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Transcription of Interview

Know Pain: A Practical Guide for Therapeutic Neuroscience Education

Chris Murphy (Director of PhysioUK)

Mike Stewart (Clinical Specialist Physiotherapist & Interprofessional practice-based educator and Tutor of award winning, evidence-based Know Pain CPD events)

A PhysioUK interview with:

KnowPain

EMPOWERING FUNCTION THROUGH EDUCATION

Full transcription of a recent 'Know Pain' discussion between:

CHRIS: Chris Murphy (Director of PhysioUK)

MIKE: Mike Stewart (Clinical Specialist Physiotherapist & Interprofessional practice-based educator and Tutor of award winning, evidence-based Know Pain CPD events)

CHRIS: So, it's great to be talking to Mike Stewart this afternoon. Mike teaches a course called "Know Pain", and it's not just the course though, you do provide lectures as well. You run internal courses, don't you Mike?

MIKE: Yes, I run courses advertised through PhysioUK and I also run internal, tailored courses for departments for in-service trainings.

CHRIS: Okay, so just with regards to the courses, one of the key things we wanted to unpack is a little bit more about the course and what would be of benefit to potential participants of the material. I just think sometimes that's quite nice is to know a little bit about how the course came about and how you've kind of come to this point in time. So could you just give us a little potted history of you? What's your history?

MIKE: I qualified in the 90s and I felt really disillusioned, and I didn't really feel that physiotherapy particularly was achieving the things that I thought it would. I was always told that it would help people get rid of their pain, and I didn't feel really good at doing that. And when I was chatting to colleagues and friends of mine, I'd hear tales of how they would cure a 50 year history of back pain with a single treatment and I never felt capable of doing it.

So I thought well, either I'm not very good or you're having a bit of a confirmation bias as to what it is that you're doing. So I went off travelling and worked in a few different countries and different places around the world, and it was interesting because I kept meeting people who felt equally as disillusioned as I had. And so it appeared that the biomedical model of practice that I'd learned about had not really worked for many clinicians. This led me onto a journey of looking at biopsychosocial model which my 'light bulb moment' was attending Louis Gifford's courses many years ago and really being inspired by what he was doing, and then looking far more into the evidence-base over many years. There's over 40 years of empirical evidence for the biopsychosocial model, and developing down that line, developing patient education groups that I run these days, spending lots of time with different experts around the country, watching what they do, being inquisitive.

And I suppose then eventually that led to me developing my own course having been on lots of pain education and psychological interventional courses. I always came away feeling that it

was great and I benefited from lots of theoretical concepts and academic understanding, but then it was always that question of now what? How do I apply that within practice with, you know, Paul, Jean and Bob and people who don't speak an academic language. And that's where I felt that the gap was between an academic understanding of the biopsychosocial model and the practical application.

CHRIS: Yes, interesting. There was just two things you said there I was just writing. One that made me smile was, I was just reading Louis Gifford, the new book out from Louis obviously, apart...

MIKE: Yes, yes, great isn't it?

CHRIS: But I was reading the first one it made me smile about when he worked in Maitland's practice and how the perception was, of course everyone in Maitland's practice would get better, and that wasn't the reality. Their success rates were relatively quite low, and it really warmed the cockles of my heart a bit.

MIKE: I remember him telling me that story it always stuck in my head that, you assume don't you that these gurus and experts are amazing and get things right all the time. And equally I think when I've gone around doing the course I always get that across to patients that just because you know more or have developed a course and have an understanding as to what's happening, doesn't make you a guru. The expert model doesn't work.

And I always remember that, Louis Gifford saying to me that he would always contact his patients, who came from far and wide, to explain to them that he was only a human with some skills. That he wasn't this miracle worker. Yes, I think that's important.

CHRIS: And one of the things that came across in the book as well was about, actually what you just said there, about matching it to the patient, Jean, Bob, whoever it be, is that there's a skill and there's an art in getting that across to the person in front of you, and everybody's different. I don't know if that's the things that you bring out in the course. So, I didn't know if you just want to sort of chat through some of the course maybe a little bit. About what the aims are really of the course. If we touch on that first of all and then see where we go.

MIKE: I think one of the big things that I always felt was, there is an art to pain education. I think there is some art involved, and the more I look into the research surrounding practice based education, the more I started to realise - two things really. First of all in healthcare we assume that we can teach. If we're going to go and do manual therapy, the underpinning for manual therapy and palpation is an understanding of anatomy. Imagine trying to use manual therapy without understand anatomy. And then if we think about education, this is pain education, but if you don't understand the underpinning of education then we're in the dark. We don't send our kids to school to teachers who've come from the pub. They've learned how to teach. So I think acknowledging that we assumed for many years that we can teach is an important thing for us to do as healthcare professionals.

