



# SHARED DECISION- MAKING IN THE MANUAL THERAPIES

## HOW YOUR CLINICAL DECISIONS MIGHT IMPACT THE SUSTAINABILITY OF OUR INTERVENTIONS.

By Walt Fritz, PT

Under the broader topic of sustainability comes the concept of how to achieve and sustain outcomes in our manual therapy practices. Such concepts of sustainability have become some of my favorite topics on which to comment, as they can be seen to align with core aspects of the evidence-based model (EBP), the biopsychosocial (BPS) model, and shared decision-making (SDM) between clinician and patient. Like many health professions across the globe, the expectation of adhering to the EBP model is becoming more common for massage therapists. How might these three acronym models apply to improve the sustainability of therapeutic outcomes?

Since jumping into the manual therapy side of the physiotherapy (PT) profession in 1992, I've gone full circle. Prior to taking my first full-scale continuing education seminar in myofascial release (MFR), armed with rather limited critical-thinking skills as a relatively new graduate, I was skeptical of the claims being made in the advertisements that I read on this particular

MFR training. Though skeptical, after some arm twisting by a co-worker and as my employer fully paid the tuition, I jumped in. With the benefit of hindsight, I can see myself being immersed in an environment that discouraged critical thinking and encouraged groupthink (Janis, n.d.) and groupthink (groupthink, n.d.), and emerging from those multiple trainings having efficacy based upon knowing what others did not, which was the fascial narrative. Negatives aside, I did learn some wonderful ways to engage my patients, with interventions that seemed quite helpful. My PT career took off on a trajectory strongly influenced by this MFR training and mindset, first in a home-care setting followed by a private practice. Over time my identity became MFR, to the point where if someone came to see me for a problem, my only offering to them was those MFR interventions.

Lars Avemarie is a Swedish physiotherapist who lectures and writes about pain from a neuroscience perspective. He, like myself, believes strongly in providing intervention from a patient-centered perspective. Though our definitions differ, I see similar messages being conveyed. Lars described the evaluation process and resulting treatment choices based on a wide variety of factors. He sees an all-too-common pattern of treatment decisions being based upon the therapist's bias and expertise, rather than truly being based upon the patient's distinct needs (Avemarie, 2019). As a patient enters your room, seeking help for a problem, are your evaluation findings and intervention strategies unbiased, or are do they swing toward your treatment of choice? Does your preference for a modality colour your decision-making, or are treatment choices truly a shared

decision-making process? How does this distinction influence the sustainability of treatment results and outcomes?

The evidence-based practice model embodies three separate but linked concepts to form what is seen to be the current best-practice view on the delivery of health services. Below, the basic three components of EBP are diagrammed. While few seem to question the importance of the evidence that supports our work, the other two aspects of EBP remain a bit unclear, at least as I observe this model being both discussed on social media as well as being put into action. Categorising "clinician expertise" requires an accepted definition, which appears. Some view this expertise as a narrow tunnel; how does one apply the evidence in making treatment decisions based not on clinician's bias but from how the actual evidence guides us, while others feel that their expertise allows them to insert what they feel is most effective. Avemarie writes that our choice of intervention should not be based on our bias, but from how the evidence (should) form our decisions. Every problem should not be treated with the same tool (modality), as the evidence does not support such a practice (Avemarie, 2019). Where I see my interpretation of a patient-centered model differing from Avemarie's is that I am primarily a therapist who uses manual therapy as my primary intervention model, supplemented by recommendations for movement and exercise to assure, that functional goals are indeed met. Though within that framework, my manual therapy tends toward what I deem a "non-denominational" approach, avoiding tissue or biomechanical causation-blaming and shifting the focus onto patient-perceptions of that manual therapy intervention. It is the third aspect of the



EBP model, "Patient Values," which is the component that I feel is underserved.



*Lebert 2017*

Patient values and perspectives, as other EBP models include (ASHA, n.d.; APTA, n.d.), seem subject to even broader clinician interpretation. When I talk with other clinicians and ask how they include this component into their interventions, many will report that they comply with this mandate by checking in with their patients regarding pressures. If the patient answers that the pressure is fine, then the clinician has met the requirement that interventions be based on the values of the patient. I believe that patient preferences and values should be incorporated throughout the interview/evaluation/intervention cycle to the point where that input, coupled equally with the evidence and clinician's expertise applying that evidence, forms the basis for equal weighting of all three aspects of the EBP model.

While often misrepresented as a requirement that all interventions be based on protocols proven in published studies, current understandings allow flexibility in the interpretation of the evidence to allow a personalised experience for each patient. In a 2014 paper published in the *British Medical Journal* titled, "Evidence based medicine: a movement in crisis?" the author breaks down limitations in the current model and in conclusion writes, "contemporary healthcare's complex economic, political, technological and commercial context has tended to steer the evidence based agenda towards populations, statistics, risk, and spurious certainty. Despite lip service to shared decision making, patients can be left confused and even tyrannized when

their clinical management is inappropriately driven by algorithmic protocols, top-down directives and population targets.

