JOURNAL AND NEWSLETTER OF THE **ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS INTERESTED IN NEUROLOGY**

SPRING 1999

Syn'apse

JOURNAL AND NEWSLETTER OF THE **ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS INTERESTED IN NEUROLOGY**

SPRING 1999

ISSN 1369-958X

CONTENTS

Welcome to the Spring 1999 edition of *Synapse.*

As usual, this edition includes our papers in other journals feature. The aim of this section, as with the similar section in our professional journal *Physiotherapy*, is to make members familiar with the titles of potentially relevant or interesting articles in other journals. In *Synapse's* case, this is a relatively economical way of keeping ACPIN members aware of significant neurologically-related publications. Feedback has generally suggested that this is a useful feature. This is particularly so as many members do not have access to some of these journals, or else do have access but are frequently too busy to peruse the contents sheets.

One way that we can expand this feature is to ask if there are ACPIN members who are regularly 'exposed' to additional journals other than those listed in the enclosed section. If so, and they feel able to make a note of any article titles which they feel may be of interest to fellow members, then they could undertake to provide *Synapse* with the necessary details. The only real commitment would be that volunteers agree to provide *Synapse* with the necessary details (if there are any) on a regular basis.

Martin Watson
Editor

JOURNAL AND NEWSLETTER OF THE **ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS INTERESTED IN NEUROLOGY** **AUTUMN 1998** ISSN 1369-958X

From the Chair...

As we count down to the Millennium, ACPIN continues to flourish through the guidance of the National Committee but the driving force being you, its members.

In this special year, we can focus on the present and the future. As for the present, ACPIN has followed in Tony Blair's footsteps with a cabinet reshuffle.

Nicola Hancock has replaced Anthea Dendy as Public Relations Officer, Jackie Newitt has volunteered to take on the role of Minutes Secretary from Ros Wade, thus releasing two long-standing committee members to co-ordinate set projects when the need arises. Sadly, we say goodbye and thank you to Dr. Sue Mawson our Education Officer.

In looking to the future therefore, we are seeking a replacement Education Officer and to recruit an innovative person to develop the role of Audit Officer – please contact me for details.

ACPIN certainly has an action packed calendar of events this year. By the time you receive this copy of Synapse our first study day and A.G.M. entitled 'Neurophysiotherapy in the Older Client' will have taken place. A full report will appear in the Autumn edition.

The postponed 'Millennium Bug' Study Day has been re-scheduled for Thursday 20th May 1999, venue being the Post Graduate Centre, City Hospital, Birmingham. The emphasis has changed slightly from Information Technology to Clinical Significance of Recent Technology.

In November last year ACPIN was approached by David Nodder who is employed by Neuro Education (quality education advancing care) to survey the educational needs of neurophysiotherapists. Funding is being made available to run educational days for physiotherapists with a special interest in neurology. ACPIN recognised this as a marvellous opportunity for its members with four regional meetings provisionally planned on the topic of spasticity and M.S. in May 1999. Look out for further information.

In October ACPIN will combine forces with the C.S.P. to host the Annual Congress titled 'A New Beginning'. It will be held at The International Convention Centre in Birmingham over three days, 8th-10th October 1999. See ACPIN's exciting programme featured in this edition of Synapse. Be sure to book your place early as places at this prestigious event will be very much in demand.

Looking even further into the future of Spring 2000, there will be four Bobath Memorial Workshops with venues planned for Northern Ireland/Scotland, London, Birmingham and Leeds. It is envisaged that each workshop will be lead by two facilitators on the topic of Single Case Studies. Watch this space for further information.

Our programme for the Second Annual Congress in the Year 2000 has been accepted by the CSP and we are now finalising the details.

As you may be aware, the CSP are currently reviewing the structure of clinical interest and occupational groups (SIG). The aim of the review being to consider the present and future role of the SIGs and how groups should be structured to meet future demands. ACPIN is actively involved with Gwyn Owen who is chairing this working party.

As we strive in the pursuit of excellence we must remain firm in our beliefs for:

- The necessity of clinical specialist posts
- The need for evidence based practice
- Issues concerning manual and therapeutic handling.

I am sure you will all agree that these matters are dear to our hearts and are worthy of being currently addressed by ACPIN.

ACPIN's continued search for improvements in its operations has hopefully assisted both the Association and its membership by the introduction of direct debit facilities for membership renewal. However if you have any difficulties or comments, please contact Clare Scott-Dempster, National Membership Secretary.

As always a huge thank you must go to the National Committee members for all their hard work and dedication. Finally, I would like to thank our members for making ACPIN a dynamic association that you should all be proud of.

As indicated in our previous edition, we were saddened to hear of the untimely death of Jennifer Bryce last year. An obituary appeared in the December 2nd 1998 edition of Physiotherapy Frontline, written by ACPIN president Susan Edwards and colleague Margaret Mayston.

Linzie Bassett MCSP SRP
Chairperson ACPIN

Justifying the provision of a standing frame for home use – a good case to quote

Kate Stainsby, Heather Thornton
The Regional Rehabilitation Unit, Northwick Park Hospital.

Summary
This article describes the clinical reasoning behind the decision to provide a standing frame to a patient for home use. The process to acquire the chosen standing frame and the means to ensure its use are described. The successful outcome illustrates the clinical and financial benefits of effective provision of specialist equipment.

Introduction
Long-term neurological patients need to be maintained in the community. Unfortunately the ideal resources of regular therapy and support from dedicated care workers is rarely available. The consideration is therefore how to achieve maintenance and if possible progression with minimal professional input. The following case study aims to illustrate this point.

The Patient
Bob presented with quadraparesis, dysphagia, dysarthria and mild cognitive impairments as a result of meningitis following a fronto-ethmoidectomy. He was referred to the Regional Rehabilitation Unit (RRU) for intensive rehabilitation from all disciplines, 6 months post onset having had a number of medical complications. His transfer to the unit was further delayed due to his positive MRSA status. He was 52 years old, retired and prior to hospital admission was living with his wife in a house.

Why we chose a standing frame
Bob's main physical problems were as follows:

1. Decreased activity in all 4 limbs.
2. Minimal trunk control with a kyphosed posture.
3. Poor head control with limited range of movement
4. Limited bilateral hip flexion
5. Tight left TA.

He also had:

6. An ineffective cough with subsequent recurrent chest infections
7. Low levels of motivation, concentration and poor exercise tolerance.

Standing was identified as an important part of Bob's therapy as it addressed all of the identified problem areas.

Bob's ultimate goal was to be able to walk again. Although this goal was unrealistic, certainly in the foreseeable time period, it underpinned his hopes for the future. He saw standing as a positive step towards this aim and was more motivated to stand than to do other therapeutic activities on a plinth or in sitting.

A standing position was initially achieved using a tilt table and was then progressed to a wooden standing frame with straps. The latter required 3 people to achieve a standing position. Bob was able to tolerate 15-20 minutes in the Oswetry frame.

The problem then arose as to how the benefits gained from standing could be achieved at home with only Bob's wife or one carer available.

Process to acquire and evaluate standing frame
The next step was to evaluate the frames on the market. The whole process of acquiring and using the frame is outlined in figure 1 (*right*).

The key requirements in this case were:

- One person could get Bob in the standing frame without difficulty
- Bob liked it
- It was aesthetically acceptable for home use.

Four types of standing frame were evaluated specifically for Bob (see Figure 2 on page 5).

The decision
The standing frame ultimately selected, the Flexistand, fulfilled all the criteria. In addition it had electronic hand held controls which Bob could operate and therefore move himself up and down and side to side, once stood. This gave him a sense of control. Later, when at home Bob even stood in the garden, and was able to teach a friend how to assist him when his wife was out. The Flexistand was £2,700 to purchase at this time.

Establishing use

Training and education
We were fortunate that the manufacturers allowed us to borrow the frame for a week. The next stage

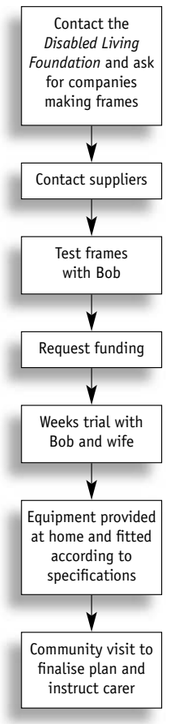

Figure 1 **Process to acquire standing frame.**

Frame	Tilt table	Oswestry	Electric frame	Flexistand
Type of support	Maximum	Moderate	Moderate	Moderate
Effort of patient	Minimal	Maximum	Moderate	Moderate
Assistance required	2	3	2	1
Comfort	Good	Limited	Uncomfortable	Comfortable
Cost	High	Low	Medium	High
Posture achieved	Good alignment but not very active	Difficult to maintain in a good position	Maintained in a position but not forward over feet	Good position
Limitations	Holds patient in one position	Difficult to get into and maintain good position	Unable to achieve good alignment not very comfortable	Able to move in frame with good alignment but needs specifically setting up for each individual patient

***Figure 2* The types of standing frame evaluated for Bob prior to discharge.** These comments are specific to Bob when evaluated prior to discharge and are not evaluative comments on the standing frames in general.

was to establish the use of the frame in Bob's normal routine. So Bob's wife who visited daily started assisting Bob into the standing frame. Initially this was with staff supervision but they quickly became independent.

The purchase

Having identified the need for the standing frame and established that Bob and his wife could effectively manage the Flexistand between them we then had to secure funding. The Health Authority approached fortunately had a very positive attitude and approved funding.

The Outcome

Discharge to the community

Following discharge the frame was provided at home and fitted according to Bob's specifications. On discharge Bob was able to stand comfortably for 20-30 minutes with assistance from one in the Flexistand. He was able to achieve good trunk and head control. He was able to use the hand controls with his right hand automatically and left-hand movement and quadriceps activity was beginning to improve. He was able to achieve a more upright supported sitting posture in the wheelchair and therefore use a computer, operate an electric outdoor scooter and interact with family and friends. The frequency of chest infections was dramatically reduced with a subsequent increase in breath control and voice volume. As Bob was still slowly improving with daily standing the need for a follow-up assessment was identified.

Review

On review Bob's standing was much improved and he required less physical support. He showed potential to improve further with regard to his transfers and upper limb function.
A re-admission for a 6-week period of further intensive rehab was therefore planned.

Readmission

Bob was readmitted in January 98, two years post onset. His need for a standing frame was again evaluated. On this occasion it was found that he could easily be stood in an Oswestry frame. The same process was followed, and he was provided with an Oswestry frame. He has now progressed to transferring with assistance using a sliding board or a standing pivot transfer. The hoist is only used at night when Bob is tired. Bob has continued to progress and is now starting to do standing step round transfers.

Bob's Progress

The provision of standing frames and the physical progression are outlined in figure 3. Bob made considerable progress in other areas of his rehabilitation that have not been covered in this report.

Effective use of resources

The use of a standing frame was thought appropriate in this case for a number of reasons. Bob needed regular daily input to prevent contractures and to maintain his chest, he liked standing and was willing to comply with this. Daily standing with a physiotherapist or three people would have been very expensive and unavailable unless privately financed. Given the long-term nature of Bob's disability it would have been extremely expensive. The standing frame that was eventually purchased for Bob cost £ 2,700. The standing frame also gives independence from hospital-based therapy, and helps with the reintegration back into the community. Bob's wife is very devoted and was determined that Bob should return home. This involved major structural adaptations to their house. She also wanted to play a key role in all aspects of Bob's care following discharge. A community care package was therefore set up with his wife as one of the main carers. Bob has exceptional care staffs who have been keen to be involved in his therapy programme.

The aim was to reassess and bring Bob back in for a short admission at a later date as he continued to make slow progress. To ensure effective progression of his therapy regime, community physiotherapy, occupational therapy and nursing services were also arranged.

Benefits of standing

The use of a standing position has been demonstrated to have a wide range of benefits for the physically impaired patient. The secondary complications, which can develop following trauma or a disease process, can have serious implications on rehabilitation and quality of life. These complications are well documented. They include bladder infections, pressure sores, contractures, muscle atrophy, noxious spasticity (Pope et al, 1992;Nickels, 1982), loss of bone density, (Goemaere et al, 1994), impaired respiratory function and psychological regression (Kunkal et al, 1993). Such complications have been shown to be reduced by regular standing either independently or with assistance (Bromley, 1985). Richardson (1991) demonstrated a positive effect on the length of soft tissues and joint position by using a tilt table to achieve an upright position.

Conclusion

This case illustrates that stopping intensive inpatient rehabilitation needn't result in a deterioration of a patient's condition. Discharge to the community of a severely disabled neurological person can be successful with effective analysis and planning. For this patient provision of a standing frame proved to be a cost-effective way of maintaining and improving his function between intensive periods of rehabilitation. The importance of establishing a maintenance behaviour regime prior to discharge should not to be underestimated.

REFERENCES

Bromley I *Tetraplegia and Paraplegia: A Guide for Physiotherapists.* **3rd Ed, New York, Churchill Livingstone, 1985**

Goemaere et al (1994) *Bone Mineral Status in Paraplegic Patients who do or do not Perform Standing* **Osteoporosis International** 4 (3) pp138-143

Kunkal et al (1993) *Effect of Standing on Spasticity, Contracture and Osteoporosis in Paralized Males* **Archive Phys Med Rehabil** Vol 74 pp73-78

Nickels V (1982) *General Principles of Orthopaedic Rehabilitation* In Nickel V (ed): **Orthopaedic Rehab New York, Churchill Livingstone** pp1-11

Pope P (1992) *Management of the Physical Condition in Patients with Chronic and Severe Neurological Problems* **Physiotherapy** Vol 78 pp12, 896-903

Richardson D (1991) *The Use of a Tilt-Table to Effect Passive Tendo-Achilles Stretch in a Patient with Head Injury* **Physiotherapy Theory and Practice** Vol 7 pp45-50

Kate Stainsbury at the time of writing this article was a Senior II physiotherapist at the Regional Rehabilitation Unit, Northwick Park Hospital
Heather Thornton is currently the Paramedical Co-ordinator and Superintendent Physiotherapist at the Regional Rehabilitation Unit, Northwick Park Hospital

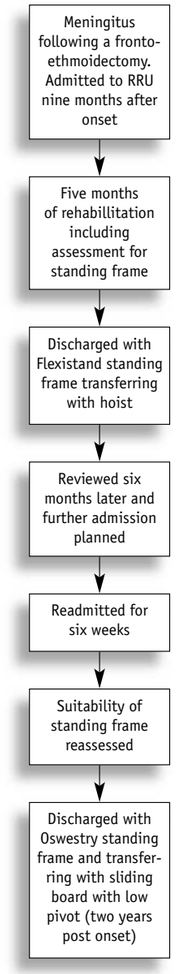

***Figure 3* Bob's rehabilitation and progress.**

Parkinson's Disease Research Project – Stage One - summary of outcomes

Physiotherapy Evaluation Project UK

Research Team
Dr Ann Ashburn PhD MPhil MCSP SRP
Dr Colin Chandler PhD, BSc
Mrs Felicity Handford MSc, MSCP
Mrs Diana Jones BA, MCSP, SRP
Ms Eleanor Kinnear MCSP, SRP
Mrs Brenda Lovgreen MSc, MCSP, SRP, DipTP
Prof Rowena Plant PhD, MSc, MSCP, SRP, PGCED

Sponsored by Glaxo Wellcome
Associated with the Parkinson's Disease Society of Great Britain

Under the auspices of the Parkinson's Disease Society and funded by Glaxo Wellcome, a team of academic and clinical partners is conducting a research project to investigate best physiotherapy management in Parkinson's disease in the UK. Stage One of the project is now complete and provides key baseline information regarding what, how and when physiotherapy intervention is best used.

