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414 – The Evidence Base and Overwhelm

With Steven Bruce and Joanne Elphinstone

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Steven

Joanne Elphinstone has worked with all sorts of people, high level performance athletes in Olympians, with musicians, with elite golfers. She's lectured all over the world about movement science, rehab, and much more. Joanne, welcome back. It's great to have you with us again. We're going to talk about something different today, I think though, won't we?

Joanne (01:54):

Well, yeah. Well, first of all, thank you for having me back. It's

Joanne (01:56):

Always lovely to be with you, Steven, and the lovely people who watch you. Can I just say I'm so excited to hear about your previous presenter on Primitive Reflexes. I find it so useful in my own clinical practice, and I'm really excited that that's been given some airplay, so I'm going to be…

Steven (02:14):

You should take a look at the show - It was really, really good. Yeah, I'm slightly regretting having you on the show. I must admit you've just come back from bloody Australia and you're looking amazingly healthy and all the rest of it. Welcome to the gloom of wintery England.

Joanne (02:29):

I know I can barely see, I'm going to have to wield these glasses here because I can barely see in the dim light.

Steven (02:40):

So what is it we're going to talk about today? It's all about coping with evidence-based medicine and the pressures it puts on us all, isn't it?

Joanne (02:50):

Yes, it is. Actually, Steven, I wanted to take the opportunity to, I decided to call this as evidence-based practice getting you down. I was trying to work out, am I going to call it letting you down or getting you down, but I'm going with getting you down because I meet so many clinicians. Either they're coaching clients or they're coming on my courses, and I see this widespread overwhelm, overwhelm and stress and pressure, and one of the sources of it is a misunderstanding about the narratives around evidence-based practice. So I thought maybe for this lunchtime chat, it's something that we could throw around. I'm sure that you have encountered something similar in your experience.

Steven (03:37):

Well, yeah, and here at The Academy, I mean, we do more than just provide CPD. We provide whatever support people need in their businesses, and I'm regularly getting people calling up saying, what do I do about this? It's just I can't cope with either the lack of patients or the stresses of running a business or whatever it might be. Before you go on though, Joanne, I talked earlier on, I mean, you've set up an organisation called JEMS, which is all about movement science, Joanne Elphinstone Movement Science - JEMS. But this is nothing to do with movement science. What's, what are your credentials for talking to people about this and who do you normally deal with? What practitioners are you dealing with as a rule?

Joanne (04:19):

Right. Well, I've been teaching clinical practitioners, osteopaths, physios, increasingly chiropractors and sports rehabilitators as well, incorporate that in, it's been almost 30 years now, and every year around about a thousand clinicians a year. It's a lot of people. And those people often have been with me, some of them over 20 years. So I have this beautiful opportunity through the teaching and through the coaching now to really intimately find out what the little lived experience that they are having actually is. And so even in our movement arc programmes, because they're now longer, they're able to be hybrid. It gives us more time with them to actually look at, here's some new concepts and materials, go and apply them, come back. And it's so interesting that once upon a time, the conversations would've been about this technique or that technique. And actually the conversations now are far more about how they're feeling about it, the things that are coming up, the struggles that they're having, conceptually where that fits in. Many of the people I meet often find themselves feeling out of place in their workplaces. They feel they don't fit in, they feel it the way that they're thinking doesn't seem to be aligned with other people. I'm sure there's people in your audience right now going, oh yeah, that's me.

(05:53):

And some of the issues, some of these feelings they don't need to be having. And some of it will start off with this whole business of what we expect from the evidence

base, but also some of the expectations we're setting up for ourselves that are creating more stress, which are completely unnecessary.

Steven (06:12):

I've had a lot of people saying that they are, I don't know, less confident about using the techniques that they've been taught and that they know, they believe work and I'd say know work, but they're worried that if it isn't backed up by robust evidence from something, then someone will complain about them, hold them to account, strike them off the register, whatever it might be. I think particularly when it comes to spinal manipulations, it's very easy for people to get very frightened about doing those because there's a lot of pressure on people to stop. And there are bodies of practitioners who are trying to argue that actually we don't need to do any of that. And I'm suspicious that the evidence that they claim backs up that theory is not really there.

