Standardised Documentation in Manual and Massage Therapy – chasing a rainbow?

Fourie W J. Nat. Dip. PT
Private practitioner, Johannesburg, South Africa.
Tel: + 27 (0) 11 763 6990
Email: willief@medi.co.za

“Teriam esse medicinae partum, quae manu curet, et vulgo notum et a me propesitum est.”
[The third part of medicine is that which cures by hand and indeed it is a common knowledge.] Celsus. De Medicina, Proemium 9, Book VII (circa 25 AD)

Background.

One of the fundamental problems of a “common knowledge” is the documentation thereof. In many cases it is transferred from the one generation into the next by a form of learning as an apprentice and then taking over from the “master” or the midwife/grandmother, as in the case of traditional post natal care and massage in traditional Indian societies.

Touch can be seen as inherently human. From the earliest times of Man’s development, touch has been part of everyday rituals and life – varying between affectionate touch, through neutral touch of everyday life to aggressive touch for establishing dominance in a group or for self defence, often needing therapeutic touch as a consequence. The latter taking the form of rubbing, kneading, effleurage or just a soothing stroke.

Over the years, the healing, soothing touch of a mother, grandmother or caregiver has become therapy in its own right with manual therapies springing from this, each defining their own boundaries and techniques.

We all know how to touch, but entering the world of therapeutic touch is a daunting task for any outsider in defined therapies. Each therapeutic branch has its own definitions and descriptions - often exclusive to a single discipline. With traditional medicine using and defining therapeutic interventions for centuries, this is even more difficult and has left us with many therapists doing the same thing, but defining and documenting techniques and outcomes differently.

Tissue mobilisation, tissue manipulation and different forms of massage have long been practiced by a wide variety of clinicians and lay practitioners. The scope of their practices is largely in either sanctioned or non-sanctioned environments (Paris, 2000; Mintken et al., 2008). Sanctioned environments are legitimised through a formal recognition process and
include physicians, physiotherapists, chiropractors and osteopathic physicians – all practicing after a process of licensure and the regulation of the professional education process controlled by professional boards.

A broad array of lay practitioners similarly use tissue mobilisation ranging from masseurs and masseuses to body workers, fitness, and self-proclaimed health specialists and healers (Paris, 2000). These individuals primarily practice in non-sanctioned environments not regulated through traditional societal or legal forms of recognition with legitimacy established through cultural norms and practices (Mintken et al., 2008).

Both clinicians and lay practitioners do inherently the same thing – they move soft tissue in a therapeutic way to influence tissue responses and to address some form of discomfort or dysfunction. Our difficulty in controlling standards in therapy between the wide ranges of practitioners can largely be traced to differences in definition of structures influenced, and therapeutic methods employed, coupled with an exclusive documentation of procedures.

With the rise in our knowledge and understanding of soft tissue and its responses comes an era of inter-therapist sharing of knowledge. This is especially evident since the scientific, laboratory side of connective tissue and fascia met with the wide range of tissue practitioners in connective tissue and fascia on common ground at the First International Fascia Research Congress held in Boston in 2007. Suddenly, research is expanding into clinical practice with controlled studies and trails being conducted in different disciplines within the “touch” therapies. A need to document what they do, how they do it and to what tissue they do it are becoming increasingly evident. This is especially important if practitioners and researchers need to evaluate and duplicate interventions intraprofessionally and interprofessionally.

An example at hand is reading the editorial in the Journal of Bodywork and Movement Therapies (Chaitow, 2009). As a physiotherapist not trained in osteopathic strain-counterstrain techniques, and also interested in the treatment of ligamentous problems as highlighted by Solomonow (2009), the end result of our two therapeutic approaches may be the same in improved function, but our documentation of the tissue procedure may not be compatible. The incompatibility of our two soft tissue languages may lead to unnecessary duplication of research and a difficulty in interprofessional review. Similarly, there are physiotherapeutic explanations for tissue movement not understood by other professional disciplines (for example the Maitland concept of tissue range in mobilisation).

**Aims.**

The final outcome of all the above is the inability of different worlds to meet on common ground limiting dialogue. The world of the research laboratory is objective, clearly measured, observed and well defined while the world of the practitioner in the field is
largely an impairment-based treatment approach having the advantage of giving the therapist the flexibility in adapting treatment to the person, rather than treating a “diagnosis”. Documenting this approach can be complex and often vague. This vagueness is not conducive to credible research in the eyes of medicine.