In Stage One 49 specialist physiotherapists (working at Senior I level or above, with at least two years' experience of working with people with Parkinson's disease and a current caseload) took part in a Delphi survey. The participants had been qualified for a mean of 20 years spending a mean of 10 years treating people with Parkinson's disease. Over 60% worked in the area of Care of the Elderly, with 65% working in a Day Hospital context. They treated an average of 11 Parkinson's disease patients per month. Over 50% were involved in Parkinson's disease clinics or groups, and almost 70% had attended specialist courses.

In the two rounds of the Delphi exercise specialists rated and re-rated a series of statements on a scale of 1-9. These related to the context of physiotherapy delivery; the reasons for its use; the actions employed by physiotherapists; and how its effects should be measured. There was marked variability in the practice context indicating that when the context encapsulated in a statement (eg long term monitoring) happened in practice, it didn't happen regularly. Physiotherapy on diagnosis occurred rarely. The most desirable context for service delivery emerged as a model with three elements: external, internal and individual. Optimal external features involve strong links with the community; contact on diagnosis; long-term management; flexible review; re-referral by patients and carers; and professional knowledge up dating. Internal features to maximise physiotherapy are working as part of a multi-disciplinary team with information sharing and a keyworker system. At an individual therapist/patient level success depends on agreed goals; standardised assessment; written information; the opportunity for individual and group work; and carer involvement.

There was consensus that the purpose of physiotherapy is to affect physical movement to maximise functional abilities and minimise secondary complications, to provide on-going education and support for physical management. An eclectic approach to treatment (techniques drawn from a variety of sources) was considered to have the best effect. It was agreed that the effect of physiotherapy should be measured directly on the stated aims and purpose of that treatment. There is a need for research effort to explore the nature of the eclectic treatment approach and to examine the equivocality around cost-effectiveness as an outcome.

Stage One of the study is a unique piece of work, which has provided purchasers, providers, practitioners and patients with a framework for best practice physiotherapy. Stage Two has used information from Stage One to identify a number of sites across the UK to contribute to a case study of best physiotherapy practice. The focus will be on the structure of the service, the nature of clinical activity undertaken and the views of patients. It is intended to extend the study to Europe, where partners have been identified and funding opportunities are being explored.

Address for correspondence:
Professor Rowena Plant
Institute of Rehabilitation
Hunters Moor Regional Rehabilitation Centre
Hunters Road
Newcastle upon Tyne
NE2 4NR

Report following Royal Society of Medicine visit to St Petersburg

1-4 June 1998

Susan Edwards FCSP
Jennifer Freeman MCSP PhD

This visit was organised by Dr Pauline Munro, a remarkable neurologist who seems to have fallen in love with St Petersburg and is striving to improve patient care in this, her adopted city.

Following her initial approach to Professor Alan Thompson at the National Hospital to participate in the proposed conference held jointly with her Russian neurology colleagues, he suggested that it may be appropriate to take a neuro-physiotherapist. Little arm twisting was needed and it was finally decided that two therapists should go to contribute to the neurorehabilitation section of the conference and to work with the Russian 'therapists' at one of the local hospitals.

We received excellent feedback from the doctors at the neurorehabilitation conference and found it very useful from our own perspective. The patient demonstrations and video seemed to be well received and worked well in stimulating more focused discussion. The Russians tend to focus more on passive interventions and were quite surprised at the more active approach to patient management we were able to demonstrate.

There seems to be a core group of 'doctor-physiotherapists' who are extremely receptive and enthusiastic. This pioneering group is currently liaising with the University of East London, the Edinburgh Stroke Group and the St Gregory's Foundation to establish a physiotherapy profession. These people appeared keen to change their practice having taken on board many of the new concepts to which they have been recently exposed.

The visit to the hospital we found very useful in that it allowed time both to discuss service issues and to treat patients together. Clearly the 'doctor-physiotherapists' had taken on board the concepts presented by the Edinburgh Stroke Team. For example, in the Stroke Unit', the beds had been repositioned, patients sat with their arms supported on tables and outcome measures were used to evaluate intervention.

We were surprised at the type of patients who were receiving rather long periods of inpatient rehabilitation; very much less disabled than our own hospital population. Our initial view 'how can they cope without wheelchairs' was soon modified once we saw the relatively minor level of disability, of the patients they were dealing with.

Our recommendation to Dr Munro with regard to future visits was that somehow, we have to tap into the more disabled population. One way of doing this we thought might be by targeting patients following neurosurgery. This may be a situation where patients with potentially severe disability could be found in the acute stage of management and where those who might benefit from continued rehabilitation could be identified. Other potential areas which would be of value for physiotherapists to visit include nursing homes, private homes and 'polyclinics'.

We very much enjoyed our visit to what is a fascinating city. In addition to our work commitments, organised sight-seeing provided a wonderful insight into the history and stunning architecture throughout St Petersburg. However, as most people would realise Russia is a very poor country and it is quite remarkable how stoical are the population in the face of such poverty. The 'doctor-physiotherapists' who invited us for dinner informed us that at one stage they had not been paid for eighteen months and had to rely on food parcels from abroad.

The plight of the NHS pales into insignificance!

What does qualitative research in stroke tell us about physiotherapy?

Ruth Parry

As part of a recent masters study (Parry 1997), I reviewed qualitative research papers which have considered stroke patients and those who work with them in rehabilitation. I was particularly interested in how physiotherapy is perceived by stroke patients. Although qualitative research focusing purely on stroke physiotherapy is rare, many insights can be gained from more general qualitative studies. This article gives a brief summary of a number of stroke related qualitative studies in tabular form. I then present a 'pot pourri' (ie not a systematic review!) of points of interest which qualitative research has raised for physiotherapists.

To date, the majority of research into stroke recovery and rehabilitation has been quantitative. However, a small body of qualitative work exists and some of this work is summarised in Table One. The culture of rehabilitation units and the professionals who staff them has been explored, (eg Gold 1983, Hoffman 1974, Lewinter and Mikkelsen 1995 a&b), as has the experience of stroke and rehabilitation from the perspective of patients and their caregivers (eg Jongbloed 1994, Kaufman 1988, Pound et al 1994b). One study (Pound et al 1994a) specifically focused on patients' perceptions of physiotherapy after stroke (see table opposite).

From these studies, there seems consensus that contemporary rehabilitation is directed at physical rather than social and psychological aspects of stroke (eg Anderson 1988, Pound et al 1994a, Forster & Young 1992). It is also commonly found that the perspectives of stroke patients and those who treat and research them are divergent (eg Lewinter and Mikkelsen 1995a & b, Gold 1983, Kaufman & Becker 1986). Another finding is that quality of life after a stroke is far less influenced by the severity of physical disability than by the individual's response to his/her disability (Anderson 1988). Nevertheless, as Churchill (1993) points out, physical limitations profoundly affect lifestyle, dependency, and ability to live in the community.

Qualitative research in physiotherapy

Having described some of the qualitative research specific to stroke, I shall now turn to qualitative studies which have considered physiotherapy. Over recent years there has been a steady growth of quantitative research in physiotherapy, particularly studies aiming to evaluate its effectiveness. However, very few qualitative studies investigating physiotherapeutic processes have been published, thus the scope of practice which has been explored is narrow and incomplete.

Payton & Nelson (1996) described their study as descriptive with qualitative elements. They explored patients' perceptions of their contribution to goal setting in physiotherapy treatment, and concluded that patients are not involved consistently or substantially in this process. The authors remark on the strength of patients' statements about the significance of therapy in their lives. Davis and Strong (1976) performed an observation study from an ethnomethodological perspective to investigate how paediatric therapists make their actions meaningful to the children they are treating. They discussed the challenges which therapists face in attaining co-operation and involvement of children, with whom appeal to usual methods of 'adult reasoning' are not available. Thornquist (1994) studied physiotherapists and patients in an outpatient musculoskeletal setting in Norway. Observations and interviews were used to investigate which aspects of the patient's body and life were considered relevant by physiotherapists. Thornquist considered what theories about the body underlay the therapists' actions and interpretations. She found that the therapists set the agenda of encounters, with non-physical aspects of patients' problems being regarded as less important. The physiotherapists 'consistently distinguished between the body and the person' (p706) – this separation is described as a 'dualistic view. Thornquist concludes that therapists' dominant 'conceptual tools, theories and terminology are based on the dualistic view and thus constrain thinking and attitudes' (p703). She further argues that therapists' models influence how patients view their bodies.

Qualitative research has suggested that physiotherapy affects well-being and not just physical disability (Pound et al 1994a, Payton & Nelson

QUALITATIVE RESEARCH STUDIES IN OR RELEVANT TO STROKE

AUTHOR AND YEAR	AREA OF EXPLORATION	DESIGN AND SUBJECTS (AND DID SUBJECTS INCLUDE PHYSIOTHERAPISTS AND OT'S)	FINDINGS AND CONCLUSIONS
Anderson 1988	Psychological and social impact of stroke on patients and their caregivers living in the community.	Mixed qualitative and quantitative survey. Semistructured interviews with 176 consecutive London stroke patients and their caregivers. Interviewed at 4 weeks, 9 months and 18 months post stroke.	Much of the report focuses on caregivers' views. Perhaps the main message of his work is that there is a need for greater attention to the causes of dissatisfaction and distress amongst this group of service users, as such understandings will enable improvements to services offered.
Gold 1983	The culture, norms and values within a stroke rehabilitation unit.	Observation, photography and interviews on the unit. Includes physiotherapists.	Considers the mechanisms of rehabilitation rather than individual experiences. Focuses on the sick role model and how patients are encouraged to leave the sick role and claim wellness through the styles of interaction within the unit. Discusses how determination and inner strength are valued within the unit and how these reflect American cultural values.
Hoffman 1974	The culture and beliefs of staff and stroke patients on a general hospital ward.	Observation, interview and review of documentation. Includes physiotherapists and occupational therapists.	Analysis focuses on how and why patients develop 'unrealistic recovery aspirations', and in particular on staff behaviour and attitudes which inculcate and encourage these beliefs. The staff believed that in stroke 'nothing can be done' and saw their work as rather hopeless. Hoffman urges staff to redefine medical 'help' and their understanding of 'doing something'.
Pound & Ebrahim 1997	Views of stroke rehabilitation professionals on a stroke unit, a general medical ward and an elderly care unit.	Questionnaire study using open-ended questions. Includes physiotherapists and occupational therapists.	In contrast to Hoffman's study above, the majority of professionals surveyed seemed to have a positive approach to their work. Nurses and physiotherapists were reported as feeling they had much to offer in stroke and found their work very rewarding. O.T.s emphasised that scarcity of staff and resources limited their potential. There are also interesting findings concerning differences between professions in how recovery is defined.
Holbrook 1982	Experiences of staff treating stroke patients on a specialist stroke unit.	Not a qualitative investigation, but an autobiographical descriptions of the experiences and understandings of the staff team.	A model of the experience of patients who have been through the unit is briefly described. Stages of crisis, treatment, realisation of disability, and finally of adjustment are listed. A 'residue of misery and maladjustment' endures after stroke which it is hard to approach in rehabilitation. She also notes that patients' and practitioners' models of successful rehabilitation may diverge.
Jongbloed 1994	Social implications of a stroke for patients and their partners.	20 couples interviewed up to 5 times over two years following the stroke. Interviewees were asked to describe their lives following the stroke and its impact upon their activities.	Findings are presented through a case study of one couple. There is an emphasis in the analysis on the changed roles of both patient and caregiver and the influence of cultural and personal attitudes. The experience of the changed body and of rehabilitation is also discussed. Jongbloed argues that practitioners and researchers need to place greater emphasis on the effects of stroke on the family unit.

➢➢

QUALITATIVE RESEARCH STUDIES IN OR RELEVANT TO STROKE (CONTINUED)

AUTHOR AND YEAR	AREA OF EXPLORATION	DESIGN AND SUBJECTS (AND DID SUBJECTS INCLUDE PHYSIOTHERAPISTS AND OT'S)	FINDINGS AND CONCLUSIONS
Lewinter & Mikkelsen 1995a	Patients' experiences of rehabilitation on a stroke unit, and their views following discharge.	Semistructured interviews with 21 patients after discharge. They were asked about their current situation and their experience of rehabilitation on the unit.	The authors particularly focus on how the physical aspect of training in rehabilitation is meaningful to patients and seems to offer the promise of normalisation. They also note the divergence in staff and patients' expectations of recovery.
Lewinter & Mikkelsen 1995b	How goals are set, progress measured and relationships experienced by staff on a stroke unit.	Quite highly structured interviews with therapists, nurses and a doctor. No observation.	In contrast to other qualitative studies of physiotherapists (e.g. Thornquist, Payton & Nelson) Lewinter & Mikkelsen report that therapists related to patients, set goals and evaluated progress with a strong awareness of the non physical aspects of the experience of stroke illness and of rehabilitation. These findings should be viewed with some caution, being based upon interview data with professionals only, and not upon observations, and as analysis was descriptive rather than theory-based. Another focus of their conclusions is that standardised scales are regarded by therapists as inadequate for measuring the multidimensional character of progress in rehabilitation.
Kaufman 1988	People's experiences after stroke, particularly of medical and social services.	Observation and longitudinal, in-depth interviews with 102 stroke patients aged over 50 at onset. Followed for one year post stroke. Caregivers were also interviewed where they existed. Patients were seen in a number of hospitals and nursing homes, and also in their own homes.	Kaufman gives two case studies, and develops themes which she believes are of primary importance to patients in their efforts towards recovery. These themes being (1) the discontinuity of life patterns, (2) the failure to return to 'normal', and (3) the redefining of self and identity. She argues that people's responses to rehabilitation are greatly influenced by these aspects and by personal history, personality and patterns of life before the stroke. She calls on practitioners and patients to come to agreements on rehabilitation goals.
Kaufman & Becker 1986	Values and beliefs of US healthcare professionals working within stroke rehabilitation.	Interviews with and observations of 32 health professionals working in several hospitals and long-term care facilities.	Kaufman & Becker conclude that stroke rehabilitation occupies a low, 'peripheral' status because (1) the U.S. health care system finance and regulation devalues rehabilitation, (2) stroke care differs from acute care as it is not curative or sensational - functional independence and motivation become the core values, (3) stroke is viewed as a geriatric problem.
Pound et al 1994a	Stroke patients' views about their physiotherapy.	Interviews using an interview guide with 40 patients taken consecutively from a stroke register in London when they were 10 months post stroke. 24 of the patients had received therapy. Content analysis of data was performed.	Patients believed that physiotherapy brought about functional improvement. The exercise component was valued as keeping them active and busy, and home programmes gave some structure to the day. Therapists were considered a source of advice and information and of faith and hope. They conclude that the impact of physiotherapy is upon both physical disability and well-being, and that outcome measures used in quantitative research should reflect this. They urge physiotherapists not to promote unrealistic recovery expectations.