Joanne (06:58):

Yeah, it's really, really a tricky place for us at the moment. And of course my area is movement, but also where manual therapy fits into that because of course we've had this big pendulum swing away from the manual therapies and this meme has gone across social media that there's no evidence for manual therapy. This isn't actually true, but you never let the truth get in the way of a good meme. It works for Donald Trump. And 2019, I stood on a stage at a national conference talking about where that evidence actually is. Now, there may be issues around the explanations we used to have for what we're doing, but there's other explanations coming up.

Steven (07:46):

Yeah, I'm glad you mentioned the date 2019, because Sam has sent in a question saying, Joanne, do you think some of this is down to a general reduction in confidence after covid or was it already happening beforehand? And I know Covid gets blamed for just about everything, but of course it does have some consequences, both physical and psychological, doesn't it?

Joanne (08:08):

Absolutely. I mean, the anti-manual therapy discussion goes back probably to 2013/2014

(08:15):

When that really started to rise. What I would say is that the effect of covid on the autonomic nervous systems of clinicians is probably driving a lot of things. I mean, in general, I mean people are probably finding with their patients the general level of arousal in people coming to us is different, and we have to recognise that it is the same for us. We are humans after all, and sometimes I think we forget that and we

sometimes feel that we have to be somehow beyond human, and that we're not recognising that this is changing some of our responses. So there's research that shows that under pressure, what we'll do is regress to whatever we know and try and go deeper into that. And that is a stress response that is observed across multiple disciplines in multiple fields. So it's a human thing.

(09:12):

And then when that is put under deep questioning, then we become very, very vulnerable indeed. Then we had the manual therapy thing, then we had people going, do you know what? Strength! Just make them strong. That was another meme, you can't go wrong getting strong. I would say that strength is a good thing, and when you are weak, getting stronger is good, but strength is not actually the solution because there is no universal panacea. So I see a lot of people who have done a lot of rehab and they're strong and they still have the same problem they had at the beginning, or it's worse. I

Steven (09:52):

Suspect you are hitting a very resonant chord there because virtually everybody who, every chiropractor, osteopath, physiotherapist, I mean, they will all realise that there's not one technique that's going to fix an injured patient. And some of the techniques that are needed are outside their remit. They might be talking therapies or whatever else. But Andy has said he's very grateful for you saying it's not true that there's no evidence for manual therapy, because all of us, he says, use our hands, and see it on a daily basis. But it feels like we're being battered by people saying that all our patients need is exercise and CBT. And exercise and CBT might be important components, but they're not everything are they?

Joanne (10:33):

They're absolutely not. And Andy, I absolutely agree, and there's a lot of reasons for this, and we did take a little bit of a bigger picture and look at where some of this has come from. Now we are hell bent at the moment on trying to get patients into boxes

(10:52):

So that we can follow a process or a procedure and then we'll feel safe. And that helps us autonomically to accept that patients don't live in boxes, patients are webs. And if we actually come into what has been established for a long time, which is dynamical systems theory, now that sounds very fancy. All it means is that humans are webs of multiple interconnecting factors and no amount of wishing and pretending that they weren't is going to change that. So what happens is that we end up trying to drive ourselves up blind alleys. So there's a psychologist called Robin Hogarth, and he said, when we're problem solving, there's two environments. There's a kind environment and a wicked environment – and they're kind of appealing

words. But let's see if you recognise if I just read out a definition for these and we'll see where we go with it.

So a kind environment means that we have repeating and repeatable patterns that we can recognise accurate feedback and rules to follow. And that's kind of where people are hoping the evidence is taking us.

So let's look at wicked. So wicked complex systems may or may not have repeated recognisable patterns. Information may be complete or incomplete. Feedback may be delayed or inaccurate. And I wonder which one of those we think that human beings and in this case patients might fit into?

Steven (12:26):

Well, surely, I mean it is wicked, isn't it?

Joanne (12:29):

Absolutely.

Steven (12:31):

I wouldn't want to use the word wicked, but of course it's incomplete. They are all different. And I'd add to that feedback might be incomplete or delayed. It might be completely absent because sometimes they just don't tell you anything. They either don't book in again, whatever.

Joanne (12:46):

Absolutely. So here's the thing, processes and process driven work works fantastically in the kind environment. I mean, given the fact there's some caveats to this, but if I took someone who's had joint replacement, they would be a protocol for them.

