Academy of PHYSICAL MEDICINE

Transcript

Functional Active Release & Rehab with Robin Lansman

Cast List

Steven Bruce	SB
Robin Lansman	RL
Charlie (Model)	C

SB: This evening we're going to be talking about functional active release and rehabilitation. We're going to focus on sciatica. And my guest has been an osteopath for over 30 years. He trained at the British School of Osteopathy as it was in those days, and he was for 10 years, their senior tutor in sports injuries. He's lectured across the world. He appears on BBC Radio and TV. He's been the president of the Institute of Osteopathy. He has until very recently been their media spokesman. But he's also very recently been appointed as an expert witness to Public Health England. Robin Lansman.

RL: Hello there. Nice-

SB: Great to have you in the studio.

RL: Thank you very much.

SB: I'm just going to start with this business of being an expert advisor to public health, expert witness, similar sort of thing. Expert advisor to Public Health England. What the hell is that? I've never heard of that before.

RL: Well basically it came through my work through the library service. We have a practice within the library system in London and some of the work we've

been doing is outreach work, working in the community. And so we published a piece of work through the Royal Society of Public Health last year in July, which went down well.

SB: Is this new research?

RL: It was case study work actually, to do with who we were encountering and how we were working with people who normally would actually not see anybody, or hadn't actually. Most of them had seen not their doctor nor osteopath or anybody for any help. So it's a new part of the sector of the community who need help actually and need some advice and so on. So, that was what they put out there. And actually that then got through to eventually the Public Health England invitation to me last year to get involved with that. Their work. And obviously Public Health England covers smoking cessation and all sorts of areas, but things that are to do with falls prevention. So starting in the osteopathic, or that, let's say the physical therapies field. So avoiding injury and that kind of thing, is all part of that work as well.

SB: Is your remit that wide? So it could be falls, it could be something sciatica, it could be-

RL: Yeah. It'll be advising as an Allied Healthcare Professional, an AHP into the mix to actually share our experience from my professional, and the professions, if you like, perspective.

SB: How's that... Are there regular meetings where you go and you tell them what you think should be done?

RL: Well there's that. The first... The big thing is actually going to be next week, funnily enough. So, the kickoff is mostly for that. They've been gathering information from lots of sources. So watch this space.

SB: So the whole thing is new? It's not just it's new for you?

RL: The whole thing is new and they brought together a new team, and particularly focusing on Allied Healthcare input to Public Health England.

SB: Sounds as if it'll keep you busy.

RL: Yeah. There's a lot of things going on, but yes. Thank you. Yeah.

SB: You, just backtracking a second, you mentioned the library at the beginning of that. What's the work with the library? Which library is this?

RL: Well, this is Westminster Library Service, in fact. So I was actually this afternoon, at a meeting in central London about their future strategy, and we've been talking about strands of how they're going to carry forward new

ventures. And one of them, they want to be there, the chief exec invited me to speak and join the group to actually discuss how, not particularly osteopaths, but that health professionals could be engaged, and that's something that they're working on and I'm working on a little bit with them as well.

SB: Where do you think it's going to go?

RL: I think it could reach... I think it could go a long way. I think with all organizations like library services, they're very established in their... Well they're in the mindset to change and grow, which is great. And then we need to see where we can move that along. But actually meeting and greeting some of the people today, a cabinet minister in fact was there. There's some really interesting people who are engaged with it across a very wide group of sectors. And we know that in Allied Health for example, music therapists, there's a wide range of people joining the 14 professions. So that mix, but the conversations, interestingly, it didn't make any difference in a sense, what people's background was. They were there for similar reasons and the conversations were incredibly powerful today. So it was really great to be there.

SB: You're possibly the wrong person to ask this, but I was just curious. Are chiropractors any closer to being Allied Healthcare professionals now?

RL: They, I think wanted to be. I'm not sure where they've got with it. So, no. At the moment, no. As far as I know.

SB: Do you see it as being an advantage to be one? To have the profession recognized in that way?

RL: Everything is a matter of run with everything that you can. It's not actually... I mean the badge... I actually did bring my AHP badge but I forgot to put it on. So, yeah. I'm happy to be an AHP. But what you want to do with that, like with anything, in anything in life, you have to make of it what you want to. And I think like with lots of things, until someone tells you not to, go ahead and try, and see who you can inspire and see who wants to work with you.

SB: Okay, let's get to the meat, what we were talking about this evening. Functional active release. If you Google that, you don't come up with anything, apart from this evening's broadcast.

RL: Indeed. Well you do a little bit but actually-

SB: Do you get active release technique? Is that the same thing?

RL: It's not the same thing. And I haven't been involved with that particular process. That's quite an American model, which some people do in the UK. I think what I've tried to do is actually explore... Well, 30 years in practice is

plenty of time to explore, and I personally have done a fair few things in that time. So I like to investigate the way I'm working, and think through what's most useful for my patients. I run a practice as well. So, these things have evolved and people do keep asking me. I've given the lectures many, many times, different ones on different branches of this functional active release, in lots of places. And people constantly ask questions and that hones, in a sense, the material from the input.

SB: So what's the overall principle behind it?

RL: It's trying to find examinations and benchmarking that is useful to actually turn that into therapy. And sometimes it's a bit like a fish out of water, it maybe the wrong expression, but it's a little bit... Sometimes you do tests. What does that tell you? Or what does that lead to, in terms of managing a patient? So the benchmarking concept is there. There's very little. I used to teach a lot and actually for the GOsC, we ran some sessions years ago actually on approaching GPs, and we ran a workshop particularly on the standing examination. And it was interesting because everyone's taught slightly differently, and so people have actually evolved their standing examination in all sorts of different ways.

So when you ask two osteopaths or five osteopaths to look at a standing exam, they're all doing something slightly different for different reasons, and therefore their inferences are going to be slightly different. So the functional active relief release idea was to standardize some things. I have taught it to GPs at one of the colleges and it went very well actually. I think probably it's very popular when I do it in Germany, Holland and Turkey soon and various places, because somehow it's... Sometimes being in another country doing other things is easier sometimes, than actually trying to change things here.

SB: Who are you lecturing to in Turkey?

RL: Turkish osteopaths in fact. So through a German school that I do a lot of work for, they've actually invited me to go and do a three day workshop in Istanbul.

SB: How good is your Turkish?

RL: It's not great, but they all speak German. My German is okay and I'm working with German colleagues so that hopefully will be okay. I know all the main words in German about bits of the-

SB: I've worked through interpreters in the past and you're always slightly suspicious that they're not saying what you want them to say.

RL: Well, this has happened, this has happened. And in fact interestingly they did change translator in one of the colleges because there was a little more interpretation of a different view, in that they wanted a bit more. I was there

doing the lectures so they got someone else who was a little more true to what I was saying.

SB: Right. So a little bit later on we're going to go and do some practical stuff, where you are going to demonstrate what you've just been talking about. Should we also consider, before we do that, the fundamentals of sciatica. What is it, what causes it, what influences it? What is it we're going to be trying to test for?

RL: Okay. Well I think the thing with sciatica, like with all the tests. And we're going to look at straight leg raises and various things briefly. The thing that often happens is that the test is a little inconclusive. In fact, most tests are inconclusive on the whole. So how'd you find a strategy through that? And we're going to particularly look at posture and how spinal posture and training, gym training and other things, can affect that lordosis. And so from there we're going to work out some strategies to work around and with the presenting symptoms.