This document therefore serves as a first step in putting what is done in practice on paper for the scrutiny and comment of others in the field of touch. It further serves as a baseline document for discussion and defining what we do across disciplines in manual therapy, and to create consistent terminology for describing techniques and interventions used in practice.

**Challenges and limitations.**

The development of descriptive terminology in manual therapy by a single practitioner from a specific therapeutic background is flawed from the outset. Similarly, inter- and intraprofessional views may prove to be too far apart for this attempt to succeed. However, in this author’s view, an attempt in documentation needs to be made rather sooner than later. See this document in that light.

Echoing the attempt and document from the task force set up by the American Academy of Orthopaedic Manual Physical Therapists to standardise manual therapy terminology starting with the intervention of manipulation (Mintken et al., 2008), some important issues are highlighted. They are well highlighted in their document (Mintken et al., 2008), and are adopted and summarised here with soft tissue and massage techniques in mind.

1. In manual therapy multiple theories exist to explain mechanisms of action and indications for techniques. Furthermore, the efficacy of techniques, qualifications for performing these techniques and a general lack of consistent definitions for manual therapy also surround the attempt to standardise. Being important issues, debate on these should continue. Terminology alone will not resolve differences between treatments, models or clinical reasoning. Language cannot question or judge what therapists do, but consistent terminology is necessary to discuss these issues.

2. Describing techniques must avoid theoretical assumptions about mechanisms or interventions in order to remain useful and timeless as theory evolves – including avoidance of theory that is considered the “best evidence of the day”.

3. It is important that the terminology must be easily understood by clinicians from multiple backgrounds and should not reflect a particular history. Clinicians and therapists obtain their training in multiple ways. Introduction into more specific techniques are often obtained at a post professional level of education. This runs the risk that there is some incentive to retain language that reflects the unique culture of
the individual programme (Mintken et al., 2008), maintaining assumptions about the theory behind the applications themselves.

**Barriers and assumptions.**

As Mintken (2008) and his task force point out, even defining aspects of one manual technique (joint manipulation in their document) within physical therapy alone needed clarification on several issues before the groundwork for a framework could be laid. As pointed out above, an attempt by a single individual to create a definable framework across professional borders has its accepted limitations.

1. In most manual and massage therapies an impairment-based treatment approach is used. The selection of treatment technique, direction and depth of treatment is commonly based on the impairments revealed during the assessment. Further, based on tissue response to treatment, intervention can be modified in line with improvement or lack of progress (Wies, 2005).

2. Manual therapy incorporates several techniques in its treatment armoury ranging from tissue manipulation, mobilisation and massage procedures with these terms often including joint and other tissue in its framework. In this document, only manual movement of soft tissues are considered as a framework for manipulating joints already exist (Mintken et al., 2008).

3. With the interchangeable use of tissue manipulation and mobilisation as though they are one and the same, an attempt will be made in describing a soft tissue movement as a definable intervention with a given set of characteristics. This may enable a practitioner in any field to document any intervention that has the same set of characteristics.

4. Applying a procedure to a highly localised, discreet region remains debatable. To overcome interpretive barriers, describing a technique needs to be limited to describing where and how force was applied within a definable region. The outcome of a procedure is what needs to be investigated and creating consistent terminology is the first step in aiding in this investigation.

5. One unifying aspect of a descriptive procedure is the existing language of biomechanics and anatomy. These disciplines already provide terminology that is universally understood both inter- and intraprofessionally. It is potentially precise for the purposes of describing the location and type of forces applied to the body. Using the same widely understood language is purely practical and should not be seen as adopting any particular school of thought.
Describing a proposed framework.

Treatment in clinical practice is seldom for a single pathology or dysfunction. Complex problems in the musculoskeletal field needs complex treatments often given at more than one location, different soft tissue structures and different intensities within the same treatment plan. Documenting a treatment as “massage”, “friction”, or “fascial release” does not give any form of continuity in treatment should the patient or client be transferred or referred to another practitioner. Secondly, sharing treatments and outcomes in a more objective way is virtually of no value both intra- and interprofessionally.

