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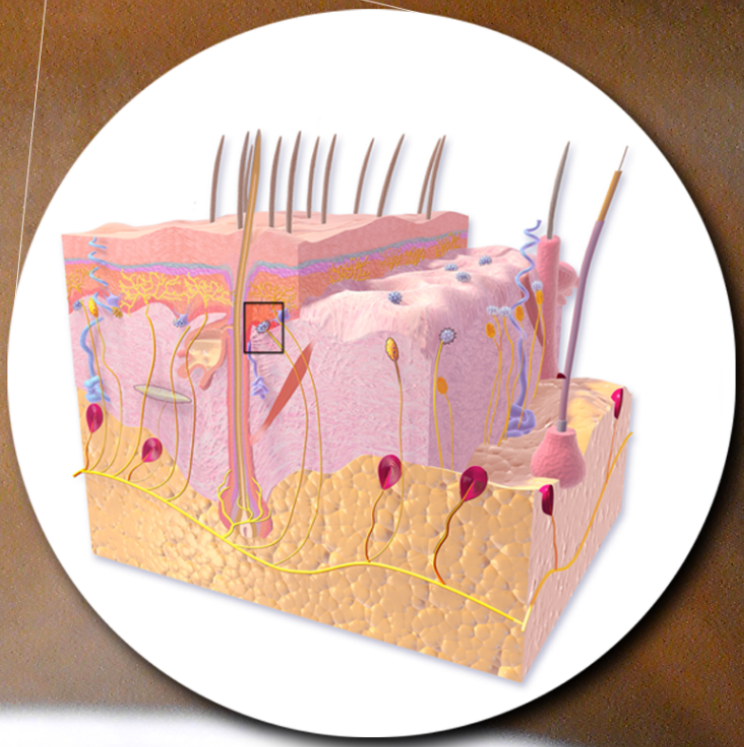

Photo: Walt Fritz. Illustration: Nick Ng

OPINION

Finding My Voice

A Patient-Centered Perspective

By Walt Fritz, PT

As manual therapists, we have opportunities to learn and grow with masters of our respective professions. I feel fortunate to have studied with some of the pioneers of various manual therapies, as well as from those whom they had taught. I originally learned myofascial release from John Barnes, studied craniosacral therapy from students of John Upledger, learned some "breakthrough" manual therapy narratives that are based on neurobiology from Diane Jacobs, and very recently trained directly from one of the pioneers of laryngeal manipulative therapy, Jacob Lieberman. There are colleagues on social media who have influenced me in ways that I cannot measure and that they will never be aware of. There were many other teachers along my path whom I took something and applied it to what I use and teach today. Each person who educates us, whether it is manual therapy or other work, inserts their unique spin, making it their own. Some invent or discover, others adapt and adopt what came before. Everyone in my past and present contributed to who I am today.

Most taught specific modalities or approaches, though a few taught me more general aspects of pain and therapeutic impact. Though some in the manual therapy field feel that the particular modality used matters little if one has a sound understanding of pain and dysfunction and how we go about influencing these issues. For most, individual modalities continue to be the most common path they choose.

As a physical therapist of 34 years—with 27 of those years spent primarily in the manual therapy field—I've observed a model that seems most common. My explanations and comments below may be such that many therapists may disagree, but I'm not intending to offend; I wish only to present how much of our education occurred and how it manifests in practice. After stating these views on the current state of manual therapy and considering a missing element, I wish to propose a different model.

While advanced certification programs in manual therapy do exist under the umbrella of universities, colleges, or schools, most therapists obtain advanced training through continuing education (CE). It is so important that most licensed health professionals are required to partake in a set number of CE hours per year as a basic way to ensure that they stay current with new information and research relevant to their respective field. One of the more common models of CE is a tiered model of training, where the therapist begins at a basic, introductory level of instruction and, if interest develops, to pursue additional coursework. There are some excellent opportunities for growth and learning available to us, and these CE classes are what provide many us our ability to better connect with our patients and help with their issues. With most CE companies offering multiple levels of training, therapists can see a predetermined track that they'd need to follow to achieve a higher level of skill and understanding of that modality or intervention. This is all pretty straightforward so far, and few would offer a dissenting opinion.