Such problems have led some to argue for the rejection of evidence based medicine as a failed model. Instead we argue for a return to the movement's founding principles—to individualise evidence and share decisions through meaningful conversations in the context of a humanistic and professional clinician-patient relationship. To deliver this agenda, evidence based medicine's many stakeholders—patients, clinicians, educators, producers and publishers of evidence, policy makers, research funders, and researchers from a range of academic disciplines—must work together" (Greenhalgh, 2014).

Greenhalgh (2014) speaks earlier in the paper about relationship care: "Real evidence based medicine builds (ideally) on a strong interpersonal relationship between patient and clinician. It values continuity of care and empathetic listening".

Learning at all levels of healthcare typically follow the lines of a hierarchical model of learning, both from the perspective of the clinician/professional as well as the patient/client. In both the medical as well as the pedagogy models, education and experience build skills and reputation. Many brands of manual therapy, be it massage, or other modalities or strategies utilized by MTs, physios, and others, tends toward learning styles that guide the clinician into an environment cushioned from the outside world and into a rabbit hole occupied solely by those who work from the same perspective. Groupthink and groupspeak are common, and as the therapist takes additional training, their view that they have a deeper understanding of pain and movement-related problems increases.

While this learning curve is a natural one, the effects of learning in a closed environment, removed from the dissonance that critical thinking can insert onto the learned concepts, can blind one to the views of others. This blinding often includes the patient. As pain and movement-related experts, people come to see us for our expertise, with hopes that we can help them when, possibly, others have not. As such, they often allow themselves to assume

a passive role, deferring to our greater knowledge. However, given the breakdown of EBP model with regards to evidence, clinicians' expertise applying that evidence and patient preferences and values, have we, as the professional, taken on too much of the decision-making process? Have we shifted the power away from the patient and toward ourselves?

Lederman (2015) contrasts this traditional model in use in physical and manual therapies with what he terms a "process approach." Moving from the traditional therapist-as-controller model, a process approach model shifts the power over to the patient to be an active participant in their own recovery. The establishment of shared goals and values is necessary for sustainable progress and growth.

Jacobs and Silvernail (Jacobs, 2011) addressed this concern over power disparity in their 2011 paper, "Therapist as operator or interactor? Moving beyond the technique". While not referencing the EBP model, their observations completely mirror my concerns, even coming up with similar suggestions for balancing out the inequities typically seen in the EBP model. Jacobs and Silvernail point to the traditional model of manual therapy, where the therapist acts as the operator, overseeing all aspects of the intervention. They put forth an alternative model, one that aligns the therapist and patient as equals or partners in the therapeutic relationship, recommending that the "the context of the treatment including the technique, the provider, the participant, the environment, and the interaction between these factors may contribute to patient outcomes." Their views are stated to align with the current and emerging "explanatory model of the multifactorial, biopsychosocial pain experience."

To further cement the need for the clinician to be a partner, not a dictator, a study was recently published in the United Kingdom looking at peoples with fibromyalgia and their perspectives on physiotherapy services. Compliance with "a mutually agreed, individualized plan of care" was found to be higher if the therapist displayed a greater awareness of and empathy toward the emotional impact of the nature of the diagnosis (Furness, 2020).



What I am proposing is to give value to what might be interpreted as the true spirit of the EBP model, reducing, though not eliminating the ego-input from the clinician. The clinician does have meaningful input, and that input is expected in most patient/client interactions. In fact, it is expected by many to be the driving force behind interventions of sessions. My suggestion would be to try to balance this expectation with demands for contribution by the patient/client. Work toward a partnership, an interactive experience. Due to pre-existing expectations as well as social/cultural differences, many patients/clients may seem incapable of assuming a partnership-type of relationship (Bialosky, 2010). However, this partnership is a goal worth meeting.

SDM follows along with these topics (Coronado, 2017). In this 2017 paper, the authors speak to emerging models of manual therapy as one of embracing BPS perspectives. Included in their concepts is shared decision-making between clinician and patient. "The traditional clinical decision-making process is one in which the provider is authoritative, while the patient is expected to agree and adhere to the prescribed intervention. SDM describes an interactive process in which the patient and provider work together to

determine mutually acceptable treatment approaches" (Coronado, 2017). While one of the references in this paper (Tousignant-Laflamme, 2017) cites that regarding musculoskeletal conditions, the "true effect of this concept (SDM) has yet to be studied, despite the reality that SDM has been advocated for many years. We recognize the potential benefits of SDM in a patient-centered care approach, as it explicitly gives a voice to individuals and renders them more control towards the health care they choose to receive." They speak at-length to how SDM has been successfully included in many other aspects of healthcare, with positive outcomes found in a variety of studies. Though not yet fully assimilated into the manual therapies, there is precedent for improved outcomes in the research (Hall, 2010) and in popular massage-related articles (Lebert, 2017). SDM has been shown to be an effective tool for improving and sustaining outcomes, though with SDM in the manual therapies having incomplete vetting, I accept the limitations in the model for its inclusion in musculoskeletal conditions as we are dealing with in our practices.