1996). Findings also indicate that therapists see motivating patients as a primary part of their role and make considerable personal investment in patients' recoveries (Kaufman & Becker 1986). However, Stachura's commentary (1994) echoed Thornquist's study (ibid) in contending that physiotherapists' approach is reductionist in its emphasis on clinical impairments and physical techniques. She commented that although physiotherapists are aware of psychological and social dimensions, they give these components little credibility in the planning and execution of treatment. She also argued that physiotherapy practice lacks a theoretical framework which addresses the more 'intangible' aspect of its effects (Stachura 1994).

Some insights for physiotherapy from qualitative research in stroke

Although qualitative research with a specific focus on stroke physiotherapy is unusual, qualitative studies with a more general focus on stroke rehabilitation can yield insights into the role of physiotherapy and the nature of the relationship between physiotherapists and stroke patients. Several studies have found that physiotherapists are given credit by patients for their recovery (Gold 1983, Pound et al 1994a, Kaufman 1988). That is, physiotherapy is seen as crucial to recovery. Studies further suggest that exercise[i] is a highly symbolic activity for stroke patients. As many writers have pointed out, there is a strong moral aspect to the idea of exercising both in 'health' and after onset of an illness (eg Turner 1984, Kaufman 1988, Gold 1983). To perform physical activity and exercise is to conform with Western values of action, perseverance, diligence, and mastery over disease (see Kaufman and Becker 1986, Jongbloed 1994). Research has suggested that participation in exercise may represent both positive and negative experiences for stroke patients. The routines of exercise often give a structure to life after stroke (Kaufman 1988, Lewinter & Mikkelsen 1995a, Pound et al 1994a). Kaufman's study also suggested that exercising may represent succumbing to external control.

As well as their moral dimension, exercises may be seen to offer the prospect of complete physical recovery (Kaufman 1988). Studying patients after discharge from a stroke unit, Lewinter and Mikkelsen (1995a) suggested that 'Training was a form of treatment that made sense to the patients…it provided them with a meaningful set of rituals offering promise of "normalization"'(9).

Pound et al (1994a) express concern that therapists may foster unrealistic hopes and urge them to balance hopeful encouragement with realism about the permanence of disability. Hoffman (1974) described strategies and communications through which, she argued, therapists generate and perpetuate overoptimistic beliefs about recovery. She believed therapists' motivation for doing so to be the avoidance of painful and difficult interactions with patients. Her work echoes and builds upon work by Davis (1960) who explored how parents of children with polio were 'kept in the dark' concerning medical prognosis long after the time when clinicians (including physiotherapists) had fairly sound expectations of likely residual disability. Apparently the time limit for what Davis called 'real' uncertainty, was between 6 and 12 weeks after the onset of polio. This seems similar to the situation in stroke. Davis suggested several motivations behind clinicians' perpetuation of uncertainty -including the avoidance of time consuming and emotionally difficult interactions and the cultivation of acceptance of rehabilitation efforts which might be refused if the unlikelihood of 'cure' was explained. As may occur in stroke, the people studied by Davis 'typically mistook rehabilitation for cure' (p45).

It was noted above that studies have found a divergence between patients' and therapists' perspectives. Professionals' goals and strategies seem to differ from those of patients. Specifically, therapists conceptualise recovery in terms of structured goals towards functional independence, whereas for patients, the subjective experience of recovery encompasses far more than this (Kaufman 1988, Holbrook 1982, Lewinter & Mikkelsen 1995b)[ii].

Finally, research offers insights into the ending of the physiotherapy process. Clinical experience tells us that for some stroke patients, discharge from physiotherapy is very traumatic. Hoffman (1974) explains that when therapy ends, 'a sense of abandonment is not uncommon…[in] patients who suddenly have to discard the hope they have been living on for the past year or more.' (p68). Jongbloed (1994) in her longitudinal study describes how, as time went on, patients realised that hard work and practice were not resulting in improved function. This realisation led to disappointment and frustration. Pound et al. (1994a) remarked that 'Patients may feel abandoned: they are left to deal with the recognition of their disability and to begin the lonely and painful task of adjusting to it.' (p73). They argue that physiotherapists need to address this through finding an improved balance between giving hope and enabling recognition of the reality of disability. Given the highly symbolic nature of physiotherapy for patients which has been suggested above, the feelings of abandonment expressed by some patients become very understandable.

Summary and conclusions

Qualitative research uses very different methods and investigates very different questions to quantitative work (see Maykut and Morehouse 1996 for a useful introduction). It can offer thought-provoking insights for practitioners. Issues of

interest to physiotherapists in stroke which have been raised by qualitative research include:

- The highly symbolic nature of physiotherapy for patients
- The suggestion that physiotherapists may foster unrealistic hopes of recovery in these patients
- The divergence between patients' and therapists' perspectives on the goals of rehabilitation and the meaning of recovery
- The sense of abandonment experienced by stroke patients on discharge

It seems to me that these points closely relate to each other. The moral and symbolic importance of physiotherapy for patients, and the way it may be seen as 'normalising' or restorative, lead to 'unrealistic recovery aspirations'. Managing such expectations is therefore bound to be a very complex task. The importance of therapy is also reflected in how patients may feel when it comes to an end. The insights offered by qualitative studies can help therapists to better understand patients' perspectives, and may even lead therapists to modify their own perspectives. The hope must be that qualitative research can enable more effective and humane communication between therapists and patients.

i To describe what physiotherapists do as 'giving exercises' is to generalise perhaps to the point of inaccuracy. However, exercise is used here as an umbrella term, encompassing the various activities involving movement which patients do whilst with a therapist, or between sessions on their advice.
ii Carpenter (1994) interviewed spinal cord injured people. Her analysis of these interviews provides relevant insights for therapists about how patients conceptualise recovery.

REFERENCES

Anderson R (1988) *The Quality of Life of Stroke Patients and Their Carers.* In: **Living With Chronic Illness**(Eds: Anderson R; Bury M) Unwin Hyman, London 14-42.

Ashburn A, Partridge C, De Souza L (1993) *Phyiotherapy in the rehabilitation of stroke: A review* **Clinical Rehabilitation** 7, 337-345.

Brocklehurst J, Morris P, Andrews K, Richards B, Laycock P (1981) *Social effects of stroke* **Social Science and Medicine** 15A, 35-39.

Churchill C (1993) Social problems post stroke. In: **Long Term Consequences of Stroke, Physical Medicine and Rehabilitation: State of the Art Reviews** Vol.7, 1, (February). (Ed: Teasell R) Hanley and Belfus, Philadelphia, 213-223.

Davis A, Strong P, (1976) *The management of a therapeutic encounter.* In: **Studies in Everyday Medical Life**(Eds: Wadsworth M, Robinson D) Martin Robertson and Co, London 123-137.

Davis F (1960) *Uncertainty in medical prognosis clinical and functional* **American Journal of Sociology** 66, 1 (July), 41-47.

Dijkerman H, Wood V, Langton Hewer R (1996) *Long term outcome after discharge from a stroke rehabilitation unit* **Journal of the Royal College of Physicians of London** 30, 6, 538-546.

Forster A, Young J (1992) *Stroke rehabilitation: Can we do better?* **British Medical Journal** 305 (December, 6967), 1446.

Gold S J (1983) *Getting well: impression management as stroke rehabilitation* **Qualitative Sociology** 6, 3, 238-254.

Hoffman J E (1974) *'Nothing can be done': Social dimensions of the treatment of stroke patients in a general hospital* **Urban Life and Culture** 3, 1, 50-70.

Holbrook M (1982) *Stroke: Social and emotional outcome* **Journal of the Royal College of Physicians of London** 16, 2, 100-104.

Jongbloed L (1994) *Adaption to a stroke: the experience of one couple* **American Journal Of Occupational Therapy** 48, 11, 1006-1013.

Kaufman S (1988) *Stroke rehabilitation and the negotiation of identity. In:* **Qualitative Gerontology** (Eds: Reinharz,S; Rowles,G) Springer, New York, 82-103.

Kaufman S, Becker G (1986) *Stroke: Health care on the periphery* **Social Science and Medicine** 22, 9, 983-989.

Kwakkel G, Wagenaar R, Koelman T, Lankhorst G, Koetsier J (1997) *Effects of intensity of rehabilitation after stroke: A research synthesis* **Stroke** 28 (August), 1550-1556.

Langhorne P, Wagenaar R, Partridge C (1996) *Physiotherapy after stroke: More is better?* **Physiotherapy Research International** 1, 2, 75-88.

Lewinter M, Mikkelsen S (1995a) *Patients' experience of rehabilitation after stroke* **Disability and Rehabilitation** 17, 1, 3-9.

Lewinter M, Mikkelsen S (1995b) *Therapists and the rehabilitation process after stroke* **Disability and Rehabilitation** 17, 5, 211-216.

Maykut P, Morehouse R (1994) *Beginning Qualitative Research* Falmer Press, London.

Payton O, Nelson C (1996) *A preliminary study of patients' perceptions of certain aspects of their physical therapy* **Physiotherapy Theory and Practice** 12, 1, 27-38.

Pound P, Bury M, Gompertz P, EbrahimS (1994a) *Views of survivors of stroke on benefits of physiotherapy* **Quality in Health Care** 3, 69-74.

Pound P, Gompertz P, Ebrahim S (1994b) *Patients' Satisfaction with stroke Services* **Clinical Rehabilitation** 8, 7-17.

Pound P, Ebrahim S (1997) *Redefining 'doing something': Health professionals' views on their role in the care of stroke patients* **Physiotherapy Research International** 2, 2, 12-28.

Sandin K, Cifu D, Noll S (1994) *Stroke rehabilitation 4. Psychologic and social implications* **Archives of Physical Medicine and Rehabilitation** 75, (May), 552-555.

Stachura K (1994) *Professional dilemmas facing physiotherapists* **Physiotherapy** 80, 6, 357-360.

Thompson S (1991) *The search for meaning following a stroke* **Basic and Applied Social Psychology** 12, 1, 81-96.

Thornquist E (1994) *Profession and life: separate worlds* **Social Science and Medicine** 39, 701-713.

Turner B S (1984a) *Introduction: Body paradoxes.* In: **The Body and Society: Explorations in Social Theory** Basil Blackwell, Oxford, 1-9.

Turner B S (1984b) *Disease and disorder.* In: **The Body and Society: Explorations in Social Theory** Basil Blackwell, Oxford, 204-226.

OTHER JOURNALS

The aim of this section is to list the titles of papers which have been recently published in key journals, and which may be of interest to ACPIN members

AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

• 1998, vol 52, no 8

• Ling-Hui C, Hasselkuss B R, *Occupational therapists' expectations in rehabilitation following stroke: sources of satisfaction and dissatisfaction* pp629-637.

• 1998, vol ?, no ?

• Stern E B et al, *Neoprene splinting: dermatological issues* pp573-578.

AGE AND AGEING

• 1998, vol ?, no ?

• Prettyman R, *Extra-pyramidal signs in cognitively intact elderly people* pp557-560.

ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION

• 1998, vol 79, no 7

• Harrison-Felix C et al, *Brain injury as a result of violence: preliminary findings from the traumatic brain injury model systems* pp730-737.

• Haselkorn JK et al, *Characteristics of drivers and driving record after traumatic and nontraumatic brain injury* pp738-742.

• Katrak P et al, *Predicting upper limb recovery after stroke: the place of early shoulder and hand movement* pp758-761.

• Klefbeck B et al, *Oxygen desaturations during exercise and sleep in fit tetraplegic patients* pp800-804.

• Kwan-Hwa L et al, *Ventilatory and mouth occlusion pressure responses to hypercapria in chronic tetraplegia* pp795-799.

• Masanic CA, Bayley MT, *Interrater reliability of neurologic soft signs in an acquired brain injury population* pp811-815.

• Mazer BL et al, *Predicting ability to drive after stroke* pp743-750.

• Nash MS et al, *Oxyhemoglobin desaturation and aberrant carbon dioxide homeostasis during electrically stimulated exercise in a ventilator-dependent tetraplegic patient* pp873-876.

• Reker DM et al, *Stroke rehabilitation outcome variation in veterans affairs rehabilitation units: accounting for case-mix* pp751-757.

• Sandstrom R et al, *Discharge destination and motor function outcome in severe stroke as measured by the functional independence measure/function-related group classification system* pp762-765.

• Shields RK et al, *Analysis of health-related quality of life and muscle impairment in individuals with amyotrophic lateral sclerosis using the medical outcome survey and the Tufts quantitative neuromuscular exam* pp855-862.

• Zuhosky JP et al, *A retrospective review of the incidence and rehabilitation outcome of concomitant traumatic brain injury and ligamentous knee injury* pp805-810.

• 1998, vol 79, no 8

• Christiansen C et al, *Task performance in virtual environments used for cognitive rehabilitation after traumatic brain injury* pp888-892.

• Hachisuka K et al, *Gender differences in disability and lifestyle among community-dwelling elderly stroke patients in Kitakyushu, Japan* pp998-1002.

• Harvey LA et al, *Energy expenditure during gait using the walkabout and isocentric reciprocal gait orthoses in persons with paraplegia* pp945-949.

• Krause JS, *Dimensions of subjective well being after spinal cord injury: an empirical analysis by gender and race/ethnicity* pp900-909.

• Max JE et al, *Adaptive functioning following traumatic brain injury and orthopedic injury: a controlled study* pp893-899.

• Skold C et al, *Simultaneous Ashworth measurements and electromyographic recordings in tetraplegic patients* pp959-965.

• Slavin MD et al, *Lower extremity muscle force measures and functional ambulation in patients with amyotrophic lateral sclerosis* pp950-954.

