Where It Hurts

A Novel About Pain, the Body and the Questions We Stop Asking

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Where It Hurts is a work of fiction. The characters and their cases are invented, and any resemblance to real people is coincidental. The notes at the back give general information about the body and pain, not medical advice, and they can't replace being properly examined. If you're worried about pain, or notice any of the warning signs described in the book, see your GP or a registered physiotherapist, or seek urgent care where the notes say so.

Chapter 1: The Crack in the Foundation

The man in the chair had a shoulder that wasn't a shoulder, and Bob Harlan knew it within eleven minutes.

He didn't say so. Forty-two years had taught him that the first idea to arrive in the room was usually the loudest, not the truest. So he kept asking.

"When is it worst, Mr Adeyemi?"

"Evenings, mostly. Sometimes it wakes me."

"After you've eaten?"

The man paused. He was fifty-four, an accountant, a little heavy around the middle, and he had come in with a GP letter that said *right shoulder impingement — please treat*. He had already had six sessions elsewhere: rotator cuff loading, a steroid injection that did nothing, a lot of confident talk about scapular control.

"Now you mention it," he said slowly. "Sunday lunch. My wife does a roast. I'm in agony by four o'clock."

Bob nodded and wrote it down. Then he did the examination anyway, properly, because a hunch was not a finding. He checked the neck first, because neck problems often send pain to the shoulder: it moved freely and nothing he did brought the pain on. He tested the shoulder: the man could lift his arm all the way up without a catch, push hard against Bob's hand in every direction without pain, and let Bob move the joint through its full range. He palpated the upper trapezius and the angle of the scapula and found the tenderness exactly where Mr Adeyemi said the pain lived, just under the right shoulder blade, and nothing he did with his hands made it any worse.

A shoulder that could not be provoked by moving the shoulder. A pain that followed fatty meals. The right side. Referred along the phrenic nerve, the old anatomy lecturer had said forty years ago, tapping a skeleton with his pointer, *from the diaphragm to the tip of the shoulder, because the diaphragm began its life in the neck.*

"I'm going to write to your GP today," Bob said. "I don't think your shoulder is the problem. I think your shoulder is the messenger. I'd like them to have a look at your gallbladder."

Mr Adeyemi stared at him. "My gallbladder."

"It may be nothing. But I'd rather ask the question and be wrong than not ask it."

When the man had gone, Bob sat down on the edge of his own treatment table and pressed one hand hard into the small

of his back, as if pressure alone could put the fire out.

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The pain had started six months earlier as a stiffness after an afternoon of weeding the narrow garden behind his flat in Marylebone. He had ignored it, the way he had taught so many patients to ignore a minor twinge until it became a signal worth listening to. Now it was a constant companion. Sharp and electric when he bent forward. A deep grinding ache that woke him at three in the morning and refused to let him settle. A dull throb when he stood too long at reception.

He was sixty-eight. In six months he would retire from Harlan Physiotherapy on Harley Street, and the plan had been simple, almost comforting: write the book. *Everything I've Learned About Backs.* Forty years of Cyriax and Maitland and McKenzie, of Grieve's textbooks read until the spines cracked, of Gracovetsky's spinal engine and Greenman's osteopathy, and — more quietly, because colleagues raised eyebrows — the older maps: the Ayurvedic marma points, the Chinese texts on stagnant qi and the cold ache of the lower back.

A legacy in print. Proof that it had all meant something.

The notebook lay open on his desk. The page was blank.

He knew exactly what was wrong with his own back. That was the absurdity of it. Craig Perry had shown him the scan seven years ago: short pedicles from birth, a narrow canal, a spine built with no room to spare. Add sixty-eight years of

wear and you had a crowded corridor. Bob had drawn the diagram for himself a hundred times, the way he drew it for patients. It explained everything.

Which was why, he would later realise, he had stopped asking questions.

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The door opened without a knock. Kate came in with a mug of black coffee, no sugar, and set it beside the empty notebook.

"You're grimacing again," she said.

"I'm thinking."

"You're doing both." She was forty-nine, dark-haired, steady. She ran the building: the diaries, the invoices, three physiotherapists and one visiting surgeon, and the endless small emergencies that nobody else noticed until they became large ones. She remembered every patient's name and most of their children's birthdays. She had come to Harley Street eleven years ago, after a marriage that had ended in silence rather than shouting, and she had arrived at 7:45 every morning since.

"Mr Adeyemi," she said. "He stopped at the desk on the way out. He said you were the first person who'd asked him about his dinner."

"His dinner is the diagnosis."

"Mm." She looked at the hand still pressed into his back. "Craig rang. He wants to repeat your MRI next week. He said

if it keeps getting worse, surgery goes on the table."

Bob exhaled through his nose. "Craig sees bodies as machines. Find the faulty part, replace it."

"And you?"

She didn't accuse. She never accused. She asked, in the particular way she had of asking when she could see someone stepping round the real question.

"I see webs," Bob said. "Tissues, nerves, beliefs, relationships. Everything connected to everything."

"Except your back," said Kate, "which is apparently just a narrow canal."

He opened his mouth and closed it again.

"Jake starts shadowing you on Monday," she went on, as if she hadn't said anything at all. "Your old student. The one you said had potential wrapped in too much ego."

Bob almost laughed, and the laugh sent a spike through his lumbar spine. "Twenty-eight. Neck pain from too many laptops and too many weekend courses. Thinks he can change the world with one pain science lecture."

"He's excited," said Kate. "And you're leaving. Someone has to carry it on."

She went out. Bob looked at the closed door for a while. Kate always saw more than the rest of them. She watched the clinic the way someone in the gods of a theatre watches a play: the whole stage at once, while the actors below stumbled through their scenes convinced each one was the whole

performance. And because she answered the phone and made the coffee, almost nobody asked her what she saw.

* * *

At lunchtime he escaped to Waterstones on Oxford Street, the one habit that still gave him room to breathe. He told himself he was going to the orthopaedics shelves to look at the new work on lumbar stenosis. As usual he drifted into philosophy instead.

A slim hardback on the bottom shelf caught his eye: *The Twelve Conditions of a Miracle*, by Todd Michael. The back cover claimed that the author had gone back to the Greek of the loaves and the fishes and found not a supernatural event but a method — a sequence of inner and outer steps by which ordinary people made extraordinary change.

Bob read the first few pages standing in the aisle. *Preparation*, he thought. *The setting of the scene. The belief that something larger is possible.* His best sessions had often felt like that. A careful history, a thorough examination, one precise intervention delivered with quiet certainty, and then something he could not quite name would settle over the room. The patient would relax into the possibility of change. Weeks later, the symptoms would be gone.

He moved on to mythology and found a book on the old masculine archetypes. The Magician, it said, was the knower of hidden things: the one who could move between the inner

world and the outer, who understood the flows of energy and the workings of machines, who needed mathematics and logic and something close to mysticism in equal measure. The one who could see the whole pattern and reveal it.

The Magician is the wise man, the sage, the knower of secrets. He sees and navigates the inner worlds, masters technology, engineering, energy flows of the outer world. He understands dynamics that require mathematics, mysticism, and logic in equal measure. He is the thinker, the mediator that reveals the truth of the universe — or of the body.

Perhaps that's what a good therapist is, he thought. *Someone who sees the pattern the patient can't.* Then, less comfortably: *And what does the Magician do when the pattern is in his own body, and he can't see it at all?*

Perhaps the ultimate therapist is one who has developed the Magician archetype in its fullness, he thought. *Jesus turning water to wine, Mohammed receiving revelation, Krishna teaching Arjuna, Buddha sitting under the Bodhi tree. They all framed reality differently — and reality shifted.*

He bought both books and walked back to the clinic slowly, each step a negotiation with the fire in his spine. He did not, on the way, ask himself a single question about his own back that he had not already answered seven years ago.

Chapter 2: The Surgeon's Shadow

The scanner hammered like a builder working inside a biscuit tin. Bob lay in the narrow tube with his arms by his sides, counting his breaths, trying to keep still while the ache in his lumbar spine dug in its heels. A calm voice came through the headphones every few minutes: *next sequence, about four minutes, you're doing really well.*

He had said those words to patients. He had never understood, until now, how little they helped.

The report came two days later. Craig Perry read it to him over the phone at 8:17 in the morning, just as Bob was lowering himself into his chair.

"Multilevel degenerative change. L4–L5 disc bulge with a small annular tear. Facet arthropathy. Mild central canal stenosis on a background of congenitally short pedicles. Moderate narrowing of the right lateral recess at L4–L5." A pause. "It's the same film as seven years ago, Bob, with the volume turned up."

"The shoes," said Bob.

"The shoes. You were born with feet two sizes too big for them. Any bulge, any thickening of the ligament, any swelling in the joint, and there's nowhere for the nerve to go." Craig's voice softened a little. "Nothing that needs a knife this week. But the word on the report is *progressive*. If your walking distance keeps coming down, we should talk about a decompression."

Bob translated it in his head, the way he would have for a patient. The discs between his vertebrae had worn and bulged, and one had a small split in its outer wall. The little joints at the back of the spine were arthritic. The tube the nerves run through was narrow, and always had been; and at the fourth lumbar level, on the right, the side channel where the nerve for his right leg leaves the spine was tighter still. Everything about it explained a tingling right leg.

Bob looked at the window. The morning light was grey over Harley Street.

"You know half of asymptomatic people our age have discs like mine," he said. "More than half."

"I know."

"And you know how many of your post-ops still hurt at two years."

"And you know when chronic back disability became an epidemic," Bob went on. "After the war, when we started telling people that rest came first and injury was to be feared above everything. Iatrogenic, Craig. We made it. I've seen

dozens avoid the knife entirely, and some who went under it still hurting years later."

"I know that too. I also know the ones who do three to six months of proper rehab afterwards do remarkably well, and the ones who vanish after two sessions don't." Craig sighed, half amusement and half fatigue. "Work your magic first. But don't be a hero. Pain like yours doesn't negotiate."

When he'd rung off, Bob sat for a long time with the report open on his screen. He read it the way he would have read a patient's: level by level, finding by finding. Every word fitted. The narrow canal, the crowded lateral recess on the right, the right leg that tingled when he walked. It was a good, clean, coherent story.

That was what he would think about, months later, when he finally understood what had gone wrong. He and Craig had argued about what to do. They had never once argued about what was wrong. Two clinicians with seventy years of experience between them had looked at one image, agreed on one explanation, and spent all their energy disagreeing about the treatment.

* * *

They had dinner that Friday at the Italian on Marylebone High Street, the one with the photographs of Sicilian fishing boats and the owner who still brought the Chianti without asking.

Craig was sixty-four, lean, silver at the temples, a brilliant and exacting spinal surgeon whose theatre lists were full for months. He cracked jokes in theatre so relentlessly that junior staff learned to laugh on reflex. Bob had known him for twenty years and knew what the jokes were for. Craig's wife had been killed in a car crash when their son was nine. The boy had gone abroad after university and had slowly stopped returning calls. Craig lived alone now in a house in Muswell Hill with too many bedrooms.

They had spent many evenings like this, chewing things over. Craig always left lighter than he arrived. Bob could see it in the way his shoulders dropped after the second glass. There had been a time when Bob would have tried to rescue him. He had grown out of that. Rescue served the rescuer more than the rescued. Now he just listened.

Tonight, though, it was Craig who listened, and Bob who talked.

"I keep thinking about the book," Bob said. "*Everything I've Learned About Backs*. And I can't write the first sentence. Because if I really know what I've been claiming to know for forty years, why can't I sort out my own?"

"Because you've got a structural lesion in a congenitally narrow canal," said Craig, "and no amount of knowing gets you more millimetres."

"That's your answer to everything."

"It's my answer to that." Craig turned his glass slowly by the stem. "You want it to mean something, Bob. You want the pain to be a lesson. Sometimes a nerve is just squashed."

Bob didn't answer. It was, he thought, very possibly true. It was also exactly the kind of thing a man said when he preferred squashed nerves to the alternative, which was that the body carried the whole of a life and he had not looked properly at his own for thirty years.

He did not say this. He said, "How's Tom?" and watched Craig's face close like a door.

"Singapore," said Craig. "Still. Probably."

They ordered another bottle.

* * *

Walking home, Bob stopped twice, once outside a shoe shop and once at the corner of Weymouth Street, both times leaning forward with his hands on his knees until the tingling in his right calf faded. He noticed, as he always noticed in patients, that bending forward eased it. The textbook sign. Flexion opened the canal; standing tall closed it. It all fitted.

He thought of his son. Nathan was twenty, in his second year at university, broad-shouldered and quick and easy to be with in a way Bob had never quite been with anyone else. They had always talked. From the beginning, from the long divorced weekends when Nathan was small, conversation had flowed between them as naturally as water finding its level. When

Nathan dropped by the clinic after lectures, Bob stood straighter and smiled harder and hid the wince, and Nathan, who was not a fool, pretended not to see it.

Bob had always been a glass-half-empty man. Dark thoughts arrived uninvited and he had learned, over decades, to sit with them and feel them without letting his busy mind turn them into certainties. A year ago he had not been especially happy, either. But compared with now, he had been fine. He would have given a great deal to go back to that ordinary, unremarkable unhappiness.

I should have been grateful, he thought. And then, because he had read enough to know it: underneath the ego, underneath the fear and the pain and the chatter, there was supposed to be a self that nothing outside could touch. The observer. The one who watched the weather without being the weather.

He had believed that for thirty years. Tonight, with his hands on his knees on a Marylebone pavement, it felt like something he'd read in a book.

How pathetic, he thought as he let himself into the flat. *I've helped hundreds resolve their pain, built a solid name in the profession, and I can't solve my own. Have I really made a difference? Or was it all placebo, framing, belief — the Magician's sleight of hand?*

That night he opened *The Twelve Conditions of a Miracle* again. The author described the feeding of the five thousand not as supernatural intervention alone, but as a sequence of precise inner and outer preparations — attention, intention,

gratitude, distribution — that allowed abundance to appear. Bob recognised the echo in his own work. When he listened deeply, framed the problem as solvable, and prescribed exactly the right movement with conviction, something shifted. Not always. But often enough that patients came back years later to thank him.

He thought of Nietzsche, who had spent most of his life in pain — migraines, failing eyes, a stomach that betrayed him — and had written, in *Thus Spoke Zarathustra*: *There is more reason in your body than in your best wisdom.* Bob had quoted it to students for thirty years. The body was not a machine to be overruled by the mind; it had an intelligence of its own, and the pain was part of what it was saying. Behind the pain, the self — the true self, the quiet observer — remained untouched. Pain was a condition, not the essence.

Yet the fire in his back felt very real.

Chapter 3: The Young Magician

On Monday morning Bob rang the buzzer at the Harley Street entrance and waited. The building was typical of the street — slightly old-school, a little grand, the kind of place where multidisciplinary practices came and went, linked up for a few years, then drifted apart when bills mounted, families called and egos clashed. Bob had always been aware of how ego could override the simple, rational idea that another therapist might help a patient get better in a different way. Referrals slowed when money and prestige were at stake.

Kate opened the door. "It's a nice day for you today!"

Bob managed a half-smile. "Life is tough, Kate, but I'm glad you're the bearer of good news."

Jake arrived an hour later like a change in air pressure. Tall, hair still damp from the gym, a stack of printed papers under one arm and a grin that seemed fixed in place.

"Mr Harlan. Bob. It's an honour. I still remember your lecture on grade four and five mobilisations. It changed how I think about end range."

Bob rose to shake his hand and hid the twinge. "You were the one who kept asking why we couldn't just explain pain away."

"Still am." Jake's eyes were bright. "Pain neuroscience education is changing everything. Pain is the brain's output, not a readout of damage. It's a protector. Reduce the threat and the pain comes down. It really is that simple."

Bob felt the irritation rise in him like acid. "Simple in a twenty-eight-year-old neck that flares after a day at a laptop. Try it in a spine that's thirty years past its warranty."

Jake's smile wavered for half a second and came back. "That's why I'm here. To learn. And maybe to help."

Help. From a boy he had taught fifteen years earlier.

* * *

The staff meeting was on Wednesday afternoons in the room at the back, the one with the anatomy posters faded to the colour of weak tea. Kate chaired it, as she always had, without anyone having formally asked her to. Craig leant in the doorway with his arms folded, between a clinic and a theatre list.

Jake presented first. "Thirty-five-year-old woman, office worker. Eighteen months of neck pain, bilateral, worse towards the end of the day. Imaging normal. High fear-avoidance scores. She's been to three people and nothing's helped." He clicked to a slide of a brain lit up in orange. "Classic central

sensitisation. I'm starting with pain neuroscience education, then graded exposure, then some mindfulness-based stress reduction."

"Or," said Craig from the doorway, "we could cut it out."

The room laughed, a little uneasily. Everyone knew what Craig's jokes were for.

Bob waited for the laughter to settle. "Can I ask some questions?"

"Of course."

"Does she get headaches?"

Jake glanced at his notes. "Some. She said they were stress."

"Where?"

"I… didn't ask where."

"Does she clench her jaw? Wake with it aching? Has her dentist said anything about wear on her teeth?"

Jake shook his head slowly.

"Has she had new glasses in the last two years? Varifocals? A bigger monitor, or a second one?"

"I don't know."

"Any dizziness when she turns her head? Double vision, difficulty swallowing, numbness around the face or mouth?" The warning signs every student learned and every busy clinician forgot: signs that the blood supply to the brain, or the ligaments holding the top of the neck together, might be involved, in which case nobody should be manipulating that

neck. “Anyone checked her upper cervical ligaments before somebody puts their hands on her neck?”

The room had gone quiet. Jake’s face had turned a dull red, but to his credit he was writing.

“She may well be sensitised,” Bob said, more gently. “Eighteen months, three failed treatments, frightened of moving. Very likely she is. But sensitisation is usually the last chapter of a story, not the first. Something started it, and something may still be feeding it. If you only treat the last chapter, you’ll get her better for a month and she’ll be back.”

“So what would you do?”

Bob shrugged, and regretted it; the shrug went all the way down to L4. “Same as always. Three things. Find out what’s aggravating it and stop doing it. Treat what the examination tells you to treat, and nothing it doesn’t. Give her the exercise that fits her, not the one on the handout. Ninety seconds under slow tension for the deep neck flexors, not three sets of ten flicked off before the kettle boils.” He paused. “And ask about the glasses.”

He had learned to tailor the relationship too, not just the exercises. Anxious patients needed calm reassurance; overconfident ones needed gentle challenge; shy ones needed permission to speak; elderly ones needed respect for the life they had already lived. The same words, said to the wrong person in the wrong way, could undo a whole treatment.

* * *

Afterwards, Jake lingered.

"That was humbling," he said.

"It wasn't meant to be."

"It was, though." Jake hesitated. "Can I offer you something? A proper pain education session. On your back. No charge. Just to see."

Bob looked at him: eager, unscarred, certain. For a moment he saw himself at the same age, standing up at the back of a Cyriax course to ask why the whole profession treated one man's diagnostic system as scripture. Left of centre, questioning everything, convinced that the next big idea would change the game.

"Not yet," he said. "But keep asking questions. It's the only way any of us learn."

Jake nodded and went. Bob sat alone in the meeting room with one hand on his back.

The pain was spreading — down the buttock now, with occasional pins and needles into the thigh. Retirement was five months and three weeks away. *What if I can't walk in the park with Nathan? What if I can't garden, can't travel, can't make love without calculating every position? Pain as the sledgehammer of time. Pain as death announcing itself early.*

Five months and three weeks to go.

* * *

Kate found him there ten minutes later. She put the minutes on the table and didn't leave.

"That was good," she said. "What you did with him."

"He'd decided what was wrong before she walked through the door."

"Mm." Kate squared the edges of the papers. "You both had."

"I hadn't even met her."

"I didn't mean her."

She went out before he could ask what she did mean. He sat there a while longer, and although he was a clever man, and had spent his life reading between the lines of other people's stories, it did not occur to him until much later that she had been talking about his back.

Chapter 4: Wednesday Clinic

The following Wednesday, Jake sat in on Bob's whole clinic list, and Bob decided to show him what he meant.

The first patient was Doreen Bell, seventy-two, a retired school secretary with neat grey hair and a handbag she held on her lap like a shield. She had a letter from her GP and an X-ray report: *mild degenerative change, right knee*. She had already had six sessions of knee exercises at another clinic. Her knee was no better.

