

Rehabilitation Research Review™

Making Education Easy

Issue 21 - 2012

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Sports Medicine Research Review

With independent commentary
by Dr Chris Milne and
Dr James McGarvey.

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Welcome to this issue of RRR where we take a different approach.

I contacted a number of colleagues asking them for their *favourite paper of all time* and/or a *recent paper that specifically piqued their interest*. So this time round I am focusing on a few of their picks with more to come from others in future issues. Because the commentaries are longer than usual (combining my words and those who have contributed) there are fewer papers in this issue, but the multiple views are hopefully just as (or more) valuable as multiple papers. I hope you enjoy this selection and the thought-provoking commentary from my colleagues.

Kind regards,

Kath McPherson

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A surrealistic mega-analysis of redisorganization theories

Authors: Oxman AD et al

Summary: This paper is an entertaining argument against structural change for 'no good reason'. Its authors propose the 'establishment of ethics committees to review all future redisorganization proposals in order to put a stop to uncontrolled, unplanned experimentation inflicted on providers and users of the health services'.

Comment: Lynne Turner-Stokes (UK), who many of you will know from her visits to New Zealand and support to the NZ rehab community, responded speedily to my invitation with her favourite paper of all time. And it's a doozy! I particularly like the author's assertion that successful redisorganisation is underpinned by four summary factors:

- A minimum amount of thought has gone into a maximum amount of change*
- 'Brownian motion' has been mistaken for progress;*
- Coincidence has been mistaken for cause; and*
- Decibels have been mistaken for leadership.*

Lynne says 'I like this paper because it is a joke with a serious message and I wish there were more like it!' She, and this paper, remind me that we should be on the lookout for change for change's sake (or of course lazy stagnation) in our health and social care systems that should be challenged. One has to pick your battles of course – but challenging those things that are a distraction from enhancing rehabilitation processes and outcomes for people is surely a good one to tackle. Perhaps, at times, with humour that has a cutting edge. I recommend reading the full paper to get a grasp of how well this can be done!

1. I had to look up what Brownian motion was and according to Wikipedia (the first word on so much I don't know) it is 'the presumably random drifting of particles suspended in a fluid'. KM.

Reference: *J R Soc Med.* 2005;98(12):563-8.

<http://jrsm.rsmjournals.com/content/98/12/563.long>



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Becoming en-wheeled: the situated accomplishment of re-embodiment as a wheelchair user after spinal cord injury

Author: Papadimitriou C

Summary: This paper describes *becoming en-wheeled* as a process of “learning to use a wheelchair and making it part of one’s way of living”. The paper focuses on how wheelchair users acquire the ability to make the wheelchair a part of their embodied existence. Thus, the wheelchair becomes an integral part of the person’s habitual actions; “a situated accomplishment with social and political consequences”.

Comment: Another response to my invitation came from Barbara Gibson, from the University of Toronto. Barb is a physiotherapist who, along with a team of co-applicants including myself, was recently funded to hold a meeting to kick start a network of those interested in re-thinking rehabilitation theory and practice. I’ll update more on this initiative in a future RRR but meantime – Barb proposes two papers saying ‘I have attached two papers that I would nominate for reasons that they bring fresh theoretical perspectives to our thinking about clinical ‘problems’ in rehabilitation.’ She goes on to say about this first paper that it ‘draws from phenomenology to discuss how adjusting to wheelchair use after SCI (becoming ‘en-wheeled’) both enables and disables wheelchair users.’

My sense is the word ‘theory’ can be off-putting if you consider yourself a practical person but – if Kurt Lewin was right in 1951 (and I think he was!) ‘there is nothing more practical than a good theory’. For me – the paper emphasises the disabling (or enabling) nature of context and situation, and I particularly like Papadimitriou’s final sentence:

Thus an interesting paradox occurs: the very accomplishment of becoming en-wheeled and of achieving re-embodiment by ‘doing’ can stigmatize users since it is this very accomplishment that brings them out in public where they are seen as unable to ‘do’.

This provides a far deeper and more powerful interpretation of ‘environment’ than a literal (and apparently more frequent) translation of the ICF.

Reference: *Disabil Soc.* 2008;23(7):691-704.

