

“The only certainties in life are ... wait, I pay no taxes, and I’m not dead, yet.” A letter from Qatar.

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WE ALL CRAVE THE COMFORT OF CERTAINTY, YET PHYSIO IS MOSTLY GREY

On day one, mostly your patients want to know:

“What’s wrong with me?”
“What’s going to happen?” and
“What can I/you do about it?”

I’m reminded though that “for every complex problem there’s always an answer that’s clear, simple ... and wrong”. So how do we look ourselves in the mirror when we can’t, typically, give our patients certain answers to those questions on every occasion?

The nihilist will throw their hands up and tell you to give the game away; the fabulist will tell you that there’s this new treatment approach that works 100% of the time for everything and everyone. I’ve been both at varying times in the 30-something years I’ve been working in sports physio, but these days I find myself more comfortable in the grey, and I’d like to explain how and why.

Complicated is sending a rocket to the moon, complex is raising a child. One is difficult but predictable; one is difficult and unpredictable. Caring for your patients is like raising children in that your protocol is helpful, but it should only be considered a guide. Crucially, the guide must have a mechanism to let you know if you’re on the right track so you can self-correct when you take a wrong turn (which you will).

MAKE A COLLABORATIVE PLAN WITH YOUR PATIENT

The plan you agree on needs to include ways to figure out the direction to head in, if it’s working, and what you’re going to do when it’s not. Develop this with your patient on day one. Don’t start until you have both agreed to the plan. This might well mean changing your plan when it turns out that with the two of you aren’t aligned on aspects of it, or

if you’ve misunderstood their goals or preferences. The rehab journey might take a while, and there can be periods of little apparent progress and probably some regression - so you and your patient must be on the same page if you expect to ride through these bumps.

SHARED DECISION MAKING DOESN’T MEAN DOING WHATEVER THE PATIENT ASKS FOR

When healthcare was paternalistic we could simply tell the patient what they were going to get, and that was it. Mercifully patients are now empowered and treatment choices should be presented and weighed according to their preferences, most of the time. This doesn’t make you a waiter who will bring whatever type of coffee the customer asks for. The internet will provide them a laundry list of treatment options, but your science degree should equip you to translate the evidence into a tailored recommendation for the individual in front of you.

YOUR PATIENT IS LOOKING TO YOU FOR SOME GUIDANCE AND DISTILLATION OF THE EVIDENCE THAT CAN BE BLENDED WITH THEIR PREFERENCES

An epidemiology journal might technically have a point about confidence intervals, but your inner Bayesian should be able to provide a recommendation to the athlete in front of you after 8,000 athletes have gone through studies using (or not) the Nordic hamstring exercise as an injury prevention approach.¹ Other cases will be less clear, but you can still couch your recommendations in a manner that’s helpful:

“It seems that this sort of exercise will help your pain if you can do it for about 12 weeks, but honestly, they haven’t done a ton of studies on this yet. We are pretty sure though that no harm will come from trying this ap-

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Table 1. Examples of patient examination and care plan summaries for an acute and a long-standing condition.

Acute hamstring strain	Non-specific low back pain	Patient questions being answered
<i>What I think is going on here is that you've damaged this muscle in the back of your leg when you were running. This happens quite a lot to people like you who have to run fast.</i>	<i>What I think is going on here is that you're still feeling pain in your back that started out as a sprain or injury quite a while ago, but now this pain has taken on a life of its own. Your pain system was initially being helpful by protecting you from further damage, but now those protective responses have become unhelpful, sort of like a car alarm that's going off for no reason. The most common protective response is muscle guarding, which actually puts more pressure on your back.</i>	<i>What's wrong with me?</i>
<i>Your body is doing a pretty good job of healing things, but we can help it along by giving it the right amount and kind of exercise, at the right time. To figure out if I'm doing this right, each day I see you I'm going to do a few tests that give us an idea of how well that muscle is doing, and then we can figure out what kind of exercise, and how hard we should be going.</i>	<i>Your body has done a good job of healing, so now we need to turn down this unhelpful protection. This protection can be influenced by thinking your back is still damaged (but we have tested this and it seems ok). It is also influenced by other things going on like how you're sleeping, your mood, how confident you're feeling and how much activity you can enjoy. What we need to do to stop that protection alarm going off is gradually show your back that it can do stuff currently it's worried about by changing how you go about it.</i>	<i>What's going to happen?</i>
<i>If I'm right, then we should be seeing improvements in how hard you can push, how much pain there is when you're doing things and when I poke on the muscle, and how fast you can run. If I've got this wrong, these things won't be improving, and they might even go backwards.</i>	<i>If I'm right, then we should be seeing improvements in how much you can do and how much pain there is. This is a low-risk approach. If I've got this wrong, these things won't be improving, and we will modify what we do. We will get you doing more things that you find tough, but in a different way - with less protection. You will also do more of things that you feel good about doing. Sometimes things change really quickly once the system is happy with protecting less, other times it takes a lot of work from both of us. At the end of this you should be in control of your back and your pain.</i>	<i>What can I/you do about it?</i>

