Peter Ward's reply:

I don't like to call myself a McKenzie therapist. My experience using the Mckenzie concept has been consistently positive, but I use many other techniques as well. In particular, I have developed an interest in chronic pain, and have collaborated with a clinical psychologist at Tameside in developing and delivering chronic pain management programmes for back pain. So when I refer to "McKenzie therapists" for therapists who use the McKenzie concept, at least some of the time, and "we" in talking about them, it is purely for the sake of brevity and convenience.

I don't think I can address every point Louis makes in his editorial. I don't see how I could ever find the time, for one thing! But I hope to cover the main ones.

In using the McKenzie concept, the last thing anyone should do is to produce a fear of flexion in patients. Louis states that the tone of my letter seems to be denying that this is an issue that needs to be addressed and discussed. That is not the case. In my letter I was making a particular point. It would have been reasonable to assume from Louis' comments in "In Touch" that the Mckenzie system consists purely of extension, and that patients are permanently discouraged from flexing. I wanted to address that misconception.

Louis also claims that I stated that 65-75% of patients with acute low back pain require extension initially, and strongly disagrees with this claim. What I actually said was that a McKenzie assessment to identify a directional preference will show that for 65-70% of patients **who show a directional preference,** the direction will be extension (i.e. their symptoms will improve with some form of extension). Obviously if you use different assessment criteria, your conclusions will be different. I was simply making the point that McKenzie is not all extension.

As to the question of whether I have caused a fear of flexion in patients, I must hold my hands up and say "Yes!" There are essentially two reasons for this. The first involves competence in using the Mckenzie concept appropriately. As I gained more expertise, I realised the importance of bringing in flexion and restoring function far more quickly than I had been doing. This made a big difference. So creating fear of flexion was no longer a problem. Actually.....yes, it still was, for some patients. Then I did Louis' courses, and other psychology based courses. These, and the time I spent at Tameside working alongside a clinical psychologist gave me a good understanding of pain physiology and psychosocial yellow flags. I now understood why some patients were still developing fear of movement and activity. Recognising and addressing fear avoidance is an important educational issue for physiotherapy generally, not just Mckenzie therapists. I am not producing fear of flexion now using the McKenzie method, and that is the point. Fear avoidance of flexion is not an inevitable consequence of using the McKenzie method. It depends how you do it!

In his "In Touch" article Louis implied that there are some clinical situations where care in introducing flexion is indicated: "fine to suggest care with some form of bending in the early stages". He also suggested that it can be restored gradually "in a graded way". He also implied that it may sometimes be delayed: "should be restored.....at some stage". I pointed out in my letter that under the McKenzie system all patients with acute LBP (when treated competently!) are given, at some

stage, a full programme of graded flexion exercises in order to restore full function and confidence in bending. Imagine my surprise, on reading Louis' editorial comment on Patient A, to find that cautiously introducing flexion is.....fear avoidance! Introducing flexion at a later stage is.....fear avoidance! Progressing flexion gradually is.....fear avoidance!

It is rather mischievous of Louis to package valid clinical considerations that we all hold, including Louis himself, as a recipe for fear avoidance. He is also missing the point. Preventing fear avoidance is not about flexing patients with no care or thought for the consequences. There are times when it is clinically valid to be cautious and gradual in progressing flexion, and extension. (Graded exposure?). What is important is the skill with which we address these concerns in our interaction with the patient, the way in which we give information to the patient, and our underpinning knowledge of pain physiology and yellow flags.

Louis talks about the pressure to rapidly correct deformities. For me it is not a problem. Most patients are happy to go along with as rapid correction of deformities and movement loss as is clinically indicated. But I am quite prepared to go slowly in the early stages, if the patient wishes. It is the patient who chooses, not me. Louis mentions the risk of producing rapid increases in movement. For me, the main danger is allowing deformities to persist for so long that they become maladaptive and difficult to reverse. I am seeing a patient at the moment who presented with a three month history of back and leg pain, with a lateral shift and flexion deformity. He had already been given general exercises and electrotherapy elsewhere, but his deformity had persisted. It could only be reversed with the application of considerable force
over two weeks of swearing, sweat and tears. But at that stage he felt much better than he had since the problem started, and quite angrily asked "Why did no-one do this before?"

I have no problem with Louis' strategy of going gently with some patients in the early stages. These problems can be very painful. The key questions for me are when to decide that delay will risk producing deformities resistant to any treatment, and the importance of giving the patient informed choices. The same is true for blocks to movement. Working in secondary care, I often see patients who have had pain for months, sometimes who have been given general exercises previously, with persisting blocks to movement, sometimes into flexion, more often into extension. These patients need specific exercises in a specific direction, and significant force, and time, is often required at that stage to restore normal movement and function.

Let me tell you about Gareth. He presented with an eight month history of back and thigh pain following an RTA. He had a major loss of extension, and a moderate loss of other movements. Three sessions spent exploring different positions and movements did not suggest a directional preference. Even prone lying exacerbated his symptoms. Psychosocial assessment revealed moderate fear avoidance and depression. He appeared to be focussing excessively on his symptoms and demonstrated marked activity intolerance. I decided to adopt a functional rehabilitation approach, and encouraged a paced increase in mobility and general exercises. At this stage his tolerance to driving was 20 minutes, and to walking was 15 minutes.