<http://www.tandfonline.com/doi/abs/10.1080/09687590802469420>

Trying out the wheelchair: the mutual shaping of people and devices through adjustment

Author: Winance M

Summary: This paper seeks to clarify how action is made possible for people suffering from neuromuscular diseases. It focuses on the interactions between these people and their wheelchairs. Actor-network theory is used by the author to show how action not only results from distribution and delegation to heterogeneous entities but emerges from hard and lengthy work that makes the relation between them possible (or not) and transforms the entities involved. This work is described as a process of adjustment, involving the links making a person, his or her body, and his or her world. The work enables new possibilities of action to emerge for the person, but also new (dis)abilities; the person’s identity is transformed and shaped. This analysis leads to a particular conception of the person as made up through his or her relations to other entities (human and nonhuman).

Comment: This is the second paper Barbara Gibson suggested, saying “this paper draws from Actor-Network Theory to radically reconceptualise the relationship between disabled persons, their assistive devices and their carers. Both papers (i.e., this and the one by Papadimitriou) provide exciting new insights by re-thinking the dominant understandings of disability that pervade rehabilitation practice and policy.”

Some ‘sociological’ research can feel a step too far for clinicians. And – I admit to reading this paper a couple of times to ‘get it’. I found it relatively hard going but worth it. For me a key contribution of this work is captured in Winance’s comment that:

“To act” implies hard work from a patient, those surrounding him or her, and the aid itself. And this work transforms them.

The author provides data to support this interpretation and also describes different methodological approaches that helped draw out her observations. I think I am going to read the paper again.... As Barb suggests – these observations have some clear challenges for how we work with disabled people, their whānau/family and the aids and appliances they use and I want to make sure I get it.

Reference: *Sci Technol Human Values.* 2006;31(1):52-72.

<http://sth.sagepub.com/content/31/1/52.short>



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Patient inclusion in goal setting during early inpatient rehabilitation after acquired brain injury

Authors: Dalton C et al

Summary: This study investigated the effects of patient participation in multidisciplinary goal setting during early inpatient rehabilitation after acquired brain injury in a regional neurological rehabilitation unit in the UK. Goal setting data and outcomes were compared before and after the rehabilitation unit made changes to the way in which it set goals for/with patients. Early data referred to the period in which rehabilitation goals were set for the patient by therapy and nursing staff without the patient present and then later agreed upon with the patient during a goal setting meeting. Subsequently, a new goal setting approach was introduced, which included a goal setting meeting with the patient and when relevant the family, and the formulation of goals using a predetermined list of domains in which goals could be formulated. This list was derived using the Roper–Logan–Tierney model of nursing care based on activities of living, items from the Barthel Index and Functional Independence Measure, and additional domains such as pain, pressure and wound care, discharge planning and spirituality. The findings showed that more goals were set after the introduction of the new approach and more goals were set in relation to sleep, continence and leisure. The proportion of goals achieved remained similar (60% pre- and 63% postintervention).

Comment: Thanks to Paula Kersten at AUT for this paper (and a second later in this issue) who says 'This study was interesting in showing that giving a predetermined list of domains results in more, and different, goals set than when a team sets goals for a patient. Also, it demonstrates that this approach results in goals that are relevant and appropriate (as judged by the researchers). However, the study has several limitations. First, the researchers reviewed clinical notes retrospectively. Thus, there was no randomisation of patients to different interventions, introducing significant bias to the study design. Second, therapists and nursing staff were aware that the process had changed and this may have influenced the way in which they carried out the goal setting process and recorded outcomes. Third, whilst the new process of goal setting involved the patient and family more than previously, the goals were developed using a predetermined list, as opposed to allowing patients to set their own goals. And fourth, there was no attempt at ascertaining patients' or families' views and whether this approach is more patient-centred or not remains an assumption that needs further exploration.'