So the course really tries to take some of the skills that I've learned from an educational background and apply that in a practical sense. You know, why do we see patients who are very frustrated or they get very angry? And is it to do with a lack of educational understanding from past clinicians, from their experiences? And often it is. But the other thing also that I look at is trying to find lots of creative and expressive ways to try and help patients make sense of their pain. So we try looking at things like song lyric analysis and we look at art and we look at poetry and it's interesting. The London School of Economics has just completed a very long project looking at just this.

It's in that when I work with clinicians and ask them their thoughts on this, most people express that they need something a bit more then what they've currently got. And they're unable to help their patients understand pain through a very scientific, rigid method. We have to start engaging some creative learning and creative thinking and helping our patients' find creative methods of coping.

CHRIS: Because one thing I know when we've spoken before one thing that was mentioned is that therapeutic neuroscience education material has been around for 10 or 12 years now. And so, I'm curious then; from what you just said there, so was it your frustrations or was it your frustrations through the voicing of others that lead to the "Know Pain" course? In the inability or the difficulty in putting that material across. Because you could argue, that materials out there, people just need to access it and they just need to teach it?

MIKE: I think your point was right there Chris. People feel frustrated. Because they're trying to teach it, but obviously they're trying to teach it without an understanding of education. And I think that, it's interesting that when people have come on to "Know Pain" courses they often leave – very experienced clinicians who've been on lots of pain education courses – and they leave with a few things but one of them primarily is "I know understand how to teach better. And that then, gives me an ability to understand: why is this patient or this person not learning this?"

A classic example was on the weekend, on the PhysioUK course we just ran together in Edgware. Somebody said to me, you know, I sat there four times repeatedly saying: "Margaret, we've been through this four times. Why do you keep coming back to the same point?" And he said now I realise that, yes, I wasn't getting through to her because it was almost that copy and paste type idea of education. It's not understanding how to facilitate learning in somebody else. It's just talking and hoping that it's going to go in.

I think that's a big issue that we have and lots of the CPD courses that I've done throughout my time, there is that general broad assumption that we can just teach. So the "Know Pain" course really starts with gaining an understanding of the practical aspects of the biopsychsocial model. Looking at where it's come from and why it's necessary and I often think, it's like a pain sandwich.

We start with pain, we look at the neurobiology of pain; which is called turning jargon into meaningful common sense. So we look at lots of abstract theoretical concepts, iron channel

sensitivity and central sensitization and long term potentiation, and we turn those into meaningful applicable, practical, communication skills through metaphor. And the whole of the afternoon of the first day is spent looking at educational theories and how they relate to our patients from helping them understand pain. So it is sort of a pain sandwich. Pain on the second day, with the education bit in the middle, yes.

CHRIS: That sounds really good because I'm imagining from what you said there that the course is quite interactive? Or is it more talk-y and discussion?

MIKE: There's a mixture really. I think one of the nice things that I've been hearing repeatedly through people's feedback is it's nice that they leave inspired. I think that's the word I keep hearing; which is lovely for me. People feel inspired. They've come on the course and I feel like I haven't done my job well if you don't leave the course with a whole range of different things you can go away and try, and modify, and you should have a new toolkit of things you could be doing. And people definitely seem to be getting that which is great. And we look at experiential learning, so learning through experience. So we do lots of experiments where we look at threat and fear and things that come directly from the patient groups that I run.

And I think that's the other thing to say, a lot of the content on the course comes from the years of working with patients so you leave with a folder, and two slides per page, which lots of people seem to like rather than the six slides you usually find. So you actually see the images and you can use those images with your patient's in practice, to take your patients through some of the work that we do. Because it's applicable for patients. There is not this huge distinction between us learning as clinicians and patients learning. And you also get a USB card which you're able to then stick into the computer and help your patients understand pain better.

CHRIS: I mean, in terms of the resources that course participants are getting, there's loads of stuff there, and I love anything that inspires people. I love that, but what I was imaging as you were talking through that, just the stories from your patients that have inspired things and sort of helped shape the course. I guess there's a couple of patients that spring to mind in my mind that just through the communication that we have, and the stories I was able to tell and weave it in with them. You just got to get the patient. You captivate them and you can make some amazing changes with that knowledge. And it doesn't have to necessarily be complex knowledge, it can be relatively simple, but it's just so poignant to them and they just think "Ah, that's exactly what I needed."

