

# Clinical Practice Top 13: Part I

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In the midst of trying to summarize some of the key elements of clinical practice and reasoning for PT and PTA students, I've found myself pulling together many of the practical aspects of "being a clinician" that I've learned over the years. After 19 years of clinical practice, there are certainly a number of things I wish I'd learned in school! In many practitioners' training, much time is devoted to the "practices" - the "what" to do - as opposed to the "principles" - the "why" to do. Very little time is devoted to the art and science of learning how to think.

So if David Letterman has his "Top 10" list - I now have my "Top 13" list. Why 13? It's my lucky number, of course! After reviewing the list, I decided to post it here as I truly believe that these principles are not only appropriate for the student, but for any and all health care clinicians - physical therapist, chiropractor, physician, and many more.

As it happens, they all start with the letter "P". That being said, I bring to you my Plethora of Practical and Philosophical Premises for Practitioners ... so let's get started ...

1. Picture - as in "the big picture". Oftentimes, we get caught in the minutiae, the one piece of information that we want to attend to while choosing to ignore (or miss) other pertinent data. Some call it "missing the forest for the trees". The scientists call it "observer bias". Just like any good puzzle, all of the pieces must fit - it is our task to find out how. We seek to understand "the big picture" or, simply put, "the essence of the problem". We have to see the forest - why is this person here to see us, in it's most elemental, functional terms.

2. Problem - The patient comes to us with a problem, and our task is to find solutions, not more problems. The example I always think of is the patient with low back pain. They come in with pain and loss of function, yet in the time they are in the office we give them more problems - oh no, you have a leg length discrepancy, tight hamstrings, a shifted cranial suture, and some bad energy flow - oh, and some back pain too you say? Every problem contains a solution - and, I might add, an opportunity ... for learning.

3. Process - There is a methodical, step-wise process to understanding any problem. Good problem-solving is the scientific method in action - establishing a hypothesis, testing that hypothesis, and providing a treatment intervention based on that hypothesis. It involves measuring baselines and then assessing change in those baselines after the implementation of the treatment intervention. Sometimes, this process gets lost. Practitioners frequently forget about "assessing change" as a means of confirming or refuting their diagnostic process.

4. Perception - as in "perception is reality". The patient has their own "map of reality" which is going to be different than our own. Frankly, one of my biggest concerns is that practitioners don't try to understand that "map". There can be a belief that "I'm the practitioner, I have all the answers, I solve the problems", when in fact the patient has all the answers. All we are doing is striving to ask the right questions. They may have a totally different perception of the problem than we do - we just need to understand their reality, whatever that is.

5. Pain - as in "concordant pain". A critical part of the assessment algorithm is to establish concordant signs and symptoms - as in "does this reproduce the pain that brought you to see us" as opposed to "oh my, that hurts - in a totally different way". More often than not, the patient comes to us with pain, and our task is to understand it and what reproduces it. There is a difference between "hurt" and "harm" - something the patient needs to understand. This brings us to ...

6. Patient Education - This process is all about the patient, not about how much the clinician knows (or professes to

know). Do they have the tools necessary to effectively self-treat? As I said above, every problem contains a solution - and an opportunity for learning. Being a good educator is not just about "telling someone to do something". As the saying goes, you can lead a horse to water but you can't make them drink. Effective education involves developing a mentoring relationship in order for the patient to understand (in terms of their core values) "why they would want to drink, and how to do so if they choose to do so".

7. Precautions - Simply put, "Is there a reason to NOT move this patient or to NOT apply mechanical loading strategies in the assessment of this person?". The principles of tissue repair and remodeling - and a good understanding of physiology and disease processes - should guide us in this decision. Knowing what TO do is rarely as important as knowing what NOT to do. As I noted in the last post ... "First, do no harm" ...

There we have the first 7 on the "top 13" list. Tune in next time for the remaining 6 ... with a surprise or two thrown in for good measure - just to keep you thinking!

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