"Everybody tells me it's arthritis," she said. "I'm seventy-two. I suppose I have to put up with it."

"Show me where it hurts," said Bob.

She didn't point to the knee. She ran her hand down the front of her thigh, from the crease of her groin to just above the kneecap.

"All of that?"

"Mostly just above the knee. But yes, it sort of runs down."

"When is it worst?"

"Getting out of the car. Putting my tights on. Turning over in bed."

Jake was writing furiously. Bob could feel him wanting to say something and not saying it.

Bob examined the knee first, because she had come about the knee and she deserved to have it looked at properly. It bent and straightened fully. There was no swelling, no warmth, no tenderness along the joint line where worn cartilage usually complains. He pressed and twisted and squeezed, and Mrs Bell watched him with polite patience and felt nothing much at all.

Then he asked her to lie on her back, bent her right hip and knee to a right angle, and gently rolled the thigh inwards.

Mrs Bell gasped. "That's it. That's the pain. Right down to the knee."

He did the same on the left. The left hip turned twice as far and she felt nothing.

"Mrs Bell," Bob said, sitting down on his stool beside her, "I don't think your knee is the problem. I think it's your hip."

"But my hip doesn't hurt."

"I know. That's what makes it so confusing. The nerves that supply the front of your hip joint also supply the front of your thigh and your knee. When the hip is irritated, your brain gets a message from that shared wiring and makes its best guess about where it's coming from. And quite often it guesses the knee." He smiled. "It's a bit like a phone call from a number you don't recognise. The brain assumes it's the usual caller."

"So all those knee exercises…"

"Were good exercises, for somebody else's knee."

* * *

That would have been enough, for most clinicians. A clear finding, a clear explanation, a hip programme. Jake had already closed his notebook.

Bob kept asking.

"Have you had any falls in the last few years?"

Mrs Bell hesitated. "I tripped on a kerb three years ago. Broke my wrist. Silly, really. I'd only stumbled."

"Has anyone talked to you about your bones since?"

"My bones?"

"A wrist that breaks from a stumble at standing height, in a woman over fifty, can be a sign the bones have got thinner than they should be. It's worth checking. There's a scan that measures bone density, and there are good treatments if it's low." He made a note. "Do you ever feel light-headed when you stand up quickly?"

She looked at him as though he'd read her diary. "Every morning. I have to hold the bedpost. I thought that was just age as well."

"What tablets do you take?"

She unzipped the handbag and produced a folded list. Two for blood pressure. One for cholesterol. A water tablet.

"When were the blood pressure ones last reviewed?"

"Oh, years ago."

Bob wrote that down too. "And since the knee started — since the hip started — what have you stopped doing?"

There was a pause that went on a little too long.

"I used to go to bridge on Thursdays," she said. "It's two buses. I don't like the steps any more. I'm frightened I'll go over again."

"So you've stopped going."

"Since the spring."

Bob nodded slowly. He could see the whole of it now, the way a map comes clear when you find the one road that joins the others up. A stiff, irritated hip that made walking painful. Walking less, so the muscles round the hips and knees weakened. A blood pressure that dropped when she stood, perhaps from tablets that had never been reviewed. A wrist fracture that hinted at fragile bones. Fear of falling, which made her walk less and more stiffly, which made her more likely to fall. And the bridge club gone, the Thursdays gone, the friends gone, one quiet week at a time.

None of it was on the X-ray report.

"Here's what I'd like to do," he said. "I'll treat the hip, gently, and give you exercises for it that you can do lying on the bed and sitting in a chair. We'll strengthen the big muscles round your hips and your thighs, because strong legs are the best protection against falling there is. And we'll practise your balance, a little every day, holding on to the kitchen worktop

to start with." He took a sheet of headed paper. "And I'm going to write to your GP and ask them three things: to review your blood pressure tablets, because I think they may be making you dizzy; to check your vitamin D; and to think about a bone density scan."

Mrs Bell looked, for the first time, as though the handbag might not need to be held quite so tightly.

"And bridge?" she said.

"Bridge," said Bob, "is part of the treatment. Let's get you back there by Christmas."

* * *

The second patient was Amira Hassan, thirty-one, five months after the birth of her first child. She came in carrying a car seat with the baby asleep in it, the handle hooked over one forearm, her whole body tilted sideways against the weight.

"My back," she said, lowering it to the floor with visible relief. "And the front of my pelvis. When I turn over in bed, it's like something's clicking and grinding right at the front. And getting out of the car. And lifting him."

"He's gorgeous," said Bob, and meant it. "Tell me about your days."

She laughed without much humour. "Which bits? He feeds every two to three hours. Longest I've slept in five months is three and a half hours, once. I'm breastfeeding. My husband's

back at work. I carry him in that seat or on my hip most of the day."

"Which hip?"

She thought. "The left. Always the left, so I can use my right hand."

"How do you sit to feed him?"

She showed him: curled forward on an imaginary sofa, shoulders round, head down, the baby held up in the arms rather than supported underneath.

Jake, who had assumed this would be a straightforward pelvic girdle pain case, began to see what Bob was doing. Every answer opened another door.

"Are you exercising?" Bob asked.

"I started running at eight weeks. I wanted my body back." A flash of defiance. "Everyone at my antenatal group was back in the gym."

"And since you started running, any leaking when you run, or cough, or sneeze?"

She went pink. "A bit. I thought that was normal after a baby."

"It's common," said Bob gently. "It's not something you have to live with. And your tummy — when you sit up from lying down, does it dome up in the middle, like a ridge?"

She stared at him. "How do you know that?"

Bob didn't answer straight away. There was one more question, and it was the one that mattered most, and he asked

it as quietly as he had ever asked anything.

"Over the last few weeks, have you often felt down, or low, or hopeless? And have you found you've lost interest in things you used to enjoy?"

For a moment she held it together. Then she put her hands over her face and cried, very quietly, so as not to wake the baby.

Bob waited. He passed her the tissues. Kate, who had been passing the door, came in without a word, put a glass of water on the desk, and went out again.

"I love him," Amira said at last. "I love him so much. But I don't enjoy anything. I'm so tired I can't think. And I feel like my body's broken and it's never going to be mine again."

* * *

When she had gathered herself, Bob drew it for her on the back of an appointment card.

"Here's what I think is going on," he said. "During pregnancy your body loosened the ligaments round your pelvis so the baby could be born. While you're breastfeeding, your hormones keep things a little softer than usual, and that's normal. Your stomach muscles were stretched apart to make room, and the gap in the middle hasn't fully closed yet. Your pelvic floor — the muscles that hold everything up from underneath — has been through a lot. And then you've asked that body to carry a growing baby on one hip all day, feed

curled up eight times a day and eight times a night, run before it was ready, and do it all on three hours' sleep." He tapped the card. "Any one of those is manageable. All of them together is too much for anyone."

"So what do I do?"

"A lot of small things." He wrote them down as he spoke. "Carry the car seat in front of you with both hands, close to your body, or better still leave it in the car and use a sling or the pram. Swap hips. Feed with a pillow on your lap so the pillow takes his weight, not your back, and bring him up to you rather than bending down to him. At night, if your midwife or health visitor is happy with it, you can learn to feed lying on your side. Roll over in bed with your knees together. And pause the running for now — not for ever, just until your pelvic floor and your tummy have been properly checked."

"Checked by you?"

"By a colleague of mine who specialises in women's health. She'll assess your pelvic floor properly and give you a plan to get you back running safely. That's her expertise, not mine, and you deserve the best." He paused. "And I'd like you to talk to your GP or your health visitor about how you've been feeling. What you've described is very common after a baby. It has a name, and it's very treatable, and it's not your fault. You're not failing. You're exhausted, and something may be making it harder than it has to be."

She nodded, and cried a little more, and then laughed at herself for crying.

Then Bob went to show her the first exercise: lying on her side, knees bent, breathing out slowly while gently drawing up her pelvic floor and her lower tummy, the way you'd stop yourself breaking wind in a quiet room. He started to lower himself to the mat to demonstrate.

Halfway down the fire went through his back like a bolt, and he froze, one hand on the plinth, unable to go down and unwilling to be seen coming back up.

"I'll show her," said Jake quickly, and was on the floor before anyone could argue.

Bob sat on his stool and coached, and pretended it had been the plan all along.

* * *

At the end of the day, Jake sat in the back room with his notebook open on his knee.

"I'd have given Mrs Bell knee exercises," he said. "And I'd have given Amira pelvic stability work and told her to stop running. Which would have been right, sort of. And I'd have missed nearly everything."

"You'd have missed the parts that were going to bring them back."

"How do you hold all of that in your head? The hip, the bones, the tablets, the dizziness, the bridge club. The

hormones, the sleep, the pelvic floor, the tummy, the mood. Every patient is ten patients."

Bob thought about it.

"I don't hold it in my head," he said. "I hold a map. Where is it? What's the anatomy in that area, and what else shares its wiring? What could it be, and what could it be that would be dangerous? How does it behave? What can they no longer do? What's going on in the rest of their health — their sleep, their tablets, their hormones, their gut? How are they, in themselves? And what are they afraid of?" He shrugged, carefully this time. "Then you go round the map with every patient, even when you think you already know the answer. Especially then."

Jake wrote it all down. Then he looked up.

"Have you done that for your back?"

Bob looked at him for a long moment.

"Go home, Jake," he said. "It's late."

Chapter 5: The Files

On Friday a letter came from Mr Adeyemi's GP. The ultrasound had shown gallstones. He had been referred to a surgeon. *Thank you for your careful assessment*, the GP had written, which in the language of GP letters was very nearly a standing ovation.

Bob read it twice and put it in his jacket pocket. He could not have said why it made him feel worse.

* * *

That weekend the rain drummed against the windows of his flat and he cancelled his Saturday list, something he almost never did. He tried to find a position in which the pain would let him think. Upright in the armchair hurt. Lying flat hurt differently. In the end he half-reclined on the sofa with his knees bent over a stack of cushions, a hot-water bottle in the small of his back, and a cardboard box of old patient files beside him that he had carried home, awkwardly, in a taxi.

He needed to know whether he had ever really helped anyone. Or whether every success had been a story he and the patient had told each other until life moved on.

He rang Mrs Ellis first. She was seventy-nine now, living in a bungalow in Kent with a garden she still dug herself.

"Bob Harlan? Good heavens."

Her voice hadn't changed: warm, faintly amused, as though pain had never quite managed to take her sense of humour. In 2005 she had come to him barely able to walk to the letterbox, sciatica burning down her right leg. He had found a clear directional preference, a pain that eased and centralised with repeated extension, and had built her up from lying press-ups to standing extensions. Within three weeks she was back in her garden.

"The exercises helped," she said. "Of course they did. But do you know what really turned it? The second appointment, when you put your pen down and let me talk. George had died the year before. I was carrying all of it in my back. You didn't just move my spine, Bob. You let me move the story. After that, the exercises worked."

He thanked her and put the phone down, and sat for a moment with his throat tight.

Mr Patel next. Chronic low back pain, no structural culprit on imaging. Bob had tried mobilisations, then a stability programme, and discharged him after six sessions feeling he

had failed. Mr Patel ran a newsagent in Ealing now. He laughed when he heard who it was.

"Your mobilisations did nothing," he said, without any malice at all. "What did it in the end was proper yoga, not the gym kind, and a therapist for the anger I'd been carrying since I was a boy in Partition. And my stomach. I'd had trouble with my stomach for twenty years, and once the gut settled the back settled with it. You gave me permission to look beyond the spine, even if you didn't know that's what you were doing."

Bob didn't tell him that he hadn't known. He wrote *gut* on the inside of the file and underlined it twice.

Then two that had gone the other way, where the mechanics had been decisive.

Harry had been forty-two in 2012: acute back and right leg pain after lifting a box at work, pain shooting below the knee, and a leg that could only be lifted forty degrees off the couch before the nerve pulled like a hot wire. Sitting slumped with his chin on his chest brought the leg pain straight on: the nerve itself was irritated. The scan showed a large disc protrusion at L5–S1 against the right S1 root. Harry had been off work for six weeks and was terrified of surgery. Bob had released the guarding muscles first, the paraspinals and quadratus lumborum, then mobilised L5–S1 in side-lying, then taught him to slide the nerve rather than stretch it. Four sessions and the leg pain was falling. Eight weeks and he was back at work.

"Bob! I was only thinking about you last week. Perfect since, mate. I still do the sliders every morning. Heavy lifting, the lot. You fixed it. Properly fixed it."

Kelly had been thirty-eight: long-standing pain around both sacroiliac joints, a leg that felt heavy as lead when she tried to lift it straight off the couch, until Bob pressed her pelvis together with his hands and it suddenly felt light — a sign that the pelvis wasn't being held steady, and a history of repeated ankle sprains that had quietly wrecked her balance. No disc, no nerve. Bob had used Guy Voyer's ELDOA positions to decompress specific levels and a long progression of single-leg balance and closed-chain work to rebuild what her ankles had lost. At twelve weeks she was running five kilometres without pain.

"I still do them every day," she said. "The L4–L5 one especially. No clicking, no morning stiffness. I owe you everything."

* * *

When the calls were done, Bob took a sheet of A4 and did something he had not done since he was a student. He drew four columns.

Over the first he wrote *Brain* — meaning, fear, grief, expectation, the sense of being safe or threatened. Over the second, *Spinal cord and nervous system* — how sensitive the system had become, how loudly it was amplifying. Over the

third, *Tissues and load* — joints, discs, muscles, the mechanics. Over the fourth, *The nerve itself* — its mobility, its blood supply, its chemistry.

Then he put each patient through it. Not *what did I do*, but *what did it actually change*.

Mrs Ellis: the extensions had changed the load on her disc, and the listening had changed what the pain meant to her. Two columns, not one. Harry: the manual therapy had calmed the guarding, the mobilisation had changed the mechanics, the sliders had got the nerve moving, and his fear of surgery had fallen away as the leg improved. Three columns, perhaps four. Kelly: load, control, proprioception, and the confidence of a body that knew where it was in space again.

Mr Patel: one column. He had treated Mr Patel's spine, and Mr Patel's problem had been in his gut, his anger, his history, his breath.

Bob looked at the sheet for a long time.

It wasn't that the techniques didn't work. They did. It was that every success he could remember had been a case in which he had kept more than one explanation open, long enough for the patient to show him which ones were true. And the failure he remembered most clearly had been one in which he had decided early, and then treated his decision.

There was no universal protocol. He had half-known it for years. The body was bespoke. The pain was bespoke. McKenzie had helped Mrs Ellis and would have done nothing for Mr

Patel. What had saved Harry would not have touched Kelly. The skill was not in any one method. It was in holding every possibility open — the anatomy, the pathology, the history, the life, the red flags always — until the right ones declared themselves.

He thought of the Buddhist perspective he had first met in his thirties: the mind is the creator of both sickness and health. Disease arises from within, not only from without. Total personal responsibility; the ability to shape one's own destiny, including the state of the body. He had never been sure how far to believe it. Tonight, with the files around him, it seemed truer than it had for years, and also more frightening.

He took a second sheet and drew the same four columns. At the top he wrote *R. Harlan, 68.*

Under *Tissues and load* he wrote: *congenital stenosis, L4–L5 disc, facets, right lateral recess.*

Then his pen hovered over the other three columns, and he found that he didn't know what to write, and that he didn't much want to find out. He folded the sheet in half, slipped it inside the cover of the Todd Michael book, and went to refill the hot-water bottle.

Chapter 6: The Questions He Never Asked

By the third month the pain had a personality. It ran down the back of the right buttock now and into the calf, and after ten minutes' walking his right foot felt as if it belonged to someone else. He treated standing, leaning on the plinth, shifting his weight from foot to foot. The staff pretended not to notice. Kate noticed everything and said nothing unless asked.

Jake noticed too. He had become a fixture, shadowing every session Bob allowed and several he didn't. He brought ideas Bob would once have dismissed out of hand, and some of them were good. He still pushed patients too hard, too fast, measuring their progress against his own young body. But he was watching, and he was not stupid.

Graded motor imagery for the sensitised cases. Pain neuroscience scripts rewritten to include the emotional and relational parts of pain. Breath work drawn from upper-quarter neuromuscular dentistry. Behavioural optometry cues

for postural awareness. Guy Voyer's layered corrective exercise progressions. Caroline Myss on emotional anatomy. Stanley Keleman's body systems, echoing the old chakra maps. Soft-tissue approaches from Stecco's fascial manipulation, KNT pole work, the developmental patterns of DNS from Prague.

Bob watched him push patients too hard, too fast, expecting insight and change they were not yet ready for. *You're still asleep*, he thought more than once. *Chasing enlightenment in protocols and gurus.* Yet the boy's fire reminded him of his own younger self: questioning Cyriax's rigidity, Maitland's dogma, McKenzie's universality, always hungry for the next edge.

Alone at night, when sleep refused to come, Bob traced the reach of pain through his own life and the lives of the people he had treated. Pregnancy: hormonal laxity, postural shifts, the weight of new life pressing on already vulnerable nerves. Babies and small children: parents carrying toddlers awkwardly on one hip, sleep deprivation turning every twinge into agony. Marriages: unspoken resentment or unprocessed grief lodging in the lower back like a second skeleton. Money: the constant tension of staying fit, looking good, performing at work, providing. Travel: airports, long flights, the fear of a flare in a foreign city far from help. Sex: intimacy blocked by the anticipation of pain, positions calculated like engineering problems. Death: the symbolic end, the sledgehammer of time, the creeping sense of uselessness his older patients had described so movingly.

The *Hog in the Trough* came back to him unbidden — life reduced to a game of fame, power, money and recognition, players gorging themselves on empty victories that meant nothing the next morning. The master game was different: self-development, seeing one's own frame clearly, knowing the difference between the mask and the face beneath. Bob's own life felt suddenly narrow. Nathan at university now, with the ordinary ambitions of money and prestige. *Play a game worth playing*, the old books advised. But what game remained, when pain threatened to take away even the ordinary joys?

On a Tuesday in early spring, between patients, Bob went to the lavatory for the third time in ninety minutes. When he came back Jake was in the corridor, pretending to read a noticeboard.

"Bob," he said. "Can I ask you something clinical?"

"If it's about Mrs Okafor's knee—"

"It's about you." Jake's ears were going red, but he kept his voice level. "You've been in there three times this morning. You've got a narrow canal, a bulge, leg symptoms. And this morning in the gym I saw you rubbing your left calf, not your right."

Bob stood very still.

"I'd like to ask you the questions," said Jake. "The ones you'd ask a patient."

Kate had come to the door of reception. She didn't say anything. She didn't have to.

* * *

They did it in Bob's own treatment room, which made it worse. Bob sat on his own plinth, where a thousand patients had sat, and Jake sat in Bob's chair with Bob's clipboard, and asked him the questions Bob had taught him fifteen years before.

"Any change in sensation between your legs, around your back passage, where you'd sit on a saddle?"

Bob opened his mouth to say no. Then he realised that he didn't know. He had never checked.

"I'm not sure."

Jake wrote it down. "Any change in your waterworks? Difficulty starting, a weak stream, not feeling when your bladder's full, any leaking?"

"I get up in the night. Two, three times. It's slower to start than it was."

"How long?"

Bob thought. "Since before Christmas. I put it down to age."

"Bowels?"

"Normal."

"Any change in sexual function?"

A long pause. Jake, to his great credit, didn't fill it.

"I'm divorced, Jake, and I'm sixty-eight. I've not had occasion to find out."

"Okay." Jake wrote *unknown*. "And both legs now, not just the right?"

"The left calf, occasionally. The last fortnight."

Jake put the pen down. He looked, for a moment, very young, and then he looked like a clinician.

"That's a *don't know* on saddle sensation, a change in bladder function over three months, and symptoms spreading to both legs, in a man with a narrow canal," he said. "If you walked in as a new patient, you wouldn't let yourself go home tonight without being seen."

Bob said nothing. He knew it was true. He had sent people to A&E on less. He had written the safety-netting leaflet the clinic still used. And he had been getting up in the night for three months, and walking with a numb foot, and not once had he put his own symptoms through the screen he would have put anyone else through in the first five minutes.

Because he already knew what was wrong with him. It was the narrow canal.

"Kate," he called. His voice sounded strange. "Would you ring Craig?"

