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To the Editor:

We appreciate having an opportunity to respond to Ms. O'Callaghan's response to our article, for it is only with such dialogue that the field can advance.

Ms. O'Callaghan concluded from our review that the work "does not reflect current practice or discuss the literature that clearly supports CPP interventions." Ms. O'Callaghan's conclusion was dead on; we were delighted that the message of the article and its focus was clear. However, as we read further, it became apparent that Ms. O'Callaghan viewed these attributes as liabilities rather than as the strength and significance of the contribution of this work to the advancement of the field.

First, the primary reason for the publication of the work and the urgency in having it published was indeed the fact that there is considerable discordance between the literature and cardiopulmonary physical therapy practice. The considerable demands placed on all health professions today to be accountable and cost effective must provide the stimulus for evaluating what it is that we do. It behooves those of us in the field to reconcile this very serious clinical dilemma and to avoid the danger of dismissing evidence that is contrary to conventional wisdom as bias or a narrow view. Without an unbiased mind and openness and willingness to examine contrary evidence, particularly if it contravenes our own belief system, a field is doomed and can never advance. An opposing view that is based on the literature does not de facto constitute bias or a narrow view. We would argue that selective attention to the literature, or lack thereof, has permeated the practice of conventional chest physical therapy over several decades and that such a practice constitutes bias and a narrow view. For a field to grow, it is essential that one not only "look where the light shines" and selectively attend to literature that supports one's point of view. For a review to advance the field, it must critically evaluate the literature in a balanced manner, synthesize this literature, identify discrepancies, and attempt to explain them on a physiologic and scientific basis. This was our objective.

Second, the virtues of classic chest physical therapy have been extolled for several decades, often indiscriminately, which has contributed to the difficulty of evaluating them in an unbiased fashion. This influence within and outside the profession has been detrimental to the critical evaluation of the application of classic chest physical therapy. Further, many practitioners often have difficulty appreciating that a patient is being appropriately treated unless the clapping sounds of a tried-and-true conventional chest physical therapy emanate from behind the curtain. Such an attitude continues to be a considerable obstacle to scientific advancement and progression of the field.

We sincerely hope that with open minds, a willingness to engage in dialogue about opposing views based on their scientific merit, and receptiveness to examination of the evidence in an impartial manner, cardiopulmonary physical therapy will ascend to its rightful place as a clinical specialty in the physical therapy profession based on its established efficacy and cost effectiveness.