(13:04):

And to a certain extent, that's the protocol. I know that there's variables, but it's the closest thing I could get while still talking about a human being. You have your chronic low back pain or hip pain patient coming in. It's not a kind environment anymore. We have a complex system here and then suddenly the whole premise for what we're looking for on the evidence base, it doesn't work anymore because we go up the process and something one of these other factors on the web comes in. So this is my clinic in a nutshell. These are my patients. So let me give you an example from yesterday that a lovely clinic yesterday, and I had a lady present who has had 10 years of hip pain and leg pain, and it's kind of got worse over time. And she's had lots of clinical work, she's had lots of rehab, she's extremely disciplined with her Pilates.

(14:02):

These are the solutions that she's been given. And so if you're reaching for some kind of process or procedure for hip pain or back pain, you can try that. But basically that's what she's already been given. We take a look at her and she's standing with very exaggerated sagittal plane curves. She's off to one side in the frontal plane. I'm looking at her and just thinking, this is very interesting. I wonder. So I do a little test, do a Beighton, and yep, she's really hypermobile. And so just like, I wonder what would happen if you were to stand on that leg. Oh, well, I'll have some pain. Okay, let's have a look at it.

(14:56):

So I'm asking this lady, can she lift her leg? And what I see is the leg lifts and the whole pelvis slides forward. Yeah. So what happens? Oh, there's my hip pain and everything's hurting down here. I'm like, okay, so is it possible? Let's see if you can feel that first. But I talk about the concept of having your pelvis like an umbrella over the stalk and the handle. Let's just feel, put your hands and does it stay? Does your umbrella stay over the handle? Well, no. Where does it go? It goes forward. Does it have to? I don't really know actually. As it turns out, there were no options until I gave her some support under her hand and then she could actually keep her pelvis over her foot.

(15:55):

How does that feel? Well, actually, funnily enough, it feels a lot better. Now if we actually look at this and you've got your femoral head going like this. We've got pressure at the front. You've got the very deep, deep, deep, deep six muscles behind that femoral head going like this, trying to stop it from racing away. And we've got the big glute muscles unable to actually do anything in this position. It's got no mechanical advantage. So simply by bringing her back onto her foot, onto her leg, things change. So the overactive things don't feel so overactive and the underactive things start to feel a bit more engaged. So that is a really, really small example of we could be sitting there going, okay, there's a protocol that we're going to follow for hips, and it's going to be around glute strengthening. And she will have done a million glute bridges in her life, tried to do squatting and various other things, but fundamentally, every time she takes weight on the leg, this is the movement that's happening. And what was beautiful, she was like, really? She was quite bewildered, but excited in a way. But can I find a specific piece of evidence around what we're doing around that? Well, actually what I'm going to is that the biological plausibility in the mechanics. So where does the hip need to be able to accept load without putting stress on other structures?

(17:37):

That's what I'm looking at.

Steven (17:39):

So this is your wicked situation of complex variables and so on, but we started off by talking about overwhelm on the part of the practitioners.

Joanne (17:49):

We did indeed. So what we're looking at here is if we are able to accept the idea of the body as a web, instead of trying to find the right box to put the patient in, then we can remain flexible and actually sit and look at what is actually in front of us. If we're trying to get to a known solution very fast, it often sends us up a blind alley and then we get stuck. So let me clarify that. What I tend to find is that people will select a technique, for example, and they have an expectation and it doesn't happen. And they usually go one of two ways. There's a certain personality that will say it's the patient, and then there's another personality that will say, oh, it's me. And a lot of really lovely clinicians will think I picked the wrong thing, I should have done it some other way. But actually the truth is it's neither of these things. It just is. You've got a web, you've made a decision with what you're going to go with. It didn't actually meet your expectations. So instead of drowning in this welter of completely unrealistic response, all you say to yourself is, that's interesting. What should I just learn?

Steven (19:15):

Yeah. Well look, Joanne, I don't want to interrupt your flow too much, but I've got a load of points that have come in from our viewers, and it would be nice to read some of those out.

(19:25):

Many of them are things which are just, they're saying, yeah, this is exactly what we feel in our own clinics.