Considering the problems encountered in documenting soft tissue procedures in daily practice, as well as the lack of terminology in documenting complex techniques, the AAOMPT Clinical Guidelines (Mintken et al., 2008) was adapted for use of a framework in documenting treatment characteristics, adding what is considered to be necessary in describing soft tissue procedures in use.

The following set of characteristics and elements are proposed for consideration when documenting soft tissue procedures.

1. **Rate of force application and duration of contact.** Describe the rate at which forces are applied to the target tissue. This includes fast, moderate or slow movement of tissue. Additional elements in rate include whether the application is intermittent or vibratory. Is contact with the target tissue transient, brief or sustained? Is there a pause between applications of pressure and if so, for how long?

2. **Therapist/practitioner contact with patient/client.** Describe the contact of the practitioner with the part being treated. This could be full hand contact, finger tips, elbow, soft fist etc. A further description here may be whether the contact is sliding on the skin, or moving the contact and target tissue as a unit.

3. **Location of the contact in the range of available tissue movement.** Describe whether the application of force was intended to be at the beginning of the available range of movement, towards the middle of the available range of motion, or at the end point in the available range of tissue movement. The term end point should not be associated with any particular anatomic structures, as more than one structure has the potential to limit tissue movement and glide.

4. **Direction of force or tissue loading.** Describe the direction in which force is applied to the target tissue following standard anatomical and biomechanical conventions. A further aspect of intended direction of therapeutic pressure includes describing the loading as tension-, compression-, rotation-, bending-, shearing- or combined loading (Lederman, 1997).
5. **Target tissue of the force.** Here the location and tissue where the therapist or practitioner intended to apply the force is described. Attempt to be structure specific as far as possible – whether the muscle tissue, a ligament, or fascial plane is the target tissue.

6. **The relative structural movement.** Describe which structure or region was intended to remain stable, and which structure or region was intended to move. Name the moving structure first and the stable structure or layer second, separated by the word “on”.

7. **Depth of contact.** Describe the depth or firmness of intended tissue pressure on or into a structure. This could be described as increasing or decreasing in pressure or as a constant rate of pressure using a numerical grading from 1 to 10 for example with 1 being very light (as in gently moving an eyelid) and 10 being severely uncomfortable as in deep cross frictions (Tellington-Jones, 1993).

8. **Patient/client position and participation.** Describe the patient position (e.g. supine, prone, recumbent, side, sitting etc.) This needs to include any pre-tissue movement positioning of a region or limb – rotated, extended, abducted etc.

Examples of using the above characteristics to describe a soft tissue technique may be as follows:

A technique for restricted tissue glide of the anterior mid-thigh may be described as “a slow, full hand, non-sliding, mid-range proximal to distal force contact to the mid rectus femoris myofascia moving the skin on the deep fascia using a pressure of 5/10 with the patient in supine”.

A technique for a trigger point in the shoulder may be described as “a sustained thumb contact at tolerable end range direct force to teres minor trigger point, using a pressure of 8/10 with the patient in prone, arm 90 degrees abducted”.

A technique for partly adhesive scarring after an knee replacement may be described as “a slow, finger tips non-sliding, oscillatory force towards the mid-tissue range using transverse medial to lateral shearing of the adhesion, moving the skin on the fascia over the patella tendon at a 3/10 increasing pressure with the patient in long sitting, knee supported in 20 degrees flexion”.

Granted, this is a long-winded way to document what we do, but a short-hand documentation method should evolve from this in time.
Concluding thoughts.

Every practitioner sees evidence in his or her work environment that soft tissue mobilisation is an effective non-invasive and cost effective treatment option for a large range of musculoskeletal problems and dysfunctions. Evidence is appearing that therapeutic touch influences the healing of damaged tissue (Bouffard et al., 2008). Increasing numbers of articles are appearing in peer reviewed journals supporting the use of soft tissue interventions.

Not having a uniform and meaningful description around soft tissue interventions creates the dilemma that where evidence for soft tissue techniques is increasing, the lack of descriptive terminology for documentation may give rise to scientifically flawed assumptions (Mintken et al., 2008). We need a language that is theoretically neutral in order to move ahead in the documentation of evidence for soft tissue intervention.

Finally, as a single practitioner from a physiotherapeutic background, the possibility of bias in this document cannot be denied, but if it succeeds in creating an interprofessional dialogue, the present bias may be deemed acceptable.

References.