SB: That seems to imply that the lordosis is always the culprit.

RL: It's not always the culprit. No, but in fact the NICE guidelines that a lot of this came through the revision of the NICE guidelines, which was a couple of years ago. I think that's on one of the links.

SB: We'll revive this, the NICE guidelines which is of the links that people can go to at the end of the broadcast, and download this wonderful document. 18 pages of NICE guidelines.

RL: Well what they did instead of, at that time they amalgamated the low back guidance with sciatica. Okay, so that was a change. It doesn't-

SB: Don't you find, you read through this, you get so fed up with the fact that they refer to patients with low back and sciatica every time. They can't just refer to the patient. It's always the person with low back and sciatica.

RL: Yes. Well it's written by committee so they'd probably have to have lots of meetings... Well, they do, to write these things. And so anyway, it is the case that obviously you could have low back pain with no sciatica. You can have sciatica with no low back pain. But the key part of it is actually looking at protocols to do something as an osteopath, whereas a lot of the guidelines are about what not to do.

SB: Yes.

RL: Which is all very good, but actually it's a strategy-

SB: Some of the ones in here surprised me. First of all, it says that Tens, they should not use Tens for low back pain with sciatica and yet... I actually sent

an email to Tim Watson who was on this show, I think he was our last guest actually, before the new year. Asking him, surely there's plenty of evidence to show that as a pain management mechanism Tens is actually very good. So we'll see what he says. And there's another one says don't use tracker. And that surprised me as well.

RL: Yeah. But there's a lot of things that they've obviously sifted through and come up with some recommendations. I'm not sure how many doctors or osteopaths or others have read it. I think it's useful as a starting point, but then you still have to work out what to do next. And that's what we are going to do today.

SB: Do you have an opinion on... When they write something like this, they say do not use Tens for low back pain with sciatica. Does that mean they have evidence that proves it doesn't work or simply they don't have evidence to show that it does work?

RL: Well, a lot of the time, it's that, the latter. Yeah. It's very much about not making a recommendation unless you definitely, definitely have evidence, therefore you won't make a recommendation. Which is unfortunate how, even for osteopaths, we suffer from that a little bit as well.

SB: Okay. So run us quickly through the mechanism. What causes sciatic pain?

RL: Okay. So there are two, I'm going to shorten it into two, main causes. One is going to be some form of prolapse or lesion within the spinal, the disc. That could be a pathology as well, in the extreme case or bony pathology. And then the other version is actually what I'm going to term traction sciatica. Yeah? So some way down the line between the low back, the hip girdle and the rest of the leg, down to the foot somewhere, you're actually getting a tension point or points, that are going to cause a pull on the sciatic nerve. Okay.

SB: So those tethered at some point and if presumably if you forward bend or raise your leg down then it's going to be fixed at that point.

RL: Yeah. And you go into a little bit like, you might say, and I explain this to my patients, that it would be similar to having a brick on a piece of string. That the brick only weighs anything when it gets to the end of the piece of string. Yeah? So, that's the issue. You put the string, instead elastic, the brick will go further and for longer, it won't have quite the same hard endpoint. Yeah? So the more elastic the system, the better it is. But tracking exactly where that point of pressure is, if you like, or points, sometimes multiple points, that's the key. And I think with osteopaths or osteopathy, the reason I love it, is the multifactorial is what we are good at spotting. And osteopaths and others spot those multifactorial influences rather than being only looking for one test that tells you one particular-

SB: Is that still a problem in conventional medicine? And I'm not really talking about GPs here, who are not trained in musculoskeletal medicine at all.

RL: Well I gave a big presentation funnily enough in Stevenage some years ago, to a group of musculoskeletal pathway GPs. So that was an interest group. So their special interest. And there were about 60 or 70 people there. And it was interesting, interesting using the word four times, that the group was very divided. That there were people who were very keen and very motivated and very participant in what we were doing. And others were actually very keen that they liked orthopedics because they, in a sense, could exclude a pathology in some ways more simply than other systemic illness. So in a sense they were doing exclusions, they were then safe. The patients, sorry you're in pain, but there's nothing we can do for you. And you're not going to die of anything nasty because we've excluded it. So then people are left with nowhere to turn.

SB: There aren't very many musculoskeletal pathway GPs though, are there?

RL: Well, this was a group of 60 or 70 in Hertfordshire, so I mean that was quite a few. But again, I haven't got the numbers across the country, but there are all different interest groups.

SB: I only mentioned that because when... Keep telling me, when we had our NHS contract here, we used to go to meetings at the local... What do they call it?

RL: CCG?

SB: CCG. Thank you. And the musculoskeletal GP there was, he was adamant that GPs knew zero about musculoskeletal medicine, which is not helpful for the population at large, is it?

RL: No. Well, were they excluding pathologies, what's important, but that still doesn't give an outcome. A bit like some of the tests that we can talk about today, the straight leg raise. There are bits that are useful in it, but actually then what do you do next? We found in the public of going back to the public health earlier conversation, that's where people end up with roadblocks. They actually end up with a pathway that's truncated. They don't know where to turn, and that leads them to feeling quite despondent. They've been told there is nothing we can do for you, which may have been told to them perhaps by their doctor. So they're left hanging in space and they trust their doctor so they think, okay. Which is bad for wellbeing, bad for health, bad for community, bad for families, workplaces. That's the thing that-

SB: It's bad for the whole NHS system isn't it? Because actually patients can go away and Google, I've got a pain here and they'll come up with an answer. It won't necessarily be the correct one. Won't even be related to it in some

cases. But they will then think, well the NHS is letting me down because it can't answer these questions, doesn't know what to do.

RL: Well, the whole thing I think with GPs these days, and they're under a lot of pressure, is they feel that they perhaps do let people down sometimes, and they feel that the job is somehow not as rewarding in some ways as it might be. And I think that they, working with Allied Health, and this is what the NHS are trying to encourage, to actually see that there are other people out there with expertise, like osteopaths, that really can make a difference. And I think there's a conference today in London about that and a different conference today, all about this first contact practitioner work that is going on.

SB: Do you want to run through any of the slides that you've got here, or do we not need to?

RL: Sure. We can have a look at the first one. I think the one with the posture particularly, I'll turn back and have a look as well.

SB: This poor gentleman has got four different pathologies going on, as well as being normal at the end.

RL: Yeah. So basically, the good posture on the far right, so called good posture means. It is determined by the type of factors including the type of training, the type of workouts people are doing, the type of footwear they're even wearing, and just how they're built, fundamentally. And this is obviously a younger, healthier person notionally and giving some rather interesting variants in their posture. But obviously we would see these in practice in different age groups and for all different reasons. But the fundamental thing that happens and the difficulty of examining someone with acute back pain or sciatica is, you ask them to bend forwards and they can't. Then what?

SB: Yeah.

RL: And then you lie them down and you do a passive exam perhaps, but you're losing quite a bit of information in that because they are too acute or too scared perhaps to actually move. So we will look with Charlie when we do our demonstrations, a little bit of changing these postures. But the other thing is looking at the paravertebral and muscular components, and how that overlays with the functional spinal component. And that's what we'll look at, to try and neutralize some of those tensions and change the posturing to then examine the spine more usefully. So, that's what we're going to come up with in a bit.