Simon, for example, says he has a friend who is a leading consultant pharmacologist who says that modern doctors tend to follow algorithms. If the patient's got A, B, C, then they treat with X, Y, Z. And he felt that The beauty of osteopathy is that we look at the whole patient taking into consideration the whole picture and treat the patient as an individual. And Simon is talking as an osteopath. Obviously that applies to chiropractors as well.

Mike says, we were taught to do HVTs during our training, and until they ban them, he's going to keep doing whatever works for his patients and we shouldn't be doubting our medical practice. And he is absolutely right, but I know that there are people who do because of actually what Dave here says.

Dave says, I find it weird how academic types, the loudest voices of which seem to rarely practise out in the real world, are convincing us not to believe our own experiences. What we do appears to work. He writes “appears” in capitals, and I'm just thinking there are some of those noisy types out there who type a lot in capitals.

And the minute I see people who write all their texts in capitals, I immediate disbelieve them.

(20:37):

I have an individual in mind, as you probably realise. And Dave says, why and how it works I accept can be debated. But to say it doesn't just collide so hard with the real world. And it does, doesn't it?

Christina says, there's no point in exercising to strengthen a poor position. Get that sorted first and strengthen a good position, which I think is a little bit of what you were demonstrating there, isn't it?

Steven (21:02):

No good doing something just for their own sake.

Joanne (21:03):

Absolutely.

Steven (21:05):

The final one, final one before we move on, Nicholas says, evidence-based care and evidence-informed care are quite different things in our professions. Don't throw away your clinical inexperience just because there's little evidence. It could just mean it's not being researched or funded. Yeah, Nicholas, I think we'd all accept that.

So I mean, quite a few comments there that I've read out one after another, and it's fantastic to have all these comments coming in. So I'm going to try and give Joanne plenty of airtime, but I will also try and get through your comments as well. Right back to you, Joanne.

Joanne (21:35):

Yeah, no, I mean I value all of these things. And the thing is, I don't want to give the impression that we should just all be doing what we think and not actually be referring to the evidence base. I love rolling around in the evidence base. I've been doing it for a very long time and it informs absolutely everything, but my expectations are perhaps a little more realistic.

So for example, at the moment I'm finding people showing up who are expecting the evidence base to tell them what to do. This is a huge misunderstanding about what the evidence base is. So if we think about it, the evidence base is like a supermarket. It is full of ingredients, and there's different aisles. We've got, obviously you've got your baking goods here and you've got your veg here. So we have all these different aisles, and this to me represents the different tracks of research. And we are

becoming more and more tram tracked into one line of inquiry. So for example, if strength is your bag…

Steven (22:39):

Would you liken that then to the ultra-processed aisle in your supermarket?

Joanne (22:44):

Oh my gosh, the ultra-processed aisle. I love that. I'm going to definitely work that in Steven because yeah, it is ultra-processed to the point where anything natural, organic has disappeared entirely from it. So I think that that actually works fantastically well with the model.

So there's a lovely book at the moment out by David Epstein called Range. I'll just read the title to you and you'll see why it's appealed. It's called Range - Why Generalists Triumph in a Specialised World. And he has a lot of very interesting things to say about what our beliefs are about what the future of healthcare is. It's not just about healthcare, it's about many things, but about part of the problem with this tram tracking. So we have this tendency to keep looking at the same kind of evidence and then forget that we have all the other shopping aisles. So for me, for example, I've got ingredients in the structure of things that tell me about anatomy. And I've got another aisle that tells me about movement and biomechanics. I've got another one that tells me about the autonomic nervous system and emotions. There's another one that's about cognition. I've got all these different aisles that I can be looking at to draw my ingredients from. So the evidence-base gives me all the ingredients. But it can't tell me what to do with a complex system. It doesn't give me a recipe.

(24:18):

And unfortunately at the moment, people are very much expecting that the evidence base will give them the recipe. So when they say, where's the evidence? Often they're looking for someone who's done a randomised controlled trial on a group of people, used a process, had an outcome hurrah. And you know what? You can, I think probably do that with any population and get some people who will respond. I don't ever meet any of those. I only meet the ones for whom that has not worked, and that means that I have the luxury of actually going, this is a complex system and it's wondrous for that. And I would like to point out that's a big difference between complex and complicated. So sometimes clinicians can start to get a bit, oh, it's all too much, little too complicated. No, if we accept that humans are a complex system, they're a web, it can really make sense of what happens, what they're coming with.

