clinicians owe it first and foremost to patients to measure and reflect systematically and critically on the quality of clinical care that is given and also received. The paucity of outcome measures, the difficulties of reviewing processes of outcome and of identifying intermediate outcomes, and the complexity of clinical decision making all contribute to the enormity of this task. Nevertheless, it is a challenge that can no longer be avoided.

Roberts would hold a monopoly on objective ratings, unbiased measures, and prospective design. Medical audit demands that the lip service paid to the scientific roots of medical practice and to quality assurance should now be converted into action.

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Physiotherapy exercises and back pain

Sir,—We would like to reply to Mr Dave Roberts's comment [1] on our review of 16 published reports of exercise therapy for back pain.2 He suggests that our search of the literature (Medline and screening of additional journals) had missed a number of eligible randomised controlled trials. We asked Mr Roberts to send us his list of 46 references from his CATS/AMED search, which he kindly did. Of the 46 publications, six were included in our review, which leaves 40 new citations to which we applied our inclusion and exclusion criteria. Of these, 26 were published in 1991 and thus could not have been included in our review. In addition, 28 were not randomised trials. The others concerned the efficacy of back schools (four trials), laser therapy (one trial), and magnetic energy and shortwave diathermy (one trial); one trial included healthy subjects only. There was one trial on exercise therapy, but both groups included received the same exercises and the only contrast seemed to be whether the exercise programme was supervised or not.

Dr Roberts's search missed 10 of the 16 eligible randomised controlled trials, and it did not add any new randomised trials to our list. Computerised bibliographic databases (no matter which one is used) cannot be compared to produce a complete list of eligible randomised controlled trials.

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Computers in audit: servants or sirens?

Sir,—Dr A N Hamlyn suggests that in our article we denigrated the role of information technology in audit. In fact, we agree that computers are indispensable for processing and analysing large data sets. We also agree that sample size calculations should always be taken into account in audit studies.

We argued that routine data collection systems should not be established to carry out audit, not least because they take no account of sample size but continue to collect data indefinitely. The real dangers of information technology, however, are the temptations to collect too many data on each patient and to combine too many other activities with audit. Dr Hamlyn recognised this with his comment that audit "must be divorced from the need to produce discharge letters, theatre lists, or other housekeeping routines." What we pointed out is that computer systems for audit are marketed with these features as a major selling point and official advice is that such integrated clinical systems should be established.3 The problem is that setting up computer systems for these varied activities will detract from the core of audit.

Dr Hamlyn concludes by pointing out that Ulysses resisted the seduction of the Sirens. He should have added that Ulysses achieved this by having himself lashed to the mast so that he could not act on his desire and casting his crew away so that they would be immune to the lure of the song. Is he suggesting that we should adopt this approach to the blandishments of information technology?

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Physiotherapy exercises and back pain

Sir,—We read with interest both the article by Dr Iain K Crombie and Mr Huw T Davies, in which they argued that the role of computer systems in audit has been overplayed,4 and the letter by Dr A N Hamlyn, who counsels their arguments and states that a basis for successful audit is the personal computer and database package.5

Though we agree with elements of both arguments, we believe that the problems extend beyond the computer system to the attitudes of doctors and their ability to use such systems. Currently many units are developing computer based audit, with medical staff, often house officers, having to enter data. It has been our experience in attempting to set up such a system that such junior staff rarely feel happy about having to use a microcomputer. It is tempting to believe that modern youth is highly computer literate compared with older generations, but we do not believe this is necessarily the case for medical students and house officers.

We recently carried out a survey of final year medical students and house officers who trained at our institution to assess their training and attitudes to computer based audit. Computer based audit was considered by 96% of the house officers owned a computer and only 28% considered themselves to be able to use one. When asked about audit, however, 90% of those who replied considered clinical audit to be either important or very important but only 20% had had any formal training or teaching in audit methods.

These findings suggest that results from computer based audit, when used by untrained juniors away from centres with a special interest in audit, will be poor. The results of computer based

Before dismissing such sources of information it would seem prudent to fully evaluate its usefulness. The clinical trial scenario has been subjected to much criticism in recent years because of the atypical way in which data are recruited, handled, and analysed.6 One of the important characteristics of clinical databases is that the patient events recorded are a reflection of actual clinical practice—there has been no treatment effect in selection.7 Observations made on such a population may prove more relevant to clinicians and patients than conclusions based on a selected group of patients from a formal clinical trial.

Our American colleagues have already shown the value of using computer data to answer specific clinical questions.8,9 This is a cheaper, more effective, and almost instantaneous way of addressing the clinical dilemmas that we encounter in our everyday clinical practice. Observations made on such a population may prove more relevant to clinicians and patients than conclusions based on a selected group of patients from a formal clinical trial.

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1 Crombie IK, Davies HTO. Computers in audit: servants or sirens? BMJ 1991;303:403-4. (17 August.)


8 lb Hamly, A. Computers in audit: servants or sirens? BMJ 1991;303:403-4. (17 August.)


