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Feature Commentary

HOW TO BECOME THE JEDI MASTER OF THE UNCHANGED DERANGEMENT: STICKING WITH THE SYSTEM WHEN THE GOING GETS TOUGH

LINNET KAZEMI, PT, DIP. MDT

Does this experience sound familiar? Your patient leaves day one and you're certain of their provisional classification of Derangement. Yet, the patient arrives on day two unchanged. You scratch your head and think, "What went wrong?" It is at precisely this moment that early in my MDT training, I would've cut bait reverting to some familiar, yet unsupported, treatment. Whether this was due to lack of knowledge or pressure from the ticking clock, thankfully, I now know better. However, I witness this trend in the clinicians around me, throwing the system out when the going gets tough rather than trusting the reassessment process. Using the guidelines below will ensure that by the end of the second visit, the patient is invested in their treatment plan and happy to pay their copay.

McKenzie and May speak of multiple dimensions for reassessment in patients with extremity or spinal pain starting with reassessment of symptoms and mechanics (McKenzie & May 2003). Thorough assessment of symptoms with variables such as frequency, intensity and location of symptoms as well as any changes in medication consumption, differences in ease of daily activities or ability to sleep can help guide your clinical decision making (McKenzie & May 2003). Regarding mechanics, note any changes in the range of a previously obstructed movement, a movement deviation or the intensity of pain associated with a movement (McKenzie & May 2003). Clarifying mechanics thoroughly is crucial as this may be an area of change that the patient is unable to identify for themselves. Next, confirm the patient's frequency and technique of their home program as a source of possible error before venturing further (McKenzie & May 2003). It is imperative to determine the lasting effect the home program has on the patient's clinical presentation as they may only be focused on the during movement response (McKenzie & May 2003).

Once you've determined your patient is unchanged, the fun begins. You get to dig in and do the work, but where do you start? What is the analytical road map you will use to make your outcome on day two more successful? A good starting point, if you are dealing with an extremity problem, is to confirm your location as pain in the extremities may have a spinal component (McKenzie & May 2000). As well, imaging studies have been found to be unreliable in determining the true pain generator (Reilly et al 2006). Therefore, performing a thorough screen of the appropriate spinal area is imperative in those patients with extremity pain (McKenzie & May 2000). Have you spent the time to appropriately rule in or out a possible spinal component as the answer may only become clear once the movement has been tested over a longer period of time (McKenzie & May 2003). Make sure you use appropriate communication with both the patient and the doctor regarding your findings if you do suspect a spinal component to keep everyone on the same page. Education is the key to maintaining trust with your patient and referring doctor (McKenzie & May 2003).

Once you've confirmed location, assess the provisional classification reached at day one. Evaluate yourself. Did you mistakenly jump into treating the patient before you fully understood what they were presenting with? This was an area of weakness for me prior to the diploma program. One of the best pearls of wisdom I learned during my time in Austin was, "Don't try to fix them. Try to understand them." Are you asking questions on the evaluation that will help you better understand what the patient is presenting with? Remember, it's a fireside chat but no one wants to be in a conversation with the person that never stops talking. Get the information that you need by listening to the patient and asking the appropriate follow up questions (McKenzie & May 2003) and move on.

The same holds true for the physical exam. Grade yourself. Are you on automatic pilot habitually performing the movement assessment? Or, do you systematically pick which movement will provide you with the most information in order to divide and conquer the puzzle before you? Review how you reached your provisional classification. If you concluded the patient presented with a derangement, was that because you witnessed a change in pain location and /or intensity or a rapid improvement in the range of a movement that was previously obstructed (McKenzie & May 2003)? If you were unsure after the history taking as to what you were dealing with, did you choose to explore flexion, in the case of spinal pain, and as a result, worsen symptoms or obstruct movement (McKenzie & May

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2003)? Bottom line, do you feel confident with the classification that you chose? Does your assessment form demonstrate sound evidence leading to a conclusion of derangement such that if viewed by another clinician it would clearly lead them to the same outcome?

Your next step would be an analysis of direction. We know reducible derangements present with a directional preference, "postures or movements in one direction decrease, abolish or centralize symptoms and often increase a limitation of movement" (McKenzie & May 2003). On day one, did you find the direction of movement that brought about a lasting improvement in the location or intensity of the patient's symptoms? Revisit this again and confirm that as a result of the movement the patient is performing you see a change in their symptoms or mechanics. If not, you may need to explore other movements in the sagittal plane or move to step four in order to exhaust it and determine the need for a lateral component (McKenzie & May 2003).

