A Physiotherapist Goes Slow

By Dave Heap

In conversation with David Tresemer

[We are privileged to have Dave Heap as a neighbour on Flinders Island, not far from Mountain Seas. He is available for private appointments. This interview gives a sense of the range of Dave Heap's experience and his approach to physiotherapy. A shorter version of this interview will appear in the book "Slow Counseling," due in March 2016.]

DT: You recently worked for the Australian Defense Force?

DH: I worked for two years for the Defense Force, looking after people who were less than 25 years of age, in complete contrast to my last year, looking after people whose average age was 85.

DT: What was it like working with the young people?

DH: Their main complaints were musculoskeletal—sprains and strains, mainly from the intensity of their training. They wanted a quick fix and they put you under pressure straight away. The military command didn't press you. The trainees wanted to get back to training to be a pilot or special forces or dog handlers, as soon as possible.

DT: "Fix me! Make me better!"

DH: Yes. And quite often it's, "You fix me, and I don't know if I want to do anything more—no exercises, nothing further—I'm too busy. Just fix me."

DT: You have some fairly high motivation yourself—you are a good runner. You completed all fifty of the so-called "Short Walks" in Tasmania in fourteen days.

You are no stranger to physical difficulties. So how did you deal with that attitude of “Fix me”?

DH: I give them the information they need to get started to look after themselves with their particular problem or problems. They need to know how to move better, more efficiently. They need to identify what caused the strain. And they need to know how to heal their present problem through self-care.

DT: Did you work on them physically?

DH: I did.

DT: I have found that your touch is particularly warm and confident, whereas some other physiotherapists hardly touch you. Instead they give you pieces of paper with instructions on exercises, sometimes without showing you how these exercises work.

DH: There were ten physiotherapists at that unit; their average age was between 25 and 30. After I’d been there a few weeks, I would hear these young military trainees say at the front desk, “Can I make an appointment with that older guy?” When asked why, they would say, “Well, he puts his hands on you and actually does something.” For most other physios these days it’s very clinical—biomechanics and core stability and strength. They tend not to look at anything else. The standard these days is ten-minute appointments, “Here’s what you’ve got, here are the pamphlets, do exercises 1, 3, and 6, that’s it. Next!”—and send them out the door. I got a big response because I put hands on them, even if it was just someone who had a stiff back. I have found that, when you put your hands on them, you warm them up so to speak, you loosen them, you listen to them—then they are much more likely to follow up on the suggestions I give about how to move, how to stretch, how to get back to their activity.

DT: Do you feel that younger physiotherapists have discomfort about physical manipulation or touching somebody?

DH: Yes. Let's take the example of chest physio, when somebody has got bronchitis or they retain sputum. The old-fashioned postural drainage was worked out a long time ago. They would lie the patient at different angles for the lobes of the lungs and the segments to drain in certain angles, then a quarter turn, and so on, combined with a clapping vibration where the clapping loosens up any phlegm deep in the lungs so that it gradually comes out. It's a system that works. But there are very few physios who move the person into different positions and clap them on the back. Now they just go for specific breathing exercises, or put the clients on a machine, and hand out their pamphlets. I still think it's helpful to get your hands on and do some manual work.

DT: How does this experience contrast with working with people whose average age was 85 years old?

DH: I learned a lot. Most of the time when you're treating people, you have goals in mind. I always have short-term or long-term or both. At an age-care facility, there are no goals. There are no goals! The twenty-five year olds are going into Special Services or dog handling or high alert. They have many goals and are impatient to achieve them. At the age-care facility, they don't have goals; they're seen as "old" people and basically they're there to die. You can't use normal physio on them, the medical physio model of testing, assessing, and treating. You have to use a complete holistic approach for each individual. I say repeatedly, "I'm talking about you as an individual, not as a diagnosis." It's not, "Hello, Mr. Jones, I'm the physio, I need to assess you—lie down on the table." You say, "Nice to meet you, Mr. Jones." Then you pause, look him straight in the eye, and say, "Now, tell me about your life." Fantastic stories pour out. Eventually they want to hear about you too, which is important. You find out why they've developed a mobility problem, or a pain problem, or whatever. That information is

essential to understanding what to do. It may be their last day, their last month—everyone feels that they could die at any moment. But more often it's their last years, and you want to help them use that time in the best way, rather than waiting to die. So you ask: "What issues do you feel you have? Would you like to improve your walking, your mobility?" You start them thinking about setting goals.