MIKE: Oh it's huge, it's huge. One of the things that we cover, when we look at educational theories. We look at one of the most vital things which is the science of interest. I did some work in my MSC which is looking at "What is interest? What is the science behind interest?" And it's, if you excuse the pun, it's interesting if you consider, if you can't get somebody interested in the first place. We've all had that patient that's sitting there looking bored and again, you're just using a copy and paste type method of didactic teaching, talking at them really. And they switch off and some of them might even DNA their next appointment and I think a lot of the skills I'm trying to teach people in the course is what is interest and how do

you gain interest in somebody else? How do you understand their preferred learning style? And how do appeal to that really so that you get the fish hook moment, you know, you dangle the line out and see whether they bite and get them interested in something. And I see that a lot within my practice and it's very nice for me to see that people leave the course with that idea.

CHRIS: And with that, I mean there's so many great things in there, with regards to the perspective of the patient. With my mind's eye I'm just sort of seeing the clinician. And I'm wondering if you've had any discussions from people, or comments from people, is that "Oh that's very well if I've got lots of time and I'm taking a more hands off approach to have that material, but no we're very hands on and therefore we don't need that." What's the sort of challenge to that or what's your reaction to those?

MIKE: I think some of the work that I do as an educator is I go around teaching GPs and I teach DRs and also physios and chiropractors, and osteopaths, a whole range of people. The key of it is when you go and speak to GPs, the one thing that they always say is "This is great. But how do I try to get this across in a minute or two? Have you got quick things that we can do?" And there's huge amounts. I mean, people will tell you, being on the course. We try to go through as many different, varied, types of experience and small experiments that you might do, in under a minute or under two minutes. Or simple physical metaphors, so yes, I think you can get across an understanding, a grounding for how pain works in a very quick way, to gain interest in patients. And we go through lots of practical ways that you can do that.

CHRIS: So if someone was thinking, with respect to the course, if they've been on the Explain Pain course, they've got some of the neuroscience education, there is still value obviously in coming to "Know Pain" because, you've got the aspect of teaching side of things. Understanding about how you might teach someone, obviously a wealth of other stories, metaphors, to throw in there. Is there anything else that you think that the course brings to people apart from the things that we've spoken about? That hasn't really come up, in terms of the inspiration, the knowledge and the teaching side of things. Anything else?

MIKE: Yes, I think really it's just making that link between the patients and what we do. So I think that by using many of the slides that come from the patient groups that we use, and applying them directly. So there's not this enormous distinction between an academic understanding and a practical understanding. I think that's a big thing that I've seen. And when I've spoken with lots of people who have, like myself really, have been on lots of different CPD courses to do with pain. And they, like me, felt that there was a gap, there's this gap between understanding theories and understanding some metaphors and simple ways of doing things, but not then being able to go immediately on a Monday morning and apply these things. And that was from my frustration that was partly what came out of me developing this course really. So very practical understanding's one thing. Being able also to integrate the psychologically informed physical rehabilitation.

Over the years I've done lots of work with MI and CBT and ACT and spent some time looking at cognitive biased modification techniques and various different psychological strategies and

again I find people who have gone and done, say a CBT course where they try to then implement that within their practice, they find they get a bit stuck. There aren't any real world practical applications of that intervention. And what I try to do in the course is everything's based on being practical. Every slide is "How does this work on a Tuesday afternoon at 3.30pm with Brian?" You know, it comes from a clinician to a clinicians rather than from an academic to clinicians.

CHRIS: When I've had some interesting patients before it's having that adaptability. It's have that repertoire to draw on. And you're assessing the person in front of you and kind of thinking "What's my number one shot?" or "what's my golden arrow that I fire with them?" Just to sort of hook them as you alluded to earlier. Cool. That sort of, will really help. The goal of this discussion, for someone reading, is to see what they would gain.

They've got a really nice overview there. And the key thing is the passion for people to go away with those skills, which just shines through. And I think that always, you know, that always made me smile. Where that's a course that is born out of frustration of wanting to empower people and equip them with the knowledge that they can go out and do things, they're better; get better results. So that always gives me a warm feeling.

MIKE: One of my favourite comments that I had recently from a course was somebody said to me that: "I've now got a vision as to where I can take my practice and I feel like I'm going to have fun with it." Whereas they felt, prior to coming on the course, even though they had a really good understanding of the biopsychosocial model, that they felt daunted as to how to actually apply all of that learning and now they felt that they had some fun ways to do this. And I think that's the other thing too, the course is fun really. We use lots of different creative learning methods as you go through to keep you interested and engaged throughout. Which I think, having gone on lots of courses before, is vital; and that's really important.

CHRIS: That's brilliant Mike. Thank you so much for that and thank you for your time.

MIKE: Thanks Chris.

CHRIS: And I look forward to speaking to you again.

MIKE: Lovely. Thank you very much.