(25:17):

It means that we have to slow down. We need to slow down, take in a bit more of the information, not jump to making a big conclusion straight away, and then be able to be responsive to an unfolding process with the patient rather than thinking, we're

going to start here, we're going to finish here, and here's the nice little steps on a single line to get from A to B. It's great when that works, but see how often does it do that?

Steven (25:54):

Yeah, but we're not assisted, are we? But you've talked about the effect on practitioners here, but also patients are becoming conditioned to expect a one click fix or a one pill or a one injection or a simple piece of surgery to solve a problem, and they have to be educated as well into accepting that they are complex pieces of equipment.

Joanne (26:16):

Absolutely, and it's so good that you brought that up, Steven, because this is where the communication aspect in our initial consultations with the patient is so important because we do have some people come in with the expectation, some of them are adhering to that, but there's a whole lot of people who if you actually say, now, tell me the rest of the story. Is there more? And as they start to be able to tell their story, they start to get less attached to the idea of a single treatment or a single pat solution because you've actually seen them in their complexity and you've accepted it. You haven't tried to drive them into one box or another. So it's a two way street. If we continue to think that we have to come to a conclusion quickly, make a diagnosis, and we've got this wonderful linear way of going forward, if we're believing that about ourselves, it's going to keep the patient in that same mindset. So the two of you then are under enormous pressure to see a change. And if it's not happening, then everybody is stressed.

Steven (27:25):

Can I bring Dave back into the conversation for a second? Dave says, I've wondered if those who work so hard on the evidence-based and argue we should only do things that are evidence-based, are actually just uncomfortable with complexity. And that's possibly the case, but there's also, isn't there? I mean, I would say there's probably good evidence for the fact that people doing research in medicine are very often looking for things to justify their preexisting opinions and that there are very, very highly qualified academic people who say that frankly you have to be very cautious about trusting almost any research in medicine and probably elsewhere as well.

Joanne (28:07):

Absolutely. I love that, Dave, because that is one of the absolute things. If Steven says to me, what's the solution? One of them is our tolerance for ambiguity. And again, there's research that shows that professionals who can tolerate and hold more possibilities for longer make much better decisions and much better predictions and hypotheses. So the first thing just to pick up on Dave's, the first part of that piece

there, Steven, the trouble with that is it feels vulnerable and we automatically interpret that as a bad thing and that we are not good enough clinicians if we are not existing in a state of certainty all the time. Now this is something that I love working with people just like what if, because sometimes people say, I'm not good enough, I want to be an expert. I say, what's an expert then in your opinion?

(29:11):

And they say, oh, someone who gets to the solution really quickly. I'm like, ah, yeah. So that's somebody who often is looking for confirmation bias or a bias towards their existing experience who is seeing pattern recognition where perhaps that pattern isn't entirely right for you. And there is of course the old saying, if you only have a hammer, everything looks like a nail. And again, there is research to show that in the world of experts, sometimes the more expert a person becomes, the more narrow they become, their confidence goes up, but their ability to entertain anything other than a relatively narrow spectrum of possibilities, it goes down. So there's a fascinating piece that was done in the United States to show that if you have a cardiac arrest, you have a much better chance of survival if there's a national cardiology conference on.

(30:16):

Isn't that interesting? So you've got your experts locked up in a conference, which means that the people who don't consider themselves to be quite so expert start looking at more possibilities, how interesting they can actually measure the survival rates. So tolerance of the feeling that may feel like, because we all know that the feelings we have our brain create stories about, and the classic examples are a feeling that is either the excitement of being on a roller coaster or the same feelings that we interpret as stress. So that is the classic example. I would say the feeling of uncertainty, that vulnerable feeling. We often interpret as some kind of personal failure, lack of certainty. I dunno enough what if instead this is actually something much more realistic, which is there are a bunch of possibilities in play, and I've only been talking to this person for 20 minutes so far, so I don't have the whole score, and I might not have the whole score today either. I will have enough to make a start, but I'm going to entertain the possibility that this is going to be a more convoluted route than a straight direct path. This doesn't make me inadequate as a clinician. So sometimes people will come back on their feedback and say, you're not doing very well. Why do you think that? I can see too many possibilities. I'm like, well done you. That's actually, but how do

Steven (31:45):

You communicate that to your patients though? Because your patient wants to know why they haven't got better after one treatment?

