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Embracing Research and Evidence in Massage Therapy

by Monica Noy '03

Amanda Baskwill, one of the few massage therapist researchers in Ontario, recently completed a PhD. Her thesis, *It's Complicated: An Exploratory Mixed Methods Study of The Professional Identity of Massage Therapists in Ontario*, explores not just massage therapist attitudes about identity, but also the knowledge gaps that continue to make our professional identity complicated.

The participants in Amanda's research, who are representative of the profession as a whole, broadly consider research to be one of the most important sources of information for our profession. However, their use of research falls "behind cumulative professional experience, previous and continued education, other massage therapists and other healthcare practitioners."(1)

> *"One of the ways in which massage therapists remain current is by being aware of the current research for practice. … Although the body of knowledge is growing, massage therapists in Ontario are not aware of the current research."*(1)

There are many legitimate reasons why use of research in the profession is dragging behind its perceived importance. Baskwill notes, "… appraisal and application of scientific evidence has only been a part of MTs' professional competencies since 2012. … Healthcare practitioners report time, understanding, and relevance of findings as reasons they do not apply research to practice … ."(1)

MSK is Changing

At the same time, musculoskeletal healthcare in Canada, and throughout the world, is changing. There are more and more requirements for that healthcare claims be supported with evidence and research. In Ontario right now, at least one insurance company is questioning the veracity of massage therapy as a healthcare treatment, and as a profession we are struggling to provide the supportive evidence base(2).

The 2016 *Inter-Jurisdictional Practice Competencies and Performance Indicators for Massage Therapists at Entry-to-Practice* (3) lists ethical and research-based knowledge and skills required of individual RMTs, but doesn't provide the supportive structures needed to develop them.

It is not a straightforward situation. Putting knowledge into practice is a particularly challenging activity throughout healthcare. In a recent review of knowledge transfer (KT) theories and strategies for healthcare, the authors identified five key KT components and came up with an informative, but "analytically and empirically 'empty'" framework. They provide the primary components for putting knowledge into practice, but how each component interacts is still an unknown(4).

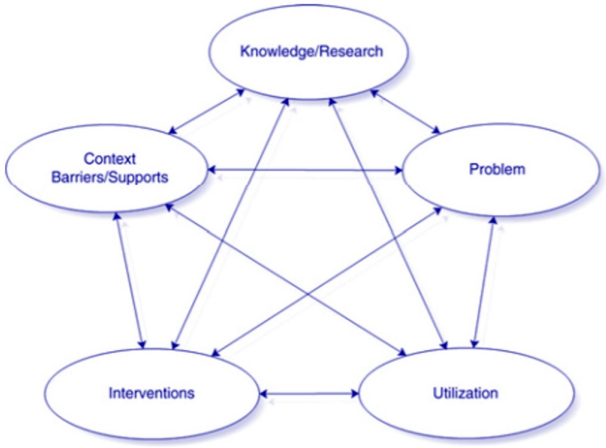


Figure 3 Conceptual framework of the knowledge transfer process

Recent changes show that we are embracing this challenge. Apart from a growing body of massage research, these changes include our attitudes about research importance(1), the inclusion of research and evidence-informed competencies by our regulatory body(3), the evidence-informed themed RMTAO conference(5), and the push information (i.e. posts/notifications/emails etc. from groups one subscribes to) coming from social media(6–8), such as *Evidence-Based Massage Therapists* on Facebook. But like any change, it's not immediate or immediately obvious how to do it, and there is no good rule book to follow.

I graduated from S-C in 2003, the year a full-term research course was first introduced. It offered the basic components of doing research including design and statistics. It was difficult and frustrating and I don't remember much of it, but something must have stuck with me because now I teach the Research Literacy course at Sutherland-Chan. It isn't the same course I took in 2003. I adapted it to suit the time restrictions and an understanding of the gaps in my own knowledge. I've attempted to make the course about how to think about research. Most of us won't end up actually conducting research, but we need to find it, read it knowledgably, and understand its place in practice. That is a complex enough process.