SB: Tell you what I found off the subject of sciatica. I found it quite interesting about this is, in his normal posture over here, his hands are laying as you'd expect, at the side of his body. In all of these you can see that his hand is actually turned... His shoulder’s internally rotated. And we had a guest on here some time ago and he was talking about autistic spectrum problems,

and he said that one of the screening tests is you get a patient to walk on the outsides of their feet, and they are some way affected in that way, their hands will turn inwards like that.

RL: Well actually... Go on.

SB: No, no. It's just intrigued me. It may just be because he's in a funny position and that's the way his shoulder went.

RL: What I would say is very interesting. I worked a lot with Phillip, who is a colleague of mine in Germany and Belgium, and he's written a book which is an interesting one about muscle chains, which is available on Thieme if anyone wants to have a look. T-H-I-E-M-E I think is the publisher. And it's a very interesting book because it looks at different muscle chain theories, and he's put those together. And I've worked with him quite heavily on that. And actually some of these things, obviously the model, although it's a picture, but it's the model may have had to cheat certain things to actually achieve these postures probably. But actually the muscle chain aspect we will look at when we look at Charlie, because some of his training and things that we looked at just as we ran through things earlier, were quite interesting to bring out, in terms of how upper body may affect lower body. Or left may affect right. That kind of thing.

SB: So there was a time when I remember one of the diagnostic screens was someone with forward head posture. That's definitely a causal factor in neck and back pain. And I think that was then suddenly proved to be wrong at some point.

RL: Well again, was there enough evidence and so on and so forth? I actually wrote an article for... I can't remember his newspaper it was. I think it was the Daily Mail, which came out about texter's neck and a whole load of people made lots of comments about, my goodness, that's crazy. But the protraction aspect, so in other words, the tightness in the chest, the pectorals, the deltoids, and indeed the thoracic outlet area, again, encourage that posture. So although the head position forwards creates sometimes back and neck pain at the rear, the release point is often at the front. And that's another topic I do quite a few lectures on. That thoracic outlet is really an interesting area that's part of this.

SB: And Leon Chatiow would have had a lot to say about the tightness of the-

RL: Anterior-

SB: -accessory muscles of respiration and the effect on...

RL: And when we look at it later, the functional aspects of this, in fact, some of the breathing, external... Sorry, the expiration and inspiration components are quite interesting as well, to build that tension loading,

SB: Okay. We need to... You said this next slide was quite an interesting one. Going on? It's not a very clear picture, but you get the idea of what is going on here.

RL: There was a theory, sometime ago, and in fact one of the original books that I read yonks ago, which was by a physio called Mackenzie, Robin, Robin McKenzie as well. Robin. Was about this sort of idea about extension being good for discs. In other words, trying to restore where the disc sits in its space and-

SB: Wasn't there a popular yoga pose as well?

RL: Well, it is a cobra pose. Yeah. I think the problem with it is that it does compress the lumber spine heavily, and if there's any facet irritation, this is a complete, not a no, no, in terms of joint space. So something that I think is being phased out, although actually is still in some of the books that exist as recommended exercise.

SB: Right.

RL: So, it's a strange conundrum that it's still out there. A lot has actually not changed in exercise prescription. So even the NICE guidelines say do exercise. They don't say what. So a lot of the stuff is still regenerated or revisited older exercises that have been going for donkey's years.

SB: And in fact the NICE guidelines in connection with lumbar pain or low back pain and sciatica, only recommend manual therapy in conjunction with exercise. Then again, they don't say what.

RL: No, they don't say what and specify. I'd agree that the two together are a great mix. So totally just treating and no remedial work or remedial exercise to go with the treatment, I think, is limiting the scope.

SB: What about the other way round? What about just the exercise? I mean again, have we got evidence to say that's not as effective?

RL: I don't about the evidence, but I know from experience that in fact giving people exercises to do, encouraged by people who are not perhaps as highly trained, they can overdo the exercises or stop because they're painful. So you may not get the therapeutic value ongoing because people don't engage with them perhaps as fully as they might, because of the way they're put across and the way they're explained isn't thorough.

SB: Yeah. Okay. And that whole business, you said then that Cobra pose compresses the spine, could aggravate the problem. Do we have evidence to show that it does that? Hard clinic evidence or is that just common sense?

RL: Well, if you ask people to do it and in fact all of the things we're going to do today, you review with the patient, you have a dialogue, communication, it's all about communication and consent. But it's not just consent, it's about understanding and exploring with the patient, which is what we're going to do now, what makes things better and worse. Not assuming that anything you think is good, is for every patient, because that would be very limiting. And certainly that extension exercise, for most people with acute back pain, it's actually fairly uncomfortable. Sometimes a little bit of engagement along the lumbar paravertebrals is a good idea, to stimulate them.

SB: From what you've just said there, how much do you vary the exercises you give your patients depending on the individual patient?

RL: Well, each of the prescriptions I give are very much modified to suit the person to start with, to gauge what they can do. And I have a set of, if you like, variables that I would make them slightly harder, or give them the chance when I'm not with them, so in between sessions, to actually rein that back in again so they still can do something rather than be feeling out of sorts that they can't do anything. So leaving with nothing, in pain, is absolutely not the way forwards. So they've got some modifiables within the prescription.

SB: Okay. Would you like to go and introduce yourself to Charlie.

RL: Charlie, hello. Thank you. We have met but I'll just... Thank you. Right. Okay, so... Can you just stand there? What we're going to look at now is looking at the posture picture that we looked at on the screen, is looking at the lordosis. Now you haven't got any major problems or anything? You do a fair bit of training and you've been doing, I think you told me earlier, some building work and so on.

C: That's right.

RL: Yeah. So a little bit of stiffness in here, we found earlier. So we're going to look at the lumbar curve and we're going to imagine in a sense that there's some presentation that might include sciatica at this point. Okay. So if you put your feet parallel, first of all, very parallel. And then just lower the lumbar spine, bottom backwards, a little bit further back and try and flatten your lordosis as much as you can to flatten it. Great. Okay. You could actually pop your arms out in front of you, just a little bit higher. Great. Okay. And just flatten that lordosis and lift a little and just drop down. Right. Okay. So what we're trying to do here is actually lose the lordosis, and on that basis, actually make the examination of the lumbar spine a little easier. Because in fixed extension, in some of the pictures you obviously... Or full sway back, you're actually going to have difficulty getting the facets to work. Okay. So if there is a facet problem, it'll still come out, but it removes some of the muscular components to the problem.

Yeah. So if you just side bend to your left, keeping the arms in that nice parallel, keeping the knees evenly bent and you keep going as far as you can. And you can palpate it or you can observe the curve. Okay, keeping the knees equally bent all the time. And watch really where you start to lose flexibility, which is clearly up about here. And I use the arms to actually amplify tension through the lats, because the lat obviously interdigitates really quite nicely down towards just above the QL area. So you get that muscular component. Okay? You're looking for a pure, no rotation, which you will get in people with other issues and stiffness or protraction as well. And now come back up to the middle, keeping the knees bent equally. And side bend now to your right again. Okay. Looking at your hands, keep going. And this side is actually quite different in the amount of rotation that's coming in, but we want to do a pure examination. So what we don't want to do is have rotation. So keep your knees bent and we're going to go right again.

