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## Usual care: the big but unmanaged problem of rehabilitation evidence

We congratulate Helen Rodgers and colleagues<sup>1</sup> for their high-quality study, and Julie Bernhardt and Jan Mehrholz<sup>2</sup> for their enlightening Comment. However, the problem of usual care in rehabilitation medicine should not be overlooked.<sup>3</sup> In rehabilitation, usual care is far from usual for many reasons, such as multiple treatments, different order of therapies, and personal behaviours that affect these factors.<sup>3,4</sup> Patients receiving usual care can be a comparison group for other interventions; however, they are most frequently used as a baseline intervention to which new technologies, such as robotics, are added. Usual care differs within and between studies. This variability affects the studied treatment with an effect (reduction or increase) that could be simply additive but also multiplicative, because of the

complex interactions in multiple interventions.

Rodgers and colleagues<sup>1</sup> discuss usual care in their study, but do not report on how different care methods were distributed in the experimental groups, their treatment effects, or the strategies adopted to tackle this confounder. Bernhardt and Mehrholz<sup>2</sup> correctly discuss the unknown aspects of robotics (mostly dose-related) that are also true for usual care, where multiple treatments multiply these uncertainties. We studied the role of usual care in stroke rehabilitation and found a big heterogeneity of programmes and terminology.<sup>3</sup> The usual care factor not only has a part in the generation of rehabilitation evidence and systematic reviews, but also in clinical replicability, as it impairs the accurate description of details needed to apply the intervention in clinical practice.<sup>4</sup> Academic researchers in the rehabilitation field seldom face this issue, and current reporting guidelines do not help.<sup>4</sup> For this and other reasons (such as complete description of, and interactions in, all components of complex rehabilitation interventions, including setting and provider competencies), Cochrane Rehabilitation is developing a new checklist to improve evidence reporting, and its generation.<sup>5</sup>

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## Authors' reply

The robot assisted training for the upper limb after stroke (RATULS) trial<sup>1</sup> randomly assigned participants to receive either robot assisted training with usual care, an enhanced upper limb therapy programme with usual care, or just usual care. This Article reports clinical and health economic outcomes and discusses some information about the administered interventions. Stefano Negrini and colleagues rightly point out that we did not include data on usual care. It is our intention to provide these data and further information on the RATULS trial in subsequent publications.

We agree with Negrini and colleagues that a scarcity of adequate data about the usual care which participants received is an important unsolved problem in rehabilitation trials that needs to be urgently addressed. Reporting the planned and actual treatment received by all randomisation groups is a key component of a trial, as it enables readers to understand and appraise the study and replicate it in future research or clinical practice.<sup>2</sup> Although various templates for planning and reporting usual care in trials are available,<sup>3,5</sup> a Cochrane checklist, as suggested by Negrini and colleagues, would be very welcome and could be an important step in improving the reporting of the content of usual care.

However, a checklist is unlikely to fully address the problem of complete and accurate data about the usual care received by trial participants. Other issues that impede obtaining accurate



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