Clinical Pearls: MDT Clinical Mentoring Program Experience
By Debbie Thrall, PT, Cert. MDT

If your goal as a certified McKenzie therapist is to be the best you can be, to have good outcomes with difficult cases, to have the recognition of doctors for your good work with their patients, to be able to formulate an accurate prognosis, and to master the subtleties of clinical reasoning, then you should probably enroll in the MII Diploma Program. If it is not possible for you to do this at present, the McKenzie Institute USA is now offering a Clinical Mentorship Program that can help you meet these goals in your own clinic with your own patients.

This past April our clinic, Advance Sport and Spine Therapy in Portland, OR was the first US clinic to participate in a pilot of the mentorship program. With 4 out of 5 participating therapists credentialed, clinic owner Noel Tenoso, PT, Cert. MDT, wanted to see if our clinic is meeting the standards of quality mechanical diagnosis and therapy. Are we all on the right track? Could the mentors help us to identify ways we could improve?

Hugh Murray, PT, Dip. MDT and Kay Scanlon, PT, Dip. MDT spent two and a half days in our clinic observing and teaching us individually and collectively. Hugh and Kay did not give us report cards, but they were unfailing in their support of each of us. They consistently directed us to the core skills of data gathering, analysis and hypothesis generation and testing. Their teaching was filled with colorful analogies and pearls to make our evaluations, patient education and compliance more effective. For example, if a patient returns who has not done his exercises (assume a derangement) ask him: "If you had cancer and your doctor gave you a pill that would cure it, would you take that pill as many times a day as recommended?"

The format of the mentorship course included two days of 1:1 mentor and clinician as we evaluated new patients; then a lecture and discussion at lunchtime. We concluded on Saturday morning with Hugh providing a patient evaluation and we discussed his clinical reasoning process as he went along. It was a great opportunity to "talk McKenzie" and share our thoughts in the reasoning and assessment process.

With our individual patient evaluations, it was very useful to have someone in the room giving immediate feedback on our data gathering. When taking a patient's history, the mentors helped us remember to clarify the patient's statements and to question openly without making assumptions or asking leading questions. One great suggestion was to lead them through a 24 hour period of time and ask when the pain waxes and wanes. This gives the therapist a lot of information about a directional preference for flexion or extension. At the bottom of the first page of the evaluation, we took a long pause after the "I wish" question. It is at this point that we should summarize briefly to the patient the main points in the history. This gives them our impression of their problem, which should be in accordance with their knowledge about it. Having completed the "S" of SOAP, it is expected that the mechanical diagnosis is already suspected and taking a moment here helps prepare for the selection of test procedures.

As you know, the first clinical or mechanical test performed is examination of posture. By this time, our patients are generally slumping on the treatment table and starting to become uncomfortable. This is our opportunity to begin patient education and to confirm our hunch about their problem. It is important to establish their baseline pain right then, including the location and a description of intensity. Next, Hugh would move the patient to a chair and provide a lumbar roll and cues for correct sitting. He would recheck the baseline and share with the patient the significance of the changes. This is a very powerful tool that I have seen Robin McKenzie do many times in his patient demonstrations. It is an effective means of education and a time saver.

If distal extremity symptoms have been present during this episode, a quick neurological screen should be done. I learned some tips for making this fast and simple. Screening for relevant myotomes in the upper extremity can be done quickly with a grip strength test with the dynamometer; and for the dermatomes with light touch. With nerve root involvement these are likely to be diminished and changes in grip strength can be reliably retested as part of a person's response to loading in the future.

Before movement testing, it was emphasized that we take the time to observe and establish our patient's baseline(s). The changes that occur with movement testing can be subtle. Finesse with examination means that one can detect a 1% change. The quicker and more accurate your assessment the more effective your teaching and treatment will be. Baselines include pain intensity and location, pain felt during movement and at end-range as well as changes in range of motion, strength, and sensation.

This is the crux of our examination. Most of us probably go through this too fast; and don't stay with one movement long enough to exhaust its potential for change. If the person responds to simple posture correction; or retraction, then no further testing need be done that day. Hugh warned us not to over-treat and not to go through too many techniques quickly. This led to a discussion of the progression of forces, another point of finesse in the McKenzie approach.

We discussed several options for where to go if the movement testing remains inconclusive. Hugh suggests we use the mnemonic "SOS." Subjective and Objective have been done but you don't have your "A" (assessment) yet, so go back to "S" and see if their functional pain history tells you if there is a tendency for a directional preference.

I was surprised at how little flexion testing Hugh used with our patients (or recommends that we do). Not wanting to be blinded by my "favorite diagnosis," if the picture is "gray'" I typically give flexion its chance. If baseline symptoms are provoked with flexion testing, then I can refer to this later when teaching about the disc model and the importance of flexion avoidance. I like to establish that flexion is the problem and then work on reducing the derangement. Hugh's thought is that even if the examination ends without a clear response to loading (of a suspected derangement), the next kinder step is to send them home with some sort of unloaded midrange extension rather than repeated flexion (which can be like a cruel joke with a punch line that you suspected but didn't tell the patient–"I want your pain to get worse so I can teach you something.") It is kinder, yes, to teach posture correction and positioning. Which patient will be more likely to keep the follow up visit?

In conclusion, our PT staff includes seven therapists with a diversity of skills and years in practice. Most of the Certs have become credentialed in the past three years. Several have certification in other approaches besides MDT (ASTYM, NAOIMT, Women's Health, OCS, etc.). I feel as though the mentorship has brought a renewed interest in the power of MDT in its purity. The method is very strong and developing the expertise of our instructors may require much revisiting of the same material, like peeling away many layers of an onion. I feel the mentorship is a very good means to that end and I recommend it highly.

For more information about the Clinical Mentoring Program, visit:
http://www.mckenziemdt.org/mentorship.cfm