Keep your knees bent and bottom backwards a touch. That's it. Okay. So we then see, just stopping there, the lat is actually here. Are you right-handed?

C: I am.

RL: So all of that tension is actually starting to act as a unit, in a sense, blocking the side bending and causing some compression here at the upper lumbar spine area.

SB: And you could see the different stress on the pelvis when he started that the first time, couldn't you?

RL: Absolutely. Yeah. Now you want to just come back up again. So for example, in those postures you're going to have a rotation of the pelvis either forwards or back. Yeah. And we actually may find that for example, that the quads are very tight rotating the pelvis forwards one side more than the other, if there's a leading leg. And also on top of that, there's going to be how much hamstring tension there is relative to the quads. Okay. So again, I'll let you stand back up again because it'll get tiring. Okay. So that's a little-

SB: It's a good job Charlie is very fit, isn't it?

RL: Indeed, indeed. But actually, funnily enough, when the muscles are tight from training-

C: Absolutely.

RL: Then they fatigue quicker. So interestingly you find you could do this with a little old lady who can stand there forever. Not that I would. But actually interestingly the muscles fatigue quicker when they're tight. Yeah.

SB: Charlie, a question for you. I'm trying to give you a microphone because we can't pin one on your chest, as you know. Speaking as a patient, how easy

were the instructions you got to follow? Because you've obviously had a rehearsal which is a benefit-

C: Absolutely. Initially quite hard. Initially is trying to work out what way to rotate and what to engage, and what to try and relax. A lot of the time I found I just went stiff immediately everywhere.

SB: Is that something that you have to take into account?

RL: Well, the thing is when you're seeing people over a plan of a few sessions, you're actually training them in their body awareness as well. Yeah. So gradually as you're teaching the function, you are literally teaching new functional awareness. So in a sense it is turning verbal instructions into actions, but it's also getting your body to feel it, because actually if your body can't do it, even if you try and you understand it mentally, verbally, you won't be able to translate that into function. So, I think it's very powerful to actually get people to know their body and go through these individual... Thank you for the question. So right. Okay. So should we have a look at you lying on the back, yeah? So we are going to look at the straight leg raise on the basis that that is part of the remit in a sense you might use. Not everybody uses it for examining. I'll take the pillow out actually, if I may. So where would you like me to stand? Just over here?

SB: Yep. Wherever you like.

RL: Thank you. Yep. So we're going to look at the straight leg raise. Now the traditional raise actually goes back 150 years, this test, which says it's a very old test that's been around a long time. And it's specificity is sometimes limited. Okay. Because there are a number of different structures and we talk about all the structures from here downwards or even higher, up into the thoracic spine, are part of the picture. So if you do... Sorry, I'm going to guide you in a lift first, so keeping the legs nice and relaxed. So we're just going to lift and compare the two sides. Now you haven't got sciatica, and you've told me you haven't, but in hamstring terms, and that's why it's confusing sometimes, that is sort of where we're starting to feel the limit of tension. I could push harder, but that'll do. If we compare the other leg... and again, a gentle lift. That is slightly more flexible, not hugely, but slightly more flexible. Now, the way you do a straight leg raise, yes, you can increase the tension here, and you're going to get dural tethering so you can start to see other pathologies.

What we also can explore is actually a leg lift, for example, if, let's say, this leg with the symptomatic side, the right one. In a severe case of a central prolapse of a disc or any other pathology for that matter, then even lifting the good leg could invoke sciatica on the opposite side. Now, when we say sciatica, it's often going to be gluteal pain. It could be other sensations down the back of the leg that move around, coldness, pins and needles, into the

sole of the foot in the extreme, and a foot drop would mean a severe sciatic nerve damage.

That would be the extremes, but again, there are other components to this, but that would be the passive leg raise. What we're going to do now is actually look something slightly different is actually doing an active leg race. I'm going to get Charlie to actually lift his own leg. I'm going to train him in two different ways of doing this to actually have something to play into the difference in the tension between the quads and the hamstrings.

Tight hamstrings are very common in lots of people. They shorten from sitting and training, but also the quads can often get over-tight from training because they're easier to train, and in running, particularly, and cycling, again, there can be issues there. If you lift your own leg, tightening the cord hard and lifting like so, keeping that leg just turned.

SB: Good example of cyclists cords.

RL: Yep. Okay. Down again, slowly. Obviously, you're doing it actually slightly differently because we did practice earlier, which does make it slightly different because the abdominal engagement is a little stronger. Just compare this side. You're going to do a pure lift with the right one, tightening the opposite leg. Good. We're getting that raise, and that clearly goes a lot further. Yep.

Now, if you drop that down... so this was the slightly tighter leg. We know that if you, for example, do the lift in external rotation slightly... Yeah, just try. You should find it's easier because that releases some of the tension in the hip girdle, of course, which works. Now, that leg is shuttering already from the effort, and that's because it's very, very tight, but what we're using in this is the antagonistic, if you like, effect of tightening and recruiting the entire quad. Most runners and cyclists actually use the muscle belly actually slightly near the kneecap, but they don't use the entire upper belly.

In fact, you can feel the difference if you just go down there where it starts to get tight mid belly and above is quite loose. The recruitment, what we're trying to do to educate the muscle is to encourage more recruitment further up that muscle, but in the same way, you're actually going to relax as an antagonist, the hamstring. When people say, "I need to do hamstring stretches," they don't. What need to do is activate more here, and by doing the lift in activation, they're actually gradually giving greater excursions to the hamstrings. This could be sciatica overlaid or not in a milder case, but this would be a good way in to start getting more function into the leg.

SB: The question that comes to my mind as often does in these broadcasts is the effect of stretches. Are they genuinely effective in your opinion?

RL: Well, the problem is that this... In fact, finally have quite a bit of research that says stretching cold is actually detrimental. Doing it after a short amount of blood circulatory warmup, doesn't have to be a lot, that will be a better time, and the most productive is after exercise. That's what the research says. But I think that-

SB: How long does the effect last?

RL: Well, the thing is that people do... Just to answer a little bit more of the question, is that actually people aggressively stretch, especially if they're sporty, and they hope that what they're doing is helping them, so they're actually causing sciatica or hamstring problems by actually aggressive stretching thinking, "This must be helping because I've been told this is what I should do." It's getting that dialogue with the patient to see what really helps and what doesn't in their particular case. I've now forgotten your question.

SB: My question was, I mean, for somebody who is doing those aggressive stretches, like how long-

RL: Okay, so how long does it last?

SB: How long does it-

RL: If they overstretch too hard and for too long, the effect will be they will kick the muscle into a greater reaction, so they'll actually make themselves worse if they don't strain any tendon ends. The effect really... really, it needs to be integrated in their training because what tends to happen is people don't want to stop the cycle of the run. They just want to do the whole 10K. In the training phase, they're going to be better to stop and actually do their stretches, perhaps activation exercises. This one could be one of them if they can lie down in the fields like that, but this could be one. We're going to go into another version of this to make the leg work even better in a sec.