* * *

Craig saw him at six that evening in a side room at the hospital, still in his theatre blues, the jokes gone completely.

He did it properly. Reflexes at the knees and ankles. Power, toe by toe. Pinprick in the saddle area: normal, both sides. The

examination nobody enjoys, done briskly and kindly: tone normal. A bladder scan after Bob had emptied it: a small residual, within normal limits.

"It's not cauda equina," Craig said at last, and Bob felt something in his chest let go that he hadn't known was clenched. "Not today. But I want bloods. You're sixty-eight, you've got night pain and waterworks trouble, and I haven't checked your prostate either." He paused. "We should both have asked months ago."

The blood results took four days.

Bob knew exactly what he was waiting for. A man of his age with night pain and a raised PSA. The prostate's old habit of sending its cancers to the lumbar spine. He lay awake doing the arithmetic, which is the worst thing a clinician can do at three in the morning. Craig rang on the second evening to say, gruffly, that the MRI from three weeks earlier showed no suspicious lesions in the bone, and that he should stop reading things on the internet, and Bob said he wasn't, which was a lie.

The PSA, the blood test used to look for prostate problems, came back mildly raised. The urologist saw him the following week, examined him, repeated the test, and pronounced an enlarged prostate: common, benign, very treatable. A tablet, taken at night. Within a fortnight Bob was getting up once, not three times, and the stream no longer made him feel eighty.

The left calf settled when he stopped standing to treat for eight hours a day. Craig was satisfied that it had been the stenosis talking, not something new. He gave Bob the safety-netting speech anyway, word for word the one Bob gave his own patients: if the saddle goes numb, if you can't pass water or can't hold it, you don't ring me in the morning. You go to A&E that night.

* * *

It was only afterwards, lying in bed with the lights off and nothing waking him at three for once, that Bob understood what had happened.

For months he had told himself, and Kate, and Craig, that the pain woke him at three o'clock in the morning. It hadn't. His bladder had woken him. He had got up, and walked stiffly to the bathroom on a spine that had been still for five hours, and the pain had been there waiting, and he had lain awake afterwards with it until dawn. He had put the waking down to the back and the bladder down to age, and never once put the two together.

Three months of broken sleep. Three months of lying awake in the dark, afraid.

He thought of the folded sheet of paper inside the cover of the Todd Michael book. Four columns, and only one of them filled in.

He had spent forty years telling students that the most dangerous moment in any assessment is when you think you know the answer. He had said it so often it had become a sort of joke, a line they wrote on the whiteboard for him on his birthday.

It had never occurred to him that it applied to himself.

Kate had watched it all from her quiet corner of the reception desk. That evening, as Bob locked up, she spoke softly.

"You and Jake are playing out your scripts on the same stage. He needs your steadiness. You need his fire."

Bob met her eyes. For a moment the pain receded.

Chapter 7: Ancient Threads

Michael had been his study partner at physiotherapy school, forty-six years ago, in a draughty teaching block that smelled of floor polish and embrocation. They had passed their anatomy viva on the same afternoon and got drunk on the same cheap cider that night. Now Michael was seventy, white-haired, retired to a small town on the south coast, and he laughed out loud when Bob described what he was going through.

Jake had insisted on driving them down. "Legacy wisdom," he'd said, notebook already open on the dashboard. Bob had been too tired to argue.

They sat in a café overlooking a grey sea. Michael stirred his tea.

"You were the wild one," he said. "You do know that? You stood up in a Cyriax course and asked the tutor if he'd ever considered he might be wrong. You read Gracovetsky on the bus. You had a book on Ayurveda in your locker and you used to go on about prana and marma points in the canteen until people moved tables." He nodded towards Jake. "You were him.

Full of fire. Convinced the next big idea would change everything."

Bob sat very still. He had forgotten. Somewhere along the line experience had hardened into certainty, and curiosity had turned into caution, and wonder into worry.

"What happened?" Jake asked. Not cheekily. He wanted to know.

Michael considered. "He got good," he said. "That's the trouble with getting good. You stop needing to ask."

* * *

They talked for three hours. About the old teachers, who were mostly dead. About the profession, which had changed out of recognition and in some ways not at all. And, because Michael had never been one for small talk, about suffering.

Michael had nursed his wife through a long illness and buried her four years ago. He said he had read everything, in those years, that anyone had ever written about pain.

"The religions all say the same thing in different languages," he said. "Job in his furnace. Isaiah's God choosing his people *in the furnace of affliction*. The Buddhists telling you suffering is real, that it comes from clinging, and that it can end. Karma. The Muslims surrendering to the will of God. The Christians with their cross." He smiled faintly. "And then the philosophers, who say the same thing without the incense. Frankl in the camps, saying the one freedom they could never

take from you was your attitude to what you couldn't change. Nietzsche asking whether you'd live your whole life again, every moment of it, the joy and the agony together, because you can't have one without the other."

"And Gurdjieff," said Bob.

"And Gurdjieff. Intentional suffering." Michael glanced at Jake. "The idea is that most of our suffering is mechanical. It just happens to us, and we react, and nothing changes. But if you choose to bear something — consciously, without complaint, without the usual reactions — it becomes a kind of fuel. It wakes you up."

Jake had stopped writing. "Do you believe that?"

"I believe it's true of some pain and a lie about other pain," said Michael. "I wouldn't tell a man with a slipped disc to go and suffer intentionally. I'd tell him to go and see Bob." He looked back at his old friend. "But a man who has already been seen, and treated, and still hurts? Then the question isn't only how to get rid of it. It's what you do with it while it's there."

* * *

Bob found himself thinking of an old book on his shelf at home: Robert de Ropp's *The Master Game*. De Ropp had divided the games people played into the ordinary ones — money, fame, power, the Hog in the Trough, as he called the first of them — and the one game worth playing, which was

waking up. Knowing the difference between the mask and the face underneath it.

For forty years Bob had been sure he was playing the Master Game. His whole practice had been built on seeing people whole. And yet it was possible, he thought, looking at the grey sea, that he had been playing a much smaller game: the game of being the clinician who sees people whole. Which was not at all the same thing, and needed a very different kind of courage.

Michael leaned across the table. "Can I ask you something you won't like?"

"You always did."

"When did it start? The back."

"Last autumn. Gardening."

"And what else happened last autumn?"

Bob opened his mouth to say *nothing*, and found that the answer was sitting in his chest like a stone. Nathan had gone back to university for his second year and taken the last of his things from the spare room. Bob had set his retirement date. And on the same October weekend he had spent an afternoon on his knees in the garden, doing the job his ex-wife had always done, in a garden that had once been theirs.

He did not say any of this. But Michael, who had known him for forty-six years, watched his face and nodded, and let it go.

* * *

On the drive home Jake was quiet for a long time. Then he said, without taking his eyes off the road, "I'm sorry about the PNE thing. At the start. Trying to explain your pain away to you."

"You weren't wrong," said Bob. "Not completely."

"I wasn't right, either."

"No." Bob looked out at the fields going past, brown and wet. "Neither was I."

The old guilt came up then, the way it always did on long drives. The marriage. Rushed, mismatched from the start, over before Nathan was a year old. He had paid, and turned up, and been present in every way he knew how. But underneath it there was always the same question he could never quite put down: how had he, of all people, the man who read people for a living, made such a mistake? And what had it cost his son?

He had spent his life being needed. Pleasing, rescuing, fixing. The shadow side of the lover, the archetype books would say: the terror of being alone, the hunger to be wanted, the habit of pouring himself outwards until there was very little left inside. He had called it vocation. Some of it was. And some of it, he thought, watching the motorway lights come on in the dusk, was a man who had found it easier to hold other people's pain than to sit still with his own.

Chapter 8: The View from the Gods

Kate had learned to watch before she had learned to read.

It was the kind of childhood nobody talked about, least of all her. What it had taught her, apart from things she had spent years in a therapist's chair unlearning, was attention. You read the weather in a house. The way a key turned in a lock. How long a silence had gone on. Which footsteps meant it was safe to come downstairs.

She had wanted to be a physiotherapist once. At seventeen she had sent off for the prospectus and kept it under her mattress for a year. Then life had happened, the way it does: a job, a marriage too young, a marriage that ended not with a row but with two people who had simply stopped speaking. At thirty-eight she had answered an advertisement for a practice manager on Harley Street, and Bob Harlan had interviewed her for twenty minutes, then put down his pen and asked what she noticed about the waiting room. She had told him: the chair by the window that nobody sat in because the sun hit your eyes, the patient who had been rubbing her wrist while

filling in the form, the fact that the receptionist before her had put the tissues out of reach.

He had hired her on the spot.

For eleven years she had watched him. She knew how he stood when a case was going well and how he stood when it wasn't. She knew he took his coffee black because he had once decided milk was a sign of weakness, and that he secretly liked the almond biscuits she bought for the patients. She knew his handwriting got smaller when he was worried.

For six months his handwriting had been getting smaller.

* * *

She waited until the last patient had gone on a Thursday evening in April. Jake had left for the gym. The building was quiet except for the old radiators ticking as they cooled.

She knocked on Bob's door, which she never did, and came in with two cups of tea and a notepad, which she also never did.

"I want to take your history," she said.

Bob looked up from his desk. "Kate, I've had it taken. By Craig, by the urologist, by Jake of all people—"

"They took your back's history." She sat down in the patient's chair. "I want to take yours."

He started to laugh, and stopped, because she wasn't smiling.

"You've been sending emails at three in the morning since November," she said. "I see the timestamps. Three-oh-seven, three-twelve, two-fifty-eight. That's six months of broken nights before anyone found your prostate."

He said nothing.

"You used to walk to Regent's Park at lunchtime. You stopped in October. You used to have coffee twice a day; it's five or six now. You used to see people — that choir, the man with the sailing boat, your cousin in Hampstead. Since the autumn you see Craig, and that's all. You stand all day to treat because sitting hurts, and you go home and lie on the sofa because standing hurts, and you don't do the exercises you'd give a patient because you're too tired." She turned the page. "You haven't mentioned Nathan's calls since he went back in October. You used to tell me every time. And you've set a date to stop the only thing you've ever wanted to do, and you haven't said a single word about how you feel about that."

The radiators ticked.

"You took your own history like a surgeon," she said quietly. "You found the part that was broken and you stopped looking."

* * *

Bob sat for a long time. Then he reached into his drawer, took out the Todd Michael book, and slid the folded sheet of A4 out from under its cover. Four columns. One filled in.

He smoothed it flat on the desk between them.

"Will you help me with the rest?" he said.

They did it together, the way he'd done it for Mr Patel's file, except this time he didn't leave anything out.

Under *Brain* he wrote: *retirement — who am I if I'm not this? Nathan leaving. Fear of decline. Fear of becoming useless. Shame: can't fix myself.*

Under *Spinal cord and nervous system*: *six months broken sleep. Caffeine. Constant low-level fear. No let-up.*

Under *Tissues and load*, below the stenosis and the disc, he added: *standing eight hours a day. No walking since October. Deconditioned. Not doing my own exercises.*

Kate had been reading upside down. "Can I ask something stupid?"

"You've never asked a stupid question in eleven years."

"Why would sleep make your back hurt more? Your back's the same back at three in the morning as it is at three in the afternoon."

It was exactly the question a patient would ask. It was a question he had answered for patients a thousand times, and had never once answered for himself.

"Because pain isn't a measurement of damage," he said slowly. "It's more like a volume control. The signal from the back is the same, but the nervous system decides how loud to play it. And sleep is one of the things that sets the volume. After one bad night, most people's pain threshold drops. They feel more pain from the same stimulus. After months of bad

nights, the whole system stays turned up. Everything hurts more, heals more slowly, and the muscles round the spine stay tense and guarding because the body thinks it's under threat."

"So the bladder was waking you up, and being woken up made the back worse."

"And the back being worse made me more frightened, and being frightened made me sleep worse, and drink more coffee, and stop walking, and stop seeing people." He looked at the page. "It's a circle. I've drawn it on the whiteboard for patients a hundred times."

"And the stenosis?"

"The stenosis is real. My canal is narrow. It'll always be narrow." He tapped the third column. "But a narrow canal in a man who sleeps, walks every day, isn't terrified and still has somewhere to be in the morning is a very different thing from a narrow canal in me."

Kate was quiet for a moment. "So which do you treat?"

"All of it," said Bob. "That's the whole point. You never treat just one."

He heard himself say it and nearly laughed.

* * *

At the door, Kate stopped.

"I kept the prospectus," she said. "The physio one. From when I was seventeen. It's still in a drawer."

Bob looked at her properly, perhaps for the first time in eleven years.

"You just took a better history than half the people I've trained," he said. "It's not too late for something."

She smiled, and didn't answer, and went home.

Chapter 9: Regent's Park

Nathan came home the following weekend. Bob met him at Baker Street with a walking stick he hated, and Nathan looked at the stick, and then at his father, and said nothing about it at all, which Bob loved him for.

They walked into Regent's Park by the York Gate. The plane trees were coming into leaf. Nathan talked about his course, his friends, a girl he was not quite seeing, a module he was failing and a module he was unexpectedly good at. Bob listened. He did not analyse Nathan's posture, which was slightly round-shouldered from too many hours over a laptop, and he did not offer any advice. He just listened, and it was easier than he had expected.

After eight minutes the tingling started in his right foot. After ten his calf felt heavy and wrong, as though it were filling with wet sand. He stopped at the railings by the boating lake and leant forward on them, forearms resting on the rail, and waited.

Nathan leant beside him. "Is that the thing?"

"That's the thing."

"Why does leaning like that help? You're still standing."

Bob thought about how to put it. Not the lecture. Not the textbook.

"Think of the spine as a stack of cotton reels with a tube running down the middle," he said. "The nerves for your legs run through the tube. Mine's narrower than most people's — I was born that way — and age has made it narrower still. When I stand up straight, or lean back, the tube gets a little bit narrower again. When I bend forward, it opens up. So walking upright for ten minutes squeezes the nerves, and they start to complain. Leaning on this rail opens the tube and gives them room to breathe."

Nathan looked at him. "So you'd be all right walking bent over."

"I'd be all right pushing a supermarket trolley," said Bob, "which is why some doctors call it the shopping-trolley sign. People with a narrow canal can walk round a supermarket for an hour and can't get to the end of the street."

"What about a bike? You're bent forward on a bike."

Bob opened his mouth, closed it, and started to laugh. "Yes. A bike would be good. Most people like me can cycle much further than they can walk."

"You've got one in the shed. From when I was fourteen."

"It's got a flat tyre."

"I'll fix it tomorrow."

The tingling had faded. They walked on, more slowly now, and Bob did something he taught patients but hadn't done himself: he walked until he felt the first faint warning in his foot, and stopped *before* it got bad, and rested a minute, and walked again. Walk, rest, walk. It was slower. But they got all the way round the Inner Circle, and he could not remember the last time he had done that.

* * *

They sat on a bench in Queen Mary's Gardens. The roses weren't out yet, just bare canes and labels.

"Can I say something?" said Nathan.

"Of course."

"You look sad. Not just sore. Sad."

Bob didn't answer at once. The old reflex rose in him: to reassure, to deflect, to turn the conversation back to Nathan. He let it pass.

"I think I am," he said. "I think I've been sad since you went back in October, and I've been pretending it was my back."

Nathan was quiet. Then he said, carefully, "Is it about Mum?"

It had never been said between them. Twenty years, and never said.

"Partly," said Bob. "I've always felt I let you down. The divorce. You were eight months old. I've spent twenty years

wondering what it did to you."

Nathan looked at him with an expression Bob couldn't read. Then he laughed, not unkindly.

"Dad. I don't remember any of it. What I remember is you turning up. Every other weekend and every Wednesday, for twenty years. You never missed one. You took me to the Science Museum so many times the guards knew my name." He shook his head. "You've been carrying that for twenty years and I didn't even know you were carrying it."

Bob found he couldn't speak for a moment. He looked at the rose labels. *Gertrude Jekyll. Peace. Just Joey.*

"I think," he said at last, "I've been carrying a lot of things I didn't need to."

* * *

That night, after Nathan had gone to bed in the spare room, Bob took out the sheet of paper and looked at the first column again. *Nathan leaving. Shame.*

He didn't cross anything out. But beside *shame* he wrote, in small handwriting that was, for the first time in months, a little larger than before: *possibly out of date.*

The next morning Nathan fixed the tyre on the old bike, pumped it up, and made his father ride it the length of the mews and back. Bob wobbled, and felt foolish, and felt his back ease forward over the handlebars, and got to the end of the mews without a single tingle in his foot.

He rode it back, grinning like a boy.

Chapter 10: Jake's Patient

Lily Marsh was nineteen, a second-year student at a dance conservatoire in North London, and she walked into the clinic as if the floor might tilt under her. She was slight, pale, beautifully upright, and she had been referred by her college with *right anterior hip pain, clicking, ? labral*.

She was Jake's patient. Bob had made a point of it. Since the afternoon in the treatment room when Jake had asked him the questions about his bladder, something between them had shifted, and Bob had begun handing him cases the way you hand a younger colleague a sharp instrument: carefully, but without taking it back.

Jake's plan was written out before she arrived. Bob saw it on the desk: *tight hip flexors — stretch; hip joint mobilisation; core stability.*

Bob said nothing. He sat on a chair in the corner, shifting his weight every few minutes, and watched.

* * *

The first ten minutes went the way Jake had expected. The pain was at the front of the right hip, deep in the crease. It clicked when she brought her leg up into a développé — the slow unfolding of the leg to the front, high as her head. Sometimes it felt as if it slipped out and back in. It was worse after long rehearsals and in the week before performances.

"And you stretch a lot?" Jake asked.

Lily almost laughed. "I'm a dancer. I stretch all the time. It feels good. It feels like it's the only thing that makes it better."

Jake glanced towards the corner. Bob was studying the ceiling.

Jake hesitated. Then he put down the pen with his plan on it and, very deliberately, started again.

"Can you put your hands flat on the floor without bending your knees?"

She did it without warming up, palms flat, easy as folding a towel.

"Can you bend your little finger back past ninety degrees?"

She could. Both hands. Her elbows bent backwards when she straightened them. So did her knees. Her thumbs folded flat against her forearms.

"Do other joints ever slip or feel unstable? Shoulders, kneecaps?"

"My shoulder came out once, doing a lift. It went back on its own. My kneecaps feel wobbly sometimes."

"Do you bruise easily?"

She pulled up her sleeve without being asked. There were yellowing marks on her forearm that she couldn't account for.

Jake was writing now, quickly, on a fresh page. His ears had gone pink, the way they did when he was concentrating rather than when he was embarrassed.

"How's your energy?"

"Terrible," she said. "But everyone's tired at college."

"Do you ever feel dizzy, or like you might faint, when you stand up? Or your heart races?"

Lily looked at him warily. "How do you know that?"

He didn't know it. He was guessing, following a path he had read about but never walked. It was Kate, of all people, who had given him the thread. Half an hour earlier she had come into the back room and said quietly, "Your three o'clock sat down on the waiting-room floor when she stood up from the chair. She said she was fine. She went very white."

"It happens a lot," Lily admitted. "Standing in the queue in the canteen. Hot showers. I have to sit down. My heart goes really fast."

"How's your stomach?"

"Bloated. On and off. The GP said it was IBS."

"And your periods?"

A pause. "They've been all over the place. I didn't have one for four months before Christmas."

"Are you eating enough for the amount of dancing you do?"

The pause was longer this time. “Probably not before shows,” she said at last, very quietly. “Everyone sort of… doesn’t.”

Jake nodded. He didn’t lecture her. He wrote it down, and let the silence be kind.

“Last one,” he said. “How are you in yourself? Stress, anxiety, sleep?”

Lily looked at the floor. “I’m anxious all the time. I thought it was just me. My mum says I’ve always been a worrier.”

* * *

Jake excused himself for two minutes and came to Bob in the corridor. He looked a little shaken.

“I was going to stretch her,” he said. “I was going to stretch the most flexible person I’ve ever examined.”

“You didn’t, though.”

“Because you sat in the corner looking at the ceiling.”

“Because you went round the map.” Bob kept his voice low. “So. What’s the map?”

Jake took a breath and laid it out, and Bob listened, and did not interrupt once.