• Tobimatsu Y et al, *Cardiorespiratory endurance in people with cerebral palsy measured using an arm ergometer* pp991-993.

• Willen C, Grimby G, *Pain, physical activity, and disability in individuals with late effects of polio* pp915-919.

• 1998, vol 79, no 9

• Bombardier CH, Rimmele CT, *Alcohol use and readiness to change after spinal cord injury* pp1110-1115.

• Cheng P-T et al, *'The sit-to-stand movement in stroke patients and its correlation with falling* pp1043-1046.

• Furusawa K et al, *Short-term attenuation of natural killer cell cytotoxic activity in wheelchair marathoners with paraplegia* pp1116-1121.

• Grade C et al, *Methylphenidate in early poststroke recovery: a double-blind, placebo-controlled study* pp1047-1050.

• Groah SL, Menter RR, *Long-term cardiac ischemia leading to coronary artery bypass grafting in a tetraplegic patient* pp1129-1132.

• Hartkopp A et al, *Bone fracture during electrical stimulation of the quadriceps in a spinal cord injured subject* pp1133-1136.

• Hooper J et al, *Rater reliability of Fahn's Tremour Rating Scale in patients with multiple sclerosis* pp1076-1079.

•Konishi N et al, *Electrophysiologic evaluation of denervated muscles in incomplete paraplegia using macro electromyography* pp1062-1068.

• Miner LA et al, *Answering questions with an electroencephalogram-based computer interface* pp1029-1033.

• Strauss DJ et al, *Long-term survival of children and adolescents after traumatic brain injury* pp1095-1100.

• 1998, vol 79, no 10

• Clar SA, Cianca JC, *Intercranial tumor masquerading as cervical radiculopathy: a case study* pp1301-1302.

• Donaghy S, Wass PJ, *Interrater reliability of the functional assessment measure in a brain injury rehabilitation program* pp1231-1236.

• Fox GK et al, *On-road assessment of driving competence after brain impairment: review of current practice and recommendations for a standardized examination* pp1288-1296.

• Gallien P et al, *Influence of urinary management on urological complications in a cohort of spinal cord injury patients* pp1206-1209.

• Lawlor BD, Stolp-Smith KA, *A new dynamic triceps-driven orthosis (DTDO): achieving elbow flexion in patients with C5 deficits* pp1309-1311.

• Macciocchi SN et al, *Ischemic stroke: relation of age, lesion location, and initial neurologic deficit to functional outcome* pp1255-1257.

• Marin R, *Scapula Winger's brace: a case series on the management of long thoracic nerve palsy* pp1226-1230.

• Powell J et al, *Measuring progress and outcome in community rehabilitation after brain injury with a new assessment instrument – the BICRO-39 Scales* pp1213-1225.

• Sherman AL et al, *Management of focal dystonia of the extensor hallucis longus muscle with botulinum toxin injection: a case report* pp1303-1305.

• Waters RL et al, *Post-rehabilitation outcomes after spinal cord injury caused by firearms and motor vehicle crash among ethnically diverse groups* pp1237-1243.

• 1998, vol 79, no 11

•Hartkopp A et al, *Suicide in a spinal cord injured population: its relation to functional status* pp1356-1361.

• Harvey RL et al, *Stroke rehabilitation: clinical predictors of resource utilization* pp1349-1355.

• Huang ME et al, *Functional outcome after brain tumor and acute stroke: a comparative analysis* pp1386-1390.

• Ijzerman MJ et al, *Speed dependence of crutch force and oxygen uptake: implications for design of comparative trials on orthoses for people with paraplegia* pp1408-1414.

• Karlberg M, Magnusson M, *Head movement restriction and postural stability in patients with compensated unilateral vestibular loss* pp1448-1450.

• Kirshblum SC, O'Connor KC, *Predicting neurologic recovery in traumatic cervical spinal cord injury* pp1456-1466.

• Middleton JW et al, *Neurological level effect on the discharge functional status of spinal cord injured persons after rehabilitation* pp1428-1432.

• Westgren N, Levi R, *Quality of life and traumatic spinal cord injury* pp1433-1439.

• Zafonte RD et al, *Moving bullet syndrome: a complication of penetrating head injury* pp1469-1472.

BRITISH JOURNAL OF CLINICAL PSYCHOLOGY

• 1998, vol 37 no 4

• Flanagan DAJ, *A retro-spective analysis of expressed emotion (EE) and affective distress in a sample of relatives caring for traumatically brain-injured (TBI) family members* pp431-440.

BRITISH JOURNAL OF OCCUPATIONAL THERAPY

• 1998, vol 61, no 8

• Turton A, *Mechanisms for recovery of hand and arm function after stroke: a review of evidence from studies using non-invasive investigative techniques* pp359-364.

• 1998, vol 61, no 11

Bowcher H, May M, *Occupational therapy for the management of fatigue in multiple sclerosis* pp488-492.

BRITISH JOURNAL OF SPORTS MEDICINE

• 1998, vol 32, no 4

• Arbuthnott K, *Sport for people with a disability: the current state of play* p275.

BRITISH JOURNAL OF THERAPY AND REHABILITATION

• 1998, vol 5, no9

• Pound P, Wolfe C, *Stroke in the community: the role of the family support organizer* pp482-.

• 1998, vol 5, no11

• Bailey MJ et al, *Is neglect neglected by the physio-therapist?* pp567-

• Dick F et al, *Developing stroke services in a district general hospital* pp573-.

• Noad R et al, *Community and hospital stroke patients: long-term rehabilitation* pp578-.

• St Denys M, *Rehabilitation: a liberating experience* pp582-.

BRITISH MEDICAL JOURNAL

• 1998, vol 317, no 7164

• Emery AEH, *Fortnightly review: the muscular dystrophies* pp991-.

• Brittain KR, *Suicide in patients with stroke (letter)* p1016.

• 1998, vol 317, no 7171

• Pallen M, Loman N (as well as others), *Videos, photographs and patient consent (letters)* p1522.

CANADIAN JOURNAL OF OCCUPATIONAL THERAPY

• 1998, vol 65, no 4

• Jongbloed L, *Disability income: the experiences of women with multiple sclerosis* pp193-201.

CLINICAL REHABILITATION

• 1998, vol 12, no 4

• Ayana M et al, *The views of therapists on the use of a patient-held record in the care of stroke patients* pp328-337.

• Butler PB, *A preliminary report on the effectiveness of trunk targeting in achieving independent sitting balance in children with cerebral palsy'* pp281-293.

• Pound P et al, *A patient-centred study of the consequences of stroke* pp338-347.

• Tekeolu Y et al, *Effects of transcutaneous electrical nerve stimulation (TENS) on Barthel Activities of Daily Living (ADL) Index score following stroke* pp277-280.

• Van Heugten CM et al, *Outcome of strategy training in stroke patients with apraxia: a phase II study* pp294-303.

• 1998, vol 12, no 5

• Hesse S et al, *Botulinum toxin type A and short-term electrical stimulation in the treatment of upper limb flexor spasticity after stroke: a randomized, double-blind, placebo-controlled trial* pp381-388.

• Stizia J et al, *Evaluation of a nurse-led multidisciplinary neurological rehabilitation programme using the Nottingham Health Profile* pp389-394.

• Tyson SF, *The support taken through walking aids during hemiplegic gait* pp395-401.

• 1998, vol 12, no 6

• Hochstenbach J et al, *Cognitive deficits following stroke in the basal ganglia* pp514-520.

• Lord SE et al, *A comparison of two physiotherapy treatment approaches to improve walking in multiple sclerosis: a pilot randomized controlled study* pp477-486.

• Mant J et al, *The impact of an information pack on patients with stroke and their carers: a randomized controlled trial* pp465-476.

• Stilwell P et al, *Measuring outcome in community-based rehabilitation services for people who have suffered traumatic brain injury: the Community Outcome Scale* pp521-531.

• Sutcliffe LM, Lincoln NB, *The assessment of depression in aphasic stroke patients: the development of the Stroke Aphasic Depression Questionnaire* pp506-513.

GAIT AND POSTURE

• 1998, vol 8, no 1

• Halliday SE et al, *The initiation of gait in young, elderly, and Parkinson's disease subjects* pp8-14.

• Vaughan CL et al, *Selective dorsal rhizotomy as a treatment option for children with spastic cerebral palsy* pp43-60.

• 1998, vol 8, no 2

Alexandrov A et al, *Axial synergies in Parkinsonian patients during voluntary trunk bending* pp124-135.

JAMA

• 1998, vol 280, no 16

• Rudick RA, *Clinical crossroads: a 29-year-old man with multiple sclerosis* pp1432-.

JOURNAL OF GERONTOLOGY: PSYCHOLOGICAL SCIENCES

• 1998, vol 53B, no 4

• Brod M et al, *Patients' experiences of Parkinson's Disease* pp213-222.

JOURNAL OF MANIPULATIVE AND PHYSIOLOGICAL THERAPEUTICS

• 1998, vol 21, no 8

• Bolton PS, *The somatosensory system of the neck and its effects on the central nervous system* pp553-563.

INTERNATIONAL JOURNAL OF REHABILITATION RESEARCH

• 1998, vol 23, no 1

• Boschen KA, Gargaro J, *Independent living long-term outcome variables in spinal cord injury: a replication of De Jong* pp285-300.

• Cools C, Manders E, *Analysis of language and communication function in traumatic brain injured patients* pp323-330.

LANCET (THE)

• 1998, vol 352, no 9125

• Scolding N, Franklin R, *Axon loss in multiple sclerosis* p339.

• 1998, vol 352, no 9134

• Gralton E et al, *Eccentric exercise and neuroleptic malignant syndrome*

• Meilof JF, *Cortical processing in persistent vegetative state (letter)* p1148.

• 1998, vol 352, no 9137

• Choo V, *Meeting the challenge of stroke* p1330.

• Golbe LI, *Parkinson's disease: nature meets nurture* p1328.

• Menegon A et al, *Parkinson's disease, pesticides, and glutathione transferase polymorphisms* pp1344-1346.

• 1998, vol 352, no 9139

• European Study Group on Interferon fl-1b in secondary progressive MS, *Placebo-controlled multicentre randomised trial of Interferon fl-1b in treatment of disability in secondary progressive multiple sclerosis* pp1491-1497.

• Goodkin DE, *Interferon fl therapy for multiple sclerosis* pp1486.

• PRISMS (Prevention of Relapses and Disability by Interferon fl-1a Subcutaneously in Multiple Sclerosis) Study Group, *Randomised double-blind placebo-controlled study of Interferon fl-1a in relapsing-remitting multiple sclerosis* pp1498-1504.

• Sawaya RA, *Interferon beta for Guillain-Barré syndrome (letter)* p1550.

• 1998, vol 352, no 9140

• Anand P, *Nerve growth factor in diabetic neuropathy (letter)* p1629.

• Hadjivassilov M and others, *Clinical, radiological, neurophysiological and neuropathological characteristics of gluten ataxia* pp1582-.

• 1998, vol 352, no 9141

• Roberts E and others, *Cranial nerve palsies and vomiting* p1674.

• 1998, vol 352, no 9143

• Krieger DW, *Evoked potentials not just to confirm hopelessness in anoxic brain injury* p1796.

• Znadbergen EGJ, *Systematic review of early prediction of poor outcome in anoxic-ischaemic coma* pp1808-1812.

OCCUPATIONAL THERAPY INTERNATIONAL

• 1998, vol 5, no 3

Lau A et al, *Visual perception and hand function in persons with multiple sclerosis* pp194-205.

• Walloch CL, *Neuro-occupation and the management of chronic pain through mindfulness meditation* pp238-.

PHYSICAL THERAPY

• 1998, vol 78, no 7

• VanSwearingen JM, Brach JS, *Validation of a treatment-based classification system for individuals with facial neuromotor disorders* pp678-689.

• 1998, vol 78, no 8

• Olney SJ, Griffin MP, McBride ID, *Multivariate examination of data from gait analysis of persons with stroke* pp814-828.

• 1998 vol 78, no 9

• Lamontagne A et al, *Evaluation of reflex and non-reflex-induced muscle resistance to stretch in adults with spinal cord injury using hand-held and isokinetic dynamometry* pp964-978.

• 1998, vol 78, no 10

• Mackay-Lyons M, *Variability in spatiotemporal gait characteristics over the course of the L-dopa cycle in people with advanced Parkinson Disease* pp1083-1094.

PHYSIOTHERAPY

• 1998, vol 84, no 9

• Lawson K, *Tizanidine: a therapeutic weapon for spasticity?* pp418-420.

PHYSIOTHERAPY CANADA

• 1998, vol 50, no 3

• Walker JM, *Profile of polio survivors in Nova Scotia: a mailed questionnaire survey* pp190-197.

PHYSIOTHERAPY THEORY AND PRACTICE

• 1998, vol 14, no 2

• Tyson S et al, *The effect of a hinged ankle-food orthosis on hemiplegic gait: four single case studies* pp75-86.

• 1998, vol 14, no 3

• Nilsson LM et al, *Assessment of walking, balance and sensorimotor performance of hemiparetic patients in the acute stage after stroke* pp149-158.

SCANDINAVIAN JOURNAL OF REHABILITATION MEDICINE

• 1998, supplement 38

Quality indicators in spinal cord injury care: a Swedish Collaborative Project

• 1998, vol 30, no 3

• Hopman MTE et al, *Blood redistribution and circulatory responses to submaximal arm exercise in persons with spinal cord injury* pp167-174.

Therapeutic handling

Sara Bent
Senior Physiotherapist
Southampton University Trust
Wessex ACPIN

Over the last year our Trust, like many others has become increasingly proactive regarding their Manual Handling policy. Representatives from various departments within our physiotherapy department have attended a three day course to become Manual Handling co-ordinators within their areas.

It was clear very early on that there would be very little reference on this course to the high risk manoevres many physiotherapists undertake daily.

In response to this we organised a workshop attended by all the physiotherapy trained Manual Handling co-ordinators and senior neuro-rehabilitation physiotherapists.The group were facilitated by the Trust Manual Handling Olficer (Jane Fisher) and a local Physiotherapy Lecturer Julian Pearce who specialises in Manual Handling.

The aim of the day was to try to define what we meant by therapeutic handling. We also wanted to gain a clearer understanding of where we stood legally when teaching other members of staff as well as carers. However, the main purpose of the day was to look at our current practise to see if we could come up with some recommendations for good practice.

The issue of teaching other professionals, notably nursing staff to undertake potentially high risk manual handling manoeuvres such as face on transfers was discussed. It was concluded that at present unless the member of staff had more than the basic manual handling training (ie rehab nurses) this practise should not continue.The implications of this, particularly in relation to carers could have a great impact as regards discharge planning in the future. Emphasis was still placed on the assessment of the individual patient situation. Potentially more high risk manoeuvres were to be taught as the least favoured option. It was also discussed whether some sort of disclaimer should be used to cover the physiotherapist in teaching the above to the carer.