Your final step is to explore force. Did you get the patient to end range on day one to confirm the direction or expose a relevant lateral component (McKenzie & May 2003)? If not, now is the time to do so in order to assess the effect on the clinical presentation. Having explored force progressions, could you possibly need a force alternative? Would this patient get a better result by doing more sets every 2 hours or more often throughout the day (McKenzie & May 2003)? This is where you get to fiddle with the program in order to best tailor it to the patient that is sitting in front of you.

Systematically moving through this analysis, rather than becoming frustrated when a patient with a derangement returns unchanged, will allow you to be confident in the program you are designing for the patient. At the same time, it allows your patient to see the cause and effect their home program has on their symptoms and buy into it making them more compliant (McKenzie & May 2003). As you navigate this journey, allow the symptoms and mechanics to guide you. Be the "Jedi of clinical presentations" and leave your biases at the door. Then, if or when the next patient presents unchanged, you will reach for your detective hat rather than the estim. Good luck and as they say, "may the force be with you."

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GUEST COMMENTARY

Are You Educating Your Patients as Adult Learners?

Yvonne Body, PT, Dip. MDT

A common learning objective course participants have is to increase patient compliance with their home exercise program. Where does the break down occur between what you tell the patient to do and what they actually do? You have invested in Web-based 2.0 applications with minimal improvement. Have you considered utilizing a patient education model based on instructional strategies for the adult learner?

First, let's identify some key characteristics of the adult learner. The adult learner is:

- Autonomous and self-directed
- Has life experiences that influence them
- Focused on relevancy
- Problem centered
- Motivated by internal factors

One key factor for the adult learner is to be able to identify the immediate usefulness of the new knowledge or skill to be learned (Falasca, 2011).

John Keller is an instructional designer who has developed the ARCS model, which is based on the current psychological literature on motivation (Dick, Carey, & Carey, 2015). ARCS stands for attention, relevance, confidence, and satisfaction. In order to motivate your patient, you will need to consider these factors when educating them. The ARCS model fits well into the educational model of a MDT clinician.

The first step is to gain the attention of your patient and maintain it during the educational process. Asking questions and including the patient in the assessment process is a good way to maintain their attention. Minimize distractions and interruptions during the patient treatment session.

The next step is relevance. Make the assessment process relevant to a functional impairment that brought the patient to your clinic. This is also a good technique to maintain the patient's attention. In conjunction with your symptomatic and mechanical baselines, identify a patient test, or concordant test, that you will recheck. Ask the patient "Can you show me one thing that you are unable to do without pain or limitations?" Once a patient test has been established, utilize this test throughout the movement testing portion of the physical examination to demonstrate cause and effect. Patients are able to see for themselves that when they move one way they are worse and when they move the opposite way their symptoms are better and now they are able to perform their specific activity more easily. They are able to identify the relevance of their home exercise program.

Step three is confidence. Patients who lack confidence in their ability to perform the exercises correctly may not perform them as directed. Take the time to demonstrate them and have the patient demonstrate their exercises, including posture correction. Have the patient recite to you the exercise prescription. Help them problem solve how they might perform the exercises at work and at home.

The last phase is satisfaction. Patient's motivation will be affected by whether they are satisfied with the outcome. Demonstrating cause and effect with their exercises will create a level of intrinsic satisfaction, which in turn will reinforce their confidence in their ability to effectively self-treat.

When designing a home exercise program for a patient ask yourself three questions: 1) Does the patient see the relevance of the exercise program? 2) Does the patient have the confidence to be successful at home with the self-treatment strategies? 3) Is the patient satisfied with the treatment and outcome? If the answers to these questions are yes, then the patient will be motivated to perform their exercises away from clinic.

Focusing your patient education on the utilization of instructional strategies for the adult learner can improve your patient compliance. Patients who believe in their ability to self-treat and improve their symptoms are more likely to obtain their (and your) goals than patients who have doubt in their ability. The use of the ARCS model may be the tool you are missing to improve your outcomes.

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A CLINICIAN'S PERSPECTIVE

2016 MDT Conference of the Americas—Miami, FL

Fiona MacKenzie, Pt, Dip. MDT

When I was first introduced to the idea of attending the McKenzie International and/or Americas Region Conferences, I had assumed these meetings were reserved solely for Diplomates and/or Faculty Members; exclusive events intended for the elite. At the time, I had recently become Credentialed in MDT and I did not feel that the qualifications of this small town girl from Ontario were adequate enough to allow me to attend. As a result, I passed on the opportunity to travel to Austin, Texas for the 12th McKenzie International Conference hosted in October of 2012.