Critical Thinking and Ethical Considerations

The course I provide helps the research novice start to understand that using research in practice is not supposed to be an individual endeavour. It takes a village, so to speak. Within that village we all have a part to play. My part is a disseminator of knowledge that will, hopefully, help the individual learner develop the skills to discover and bridge their own knowledge gaps about using research in practice. A key part of the course I teach is critical thinking.

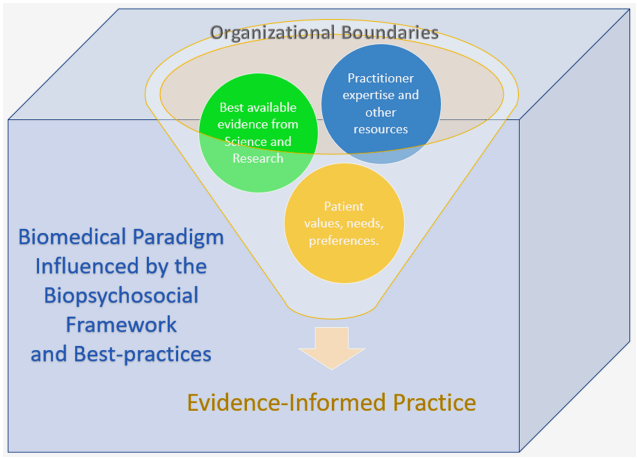
Critical thinking is the awakening of the intellect to the study of itself(9). It requires development and maintenance of intellectual dispositions like humility, integrity and autonomy, and intellectual values like accuracy, consistency, and fairness, to name a few. The first part of thinking critically about any subject is understanding the kinds of automatic thinking processes humans normally engage in(10). We like simplicity, but that can also mean defaulting to thinking that is biased and preferential. Stereotypes and generalisations can make the complex more understandable, but they lack nuance. When we make assumptions based on information we already agree with, there is no reason to continue thinking about it, but that doesn't mean the information is correct.

If one is not engaged in self-directed thinking, the ethical complexities inherent in healthcare interactions may not readily present themselves. By its very nature evidence-informed practice is more ethical than non-evidence-informed practice. For one, evidence itself requires adherence to certain standards. If it's a research study, there are protocols, provisions and peer review to contend with. If it's basic science there is usually a developed general consensus that has helped establish the boundaries of subjects like anatomy, physiology and neurology. The type of information that makes up an evidence base is the culmination of years of collaboration and exploration.

An evidence base may not be complete, and it may not constitute the ultimate truth, but it's a guide for establishing the best case at the time. Non evidence-informed practices are generally the result of personal observation and subjective reports. They're not externally scrutinized or bounded by regulations. Treatment decisions are driven by an individual moral compass that, if not internally scrutinized, can be easily persuaded toward treatment that on the face of it seems to be, but may not be, in the best interest of the patient.

Evidence-Informed Practice in a Box

Like KT, evidence-informed practice has its own challenges. In the conscious process of making a rational decision about how and why to treat the person in front of you, the merging of information from the evidence, patient and practitioner doesn't happen in a vacuum. It happens in a biomedical healthcare culture, and has boundaries set by the regulatory bodies that reflect that culture. It's a complex, active, and interactive process.



The box in which evidence-informed practice sits is the biomedical model, the dominant discourse in healthcare and the overarching framework though which most healthcare is delivered(11). Fuller(12) notes that a biopsychosocial influence mixes old practices with new evidence-based clinical guidelines(13,14). In a nutshell, the biomedical model links symptoms with, primarily, single causes and the biopsychosocial framework introduces complexities in patients' cases that defy single cause verification of experiences that include pain and suffering(15).

This is the changing environment the modern-day massage therapist must negotiate. We learn for the most part to pin single causes on to complex symptoms. But like the biomedical model under which we operate, we're starting to be influenced by other ways of seeing, understanding and treating those symptoms.