For a moment, could you imagine being an observer in a huge room: one filled with therapists, each with a patient on their table. You sit on a chair quite far from each table. You can see what other's are doing, but with little detail. As that observer, you have no prior experience with any of the skills and actions being demonstrated; you were just plunked down and told to observe and report what was taking place quietly. Unbeknownst to you, every patient has pretty much the same issue, which for the sake of discussion, we will call it neck pain. Also, unbeknownst to you, every therapist was trained from a different CE model. Included in the group are therapists trained in the many versions of MFR, CST, trigger point, neuromuscular therapy, and a host of other named and branded modalities. There would be dozens of MFR-trained therapists, for instance, but each would have been trained through a different model or CE company. As each of those modality styles have often dozens of presentations, each from a different educator or company, the group you are observing could number in the hundreds.

Let's assume that all of the work is done with no lubricant. Can you picture this so far? A room filled with hundreds of treatment tables, hundreds of therapists using different modalities and sub-modalities, and hundreds of patients with nearly identical neck issues. If you were sitting at that distance far enough out of earshot, and just sat and observed, what might you see? Would see patterns emerging, wherein each therapeutic encounter was seen as unique? Or might there be a general blurring of one into another?

One of your tasks was to determine if there was similar work taking place on each treatment table. Without specific knowledge of the intricacies of each modality, would you, as the untrained observer, be able to distinguish one from another? Not that you could name each modality, which of course you couldn't, but do you think that you would be able to write down the unique aspect of each and every work, stating how it differed from the next? I guess that you would have quite a difficult time with this task and would find more that was similar than that was different.

Now imagine that you begin to move closer and hear the conversation occurring between therapist and patient. Now is when you may be able to form opinions on differentiating factors, as the language (or silence) that the therapist begins to reveal differences. But step away again. The noise lessens and each of the works blends back into a more uniform "thing" that the therapists are doing. The story from each modality is the primary differentiating factor versus the actions of the therapists' hands. To some degree, differences exist between methods of application, but can holding a static engagement (MFR-style) with the patient's tissues (fascia or otherwise) be accomplishing something so different that the more focal pressures of a trigger point therapist? When one observes cervical traction performed by a therapist trained in CST does it look so dramatically different that one trained in MFR or neuromuscular therapy? I believe there is only one answer to these questions: no, they don't. But the stories told along with each intervention varies so widely that one wonders if therapists were trained in parallel universes. Can the body be so different? Can the person on our table indeed have chosen us precisely because it is their fascia, craniosacral rhythm, trigger points, pooled lymph, knotted muscles, etc. were the actual problem, or are there more universal issues at play? Might we actually be working on a much smaller subset of problems that we were led to believe? Might the story of our modality be less than entirely accurate?

I get my fair share of negative press for speaking in such terms, as most take this as insulting a modality, the originator of it, or the therapist who use it. I get accused of not understanding enough about the latest evidence that has finally begun to show that the modality's originator has been right all along. I see most of this talk as rubbish, told from the closed society of that modality. But what gives? The story each modality teaches and tells is entirely different from the next, with nearly all telling a tale of causative factors, both environmental and tissue-specific, a highly unique evaluative process, and claims to be able to singularly and selectively target their target tissue or pathology to the exclusion of all else. MFR training, in general, teach how fascia becomes restricted and cannot be seen by any diagnostic testing or imaging. Only highly trained therapists (i.e., ones who have taken lots of CE classes) can detect these restrictions and release them from their patients. Sift through some websites of various models of MFR, and you will read unique phrasing coming from each of those sub-modalities, with regards to how fascia gets tight and even more different versions

Speech therapists and physical therapists practices on each other at Walt Fritz's class in Los Angeles, California. August 2017. Photos: Nick Ng