The hip: a joint with too little restraint, not too much stiffness. The clicking and slipping were the hip moving further than it was built to, the joint’s lining and the rim of cartilage taking the strain. The stretching felt good because it briefly quietened the protective tension in the muscles; but

those tight-feeling muscles were probably working overtime to hold together a joint the ligaments couldn't. Stretching them further would be pulling down the scaffolding.

He had checked the hip joint itself properly. Bringing her knee up towards the opposite shoulder and turning the thigh inwards reproduced the deep pinch in the groin, which fitted irritation at the front of the joint. Her hypermobility score was nine out of nine: thumbs, little fingers, elbows, knees and hands flat to the floor. And then he had done what mattered most, which was to watch her dance.

She had shown him a développé to the front, slowly, and he had put his fingertips lightly on the front of her hip as the leg rose. At about ninety degrees he had felt the top of the thigh bone drift forwards in the socket, pressing into the front of the joint, instead of spinning neatly in place. At the same moment the front of her hip tightened like a cable, and her lower back arched to help lift the leg. Her deep buttock muscles, the small ones at the back of the hip whose job is to keep the ball centred in the socket, were barely working. The long muscles at the front of the hip, which are built to move the leg rather than hold it, were doing everything.

"Shirley Sahrmann would call it a movement impairment," Bob said, when Jake described it. "The joint isn't damaged so much as used badly, thousands of times a week, the same way. The ball slides forwards instead of rotating, and the front of

the joint takes a knock every time. Fix the way it moves and you take away the knock."

The body: widespread hypermobility, the shoulder that had dislocated, the knees, the bruising. Possibly a hypermobility syndrome, perhaps one of the connective tissue conditions that ran in families. That was for a specialist to decide.

The dizziness and racing heart on standing: in hypermobile people, the blood vessels can be stretchier too, and blood pools in the legs when they stand; the heart races to compensate. Sometimes that was a condition in its own right that deserved proper assessment.

The gut, the fatigue, the anxiety: often clustered with hypermobility, and not imagined. A body that couldn't quite trust its own joints or its own blood pressure was a body on permanent alert.

And the periods and the eating: the most urgent thread of all. A young dancer training hard and not eating enough could lose her periods, weaken her bones, and exhaust herself in ways that no amount of hip exercise would reach.

"So what's the plan?" said Bob.

"Not stretching," said Jake. "Control. Keep the ball centred in the socket. Train the deep hip muscles first, in the middle of her range, where she's strong, then take the control out towards the end of range, where she keeps getting into trouble. Balance, so her joints know where they are. And she stops hanging on her ligaments in positions that feel good but aren't

— standing with her knees locked back, sitting in the splits between classes." He hesitated. "But most of it isn't mine. I need to write to her GP about the dizziness, her heart rate, her iron and the hypermobility. And about the periods and the eating — she needs the sports medicine people and a dietitian who knows dancers. Maybe someone for the anxiety."

"Write it down," said Bob. "Like a prescription."

Jake wrote, and Bob read over his shoulder.

- Lying on her back, knees bent, gently drawing the thigh bone back into the socket before lifting one foot a few centimetres: 3 sets of 10 each side. Tempo: 2 seconds up, 3 seconds hold, 3 seconds down. Rest 30 seconds.
- Side-lying clam with the pelvis stacked and still, a light band above the knees: 3 sets of 15. Tempo: 2 seconds open, 2 seconds hold, 3 seconds close.
- Four-point kneeling, lifting one knee a centimetre off the floor without the pelvis moving: hold 20 seconds, 5 each side.
- Standing on one leg on a cushion, knee soft, not locked: 3 holds of 45 seconds each leg, eyes open, then closed.
- Développé practice at the barre to 60 degrees only, keeping the front of the hip soft and the ball centred: 2 sets of 6, very slowly. Raise the height by 10 degrees each week only if it stays pain-free and controlled.
- No passive hip-flexor or splits stretching for four weeks.

"Slow, light, and long," said Bob. "For stabilisers, that's the dose. The speed and the height come last."

"And what do you say to her now, today, so she doesn't go home thinking she's falling apart?"

Jake thought about it for a long moment.

"That none of this is in her head," he said. "That it all fits together. That there's a lot we can do."

Bob smiled. "Then go and say it."

* * *

Jake went back in. Bob, from the corridor, could hear some of it through the door.

"I think your hip's clicking because it's too mobile, not too stiff," Jake was saying. "So stretching it more is like loosening the guy ropes on a tent in the wind. We're going to do the opposite: build the muscles round it so they hold the joint where it should be. I also think a lot of other things you've told me might be connected — the dizziness, the tiredness, your stomach, even some of the anxiety. I'm going to write to your GP so they can check some of those properly."

A pause. Then Lily's voice, smaller.

"Everyone just told me I was a worrier."

"You might be," said Jake, and Bob could hear the smile in his voice. "But you might also have a body that gives you quite a lot to worry about. Let's find out."

* * *

That evening Bob sat alone in his room with the four-column sheet from the Todd Michael book in front of him, as he did most evenings now.

He thought about Lily, whose most flexible joint had fooled everyone into thinking it was stiff. About Mrs Bell, whose hip had pretended to be her knee. About Mr Adeyemi, whose gallbladder had pretended to be his shoulder. About himself, whose bladder had pretended to be his back.

The body lied constantly, he thought. Not maliciously. It simply spoke in a language of shared wiring and borrowed signals, of one thing standing in for another. The pain was always telling the truth about something. It just wasn't always telling the truth about where.

He wrote at the bottom of his sheet: *Jake went round the map without being asked.*

Then, after a moment: *He's going to be better than me.*

The thought surprised him by how little it hurt.

Chapter 11: The Prescription

Tony Walsh was forty-seven, a scaffolder from Dagenham, and he came into the clinic sideways.

Not metaphorically. His trunk was shifted a hand's width to the left of his pelvis, as if someone had pushed his shoulders along a shelf, and he walked with short, careful steps, one hand on the small of his back. He lowered himself into the chair in reception like a man getting into a cold bath.

"I've got three weeks," he told Kate before he'd even given his name. "Big job at Canary Wharf. Twelve storeys. If I'm not up there, I don't get paid, and the lads don't either."

Kate wrote *three weeks — Canary Wharf* at the top of his form, and underlined it, and put the form on Bob's desk. She had learned years ago that the reason a patient came in was the most important line in the notes, and that it was very often not the pain.

* * *

Bob let Jake lead. He sat on his stool by the window and said almost nothing for the first twenty minutes, which Jake had learned was the most demanding thing Bob could do to him.

Jake started well. He took the history slowly. Right-sided low back pain, spreading into the right buttock, nothing below the knee. It had come on four days ago, lifting a bundle of tubes off the lorry with his back bent and his knees nearly straight, twisting to pass them up. Three previous episodes in five years, each one worse and each one slower to settle. Worst when he bent forward, when he sat in the van, when he put his socks on. Easier when he walked. Stiff in the morning for ten minutes or so, then better once he got moving.

Then, without being prompted, Jake ran through the questions that had once been asked of Bob in this same room. Any numbness between the legs. Any change in his bladder or bowels. Any weakness or pins and needles in either leg. Any weight loss, fever, night sweats, history of cancer. All clear. He did it briskly and kindly, the way you check the brakes before a long drive, and Bob felt something in his chest that he recognised, after a moment, as pride.

"How bad, on a scale of nought to ten?" Jake asked.

"Seven. Eight when I bend."

"And when you bend to put your socks on, and it goes up to eight — how long before it settles back down?"

Tony thought. "Forty minutes? An hour? I have to lie on the floor."

Jake glanced at Bob, and Bob gave the smallest nod.

That single question was, Bob had always believed, the most useful thing a physiotherapist could ask, and the most often forgotten. Not *how much does it hurt*, but *how easily does it flare, and how long does it take to calm down*. Geoff Maitland had called it irritability. A back that flared at the slightest movement and took an hour to settle was a back you examined gently, a few movements only, stopping at the first sign of pain. A back that hurt a great deal but settled in moments could be examined fully and loaded quite hard. The same score out of ten could mean two entirely different patients, and two entirely different treatments.

Tony's back was irritable. Jake would do less today, not more.

* * *

He asked Tony to stand, and then — this was the part Bob had spent years trying to teach — he didn't start with the back at all.

"Show me how you lift a tube," he said. "Use this." He handed Tony the wooden broom handle they kept behind the door for exactly this purpose.

Tony shrugged, set the handle on the floor, and bent to lift it, and Jake and Bob watched the whole story of his back unfold in about two seconds. His knees stayed almost straight. His hips barely folded. All of the bend came from the lower

back, the lumbar spine curling forward like a question mark. As he came up he twisted to his right to pass the imaginary tube up to the next lift, and the twist came from the same place — the low back — while his feet stayed planted and his hips stayed still.

"How do you carry the boards?"

"On my shoulder."

"Which shoulder?"

Tony touched the right one, without thinking.

Jake stood behind him and just looked. The trunk shifted to the left. The lower back flat, its natural hollow gone. The right shoulder higher than the left, the muscle across the top of it thick and hard from twenty-five years of boards. The right foot turned out a little further than the left, and its arch lower.

Bob, on his stool, was thinking the way he had always thought, without any of it being a list. The pain was in the right low back and buttock. What lived there? The discs and the small facet joints at the bottom of the spine. The sacroiliac joint where the spine met the pelvis. The deep muscles along the spine, and the big buttock muscle, and the fascia binding them together. And the pattern of a man who bent from his back instead of his hips, who twisted from his back instead of his feet, who carried a heavy load on the same shoulder every day of his working life. Then the question underneath all of it, the one he had nearly forgotten how to ask of himself: *and what else could this be?*

* * *

Jake tested movement next. Bending forward, Tony's fingertips reached only to his knees before the pain stopped him, and it spread further into the buttock as he went. Bending back was stiff, but when Jake asked him to repeat it slowly — hands on his hips, leaning gently back, five times — something changed. The buttock pain eased. It drew back towards the middle of his spine.

"Does that feel different?"

"It's… moving. It's more in the middle now. Less in my backside."

Jake looked at Bob again. Bob didn't nod this time. He didn't need to. Both of them knew what it meant. When pain retreats from the leg or buttock back towards the spine with a repeated movement — centralises, Robin McKenzie had called it — it is one of the most encouraging signs in back pain. It tells you the problem is very likely in the spine itself, that it responds to a particular direction of movement, and that it will probably get better.

For Tony, the direction was backwards. The very movement that would have narrowed Bob's own canal and set his leg tingling was Tony's medicine. Bob thought that if he could teach the profession one thing in the few months he had left, it would be that sentence.

Jake had been going to test the sacroiliac joint next. Bob could see him reaching for it.

"Which test?" Bob asked, very quietly.

"I was going to do Gillet's. The standing one, feeling the pelvis move."

"How good is it?"

Jake hesitated. "Not very. Two people doing it on the same patient often disagree."

"So if you needed to know about the sacroiliac joint, what would you use?"

"The provocation tests. Mark Laslett's cluster. Five of them — distraction, compression, thigh thrust, sacral thrust, Gaenslen's. If three or more reproduce the pain, it's probably the joint."

"And do you need to know today?"

Jake thought about it. "No. His pain centralised. That points to the spine. Laslett said the joint tests matter most when the pain *doesn't* centralise." He put down his hands. "And his back's irritable. Five provocation tests would just flare it."

"The right test," said Bob, "at the right time, for the right reason. Otherwise it's just a ritual."

Jake checked the nerve quickly, because Bob would have asked if he hadn't: a straight leg raise and a slump test, both clear, reflexes and strength normal. Then he did what the history and the movement tests had pointed him towards. With Tony lying face down, he pressed gently on each vertebra

in turn, feeling for stiffness and asking about pain. At the fifth lumbar vertebra, the lowest, the joint felt stiff under his thumbs, and the pressure brought on Tony's familiar pain.

"That's it. That's the one."

He tested the hips: the right hip rotated inwards only half as far as the left. He checked the muscles at the front of the hip, which were tight on both sides, and the hamstrings, tighter still. Then he asked Tony to lift one straight leg a few inches off the couch while lying on his front, and put his fingertips lightly on the buttock, the hamstring and the long muscles of the back, to feel which fired first. The hamstring and the back muscles tightened before the buttock had even woken up.

"The glute's asleep," said Jake.

"Not asleep," said Bob. "Late. Which in a man who lifts for a living is worse."

* * *

Tony sat up slowly, the way Jake showed him. "So what's wrong with it? Is it a slipped disc?"

Bob got off his stool and came over. This part he still liked to do himself.

"Discs don't slip," he said. "They're more like tough jam doughnuts sitting between the bones of your spine. When you bend forward over and over, especially while twisting and lifting, you squeeze the front of the doughnut and push the jam

towards the back. After enough years of that, the back wall gets tired and irritated. That's very likely what's happened to you, at the bottom of your spine. The good news is that the way it behaved just now — the pain moving back to the middle when you leaned back — tells us it's the kind that tends to settle well."

"So why does it keep happening?"

Bob took Tony's hand and put it flat on his own lower back, over the diamond of muscle and tissue just above the pelvis.

"Under there," he said, "is a sheet of very strong tissue called the thoracolumbar fascia. Think of it as a big diamond-shaped belt across your lower back. Your large back muscle, the one under your armpit, pulls on the top of it from one side. Your big buttock muscle pulls on the bottom of it from the other side. So your right buttock and your left shoulder are connected through that sheet, crosswise, like the straps of a rucksack. Some anatomists call it a sling. When you lift and twist, that sling is meant to take the load and pass it across your back, from one hip to the opposite shoulder, like a spring."

Tony was frowning, but he was listening.

"But your buttock muscle is firing late," Bob went on, "and your hips don't bend or turn properly. So when you lift and twist, the sling can't do its job. All that load goes into the small joints and the discs at the bottom of your spine instead.

The deep tummy muscle, the one that wraps round you like a corset, is meant to tighten that belt as well, and yours isn't doing much." He smiled. "You've got a very strong back, Tony. It's just doing everybody else's job as well as its own."

Tony laughed, and winced, and laughed again. "Story of my life."

* * *

After Tony had gone for the day, Jake sat down to write the exercises. Bob watched him type *core stability exercises and hip mobility, 3 × 10, daily*, and reached across and closed the laptop lid.

"What does three times ten mean?" he asked.

"Three sets of ten reps."

"Of what? At what speed? How heavy? How long between sets? How many times a day? For how many weeks? And what do you do when it gets easier?"

Jake opened his mouth.

"When a GP gives a patient a medicine," said Bob, "they don't write *some tablets, daily*. They write the drug, the dose, how often, for how long, and what to do if there are side effects. An exercise is a drug, Jake. It has a dose. Give too little and nothing changes. Give too much and you make them worse. Give the right exercise at the wrong speed and you train the wrong muscle."

He took a prescription pad from his drawer — an old one, printed years ago, with *Rx* in the corner — and pushed it across the desk.

"Paul Chek taught me this, thirty years ago," he said. "He's a strength coach and a pioneer of corrective and holistic exercise. Not a physiotherapist, but his insight has taught a great many clinicians over the course of his career. He understands the human body better than most of us. The deep muscles that hold your spine and joints steady — the corset, the small muscles between the vertebrae, the deep hip muscles — are endurance muscles. They're built to work gently all day long. So you train them gently and for a long time: light load, slow tempo, long time under tension, short rests. The big muscles that move you — the buttocks, the thighs, the big back muscles — are built for force. You train those with heavier loads, fewer reps, a controlled speed, and longer rests to let them recover. If you train the stabilisers like movers, or the movers like stabilisers, you get neither."

"And the order?"

"Chek built it as a ladder. At the bottom: posture, flexibility and the deep core, because there's no point strengthening a movement pattern the body can't control. Then stability. Then strength. Then power and speed, and finally the specific things the person actually has to do, in the way they have to do them." He tapped the pad. "And you only

move up a rung when the body has earned it. Not when the diary says so."

* * *

They wrote Tony's first prescription together. Because his back was still irritable, it was gentle, and short, and very specific.

Week one. Settling the back.

- Lying face down, then up on the elbows: hold 2 minutes. Every two to three hours.
- Press-ups from lying, hips staying on the floor: 10 repetitions, slowly — 3 seconds up, 3 seconds down. Four times a day.
- Four-point kneeling, drawing the tummy button gently up towards the spine without moving the back, breathing normally: hold 10 seconds, rest 10 seconds, 10 repetitions. Twice a day.
- Walking: 10 minutes, three times a day. Increase by 2 minutes a day if the pain allows.
- Avoid: sitting for more than 20 minutes; bending first thing in the morning; long drives without a stop. Use a rolled towel behind the low back in the van.
- Rule: pain during exercise no higher than 3 out of 10, and back to where it was before by the next morning. If not, drop back a step and call us.

Jake read it through. "It looks too easy."

"It's week one," said Bob. "A back that takes an hour to calm down doesn't need to be challenged. It needs to be convinced."

* * *

Tony came back twice a week. Jake mobilised the stiff joint at the bottom of his spine with slow, rhythmic pressures — gentle ones in the first week, just enough to ease the pain; firmer ones as the back settled, reaching into the stiffness. At the start of every session he checked the same few things: how far Tony could bend, whether the pain stayed central, how well the corset muscle switched on, which muscle fired first when Tony lifted his leg. If they improved, they carried on. If they didn't, they changed something.

By the second week the shift in his trunk had gone and he could bend to mid-shin. The irritability had dropped: bending now took the pain up a little and it settled in five minutes, not an hour. So the prescription climbed a rung.

Week two. Stability and control.

- Hip hinge with the broom handle along the back, touching the back of the head, between the shoulder blades and the base of the spine throughout: 2 sets of 10. Tempo: 3 seconds down, 1 second pause, 2 seconds up. Rest 30 seconds. Daily.

- Glute bridge, squeezing the buttocks before lifting: 3 sets of 12. Tempo: 2 seconds up, 2 seconds hold, 2 seconds down. Rest 30 seconds.
- Side plank from the knees: hold 20 seconds, building to 40, three each side.
- Hip flexor stretch in half-kneeling, tucking the tail under first: hold 60 seconds, twice each side.
- Right hip turning in, lying on the back with the knee bent: 15 slow repetitions.

On the Tuesday of the second week, Tony arrived early and sat in reception with Kate. She came into Bob's room afterwards.

"He asked me what his wife should cook," she said. "He eats in the van. Pies, mostly, and energy drinks. He's up at half four, home at seven, and asleep in front of the telly by nine with a can in his hand. He said the only time he doesn't hurt is when he's with his daughter at the swimming baths on a Sunday."

Bob wrote it in the notes, word for word. Chek had called them the four doctors: Dr Diet, Dr Quiet, Dr Movement and Dr Happiness. The body was not only a set of levers. Food, sleep, rest and joy were part of every back, and Tony's life had room for very little of any of them. None of it was a hidden disease. All of it was part of why his tissues healed slowly and why his back kept flaring. At the next session Jake asked Tony about his sleep and his breakfast before he asked about his

pain, and Tony looked at him as though no one had ever asked him that in his life.

* * *

In the third week, the prescription changed character entirely. Tony's back could now tolerate load, and his job was load.

"What does he actually have to do up there?" Bob asked. "Not what's on a handout. What does his body do on a Monday morning at Canary Wharf?"

They wrote it down: bend and lift tubes from the ground; twist and pass them up; carry boards on the shoulder; climb ladders; reach overhead to fix couplers; stand and brace on a narrow board in the wind. Chek had called these the primal patterns — squatting, lunging, bending, pushing, pulling, twisting and walking — the movements human bodies had always done. Tony's work was nothing but primal patterns, done heavy, done fast and done thousands of times.

Week three. Strength for work.

- Kettlebell deadlift from a low step, hinging from the hips as practised: 3 sets of 8. Tempo: 3 seconds down, no pause, 1 second up. Rest 90 seconds. Start at 16 kg and add 4 kg each session if form holds and pain stays under 3 out of 10.
- Cable woodchop, turning from the hips and feet, not the low back: 2 sets of 10 each way. Tempo: 2 seconds each

way. Rest 60 seconds.

- Split squat: 3 sets of 8 each leg. Tempo: 3 seconds down, 1 second up. Rest 60 seconds.
- Suitcase carry, a heavy weight in one hand, walking tall: 4 lengths of the gym, alternating hands. Rest 60 seconds.
- Carrying practice: a light board on the left shoulder as well as the right. Swap every trip.
- Before work, every day: a six-minute routine of press-ups from lying, bridges, hip hinges and woodchops with a light band, to switch everything on before the first lift.