Comparing the two sides is good to start with. What we'll also do now is palpate the lumbar spine because what I want to try and do... Just keep the arms just on the belly for now. Just going to put the hand under the lumbar spine. What we're trying to do, it's a couple of things here. We're trying to look at the engagement of the erector spinae. First, we're going to go on this side, and we're going to do the leg lift, straight and tight, to see how much engagement there is with the muscles and whether they're actually able to fix my hand down.

If they can't at any level between upper lumbar and lower lumber, those are areas which are not as functional. Now, it could be spinal if we just go... That's great. We can see where there's a limit of tension being created because you can't recruit, perhaps because of training habits, those muscles, or sitting habits or bad posture. If we just get the fingers just into the spinal area, we actually palpate the spinal function doing exactly the same. We can

start to see where if you like the ripple effect is even and flowing between the lumbosacral joint and above.

SB: At what point do you expect to feel it?

RL: Well it should be one, two, three, four, five or five, four, three, two, one, in fact. If it isn't, then that's an area that we know is not very happy or not very functional. It may correlate to what you've seen standing up, and it probably should, but it may not.

What we then add in, apart from the other side, which we'll come on to, is we're going to use the arm position because thinking of the postural compromises we saw in the standing images... Can you put your arms up above your head? If you are particularly kyphosed, as in curved, we probably want to lift the arms slightly higher to reduce that curvature in a recumbent position. Then we do exactly the same. Now, you're going to extend... You are extending lumbar spine by more, but with that tension created up here, let's just see now whether you can actually work that better. Actually, it is much harder because you're so stiff in your upper body.

C: Absolutely.

RL: What we're going to do now to help that is actually to use your breath, which we haven't done yet. Actually, we're going to use an expiration to flatten and use your diaphragm to actually push that upper lumbar spine down.

C: So exhale on the-

RL: Exhale through the entire up movement. Starting at the beginning, and breathing in first, and then breathing out with that lift, so pressing down with the lift, pressing down, pressing down, pressing down, pressing down, pressing down. That engages the lumbar spine, and it engages a lot more muscles. And down. Actually, just straighten your elbows out because they're just bent. Just straighten it. That's, really... lock them out. Yeah. That's a way-

SB: Why doesn't it have an effect?

RL: You're actually recruiting more muscles in the crura of the diaphragm, so you're actually getting the L1-2 working differently, so engaging that different will get the whole lumbar spine working strong. You can feel it, I mean, palpating that, and you could, I think, feel that as well, Charlie. Yeah?

C: Absolutely. Yeah.

RL: You can feel that straight away. You actually feel the difference in the recruitment. Now, if you go a little closer with the arms and push a bit longer just to a slightly more engaged. Again, let me just come into here, and again-

C: Same breathing?

RL: Same breathing out as you lift. So down, and lifting that leg. Pressing the back down a little bit just as you... Yeah, and that's an even stronger in engagement as well. Just let it go. Great. Okay. There's some use of information there, especially if you're rehabbing someone in some detail. Doesn't rely on pain. It relies completely on function and actually palpation.

SB: We have a question from Martin. Martin's asked, "Why you took his pillow away?"

RL: Well-

SB: Doesn't it affect the task?

RL: Sorry?

SB: Doesn't it affect the task?

RL: Well, for the straight leg raise or for this part.

SB: When you took it away at the beginning for the straight leg raise.

RL: Because, again, if I was treating someone more kyphosed, I would have to look at how kyphosed they are, and I would normally take the pillow out to a degree. If they're very kyphosed, we're going to have to leave the pillow in, but for you, because you're flexible enough, I've taken the pillow out.

SB: Doesn't help that we don't have the nose hole in.

RL: Well, indeed. You're okay with that. Yeah?

C: Yeah. Absolutely.

RL: We won't necessarily repeat the other side, but we would palpate and see the different levels between all of those number joints and to see sequential flow movement.

SB: Like so many things. What you've implied here is that this is a diagnostic tool, but it's also an exercise for him as well.

RL: It becomes an exercise, a focusing tool, and if, for example, he can't achieve what we've been talking about, then that will be an area for me to target for treatment, whether it's manipulation or functional active release. We'll look at that in a minute, but there's other techniques we might apply to actually make that work better. The concept is really to make exercise at home work better for the patient by targeting the treatment appropriately and really appropriately for the individual.

SB: As we know, Charlie doesn't actually have a problem, but you've diagnosed that... you've demonstrated that-

RL: Well, there's a few-

SB: ... there are imbalances there.

RL: Indeed, there are imbalances in things that actually you or any other osteopath or anyone palpate. I could show them straight away, and the patient corroborates it very easily, which is why I enjoy the technique because me thinking it might be the case, and someone else can't palpate that, or particularly the patient can't get it, we're losing-

SB: In the absence-

RL: ... we're losing-

SB: In the absence of any symptoms, would you still be saying to them, "Next time you go for one of you hundred mile cycle ride, you've got to get out for 50 miles and do these exercises."

RL: Yeah, or do them at home before you go or something. There's a bit of a, I could say, a methodology and a management approach to that rather than kind of leaving it a little bit open to any exercise will do. Bit more prescriptive.

SB: Right on.

RL: Yeah. We're going to do the hip girdle excursions. This is slightly different again, and it's looking very much at actually using the hip girdle muscles and indeed relating to the balance between... and this happens a lot, adductor strains are very common. We're looking at the balance between the external rotators, the hip, and if you like, the internal and adopter muscles at the same time.

Now, the hip exam, if someone had an arthritic hip, that would be an interesting overlay to look at this, but we'll look just at... Charlie is healthy and able to actually lift, and we're going to do circumductions of the hip in two different directions. What's interesting about this, apart from comparing right and left, we spoke earlier about the muscle chains. You've got the upper and lower body. You've also got the right or left body.

SB: Tell you-

RL: So-

SB: ... what, before you start, I'm getting very nervous about your radio pack.

RL: So am I.

SB: Would you like to put it in a pocket or clip it through a belt or something-

RL: Yes.

SB: ... rather than we risk the-.

RL: I was getting slightly nervous this is where I- Yeah, thank you. Much better. What we've got here is we're going to do the leg raise, and we're going to do internal and external circumductions. Now, the hip girdle is interesting. Like the shoulder, you've got a certain excursion range that is... well, what you... normal, but the important point about this is not the range so much as the quality of the circumduction circle.

What I'm going to look at and what I would advocate is a useful way to address these issues with hip girdle is to actually look at how. If you just lift your leg, keeping the vertical on the big toe, and now you're going to go out to the side keeping the big toe vertical. That's it. Lovely, and round. Now, if you have a look at where the abs even kick in in this, they're quite different as they're trying to balance that movement. Just do that one more time with that leg.

SB: When you say big toe vertical, do you mean-

RL: Well, it's just because the hip girdle on this side, we know it's a little bit stiffer. He's trying to actually relieve tension-

SB: Oh, I see. Right.

RL: ... by external rotating, so I'm actually making him, if he can do it, and it depends how stiff and how his hip is, but if he can mechanically do this, we're going to maximize his potential. If there's a joint issue, then that may be something else in the way-

SB: From a therapist's point of view, what we're saying is don't externally rotate the hip up.