How to be an Evidence-Informed Massage Therapist

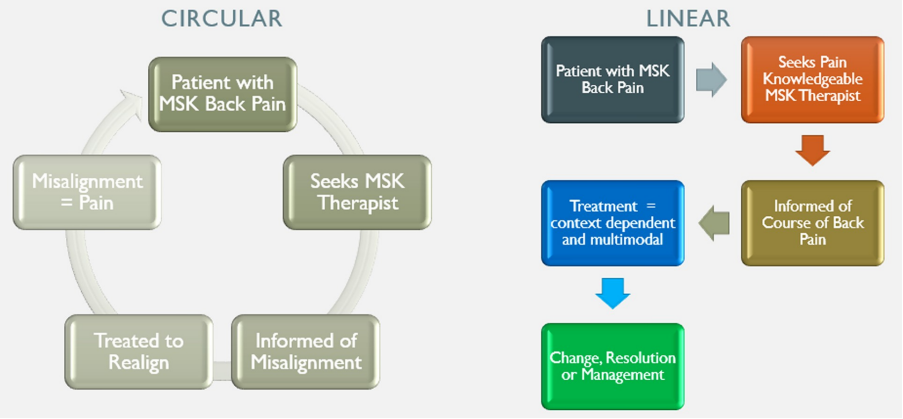
There isn't a single course available to teach the RMT to start being an evidence-informed therapist. It's a bit of a journey, and not necessarily a smooth one. It has taken me years and the pursuit of higher education to get here. Being evidence-informed isn't really a destination in that we never actually get to a single place, it's more of a continual process. Pursuit of higher education in order to become evidence-informed is not necessary, but the process does require some work.

The good news is that some of that work has been done for us in the form of best practice guidelines(16). A common complaint we see in our clinics, low back pain, has updated clinical practice guidelines (CPGs) readily available to the musculoskeletal therapist. We have accessible resources like the *Quality Standards for Acute Low Back Pain*(13) based on CPGs. The problem with these documents is that they are written for the general practitioner (GP). Massage therapists have to figure out what the recommendations mean interpreted for their hands-on practice.

Massage therapy is recommended as an adjunct, not primary or first-line treatment for sub-acute and chronic back pain. Yet we often see patients with low back pain who may have been to their doctor or musculoskeletal therapist many times, but not been provided with sage advice or an honest recovery picture. So how can we help?

RMTs are actually in a better position to follow through on low back pain recommendations than are GPs. Medical care in Canada is compartmented, at the general practice level, to one medical issue per visit(17), and at a larger level with specialisation throughout the system(18). This doesn't allow the GP the time to follow through with the two top recommendations for low back pain, which are: 1) education and reassurance, and 2) advice to stay active.

The caveat RMTs need to know about these recommendations is that education and reassurance are specific to the average course of low back pain, that hurt and harm are not the same, and the reason that scans are not necessary for recovery. This may challenge our biomedical training of providing a specific cause for a person's low back pain. Education, in this context, doesn't mean telling them what we think is wrong with them, it means providing reassurance that their experience is not abnormal and that recovery is a process. It means changing circular biomedical reasoning for complex presentations like low back pain, to a linear process that aims more directly for change, resolution or management of the situation.



Welcome to the Village

Right now, the local, national, and international 'villages' for evidence-informed massage therapists are most easily accessible through social media. The villages aren't always harmonious, but they are resource heavy and can provide a plethora of next steps. Critical debate, argument, and challenging ideas are part of the (often messy) process.

If you plan to venture into one or more of the villages, I hope to see you there. In the meantime, I'll offer the advice I give to my class at the beginning of the term: *You do not have to believe, accept, or use any of the information being presented, **BUT** you are expected to **engage** with it. The information might be challenging, and sometimes uncomfortable. It can illicit stress responses and emotions like anger, and feeling personally attacked. That's normal. It might make you want to stop engaging and it might make you want to leave the village, but that's normal too. Take a deep breath and keep going(19), there is a way through.*

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