Jake read it back and looked up.

"So the stabilisers first, then the movers, then the actual job."

"Because you can't strengthen what you can't control," said Bob, "and there's no point strengthening something he doesn't need. The final exercise is always the patient's own life."

* * *

Tony didn't go back up the scaffold at three weeks. He went back at four, which Bob had quietly predicted on the first day and hadn't said aloud, because a man who is told he'll be late stops trying to be early.

On his last visit he brought his prescriptions to reception, all three of them, and asked Kate to photocopy them.

"For the lads," he said. "Half of them have got backs like mine. I'm going to make them do the six-minute thing before we start." He grinned. "They'll love that."

When he'd gone, Jake sat in the back room for a long time without saying anything.

"No hidden disease," he said at last. "No gallbladder, no prostate. No referred pain from anywhere. Just a back."

"Most of the time," said Bob, "it's just a back. And that's the hardest thing to get right. Anyone can be dazzled by the rare case. The craft is doing the ordinary case properly: the history, the movement, the right test, the right dose, and changing it when the body tells you to."

He looked at the prescription pad, still on the desk.

"The Greeks had a word for it," he said. "*Techne*. Craft. The knowledge that lives in the hands and in doing things exactly, repeatedly, until it becomes a kind of care. Aristotle thought it was one of the ways a person reaches the truth."

Chapter 12: Intentional Bearing

Five weeks before he retired, Bob wrote himself a treatment plan.

He did it the way he would have done it for a new patient, on a clean sheet, starting from the four columns and working outwards. He made himself write down what he would *not* do as well as what he would, because he had learned from Mr Patel that a plan is as much about what you leave out.

The first thing he crossed off was extension.

The repeated backward bends that had given Mrs Ellis her garden back would, for Bob, narrow a canal that had no room to spare. It was the same exercise, taught with the same care, and for one spine it was medicine and for another it was a mistake. He had written *McKenzie — no* at the top of the page, and then, underneath, *Not because it's wrong. Because it's not me.*

Then he built the rest.

Sleep. The tablet from the urologist, taken at night. No coffee after midday; two cups, not six. No emails after nine. Ten minutes before bed lying on his back with his knees bent,

doing what Jake called a body scan and Bob privately called paying attention: moving his awareness slowly from his feet to his head, noticing without trying to fix.

Moving. The bike every morning, twenty minutes, round the Outer Circle while the park was empty. Walking every afternoon in intervals: walk until the first whisper in the foot, stop, lean, breathe, walk again. Each week, a minute more before the first stop. No heroics.

Opening the canal. Gentle positions that bent the spine forward and gave the nerves room: lying on his back and drawing his knees towards his chest; kneeling with his forehead on the floor and his arms stretched out, the position yoga teachers call the child's pose. And the specific decompression positions from Guy Voyer's ELDOA work that had served Kelly so well — not copied from Kelly, but chosen for his own levels, L4–L5 and L5–S1, held for a minute at a time.

Strength. The deep muscles that hold the spine steady — the ones that wrap round the waist like a corset, and the small ones that run between each vertebra — don't respond to fast, heavy work. They are endurance muscles. So he trained them slowly: gentle holds, ninety seconds under light tension, short rests. And because Paul Chek had taught him long ago that stability comes before strength, and strength before speed, he didn't move on to anything harder until the easy things were easy.

Work. A tall perching stool in the treatment room, so he could stop standing for eight hours a day. Handing his heavier cases to Jake.

The rest of it. He rang his cousin in Hampstead. He went back to the choir on Tuesday evenings and stood at the back and sang badly. He booked three sessions with a counsellor Kate had found — not for his back, he told himself, but for the retirement. And every night he wrote three lines in a notebook: *one thing the pain stopped me doing today, one thing it made me notice, one thing I can make of it.*

He had also begun integrating the threads Jake had brought — without adopting any of them wholesale. Pain neuroscience education, reframed not as dogma but as one possible story: pain as a protector, not a measure of damage, and threat that could be changed through understanding and graded exposure. Breath work from the upper-quarter neuromuscular influences, which helped him release the tension that had settled into his neck and shoulders from years of leaning over plinths. Behavioural optometry — simple eye-tracking exercises that reminded him posture was not just mechanical but perceptual. Chek's layered progressions, stability before mobility. Caroline Myss's maps of emotional anatomy, where unexpressed grief lodged in the lower back like a second skeleton waiting to be acknowledged.

The journal had questions in it, too, not only lines. *What is this pain teaching? What part of me has been ignored? What meaning*

can I make here?

* * *

He did not expect the pain to go. That was the part he decided to bear on purpose.

It was what Michael had meant, in the café by the sea. There was the pain that could be changed, and he would change it, patiently, by every means he had. And then there was the part that remained on a given day, after he had done everything right. That part he stopped fighting. He did not grit his teeth against it or make it into a verdict on his life. When it flared, he noticed it, named it — *there you are* — and went on with what he was doing.

He found, to his surprise, that this made the pain smaller. Not the sensation, perhaps, but the space it took up. The fear around it shrank, and the fear had been a lot of it.

It was a decision, and he made it quietly: no escape into heavy medication, no rush to surgery. He would bear it intentionally. The old voices kept him company. Frankl: 'even in unavoidable suffering, meaning is found through attitude, turning fate into human accomplishment'. Gurdjieff: 'intentional suffering, the voluntary bearing of what is displeasing, the deliberate sacrifice of mechanical reactions in order to wake up'. Gregory Bateson's dry definition: 'a miracle is a materialist's idea of how to escape from his materialism'. Bob had always taken it to mean that what looks like a miracle

is usually a deeper pattern that a narrow way of looking cannot see — not supernatural, but a resonance that shifts the frame. And placebo, the Magician's oldest sleight: danger reframed as safety, threat as possibility.

And one line of Nietzsche's that Bob had underlined twice, decades ago, without understanding it, from the preface to *The Gay Science*: *'Only great pain is the ultimate liberator of the spirit… I doubt that such pain makes us "better"; but I know that it makes us more profound'*. He understood it now. The pain had not made him a better man. But it had taken him deeper into himself than forty years of success ever had.

He went back through his notes for the patients who had turned suffering into growth — who had made chronic limitation into compassion, and physical restriction into inner expansion. One woman had used her years of back pain to face, at last, the abandonment of her childhood. One man had found a community in a support group he would never have joined if the pain had not slowed him down.

The pain had not vanished. It never promised to. But it had changed shape. Where once it had been a tyrant — sharp, demanding, dictating every movement and every thought — it had become a constant companion, insistent but no longer sovereign. The terror that had come with it, the sense of the sledgehammer of time smashing through the life he had planned, had receded. In its place was something quieter: curiosity.

Pain remained. But it was becoming a teacher.

* * *

Jake started joining some of these quiet sessions. At first he came to learn. After a while he came to watch, and then just to be there.

One afternoon Bob looked up from his stool and said, "Do you get headaches?"

Jake blinked. "Sometimes. Stress."

"Where?"

Jake started to answer and stopped. He put two fingers to his temples, then to the angle of his jaw.

"Do you clench your teeth? Wake up with your jaw aching?"

There was a long pause.

"You asked me all this about Mrs Hollis," said Jake slowly. "In the staff meeting."

"I did. How is she, by the way?"

Jake coloured. "She'd had new varifocals eight weeks before her neck started. She was reading her second screen through the bottom of her lenses with her chin stuck out. We fixed the monitor height, the optician changed her prescription for computer glasses, and she's seventy per cent better." He hesitated. "She was sensitised too. The pain education helped. But you were right. It wasn't the first chapter."

"And your neck?"

Jake went to his dentist the following week. He had been grinding his teeth so hard at night that he had cracked a molar. A night guard, a physiotherapist who knew about jaws, and a habit of dropping his tongue to the roof of his mouth and letting his teeth part when he caught himself clenching — and within a month the neck pain he had carried since university was mostly gone.

He spoke less in sessions after that. He listened more. When a patient resisted his explanations he no longer pushed harder; he paused and asked what the pain meant to them.

One afternoon, after a particularly difficult chronic pain case, Jake found Bob in the back room.

"I used to think I had to change everyone," he said. "Now I'm starting to see that the only person I can really change is me."

Bob looked at the young man — still eager, still bright-eyed, but quieter now. "That's the beginning of wisdom," he said. "The rest is practice."

Kate watched from the doorway, arms folded, a small smile at the corners of her mouth. She said nothing. She never needed to.

* * *

Craig took Bob to the Italian on Marylebone High Street one last time before the retirement. The Chianti came without being asked for. The jokes were fewer.

"I'm not pushing surgery anymore," Craig said. "Not on you. You're walking further than you were in January. You're riding a bicycle, God help us."

"It's still there. The pain."

"It'll always be there in some form. Your canal isn't going to get wider." Craig turned his glass. "But if it gets worse again — if you can't get to the end of the street even with all this — I'll still be here, and decompression is a good operation for the right person. That's not failure. It's just the next option."

"I know."

Craig was quiet for a while. "Can I tell you something? Watching you these last months. I've spent twenty years cutting out other people's problems because I didn't want to look at my own. It's easier to fix a spine than to ring your son. Maybe we're all asleep."

Bob reached across the table and put a hand on his friend's forearm.

"You're not asleep, Craig," he said. "You're just tired. There's a difference."

Craig smiled then, a real smile, the first Bob had seen from him in months without any irony in it at all.

"Maybe I'll book a session with Jake," Craig said. "See what the kid's got."

Bob laughed softly. The pain flared, and he let it pass through without resistance.

"Maybe I'll ring Tom," he said. "See what time it is in Singapore."

Chapter 13: The Handover

In the last fortnight before he retired, Bob and Jake spent their evenings in the back room going through the handover files. There were forty-three active patients. Bob had decided that each would get a proper handover: not a line on a list, but a conversation.

He did it the way he had always done it with students. He didn't tell Jake what he thought. He handed him the file and said, "What's missing?"

Most evenings Kate stayed late too, doing the end-of-month invoices at the desk in the corner. She said it was to get ahead. Bob suspected otherwise. Every so often, without looking up from her screen, she would say something that changed a case.

* * *

Daniel Okoro, 26. Low back pain, three years. "Mechanical."

That was the word on the referral: *mechanical*. Daniel was a software engineer, fit, a keen runner, and he had seen two

physiotherapists and an osteopath before he found his way to Harley Street. Bob had seen him four times.

Jake read the notes aloud. "Back pain for three years. Came on gradually, no injury. Core stability programme, some manual therapy. Improving, slowly." He looked up. "Seems fine."

"Read the subjective again," said Bob. "Slowly."

Jake read it again, and this time Bob stopped him at each line.

"*Worst first thing in the morning.* How long does the stiffness last?"

Jake checked. "Over an hour. Sometimes two."

"A mechanical back is usually stiff for a few minutes. What else?"

"*Wakes in the second half of the night with pain, has to get up and move about.*"

"A mechanical back usually eases with rest. What else?"

"*Better after exercise, worse after sitting still.* Well, lots of backs are like that."

"Many are. Keep going. Page two."

Jake turned the page. "*Heel pain, right, at the back where the Achilles attaches. Put down to running.* And…" He stopped. "*Painful red eye last year, treated with drops at the eye hospital.*"

"Did anyone ask what the eye hospital called it?"

Jake shook his head.

"And his family history?"

"An uncle with 'a bent back'."

Bob waited.

Jake sat very still. Then he said, slowly, "It's inflammatory. Young man, gradual onset, long morning stiffness, night pain in the second half of the night, better with exercise, worse with rest. Pain where tendons join bone. An inflamed eye. Family history." He looked up. "It's axial spondyloarthritis. Or it could be. And he's had three years of core stability."

"Does ibuprofen help him?"

Jake checked. "He says it's the only thing that does. Dramatically."

"That's another clue." Bob leaned back. "On average, people with this condition wait the better part of a decade for a diagnosis in this country. Not because it's rare — it isn't — but because everyone looks at a fit young man with back pain and sees a mechanical back. And every year it goes untreated, the inflammation can stiffen the spine a little more."

"So we refer him."

"We write to his GP today, asking for a referral to rheumatology, and we list every clue, so nobody can read it as a mechanical back. The eye, the heel, the uncle, the morning stiffness, the night pain, the ibuprofen." Bob tapped the file. "And we don't stop his exercise. For this condition, movement is part of the treatment for life. Stretching into extension, breathing deeply into the ribs to keep the chest mobile,

staying strong. The rheumatologist can treat the inflammation. We keep him moving."

Kate spoke from the corner without looking up. "Is that the young man who always stands at reception rather than sitting in the waiting room?"

They both looked at her.

"He told me once he can't sit for longer than twenty minutes in the morning," she said. "He goes for a walk round the block before his appointment. I thought you knew."

* * *

Parminder Kaur, 53. Frozen shoulder, right, four months.

"This one's straightforward," said Jake, with the air of a man who has been caught once and doesn't intend to be caught twice. "Classic frozen shoulder. Night pain, can't lie on it, can't do her hair or fasten her bra. Loss of rotation outwards more than anything else. X-ray normal." He paused. "So… what's missing?"

"What does a frozen shoulder like to keep company with?"

Jake thought. "Diabetes. Thyroid problems. Women around the menopause."

"Has she been checked for any of them?"

Jake read the notes. "She's fifty-three. Periods stopped a year ago. Hot flushes. And… here. *Thirsty all the time. Up at night to pass water. Tired. A cut on her finger took weeks to heal.*" He looked up. "That's in the notes. Who wrote that?"

"I did," said Bob. "Session three. And then I didn't do anything about it, because I was thinking about her shoulder." He said it simply, without drama. "That's what it looks like when a clinician anchors. It's not that you don't see the clue. It's that you see it and it doesn't join up."

They wrote to her GP that evening. Two weeks later, the blood test came back: her blood sugar had been running high for some time. She had type 2 diabetes, undiagnosed.

"Does that change the shoulder?" Jake asked, when the result came.

"It changes everything around the shoulder. Frozen shoulders in people with diabetes tend to be more stubborn and last longer. Getting her sugar under control matters for her tissues, her healing, her heart, her eyes, her kidneys. For the shoulder itself, in this painful early phase, gentle movement within what's comfortable, not forcing it. And an injection into the joint may help the pain, if her doctor agrees — though they'll want to watch her sugar for a few days afterwards, because steroids can push it up."

"We'd have got her shoulder moving in a year or so anyway."

"Probably. And she'd have gone on with diabetes nobody had found."

* * *

Siobhan Doyle, 44. Achilles pain, both sides, six weeks.

Jake read it through twice before he spoke.

"Both Achilles at once is odd," he said. "One side, you think about load. Running, a new pair of shoes, a jump in training. Both sides at once, with no change in activity…" He frowned. "What happened six weeks ago?"

"Good question. Ask it of the notes."

Jake read. "She's an intensive care nurse. Moved on to nights two months ago. New work shoes. Gained some weight since the spring." He turned the page. "Asthma, flared up in the summer, course of steroid tablets. Urine infection seven weeks ago… treated with ciprofloxacin."

He put the file down.

"That's an antibiotic that can damage tendons," he said. "The Achilles especially. And the risk goes up if you've had steroids as well."

"Does she know?"

"It doesn't say."

"Then she needs to, and so does her GP, so it goes on her record and she isn't given one again without it being weighed carefully." Bob pulled the file towards him. "But don't stop there. That's the trigger, perhaps. What else has made those tendons less able to cope?"

Jake went back through it. "Nights. Twelve-hour shifts on her feet on hard hospital floors, with broken sleep, which slows tissue repair. New shoes, flatter than her old ones, which puts more strain on the Achilles. Weight gain, more load. And she's

forty-four…" He looked at the notes again. "Irregular periods. Hot flushes at night."

"Which means?"

"Perimenopause. And oestrogen affects tendons. When it falls, tendons can become less resilient. That's part of why tendon problems become so common in women in their forties and fifties."

"So is it the antibiotic?"

Jake smiled slightly. "It's all of it."

Kate looked up from the invoices. "She told me in the waiting room she's been resting completely. Lifts instead of stairs, feet up on her days off. She thought that was what she was supposed to do."

"That's the other thing she needs to know," said Bob. "Tendons don't like complete rest any more than they like overload. They get weaker. What they need is the right amount of load, built up gradually. Holding a calf raise still for a while first, to settle the pain. Then slow, heavy calf work over weeks and months, so the tendon gets stronger than it was before. Better shoes for her shifts. Help with sleeping after nights. And a conversation with her GP about the menopause, because treating that may help more than just her tendons."

Jake wrote it all down. Then he wrote something else at the top of the page and underlined it: *Medication. Hormones. Sleep. Shoes. Load. Always.*

* * *

Megan Price, 34. Right anterior knee pain, four months. Marathon training.

"Patellofemoral pain," said Jake, reading. "Pain round the front of the kneecap. Worse coming downstairs, worse after long runs, worse sitting through a film with her knee bent." He turned the page. "I saw her twice. I did Lachman's, McMurray's, the collateral ligament tests—"

"Why?"

Jake stopped. "To rule out the ligaments and the meniscus."

"Did she twist it? Did it swell within hours? Does it lock, or give way, or catch?"

"No. None of that."

"Then what did those tests tell you that her story hadn't already told you?" Bob said it gently. "Every test is a question. If the history has already answered it, you're just going through the motions. So what question does her story actually ask?"

Jake thought. "Why is her kneecap being overloaded. And why now."

"So start with *why now*."

The answer was in the notes, on the first page, where Jake had written it and moved on. In the six weeks before the pain began, Megan had gone from twenty miles a week to thirty-five, joined a club that trained on hills, and bought new, lighter

shoes. Three changes to her load at once, in a body that hadn't had time to adapt to any of them.

"And *why her*?"

Jake had filmed her doing a single-leg squat on her phone, and they watched it together. As Megan bent her right knee, the knee drifted inwards past her big toe. Her left hip dropped. Her trunk leaned to the right to keep her balance. Her right arch collapsed.

"That's not a knee problem," said Bob. "That's a whole-leg problem that the knee is paying for. Where does the knee dive in from?"

They went through it, joint by joint, from the ground up and the top down. The ankle: when Jake had measured how far her knee could travel forward over her foot with the heel down, the right reached five centimetres from the wall and the left eleven. A stiff ankle can't let the shin travel forward, so the knee finds room by collapsing inwards instead. The hip: the muscles at the side and back of the hip, whose job was to hold the thigh from rotating inwards and the pelvis level, tested weak on the right. The trunk: her side plank on the right lasted twenty seconds; on the left, fifty.

"Think of the leg as part of a chain," said Bob. "There are lines of muscle and fascia running from the foot, up the outside of the leg, round the hip and across the trunk. Thomas Myers mapped them as tracks, like railway lines. When one link is weak or stiff, the load moves along the line to the next

link. For Megan, the link that's shouting is the kneecap, but the links that are failing are her ankle, her hip and her trunk."

"So what's the prescription?"

Bob pushed the old pad across. Jake wrote it without being asked twice.

- Running: keep running, but cut back to twenty miles a week, flat routes only, for three weeks. Pain during a run no higher than 3 out of 10 and settled by the next morning; if not, shorten the next run.
- Cadence: take slightly quicker, shorter steps, about 5 to 10 per cent more per minute. It reduces the load on the front of the knee with every step.
- Wall sit with a band round both knees, pushing them gently outwards: 5 holds of 45 seconds, rest 60 seconds. Daily. It's there to settle the pain before running.
- Side-lying hip lift, top leg slightly behind the body, toes pointing forward: 3 sets of 12. Tempo: 2 seconds up, 2 seconds hold, 3 seconds down. Rest 45 seconds.
- Single-leg step-down from a low step, knee staying over the second toe, watching in a mirror: 3 sets of 8. Tempo: 3 seconds down, 1 second up. Rest 60 seconds.
- Ankle stretch, knee to the wall with the heel down: 10 slow repetitions, three times a day.
- Calf raises on the edge of a step: 3 sets of 15, slowly, building to single-leg with a rucksack.

- Progression: after three weeks, single-leg Romanian deadlifts and weighted step-ups, then reintroduce hills.

"No hidden disease," said Jake. "No drama."

"No," said Bob. "Just a body that was asked to do too much, too soon, with one weak link. Which, if you want my honest opinion, is most of physiotherapy."

* * *

Colin Fry, 58. Right shoulder pain, reaching overhead. Painter and decorator.