RL: Indeed, indeed, if you can help it. Again, just try that again. Up and out. Up and out. Keep going. Keep going. Nice, circular circle if you're able. Now, what you'll tend to trace it is you get a hexagon, where you get a triangle, where you get some of the shape to the base of that cone, which isn't a cone, so you end up with a very different shape. That's actually quite easy because that actually helps me work out where we need to treat to recruit the muscles more completely to get a better arc.

SB: To me, it looked a little bit as though Charlie was a bit wobbly coming back to the starting position. What's that telling you?

RL: Well, he's carrying the weight on the front of the leg. If you watch also the abs, whether they twitch and how they're working, which ones are recruiting, if we compare that to the other sides of the same up and out, up and out, and just have a little look at the other side, that's actually quite a different circle just without the external rotation. Yeah. It's fine. It's fine. We're using terms, but we went through this just once before, but so that's actually limited in range, but a better circle. What we then compare is how the muscles recruit... and you felt that?

C: Less abs.

RL: Less abs.

C: Less abs. Yeah.

RL: Right. Okay. So if you could now recruit everything in the opposite direction, and it's quite weird in terms of gait and how people walk, this is almost simulating the way, in a sense, you might recruit muscles for walking. Just compare that just one more time on that side. What you then do... Again, the muscles are struggling up here quite a lot. And down, and now do the same leg in the opposite direction, so you're going to up and out. Yep, so we're going to get that... So now, the same... Sorry.

C: Sorry. Sorry.

RL: Just so we can see because I think... Okay. Okay. Just bring that in and around. Okay. Let's do... Yeah. Okay. Now, we can see how much roll is happening in the torso as well.

C: Absolutely.

RL: If you just put the arms in the air, just to amplify that a little bit and try and do the same with the leg.

C: Same-

RL: Same leg.

C: Same leg?

RL: Right leg. Yeah. You can see how much rotation is coming through here. Quite a lot to achieve that movement. If we go the... Same leg, but the opposite direction. Big toe in a bit. Yep. This way. That's it. That, is that an easier option than the other way round, which is the-

C: I would say so. The leg feels heavy on the descent.

RL: Right. Okay, so just try this leg again, arms up and straight if you can in both directions, so going to go up, keeping the big toe. Yep. A big roll there. Yep. Down again, and again, controlled, and try the opposite direction. We can start to see also how much lumber engagement there is as well. We can even palpate the difference, and you can feel how much roll there is and how that feels.

C: Absolutely.

RL: How did it feel to you?

C: If it felt to me like the glute med on the almost upstroke on the second time around was activating a lot more than coming back down-

RL: Then it had back down.

C: ... but feels heavier on an upstroke than it does on the downstroke.

RL: On the downstroke. As the muscle is what I'm calling de-contracting, the control of de-contracting as an active process, and actually is finding that really difficult. A lot of people-

SB: Is that we call eccentric contractions?

RL: No. No, in fact. Well, yes, I suppose it is because it's got the loading and it's actually gradually letting it go, so that control is not ideal. With the way you may be striding and running, we could watch a running machine, but the problem with running machines, as you, I'm sure, have all seen how they work, it's a few minutes on a running machine, not at a point of fatigue. If I watched you at 10K on a running machine, that would be a totally different argument than watching someone after five minutes on a running machine, especially if they fit in can run 10K.

A lot of the inferences that are made for sports shoes can actually be made on a very short observation of someone who isn't fatigued yet. The fatigue patterns are part of what we're looking at here. How do you control the muscles? How do you fatigue in certain cycles of movement? That's very telling in sports people that I treat and very useful to actually work out how to give them remedial exercise or what to treat.

I mean, Charlie can actually correct them because he's got the strength if we kind of get the mind and body engaged properly, and that's a useful training. People who are much stiffer or have got pathologies in joints, that becomes much harder for them to recruit, and we think of different ways of approaching things.

C: Is it worth... Just a quick question. Is it worth doing the exercises after the training to recruit the tight muscle groups?

RL: On the days off is when I'd be doing it.

C: On the days off.

RL: Yeah. This would be remedial. This would be the sort of thing that you'd be doing on a day off when you're not exercising properly. Might make probably swimming and other off weight bearing exercise, bear in mind the compression in this is nil because you're lying down, and that's why it's very therapeutic and useful because it's not like doing loads of squats or doing heavy weight bearing exercise, which just provokes things.

SB: The obvious question is then how many times, how often?

RL: Well, in terms of reps, you're going to look at the quality deterioration. What I look at is left and right, work out whether in or out is the most useful, looking mostly whether the actual circumduction is irregular, and it could be the two legs are going in two different directions when you do it, not at the same time. One may be internal, one may be external to achieve that change in balance of muscles. You can do them until you begin to fatigue but you're not losing quality, so really, the number of reps we would go through and say, well if it's 20 or 15, once you start deviating from quality, then there's no point doing more.

SB: Your average normal sporting patient will recognize when that quality is disappearing, right?

RL: Yes.

SB: So if-

RL: Yeah. Well, part of the dialogue is training someone to understand the process, and that's what I enjoy. That's what stimulates me to do what I do, really.

SB: Yeah, sure.

RL: That's some of what we were going to look at. I think we've... Do you have any other immediate questions?

SB: Well, no, I've got lots of questions, but I don't want to interrupt your flow-

RL: Okay, well, let's do the side bit. Can we do the sideline-

C: Absolutely.

RL: ... version of events. Yes, so face this way. Thanks. I'll give you the pillow for this because I'm helpful. Put your head down. Good. Now, I'll give you the setup for this because obviously you can't get the extension of the hip doing

all the other things we just looked at, and we can't get the lumbar spine fully engaged because we haven't got that movement lying on the back. What we're going to do is setting the arms first, which may sound strange, is we're going to put the arm in I call it a prayer position, elbows locks together, which becomes important later. Most people think, "I've got that," but actually it becomes very important to balancing the core aspects of this. Elbows together. Hands together. Using a pillow always.

SB: Right angles.

RL: Right angles at the top. Yeah. What we do is bring the-

SB: Get out of your way.

RL: ... bottom... Thank you. Bring the bottom knee up to a 90 degree flexion with a 90 degree bend on the ankle as well, so the leg is basically locked in that position if it's happy to go that far. Depends on the hip or the other hip. What we're going to do is bring the leg up into the air so you're activating all of these groups of muscles, including some of the lumbar spine, and curling the foot. Now, this for someone with acute sciatica would not be the way to start, so we will assume sciatica and do this with a bent knee.

Now, obviously, if there were a pathology in the spine that we found earlier, this may be also difficult, but it may be very possible to do so. I just want to try keeping the elbows together, which you see they do rise because the tension is there straight away. I want you to use that knee movement on a breath out without any sort of roll in the hips, so keeping it very much in line with the rest of the body.

SB: When you said curling the foot earlier on, did you mean-

RL: Dorsiflexing.

SB: Dorsiflexion ankle.

RL: Yeah, I didn't... Yeah, to the patient-

SB: Indeed, but I just want to make sure the audience knew.

RL: Meeting the two together. Yes. So bringing the leg behind you, using that a little bit of height we have to make sure these glutes are engaged, and just bringing that leg back, and keeping that, if you can. I'm going to guide you initially, but you're doing the work into extension.

