

The Mastery of Patient-Centered Practice

Time in Traction, Patient Management And Motivation

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In managing thousands of patient cases in my many years in practice, I observed the following; *the more change patients made as demonstrated on re-x-ray, the greater likelihood they were to continue with additional care as needed.* Therefore, I began to work patients into rehabilitative procedures including forms of mirror image exercise and traction, as soon as possible in their initial phase of care, usually, long before their presenting symptoms were resolved. Therefore, their total time in traction, as well as their utilization of rehabilitative exercise in phase one of care was optimized. The more time they spent exercising and in traction, the more change was evident on their first follow up radiographic exam. Patients noting change after phase one were usually quite happy with their progress, and were willing to commit to 3-4 weeks of additional care (at 3-4 visits per week depending upon their condition and response to care to date) followed by another re-x-ray. Many patients continued for additional phases of care when needed with this approach. *The fact is patients want to succeed. Incremental success is critical to their motivation to continue with care.*

The second significant observation I made in patient progress and management was that most patients made greater change in their second phase of care, despite my initial, often Herculean efforts to get them in traction and exercise in phase one. *I discovered that since traction was the primary factor in spinal change, and that total time in traction was the most important variable that I could control in delivering my care, that the second phase of care and beyond was often the most productive in terms of spinal change.*

Here is why.

Consider that even in a case of 36 visits prior to re-x-ray, the total time in traction is far less than in phase two of care. Subtract 8-12 visits of manipulation, modalities, soft tissue therapy, and ice during the pain relief phase of care, which leaves 24-28 visits for traction and exercise. Remember that traction starts with 1-2 minutes, without load, and builds to 20 minutes over a 2-4 week period. This time frame results in a fraction of the total time under load applied in the second phase of care; for example, 12-16 visits at 20 minutes per session, 240-320 minutes of time under load in care phase two. Therefore, the greater change will occur over a shorter time period in the second phase of care. Furthermore, the patient's tissues are prepared to take more load in phase 2 as the microcirculation has had time to adapt by the time the second phase of care is undertaken, resulting in healthier tissues better acclimated to the process.

Why is this important?

If you are a doctor, as opposed to a technician, you must consider the patient as an individual, and all the variables possible that they present. You must never fit the patient to the system, but rather apply the fundamental principles of practice and your technique, while considering the variables related to each patient. Remember the bell shaped curve, and remember you are dealing with flesh and blood, emotions, and a psyche. No two patients are exactly alike. Don't treat them as if they are. Success in patient care is a combination of science, and art, and blending the two to fit each individual.

The general treatment guidelines for patient care in a practice offering spinal rehabilitation as a treatment option, for viable candidates, are well established. For symptomatic patients presenting for care, re-evaluation with radiographs is routinely performed at 36 visits. However, this frequency of care is a guideline only, and is open to interpretation by the doctor who is cognizant of the variables applicable to his patient. These many variables include, the patient's presenting complaints, age, duration and or severity of the present condition, and any pre-existing condition/conditions; overall health and fitness, presence or absence of systemic conditions, (diabetes, collagen vascular disorders, blood dyscrasias) or other general debilitation resulting in altered healing time, or genetic conditions such as tendency to form keloid, all affect the patient's potential for progress. For example, a patient presenting with few, or no overt symptoms, may begin spinal rehabilitation immediately, thereby becoming eligible for re-evaluation sooner than the standard of 36 visits, if the patient's escalation to full duration and intensity of

traction is achieved quickly. The time and intensity of traction is far more important to patient progress than a visit count alone.

The doctor's role in managing patients includes an initial presentation of findings, and subsequent follow up presentation of findings. The purpose of these visits is to present the facts, no pressure, sales, or scare tactics are needed. In the follow up presentation of findings, the doctor presents the patient's progress to date, as compared to the starting point in care, and options for future care at that point in time. The points that must be presented are as follows:

- The Preamble: An explanation of what the presentation is about, while addressing any stated or anticipated concerns the patient has expressed or intimated
- Comparison-contrast: A presentation of the original films (and or PosturePrint findings) and examination findings
- Explanation of the percentage of overall improvement
- Presentation of the legitimate care options available to the individual patient at that time: I suggest the options are, continuing care for 3-4 weeks with an additional follow up radiographic exam, stopping care, or if maximum improvement has been achieved for a particular individual, the offer of supportive care
- A reiteration of the frequency of care going forward, and any changes to the care protocol to be employed
- Scheduling a follow up patient education program to further assist the patient in learning more about their condition and ways to maximize improvement and benefit

The benefits of offering a 3-4 week second phase of care are as follows:

- It is easier for patients to commit to a shorter time frame
- It is an easier financial commitment
- It is a time frame most can envision completing
- Re-x-ray in this time frame allows for more information on the patient's status to date, and therefore, reduces the likelihood of error in traction type applied
- Based upon total time in traction, significant change is likely in this time frame
- Motivating patients with daily communication is easier when the goal is a shorter time frame

When managing a patient's case, individual attention to the person, their condition, their wants and needs must all be strongly considered.

All the variables related to patient care must be evaluated and understood. The patient's response to care, and to the techniques and procedures applied to the patient at the time the patient is re-evaluated radiographically, must be noted prior to proceeding with additional care. In every instance, the approach must be patient-centered to be maximally effective. By using common sense, honest motivation, and defining realistic expectations for each individual patient, a successful, honest practice will be the result.