Joanne (31:55):

They Do. You know what? It's really interesting. You're not saying to the patient, I don't know what's wrong with you. That's not true either. Okay, there's not a binary thing. So I find that transparency is a wonderful, wonderful tool if we get off our pedestals or where we think we're supposed to be in our expert fixer role and actually get transparent. So sometimes I've got a chronic pain patient that's saying, can you fix me? I first of all need to know what does fixed look like to you? What does that mean to you? Now realistically, I know that we have a bunch of things that we can explore that you haven't explored before, and I know that we have a good chance of being somewhere other than where we are, what the end result is. I can't predict that right now. And it's really interesting seeing them kind of go because actually, okay, yes you do.

(32:54):

I'm not saying you don't have the occasional one who's just still looking for the quick fix, but they're the people who are just going to keep professional shopping anyway, possibly. Yes. Okay. They're not the ones actually, if you're trying to clinging onto those patients, you've got to understand that if you're familiar with the stages of change model, people have to be in a certain place to be able to move towards change. And so if they are in the early stages where people are not even contemplating change, they're still looking for the silver bullet, it doesn't matter what you do actually. So don't pin all of your self-esteem and confidence around those people

Steven (33:38):

Because

Joanne (33:38):

It's not about you.

Steven (33:40):

But possibly one of the things which people are worried about, it's been brought up by two people, by Kim and by Bertand, is that they are frightened of the regulators. And so they're worried that that person who's looking for a quick fix, he's going to complain that, well, they didn't fix me. They did this and it was the wrong thing. I didn't get better. And you must see that an awful lot in the people you work with, that fear of somebody complaining about what they failed to spot or whatever.

Joanne (34:04):

Absolutely. And if we are looking at things like missing red flags for example, that's absolutely the case. We are trained to be first contact practitioners. We need to pick up red flags. And in my career, I've picked up aortic aneurysms and DVTs and cancer and all sorts of things, and we do have a professional obligation to be able to

do that, to be able to fulfil that. After that, it comes down to a totally different model of communicating with the patient, which comes back to two things, transparency and agreements. Now, often we don't think about agreements with our patients. So if they're coming in with the expectation, you'll fix me and you are there going, I can fix you and please give me your money, and they don't get fixed, then yeah, okay, that could be reality. But if they're doing something instead they're giving you a history, you're taking that you are being quite honest about what you're going to do, why you are going to do it, and then have their agreement.

(35:19):

Does that sound okay with you? We're going to look at this and then we're going reevaluate the situation. This is based on my experience and my professional standing. I think this is our best option to begin with, is that okay with you? You entered into an agreement with the patient. If you reevaluate and that isn't the outcome, first of all, we have to check, are you willing to be responsive to that? Which means that you're not overly attached to that one technique and you're willing to then entertain that something different may have to happen. That's the first thing. Can you be flexible?

(36:06):

So can you see where I'm going here? The communication we have with the patient is the thing that is going to help with the fear about the regulators. If you've gone in with these, yes, I'm going to be the great saviour, then yeah, maybe that could happen. But if you've actually been transparent and you have actually got the patient's agreement that they understand what you've told them, they understand that there's some uncertainty in there because each person has biological differences and they have agreed to looking at that course of treatment, then you have an agreement. Now, I'm not saying it's foolproof, but I think you can possibly imagine that if you've had that dialogue and you are checking in with somebody to say, right, this is where we're going at the moment, we might have to make a change of direction. Is that okay with you? Again, you've had agreement. If you've done a couple of treatments and you feel we are going in the right direction, it's not quite there. Again, we are transparent with the patient, this is what I feel. Is that okay with you? Yeah. So how often do people not do that? Because taking all of this responsibility, feeling an enormous amount of pressure

(37:28):

And its performance pressure, and is the patient going to be happy? Well, at any point you can check in with that patient about that because you've been transparent.

