WCPT no longer requires 1000 hours clinical experience

Recent debate on physiotherapy education, including the Editorial by Robertson et al (2003) in the Australian Journal of Physiotherapy, has revealed a widespread misconception that the World Confederation for Physical Therapy (WCPT) still requires physiotherapists to have a minimum of 1000 hours of clinical experience to be eligible for membership.

In fact, the 1000 clinical hours requirement was dropped by the WCPT in 1991 and a Declaration of Principle on education adopted in its place. The Declaration stated that: ‘WCPT recommends its Member Organisations to promote in their own countries, physical therapy education based on university or university level studies or the equivalent, of four years minimum full time (or equivalent) duration.’

The Declaration led to numerous complaints that four year education for all Member Organisations (MOs) was unrealistic and, given the fact that Declarations of Principle are binding on MOs, the membership status of those unable to comply would be jeopardised. To address such concerns, delegates to the 13th General Meeting in 1995 passed the following motion:

That the current WCPT recommendations on 4 year education adopted in 1991 be rescinded and replaced by a Position Statement titled ‘Education for Entry-Level Therapists’ and worded: ‘The World Confederation for Physical Therapy recognises the fact that there is considerable diversity in the social, economic and political environments in which physical therapy education is conducted throughout the world.

WCPT recommends that education for entry-level physical therapists be based on university or university level studies, independently validated and accredited as being at a standard that accords graduates full statutory and professional recognition… WCPT will assist national physical therapy associations with the development of appropriate educational standards and with the development of accreditation processes.’

The next step was taken at the 15th General Meeting in 2003, with the passing of a motion that:

‘WCPT develop international guidelines for physical therapist professional education (entry level) that can be utilized worldwide.’

Currently, a WCPT Committee has called for MOs to provide local standards, core curricular guidelines, accreditation processes and other relevant information. Once the knowledge bank is compiled, a task force will commence development of the international guidelines.

Sandra Mercer Moore
President, World Confederation for Physical Therapy

Conclusions are compromised by lack of methodological quality. (Comment on Hayes et al, Australian Journal of Physiotherapy 50: 77–83.)

I was surprised and disturbed by the findings of a recent randomised trial published in the Australian Journal of Physiotherapy (Hayes et al 2004). Physiotherapy was found not to produce better outcomes than a standardised home exercise program. I believe that the conclusions of effects at 24 weeks are compromised by a lack of methodological quality.

My first criticism is that manual muscle tests are too insensitive to use as a test of shoulder strength. Objective measures of force production were not used to define normal strength. Table 3 shows that median scores for almost every strength measure are 5 out of 5 or ‘normal strength’ (except for elevation at 0 weeks, 6 weeks, and 12 weeks for the home exercise group). Clinically it is obvious that no patients have full functional strength in their shoulder six or 12 weeks after rotator cuff repair surgery. Furthermore, manual muscle tests do not evaluate strength in outer range positions — yet patients always notice weakness when performing tasks such as lifting overhead, lifting into abduction, and abduction/external rotation. Also, manual muscle tests do not assess power, or isokinetic force production. There is a large difference between subjects who can use a yellow theraband and those who can use black or grey, just as there is a considerable difference in strength between people who can lift 500 g and 10 kg above shoulder level.

A second criticism is that the patient loss to follow-up and missing data at 24 weeks were unacceptably high. It appears that 16 out of 58 subjects (28%) were unavailable for follow-up at 24 weeks. The acceptable level for dropouts is usually considered to be around 10%. If the people lost to follow-up in the two groups differ in their outcomes, then the findings may be biased. There are no reasons given as to why these patients dropped out and no information regarding their outcomes. At 12 weeks, five patients were lost to follow-up but a further six patients in the home exercise group obtained physiotherapy, effectively skewing the results — particularly if these patients were having a ‘suboptimal’ rate of recovery prior to having physiotherapy (effectively 20% of home exercise subjects). At 24 weeks, nine subjects in the home exercise group had received physiotherapy treatments.

Of further concern is the varying amount of ‘missing data’. This was evident for all outcomes, but was particularly evident in the questionnaires. At 24 weeks in the home exercise group there was a massive 37–44% of questionnaire items missing, and in all questionnaires there seems to have been an unacceptably high proportion of unanswered categories. The physiotherapy group had a mean functional residual deficit of 14%, 18% better than the exercise group (32%), yet this was not significantly better. How much of a difference would be required to achieve statistical significance?