A year later, I registered for the Diploma MDT Program. Only then (with encouragement) did I feel that I could consider attending the Conference of the Americas in Denver, Colorado in July of 2013. It was here that I experienced all that a MDT conference has to offer. I absolutely LOVED it! I quickly learned that my view of McKenzie International and/or Americas Region Conferences was completely mistaken; They were intended for MDT clinicians of ALL levels! I was quite disappointed in myself for not having attended one of these amazing events earlier.

I made a tough decision to pass on the 13th McKenzie International MDT Conference hosted in Copenhagen, Denmark in September of 2015. I was busy preparing for my Diploma Exam the following month. So, when the opportunity arose to attend the 2016 Conference of the Americas in Miami, Florida, I jumped at it. I might have even been one of the first to register, I was THAT keen. Even if it meant that this red-haired, fair-skinned, snow-loving Canuck would likely swelter in the blazing sun unprotected!

My second MDT conference lived up to my expectations and then some! This year, I was able to celebrate my new designation and quietly spent a moment staring at my nametag. While the 2016 Olympics had already begun and the athletes were in search for a gold medal in Rio, I had already found mine in Miami, Florida.

So what's the lure, you ask? What is it that these conferences can offer us as MDT clinicians? The answer in short - a perfect mix of EVERYTHING!

Academically, the conferences act as an added opportunity to continue your professional development. You'll attend general sessions where some of the brightest researchers and clinicians will present advances in evidence-based practice. In addition, you'll learn about how we can promote the role of MDT within the healthcare environment and review research supporting its use clinically. You'll attend problem-solving workshops where you'll learn directly from numerous Faculty Members of The McKenzie Institute. Their unique approaches and cumulative experience will assist in improving your clinical reasoning strategies and practical application of the MDT Method.

Socially, the conferences are helpful in building an international, professional network among other like-minded clinicians who share your passion towards MDT. You'll also be reunited with previous course instructors, colleagues and classmates. You can be sure to expect many laughs as you reminisce and create new memories!

Culturally, the conferences allow you to explore the world, in addition to the values and customs of each new host venue. And, let's not forget the appeal of new foods and beverages!

Where else can you combine over 10 hours of education with travel AND fun?!?!? Nowhere.

Grab a pen and mark your calendar! Save the date for the 14th McKenzie International Conference to be hosted in San Francisco, California, September 22-24, 2017!

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LITERATURE REVIEWS

Summary and Perspective of Recent Literature
Paul Nelson, PT, Dip. MDT

Stynes, et al. (2016). Classification of patients with low back-related leg pain: a systematic review. *BMC Musculoskeletal Disorders*; 17:226

Stynes et al undertook this study to better understand the classification of patients with low back related leg pain. This subgroup is associated with increased levels of disability and higher health costs, but has no consistent and clear definition to identify low back-related leg pain (LBLP) due to nerve root involvement. This review looks at the relevant literature that classifies or subgroups populations with LBLP, and how leg pain due to nerve root involvement is described and diagnosed in the various systems.

A lit search identified 13,358 papers that were eligible. The authors also hand–picked from a review of referenced articles that were cited, producing an additional 21 papers. From this, 50 relevant papers were identified that reported on 22 classification systems. Five themes were identified:

Classification System Themes
(1) Clinical Features
(2) Pathoanatomy
(3) Treatment-Based Approach
(4) Screening and Prediction Rules
(5)Pain Mechanisms

CLINICAL FEATURES
This category included six papers. The Quebec Task Force Classification was the only system that had supporting work on validity and generalizability. Of interest is a study by Werneke et al in 2004 that compared the QTFC system to classifying whether leg pain centralized or peripheralised. Centralizaiton or peripheralisation was superior in predicting outcomes and long term work status. There were no reliability studies identified for the QTFC. Kappa value for physicians reviewing case studies was 0.69.

PATHOANATOMY
This category included six classification systems which tried to identify the patients' source of pain. Overall, the systems did not fare well due to lack of supporting work on systems validity and generalizability. All the systems studied recognized the lumbar disc as a source of pain, facet joint was included in five of the systems, four included stenosis, leg pain of radicular origin was recognized as a pain producer in all six systems, but nomenclature and consistency of definition varied widely. One study by Petersen et al, showed a low kappa value of 0.31 with chosen reference standard (Imaging, injections or discography).