Might there be a universal paradigm at play for all manual therapy techniques?

on how best to deal with that tightness. MFR encompasses many different styles of intervention, from very light work to work that is really quite aggressive. Holds or strokes can be short and brief or slow and sustained. The various CE lines teach MFR in a wide range of styles, but each claim to be MFR. Even odder is that each tends to rely on nearly identical historical fascial anatomy and physiology, with little regard for outside validation of how the effects of a hands-on intervention are said to affect the fascia. Despite what is claimed, there is little actual research (that is accepted by outside/neutral sources) to show that:

1. fascial restrictions, as defined by the MFR communities, exist;

2. we can actually release said unknown restrictions, but MFR folks cry the equivalent of "Fake news!" They state that their patients get better, and that is all the evidence MFR needs. Even I used to make these identical claims.

While it may seem like I am picking on MFR, similar problems exist in nearly every modality. There appears to be effectiveness, but is it due to the reasons stated? Might the effects be less about the tissue or pathology, about the thing we think we are doing to that tissue, and be more about the therapeutic relationship that is established? Might this matter more than the actual perception of tissue effects?

We have the opportunity to spend more uninterrupted time with patients than most in the health professions. Much of that time might be seen to be spent dealing with reducing the offending tissue or pathology, but one cannot deny that one of the most fundamental aspects of our interactions is based on a therapeutic partnership. We are spending time listening to someone with a problem, offering empathy and hope for change. We commit ourselves to help our patients, offering up our unique perspectives and skills. The buy-in is there, started by the patient reading about us online or receiving a referral from a trusted source and booking an initial session. The buy-in is bolstered by our claims of our belief that we can help them and our repeated patience, following them through the process feeds that perception of benefit. That is some pretty strong mojo. If we are ambivalent, stating that we don't know if we can help, the chance of a positive outcome probably drops. These sound like relevant aspects of the therapeutic relationship, and many believe these relationships have a more significant impact that the thing we think we are doing to their tissues. If it sounds like I am dismissing your professional skill, trust me I'm not, though the true talent may not be in what we think we are doing.

When I began searching for my voice in the field of education, I struggled a bit, not because I was uncertain of my ability to translate hands-on skills to others, but more in how to present it. MFR had served me well as a clinician in private practice, but the more I learned about the wide-ranging explanatory narratives used to explain manual therapy the more I doubted my ability to teach MFR from the perspective of the historical explanations traditionally used. I wandered a bit and began to educate by explaining the effects of our work from layers of plausible sciences vs. one story. Things started to gel, but it wasn't until I sat back and acted as that neutral observer of my own sessions, much like the observer from above, that I saw what it was that my patients seemed to benefit from. I was using my voice to question them about things that they were seldom asked. I used the word "seemed" because I wasn't sure.

The need for a voice.

Are you familiar with "patient preferences and perspectives?" If you are among the professionals who are expected to work under the concepts of evidence-based practice (EBP) model, they should, as they constitute one-third of that model. If you are unfamiliar with them, there are many places to learn more, starting with your own professional organization. The typical EBP model is diagrammed by either an equilateral triangle or three overlapping circles, each equal in size. The three equal "parts" are:

1. The actual published evidence;
2. the clinician's experience in applying work derived from the evidence;
3. The patient's perspectives and preferences.

Three equally weighted parts, though few actually implement it in that way.

Reading through professional forums across the spectrum of health professions, one might see a movement to change those equal weightings. Many are pushing to require that the actual published evidence, which take a much more significant role than the other two, with patient perspectives and preferences often being relegated to a very distant last place in weighting. However, no changes have taken place from the professional organizations that I monitor. Evidence matters, and it should be what drives our interventions, but there will always be arguments within fields. My physical therapy field regularly fights about which reigns superior, manual therapy models of strengthening models. I receive blog posts from a well-known physical therapist who rallies for a near abolishment of manual therapy from the profession, bolstering his claims by posting evidence to support such views. But put up for comparison the legions of physical therapists who put their patients on standardized exercise programs under the guise that their pain is due to their weakness. Both have evidence to support their work and some significant limitations. Patients are helped by one, the other, or both.