Jake had written *subacromial pain* on the front, and then eleven different shoulder tests on the inside, each with a tick or a cross.

Bob read the list and handed it back.

"Which three matter?"

Jake had been waiting for this one. "The cluster. Hawkins-Kennedy, the painful arc, and weakness when he pushes his arm outwards against resistance with the elbow at his side. If all three are positive, the pain is very probably coming from the tendons under the arch at the top of the shoulder. All three were positive."

"Good. And what else could it be?"

"His neck — I cleared it; neck movements didn't touch the shoulder pain. A frozen shoulder — but when I turned the arm outwards passively it went all the way, and a frozen shoulder

loses that first. A full-thickness tear — he can lift his arm and hold it there, and there was no injury."

Bob nodded. "So you know where it hurts. Now, why does it hurt?"

That was harder, and that, Bob said, was the point. Jake had filmed Colin raising both arms slowly in front of a mirror, and they watched it frame by frame. The right shoulder blade didn't turn upwards as the arm rose, the way it should. It tipped forwards instead, and hitched up towards the ear, and on the way down its inner edge lifted off the ribs like a wing. Colin's upper back was rounded, his head pushed forward, his chest tight.

On the one occasion he'd come into Colin's session, Bob had asked him to sit tall, lift his breastbone and lengthen the back of his neck, then raise the arm again. It went twenty degrees higher before the pain began. Then Jake had placed his hands on the shoulder blade and helped it rotate upwards as Colin lifted, and the painful arc almost disappeared.

"The shoulder isn't one joint," Bob told Jake now. "It's four, and it floats on the ribs, and it's held there almost entirely by muscles. For the arm to go up without pinching the tendons, the shoulder blade has to turn upwards and tilt back, driven by two muscles working as a pair — the lower part of the trapezius, which pulls from below, and serratus anterior, which wraps round the ribs under the arm. If the upper back is stiff and rounded and the chest muscles are tight, the shoulder

blade can't tilt back. So every time Colin reaches up with a brush, he squeezes the same tendons under the same arch. Eight hours a day, five days a week."

"So we treat the upper back, not just the shoulder."

"We treat the tendons, the shoulder blade, the upper back, and the way he works. All four."

The prescription came in two parts.

Exercise.

- Pressing the arm outwards against a wall, elbow at the side, without moving: 5 holds of 30 seconds at a firm but comfortable effort. Rest 60 seconds. Twice a day, to settle the tendon pain.
- Turning the arm outwards against a band, elbow tucked in with a rolled towel under it: 3 sets of 12. Tempo: 3 seconds out, 1 second hold, 3 seconds back. Rest 45 seconds. Increase the band when the last three repetitions feel easy.
- Sliding the forearms up a wall while gently pushing into it, feeling the shoulder blades wrap round the ribs: 2 sets of 10, slowly.
- Lying face down, lifting the arms into a Y shape with the thumbs up, shoulder blades drawn down: 3 sets of 8. Tempo: 2 seconds up, 3 seconds hold, 2 seconds down.
- Lying lengthways on a foam roller, arms out wide, letting the chest open: 2 minutes a day.

- Upper back extension over the foam roller, moving it up a few centimetres at a time: 10 slow repetitions.

Work.

- An extension pole on the roller for ceilings, so the hands work below shoulder height.
- A higher platform rather than reaching up from the floor.
- Swap hands for cutting in, where he can.
- A five-minute break every forty-five minutes, with ten arm turns against the band.

Jake wrote a line across the top of the page and underlined it: *Where it hurts. Why it hurts. What it has to do.*

Kate, in the corner, didn't look up from her invoices. "He told me he's been painting since he was fifteen," she said. "He's frightened that if he stops he won't know what to do with himself."

"Then that's in the notes too," said Bob. "Because a man who is frightened of stopping will push through the pain rather than pace himself, and his tendon won't settle. His fear is part of the dosage."

* * *

It was nearly nine when they finished. Kate had gone. The radiators had long since gone cold.

Jake stacked the last of the files. “Forty-three patients,” he said. “And in eleven of them we found something that wasn’t in the diagnosis on the referral. Eleven. The ankle behind the knee, the upper back behind the shoulder, the three weeks of too many miles, the antibiotic behind the Achilles.”

“In a quarter of them. Because the painful part is rarely the whole story.”

“You’ve been doing this for forty years. How many did you miss?”

Bob didn’t flinch from it. He had asked himself the same question most nights for months.

“More than I’d like,” he said. “Fewer than I would have if I hadn’t kept asking. The point isn’t to be perfect, Jake. Nobody holds all of it in their head. The point is to have a way of looking that makes it harder to miss things. And to know that the moment you’re sure is the moment you’re most likely to forget about other possibilities.”

“Mrs Kaur’s thirst was written in your own handwriting. And Megan’s extra miles were in mine. On page one.”

“They usually are.” Bob stood, carefully, one hand on the table. “So was my bladder, in a manner of speaking. Go home. You’ve got my whole list from Monday.”

Chapter 14: The Final Days

The last week came without fanfare. Bob cleared his diary a patient at a time, handing each one over to Jake with careful notes and a proper conversation. Some patients cried. Some hugged him awkwardly. Mr Adeyemi came in, three weeks after his gallbladder had been removed, with no shoulder pain whatsoever and a bottle of whisky he said Bob was not allowed to refuse.

Doreen Bell came on the Tuesday, without her handbag clutched to her chest, and told him that her GP had reduced one of her blood pressure tablets, that the dizziness in the mornings had almost gone, that the bone scan had shown thinning and she was now on a tablet for that too, and that she had been back to bridge twice. "Two buses," she said. "And the steps. I held the rail." She had brought him a tin of shortbread, and a scorecard from Thursday, which she had won.

Amira Hassan sent a card with a photograph of the baby, now sitting up and grinning. Inside she had written that the women's health physiotherapist had been wonderful, that she

was back to gentle jogging with a plan, and that she had talked to her GP and was having some help. *I'm starting to enjoy him*, she had written. *I didn't know I wasn't, until you asked.*

An elderly woman Bob had treated for a frozen shoulder a decade earlier pressed an envelope into his hand at the door. Inside was a card in shaky handwriting. *You didn't just fix my shoulder. You listened. Thank you.*

He kept it in his jacket pocket for days, beside the GP's letter about the gallstones.

* * *

On the Wednesday he wrote a letter he had been composing in his head for a month. It was a reference, addressed *To whom it may concern*, and it described in plain terms a woman who had managed a busy multidisciplinary clinic for eleven years; who noticed what trained clinicians missed; who had, on one occasion, taken a history that changed the course of a senior physiotherapist's care. He recommended her without reservation for any course in physiotherapy, counselling or any other caring profession she chose.

He left it on Kate's desk in an envelope with nothing written on the front.

She didn't mention it that day, or the next. On Friday morning, when he came in, there was a mug of black coffee on his desk and, beside it, an almond biscuit, and an application

form for a part-time degree with the personal statement already half-filled in.

* * *

The party was small. Clinic staff, a few long-term patients, Craig, Jake, Kate, Nathan down from university for the night. No speeches, by Bob's explicit instruction, which everyone ignored.

Craig raised a glass. "To Bob. The most stubborn magician I know. Who has finally agreed that his back might be something other than a narrow canal." There was laughter. Then, more quietly, looking into his glass: "I rang Tom on Sunday. It was three in the morning in Singapore. He picked up anyway."

Nobody quite knew what to say to that, so they drank.

Jake said, "To the best teacher I ever had. Who taught me to ask where the headache is."

Nathan didn't make a speech. He just stood close to his father all evening, and that was better than any speech.

Kate raised her glass last.

"You've played your part beautifully," she said. "Now go and live the next act."

* * *

Bob walked home alone. The streets of Marylebone were quiet, the air cool and smelling of rain. His back ached with every step. At the corner of Weymouth Street the tingling began in his right foot, and he stopped and leant on the railings of a basement area, forward, forearms resting, and waited for it to pass.

It passed. He walked on.

The ache felt different now. Not gone. Familiar, almost companionable. He did not fight it. He walked with it.

Chapter 15: Retirement Dawn

On the first morning of his retirement Bob woke at six, with no alarm and no diary and no patient waiting, and realised that he had slept through the night.

He lay still for a moment, not quite trusting it. Then he got up, slowly, the way he'd taught a thousand people to get up with a sore back: roll onto the side, knees bent, push up with the arms, sit for a breath on the edge of the bed before standing. The ache was there. Low, steady, unremarkable. It no longer filled the room. It shared it.

He made coffee — one cup — and sat at the kitchen table and simply breathed.

Then he took the old bike out of the shed and rode round the Outer Circle of Regent's Park while the mist was still on the grass and the joggers were few. Twenty-five minutes. No tingling. At the top of the Broad Walk he got off and walked for a while, and when the warning came in his foot he leant on a bench and watched the park wake up.

A young mother went past, carrying a toddler on one hip, her whole trunk bent sideways to take the weight; he winced in sympathy for her lower back and resisted the urge to say anything. An older couple walked hand in hand, their pace perfectly matched. A man about his own age limped by with a stick, smiling at something his grandson was telling him.

Life went on. Pain or no pain. Everyone in the park was carrying something, and most of them were walking anyway.

* * *

In the afternoon he did his exercises on the living-room floor: the knees to the chest, the long slow holds, the kneeling stretch with his forehead on the rug. Afterwards he wrote his three lines in the notebook.

The pain stopped me: walking the whole Broad Walk without a rest.

It made me notice: the mother with the child on her hip. How much we all carry without thinking.

What I can make of it: I am not in a hurry any more.

* * *

He rang Nathan that evening. They talked for an hour about nothing much: a lecture, a football match, whether Nathan should go travelling in the summer. Bob listened. He gave no advice, because none was asked for.

When they'd said goodbye, he went to his desk and took out the notebook he had bought six months earlier, the one meant for *Everything I've Learned About Backs*. He looked at the blank first page for a long time.

Then he wrote one line.

There is no one method. There is only the meeting — and the courage to keep asking questions, even of yourself.

He closed the book. He would not write the textbook. It occurred to him that there were a great many textbooks already, and that the things he had learned in the last six months had not come from any of them. They had come from a receptionist, a student, a surgeon, an old friend and a son.

He would live the rest of it instead.

Chapter 16: The Surgeon's Hands

Two months into his retirement, Craig rang at eleven at night, which he never did.

"I need you to look at something," he said. "Don't tell anyone."

He came to the flat the next morning before his theatre list, in a good coat, looking as if he hadn't slept. He sat at Bob's kitchen table and put his right hand flat on the wood, palm up, like a man laying down a card he didn't want to play.

"The thumb, the index and the middle finger," he said. "Numb. Tingling. It wakes me at night and I have to shake my hand out, like this." He flicked his wrist, the gesture every physiotherapist knows. "Then it goes away. For a few months it was only at night. Now it's in theatre. Yesterday I was closing a wound and I couldn't feel the needle properly."

Bob looked at the hand. Then at Craig's face.

"How long?"

"Six months. Perhaps eight."

"And you've told nobody."

Craig gave a short laugh. "Who would I tell? I'm the one people tell."

* * *

Bob didn't examine him. Not properly, not there. He was retired, and he knew it, and more to the point he knew what Craig needed was not a friend with a tendon hammer at a kitchen table.

"Jake," he said. "This afternoon. I'll come with you."

"The boy?"

"The boy found the thing you and I both missed in my back," said Bob. "And he won't be frightened of you, which is more than you can say for most of your registrars!"

* * *

Jake did it thoroughly, and Bob watched him go round the map with a quiet pleasure he didn't show.

First the wrist. Tapping over the front of it sent tingling into Craig's fingers. Holding the wrist fully bent for a minute brought the numbness on. The fingers affected were the ones supplied by the median nerve, which runs through a narrow tunnel of bone and ligament at the wrist. And the wrist-flick that brought relief at night was a classic clue.

"Carpal tunnel," said Craig. "I could have told you that."

"You could," said Jake, and kept going.

Next the neck. Craig had spent thirty years bent over an operating table looking down through magnifying loupes, his head pushed forward for hours at a time. His neck was stiff turning to the right; pressing down on the top of his head with it tilted brought on a faint ache into the forearm. The reflex at his right elbow was a fraction softer than the left.

"So it's the neck," said Craig.

"Possibly both," said Jake. "A nerve that's a little bit squeezed in one place is more vulnerable to being squeezed somewhere else along its length. Some people call it a double crush. So a slightly irritated nerve root in your neck may be making the wrist more sensitive, and the other way round."

To find out, he tested the nerve along its whole length. With Craig lying on his back, Jake lowered the shoulder slightly, turned the arm out, straightened the elbow, and then gently bent the wrist and fingers back, the way you might take up the slack in a rope. At the last step Craig's fingers began to tingle. When Jake tilted Craig's head away from that arm, the tingling grew; when he tilted it back towards the arm, it eased. "That's the nerve," said Jake. "Not the muscle. The whole track, from the neck to the fingers, is sensitive to being stretched."

Then he looked at the neck in the way surgery had shaped it. Thirty years with his head bowed over a table, looking down through loupes, had left Craig with his chin poking forward, the top of his neck tipped back to keep his eyes level, and the base of his neck bent forward beneath it. The upper back

between his shoulder blades was stiff as a board. The muscles running from his neck to the tops of his shoulders were hard and overworked. Jake put a small air-filled pressure cuff behind Craig's neck and asked him to nod very gently, as if saying yes, without lifting his head. The deep muscles at the front of the neck, which should hold that gentle nod steadily for ten seconds at a time, gave out after three.

"Vladimir Janda called that pattern the upper crossed syndrome," said Bob from the corner. "Tight at the back of the neck and the front of the chest, weak at the front of the neck and between the shoulder blades. A cross of tight and weak. Nearly every surgeon I've treated has it. So do dentists, hairdressers and anyone who works looking down."

Then he did what Bob had taught him, and went beyond the arm.

"How's your sleep?"

"Terrible. Always has been."

"Do you sleep with your wrists curled up under the pillow?"

Craig opened his mouth and closed it. "Probably."

"Have you had your blood sugar and thyroid checked recently? Both can make nerves more vulnerable at the wrist."

"No."

"How much do you drink?"

There was a long silence in the room. Bob looked at the anatomy posters on the wall.

"More than I should," Craig said at last. "A bottle most nights. Since Helen. I've never said that out loud."

Jake nodded and wrote it down without comment, and Bob thought that of everything he had ever taught him, that neutral nod was the thing he was proudest of.

"Alcohol can affect nerves in its own right," Jake said. "And it lowers vitamin B12, which nerves need. And it fragments sleep. I'd like your GP to do some bloods. And you need nerve conduction studies to see how squeezed the nerve at the wrist really is." He hesitated. "There's one more thing. The muscles at the base of your thumb."

He held Craig's hands side by side. The fleshy pad at the base of the right thumb was very slightly flatter than the left.

"When those muscles start to waste, the nerve has been squeezed for long enough to cause damage. That's the point where you don't wait. You get a surgical opinion quickly."

Craig looked at his own thumb for a long time.

"I tell patients that," he said quietly. "Word for word."

* * *

They walked back together along Wimpole Street afterwards, Bob slowly, Craig matching his pace without comment.

"You know what I'm frightened of," Craig said.

"Tell me anyway."

"That these are the hands. That's all I am. Take them away and there's a man in a big house in Muswell Hill with nobody

in it."

Bob thought of himself six months earlier, standing at a plinth he could barely lean on, terrified of retiring because he did not know who he would be without the work.

"Gurdjieff had a word for the things we build so we don't have to see ourselves," he said. "Buffers. Like the buffers on a railway carriage. They soften the collisions between the different parts of us, the parts that contradict each other. So a man can be tender and brutal, generous and mean, frightened and fearless, and never feel the shock of it."

"And my buffer is…?"

"The jokes," said Bob. "And the Chianti. And being the man people tell things to, so you never have to tell anyone anything." He smiled faintly. "Mine was a narrow canal. It explained everything, so I never had to look at anything else."

Craig laughed, but it wasn't his theatre laugh.

"Buffers can make life more comfortable but keep you asleep," Bob went on. "The only way to wake up is to let them go, one at a time, and feel the collisions. It hurts. It's supposed to."

"That's a hell of a thing to say to a man with numb hands."

"You're a hell of a man with numb hands."

They walked on in silence for a while. At the corner of New Cavendish Street, Craig stopped.

"The Stoics used to say you should only worry about what's in your control," he said. "Epictetus. My father made me read

him when I was fifteen. I used to think that meant the operation. The things you can fix."

"And now?"

"Now I think perhaps it means the only thing in my control is how I meet what I can't fix." He flexed his fingers slowly. "Which is most things, it turns out."

* * *

The nerve studies showed moderate compression at the right wrist. A hand surgeon Craig had trained twenty years earlier released it under local anaesthetic on a Friday afternoon, and Craig lay on the trolley afterwards and said it was the most humiliating and the most interesting two hours of his professional life.

"I've never been the one on the table," he told Bob. "Do you know, the ceiling tiles in that theatre are cracked? I've operated in there for fifteen years and never looked up."

He wore a splint at night to keep his wrists straight. Jake gave him a prescription, which Craig pinned to his fridge. It set the dose for a surgeon the way Craig would have for a patient: gentle nerve glides, sliding the nerve rather than stretching it, 10 slow repetitions three times a day; the gentle nod against the cuff, 10 holds of 10 seconds, twice a day, building towards the full thirty seconds; the upper back moved over a foam roller, a vertebra at a time, 10 slow repetitions; lying on his front and lifting his arms into a Y, 3 sets of 8,

holding each lift for 3 seconds; and a doorway stretch for the chest, 60 seconds twice a day. Before theatre, three minutes of it in the changing room. Between cases, standing tall, chin gently drawn back, shoulder blades drawn down, five slow breaths. And they changed his theatre, too: the table raised so he stood straighter, loupes with a steeper declination angle so his eyes could look down without his neck having to. The bloods showed a low B12 and nothing else. Craig cut down on the wine, not to nothing, but to a glass or two at weekends, and was surprised to find that he slept better, and then surprised again to find that sleeping better made the evenings in the big house harder, not easier, because there was nothing to blur them.

So he did the thing he had been avoiding for eleven years.

He booked a flight to Singapore.

Bob drove him to Heathrow, in the rain, on a grey Thursday in November. At the drop-off, Craig sat in the passenger seat with his bag on his knees and didn't get out.

"What if he doesn't want me there?"

"Then you'll know," said Bob. "And you'll have gone anyway. That's the part that's in your control."

Craig nodded. He looked, for a moment, not like a senior consultant but like the frightened young father he must once have been, standing in a hospital corridor with a nine-year-old boy, being told that his wife had died.

Then he got out of the car and walked into the terminal without looking back, his right hand, scarred now at the wrist, holding the handle of his bag.

Bob sat in the car for a while, watching the rain, and thought that a hand was never only a hand. The body always carried the whole of a life. Sometimes the kindest thing it could do was stop working long enough to make you look.

Chapter 17: The Sea Again

In December Bob took the train to the coast to see Michael. He sat the whole way, and watched the frosted fields go past and thought about nothing much, which he was also learning to do.

Michael met him at the station. Bob saw him before Michael saw Bob, and in that half-minute, before either of them had put on the face you put on for a friend, Bob noticed four things, and wished he hadn't.

Michael was more stooped than he had been in the spring. His left arm didn't swing when he walked; it hung by his side, a little bent at the elbow, while the right arm swung normally. His steps were shorter. And his face, when he finally spotted Bob and smiled, seemed to arrive at the smile slowly, as if from a long way off.

"You look well," said Michael. His voice was quieter than Bob remembered.

"So do you," said Bob, and felt the lie in his mouth like a stone.

* * *

They went to the same café overlooking the sea. It was cold and nearly empty. The windows were fogged.

Michael talked about his daughter Susan, who had moved nearby, and the grandchildren, and the book group he'd joined and then left because everyone wanted to read thrillers. Bob listened. He tried very hard to listen as a friend, and not as a physiotherapist. He mostly failed.

When Michael lifted his cup, the left hand, resting on the table, trembled gently, rhythmically, a slow roll of the thumb against the fingers, like a man counting coins. When he reached for the cup with that hand, the tremor stopped.