TREATMENT BASED APPROACH
This category included four treatment-based classification systems. McKenzie had good support for its validity, reliability and generalizability. Peripheralization was a good predictor of outcome and there was conflicting evidence for inter-rater reliability. Overall, there were few studies included on McKenzie assessment and treatment in this systematic review.

Hall et al described five patterns of low back pain including leg pain, (treatment in this system is very loosely based on the limited use of McKenzie principles). Their terminology included 'painful discs', 'worn spinal joints', 'pinched nerve' and 'bony spurs within the spine'. Further study by Hall demonstrated that patients classified according to their system had more pain relief post treatment, resulting in less treatment days and patients were less likely to use medications. The study had several limitations that would significantly damper any positive conclusions drawn (cohort vs randomized controlled trial, significant baseline differences between groups). Reliability was good with a kappa of 0.6.

Albert et al classified patients with sciatica according to whether their pain centralized, peripheralized or did not change. All patients received exercise and advice. Improvements were seen in both peripheralizers and centralizers which the authors state refutes some of the McKenzie model theory. Interestingly, symptoms centralized in over 90% of the patients with MRI confirmed sequestrated of

extruded discs. Essentially this is a study exploring the McKenzie system, but in this review was deemed to represent a separate classification.

SCREENING TOOLS/CLINICAL PREDICTION RULES

This category included three papers. The purpose of the system is to identify clinical features that either guide diagnosis or assist in treatment. Fritz et al. identified a subgroup of patients who benefited from unloading (traction) when the peripheralized with extension. Scholz et al. used statistical methods to identify items in a standardized assessment that would differentiate between LBP patients with and without radicular leg pain. Roach et al. used screening test algorithms, based on a questionnaire to place patients into four predetermined "structure based" classifications (disc, spinal stenosis, disc disease with spinal stenosis and benign low back pain). The reliability of Roach's system had kappa values ranging from 0.57-0.91. Scholz's system identified patients with radicular pain with high sensitivity and specificity. However, there was no published work on applicability of the rules to different populations.

PAIN MECHANISMS

Three pain mechanism systems were identified; Smart et al used statistical analysis to identify discriminatory clusters of signs and symptoms related to each of the categories. Smart's system classifies into:

Smart et al's Classification System
1. Central sensitization pain
2. Peripheral neuropathic pain
3. Nociceptive pain

There was some support for the discriminative validity of the system. Reliability kappa values were substantial at a Kappa of 0.77.

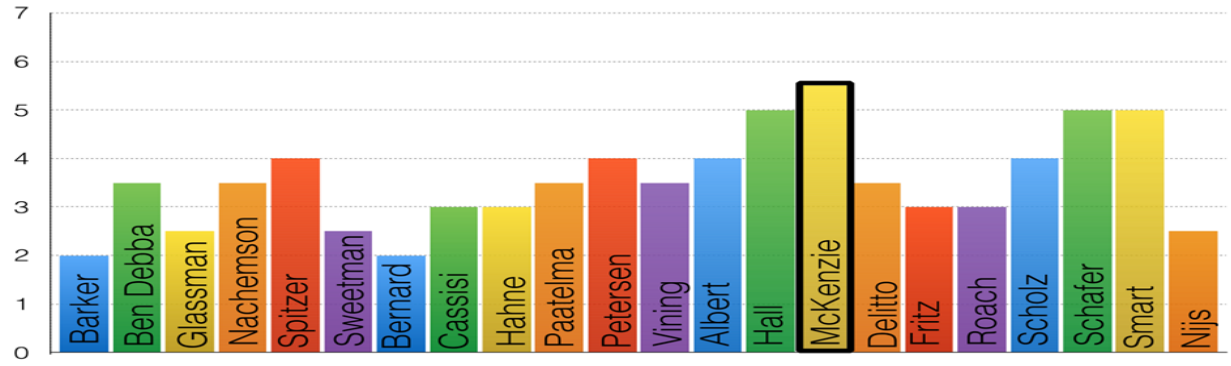
Schafer et al. described a four-group system:

Schafer et al's Classification System
1. Central sensitization
2. Denervation
3. Peripheral Nerve Sensitization
4. Musculoskeletal

Reliability for the Shafer system was substantial with a Kappa of 0.72. Some doubts were expressed about the construct validity of this system.