In many manual therapy circles, the therapist's experience in applying work derived from the evidence historically takes on the most substantial role. Look at our training; the more workshops you've taken, the more you are considered the "expert." You certainly do get better at your craft with additional training, but I often wonder whether the hands-on skills and all related to them, are what improves, or you just are better able to repeat the narrative; the story of that modality. Having experience and training is crucial, but (here is the tough part, so brace yourself) with that elevated status bring ego-expression. Therapists tend to override what patients think about their problem and even dismiss what other health professionals have stated. If the person has seen another practitioner in the past who did not help them, false assumptions are made that that person just couldn't find the problem or didn't know enough about the condition. They sought us out as we sold them on a new and different story.

Therapists tend to feel that they know what is wrong with the patient and often need to spend time "educating" the patient on the problem. I put quotation makers around that word, as the education tends toward the biases of their chosen modality and is seldom information widely accepted across the spectrum of professions. With this therapist-led model, patient perspectives and preferences are typically relegated to a lesser role. Many patients even give up their power from the initial therapeutic encounter, in the hope that we will find the answers that others have missed. This abdication of power creates a potentially dangerous disparity, one that at least minimizes the patients' voice. At most, serious consequences occur.

What's missing? The patient's voice.

Requesting the patient to accept the responsibility to be a fully active participant in their care is a growing trend in medicine as a whole, but seems to be largely ignored by many in the manual therapy-related professions. Sure, most ask their patient how the pressure feels, but are you creating a therapeutic scenario where you put the perspectives and preferences of your patients at a level at least equal with your own, if not greater? Few do, in my opinion, as I believe most manual therapy (and other) training puts the knowledge of the practitioner above the patients' perspective.

I'm not sure when it started, but there came the point where I began asking my patients what they were feeling and allowed it to influence the session. Not just "what" they were feeling, but if that feeling was "familiar." Was the feeling we were creating replicating a familiar aspect of why they came to see me? Did my intervention at that moment in time feel relevant? As I worked this new line of inquiry, I added more questions to the process. If the feeling that I am creating with my pressure, stretch, conversation with your nervous system and perceptual awareness is replicating a familiar aspect of your problem, does it feel like what I'm doing might be helpful?" "Is there anything about what I am doing that feels like it might be harmful?" "Would you like me to continue with what I'm doing or continue to seek?"

Photo: Walt Fritz

The phrase, "Is that familiar?" became my trademark. My approach began to mature, but not every patient wished to play along with me. Some patients were so invested in the existing model, where they were told what was wrong with them and then be told what needed to be done, that they didn't quite know how to respond. I was turning that old model on its ear. Some left my care, seeking instead a practitioner who would tell them what they wanted to hear and didn't ask so many questions. However, many stayed. Recently, a patient said to me, "You are the first person throughout this long process (since the emergence of the problem) who asked me what I thought. I like it."

That sold me. I realized that by giving my patient a voice in their treatment, I had found my voice. The aforementioned process is how I teach manual therapy, or what I continue to call "myofascial release." Whether it be for physical therapists and massage therapists, or my emerging role in educating speech-language pathologists and voice professionals, my place is teaching a manual therapy approach presented from a patient-centered perspective. It was one that honors the equal weighting of the evidence-based model and respects the voice of the patient in having an active role in determining their care.

I do see the art in our work, one honed by both experience and evidence. However, I know the necessity of a therapeutic partnership between the clinician and patient that seldom exists. Moving our professions toward accepting (demanding) the need for this partnership is how I wish my voice to be remembered. •

Walt Fritz, a physical therapist who practices in Rochester, New York, educates health professionals in a patient-centered model of manual therapy care. For information, view his content at www.WaltFritz.com