Now, depending on how much tightness is the other leg, that may be a limitation. Just holding that for a second for the point of view of the palpation aspect of it, what we're actually going to do is get into here and actually start to palpate the joints and also the musculature engagement. Just

bring that knee towards me. We can start again in the same way that we did before palpating that flexion. We're now doing this in sideline and actually get the extension, so going back out again.

If we use the breath, again, it's increasing the amount of... well, it makes space certainly breathing out to bring the knee higher. Just keep the elbowstogether. Push the leg behind you a little further. Great. Okay, and bring that forward. This could become therapeutic. It could become treatment. It could become an examination.

SB: It's going to be very hard for a little old lady.

RL: Believe or not, not, and they love it. I'll tell you why, because people who've had... No, I say they love it. When they've actually had hip replacements that haven't really given the full range of movement back or planning on a hip replacement or might one day have a hip replacement, it's very useful exercise for that hip excursion experience, and when they see results very quickly, they are very engaged with it. They just love it.

C: Why can I feel it on the other side?

RL: Well, because of the tension in there, again, between the two hip girdles. You may have to just ease that bottom one up a little to take the tension off.

SB: I don't know if the question got out there. The problem was you can feel the strain on the opposite angle?

RL: On the opposite.

C: On the opposite side, absolutely.

RL: Well, again, the tension difference we know in that quad is tighter. I'm hoping the other way around, you wouldn't feel it. We're doing lots of examinations here. We may have already decided to treat that quad and that adductor and do something before we even got this far. But for the sake of the demonstration, that's what we're doing.

C: Absolutely.

RL: Again, communicating-

C: You can feel a lot of engagement.

RL: You can feel a lot of engagement there and obviously we don't want you to feel pain, so we'll take that knee just slightly off your flexion. That's that. Now, what we're going to do now, it's similar, but we're going to do that with a straight leg. Now, this is very useful actually, even in hypermobile patients, let alone restricted patients or even sciatic patients because you really can

allow, if they're hyper mobile in their lumbar spine, to actually get more movement.

Now, actually, in about, I think the straight leg raising test I was reading just up again today in hypermobile lumber spines actually is very ineffective because there's so much movement in the spine, but this engagement is incredibly powerful. We don't hold it for this long because I'm talking, and you bring that leg nicely backwards, but without the elbow separating. You've got to keep those together.

SB: So-

RL: Knee straight. Knee straight. That's great. Okay.

SB: Run that past me again. The straight leg raising test is, as it says, a test. Now, are you testing for exactly the same things in this position in a hypermobile spine-

RL: Exactly.

SB: ... so the ranges of motion would be similar to those on the diagram that we haven't shown anybody yet?

RL: Yes, yes. I mean, but you're also getting an extension to see, A, if there's any compression, and B, really to see really how the quads and hamstrings are balanced or not balanced with the pelvis. You can actually see that very quickly. You can feel when there's a block that the elbows that we keep talking about start to separate because actually you're starting to rotate, which we're going to stop you doing, to make more range of movement. You lift that elbow, you'll immediately start to rotate back further, and we don't want you to. We want to see-

Yeah, and also, if you're over-engaging your core, and I'm not into the core exercise thing, but if you're over-engaging or overusing it in your psoas and so on to do deep exercises, you start limiting, you hip range, so that isn't a great thing.

SB: Good old Charlie you came in here thinking he was perfectly healthy and fit and-

RL: Well, we're dissecting... I'm breaking it down into tips, hopefully, that he can use for his own benefit so-

C: Absolutely.

RL: ... that'd be good. Basically, that's the excursion range going in both directions, forwards and back, bent knee if there is some sciatica, straight leg when things have moved forward a bit further in a sense where you've

started to treat or maybe even session one or two or three... two or three... and that straight leg movement is safe to do as long as you're not provoking literal sciatic symptoms. We can do the other side if you want, or do you want to do questions, or what would you like to do because the opposite side-

SB: Well, let's ask a few questions, and you can have a rest for a minute. I think you're-

RL: Yeah, thank you. Thank you. Thank you.

SB: ... getting tired by now.

RL: Wander over.

SB: We will be back. I've got quite a few that have come through actually when we were over there. Not all directly related to that. Some rather abusive one saying that that nasty picture we showed, they weren't sure if it was patients or whether it was us that they were seeing on the screen with all those swaybacks and so on.

RL: Oh, I see.

SB: We get a funny sort of viewer watching this certainly. Somebody who hasn't given their name asks about placebo and says, "Even if it's a placebo effect, why is it a bad thing to give patients something like Tens because the placebo effect,"-

RL: Well, I'm not against it. I mean, the NICE guidelines, because it says what it says. I think if you're an experienced practitioner and you're suggesting something and there's a relief from it, then there's certainly... I mean, if there are negatives to it that actually promote other problems, that's another matter.

SB: Because we're not here to talk about Tens or about placebo, but we've done several broadcasts with Tim Watson on electrotherapy. We also did one with Jeremy Howick on the placebo effect, and so there's quite a lot of information in those about the benefits of placebo, and there's not much we can do about the NICE guidelines in the short term. Maybe they'll change.

Danielli. Danielli's one of our favourite questioners. "Sciatic is a symptom," says Danielli, and he says, "This constant reference to sciatica creates an issue of nothing but hassle. I'm constantly finding myself having to explain to patients who've been told primarily by GPs that they have," in inverted commas, "sciatica." Danielli always writes long questions.

RL: Yeah, that's good.

SB: "That's so-called sciatica is a symptom and not strictly speaking a condition. They usually get something that resembles a laugh when I tell them they've gone to the GP saying, 'Hey, you, I've got pain down the back of my leg,' and the GP confirming it says, 'Yes, you've got sciatica,' the thing that they simply tell you the same thing back-“

RL: Sciatica isn't- I've heard it all.

SB: Oh, so Danielli's just making the observation that it doesn't actually tell-

RL: Totally. Totally. I mean-

SB: ... them what's causing the symptoms.

RL: ... we call this session sciatica, we gave it a headline. I'm glad some people are finding questions to ask. I think the point is, it's dissecting that down as we've done and explored it and broken it down into other components because that's what it is, and that's how I'd like to think lots of people would approach the problem.

SB: Quite unrelated. Sally Matthew says, "The couch!" with an exclamation mark. "What make is the portable bench, please?" Apparently, Claire's already told her what the bench is, but for other people, it's a bench that we sell through the Academy to our members. We don't make any profit. I think we make a quid on it or something to make sure that we lose out in the admin, but they are brilliant couches. They're a bit heavier than wooden ones, but, my god, they're robust as I'm sure you will-

RL: No, that's fine. Yeah.

SB: ... bear me on that. If you need any more information, then just give us a ring. Happy to tell you about those. Lucy Osborne-Kirby says, "Stretching," she's heard that cold stretching is detrimental, and it's best, as you've just said, it's best to stretch after exercise. Are you-

RL: Or early into, the beginning of.

SB: Or early into the exercise. Yeah. Do you have a reference for that?

RL: I could dig one out. I did actually do some research on a paper that was written comparing a lot of the research on stretching, and someone compose that and put that together. I can let you know. I can't... I just can't-

SB: Claire, we will-

RL: ... remember off the top of my head.