The facility has a very caring staff, but it's a private organization, all about the bottom line, so the staff is stretched, always busy. They provide just enough care to look after the patients, and have no spare time to do things. Because of my contract, I had 25 people to look after in four days a week, and it worked out that I had time to start organizing a few things. "Right, what would you like to happen here? What would really make you happy in this facility? What would you like to do?"

One said, "I like bowls … if we could find an indoor bowl… I'd like bowling competitions." Another said, "I'd like a bit of fresh air." Gradually over the twelve months, apart from seeing them individually, we worked at individual goals. There was one chap who hadn't walked for two years and he felt that he could walk, but hadn't been given the opportunity because he was at higher risk for falls. The staff had decided, "We don't want him to fall and break his hip." They had to use a full hoist for him to go to the toilet—they hoisted him up and out of the wheelchair with a chain. But he told me that he thought that he had the strength in his legs to walk. I started him off just with pedaling, cycling, while in his wheelchair. Then some weights. After some weeks, I said, "It's time to get a walking frame, with four legs, with a crosspiece where you can rest your forearms." I paused and looked him in the eye, "You know, you're a high falls risk"—there's that labeling again—"so you might fall." At 87 years old, he just turned to me and he said: "Shit happens. Let's do it." And he stood up! He had some contractions behind his knees because he'd been sitting in a chair for two years. I had been working on that, but hadn't stretched his legs out completely at

that point. Despite his bent legs, he got up and started walking. He burst into tears. He's been walking every day since.

Very soon, he could spend the day with his wife, because his wife lived twenty kilometers away. Before, it required a special wheelchair taxi, a big deal. Getting him mobile, he could get into a car, she'd take him home, and he'd spend days at home. Very simple. This is not rocket science.

DT: It's a caring science.

DH: At the group level, somebody talked about bowls and suddenly I heard from many: "Well, I used to bowl," and from another, "I used to bowl." I ended up with four people and I let them know: You've got to find a couple of people who have never bowled before; we'll get four teams; we'll get a roster; and I'll see what I can find.

Searching about the place, I found stashed in a cupboard a set of bowls, never used, brand new. We had bowls every Tuesday afternoon; there was bowling and all the other residents would come down and watch. Four teams played each other twice for twelve weeks. It required balance work even if I had to hold onto them. Those that couldn't get out of the chair bowled from the chair, but at least they were moving. That twelve-week roster finished and we had prize presentations down at the local pub. I took them there for lunch; and they loved it. It was great. That's what they wanted to talk about, bowling. For them, that was a worthy goal.

DT: Why hadn't this happened before?

DH: The so-called Lifestyle Team had organized a few things, but they were limited in what they could do because they were frightened of liability, that someone might fall. They tended to do things like a game of bingo or sitting-out-on-the-terrace,

which is fine, but it tended to be sitting type activities. In my exercise classes we worked them very hard. We started off with the white Theraband, progressed them very quickly, doing 20 and 30 repetitions – worked them hard for an hour. There were a lot of sore muscles afterwards, which is right because that's what you're supposed to feel. If you're doing a workout, it's no good just waving your arm in your air. The first weekend there were five people in my class and then gradually more till probably 24 residents out of 37 had joined for exercise classes and enjoyed it. They got very strong.

DT: The caution about falls seems to be driving the system in some way.

DH: It seems to be. There were actually people in that facility who had had one fall at home and then suddenly they go through the hospital system and they're in the age care facility. The medical people and the family too would say, "Well, it's time, you've had a fall; it's time somebody looked after you." I often asked these people: "How did you fall? Did you black out? Did you seriously lose your balance?" "Oh, I tripped over the vacuum cord." Well, anybody can trip over a vacuum cord! But suddenly they end up in hospital, and then they are treated as "old" persons. They aren't put through the same rehab channels as if they were younger persons.

Then the family gets involved and quite often the family will push for that person to move to a facility. I heard on quite a few occasions: "Oh, the family said it was time." Then I'd say to them: "Look at you now, you're stronger and more mobile—you could have managed at home with just a little help." "Yes, but the family thought it was time." "However, Mr. Jones, I'm talking to *you*. What do *you* feel?" "Oh, it would have been lovely to stay at home, but the family said it was time." After a fall it's protection mode. To some degree you have to be more careful. But so often it's weak muscles and lack of mobility, lack of flexibility, balance issues; we can address those. Instead it's, "Lock everything down and cocoon this person to make sure they can't fall again."

DT: You listen to these individuals.

