

Supporting Physical Recovery After Sepsis

A Practitioner's Questions

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Who I Am & Why I'm Here



My Background

- Complementary therapist — nearly a decade of clinical work
- Trained in sports science & rehabilitation (University of KwaZulu-Natal / Sharks Rugby Academy)
- Registered with the Federation of Holistic Therapists
- UK trademark holder: MyoREFORMATION®
- Originally from Zimbabwe, relocated during COVID



Why I'm Here

- I have observations I cannot explain
- Questions I cannot answer
- The people in this room are better placed to judge whether this is worth investigating

"I am probably the least formally qualified person in this room."

Where This Technique Comes From

The Origin

Created in Zimbabwe by Jacquie Simpson in the 1980s after a severe spinal injury left her declared quadriplegic. Over years of careful trial and error on her own body, she developed a whole-body manual approach — treating the body as a connected system. She eventually walked again and spent 35 years refining the technique.

Approach

Targeted myofascial and soft-tissue mobilisation across the line of muscle attachments

Principle

Working near the edge of comfort threshold — where meaningful shifts consistently occur

Observations

Shifts in breathing, muscle tone, and how safe people feel to move

"That's an interpretation based on what I observe, not a proven mechanism."

The Parallel Challenges

Patterns I recognise from my wider practice:



Chronic fatigue that doesn't resolve with rest



Profound muscle weakness and deconditioning



Nervous-system dysregulation — anxiety, hypervigilance, poor sleep



The gap between "medically stable" and "physically confident"



Rehabilitation ending while recovery feels incomplete

"If a certain kind of ongoing physical work seems to help in one vulnerable population, is there any possibility it might offer useful perspectives in another — or am I making a category error?"

One Clear Long-Term Case

6

years

Long-term C4/5 incomplete tetraplegic

Previously faced recurring pressure sores serious enough to require hospitalisation.

Since beginning regular, whole-body treatment:

Zero hospitalisations for pressure sores in six years.

I am not claiming my treatment prevented pressure sores.

Plausible explanations include: better overall care and vigilance, changes in daily routine, improved circulation from any regular manual work, the relational effect of consistent attention, or simple coincidence.

Something in his overall context changed. That makes me curious.

A Working Hypothesis



The Physiological Context

Excess interstitial fluid returns via the lymphatic system into venous circulation, carrying proteins, lipids, and immune-relevant material. Structured tissue mobilisation may influence how that fluid moves.

HYPOTHESIS

Regular, whole-body manual treatment, applied at the edge of comfort, might offer some supportive effect for people who are medically stable but still physically vulnerable — perhaps through a mix of tissue mobility, circulatory, and nervous-system changes.

"I do not know if that is true. That's precisely why I'm in front of you rather than marketing this as a solution."

What I'm Asking From You

1

Is there any plausible reason to think this kind of work could support post-sepsis recovery — or is this the wrong question entirely?

2

If worth exploring, how would you investigate it properly? What outcomes, documentation, or study design would you need?

3

What risks and contraindications for post-sepsis patients am I most likely to miss?

4

Would anyone be willing to have an exploratory conversation about what a safe, well-designed pilot could look like?

*"Recovery does not end at survival,
or even at discharge."*

There is a real gap between 'you're medically stable' and 'you feel physically confident living in your body again'. My entire practice sits in that gap.

*"I'd rather be honestly uncertain
than confidently wrong."*

Thank You

I'm keen to hear your thoughts.

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Questions I'd love you to ask me:

1. What specific changes do you observe in your clients that you can't explain — and what would help you understand them?
2. If we were to design a small observational study around your tetraplegic case, what would you want it to measure?

"I'd rather be honestly uncertain than confidently wrong."