Overall, there was a significant lack of consistency of terminology between all of the systems used. Up to 11 different terms were used for nerve root presentations. Findings from the clinical examinations also showed great inconsistencies between systems, from being very specific to being very vague. The validity of the systems was very poor, particularly in content and construct validity. There were very few systems that had any reliability data. The ability to judge the generalizability of the systems was very limited as well. Only three of the 22 systems focused specifically on LBLP patients. Within all of the systems the need for a more common language to define nerve root involvement and clinical criteria to diagnosis it was very evident.

The authors went on to conclude that the QTFC was the best place to identify leg pain due to nerve root involvement. McKenzie was given a brief mention in the discussion, but was dismissed based on the minimal studies included where McKenzie was not deemed superior to other treatments, even though they stated that its validity, reliability and generalizability had been supported in the literature. Interestingly, McKenzie principles were echoed in three of the five themes identified by Stynes et al. Centralisation and Peripheralisation were mentioned on three separate occasions as good predictors of outcome. Overall though, the McKenzie system scored the highest of any system in any category, as seen in the graph on the following page.



Out of a maximum of seven, the McKenzie system scored 5.5 on criteria based on content validity, face validity, feasibility, construct validity, reliability and generalizability. Two independent reviewers scored the systems.

Since the purpose of the study was to identify how leg pain to nerve root involvement is described and diagnosed in various systems, it seems that language and lack of consistency has gotten the better of us. Using such different language, the diagnostic accuracy of identifying such subgroups on a consistent and reliable basis. What was underscored was the need for more consistent language and nomenclature, so that when clinicians are speaking, we, as a group, are all on the same page. As within the McKenzie system, when a clinician talks about a Derangement a clinical picture emerges that allows for a clinical conversation to ensue. What has emerged from this study is the need for a common language so that clinicians can be part of the bigger conversation that helps to diagnose and treat low back related leg pain. In the long run, McKenzie belongs in that conversation and can be at the forefront because its identification of centralization and peripheralisation and essentially the identification of Derangements have such a big impact on outcomes, as well as performing all the legwork for validity, reliability and generalizability.

Summary and Perspective of Recent Literature
Andrei Altavas PT, Cert. MDT. Celia Monk PT, Dip. MDT, Richard Rosedale PT, Dip. MDT

Thackeray A, Fritz J, Childs J, Brennan G. (2016). The Effectiveness of Mechanical Traction Among Subgroups of Patients with Low Back Pain and Leg Pain: A Randomized Trial. *J Orthop Sports Phys Ther*; 46: 144-154.

The study had two purposes:

- To examine the effectiveness of traction in patients with nerve root compromise within a specific subgroup in the Treatment Based Classification (TBC) system.

- To determine if mechanical traction in addition to an extension oriented treatment approach (EOTA) will have better outcomes than an EOTA without traction after six weeks, six months and one year.