At 24 weeks there were missing data for 37% of individual ROM and 44% of individual muscle force tests in the home exercise group. It is a concern that the researchers did not collect a significant amount of data from some clients.

Reference
A few other points to note include the lack of compliance monitoring. Compliance is always an issue when prescribing exercises, and could potentially affect outcomes in both treatment categories. We have found in our clinic that providing quota sheets with written exercises has helped improve patient-reported compliance, and that physiotherapy sessions which emphasise, correct, modify, and progress postoperative exercises improve patient accountability.

It is unclear whether the physiotherapists followed a suitably aggressive postoperative protocol. All aspects of management were determined by the treating physiotherapist, so it could be that some of the physiotherapists may have used modalities with no supporting research. (For example, they may have emphasised use of electrotherapies rather than a functionally-directed active ROM and strengthening program.) Physiotherapists were ‘advised not to advocate exercises or functional activities that caused an increase in pain above resting intensity.’ This seems contrary to accepted clinical practice, especially in the earlier phases of rehabilitation where patients often find that performing capsular stretches and even light strengthening exercises can increase their resting level of pain for an hour or so. Instructing patients and therapists to avoid increasing resting pain levels with exercises may have promoted a less than appropriately aggressive approach.

From a clinician’s perspective this is a disappointingly poor clinical trial which does nothing to promote the physiotherapy profession. Another study needs to be completed with a larger number of subjects, utilising relevant objective strength measures, ensuring accurate and complete data collection and monitoring, and encouraging compliance to a peer-accepted postoperative physiotherapy regime.

**Guy Higgins**

*Private Practitioner, Engadine*

**Reference**


**Methodological concerns do not undermine the principal conclusions. (Reply to comment on Hayes et al, Australian Journal of Physiotherapy 50: 77–83.)**

The report of our study (Hayes et al 2004) acknowledges many of the concerns raised by Mr Higgins. As discussed in the original report, missing data and dropouts (particularly at 24 weeks post rotator cuff repair) reduced the power of the study to detect statistically significant differences between the treatment groups in the longer term. However, 53 subjects were available for re-assessment in both the short (6 weeks) and medium (12 weeks) term, representing an acceptable dropout rate of 9%. In addition, the authors acknowledge that the use of a more sensitive measure of muscle force would have increased the likelihood of detecting statistically significant between-group differences in this outcome. Having already considered and acknowledged the limitations highlighted by Mr Higgins, we believe the conclusions we drew from this study are valid.

In commenting on the unequal distribution of the 10 subjects who did not comply with their allocated treatment, Mr Higgins has highlighted an important finding from this trial. Ninety percent of treatment non-compliers were initially allocated to the standardised home exercise group. All of these subjects sought additional rehabilitation assistance in the form of physiotherapy treatment. We have argued that the decision to seek out physiotherapy implies a preference for greater rehabilitation assistance from physiotherapists in some subjects following rotator cuff repair.

As Mr Higgins points out, compliance with prescribed exercises was not recorded and we are, therefore, unable to comment on any differences between the treatment groups with respect to this factor. However, exercise compliance was an issue for both groups in this study, and is therefore unlikely to be a source of bias.

Although the optimal postoperative protocol following rotator cuff repair has yet to be determined, Mr Higgins’ criticisms of the individualised physiotherapy treatment employed in this study are not supported by the description of the treatment provided in our paper, or by the limited clinical research available evaluating exercise therapy for shoulder pain. Electrotherapy modalities were not part of the treatment options available to the physiotherapists in this study. Treatment for subjects in the physiotherapy group could consist of any combination of ‘exercises, manual therapy techniques, physical modalities of ice and moist heat, and rehabilitation and home exercise advice’ (Hayes et al 2004, p. 78). In addition, recent research into the treatment of shoulder pain supports the protocol used by the physiotherapists in this study of not advocating exercises or functional activities that caused an increase in pain above resting intensity (Ginn 2001, Ginn and Cohen in press). Subjects in this study who received a pain-free exercise programme had equally favourable short term outcomes as subjects who received corticosteroid injection or a combination of passive joint mobilisation, electrophysical modalities, and range of motion exercises (Ginn 2001, Ginn and Cohen in press).

The authors support Mr. Higgins’ call for further research in this field wholeheartedly and highlight the need for the early identification, and implementation, of effective postoperative strategies for those subjects who are unlikely to rehabilitate successfully with a standardised unsupervised home exercise regime after rotator cuff repair.

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**References**