To get the grey matter working on the day we also included two very brief patient demonstrations to help focus the group. One patient was still needing two therapists to transfer, the other patient was just starting to walk.

At the end of the day we decided to start off looking at the initial assessment of sitting to standing, the following is what we came up with:

Guidelines for good practice – sitting to standing assessment

- Assess premorbid ability
- Two physiotherapists or one physiotherapist and a physiotherapy assistant present throughout the manouvre.
- Assessment made of patient's likely level of compliance ie confusion, perception.
- Use a firm surface with an adjustable height.
- Feet flat on floor.
- Assess degree of sitting balance.
- Assess lower limb mobility and strength.
- Assess sensation/proprioception.
- Assess upper limb function.
- Assess when and how to abort manoeuvre.

As ACPIN are planning to take this issue forward we look forward to hearing what other regions are up to – and more to the point what is therapeutic handling?

ACPIN's response to queries on Manual Handling

In response to the growing numbers of enquiries regarding Guidelines on Therapeutic Handling of Patients in Neurology, the following is a summary of what ACPIN and the CSP are undertaking

- The CSP have launched a new pack which is available from Jane Langley at the CSP (price £10).
- The CSP are looking further into therapeutic handling, and have set up a Moving and Handling Development Group, and Anthea Dendy will represent ACPIN with members' problems.
- ACPIN is currently collating a Database of Manual Handling forms, which will eventually be used in conjunction with the CSP to create Guidelines. We need your help to collate this database. Any hospitals who have devised their own manual handling forms should send a copy to: Clare Scott-Dempster, Physiotherapy Department, Stoke Mandeville Hospital, Aylesbury. Bucks HP21 8AL.

The ACPIN membership list (database) for research and commercial purposes

The ACPIN membership list is now collated on a database. This enables easier access to a variety of information about the membership (subject to the compliance with the Data Protection Act 1984) However, production of lists, whether in full or a selection of names requires some monitoring and is a time consuming process. Therefore, ACPIN, with the support of the CSP, now charges a minimal fee for the service provided.

Priority will be given to ACPIN members, particularly those pursuing a research interest that endorses the mission statement of ACPIN.

The membership list is compiled from January to January of each year (from 1999), so the total number of fully paid up members changes throughout that period. However, a total number of members at any given time is always available. Full membership is open to all Chartered Physiotherapists with a special interest in the field of neurology, whilst associate membership is open to other suitably qualified persons. This point may need to be considered when choosing your target group as they are not listed separately.

Membership lists can be obtained:

- Either by regions (17 in total) or by the full membership
- By consecutive listings or every third name on the list
- FULL members only or mixed full/associate members
- Other altematives may be available on request but may incur extra charges

A fee is charged for this service. The rates set for 250 names are:

- For full ACPIN members £10
- For associate members £15
- For non-members (health professionals) £25
- For physiotherapy students £5
- For commercial use – fee subject to Executive Committee decision

So as to prevent our members being inundated with requests, the number of times each members name is released will be monitored for the first year - excluding official or endorsed mailings by ACPIN. Therefore, all requests for membership lists will be considered by both the membership secretary and research officer before details are released. To aid this selection process, the attached application form (on page 37) requires details of the purpose for the request.

The membership list is released subject to the following conditions:

- Any lists requested and approved will not be released until full payment has been received (cheques made payable to ACPIN)
- When the list is required for research purposes the named person is required to sign an agreement that they will write a report of their results for Synapse.
- The list is released subject to a once only understanding. (The list must not be reproduced/passed onto others in any form).
- The ACPIN member is informed, by the purchaser, that their name has been obtained from the purchase of the ACPIN membership list.

Update on Membership for 1999

Many, many apologies to those of you who have renewed your ACPIN membership through the CSP and have not yet received your ACPIN membership card or welcome letter.

The delay though anticipated has been longer than expected, due to the teething problems of setting up the new system. It is anticipated that members should receive their cards by mid March.

If you are uncertain as to whether you have renewed for 1999 please contact your regional secretary (see adresses on page 40) who can provide you with an application form.

The nature of physiotherapy

Rosie Hitchcock
CIG Liaison Officer

Annual Specific Interest Group conference
Chamberlain Hotel Birmingham
24th-25th September 1998

This year's Specific Interest Group Conference proved to be an effective forum for lively debate addressing a variety of current key issues, all directly related to the future of the profession.

Day 1 was devoted to reviewing the current status of physiotherapy. The keynote speaker, Dr Dylan Tomlinson, sociology lecturer at South Bank University, discussed the implications for physiotherapy in the content of the current and previous health refoms. He felt that the current reforms with their emphasis on quality and inter-professional collaboration were likely to be much more effective in improving service delivery and patient care. This is an area which is strongly advocated in physiotherapy, however Dr Tomlinson felt that physiotherapists still needed to constitute their role within this forum and trust other professions to implement measures that affect physiotherapy delivery and practice.

The keynote speech was followed by a panel presentation on perception of physiotherapy. The panel was composed of a medical correspondent, an orthotist, a GP and a member of the Patient's Association. The most relevant views were voiced by the member of the Patient's Association who is also a Council Member. He gave constructive ideas on how the public's views of physiotherapy could be improved, eg better information at the point of referral - encourage GPs to hand out leaflets to patients.

In the afternoon a debate was set up which attempted to pitch traditional practices against the new. The motion was as follows: *'This house believes that physiotherapy should focus its practice within the traditional boundaries of orthopaedics, neurology and respiratory care. It should cease expanding into further and untried approaches and modalities as is the current practice.'*

It became increasingly apparent that the arguments given for and against the motion were actually representing views from the public sector and private sector respectively, particularly as the argument for the motion was based around the need for clinical effectiveness to substantiate physiotherapy within the public sector amid ever increasing pressures.

The argument against the motion indicated that proof of clinical effectiveness was less necessary and more emphasis on what the patient requested was more relevant. Although a very lively debate issued, it appeared to merely highlight very different work place pressures between the two sectors.

Day 2 was devoted to the future of physiotherapy and in particular specialism within the profession and how this will fit in with the Government's new proposals in health care. Penny Bromley, CSP Industrial Relations Officer, discussed the issues of work becoming more specialised in acute hospitals and most physiotherapy will be delivered in the community within multi-disciplinary teams working towards set targets. This will be potentially very prescriptive. Another issue raised was in relation to the Health Minister's suggestion that there was an imbalance between degree and non-degree nurses and that not all nursing staff needed to have a degree. If this was then applied to physiotherapy which may 'move up or out', then careful consideration of filling the gap would have to occur.

A workshop on specialism then took place addressing issues such as advantages and disadvantages of specialist, compiling a more rigorous definition with reference to current models produced by the WCPT, CSP and SLCP. This produced much intense debate and is clearly a current political hot potato. However, inevitably more questions than answers were raised with no clear conclusions made.

Overall the Conference was a key forum for discussion of several current significant issues relating to the profession. Due to the large number of SIGs represented there were many differing views expressed. Although no major conclusions were made the Conference provided an important source of opinion in relation to the formation of future CSP policies.

Courses

PHYSIOLOGICAL BASIS OF NEUROLOGICAL REHABILITATION

Bernhard Haas
School of Healthcare Professions
University of Brighton

18th-22nd January 1999

A very successful first run of a new masters level module has just been completed at the University of Brighton School of Healthcare Professions. The group of physiotherapists and podiatrists from the UK and Belgium worked hard all week to get to grips with neurophysiological issues that underlie the basis of rehabilitation of patients with neurological conditions. At the end of the week the participants were clear that the module aims were clearly fulfilled. These included:

- Provide students with an in-depth exploration of current neurophysiology related to the control of human movement.
- Evaluate current motor control theories and discuss their relevance to the rehabilitation of patients with a variety of neurological conditions.

The content of the module covered:

- Current theories of motor control.
- Neuromuscular and muscular plasticity and the implications for neurorehabilitation.
- Aspects of aetiology and management of abnormal motor control.
- Evaluation of current treatment approaches in neurological rehabilitation.
- The contribution of approaches from other physiotherapy areas to the management of patients with neurological disorders (eg neurodynamics, muscle imbalance and their physiological basis).

Lecturers included staff from the University of Brighton as well as Dr Lynn Rochester from Aukland/ New Zealand and Professor Rowena Plant from Newcastle. The success of the module has ensured that it will run again next year (17.1. – 21.1. 2000) and in addition the module team has been inspired to develop new neurology modules which could count towards a distinct award in neurological rehabilitation. For further information and application forms contact:

Bernhard Haas, Course leader
MSc in Physiotherapy, School of Healthcare Professions,
University of Brighton,
Robert Dodd House, 49 Darley Road, Eastbourne BN20 7UR.
Tel 01273/643771
e-mail: b.m.haas@bton.ac.uk

SPASTICITY REHABILITATION: SETTING STANDARDS

Ros Wade BSc MCSP SRP
ACPIN

19th September 1998

The title of this one day conference had inspired many nurses and therapists to give up a Saturday to participate in discussion around setting standards for the management and rehabilitation of spasticity.

The day was sponsored by Athena Neuroscience who are the company marketing Tizanadine (Zanaflex), the 'new' anti-spasticity drug to the UK in 1997. There have been a number of research trials done, and Tizanadine has been widely used in Europe for many years, particularly with spinal-injured patients with some very positive outcomes.

The study day comprised of lectures and workshops. Although in the morning there were some excellent talks on the medical and physiotherapy management for spasticity, several of the other speakers failed to address the topic at all.

The afternoon workshops again, although having stimulating titles, failed to address any aspect of setting standards for managing spasticity, training needs or implementation and dissemination of standards.

Overall I felt the day was very disappointing and did not address the aims of the day or meet the expectations of a number of the course participants that I spoke to.

Articles

THE SUPPORT TAKEN THROUGH WALKING AIDS DURING HEMIPLEGIC GAIT.

Tyson S F
Clinical Rehabilitation 1998; 12:395-401.

Emma De Vinã
Anne McDonnell

The article stated where the author works and gave a correspondence address but there was no indication as to her profession, although we are aware that she is a physiotherapist.

OVERVIEW
The article aimed to assess the effects of different walking aids (a tripod, a stick and a high stick) on the support taken (as a percentage of body weight) by hemiplegic subjects during gait. It also examined the relationship between the support taken (measured by a strain gauge in the aid); the severity of the hemiplegia (assessed using the gross function section of the Rivermead Motor Assessment Scale); and walking ability (assessed using velocity). Aid contact time, placement of the aid and lateral shift of the pelvis when weight-bearing were also measured by using 'Coda' -a non-invasive movement analysis system.

Subjects who had a hemiplegia of a duration greater than three months and who could walk were recruited to the study.

The results documented that no differences were observed in the amount of support taken, or walking ability when trying the different walking aids. A significant relationship was found between severity of hemiplegia and percentage of body weight taken through the aid; between aid contact time and severity of hemiplegia; and between aid contact time and walking ability.

It was concluded that different types of walking aids do not influence the amount of support taken by hemiplegic subjects during walking. The author highlighted that this contradicts the beliefs of many neurological physiotherapists in Great Britain.

CRITICAL REVIEW

Introduction
The author provided a clear background of information appropriate to stroke patients and the use of walking aids. She cited a recent survey (Sackley, 1996) which stated that '62% of physiotherapists said that they rarely supplied a walking stick to stroke patients and 87% said they rarely supplied a tripod'. The author highlighted the fact that there had been very little investigation into the effects of walking aids on hemiplegic gait and presented some relevant pieces of literature, two of which were written by herself.

It was felt however that the results from one of the references (Tyson and Ashburn, 1994) were inaccurately presented, thus biasing the reader's view of walking aids. Tyson (1998) stated in reference to Tyson and Ashburn (1994) that 'an earlier part of the study… found different types of walking aid (a stick, a high stick, a tripod or walking unaided) had little effect on the temporal distance factors of gait'. In contrast Tyson and Ashburn (1994) summarised that none of the aids emerged as being the aid of choice but for 40% of subjects the tripod produced worse temporal distance parameters. This appears to be a clinically, if not statistically, significant effect of a walking aid.

The aim of the study was then clearly stated and three hypotheses were presented:

1. That stroke patients would take more support from a tripod, then a stick and then a high stick.
2. There would be a relationship between the amount of support taken from the aid and walking ability.
3. There would be a relationship between the amount of support taken and severity of hemiplegia.

Method
The method was clearly presented. However, there was little information as to how the small subject group (N=15) was recruited to the study or from where, although exclusion criteria were defined. The main inclusion criteria appeared to be subjects with a non-acute, residual hemiplegia who were walking, either with or without an aid. There was no reference to subjects who may have fulfilled the inclusion criteria but did not form part of the subject group.

The measurement tools were clearly defined and their reliability and validity established. The author provided all appropriate and relevant information when describing the test procedure and the methods of analysis applied to the data gained.

Results
The results were presented descriptively and in tabulated form. It was reported that the different aids did not produce any significant changes in velocity or support parameters. However on closer inspection of the tabulated data it was noted that the mean values did not demonstrate a statistical trend, but the subjects who tended to put an increased percentage of body weight through the aids on testing, showed a much more obvious (perhaps clinically significant) trend towards putting more weight through the tripod, then the other aids. It was felt that this information was omitted from the article.

Discussion and conclusions
Here the author revisited the three hypotheses, clearly stating that on the basis of statistical analysis:

- Hypothesis 1: is rejected as no significant differences in support parameters were found.
- Hypotheses 2 and 3: were partially supported; ie there was a significant correlation between:
  1. aid contact time and walking ability

ARTICLES (CONTINUED)

2. % body weight and severity of hemiplegia
3. aid contact time and severity of hemiplegia.

(Although only 1 and 2 were significant at a level of 0.05)

The relevant results were discussed with reference to previous literature and it was suggested that the use of an aid may offer a biomechanical advantage which would reduce the effort required to support the body weight over the hemiplegic leg, thus facilitating more rapid weight transfer over it as with orthopaedic hip pathologies (Blount, 1956). It was highlighted that more detailed biomechanical analysis of walking with an aid was required.

The author then questioned physiotherapists reluctance to use walking aids and the widespread abandonment of tripods, suggesting that the results of this study challenge this idea.

A limitation of the study was discussed: the small specific subject group. The author ended by encouraging greater flexibility in the use of walking aids.

Summary of critical appraisal

Generally, the article was clearly written, continuing on from previous studies carried out by the author in this field. It provided an interesting analysis of walking aids and the support taken by hemiplegic patients. However, there appeared to be some flaws to the study.

■ **Subject Group** All subjects had non-acute hemiplegia and were walking. Some were not using an aid at all or were only using one outdoors and none of the subjects were using a tripod.