In addition to Paula's observations, my own view would be that whilst a 'typology' or menu of potential goals holds some appeal (for say establishing standardised goal attainment scale descriptions), it brings with it the risk that we might miss goals that are really important to people (but not on the list). It seems to come down to just why we use goals. Does the number of goals indicate the quality of goal setting? Is goal attainment the best outcome that can occur? Or is goal setting something much bigger. NZ is actually at the forefront of research about goals in rehabilitation with both our own team and colleagues at Otago like William Levack investigating the outcomes that are possible, and how best to achieve these with patients and clients. In fact, Richard Siegert (soon to return to NZ) and Will Levack are editing a book on goals that should be published later in the year so – as seems to have been perennially the situation with goals – it's a watch this space scenario....

Reference: *Clin Rehabil.* 2012;26(2):165-73.

<http://cre.sagepub.com/content/26/2/165>

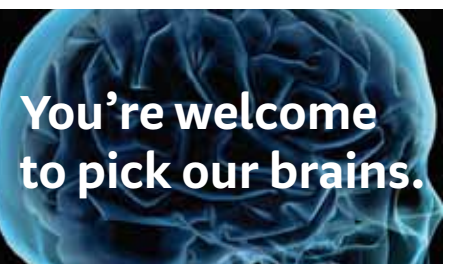
Disclaimer: This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

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Strategies for assessment and outcome measurement in Physical and Rehabilitation Medicine: An educational review

Authors: Küçükdeveci AA et al

Summary: The aim of this educational review, which is based upon expert opinion, is to describe to clinicians training in Physical and Rehabilitation Medicine and research students training to work in the field, the appropriate attributes and standards required for assessment and outcome measurement. The review discusses decision-making surrounding what is to be assessed, why the assessment is to be made, the setting in which the assessment will be used, and recommendations or guidelines for what should be measured and how. It goes on to consider the selection of assessment tools, with examples from two diagnostic groups: stroke and rheumatoid arthritis. Finally, the basic psychometric standards required for any assessment tool, and additional requirements for outcome assessment, are explained.

Comment: Paula says If the topic of outcome measurement puts you off because it seemingly ignores broader aspects of patient assessment or simply because the statistics associated with measurement are a little daunting, I recommend this paper to you. The paper is written by a group of international experts in outcome measurement and is an excellent educational overview for therapists. It sets out clearly why measuring outcome in rehabilitation is important, frameworks that can be used to decide what to measure, the difference between assessment and measurement of outcome, and finally how to judge the quality and appropriateness of an outcome measure for practice. Without going into statistics, this paper should support the practising rehabilitation professional in deciding why, what and how to evaluate their practice or service. Given that outcome measurement is increasingly being mandated or encouraged in our field it should support those that want to drive this more from the grass root levels.

Kath says With the advance of Evidence-Based Practice, the value placed on 'expert opinion' took a dramatic (and in many ways a well-deserved) dive. Whilst I adhere to the notion of questioning experts (and the importance of evidence or I'll be out of a job after all), the complexity of understanding and interpreting evidence via meta-analysis, metasynthesis and various other 'metas' and complex analysis, means at times it is a relief to read a viewpoint, don't you think! I sometimes wonder if the shift towards doubting expert opinion has led to a lack of transparency about just where the evidence ends and interpretation begins, so more papers like this please as long as there is a) transparency in the writing and b) continued good reason to trust the writers.

Reference: *J Rehabil Med.* 2011;43(8):661-72.

<http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0844>

Independent commentary by



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(Laura Fergusson Chair) at the Health and Rehabilitation Research

Centre, AUT University in Auckland. Kath has been at AUT since 2004 and has been building a research, teaching and consultancy programme focused on improving interventions and outcomes for people experiencing disability. For full bio [CLICK HERE](#).

Paula Kersten is a physiotherapist and Associate Professor of Rehabilitation at AUT who moved to NZ from the UK in 2011. Her main research interests are in improving outcome measurement.

Barbara Gibson is a physiotherapist and Assistant Professor at the University of Toronto. Her research focuses on: social and ethical dimensions of disability and rehabilitation with children, youth and young adults; critical approaches to qualitative research; critical disability ethics.

Lynne Turner-Stokes is a physician at Northwick Park Hospital in London and Professor of Rehabilitation at King's College London. Her research includes much on the FIM, FIM+FAM and the suite of Northwick Park measures as well as Goal Attainment Scaling. She is a frequent visitor to NZ in her role as an Adjunct Professor at AUT.

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