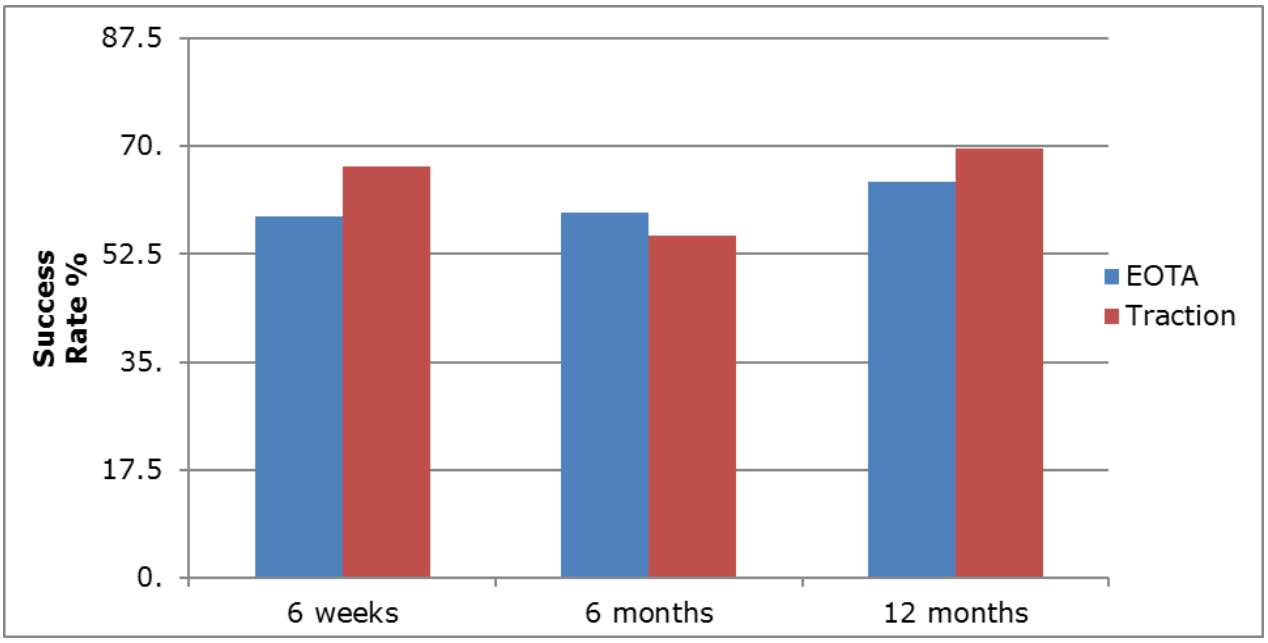
It has long been proposed that classifying LBP patients and making treatment decisions based on a patient's clinical presentation would yield better outcomes. Mechanical traction in the treatment of LBP with nerve root involvement has been used for many decades, but, as yet, has unproven efficacy. Some clinicians feel that traction may have a place in musculoskeletal care with patients presenting with highly 'irritable' symptoms, a greater intensity of leg pain and exhibiting signs of neurological compromise. Initial studies conducted by Fritz (2010) found greater improvement in disability in the first two weeks of treatment using an EOTA with traction, but no difference at six weeks.

A subgroup criteria was first defined in the TBC system identifying patients who would likely benefit from traction. Patients who either peripheralised with extension movement on testing and/or those who exhibited a positive crossed straight leg raise (CSLR) test were proposed to benefit.

This study examined changes over time (six weeks, six months and one year) and interaction between treatments and subgrouping status. An intention-to-treat analysis was used to account for lost participants. 120 patients with LBP and signs of nerve root compression were randomized using predefined subgroup criteria at baseline. Patients who peripheralized with one extension movement and/or had a positive crossed SLR were assigned to the EOTA with traction, and those who were negative on both of these findings were assigned to the EOTA. The study outcomes included the Oswestry Disability Index (ODI), global rating of improvement, as well as average LBP and leg pain.

RESULTS:
At the end of 12 months, 49 participants were lost to follow-up and 71 completed the study. The proportion of patients reporting a successful outcome at six weeks, six months and one year did not differ between groups, even when analyzed by matched treatment.

The table below shows the percentage of participants reporting a successful outcome at each timeline. Furthermore, reports on treatment side effects were obtained at six weeks and found no significant differences between treatment groups in severity of reported side effects.



A successful outcome was defined in the study as a patient who reported his/her change in global rating scale with treatment as “quite a bit better” or “a very great deal better.”

Correspondingly, the authors analyzed the impact on duration of symptoms as a predictor of poor prognosis, but this only had a ‘marginal effect’. Patients lost to follow-up (n=49) had a higher level of leg pain intensity, higher scores in Sciatica Bothersome Index, FABQ-work, and Pain Catastrophizing scale.

VIEWPOINT:
The aim of this well-designed study was to determine the clinical effectiveness of adding mechanical traction to a treatment approach utlising the extension principle (which they refer to as EOTA). As MDT trained clinicians we can find many shortcomings in their EOTA treatment protocol, namely the lack of training (each clinician was given only 90 minutes of training), the lack of patient-specific clinical reasoning which should occur each treatment session according to the symptomatic and mechanical response, the lack of information of the specifics of the self-management programme (we are not informed as to whether the EOTA patients performed frequent sessions of the appropriate repeated movements throughout the day or not), and the significant number of treatments given (average 10 treatment sessions over six weeks). However, the purpose of the study was to prove the additional benefit mechanical traction can provide to patients within a specific subgroup, namely low back pain and radiculopathy, thereby justifying its continued use in some clinical settings. Their conclusion is that there is no clinical benefit to adding mechanical traction to this group of patients.

In their discussion, the authors suggest that perhaps mechanical traction could be used to determine if centralization can be achieved. However, if there is no clinical benefit to using traction, why not correctly use the repeated movement testing sequence and follow MDT protocols to determine centralisation instead?