It would seem fair to assume that all these individuals had established their own walking patterns following rehabilitation. It is therefore unlikely that the walking pattern would alter significantly with different walking aids (although there would be differences between subjects). Thus it may not be appropriate to assess the amount of support taken from different walking aids in this subject group. This point had previously been discussed in Tyson and Ashburn 1994 and Tyson, 1994, but had been omitted in this article.

In the discussion, the author challenged physiotherapists attitudes towards the use of walking aids (this was also alluded to in the survey in the introduction) in the rehabilitation of hemiplegic gait. She suggested that the results from this study indicate that there is no difference in the support taken from different aids. Our concerns regarding the appropriateness of the subject group could however, challenge this point before the results could be generalised.

■ **Biased presentation of information** It was felt that the article was written in such a way as to bias the readers towards the results found in the study. Information from the literature cited was selective and occasionally inaccurate. Problems associated with the subject group, measurement tools and test procedure could have been discussed and more of the limitations of the study could have been highlighted.

■ **Clinical relevance** The measurement tools used were well recognised, with established reliability. However, we would like to argue the clinical validity of the tools. All the measurements were biomechanical assessment methods –the only reliable tools available for measuring gait! We are aware that there are no well-established neurological assessment tools available, but there was little or no mention of 'neurological' aspects of walking except the use of the Rivermead Motor Assessment scale, to assess severity of hemiplegia, which was not elaborated on. We are aware that components such as effort or tonal changes cannot easily be measured, but these are aspects of walking that are highly relevant to both the patient and the therapist. These aspects were not mentioned in this article, the bias being towards a very biomechanical analysis, which may not be entirely relevant to this group of subjects.

This was an interesting article to evaluate, as it covers a contentious clinical topic, of which there is little research data.

REFERENCES

Blount W P *Don't Throw Away The Cane* **Journal of Bone and Joint Surgery** 1956; 38A:695-708.

Sackley C M, Lincoln N B *Physiotherapy Treatment for Stroke Patients; A Survey of Current Practice.* **Physiotherapy Theory and Practice** 1996; 12:87-96.

Tyson S F, Ashburn A *The Influence of walking aids on hemiplegic gait* **Physiotherapy Theory and Practice** 1994; 10:77-86.

Tyson S F *Hemplegic Gait Symmetry and Walking Aids* **Physiotherapy Theory and Practice** 1994; 10:153-159.

■ THE EFFECTS OF COMMON PERONEAL STIMULATION ON THE EFFORT AND SPEED OF WALKING: A RANDOMIZED CONTROLLED TRIAL WITH CHRONIC HEMIPLEGIC PATIENTS

Burridge JH et al (1997) Clinical Rehabilitation 11 pp201-210

Sharon Griffin MCSP SRP
Northgate Hospital and Community
James Paget Healthcare NHS Trust

This article was appraised using eleven questions adapted from Guyatt GH, Sackett DL, Cook DJ *Users' Guides to the Medical Literature II. How to use an article about therapy or prevention. JAMA* 1993; 270: 2598-2601 and 271:59-63.

The objective of this article was to measure the effect of the Odstock Dropped Foot Stimulator (ODFS), a common peroneal stimulator, on the effort and speed of walking using a randomized controlled trial.

The article was quite clear about its aims and the criteria for inclusion in the study. There was a good introduction explaining the interest of the researchers and why the study was completed. All the patients entered onto the trial were properly accounted for at the end and reasons given for their non-inclusion if this occurred.

The two different groups consisted of those who had stimulation (FES) and physiotherapy and those who had physiotherapy alone for a period of a month. They had ten sessions during this time. There was no indication of what the physiotherapy consisted of, except that it lasted for an hour, was given by a Bobath trained therapist of at least three years experience and was not limited to any one aspect of the patients' needs.

Unfortunately none of the people, patients or researchers were blind to the study, due to the impossibility of this. Also due to the random allocation of the patients the groups were not similar at the start. The patients in the FES group appeared to be younger although the details given were only mean ages and an SD of age. They also had their CVA more recently than the control group. The sex allocation was also different but this had been commented on and statistically analysed as being insignificant.

When appraised it did not appear that the groups had been treated similarly either. The FES group had the simulator applied as part of their treatment time, as well as being taught how to use it. There was also extra time given to them for breakdown of equipment and replacement of wires etc. This extra time was mentioned but not calculated.

The outcomes used to measure the treatment effect were changes in walking speed over a ten metre distance and the effort of walking measured by the physiological cost index (PCI). The results tables were well presented, but could be a little confusing if statistics are not your 'thing'. The only significant result was at the end of the trial, with the FES group having a faster walking speed than the control group. There was a weakly significant difference in the PCI when the FES group had the simulator first applied. The confidence limits for the previously mentioned results were small, suggesting that they were accurate.

The article was valuable in that it addressed an important issue and was well carried out. It could have been improved by using a bigger sample and it needs to be remembered that some of the patients volunteered themselves for the trial and so were more motivated than they might usually be. It would also be useful to have some idea of patient satisfaction and was the quality issue addressed? Would a longer trial period have improved the outcome?

The authors admit that there are weaknesses in their study, but conclude that subjects who have a drop foot as a result of stroke, may find their walking less hindered if they use the ODFS. All the subjects continued to use it after the trial finished and five of these later discontinued it. Two of these had improved gait without stimulation.

REGIONS

BRISTOL

Liz Britton
Regional representative

Bristol ACPIN had a varied year of evening lectures and weekend courses. One of our most popular events was a half-day workshop on 'Strapping' and apologies to those who could not get a place. Evening lectures varied from 'drugs in neurology' to an excellent lecture discussing 'hysterical/functional problems'.

A weekend course in the Motor Relearning Approach was over subscribed without advertising!

We were lucky enough to benefit from the sale of Halifax Building Society shares. It was suggested at last year's AGM that some of this money could be donated to local members to attend National ACPIN's AGM and conference. This proposal was agreed with those present and ten members received monies towards their costs.

We felt that it was important for local members to pass on their own ideas and experiences. From this the idea for our AGM entitled 'Hands Off - adjuncts to neuro-physiotherapy' developed and hopefully this is a good beginning for next year's programme.

Plans for next year are under way but at the time of going to press the committee are running round trying to get confirmaton before publishing any dates. Ideas include 'Hydrotherapy in Neurology', 'Muscle imbalance' 'splinting' and 'FES'. If any of you have any further suggestions please contact one of the committee.

At present we are trying to update our mailing list. Please could you contact us if you feel your hospital department or private practice is not receiving our flyers.

Bristol and South Wales ACPIN covers an extensive geographical area. The present committee are very aware that the events organized reflect the dominance of the Bristol/Bath areas. However we are unable to change this unless any of you from Cheltenham, Taunton or South Wales etc steps forward to join the dedicated committee. We as always are looking for new blood to join the committee and look forward to meeting you.

EAST ANGLIA

Sharon Griffin
Regional representative

For the current year we believe that the membership stands at about 40.

The East Anglian committee has a vacancy for regional rep to the national council, due to Sharon Griffin being on maternity leave. Are there any interested people out there who would be interested in filling in? If so please contact Sharon on 01603 712889.

There has not been much local interest in ACPIN activities with no suggestions from the region as to what they would like from the regional group. If anyone has any ideas about the type and timing of study days/sessions, the committee would love to hear from you. We would also be interested in what you see the regional group's role as being.

There are no plans for an AGM as at least half the committee is quite busy on other projects. After a discussion with the membership secretary, we are going to wait and see what type of response there is to the above plea, and then make plans as appropriate.

KENT

Janice Champion
Regional representative

Our current membership is an unknown quantity as the changes in the ACPIN membership year have caused us some confusion!

However we have had good attendance at our three meetings and a successful day course on Ataxia. Our AGM was held in March at Medway Hospital where Janice Champion demonstrated a patient treatment. Our June meeting, held in Maidstone, looked at a computer programme developed for perceptually damaged patients and November saw our last 1998 evening meeting 'Evaluating Research Articles' with Cecily Partridge which was held in Ashford. This was an extremely valuable evening and we hope this will spur us on to share papers and articles together at future meetings. Our Study day on Ataxia at Nunnery Fields with Ann Holland and Jon Marsden was well attended and very stimulating.

Our Committee membership changed this year as Gill Williams passed the role of Regional Rep to me. We are also looking for any new committee members if anyone is interested.

Next year's programme is still in the planning stage but the AGM is confirmed as 17th March 1999 and 'Patient Demonstration' by Janice Champion – Bobath Tutor.

LONDON

Emma De Vina
Regional representative

1998 has been another successful year for the London Branch with membership at 172. This is very slightly lower than the previous year and a recruitment drive is planned to invite new membership for 1999!

We have continued this year with a programme that mixed evening lectures with half or full weekend days. This combination has been successful with good attendance at all events. Evening lectures included: 'Speech and Language Therapy', Kay Coombes; 'Functional Electrical Stimulation', Jane Burridge; 'A Spinal Injury Patient Demonstration' by Sue Rawley; 'Biomechanics in Neuro-Rehabilitation', Fiona Coutts; and 'Taking the Plunge: Evaluating a Research Articic', led by Sian Goldberg. The weekend events included 'Balance Workshop', Kathryn Keaveney; and 'Neurosurgery Study Day'.

PROGRAMME FOR 1999

- April 6th (Evening)
  Orthotics
  Chris Drake
  St George's Hospital, London
- May 8th (Half Day)
  Musculoskeletal Approach to Upper Limb Neurology
  Heather McKibben
  Venue to be arranged
- June (Half Day)
  Neurophysiology
  Margaret Mayston
  The Bobath Centre, London
- July 6th (Evening)
  Cognition and Perception
  Theresa Jackson
  St George's Hospital, London
- August 1999
  No meeting
- September (Evening)
  Vestibular Disorders
  Jon Marsden
  NHNN, London

Any further events are to be arranged.

The Committee has remained stable though a new Regional Representative, Sandy Holmes, will replace me [Emma De Vina] when I resign in February 1999. The Committee will then stand as:

- **Chairperson** *Sarah Farmer* The Wolfson Rehab Medical Centre
- **Secretary** *Claire Dunsterville* Haslemere Hospital
- **Treasurer** *Teresa Sweidan* Homerton Hospital
- **Regional Rep** *Sandy Holmes* The Bobath Centre, London
- **Events Coordinator** *Helen Edwards* Putney Hospital
- **Committee Members** *Anne McDonnell* Royal Free Hospital, *Clare Ronzeau* King's College Hospital, London, *Natasha Toohey* NHNN, London

I would like to take this opportunity to thank members for their continuing support.

MANCHESTER

Joanna Ritchie
Committee menber

Manchester ACPIN has had a full programme of evening lectures throughout the year. The format has been the same as previous years with a mixture of patient treatment demonstrations, lectures and research presentations.

In September/October '98 we ran a four day course on 'Muscle Imbalance, related to neurological patients' with tutor Nick Hodi. The feedback from course participants was enthusiastic and Nick is going to do some sessions on this year's programme.

For 1999 the programme has almost been finalised and will shortly be sent out to members. We are currently running at a membership of 60. The committee needs support from its membership to keep dynamic and viable, and we really need some new members on the committee. Although our membership is mainly made up of physiotherapists we do get many occupatioal therapy colleagues attending, as well as students.

As always we welcome feedback on the programme and how Manchester ACPIN is run. Please contact any of the members below if you are interested in joining the committee, or have any new ideas. This will help provide all members with the information and support they want.

- **Membership secretary** *Alison Edmunds* 01706 576195
- **Secretary** *Gill Dean Lofthouse* 01204 360010
- **Research facilitator** *Hilary Chatterton* 0161 672 8704
- **Treasurer** *Jane Mallard* 0161 969 1985
- **Committee member** *Joanne Ritchie* 0161 276 3576

MERSEYSIDE

Jenny Craig
Regional representative

ACPIN has continued to have a high profile within the Region this year with support from local speakers, members and other disiplines. The programme for the year has been varied including evening lectures and a Saturday morning course. We would like to thank all our speakers for their time and their expertise. Lectures have in general been well attended by members and non- members although the turnout for the very well presented 'Evaluating a Research Article' lecture was disappointing.

Other interesting lectures have included: Perceptual Testing, Neuropsychology, Neuro Physiotherapy in Private Practice, Muscle Imbalance in Neurology and Speech and Communication. Sharon Williams again kindly gave her time to support us both as President and by leading a Workshop session.

The Committee continues to be strong at present with nine members and still meeting every 6-8 weeks. There have been a few new committee members this year and a few changes to the post holders. Earlier in the year we purchased a second hand laptop and printer to use for ACPIN letters and databases. We are slowly learning how to use it! We still have a healthy bank balance and will be able to continue to have free evening lectures for members next year. We also plan to organise a couple of income generating courses next year eg 'ANT in Neurology' and a half-day 'Evaluating Research Articles' course.

We currently have 59 members and are one of the strongest SIGs in the Region. The lecture programme for next year is coming together well with most speakers confirmed. (see list).

PROGRAMME FOR 1999

- April 17th (Saturday am)
  Evaluating a Research Article
  Hilary Chatterton
  Halton Hospital
- April 19th
  Trigger Points
  Heather Cameron
  Walton Hospital
- May 13th
  Workshop
  Sharon Williams
  Ellesmere Port Hospital
- June
  CJD and New Variant CJD
  Dr Mike Boggild
  Countess of Chester Hospital
- July
  Conversion Syndrome
  Professor Wilkinson
  Ellesmere Port Hospital
- August
  ANT
  Anita Wade
  Royal Liverpool University Hospital
- September
  PVS
  Dr Caroline Young
  Walton Centre
- October
  Workshop
  Sharon Williams
  Ellesmere Port Hospital
- November
  Wine Tasting
  Broadgreen Social Club
- December
  Dystrophy
  Dr B Lecky
  Walton Centre

We are also hoping to organise a Muscle Imbalance in Neurology – a two-weekend course this year.

NORTHERN

Lesley Yule
Regional representative

Northern ACPIN have had an action packed 1998 with

monthly weekend courses or evening lectures. We would like to thank all the speakers who have educated and inspired us over the last year.

During 1998 events included two Bobath Workshop weekends with Sharon Williams and Patty Shelley and an Introductory Normal Movement course (three weekends) with Linzie Meadows. All were well attended. However, in September it was disappointing to cancel an MS workshop with Sharon Williams due to poor subscription. Nigel Lawes re-visited us with a Neurophysiotherapy workshop and evening lectures have included Behavioural Problems in Head Injury, MND and Critically Evaluating Research Articles. We have also had three Journal Club meetings which have been a forum for discussing current research literature in relation to clinical practise and group interest. This will continue in 1999 provided there is sufficient interest.