"I can't smell the sea any more," Michael said, looking out of the window. "Isn't that odd? Forty years I've lived here. It went a couple of years ago. Gradually. I thought it was a cold that never cleared."

Bob said nothing.

Michael wrote his new address on a napkin for him, and the letters started at a normal size and got smaller as they went across, crowding together at the end of the line.

* * *

On the walk back along the promenade, into the wind, Bob found he was arguing with himself.

He was retired. He was not Michael's physiotherapist. He was his friend. A friend does not examine you across a café table and diagnose you over a napkin. A friend lets you have your life.

And yet. A slow tremor at rest that stopped on movement. One arm that didn't swing. Smaller steps, a quieter voice, a face slower to change. Handwriting that shrank as it went. A lost sense of smell. None of them alone meant anything much. Together they made a pattern he had seen many times, and there was treatment for it, and the sooner it began the more of his life Michael might keep.

He thought of Kate saying, *you took your own history like a surgeon*. He thought of Jake in the corridor, asking if he could ask the questions. He thought of what it had cost him that nobody had asked sooner, and of how angry he'd been with them when they finally did, and of how grateful he was now.

There was a bench facing the sea. Bob sat on it, and after a moment Michael sat beside him.

"Can I ask you something you won't like?" said Bob.

Michael looked at him. Something in his face, slow as it was, changed.

"You always did," he said. It was Bob's own line, from the spring, handed back.

"Your left hand. Your arm when you walk. Your writing on that napkin. Your sense of smell." Bob kept his voice as gentle as he knew how. "What do you think it is?"

The sea hissed on the shingle. A gull hung in the wind above them, not moving.

"I know what it is," said Michael quietly. "I've known for a year."

"Have you seen anyone?"

"No."

"Why not?"

Michael smiled, very slightly. "For the same reason you didn't ask yourself about your bladder. If I don't see anyone, it isn't true yet." He was quiet for a moment. "I act out my dreams, too. When I stayed with Susan at Christmas she heard me shouting and thrashing in my sleep. I've fallen out of bed twice. And I've been constipated for years, and low, and I've told myself that was grief, and some of it is." He looked down at his left hand, trembling on his knee. "I can list the early signs as well as you can, Bob. We learned them in the same lecture."

* * *

They sat on the bench for a long time.

"I keep thinking about Montaigne," Michael said eventually. "He said that to philosophise is to learn how to die. I always thought that was rather morbid. Now I think he meant something else. That you can't really live until you've looked at the end squarely. Everything before that is rehearsal."

"You're not dying."

"No. But I'm changing, in a direction I didn't choose and can't reverse." He watched the gull. "The Buddhists would say that's true of everyone, all the time. Everything that arises passes away. It's just that most of us don't have to watch it happen in our own left hand."

Bob thought of his canal, which would never get wider. Of the notebook with its one line. Of the ache that shared the room with him now instead of owning it.

"Here's what I know," he said. "It isn't a verdict, it's a road, and the road is long for most people. There's good medication. And there's exercise — real exercise, hard enough to make you breathe, most days. It's one of the best things there is for this. Cycling, walking fast, dancing, even boxing. People who keep moving keep their walking, their balance and their mood for longer." He paused. "And you need to see your GP, and a neurologist, and let them tell you properly, because I can't, and neither can you. We could both be wrong."

"We're not wrong."

"Probably not. See them anyway."

Michael laughed, and it was his old laugh, from the canteen forty-six years ago, and for a moment his face moved as quickly as it used to.

"Do you know what the worst of it has been?" he said. "Not the tremor. Being alone with it. Knowing, and not saying, and pretending in front of Susan and the children. I've been more frightened of that bench than of the disease."

"Which bench?"

"This one. The one where someone finally says it out loud."

* * *

On the train home Bob sat with his forehead against the cold window and let himself feel it: the grief of watching a friend begin a long descent, and the strange, fierce gladness of having been the one to sit on the bench.

The Ecclesiastes verse his grandmother had embroidered on a cushion came back to him from nowhere. *To every thing there is a season, and a time to every purpose under the heaven.* As a boy he had thought it was about harvests. As a young physiotherapist he had thought it was resignation, and had wanted none of it. Now he wasn't sure it was about either. Perhaps it was about paying attention: knowing what season you were in, instead of pretending it was always spring.

In February a letter came, in handwriting that started large and shrank towards the end of every line. The neurologist had confirmed Parkinson's disease. Michael had started tablets, and they helped. He had joined a boxing class for people with Parkinson's in a church hall on Tuesday mornings, and a dance class on Fridays, and he said the dancing was worse than the boxing because the instructor was merciless about the cha-cha-cha!

I told Susan and the children the night I got home, he wrote at the end, the letters very small now. *We all cried, and then we all*

had supper, and it was the best evening we'd had in a year. Thank you for asking me something I wouldn't like.

Bob put the letter in the drawer with the GP's letter about Mr Adeyemi's gallstones, and the card from the woman with the frozen shoulder, and Nathan's rose labels from Regent's Park, which he had pocketed without quite knowing why. A drawer, he thought, of the moments when someone had been brave enough to look.

Chapter 18: Anatomy for Beginners

Kate had not sat in a lecture theatre for thirty-one years, and on the first morning she nearly went home.

She was the oldest person in the room by two decades. The others had water bottles covered in stickers and laptops they typed on without looking. She had a new pad of paper, three pens, and a feeling she recognised from childhood: the need to find the exit, sit near it, read the room, and make herself small.

She sat at the end of the third row, near the door. She told herself it was for the light.

The lecturer was a small, brisk woman called Dr Okafor who taught anatomy as though it were a detective story. On the third week she drew a dome on the whiteboard, like an upturned bowl.

"The diaphragm," she said. "The most underrated muscle in the body. Put your hand on your belly, just under your ribs. Breathe in."

A room full of students obediently breathed in.

"When it contracts, the dome flattens and pulls down, like a piston. Air rushes into your lungs to fill the space. Your belly moves out, because your organs have been pushed down and forwards. Your lower ribs widen, sideways and backwards. When it relaxes, it rises again and the air goes out." She tapped the board. "That's what's supposed to happen. Now look at the person next to you and tell me honestly whether that's what their body just did."

The boy next to Kate, who was nineteen and called Theo, looked at her sideways and went pink. "Your shoulders went up," he said apologetically. "And your tummy went in."

Kate looked down at her own hand. He was right. She had breathed in by lifting her chest and drawing her stomach in, the way she had always breathed, the way she had not known was a way.

"A lot of you will have done that," said Dr Okafor. "Upper-chest breathing. You use the muscles in your neck and at the top of your ribs to lift the rib cage instead of letting the diaphragm do the work. It's what we all do when we're startled, or frightened, or running for a bus. It's meant to be for emergencies. Some people live in it."

* * *

She went on, and Kate wrote faster than she had ever written anything.

The diaphragm did not live alone. Its back edges were anchored to the front of the lumbar spine, right down to the third vertebra. The great hip flexor, the psoas, began just there too, the two muscles meeting at the spine like old neighbours. Below, the pelvic floor moved in time with the diaphragm like the other end of a piston: down together as you breathed in, up together as you breathed out. The deep corset muscle of the abdomen wrapped around the whole cylinder. Breath, spine, hips, pelvic floor, tummy: one system, not five.

Kate thought of Amira Hassan, crying quietly over a car seat. Of Bob at the plinth with his hand pressed into his back. She wondered how he'd breathed, those months. She suspected she knew.

"And here's the thing I want you to remember from today," said Dr Okafor. "Breathing is the only one of the body's vital automatic systems that you can also take over consciously. Your heart beats whether you want it to or not. Your gut digests without asking. But breathing runs by itself, and at any moment you can decide to take the controls. It's a bridge between the part of you that happens automatically and the part you can choose."

She drew a long, slow line on the board.

"When we breathe slowly, especially with a longer out-breath than in-breath, the nervous system tends to shift towards what we call rest-and-digest: heart rate slows, muscles soften. When we breathe fast and high, we signal danger, even

if there isn't any. You can't talk your nervous system out of being frightened. But you can sometimes bring calm to your nervous system by breathing well."

Kate put down her pen. Her hands, she noticed, were shaking slightly.

* * *

She met Bob for coffee on Thursday, as they had begun to do every few weeks since his retirement. He had taken to walking to the café by the canal; it was twenty minutes each way now, and he only had to stop once.

She told him about the lecture.

"I've breathed like that my whole life," she said. "High. Holding. I hold my breath when I'm concentrating; I only noticed this week. When I'm reading an email. When someone comes into reception. My jaw's always tight. My shoulders are always up." She looked at her coffee. "I learned it before I learned to read. You listen for which footsteps are on the stairs, and you hold your breath so you can hear better. And then you just… never stop."

Bob was quiet for a while. He didn't try to fix it, which she was grateful for.

"Gurdjieff used to say the first step is self-observation," he said at last. "Not changing anything. Just watching yourself, as if you were someone else, without judging. Most people think they know themselves. Almost nobody has actually watched."

"I've spent my whole life watching other people."

"I know. You're the best watcher I've ever met." He smiled. "You watched me take my own history like a surgeon. I think you've just turned round and watched yourself, for the first time."

Kate laughed, a little shakily. "So what's the second step?"

"I'm not sure there is one, in a hurry. The old teachers were suspicious of people who tried to change themselves too fast. They said you mostly just exchanged one habit for another." He turned his cup on the saucer. "Jung called it individuation. Becoming who you actually are, rather than who you had to be to survive. It takes a long time!"

"That's not very encouraging."

"It wasn't meant to be encouraging. It was meant to be true." He hesitated. "But I'll tell you something encouraging, since you've taught me something today. The breath is the one place where that work can start with the body instead of the mind. You can't decide to stop being vigilant. But you can notice you're holding your breath, and let it out, slowly. Ten times a day. A hundred. And the body learns a little, each time, that it's safe now."

"Is it, though?" said Kate. "Safe?"

Bob looked at her for a long moment.

"You're fifty," he said. "You're in a lecture theatre, learning the anatomy of the diaphragm, because you finally opened a

prospectus you've kept in a drawer for thirty-three years. Nobody is on the stairs, Kate."

She had to look out of the window at the canal for quite a long time after that.

* * *

She practised. Not heroically. Sitting on the bus, one hand on her belly under her coat, letting the breath drop low, making the out-breath longer than the in-breath. At her desk at reception, which she still worked three days a week, noticing when she'd stopped breathing because a patient walked in, and letting it go. At night, lying on her back with her knees bent, as Bob had once described to her, feeling her lower ribs widen at the sides like a bellows.

The neck pain she had carried so long she'd stopped calling it pain began, over weeks, to ease. Her jaw, when she caught it clenched, let go more quickly. She slept better. None of it was dramatic. All of it was new.

And something else changed, which she had not expected.

In the seventh week there was a seminar: a case study, a middle-aged man with chronic low back pain, presented on a slide with his scan and his exercises and his lack of progress. The tutor asked the group what they'd do. The students talked about core stability and manual therapy and graded exercise. Kate sat at the end of the row, near the door, and listened, and for the whole first half of the seminar she said nothing at all, as

she had said nothing at all in rooms full of people for most of her life.

Then she noticed she was holding her breath.

She let it out, slowly. Put up her hand.

"Has anyone asked him how he's sleeping?" she said. "Or what else happened in his life the autumn it started? Or how he breathes?"

The room turned to look at her. Theo, next to her, grinned.

Dr Okafor put down her marker. "Go on," she said.

And Kate, who had spent her whole life in the gods watching the play, went on.

Chapter 19: The Second Brain

A year after he retired, Bob sat on the wooden bench at the far end of his garden. The narrow lawn was bordered with lavender and rosemary now, plants he could tend without rushing, without calculating how many minutes he could kneel before the fire in his back demanded he stop. The late sun was low and golden. A blackbird hopped along the fence and paused to look at him, as though deciding whether he belonged there.

The pain hadn't gone. It had never promised to. The narrow canal, the worn disc, the arthritic facet joints were still part of the architecture of his spine, and they always would be. After a long day, or too ambitious an afternoon in the garden, or a hard conversation, the old ache still came back. But it came as a visitor now, not a resident. He could see the flares coming and he knew what to do with them. And the terror that had once come with every one — the sense that this was the beginning of the end — had quietly dissolved.

* * *

In the spring Jake had come round with his laptop and an expression Bob had learned to recognise: the look of a young man who had built something and wanted his old teacher to break it.

"We're drowning," Jake said. "Every patient has a history, imaging, other conditions, tablets, sleep, work, stress, worries — and all the associations and relationships between them. There's too much to hold in one head in a thirty-minute appointment, and in a busy clinic time is the one thing you never have. No single app or textbook connects it all without bias or gaps. You taught me to consider everything. I can't always remember what everything is." He opened the laptop. "So I've been building something that thinks like a team of experts. A resource. It doesn't diagnose, and it doesn't tell anyone what to do. You give it the case, and it gives you back everything worth considering, and how it connects. The thinking is still yours."

"Put me in," said Bob.

They entered everything: the scan, the history, the prostate, the sleep, the retirement, forty years of standing at a plinth, the old ankle sprains from his rugby days that he had not thought about in a decade. Jake pressed a key.

The screen filled in less time than it took Bob to put his reading glasses on.

He read it the way he had once read students' essays, slowly, with his glasses on the end of his nose. It was organised the way he had always tried to think and so rarely managed to on a Friday afternoon: the anatomy of the region and everything that lived there, from the discs and facets to the fascia and the nerve roots; the pathologies that were likely, the ones that were possible and the ones that must not be missed; the behaviour of the symptoms; the tests that would tell him something; the way he moved; his health and his life; how he was in himself; and what each kind of treatment would actually change. Then a short section at the end headed *Other considerations*, which was, he realised, the question he had written at the bottom of his own sheet a year ago: *and what else could this be?*

He scrolled. It went on for a long time.

- Congenital narrowing of the lumbar canal, with degenerative change at L4–L5.
- Symptoms eased by bending forward and by sitting: consistent with a spinal cause. Consider vascular claudication; check the foot pulses.
- Night-time urination: prostate, now treated. Sleep disruption as an amplifier of pain.
- Sustained standing at work: consider a sway-back posture, the pelvis pushed forwards, increasing extension of the lumbar spine.

- Loss of hip extension, especially on the dominant side after years of lunging at a plinth: compensatory arching of the lumbar spine in walking.
- Previous ankle sprains: reduced push-off and a shortened stride on that side.
- Breath-holding and bracing during effort: the diaphragm's attachment to the upper lumbar spine; tension through the psoas.
- Deconditioning and fear of movement after months of reduced activity.
- Retirement, loss of role, a child leaving home: identity, meaning and mood as modifiers of pain.
- Caffeine, alcohol, screens at night.
- Red flags screened: cauda equina, malignancy, infection. Safety-netting given.

And on, and on.

The resource laid it out as a map. Biomechanical: the disc and the congenitally narrow canal, loading the facet joints. Neurological: a sensitised nervous system amplifying threat. Myofascial: chronic guarding of the quadratus lumborum from years of poor ergonomics at the plinth. Proprioceptive: an old history of ankle sprains feeding a subtle asymmetry through the pelvis. Psychosocial: fear-avoidance loops tied to his anxiety about legacy and the loss of his identity in retirement. And even symbolic: pain as the sledgehammer of time, and as a teacher of presence.

Bob sat back.

"Well?" said Jake.

"I knew nearly all of it," Bob said slowly.

Jake's face fell a fraction.

"No — listen. I knew it because it took me a year to find it. Kate found the sleep. You found the bladder. Michael found October. Nathan found the sadness. Craig found the prostate. It took five people and twelve months and a great deal of pain." He tapped the screen. "This put it all in front of me before I'd finished my tea."

He went back through it with a pencil, the way he always had. Some of it he crossed out. His foot pulses were strong; Jake checked them there and then in the kitchen, and the symptoms eased when he bent forward, not just when he stopped. Not his arteries. Some of it he had already dealt with. And a few things he hadn't considered at all — not answers, just stones he had never thought to turn over.

So they turned them over. Standing at the kitchen worktop, Bob let Jake watch him as he would have stood at the plinth, and saw it himself in the dark window: his pelvis drifting forwards, his upper body leaning back, his weight hanging on the front of his hips. Lying on the edge of the kitchen table, one knee hugged to his chest, his right thigh stayed lifted where the left dropped flat. When he walked the length of the hall, his right foot pushed off a fraction less than his left. And when Jake asked him to lift something, he caught

himself doing what Kate had described: holding his breath and bracing, as if the kettle might attack him.

None of it was the answer. That was the point. Each was a few per cent. A hip that couldn't straighten made his lower back arch a little with every step; a sway at the plinth arched it a little more; a stride shortened by an old ankle and a breath held against every effort added their own small loads, all on the side where his leg tingled. Together, perhaps, they made a difference.

So he added them to the plan he already had. A slow stretch for the front of the right hip with his back kept flat. Teaching the buttock muscles to straighten the hip on their own. Standing tall with his weight over his heels instead of hanging forward on his hips. Calf raises and balance work for the old ankle. Breathing out, not holding, when he lifted. Targeted decompressive positions at the key levels, gentle nerve glides, long postural holds for the deep stabilisers, Paul Chek's layered progressions from core control through to the movements of his own life. And the journal, still, every night, turning each flare into a question: *What is this teaching today? What meaning can I make?*

It helped. Not dramatically. He could walk a little further most weeks, and some weeks not. He could tend the lavender without calculating every bend, and sit through a meal with his son without bracing. It was not a cure. It was a better way of living in the body he had.

* * *

What stayed with him afterwards was not the list. It was what the list had done to him.

He had expected to feel replaced. Instead, reading it, he had felt the way he used to feel in the best case discussions of his career, with the whole team round the table — surgeon, physio, GP, psychologist — each of them seeing something the others had missed. The resource didn't think for him. It made him think. It put every possibility in front of him at once, and then it left the choosing to him: which to test, which to discard, which mattered for this man, today. It had the breadth. He still had to bring the judgement.

Over the summer he found himself thinking about how much the work had changed since he had started.

When he qualified, physiotherapists tended to follow a single approach, and spent hours with their heads in textbooks trying to understand it further. A few great teachers, a shelf of textbooks, Cyriax and Maitland and McKenzie. Most of the patients had one thing wrong with them. Now people lived longer, appeared more stressed, and came in with three conditions and six tablets and a history that ran to four pages. The knowledge had multiplied beyond anyone's ability to hold it. And the standards had risen with it: the professional body expected a physiotherapist to understand not just anatomy and physiology but the interconnected systems of the whole

body, and the physical, biological, clinical and behavioural sciences besides. A physiotherapist was being asked to be a polymath, in thirty minutes, at five o'clock on a Friday.

Meanwhile the simple cases were leaving the building. Straightforward sprains, uncomplicated back pain, the standard post-operative knee: those were already moving onto apps and video calls and exercise programmes on a phone.

Bob didn't think that was a tragedy. For many people it was quicker and cheaper and good enough. But it meant that what came through the clinic door, more and more, would be the tougher cases: the layered, the complex, the poorly defined. Mrs Bell with her hip and her bones and her tablets and her lost bridge club. Lily, whose most flexible joint had fooled everyone. Bob himself.

He remembered a line from a physician called Ian Scott that he had once pinned to his noticeboard: that most errors in clinical reasoning are not due to incompetence, but to the frailty of human thinking under conditions of complexity, uncertainty and pressure of time. And Daniel Kahneman had a word for what happened when good professionals looked at the same problem and came to different answers: *noise*.

Two physiotherapists examining the same back and disagreeing about what was wrong with it. Two doctors reading the same history and one of them missing the red flag. Bob had seen it all his life. He had done it himself, to himself, for a year.

Not incompetence. Frailty. A tired mind, a full diary, an early idea that felt like certainty.

That was what the resource was for, he decided. Not to replace the clinician, but to steady him: to put the whole of what was known in front of a pressured mind. The old masters had had their hands and their eyes and their notebooks. Jake's generation would have those, and this as well.

Heraclitus had said you can never step into the same river twice, because it is not the same river, and you are not the same man. Physiotherapy was not the same river it had been when Bob first waded into it. It would not be the same river in another forty years. But the thing at the centre of it would not change, because it could not. A person in pain, sitting across from another person, trying to be understood.

* * *

This evening Jake was on the bench beside him. The clinic used the resource now, and a few others had started to as well. Jake called it a second brain that never got tired. He had kept its knowledge base private and carefully curated, and every consideration in it could be traced back to its evidence.