It is certainly worth noting that despite all the patients having nerve root compromise, and the fact that it is acknowledged that this group can be “challenging and costly to manage”, significant improvements were gained and maintained for all these participants with a directional-oriented approach. Though, with no control group we cannot draw too many conclusions about this how much of this change is due to the effect of the treatment itself.

There are a couple of limitations to this study that need to be taken into consideration. One is that the 120 patients were spread over nine clinics in two cities, which could make it difficult to ensure the treatment protocols were strictly followed by the number of clinicians which must have been involved. The clinicians were only given one 90-minute training session, which could result in a lack of clinical reasoning process to ensure optimal outcome. This could have been addressed by close clinical supervision, but we are not told at what level this occurred, if at all. Another limitation is the large percentage lost to follow up (41%). This resulted in a small number of patients having adequate data at one year follow up.

This study was very specific in its patient selection, targeting those that should, in theory, benefit from traction being applied to a lumbar spine with a compromised nerve root. However, there was no benefit found, as well as there being more side effects reported with the traction group. It does, therefore, raise the question of why some clinicians are still choosing to use mechanical traction for treating their low back pain patients. Surely, this study is another nail in the coffin for the use of lumbar traction…maybe the final nail?

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BUSINESS & MARKETING CORNER

Strengthening Your Business Through Internal Marketing

Fortino Gonzalez, Pt, Dip. MDT, FAAOMPT, OCS

I am a firm believer that people will rise to the level of expectation that one has of them. By the time I went into business for myself, I had very specific ideas about how I wanted my office to run. Because my patients expect and deserve my very best, I have spent my 28-year career training to be the best possible clinician. Moreover, I feel that my staff should also have the opportunity to train to be the best that they can be. In business many will say that treating the customer right is foundational to your success. I would take that a bit further and say if you treat your employees right, they will, in turn, take good care of your customers.

When I opened my doors for business, I felt that there were three areas that needed special attention: 1) a staff that was courteous, polite, and well informed, 2) a clinic that was clean and well organized and 3) a level of clinical expertise commensurate to delivering the highest level of care. My OCD personality pretty much took care of the clean and well-organized part, and my MDT training guaranteed the highest level of clinical expertise. The area where the most potential rested was in my staff. Your staff is an extension of you, and they will follow the tone you set. In the past I have worked at different facilities that invested ample time, money and effort into guaranteeing that the physical therapists were well-trained, but no investment was made in the administrative staff. This was a philosophy that I never really understood.

When a patient comes in to see you, they are not happy. They are in pain, they are frustrated, they are tired, they are worried about their health and well-being and they have taken time out of their busy day to see you. It is imperative that they are met with a friendly, courteous, well informed front-end staff. When hiring an office staff member, I look for one simple trait: Is s/he interested in being the best that s/he can be? If the answer is yes, from that point on it's all about the training. Beyond the day-to-day operations of running an office, I spend many hours training my staff in basic customer care principles by carving out time for crucial professional development. The foundation of this training begins with *The 7 Habits of Highly Effective People* by Stephen R. Covey, which I require all my employees to read. I have found that these basic principles transfer well into our day to day operations.

My office is a Certified McKenzie Clinic. It is who we are. I market it as a McKenzie Clinic and everything we do revolves around the principles of MDT. So, as you can imagine, all my employees are well versed in the Method, including my front office staff. I schedule regular meetings and allot time for my staff to sit and learn, review, or revisit our McKenzie Method library. Both the McKenzie Institute USA's website and Facebook page have become an excellent resource for these continuing education sessions. By using these sites my staff become very familiar with them, and they, in turn, are able to share this information with their families, friends and, more importantly, my patients. This all goes back to my basic philosophy of treating your employees right and empowering them with knowledge. They will, in turn, use that knowledge to empower others.

This idea is foundational to us at McAllen Physical Therapy, Inc. My staff is able to reinforce the information and principles that I have already discussed with my patients. The better understanding my staff has, the better understanding my patients will have. Informed patients are then better able to share and relay the McKenzie Method principles to their friends, families, and, many times, their physicians. I feel that much of my success and growth as a company has not only come from me being a MDT clinician, but also from taking the time and effort to train my staff in the same principles. All of the information you need to do the same is at your fingertips! I encourage everyone of you to consider the idea of training all members of your staff in MDT. It can only strengthen your practice.