At present we have a membership of about 70. The committee has had a reshuffle and is as follows:

- **Chairperson** *Paul Johnson*, Ryhope General Hospital.
- **Treasurer** *Sue Raine* Hunters Moor Rehabilitation Centre
- **Secretary** *Jackie Neild*, Ryhope General Hospital.
- **Regional Rep** *Lesley Yule*, North Tyneside Community Rehabilitation & Long Term Social Work team.
- **Membership Secretary** *Liz Flynn*, Penrith Hospital.
- **Committee Member** *Pam Thirlwell* Hexham General Hospital.

We will be looking for new committee members in the new year.

The programme for 1999 has not yet been finalised. Events to date are:

- March
  Neurophysiotherapy and Bobath Weekend Workshop
  Nigel Lawes and Lynne Fletcher
- July
  Bobath Weekend Workshop
- December
  Bobath Weekend Workshop

Members will be informed of the completed programme.

NORTHERN IRELAND

Laura Wheatley-Smith
Regional representative

PROGRAMME FOR 1999
All evening meetings will be held in the physiotherapy department, Belfast City Hospital at 7.30pm.
Admission Non-members – £2.00. Students – £1.00

- Friday May 14th
  3.00-7.00pm
  Saturday May 15th
  9.00am – 5.00pm
  Course with practical: Assessment and treatment of the adult with low tone
  Rita Walls
- Thursday, Friday and Saturday, June 17th, 18th and 19th
  Three-day course; Plastering in Neurology
  Susan Edwards
- Tuesday September 21st
  Practical Workshop: Trunk, shoulder, girdle and upper limb
- Friday October 15th
  3.00-7.00pm
  Saturday October 16th
  9.00am – 5.00pm
  Course with Practical: Assessment and treatment of the adult with high tone
  Rita Walls
- Tuesday November 16th
  Practical workshop: Pelvis, lower limb, foot and ankle

NIBTT (Acpin sub-group open to all those who have completed a three week Bobath Course). All meetings held at the Joss Cardwell Centre at 7.30pm, 2nd March; 4th May; 7th September; 2nd November.

NORTH TRENT

Steve Cheslett
Regional representative

Membership numbers remain steady at 35. There is presently one committee vacancy as Sue York is due to give birth imminantly

Over the last year we have arranged meetings and events every two months, as we felt every month was stretching the committee too far. This has proved successful and this will be repeated again this year.

Events have included; 'A presentation evening on local research by Final Year Sheffield students, and local clinicians' which was highly succesful and was repeated again in 1999! The AGM was combined with a lecture on Multiple Sclerosis by Dr Neil Jordon. An evening presentation on splinting in acute head injuries was held at the Royal Hallamshire Hospital. Lynne Fletcher, a Bobath Tutor, led a weekend practical workshop and the funds generated from this, and other events helped keep the bank balance healthy for another year!

PROGRAMME FOR 1999

- April/May
  Paulette Van Vliet will speak on **'The Carr and Shepherd Approach'**
- 19th June
  A day course covering strapping and taping in neurology
- 28th September
  Update on Parkinson's Disease and Management

For further details please contact Alison Clarke Tel: 0114 2713090

OXFORD

Louise Gatehouse
Regional representative

ACPIN in Oxford have had a busy and successful 1998. There has been a course or evening lecture every four to six weeks. We only paused for breath in August and December when we allowed ourselves some time off!

We would like to welcome a new committee member Rosie Beasley and wish our Secretary, Maureen Bartley all the best with her forthcoming baby!

With our membership remaining in the forties all of the evening lectures have been well attended by both members, non members and other disciplines in the region.

We ran a very successful and interesting one day Hydrotherapy Workshop with Jackie Pattman in April. The evening lectures have been well attended and interesting topics have included Apraxia, Multiple Sclerosis, Cognition and Motor Planning, Management of the Incomplete Spinal Injury and a review of the new physio-therapy degree course at Oxford.

Looking ahead to 1999 we already have many of the forthcoming years lectures in the pipeline and all members will receive a copy in 1999. It promises to be another exciting year for Oxford ACPIN. Thank you to all members for your continuing support.

PROGRAMME FOR 1999

- April
  Two day Splinting Course

SCOTLAND

Gill Baer
Regional representative

Scottish ACPIN has a healthy membership of 75.

We try to meet our member's needs by offering a diversity of course programmes with evening lectures, ½ day, 1 day and 2 day courses. We are always keen to hear from members about any suggestions for courses and will always try to support our member's needs.

In 1998 we ran three out of four planned courses. These included two very successful two-day workshops on the 'Motor Relearning Programme' run by Paulette van Vliet, and 'Treatment of Incomplete Spinal Cord Injury' led by Sue Edwards, plus an evening session on 'How to evaluate a research article'. Due to the geographical spread of our membership the evening session was slightly experimental but received good support. The fourth course on 'Stress Management' was cancelled at short notice due to illness of the speaker.

Due to retirement and change of jobs etc we currently have two vacancies on the Scottish ACPIN committee. So if anyone is keen to influence the way Scottish ACPIN runs and is enthusiastic about joining the committee, please contact the chairperson – Fiona Moffat (tel: 01786 434000 bleep 058).

PROGRAMME FOR 1999

- April
  Patient Focused Workshops + AGM
- May
  Stroke Rehabilitation in Russia (to be confirmed)
- September
  To be confirmed
- November
  Provisional joint study day with Scottish Neuroscience Nursing group

SOUTH TRENT

Nicola Goodwin
Regional representative

1998 has been another busy year for South Trent ACPIN Committee. There was a full programme of evening lectures and a course on Posture and Seating by Pauline Pope.

There was an increased attendance by members to evening lectures and continued support for weekend courses. We are hoping to have a further successful year in 1999 with a broad range of both evening lectures and weekend courses. We hope to continue to subsidise these for south Trent ACPIN members to make membership even better value.

We have had some committee changes, Sam Hancox (membership sec.) and Nicola Goodwin (regional rep) both retired and were replaced by Wendy Collingwood from Queens Medical Centre and Miriam Duffy from Nottingham City Hospital respectively. Other new committee members are Alison Attenborough from the Kings Mill centre for Healthcare and Jenny Duthie and Hannah Paine from Nottingham City Hospital.

PROGRAMME FOR 1999

- April (date to be confirmed)
  Gait Analysis
  Fran Polak
  Physiotherapy, Derbyshire Royal Infirmary
- Wednesday 12th May
  Normal movement related to the upper limb
  Erica Malcolm
  Physiotherapy day Hospital, Derbyshire Royal Infirmary
- Wednesday 9th June
  Reliability of outcome measures (the modified Ashworth Scale & Nottingham Stereognosis scale)
  Marjan Blackburn/Cordy Gaubert
  Sherwood Wing, City Hospital, Nottingham
- Saturday am 25th September
  Movement Science Patient Workshop
  Paulette van Vliet
  QMC, Nottingham
- November (date to be confirmed)
  Vestibular rehabilitation
  Maggie Campbell
  (Venue to be confirmed)

There are more evening lectures being arranged. When the times and venues are confirmed fliers will be circulated.

SUSSEX

Julia Buck
Regional representative

1998 proved yet another difficult year for Sussex ACPIN with varied and interesting lectures but unfortunately not consistently well supported.

In March 1998 Fiona Jones presented the results of her MSc re outcome measures in Physiotherapy. This assisted us all in our understanding of outcome measures and provided us with a starting point to evaluate our own working environments.

In May 1998 Bernhard Haas facilitated a group using the new research evaluation package. The session was very interactive and assisted those present in enhancing their research evaluation skills.

In September 1998 we were very pleased to have Jonathon Cole present a fascinating lecture/ presentation on Proprio-ceptive Loss and its implications for physiotherapy. This was very well attended. Part of the attraction may have been the speakers notoriety as he had presented this case on BBC's *Horizon*.

In November 1998 I presented feedback from the National Millennium Conference (March 1998). This, although not well supported, promoted much discussion as to the lack of research and evidence based practice in neurophysiotherapy

Onto 1999 which has many activities already arranged. The first being a Muscle Imbalance course at Harrowlands 26-27 Feb 1999. In April an evening lecture by the Post Polio Syndrome Group to assist us in our understanding of this condition and how we as physios can be effective in treatment.

PROGRAMME FOR 1999

- June 1999 Half day course on **Trophic Stimulation**
- Sep 1999 Evening lecture on **Physiotherapy and Exercise in Parkinson's Disease** by Bernhard Haas
- Dec 1999 Day course on **splinting, reviewing guidelines and practical skills**

Can I take this opportunity to thank everyone on the committee and others who have been involved in arranging or presenting ACPIN's programme. Anyone in the Sussex area who is interested in joining ACPIN would be very welcome. For more information please contact Julia Buck 01323 417400 ext 4794

WESSEX

Helen Foster
Regional representative

Towards the end of 1998 Wessex region have had to say 'Good-bye' to Caroline Fritton as Membership Secretary and Sara Bent as Regional Representative and Chairman. Sara, however remains an active committee member although we may allow her a day off on the 24th Jan to have her baby! We welcome Clare Blaxill to her role of Chairman and Ros Cox will be taking over as Secretary in early 1999.

Our membership currently stands at 67

We have had a successful year with four evening lectures and four well attended courses including a 'Study Day on Ataxia' by Ann Holland and John Marsden and a 'Senior workshop on Gait' by Katherine Keaveney.

One of the most notable aspects of 1998 has been an outbreak of pregnancy amongst the committee which has now reached epidemic proportions. Clare Blaxill (Chairman) had a baby boy called James in November, Sara Bent (Regional Rep 1996-1998) is due in January and I [Helen Foster] am due in April. So Ros and Carol (treasurer) will be keeping Wessex ACPIN running smoothly and their legs firmly crossed for the first few months of 1999!

PROGRAMME FOR 1999

- March 23rd at 7.30
  Medical Management of Spasticity
  Dr. Caroline Hutchins
  Consultant in Rehabilitation Medicine.
- April 14th at 7.30
  AGM followed by **Sexuality issues in Neurology**
  Dr Elaine Cooper
  Southampton General Hospital, Small Gym
- May 15th
  Study Day – Spinting in Neurology
  Phillipa Carter
  Salisbury District Hospital
  Organizer Carol McFadden
- June 16/17th
  Facial Management
  Lorraine Clapham
  Physiotherapy Department, Southampton General Hospital
- September 3rd
  Study Day – Risk Assessment of Manual Handling in Neurology
  Southampton University
- October
  Half study Day – Neurology Application of Shoulder Strapping
  Salisbury District Hospital
  Organiser Carol McFadden

WEST MIDLANDS

Kate Duffield
Regional representative

Unfortunately 1998 said goodbye to two committee members from West Midlands ACPIN. Janet Cozens retired as chair and Fiona McCann as committee member. I would like to express great thanks on behalf of the committee and also to welcome Katie Marsland as our new chairperson.

This year's membership is slightly down at 55 and we would like to thank existing members for their continued support.

Great effort was put into varying last year's programme and attendance was also varied! Lectures included Dynamic Lycra Splinting, Continence in Neurology, Botox Update, Critical Analysis of Articles, Psychosexual problems in Neurology and CJD. There was also a successful one-day course on Muscle Imbalance in the Upper Limb.

As a regional committee we meet monthly to arrange the lecture programme. This year we intend to organise more weekend study days and hopefully encourage attendance and interest from our region.

Ideas so far for 1999 are:

- April **Half study day on Adult CP (to incorporate AGM)**
- June **Basic Neurology for Juniors**
- September **Half study day, title yet to be arranged**

This is a provisional programme; February 27th is a secured date.

We always welcome ideas for lectures and offers for alternative venues.

We would like to express thanks to our speakers for their inputs for the last year. I would also like to say a big thank-you to our regional committee for their hard-work, perseverance and commitment.

For further information please contact myself on 0121 766 6611 Ext. 4194.

YORKSHIRE

Jill Hall
Regional representative

Membership remains at 70-75. The previously successful formula of Friday – Saturday courses with fewer evening lectures seems once again to have been the best way of allowing members to learn and still have a social life! The 1999-2000 programme is currently being finalised so please let us know if this format remains acceptable.

The committee would like to thank all retiring committee members for their hard work and extend its thanks to Alan Bass for his continued support for ACPIN.

During 1998 we have offered courses on subjects as diverse as; 'Outcome measures in rehabilitation'; 'The challenge of ataxia'; 'The pelvis and gait and physiotherapy in MS'. We have tried to strike a balance between academic subjects such as the evaluation of research articles and more 'hands-on' workshops and practical courses.

In 1999 we hope to organise the following events:

- **Muscle Imbalance** – you've seen the lecture now experience the weekend course!
- **Seating** – everything you wanted to know but were afraid to ask.
- **Medical management of acute head injury**.
- **The effects of perceptual and spatial problems on motor recovery**.

Finally we are constantly on the look out for new ideas so if nothing in the above programme whets your appetite, join the committee and make sure there's something which does!

LETTERS

THE OXFORD SCALE

We read with interest the article 'To Oxford or not!' (Autumn Synapse 98) and felt the need to reply and promote further discussion on this topic.

The use of the Oxford scale has been frequently debated both within our spinal injuries unit and with colleagues from other centres. We have concluded that its use certainly has a place, be it limited, within the total management of the patient with a spinal injury. The Oxford scale is just one of the measures used within the neurological assessment and outcome indicators of this group and should not be treated in isolation. Consequently, we feel misinterpretation and information out of context may have been obtained by the telephone survey made to personnel within the spinal injury units.

We feel it is worth highlighting the following:

- Spinal injury units are dealing with acute patients. There is a need to document changing neurology within the limitations imposed by the acute management (eg position, immobilisation etc). Rate of recovery, ie change in Oxford grading, can be a valuable indicator at this time, when other methods of assessment are not possible.
- The Oxford scale forms only part of the ASIA impairment score at any stage following spinal injury. This gives a more meaningful overall outcome measure. Other neurological and functional outcome measures can also be used, but the ASIA score has significance in identifying the level and degree of initial and subsequent spinal cord injury damage and includes consideration of sensory and functional elements. This has been validated and accepted internationally within spinal injury management.
- It is accepted that spasticity and tone are significant influences on muscle testing. We tend to acknowledge its presence within our charting and any grade is qualified with comments. It has been found useful to indicate voluntary muscle activity even in the presence of spasticity since this can influence subsequent management.

Issues and debates regarding muscle testing are valuable and stimulating. It has been our experience at Stoke Mandeville that the Oxford scale has its place and is a useful means to document the recovery through the acute state into rehabilitation. Its role may be limited in the longer term follow up. The ASIA scale (of which manual muscle testing is part) has been accepted internationally and this is therefore the way those working in spinal units will proceed unless a more valid alternative is presented.