DH: I do. You have to listen. With the age care people, that initial introduction of finding time to sit down and listen to their story is really important because not many professionals do that. You need to know how that person ticks to get the full picture. It took me a while to realize that that was the difference. A traditional physio goal is to get that chest feeling better. But especially in an age-care facility, the goal is bigger than that. It's about how people grasp the last weeks and years of their lives to make something of it.

People die, and then everyone—residents and staff alike—are down for a few days. So then you've got to get everybody up again and say, "Come on, let's get back into it." Residents kept saying to me: "Oh, I'd love to go outside and get some fresh air!" This particular facility was near a busy main road and there weren't really any plans to go and walk about. It was a noisy dangerous road. So I said, "Let's start a walking group." We started a kind of "walking," because most of them are in wheelchairs, and announced if any of the family members or volunteers could come on Tuesday morning, we'll take as many people out as we can, and "walk" into town to have a cappuccino.

The first week we expected two or three volunteers and family members to come, and saw twelve walk up. We had twelve wheelchairs and twelve carers pushing these people in a convoy down the main street into the town, up to the bakery. We got everybody parked around tables and then went up to the counter and said, "We'll have twenty-four cappuccinos please." It became a weekly thing and it still is.

There were days where it looked like it might rain and the facility manager would say, "We don't think you should go because they might get wet." I said, "Let the residents decide." I asked them, "What would you like to do?" They all said, "I

don't care if I get wet. What's the worst thing that could happen? I could get pneumonia and die. Come on, let's go!" It's important to them to get out. And treat them like people, not "old" people. That's the one thing that I learned: Don't treat old people like "old" people; treat them like people. That's all I was doing.

DT: We have different images of what a human being is, with labels and categories. We don't often consult the person about they feelings about what they've been labeled. The facilities manager was probably going by regulations, but, as you say, they weren't consulting the individuals.

DH: Many decisions in such a facility come from top-down and not bottom-up. You get a different response if you go from the bottom-up.

DT: Bottom-up takes more time. To listen takes more time.

DH: These days physiotherapists are getting patients in and out, in and out. I could never do that, just could never do it. I can't strictly give a timeframe because I'll sit with the person for as long as it takes, which is tricky when you're doing visiting-professional work, called "locum" in Australia, and the facility is pushing you to try to see more people. I'm pretty uncomfortable with that, those 10-minute appointments.

DT: Why does a session take longer than 10 minutes?

DH: In the 10-minute appointment you are a number. You do some tests, then announce, "This is your problem, this is what I'm going to do. Bim-bam. Here are some pamphlets. Off you go!" As opposed to, "Oh, this is a real person, let's have a chat, tell me what's going on, let's see if we can help you set a goal and then achieve it." My specialty is physiotherapy so I do see through the shape and movements of the body, but the person's life story is in there, behind it all. Also from that approach you get far more feedback about how your suggestions are

working out. With the short appointments, you have many more people never coming back, so you never know what worked, what didn't.

DT: What trends do you see in health care?

DH: A specialist in Auckland, who was running a diabetic clinic for the last fourteen years and working in chronic disease management, resigned a couple of weeks ago saying that nothing has changed—the information may be better but the public are getting worse. She said that she didn't feel as though she actually changed anything in her fourteen years. But in the smaller picture, the Healthy Islands Project [a program that Dave Heap led on Flinders Island] was quite a success. Rather than looking at health promotion on a big scale, we were running health promotion at a small community level, which did seem to engage the community when the local people designing programs. We had what the big projects have—leaflets and posters, some of those—and we had much more, at very little cost. We set up the Pedometer Challenge, where groups of people signed up to register how many steps they had taken in a week, every week for sixteen weeks. One seventh of the entire population of Flinders Island signed up for this! They were writing down their numbers and trying to push themselves. As simple as that. Many people still stop me, "Can we have another Pedometer Challenge?" A pedometer is cheap; it costs $10. You can still see differences in the health of this community after that simple thing. More people are walking, cycling, jogging, stretching. I wonder whether the millions of dollars that we spend on leaflets and posters for chronic disease management would be better employing these simple models in different communities. The Pedometer Challenge idea came from the community. We based everything off what people in the community requested, a bottom-up approach.

DT: What's your ideal set-up for physiotherapy?

DH: The present model of physiotherapy is a small room with a treatment bed, and to me that's an admission of failure. You need an area where you can sit and chat, hear their story, set some goals, put hands on where necessary to give them a feeling of something moving, have some exercise equipment nearby, and say to them, "There are a few options here. Let's get you organized." It's preventative. I guess you're counseling. At least as much as biomechanics, in physiotherapy you're counseling.