Steven (37:39):

We had a show a couple of weeks ago here, which I thought was really helpful in that regard because we had a live patient in the studio - a live patient, you know what

I mean! A real patient in the studio, obviously alive, who was seeing my guest speaker who is an orthopaedic consultant for the first time. And obviously I'd passed the basic details over to the orthopod, but the patient had been seen by a sports therapist, by an osteopath a couple of times now is being seen by the orthopaedic consultant. And I think a lot of people find it really reassuring that at the end of that session, obviously the sports therapist had tried something that hadn't worked. The osteopath had tried something else that hadn't worked, but even the orthopaedic consultant said, well, on the basis of the MRIs and the tests I've done in here, I really dunno what's going on with this patient. And I might try this, but I suppose that a lot of us are worried that a consultant would instantly come to the right diagnosis. But as you say, patients are complex and they don't always do it. And so the patient's gone back into my clinic and he's seen a physiotherapist and actually the problem's now moved and the physio says, crikey, I need a test for this other thing now as well. So he's a really good example of a very complex patient. A wicked patient.

Joanne (38:55):

Yeah, absolutely. I mean you, I'd prefer a different word, but it does make a lot more sense. So for example, I had a patient last week who she had had a really traumatic injury at the beginning of Covid. She'd had a surgery at the worst possible time in our history, hadn't received the rehabilitation support, had painstakingly managed to retrain herself back into being able to walk again. But when we looked at, well, did she even have the availability? So for example, she couldn't stand on one leg with any balance, but when you looked at her, she's standing on the outside of her foot, she can't get her foot to the ground. Well, let's just see, are you stuck in external rotation in your tibia? Well, we sat down to test it, put my hand gently on the leg, and she had an enormous pain response. I'm just like, right. So I know that actually the contact is unlikely to be provocative to the tissues. So we have something happening in the nervous system,

(39:56):

And actually it meant that I needed to take a little deviation to explain to her about how we process sensation, how our brain creates stories and the enormous stress and fear and anger and anxiety were locked up in her around this issue. And she told me what the imagery was that she saw in that leg from the surgery, and it was a horrifying, frightening imagery. So I needed to actually help her to mobilise her brain to enable her to then tolerate the skin contact, which then let me do the mobilisation she needed such that she could then stand up and stand on her foot for the first time.

(40:43):

Well, you can't predict for that. That is the complex system right there. The thing for me is I hold in my head what my overall objective is. So my overall objective is for this lady, she wants to be able to stand on her leg. Okay. Does she have what is necessary for doing that? Well, at the moment it doesn't look like, it just doesn't look

like because it was a tibial plateau fracture, so she's actually got stuck in external rotation. I can help her with that, but I can't get past it until I deal with this driver, which is actually happening as an output from the limbic system. Now if you go and have a read around, you'll find lots about the limbic system and you'll read around the pain science to explain about how the brain interprets sensation. All of that is there, but they're in different aisles in the supermarket. So it doesn't mean it's not there. It's just not all nicely packaged and in cling film on one particular location on a particular shelf. So again, we come back to complex, but if we are embracing complex, then that makes this patient not difficult to treat. It actually helps us to understand why she can't do this. This movement, it makes sense of it instead of making it harder to treat. It makes it easier because we are willing to actually see, oh, that's a strand of the spider web. I need to bring that in right now so then I can get back to the structure, which then will help me work with the biomechanics and now the patient can stand on her leg.

Steven (42:27):

There's a question for you, which is not really about overwhelm here, but it's about that patient journey if you like, and it's based on something sent in by Annie a little while ago about the, do you feel there's a need to at least have something which shows your patients some degree of improvement after each appointment?

Joanne (42:45):

Yeah, absolutely. What I would say rather than using the word improvement, I would use the word change because change then allows for the fact that the improvement, if you might be that patient, has a far greater understanding of what's going on in their body. So my patient, the hip patient that I alluded to earlier, have we fixed her? Well, no, not yet. It's not likely at the end, but have we changed her understanding of herself? Have we changed her awareness of this? Yes, and she was very happy with that. So sometimes what we're actually looking for, we are change agents. We're in the business of change. We forget that. And so by the end of the first session, yes, I expect that there will be some kind of change. What I can't say is which domain is going to be in.

Steven (43:43):

Yeah, sure. That's a useful takeaway there that we should looking for change or expecting change rather than expecting improvement. Obviously we're hoping for improvement and trying to achieve improvement. I've got a whole load of comments that have come in and I'd like to run through a few if I can. Most of them are about evidence-based medicine and its relevance or its value in treatment.