Dot Tussler MCSP
Superintendent
Physiotherapist
National Spinal Injuries
Centre

CHARTER MARK AWARD FOR PORTSMOUTH HEALTHCARE TRUST NEUROGYM

The Neurogym team are very proud to have received a Charter Mark Award. We thought that if any ACPIN members were thinking of applying for a Charter Mark they might be interested in our experience and might like to contact us about the process.

The neurological team consists of three physiotherapists and two physiotherapy assistants. We treat neurological patients between the ages of 16 and 65 in an outpatient setting.

A patient nominated us for this award and our first thought was "how kind but no thank you" when we realised a ten page document with cross referenced evidence was needed.

However. we had missed the deadline in the summer of 1997 and decided to use the following year to work through the application looking at each category eg user satisfaction, value for money, and using it as a bench marking process. We found that we met most of the criteria and in the process altered some of our practices, eg introducing an answering machine, looking at patient focused groups etc.

Our application was accepted and an assessor visited us for a day. This involved a very detailed assessment talking to patients and staff and watching our working practices. One particular aspect that she liked was our Resource Centre which loans books, videos and tapes to our patients and carers to help them understand their neurological conditions.

At a later stage we were sent a report of the assessor's findings and letter explaining that we had won an award, which we would receive at the Award ceremony on 26th January 1999 at the Methodist Hall, Westminster, London.

The process involved a lot of work, some of it outside working hours, but the staff benefited from working towards a common goal and winning the award is a real boost to staff morale.

Sue Roberts
Senior I Physiotherapist
Queen Alexandra Hospital,
Portsmouth

PHYSIOTHERAPY AND PARKINSON'S DISEASE

Thank you very much for your help earlier this year to target physiotherapists who may have been interested in helping with this project.

I have pleasure in enclosing a copy of the Executive Summary of Stage One of the above project (see article on page 6). A full report on Stage One is currently being completed. Updates on the project are being prepared for Frontline and Therapy Weekly, and full papers will be submitted to relevant journals. Stage One of the project is being presented as a poster at the European Parkinson's Disease Association Conference in Barcelona later this month. It is also hoped to present aspects of Stage One results at the Thirteenth International Congress of the World Confederation for Physical Therapy in Yokohama, Japan, next May.

Would it be possible for you to include an item on the project, based on the Executive Summary and this letter, in Synapse?

Stage Two of the project - case studies of best practice sites - is about to commence and again results will be reported widely. We will provide you with an update in due course.

The research team want this piece of work to raise awareness of what can be done now to improve physiotherapy provision in Parkinson's disease, and what needs to be done in the future to evidence our practice in this area. It is hoped that future work will be undertaken within a European framework.

Thank you again for your facilitation of this project.

Professor Rowena Plant
Professor of
Rehabilitation/Therapy
Hunters Moor Regional
Rehabilitation Centre
Newcastle upon Tyne

NEW AND IMPROVED

I write to congratulate you and the production team on the new and much improved format of 'Synapse'. It is both reader friendly and informative.

Regarding the low level of research articles, I wonder whether approaches could be made to course leaders of Occupational Therapy and Physiotherapy courses whose students produce a considerable amount of undergraduate and increasing volume of postgraduate research.

Keep up the good work, we do appreciate it.

Dawn Edge
Clinical Education
Co-ordinator
Department of Rehabilitation
The University of Salford

RESEARCH TO EVALUATE PHYSIOTHERAPY FOR PEOPLE WITH STROKE

A ONE DAY CONFERENCE ON TUESDAY APRIL 20TH 1999 AT THE CHSS AT THE UNIVERSITY OF KENT AT CANTERBURY

Presentation of the results of a randomised controlled trial comparing different levels of Physiotherapy for people with stroke and discussion of key issues for future research.

No fee but it is essential to register. For a place contact Cecily Partridge.
■ Tel 01227 823940 ■ Fax 01227 827868 ■ email C. Partridge@ukc.ac.uk

Management of spasticity in Multiple Sclerosis

Study Day and Workshop

ACPIN and ***Neuro Education*** have worked together to organise this exciting multi-disciplinary focussed study which will be available at four different venues. Neuro Education have organised sponsorship from Athena Neuroscience, so this day will be **FREE for ACPIN members.**

DATES	**THE PROGRAMME WILL INCLUDE:**
Wednesday 2nd June ■ Heartlands, Birmingham	■ Update on Medical Management
Thursday 3rd June ■ St Georges, South London	■ Physiotherapy: where to start and when to stop
Monday 21st June ■ Chase Farm, Enfield	■ Community Management: Preventing Readmission
Tuesday 22nd June ■ St James, Leeds	■ Challenges of the MS Nurse
	■ Workshops discussing 'Case Presentations' and 'Addressing Priorities'

These are **FREE** study days with lunch included, so chose the venue most convenient to you and book your place.

For information and application form please contact:
David Nodder, Southern Office, PO Box 247, Pirbright, Woking GU24 0XX

A NEW BEGINNING **8–10 October 1999**

1999 Congress and Exhibition of the Chartered Society of Physiotherapy

International Convention Centre, Birmingham

REGISTRATION FORM

Title Mr/Ms/Mrs/Miss/Dr/Prof (DELETE AS APPROPRIATE)

First name ..... Surname .....

PLEASE USE BLOCK CAPITALS

Job Title ..... Place of Work .....

THE ABOVE INFORMATION WILL APPEAR ON THE DELEGATE LIST AND YOUR NAME BADGE

Address .....

Town/Country ..... Post code .....

Telephone number ..... Fax.....

Do you have any dietary/special requirements? Would you like details about creche facilities?

If YES, please detail .....

A · REGISTRATION DETAILS

Are you a:

PLEASE TICK ONE BOX ONLY

01 ☐ CSP member

02 ☐ non CSP member

04 ☐ Physiotherapy student

05 ☐ Retired/unwaged CSP member

06 ☐ Exhibitor

07 ☐ Exhibition visitor only (NO FEE)

B · SPECIFIC INTEREST GROUP PROGRAMMES

If you are registering for the conference sessions please state which programme you will be **mainly** attending (for room allocation).

PLEASE TICK ONE BOX ONLY. You can swop between sessions.

08 ☐ paediatrics

09 ☐ personal development

10 ☐ neurology

11 ☐ sports medicine

12 ☐ mental health

13 ☐ physiotherapy and pain

14 ☐ reflextherapy

15 ☐ undecided

Are you a member of a SIG
YES/No if YES which one? .....

19 99
A NEW BEGINNING

C · REGISTRATION FEES PLEASE SEE NOTES ABOUT BOOKING

Full registration to include all daytime catering as specified on the programme, entry to all conference sessions and trade exhibition (open Friday and Saturday only) and VAT at the current rate. Please note the delegate rates are **NOT** interchangeable. All fees are strictly as stated below.

				PLEASE TICK BOX	
CSP MEMBERS	Full registration	**BEFORE 30 JUNE 1999***	£115.00	☐	
		1 JULY - 31 AUGUST 1999*	£140.00	☐	
		AFTER 1 SEPTEMBER 1999*	£165.00	☐	
		***DATE AS POSTMARKED**			
	Day delegate rate (half day rates are not available)		£75.00	☐	state which day .....
NON CSP MEMBERS	Full registration	**BEFORE 31 AUGUST 1999**	£140.00	☐	
	Full registration	**AFTER 31 AUGUST 1999**	£185.00	☐	
	Day delegate rate		£90.00	☐	state which day .....
DISCOUNTED RATES					
PHYSIOTHERAPY STUDENTS	(please attach a letter from your physiotherapy school)				
	Full registration		£65.00	☐	
	Day delegate rates		£40.00	☐	state which day .....
RETIRED CSP MEMBERS/UNWAGED	Full registration		£70.00	☐	
	Day delegate rates		£50.00	☐	state which day .....

D · SOCIAL EVENTS AND OVERNIGHT ACCOMMODATION

FRIDAY NIGHT SUPPERS

Would you like to receive details on any of the suppers being organised by the groups in section B.

YES/No if **YES** which ? .....

CSP ANNUAL DINNER - SATURDAY 9 OCTOBER 1999

CSP members	£35.00 per ticket	No. of tickets required .....
Non-members	£40.00 per ticket	No. of tickets required .....

Ticket price to include pre-dinner wine reception, four course meal and entertainment and VAT at the current rate.

E · PAYMENT DETAILS

Registration fee	£	all cheques to be made payable to the Chartered Society of Physiotherapy
CSP Annual Dinner	£	
Total	£	payable in pounds sterling only Inclusive of VAT (reg. VAT No. 232323500)

CREDIT CARD PAYMENTS VISA/MASTERCARD/ACCESS are accepted

Card number ..... Expiry date .....

Card holders signature ..... Amount to debited .....

ACCOMMODATION INFORMATION

A list of hotels will be sent to you. Please make reservations via the Birmingham Convention and visitor Bureau. All the information will be on the booking form.

BOOKING CONDITIONS PLEASE NOTE

- Please enclose full payment to secure your booking
- All delegate fees and the Annual Dinner costs are inclusive of VAT at the current rate of 17.5%
- Please note that delegate fees do not include travel or accommodation or social events
- Please use one registration form per person - please photocopy this form if necessary. Delegates are advised to take a copy of their registration form for their own records.
- Cancellations will be refunded up until the closing date but subject to a £15.00 fee, however substitute delegates are welcomed at no additional charge

CLOSING DATE FOR APPLICATIONS IS 30 SEPTEMBER 1999 · BUT PLEASE REGISTER AS SOON AS POSSIBLE

Any queries regarding your booking, please contact: The Events Unit · CSP
14 Bedford Row, London WC1R 4ED · Tel: 0171 306 6621/2 · Fax: 0171 306 6611 · E-Mail durhams@csphysio.org.uk

☐ Please tick this box if you do not wish to receive separate mailings of commercial nature eg. from CSP exhibitors/sponsors

APPLICATION FORM TO OBTAIN A LIST OF ACPIN MEMBERS

PLEASE FILL IN ALL FOUR PARTS CLEARLY

PART 1

NAME _____

CONTACT ADDRESS _____

_____

_____

POSTCODE _____

DAYTIME TELEPHONE NUMBER _____

PART 2

Are you a current ACPIN member? **YES** ☐ **NO** ☐

If **YES** please state regional group _____

If **NO** please state profession/business _____

PART 3

Purpose of request for a list of ACPIN members (enclose protocol if appropriate)

_____

_____

_____

_____

- Please state number of names required _____
- Do you require names from specific regions or the total membership?

  If specific regions please specify _____

  Full members only or mixed membership? _____

PART 4

Sales agreement

By purchasing the ACPIN membership list, I agree to abide by the Conditions of Sale listed right.

SIGNED _____ DATE _____

Research purposes: additional agreement

By obtaining a copy of the ACPIN membership list for research purposes I agree to provide ACPIN with a report of my results for publication in *Synapse*.

SIGNED _____ DATE _____

ACPIN is registered under the Data Protection Act (1984) with members being given the option of receiving other mailings. Therefore, the list you obtain may only be a proportion of the full membership list.

THE MEMBERSHIP LIST IS RELEASED SUBJECT TO THE FOLLOWING CONDITIONS:

- Any lists requested and approved will not be released until full payment has been received (cheques made payable to ACPIN)
- When the list is required for research purposes the named person is required to sign an agreement that they will write a report of their results for Synapse.
- The list is released subject to a once only understanding. (The list must not be reproduced/passed onto others in any form).
- The ACPIN member is informed, by the purchaser, that their name has been obtained from the purchase of the ACPIN membership list.

FOR OFFICIAL USE ONY

☐ **Checked with database that applicant is an ACPIN member**

Request details known to:
- ☐ Membership secretary
- ☐ Honorary Research Officer
- ☐ *Synapse* Editor

☐ **Application accepted and relevant regions informed**

SIGNED _____

DATE _____

GUIDELINES

FOR AUTHORS IN SYNAPSE

Synapse is the official newsletter of ACPIN. It aims to provide a channel of communication between ACPIN members, to provide a forum to inform, instruct and debate regarding all aspects of neurological physiotherapy. A number of types of articles have been identified which fulfil these aims. The types of article are:

RESEARCH REPORT
A report which permits examination of the method, argument and analysis of research using any method or design (quantitative, qualitative, single case study or single case design etc).

AUDIT REPORT
A report which contains examination of the method, results, analysis, conclusions and service developments of audit relating to neurology and physiotherapy, using any method or design.

REVIEW PAPER
A critical appraisal of primary source material on a specific topic related to neurology.

TREATMENT REPORT/CASE STUDIES
A report of the treatment of a patient or series of patients which provides a base line description of established treatments, or a new insight into the techniques or treatment of people with a specific problem.

SERVICE DEVELOPMENT QUALITY ASSURANCE REPORT
A report of changes in service delivery aimed at improving quality.

ABSTRACTS
Abstracts from research projects, including those from undergraduate or higher degrees, audits or presentations. They should be up to 300 words and where possible the conventional format: introduction, purpose, method, results, discussion, conclusion.

TECHNICAL EVALUATION
A description of a mechanical or technical device used in assessment, treatment, management or education to include specifications and summary evaluation.

PRODUCT NEWS
A short appraisal of up to 500 words, used to bring new or redesigned equipment to the notice of the readers. ACPIN and Synapse take no responsibility for these assessments, it is not an endorsement of the equipment. If an official trial has been carried out this should be presented as a technical evaluation.

POINTS OF VIEW
Articles discussing issues of contemporary interest and any other matters relating to neurological physiotherapy.

LETTERS TO THE EDITOR
These can be about any issue pertinent to neurological physiotherapy or ACPIN. They may relate to material published in the previous issue(s) of Synapse.

COPY SHOULD BE:

- typed or printed
- double spaced
- on one-sided A4 paper with at least a 1" margin all round
- consecutively numbered
- include the name, qualifications, current position, and contact address of the author(s).
- Ideally, a disk copy of the material should also be included. Documents preferred in *Microsoft Word* for Macintosh or Windows.

References should use the Harvard system. In the text quote the author(s) surname and date (Bloggs 1994). At the end of the article give the full references with the first author/editors name in alphabetical order, eg Bloggs A (1994). 'The use of bandages in the treatment of people with head injuries'. *Physiotherapy* 67, 3, pp56-58.

Tables and figures should be given appropriate titles and numbered consecutively as they appear in the text. Each should be presented on separate sheets of paper after the text.

Any **photographs** and line drawings should be in black and white, in sharp focus with good contrast and at least 5" x 7".

Two copies of each article should be sent to:

Martin Watson
Editor of Synapse
Occupational Therapy and Physiotherapy (OPT)
Schools of Health (HEA)
University of East Ariglia
Norwich
NR4 7TJ

Note: all material submitted to the editor is normally acknowledged within two weeks of receipt.