



Attitude Towards the Use of Mechanical Diagnosis and Therapy and Reliability of Classification Extremity Problems by Credentialed Therapists

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Abstract

Objective: The purpose of this study was to investigate attitudes towards Mechanical Diagnosis and Therapy (MDT) for extremity problems and inter-examiner reliability of classifying extremity problems into MDT subgroups by credentialed practitioners in MDT (Cred.MDT) in Japan.

Methods: A cross-sectional survey was used and all 120 Cred.MDT practitioners registered in the McKenzie Institute International Japan branch were asked about their attitude towards MDT for extremity problems and were asked to select the most appropriate MDT subgroup for each of the 25 extremity patient vignettes. Model classifications were used to investigate accuracy of classification. Percent agreement and Kappa analyses were examined.

Results: Sixty practitioners (50%) participated in this study. For the management of patients with extremity problems, the majority did not use MDT most of the time (53%) due to a lack of confidence in using MDT in the extremities (78%). The overall accuracy for their MDT classification for extremity problems was 87% (Fleiss's $\kappa = 0.78$).

Conclusions: The majority of the Cred.MDT practitioners in Japan did not use MDT frequently and were not confident to use MDT with extremity patients. However, accuracy and inter-examiner agreement of their MDT classification from the information on the assessment sheet was good.

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Introduction

Mechanical Diagnosis and Therapy (MDT) (ie, McKenzie approach)^{1–3} is a conservative treatment for musculoskeletal disorders including extremity

Table 1 Features of Diploma in Mechanical Diagnosis and Therapy (MDT) and Credential in MDT

	Requirement	Qualification
Credential in MDT	Completion of classroom training, including: • Part A (lumbar spine): 28 hours • Part B (cervical and thoracic Spine): 28 hours • Part C (advanced lumbar spine and lower extremities): 28 hours • Part C (advanced cervical and thoracic spine and upper extremities): 28 hours	Minimum required level of clinical competency
Diploma in MDT	Passing of Credentialing examination (written tests and procedure tests): 1 day Attainment of Credential in MDT Completion of Diploma programs, including: • 300 hours of E-learning about the principles related to MDT within musculoskeletal management, features of MDT in comparison to other manual therapy approaches, potential tissue responses associated with MDT, evidence-based clinical reasoning, and contraindications, precautions and limitations of the use of MDT • 360 hours of man-to-man training (supervised patient treatments of various musculoskeletal disorders)	Maximum required level of clinical competency
	Passing of Diploma examination: 1 day	

problems^{4–7} using classifications into subgroups through a systematic physical assessment. Formal and standardized training has been conducted in 32 countries throughout the world, including Japan. Therapists' education level is categorized into two levels; (1) MDT Credentialed therapists (Cred.MDT), which is supposed to confer a minimal level of knowledge and skills in using MDT; and (2) MDT Diploma therapists (Dip.MDT), which is the highest certification of MDT. While Cred.MDT practitioners could credential in the method having only studied the spinal components until 2013, Dip.MDT practitioners have more intensive training than Cred.MDT practitioners for various musculoskeletal disorders including extremity problems (Table 1).

In MDT, extremity problems are categorized into one of six subgroups: (1) Derangement, (2) Articular Dysfunction, (3) Contractile Dysfunction, (4) Posture, (5) Spinal, and (6) Other. Features of the four subgroups except the 'Spinal' and 'Other' are detailed in elsewhere.⁸ 'Spinal' means that the extremity problem is associated with spine. 'Other' means that the problem does not fit in any of the five subgroups and MDT may not be appropriate as an effective management for the complaint (e.g. trauma). It is important to identify an accurate subgroup corresponding to patient's symptomatic and mechanical presentation since management strategy is different in each subgroup.

In a previous study,⁸ inter-examiner agreement for the MDT classification corresponding to 25 extremity patient vignettes were investigated in Dip.MDT therapists. The study showed that 96% of the Dip.MDT practitioners used MDT for extremity patients all the time or most of the time. In addition, the overall agreement of corresponding classification was good (Fleiss's κ 0.83).⁹ However, the majority of practitioners using MDT clinical practice do not hold the Dip.MDT. Therefore the attitude towards MDT for extremity problems and inter-examiner classification reliability in the previous study⁸ may not be generalized to the majority of practitioners with Cred.MDT clinical practice. Thus, it was warranted to investigate the attitude towards MDT for extremity problems and inter-examiner classification reliability using the same patient vignettes in Cred.MDT practitioners.

The purpose of this study was to investigate Cred.MDT practitioners' attitude towards MDT for extremity problems and their classification inter-examiner reliability into MDT subgroups for patients with extremity problems from information on the MDT assessment sheet.

Methods

A national questionnaire survey with vignettes representing actual patients and established answers⁸

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