But I do like Jammi's comment. I was talking about people who write in capital letters earlier on, and Jammy says that apparently the Daily Star in Tesco today had a front page headline saying, gen Z is terrified of capital letters, and therefore I must be very young at heart, which is very kind of Jammy.

(44:26):

I do a Friday post about, we call it dictionary corner. I'm not Susie Dent, but we call it dictionary corner anyway, I am very keen on decent grammar and punctuation, capital letters in the right place. But yeah, thank you for that, Jammy.

Dave says he has real problems with saying X, Y, Z doesn't work, and our experiences just anecdotal because there is at some level an aspect of saying that the patient's experience isn't real, and I see what he means by that, and it belittles the actual real world experience of the recipient of manual therapy.

DT says, just because something can't be proven doesn't mean it doesn't work. It may be just a reflection of our limited understanding or scientific approach at this point in time.

And Rachel's got a nice comment here. Rachel says, I was taught that practice is a mixture of art and science, and you graduate with more science than art, but as time goes on, the art is learned and it becomes more instinctive.

So ways of looking at practice, I suppose, given that we've got five minutes left, I now need to know from you, Joanne, what is the one thing that's going to fix overwhelm in all of our viewers today?

Joanne (45:39):

Okay,

Steven (45:40):

So we're not complicated, are we? We're not wicked. So one thing will do it.

Joanne (45:43):

Okay. Well, much as I like to give you one thing I just have to pick up off Dave for a minute. Again, if we think about every input we're offering for the patient is a form of information. So when we look at manual therapy, where our understanding of that is going is about it is a way of introducing information into the system for a specific response that has some basis. And when we look at, I was looking at, well, what's the definition of evidence-based practice? It says here, it's a process that uses the best available scientific evidence to make decisions about healthcare. I would say that everything that I do and everything I teach has a basis in something that exists in the science base that is not the same thing as expecting the evidence base to tell me the answers. That's incredibly important. So when it comes down to when you're talking about how do we overcome overwhelm, okay, the first thing is that we slow down, okay? If we think that we're going to jump to a conclusion quickly, now usually that could just confirm us and take us down a blind alley. It's okay to slow down. It's okay to actually take in that. There's a few possibilities,

Steven (47:07):

Joanne. We use a slide on my first aid courses where it says, don't just do something, stand there.

Joanne (47:14):

Absolutely. And again, the evidence is there for that. So the evidence base around this is huge. So Daniel Kahneman's work “Thinking fast and slow”, it showed us that actually if we just slow down and consider the possibilities and then make a decision, that's when actually your intuition comes in. It's after that process, not before. We misunderstand what intuition is.

So it is absolutely slow down, calm down. Your job is not to fix people, it's to help them to help themselves. You are introducing information either manually, verbally, whatever it is you are introducing information to help them in the process of change.

Joanne (48:01):

I'm not saying willy-nilly, just go off and do what always works for you because we are at risk of confirmation bias there. What I would say is if something is working for you, go seek what is actually available to you to actually support what it is that you are doing.

Steven (48:20):

Are you looking for confirmation bias here?

Joanne (48:27):

Well, what you're looking for is to seek to understand, and this means you have to be objective about it. Don't just reject what doesn't suit you.

Steven (48:36):

Joanne, we've got very little, very little time left. You do run training courses yourself, training courses in this as well as in movement science.

Joanne (48:43):

It is part of the whole thing. So JEMS is about actually both the practitioner wellbeing and patient wellbeing. It's about learning how to work the spider web so that we don't get overwhelmed and think things are complicated. We know actually where we can start on the web and then how we can respond so we don't end up going down blind alleys. And it's about how we can stay curious and keep the curiosity going using movement. I gave you a little example there. It was quite simple, wasn't it? It wasn't complicated. And so we take you through actually over a series of months so that we can really support you in all of these feelings that you have while you're

accumulating new knowledge and skills so that at the end of it, then you can, actually, feel…

Steven (49:30):

See, this is why I need to get you back in the studio for a longer show because we are out of time and I'm going to have to stop you there, I'm afraid.

That's been brilliant. We will share the information about your courses and I think we've talked you into providing a discount for the members or anybody who wants to attend one of those courses, so we'll share that as well. But I'm afraid that's all we've got time for today. Joanne, thank you so much for joining us. It's been great fun as always.