You should notice that rarely can we ever definitively say: "I am 100% sure that...". The hard-nosed nihilist researcher might prefer you to say: "we have no definitive evidence for anything". The pragmatic approach I'm suggesting here is to act on what is most likely true given the current evidence we have. The fun part of physio is that this evidence can, and will, change. If you take part in this process, it's the most fun you can have with your clothes on.

proach and we will track your progress to check it is helping"

IN PRACTICE HOW CAN I DO THIS SINCE ALL MY PATIENTS ARE SO DIFFERENT?

I like the relative simplicity of acute musculoskeletal injury. The main challenges here are figuring out the tissue that's damaged and the extent, and then figuring out how to help the patient get back to their desired level of loading through that tissue in a way that works for them (unless there is no initial trauma or tissue damage but that is another story). More difficult is when you're dealing with persistent pain where there's no longer a clear relation between tissue damage and your patient's pain/disability. Both broad categories, however, benefit from having a testable plan.

TEACH BACK AND THE FOLLY OF "DO YOU UNDERSTAND?"

Keep bringing yourself back to those questions patients want answered "what's wrong with me, what can I do about it, what's going to happen?" Don't fall for the trap of simply asking your patient "do you understand?" Like you, your patients don't want to seem dumb, so they will always tell you they understand. A better strategy is to put the onus back on yourself:

"It's important that I've explained this to you properly, and I often get that wrong. To see if I've done my job, can you tell me what you're going to tell someone at home: what is wrong with you, what you're going to do about it, and what's going to happen?"

Your patient's answers to these questions will let you know how much more work you've got to do until you're both on the same page for this plan.

It really helps to have some slides/handouts to annotate your explanations – not only for your benefit to keep you on track, but I think the patients feel some relief that this isn't your first rodeo when they can see you've gone to the trouble of making these resources.

WHAT SHOULD BE THE DIAGNOSTIC CRITERIA, AND MILESTONES FOR THE TREATMENT PROGRESSIONS? EXPERIENCE AND WISDOM AREN'T TIGHTLY CORRELATED

Nothing beats getting miles under your feet at the same time as measuring your outcomes. Just because you've done something a lot of times, doesn't mean it's right. Similarly, just because there's no research to back up what you're doing, doesn't mean it's wrong, but where that's the case, you have a duty to your patients to try to improve your knowledge. About the only thing I'm certain of clinically right now is that in about 10 years, I'm going to look back at what I'm doing now and cringe about certain parts of my ap-

proaches. I am completely certain that I have no idea which parts I will be most embarrassed about, but if I keep track of what is and isn’t working, I have a chance of figuring that out. Clinical research makes this easy as I pretty much have to keep score on every patient I see, since most every one of them ends up a participant in a study of some sort. You don’t need to be as formal as this but gathering your own normative data for the patients you see is a great exercise in reflection and helps you iterate your processes.

We’re lucky here at Aspetar in Qatar as we’ve got a centralized system of medical care for our athletes, professional and recreational, so it’s relatively easy for us to pull together bigger numbers of patients for analyses.^{2,3} Your average sports physio working in a club, looking after a single team, will likely only get a couple of any specific injury in any given year, yet patterns only start to emerge once you’ve seen dozens, or likely closer to hundreds of a specific thing. We’re happy to share our experiences and our outcomes where a lot of the clinical gold is in the normative data. Here’s where the connectivity the internet and social media has given us can be leveraged. Your 3 patients with

this one condition can be shared with 10, 50, maybe 100 other clinicians around the world, and together you now have a lifetime of information that can inform your practice, and more importantly, your patients. How, and even if, we as a profession choose to do this remains an open question.

I have dodged death and taxes for a while now here at Aspetar, but I am increasingly comfortable that the only thing I am certain of is uncertainty, and that’s a nice place to be.

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