"You didn't cure me," Bob said, watching the blackbird.

Jake smiled. "I never thought I would. The resource didn't either. It just asked the questions all at once. So did Kate. So did Nathan."

"I'm better at living in this body. That's a different thing, and I think it might be the better one."

"We never got to the bottom of it, did we?"

"No," said Bob. "We got to the bottom of how to live with it. Together."

The pain was quiet tonight, a low hum in the background. He felt it without fear.

He thought of Craig, who had rung from Singapore at Christmas, sounding ten years younger, to say that Tom had met him at the airport. Of Michael, boxing in a church hall on Tuesday mornings. Of Kate, who had sent him a photograph of her first anatomy exam result with no message at all, because none was needed. Of himself, a year ago, sure that his whole problem was a narrow canal.

He had spent forty years looking for the universal fix. In the end there had been no single fix at all for him, but there had been for others.

The web held — body, mind, relationships, knowledge, legacy, presence. Pain was part of it, but no longer the centre.

The lavender released its scent on the breeze. Bob smiled — not at the absence of pain, but at the presence of life around it.

Enough.

He rose from the bench slowly, sinking into a squat first the way his hips now let him, feeling his whole body organise

itself around the movement. Then he stood, and walked back towards the house with a lightness in his step.

The blackbird sang once, sharp and clear.

The garden answered.

The Body Behind the Story

These notes explain, in plain English, what was happening in the body in each chapter, what anyone in a similar situation might consider, and when to get help. They are not a substitute for being examined. If you have pain that worries you, see your GP or a registered physiotherapist.

Before you start: the questions worth asking about any pain

Bob's lesson is that pain rarely has one cause. If you are in pain, these questions are worth answering honestly, on paper, before any appointment:

- Where exactly is it, and does it spread anywhere?
- What makes it better, and what makes it worse? Movement, position, time of day, eating, breathing?
- How are you sleeping? What wakes you?
- What else is going on with your health? Other conditions, medication, bladder, bowel, weight,

appetite?

- What has changed in your life in the months before it started? Work, loss, stress, a move, a new pair of glasses?
- What do you believe is wrong, and what are you afraid it might mean?
- What have you stopped doing because of it?

Chapter 1: A shoulder that isn't a shoulder

What was happening. Organs share nerve pathways with muscles and skin, so the brain can misread where a problem is. The gallbladder can refer pain to the right shoulder blade or shoulder tip; the heart to the left arm, jaw or neck; the kidneys to the side and back.

What to consider. Pain that doesn't change when you move the painful area, or that follows meals, breathing, or passing urine or stools, may not be coming from muscles or joints.

When to get help. See your GP if pain is linked to eating, or comes with fever, nausea, yellowing skin or feeling generally unwell. Chest, arm or jaw pain with breathlessness or sweating is an emergency: call 999.

Chapter 2: What scans show, and what they don't

What was happening. Bob has spinal stenosis: a narrowing of the canal that carries the nerves to the legs. Some people are

born with a narrower canal; age-related changes in discs, joints and ligaments narrow it further.

What to consider. Disc bulges and wear are common in people with no pain at all, and become more common with age. A scan matters most when its findings match your symptoms and examination. Typical stenosis symptoms are heaviness, tingling or pain in the buttocks and legs on walking or standing, eased by sitting or bending forward.

When to get help. Surgery (decompression) is a good option for some people, especially if walking distance keeps falling despite a thorough rehabilitation programme.

Chapter 3: Neck pain in this case wasn't just the neck

What was happening. Jake's patient had neck pain from new varifocals, read through the bottom of the lens with the chin pushed forward.

What to consider. Headaches (and exactly where they are), jaw clenching or teeth grinding, eyesight and glasses, screen height and number of screens, and stress all load the neck. Long-standing pain can also make the nervous system more sensitive. That is real, but it is usually the last chapter of the story, not the first.

When to get help. Seek urgent assessment if neck pain comes with dizziness, double vision, difficulty swallowing or

speaking, numbness around the face or mouth, sudden falls, or after a significant injury.

Chapter 4: A knee that's really a hip, and a new mother seen whole

What was happening. Mrs Bell's hip shared its nerve supply with her thigh and knee, so the brain misread hip pain as knee pain. Around it sat a web of falls risk: a wrist broken in a minor stumble, dizziness on standing from blood pressure tablets, weaker legs, fear of falling, and a shrinking social life.

What to consider (knee or thigh pain in older people).

- If the knee looks and feels normal on examination, check the hip, and the lower back too.
- A bone broken from a fall at standing height, after the age of fifty, can signal thinning bones. Ask your GP about a bone health assessment.
- Dizziness on standing is worth mentioning. Blood pressure tablets sometimes need reviewing as we age.
- Strength and balance exercises reduce the risk of falls. Staying socially active is part of recovery, not an extra.

What was happening (Amira). Pelvic girdle pain after birth is common. It was being driven by several things at once: hormonal changes while breastfeeding, a stretched tummy (diastasis), a pelvic floor that needed rehabilitation, one-sided

carrying, hunched feeding, broken sleep, running too soon, and low mood.

What to consider (after having a baby).

- Leaking when you cough, sneeze or run is common but not normal to put up with. A women's health (pelvic health) physiotherapist can assess and treat it.
- Many guidelines suggest waiting until at least around twelve weeks after birth, and having a pelvic floor assessment, before returning to running.
- Carry car seats close in front with both hands, alternate hips, and use a feeding pillow.

When to get help. If you have felt low or hopeless, or lost interest in things you usually enjoy, for more than a couple of weeks after having a baby, talk to your GP, midwife or health visitor. Postnatal depression is common and treatable. If you have thoughts of harming yourself or your baby, seek help urgently.

Chapter 5: How treatment actually works

What was happening. Bob sorts old successes by what the treatment *changed*, not what he *did*.

What to consider. Treatments work on several levels at once:

- **The brain:** meaning, fear, expectation and feeling safe. Being properly listened to is part of treatment.
- **The nervous system:** how sensitive it has become and how loudly it amplifies signals.
- **The tissues:** joints, discs and muscles, and the load placed on them.
- **The nerve itself:** how freely it moves and how well it is nourished.

The gut, inflammation, stress and old emotional wounds can all feed pain.

When to get help. If one approach hasn't helped after a fair trial, the answer may be a different question rather than more of the same treatment.

Chapter 6: Red flags, and why they matter

What was happening. Bob's bladder was waking him, and he had put it down to age. It turned out to be an enlarged prostate, common and benign, but it needed to be checked.

When to get help: go to A&E immediately if back pain or sciatica comes with any of these signs of cauda equina syndrome, a compression of the nerves that control the bladder, bowel and sexual function:

- numbness or tingling between the legs, around the back passage or genitals

- difficulty passing urine, not feeling when the bladder is full, or leaking
- loss of bowel control or sensation
- change in sexual function or sensation
- sciatica in both legs, or leg weakness getting worse

Don't wait for a morning appointment. Early surgery can prevent permanent damage.

Also see your GP promptly if back pain comes with unexplained weight loss, a history of cancer, fever, night pain that no position eases, feeling generally unwell, or new back pain after the age of fifty with no obvious cause.

Chapter 7: Pain and the life around it

What was happening. Bob's pain began in the same season as his son leaving, setting his retirement date, and gardening alone in a garden that had once been shared.

What to consider. Saying that life events affect pain does not mean the pain is "all in your head". Grief, fear and stress change muscle tension, sleep, activity and how sensitive the nervous system is. The body and the life are one system.

Chapter 8: Why sleep changes pain

What was happening. Months of broken nights had turned up the volume on Bob's pain.

What to consider. Poor sleep lowers the pain threshold, and pain disturbs sleep: a loop that feeds itself. Look for what is actually waking you (bladder, pain, worry, a partner, heat). Useful habits include limiting caffeine after midday, keeping regular times, and winding down without screens.

When to get help. See your GP about night-time urination, snoring with breathing pauses, or persistent insomnia. All are treatable.

Chapter 9: Walking with a narrow canal

What was happening. Standing upright narrows the spinal canal slightly; bending forward opens it. That's why people with stenosis can often push a supermarket trolley or cycle much further than they can walk.

What to consider. Walk, rest, walk: stop before symptoms build, rest leaning forward, then carry on. Increase gradually. Cycling or a recumbent bike is often an excellent way to stay fit.

Chapter 10: When flexible isn't the same as healthy

What was happening. Lily's hip clicked and slipped because it moved too much, not too little. Her muscles felt tight because they were working hard to hold loose joints steady.

How the hip was moving. In some hips, the ball of the thigh bone slides forwards in the socket instead of spinning in

place, especially when the leg is lifted high. The front of the joint takes a small knock each time. Treatment aims to restore control: training the deep hip muscles that keep the ball centred, first in the middle of the range and then towards the end, slowly and with light loads.

What to consider. Hypermobility (joints that move beyond the usual range) is often harmless. In some people it comes with pain, joints that partially dislocate, easy bruising, fatigue, dizziness on standing, gut symptoms and anxiety. These can be connected, and they are not "in your head".

- Stretching already-mobile joints rarely helps. Strength, control and balance training usually do.
- A racing heart or faintness when standing deserves proper assessment by your GP.
- In dancers and athletes, missed or irregular periods may be a sign of not eating enough for the training load. Over time this can weaken bones and affect health. It needs medical and specialist dietetic support, not just more willpower.

When to get help. See your GP about fainting, a racing heart on standing, periods that stop for three months or more, or concerns about eating.

Chapter 11: How a physiotherapist thinks about an ordinary back

Irritability and severity. Two questions shape the whole assessment: how bad is it, and how easily does it flare and how long does it take to settle? An irritable problem is examined gently, with fewer movements, and treated with a low dose to begin with. A problem that is painful but settles quickly can be examined and loaded more fully.

Centralisation. When repeated movements in one direction make pain retreat from the buttock or leg towards the middle of the back, it usually means the problem comes from the spine and is likely to improve. The helpful direction differs from person to person: bending back helped Tony but would have aggravated Bob's narrow canal.

The right test at the right time. Every test answers a question. Choose tests that are reliable and that answer a question the history has raised, and do fewer when a problem is irritable.

The thoracolumbar fascia and slings. A strong diamond-shaped sheet of connective tissue covers the lower back. Through it, the large back muscle on one side connects to the buttock muscle on the other, forming a diagonal "sling" that transfers load from the legs to the arms when lifting and twisting. The deep corset muscle of the abdomen tensions it from the front. When the buttock muscle fires late, or the hips

are stiff, more load falls on the joints and discs of the lower back.

Exercise as a prescription. A good exercise programme states, for each exercise:

- sets and repetitions
- tempo, the speed of each part of the movement, e.g. 3 seconds down, 1 second pause, 2 seconds up
- load or resistance
- rest between sets
- how often, and for how long
- how to progress, and what to do if pain increases

Deep stabilising muscles are usually trained with light loads, slow tempos and longer holds. Large movement muscles are trained with heavier loads, fewer repetitions and longer rests. Programmes usually progress from control and flexibility, to stability, to strength, to power, and finally to the specific movements of the person's work, sport or life.

A useful rule of thumb used by many physiotherapists: pain during exercise no higher than about 3 out of 10, and back to its usual level by the next morning. If not, reduce the dose.

Beyond the back. Sleep, food, rest and enjoyment all affect how tissues heal and how sensitive the body is to pain.

Chapter 12: Your plan is not someone else's plan

What was happening. The backward-bending exercises that helped Mrs Ellis would have narrowed Bob's canal further. The same exercise can help one person and aggravate another.

What to consider.

- The deep muscles that support the spine are endurance muscles. Slow, sustained, gentle work tends to suit them better than fast, heavy exercise.
- Build stability first, then strength, then speed.
- Teeth grinding and jaw clenching can drive neck pain and headaches. A dentist can check for wear and fit a night guard.
- Accepting the pain that remains, rather than fighting it, often reduces the fear and distress around it. Psychological approaches such as acceptance and commitment therapy use this.

Chapter 13: What the referral didn't say

Inflammatory back pain (Daniel). Axial spondyloarthritis is an inflammatory condition affecting the spine and pelvis, often starting in young adults. It is frequently diagnosed years late because it is mistaken for ordinary back pain. Clues include:

- back pain starting gradually before the age of about forty-five, lasting more than three months
- morning stiffness lasting more than thirty minutes
- waking in the second half of the night with pain
- improving with exercise but not with rest
- a good response to anti-inflammatory tablets
- pain where tendons attach to bone (such as the back of the heel), inflamed eyes (uveitis), psoriasis or inflammatory bowel disease
- a family history

If several of these fit, ask your GP about referral to a rheumatologist. Exercise remains essential throughout.

Runner's knee (Megan). Pain around the front of the kneecap in runners is often caused by a combination of a sudden increase in training load and a weak link elsewhere in the leg. Common links are a stiff ankle, weak hip muscles that let the knee fall inwards, and a weak trunk. The painful area is often not where the problem starts. Treatment usually includes reducing (not stopping) running, slightly quicker and shorter strides, and strengthening the hip, knee and calf. Tests for ligaments and cartilage are only needed if the history suggests injury, swelling, locking or giving way.

Painful shoulder when reaching up (Colin). Pain under the arch at the top of the shoulder is common in people who work with their arms overhead. A combination of tests (a painful arc of movement, the Hawkins-Kennedy test and weakness

turning the arm outwards) makes it more likely. The shoulder blade must turn upwards and tilt back as the arm rises. A stiff, rounded upper back and tight chest muscles can stop it doing so. Treatment usually combines loading the shoulder tendons gradually, training the muscles that control the shoulder blade, mobilising the upper back, and changing how the work is done.

Frozen shoulder and blood sugar (Mrs Kaur). Frozen shoulder is much more common in people with diabetes and thyroid disease, and in women around the menopause. Thirst, passing urine often, tiredness and slow-healing cuts can be signs of diabetes. If you have a frozen shoulder, it is reasonable to ask your GP whether you should be checked. In the painful early phase, gentle movement within comfort is usually better than forcing it.

Tendon pain and medication (Siobhan). A group of antibiotics called fluoroquinolones (including ciprofloxacin) can damage tendons, especially the Achilles. The risk is higher with steroid tablets and in older people. If you develop tendon pain while taking or after taking one, stop and contact your doctor promptly. Other things that make tendons less able to cope include changes in hormones around the menopause, poor sleep, weight gain, changes in footwear and sudden changes in load. Tendons usually need gradual, progressive loading, not complete rest.

Chapters 14 and 15: Everyday habits

What to consider. Getting out of bed with a sore back: roll onto your side, bend your knees, push up with your arms, and sit for a moment before standing. Small daily routines (movement, reflection, keeping in touch with people) add up over months.

Chapter 16: Numb fingers

What was happening. Craig had carpal tunnel syndrome: the median nerve squeezed as it passes through a narrow tunnel at the wrist. Years of looking down through magnifying loupes had probably irritated a nerve root in his neck as well. A nerve under pressure in one place can be more vulnerable somewhere else along its length.

What to consider.

- Typical carpal tunnel symptoms are numbness and tingling in the thumb, index, middle and half of the ring finger, often worse at night and eased by shaking the hand.
- Things that make it more likely: sleeping with bent wrists, repetitive gripping, pregnancy, diabetes, an underactive thyroid, rheumatoid arthritis, and carrying extra weight.

- Neck problems can cause similar symptoms, and sometimes both are involved. A physiotherapist can test how sensitive the nerve is along its whole length, from neck to fingers. People who work looking down for long periods (surgeons, dentists, hairdressers, laptop users) often develop a pattern of tight neck and chest muscles with weak deep neck and upper back muscles. Gentle deep neck muscle training, upper back mobility and changes to work posture help.
- Heavy drinking can affect nerves directly and lower vitamin B12.
- Treatment often starts with a night splint to keep the wrist straight, changes to work and sleep positions, and sometimes an injection. Surgery is effective when needed.

When to get help. See your GP promptly if numbness becomes constant, your grip weakens, or the muscle at the base of your thumb looks flatter. Sudden numbness or weakness in the face, arm or leg on one side, or trouble speaking, is an emergency: call 999.

Chapter 17: Small changes that add up

What was happening. Michael had early Parkinson's disease, a condition in which the brain gradually loses cells that produce dopamine, a chemical messenger that helps control movement.

What to consider. Early signs can be subtle and often appear years apart:

- a tremor in one hand at rest that eases when the hand is used
- one arm swinging less when walking, shorter steps, and a stoop
- handwriting that gets smaller across the page, a quieter voice, and a less expressive face
- stiffness and slowness
- earlier, non-movement signs: loss of sense of smell, constipation, acting out dreams in sleep, and low mood or anxiety

None of these alone means Parkinson's. Several together are worth checking.

When to get help. See your GP, who can refer you to a neurologist. Regular exercise that makes you breathe harder (walking briskly, cycling, dancing, boxing classes designed for Parkinson's) is one of the most helpful things people can do alongside medication.

Chapter 18: The breath

What was happening. Kate had breathed high in her chest and held her breath for most of her life, a habit learned in childhood as part of staying alert to danger.

What to consider.

- The diaphragm is the main breathing muscle. It is anchored to the lumbar spine, sits alongside the hip flexors, and works together with the pelvic floor and deep tummy muscles. Breathing, back, hips and pelvic floor are one system.
- Habitual upper-chest breathing and breath-holding load the neck and shoulders and can keep the nervous system on alert.
- A simple practice: one hand on the belly, breathe in gently through the nose so the belly and lower ribs widen, then breathe out slowly for longer than you breathed in. A few minutes, several times a day.
- Changing lifelong habits is slow. Noticing comes first.

When to get help. New or worsening breathlessness, or chest pain, needs urgent medical assessment. For panic, persistent anxiety or a breathing pattern that won't settle, see your GP; some physiotherapists specialise in breathing pattern disorders.

Chapter 19: Many small things

What was happening. No single finding explained Bob's pain. Several small things each added a little load to his narrow canal: a right hip that no longer straightened fully behind him

after decades of standing in a lunge, a sway-back standing posture at work, a shorter stride from old ankle sprains, and holding his breath when he lifted. Each made his lower back arch a little more. Addressed together, alongside sleep, fitness, fear and mood, they made a real difference, though not a cure.

What to consider. A problem in one area can load another: stiff hips can strain the back, and stiff ankles the knees. The painful area isn't always the cause.

Leg pain on walking can also come from narrowed arteries (vascular claudication). Clues that point to circulation: the pain eases simply by standing still, cycling brings it on too, the feet are cold, or the foot pulses are weak. Clues that point to the spine: bending forward or sitting eases it, and cycling is comfortable.

When to get help. See your GP if you suspect a circulation problem, particularly if you smoke, have diabetes or have heart disease.

About resources. Checklists and clinical decision-support resources can help a clinician consider a wide range of possibilities quickly, including ones they might have missed. They don't examine anyone. The examination, and the judgement, remain the clinician's.

The Ideas Behind the Story

Bob's recovery is as much about how he meets pain as about what is done to it. These are the thinkers the characters draw on, for readers who want to go further.

- **Viktor Frankl**, psychiatrist and concentration camp survivor: we cannot always choose what happens to us, but we can choose our attitude to it, and find meaning even in suffering.
- **Epictetus**, Stoic philosopher: distinguish what is in your control from what isn't, and put your effort into the former.
- **Michel de Montaigne**, essayist: to philosophise is to learn how to die. Facing our limits honestly is what frees us to live.
- **G. I. Gurdjieff**, teacher of the Fourth Way: most of us live mechanically, protected by "buffers" that stop us seeing our contradictions. Waking up begins with honest self-observation, and with bearing discomfort consciously rather than reacting to it.

- **Robert de Ropp**, *The Master Game*: the ordinary games of money, status and recognition, set against the one game worth playing in his opinion, which is 'waking up'.
- **Carl Jung**: individuation, the lifelong process of becoming who you actually are rather than who you had to be.
- **Friedrich Nietzsche**: to affirm one joy is to affirm all of life, the pain included, because everything is bound together; and, from Zarathustra, "There is more reason in your body than in your best wisdom."
- **The Book of Job, Ecclesiastes and the Buddhist teaching of impermanence**: suffering as refining fire, a season for everything, and the recognition that all things arise and pass away.

The question the book leaves with you is Bob's own: what have you stopped asking about yourself, because you already think you know the answer?