Allowing an equal weighting of the three components of EBP and inclusion of SDM described above is, to me, an embodiment in a BPS approach, but we must go further in understanding the person who comes to

us for help. Collecting history is standard practice, but that history must be viewed as only the beginning. Much will be stated, both before the first visit on written history forms, as well as during the initial interview/session, but other information may be released over time. Other information may be chosen not to share or may not be accessible by the patient. Cultural, social, and religious customs, sexual role expectations, language barriers, and other factors should be considered when interviewing, evaluating, setting goals, treating, and prescribing homework. Each patient should be viewed as the "N of 1" (Lillie, 2011), in that every patient encounter should be viewed as an individual with regards to determining a treatment plan solely appropriate for that person. While it is impossible to forget our past experiences and while still reaching for an evidence-based perspective on the conditions presented, efforts should be made to assure that past biases do not cloud objectivity in the present moment. The BPS model "does not recommend any particular approach but provides a framework for understanding and facilitating behavioral change" (Behlau, 2019).

With this theoretical background, how might you begin to be able to promote sustainable outcomes in your practice?

1. Begin by assessing your interview style. Do you allow sufficient time for your patient to tell their story? If your practice is set up to charge for "time on the table" only, is there a rush to conclude the interview? If so, how might you modify your situation to allow the patient to more-fully express their history and concerns?
2. Use open-ended questioning to find out why your patient is seeking your services. Pain is a common reason for referral, but I like to ask, "what is it that pain keeps you from doing or enjoying?"
3. Set goals that have meaning to the patient, which makes finding interventions and possible home carry-over to be more sustainable than interventions and homework prescribed based solely on your judgment and bias. If there is no "buy-in," you stand less of a chance of being impactful in a lasting way.
4. During the interview and evaluation, do you tend to steer your patients into your bias?

While patients will frequently defer to our knowledge and experience, encourage equality in decision-making. When presented with a patient telling me, "you know more about

this stuff than I do," I will turn it around and say, "Yes, I know a lot, but I don't know what you are feeling, hoping for, and fearing." This type of statement will open up a dialogue that may allow them to contribute more.

5. When asking questions, patients will often say, "how do I say this to make it make sense?" This may come from past experiences where they were made to feel foolish or ill-informed. I will ask them not to "make it make sense," but to say what they are thinking or feeling, unfiltered. It is up to us, after a conversation, to make it make sense.
6. When responding to questions regarding physiological causation of the problem or what it is that you feel when you palpate/treat, try to understand that your responses are strongly dictated by your training and that those beliefs may not align with current evidence. For instance, if you were trained in a trigger point model, your explanation for why a person is having pain will tend to be explained from that trigger point perspective, as will be your response to, "what do you feel?" To add even more to this problem is that many patients come to us, repeating what someone has told them about their



problem. Let's continue along with the assumption that you work from a trigger point perspective, and your patient comes in being told they are having difficulties due to weakness. How do you move forward? Should you negate the patient's beliefs as being less-than your beliefs? Try allowing multiple correct responses. "Well, it could be a weakness, as your doctor told you, or it might be trigger points. But no matter what it is or caused the problem, can we look at how you feel right now? As I press here, what do you feel? Does my pressure feel like it replicates or reduces your symptoms? Does it feel like what I am doing right now will be helpful or harmful? I want to do something that to you, not to me, feels like it is a useful intervention." This way of responding allows uncertainty to be acknowledged for the fact that it is (Bialosky, 2009; Bialosky, 2018; Bishop, 2015), despite how we were trained.

7. Won't admitting uncertainty make me, the clinician look less knowledgeable? I see the opposite to be true. Let your patient know that you know enough about manual therapy and pain to know that there are many theories, so many so that it is impossible to know with certainty what is wrong with

them and also that the full effects of any intervention are not fully known. From the interview, goals set by the patient, which stemmed from their own values and preferences, and the results of your therapeutic interaction, can you come up with home activities (as allowed by individual practice acts) that align with their values and not your own?

8. Poor outcomes are often blamed on the patient for not following through on the recommendations of the clinician. However, the greater that the homework aligns with core patient values and perspectives, the greater the chance of having meaningful follow-through. "Research has shown that patients who are more informed and more involved in their own decision-making are more accepting of their treatment regimens and experience better health outcomes" (Bainbridge, 2006). This principle is now even being seen as a reason why patients do not always comply with medication recommendations by their physician (Lauffenburger JC, 2018). To best create sustainable outcomes, learn to craft homework recommendations that align with patient values and perspectives.

Creating a practice that promotes sustainable results may require some major changes in the way you view your role and the role of your patient. However, with time and practice, the suggestions above will become your go-to way to work.

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You can learn more at [wwwFOUNDATIONSINMFR.com](http://wwwFOUNDATIONSINMFR.com) and his accompanying blog, <http://www.waltfritzseminars.com/blog/>

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# *Sustainability*

**Ideas for sustaining your  
practice, your career, and yourself.**

BUILT TO LAST • SHARED DECISION-MAKING IN THE MANUAL THERAPIES • BUILDING SUSTAINABILITY IN PRACTICE THROUGH THERAPEUTIC ALLIANCE • PART OF YOUR SUSTAINABLE PRACTICE IS PERSEVERANCE  
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