During the next three months Gareth made steady progress. He added swimming to his activities and coped well with gym sessions. His driving tolerance increased to one hour, and walking to 30 minutes. He also increased his range of lumbar flexion. However, his pain had only improved a little. What concerned me particularly was that Gareth still had a major loss of extension. Extension exercises and mobilisation techniques exacerbated the pain. I discussed this with him and we agreed to try something different.
I decided to treat him by gradually extending him from prone lying by raising the head of the bed. However, due to the sensitivity of his symptoms, I would have to take it very gradually. I decide to try this technique daily, increasing a little at a time.

On the first day he managed 11 degrees. (It was easy to measure by measuring the angle of the bed). The next day he reported a severe increase in pain, which had not quite settled. However he was keen to continue.

The next day he felt “as stiff as a board”, but the increase in pain was not as bad as the first day. This time Gareth managed 13 degrees. The following day he said that the pain felt a little easier and he felt less stiff. This time he managed 16 degrees.

After four weeks of this approach, combined with self treatment at home, Gareth was able to extend to 32 degrees, and he was able to extend more rapidly and with less pain. His driving and walking tolerance had improved to more than two hours. He was able to perform extension
exercises and feel better following. He reported a 40% reduction in pain over the four weeks.

Gareth’s problem raised some interesting points. It certainly didn’t behave as a familiar mechanical problem, and there were significant yellow flags. It is impossible to be certain with so much going on, but with hindsight I believe there was a mechanical component to his problem, and at 12 months it wasn’t getting better, even with fairly vigorous general rehab.

The impression Louis gives that extension is a movement possibly to be feared may discourage therapists from moving patients into extension even when clinically indicated. As in Gareth’s case, it isn’t always the comfortable option that helps.

I quite agree with Louis that attention and expectation can produce variations in pain intensity and distribution. I have observed the same phenomenon myself. It is fascinating. And it is something we need to be aware of. However, my experience is that beneath this shimmering mist of fluctuations in facilitation, we often see solid, mechanically mediated patterns of pain distribution and movement loss that are consistent in their presentation and response to treatment. (Try doing the opposite to Louis during repeated movement testing, deliberately giving the patient no clues as to what you expect, and asking no leading questions).
“If you focus on the pain so will the patient. Place equal importance on changes to range of movement to establish a directional preference”. (Julie Shepherd, McKenzie Newsletter, July 2000).

Louis describes the normal reaction of feeling often very stiff in moving in one

direction, after sustained time moving or positioned in the opposite direction. However, this normal reaction does not produce blocks to movement lasting weeks, or deformities. So there are two mechanisms operating here, one physiological, the other pathological. I think it is important clinically to recognise the difference.

I also agree with Louis that backs need to be moved in all directions for good tissue health. As part of my prophylactic advice to patients I often say something along the lines of: "It's fine to bend. Your back is meant to bend. But if your job involves bending forwards continuously, stop and bend backwards a few times occasionally. Balance the stresses out." (Not quite the same as telling patients never to bend).
We are each entitled to our unique view of reality, shaped by our own experiences and influences. And we all sometimes use that view as a basis for generalisation. Louis talks about extension producing full-blown radiculopathies, and says that the clinical reality is that this outcome is common. Maybe for you, Louis, not for me! In fact, I cannot remember this happening at all. Your personal experience has led you to be fearful of extending patients. Fair enough. But my reality is different. Maybe I've just been lucky. Or maybe I'm better at deciding which patients to extend and which not to extend; and which patients it is safe to extend quickly, and which need to be extended more gradually, perhaps over several sessions. It is worth remembering that patients with sciatica will often be made worse by extension.

I began by stating my dislike of the term "McKenzie therapist". The term does imply a narrow view, and I believe, strongly, that any therapist who treats pain needs to widen their horizon. In particular, knowledge of pain science and psychosocial yellow flags is vital. It is important to see mechanical pain in the context of pain physiology as a whole.

I appeal to those reading this in the Mckenzie newsletter- learn about yellow flags, find out how to recognise fear avoidance and deal with it, learn more effective ways of communicating with patients. These are important issues for our credibility as a profession. Louis Gifford's courses are a good place to start, and I recommend joining the Physiotherapy Pain Association and reading their yearbooks, which are full of excellent articles and useful information.

To those on the other side of the debate, my view is this. I expect criticism of the McKenzie system to continue. I welcome it as something we can learn from. I have taken on board ideas from Louis' editorial and In Touch articles that I will try in practice. However, it is reasonable to expect criticism to be based on what is happening now, and on an accurate picture of what the McKenzie concept involves.

It is obvious that much of Louis' criticism is based on the effects of the McKenzie method being applied incompetently and inappropriately. The McKenzie institute can only do so much in the way they deliver their courses. It may well be that it would be useful to make some changes. Ultimately, though, it is the individual's responsibility to acquire competency, and to remain aware of developments in pain science.

Louis began by asking: Does the McKenzie approach – need a shift? The answer is that it has already shifted, and is still shifting. Louis is quite right to say that we should not produce fear of bending in patients. What he does not seem to appreciate is how much work has already been done by the McKenzie Institute in this country to

address the issue of psychosocial yellow flags. Only last month, The McKenzie annual seminar included a workshop on ways of giving information to patient and interacting with them in order to reduce resistance, anxiety and fear avoidance. More needs to be done of course, for which the input of Louis and others in the PPA is important. That is why I am slightly disappointed by the confrontational tone of Louis' editorial. Clearly Louis will never agree with our methods. However, we have the same aim of empowering the patient and giving them the information to manage their own pain. I believe that there is more that we agree on than disagree. Were we to become more confrontational and entrenched, constructive dialogue on how to address psychosocial yellow flags and fear avoidance would be discouraged. That would be a pity.

Peter Ward