SB: Once we get to them-

RL: Yeah, there is. It was used for-

SB: ... we will post that reference. We'll send you the reference, Lucy. We will also post it on the recording page with the other information that's going out later today. I don't know. Somebody who hasn't given their name asks about flossing. What's your view on sciatic nerve flossing?

RL: Well-

SB: It's very à la mode at the moment, isn't it?

RL: Yeah. Well, you know what, I think, again, if it becomes localized to one tissue, I think that that's not the way I'm approaching this. I think if it was just one tissue, well, that could be a different approach that I would use.

SB: Do you use flossing as a component in any of this?

RL: No.

SB: No?

RL: No.

SB: Okay. Last question that's coming in at the moment, Jason is just making an observation I think here about those lumbar extension at that cobra pose that we saw. He says he doesn't think he's exaggerating to say that at least 90% of the patients he's treated who've been seen by other therapists prescribing exercises for lower back pain or sciatica have been given lumbar extension or cobra pose exercises, and it always seems common sense to him to avoid that irritation, as you said.

RL: Well, unfortunately, as I said, it's still out there, and it's still used. It's almost like the guidelines say what they say, but the revision of how people are thinking about rehab exercise doesn't seem to have moved on quite enough. When I rehab, the stretching exercises, and there's rehabilitation exercises, and there's remedial exercises. I think they're all quite different.

SB: Yeah. I think when I... I don't know what your training was like when you went through the BSO, but I don't believe that we got very much as osteopaths in the way of education about rehab exercises. I'm not sure how much people even mentioned it. It might've been sort of-

RL: It was more by accident rather than on purpose at times. I taught a clinical rehab course for three years at the BSO sometime ago and wrote a lot of material. I think it was also getting people to, I say dissect again, I keep using that word, but look at yoga and Pilates and actually break it down, not just say, "It's the answer," but it has to be for the individual. Even those well-established types of exercise that are often given out I know by osteopaths, it

still has to be exactly what the individual needs, and I think there are limits. I know some osteopaths trained as Pilates teachers, and I know people who've done other courses to bring that in-

SB: And vice versa.

RL: ... but as you say at the beginning, at the beginning it was very... there was little of it, and actually, some people state that is still not a major part of the course material.

SB: Yeah, lots of people would say that it's a big mistake, almost a red flag to indulge in prescriptive treatments. "You got this condition, this is your box of exercises or this is the array of HVTs," or whatever that I do, and I kind of get the impression that exercises do very much fall into that packet.

RL: They can.

SB: There's a list. "This is what we do for sciatica." You go in-

RL: They can. They can.

SB: ... and take these. I have to say, I have not seen any of those exercises before that you've been doing or exercises, examinations-

RL: Well, yeah, examination, and they turn into remedial work, so you kind of... When I say remedial as against rehabilitative, they're slightly different concepts. You're looking at people doing exercises that are not replicating necessarily exactly real life, and you actually get exercises that actually replicate functional exercise in real life, so the problem is actually why I think patients sometimes lose it is that doing a, for example, a shoulder exercise that isn't actually really connected to what they need to do, like putting the kettle on or whatever, then loses some of the purpose in minds about why they're doing them. It's easier to do something that actually connects to what you need.

SB: Charlie might say that he doesn't often lie on his side lifting his leg, the right-angle bend-

RL: Indeed.

SB: ... at the knee and hip-

RL: Indeed.

SB: ... and that's not-

RL: True.

SB: ... a directly functional exercise-

RL: No, no.

SB: ... in terms of what you

RL: ... but that would be remedial to start with.

SB: Yes.

RL: So in that sense, that would be okay. We'd then move, if, depending on the case, you'd actually start doing... I've got a whole list of other ones I'd do to actually move things forwards in different ways. This is more examination into remedial. If we were looking at rehabilitation, you'd take things on to weightbearing, for example.

A lot of the stuff I do off weightbearing is very much when someone's more acute. And as we said at the beginning, bending forwards hurts. So you're not going to do lots of standing weightbearing squats or anything. You need to do stuff that's off weightbearing that enables people to feel positive that they can do something, even though it may hurt a bit. But they can do something that isn't going to make it actually worse.

SB: We've had another observation about the cobra exercise. This person says that he or she has often been told when doing the cobra thing that it's about extension, lengthening the spine rather than overextending, which doesn't move the posterior joints. I've always struggled with this concept of extending the spine. I'm not quite sure how I extend my spine.

RL: Well, you know-

SB: Other than by handing from something.

RL: Well, if you're decorating a ceiling or something, where your actual... You're doing it-

SB: Sorry, did I say extend? I meant lengthen.

RL: Oh, sorry. Okay. You said extension.

SB: How do you lengthen? Right.

RL: So lengthen the spine. Well, again, that's perhaps a mental exercise rather than a physical exercise. I think people do overcorrect their posture. So in other words, they actually sit up too much. They don't use the seat properly, because they feel, can I say, holier than thou that they're actually sitting up straighter and actually holding that posture, which actually gets very fatiguing.

SB: Yes.

RL: So using a chair properly is a better option.

SB: Here's one from Michelle. Michelle J. Cheatley, I'm told. She says, oh, "The NICE guideline's out of date." I think they're the latest revision-

RL: They're the latest revision, yeah.

SB: This says they are November 2016, which is pretty recent for the NHS, I think.

RL: Yeah. They reviewed them... Yeah. That, I think, is the latest version. The one before that was a few years before that. If you actually look on any of the NHS websites, they now have review dates. So I daresay there will be one for this, that they'll look at it again in eight years' time.

SB: Certainly. This came from the NHS website.

RL: Right, okay.

SB: Unless there's a link that goes to out-of-date guidelines, which I'd be very surprised by.

RL: No, but all of the stuff on the NHS website will have that little date that says "reviewed in" or "will be reviewed in 2022" or whatever they... Yeah. So it's on the site.

SB: So the answer is, possibly, they may not be completely accurate, but they are...

RL: What's in date.

SB: In date, as released. Again an anonymous contributor says that they've trained as a British Wheel of Yoga teacher, which doesn't mean much to me. But they're also a chiropractor, and they were taught the cobra pose should not be conducted if any pain is felt in the lumbers, and modify to sphinx. I don't know what the sphinx is. I thought that was the sphinx.

RL: I don't know the nuance of the sphinx, but, yeah. Yeah. And it's also whether you actually translate that into a bigger movement. So you actually would go up onto the arms and actually change that as well. So you can take that a step further.

SB: But it's interesting we've got this one, because it's from someone who is a yoga teacher, which is very helpful because they've got far greater knowledge about-

RL: Treating yoga teachers is a very interesting phenomenon, and even Pilates teachers, because I think they're taught in a particular fashion. They're very expert at that. But the trouble is breaking that down again, they feel a little... Sometimes it's quite difficult to go and see someone like an osteopath who has another way into the way they've been thinking. So that's, yeah.

SB: Yeah. This person actually is a chiropractor, as I said. They said that, in this exercise, they were taught the cobra should not be conducted with any pain in the lumbers. The emphasis should be on extension through the thoracics and the aim to strengthen the upper paraspinals.

RL: Agreed, agreed. If people can do that with the coaching. I think probably they'll watch the video somewhere and copy it; they may actually make themselves worse. That's the problem.

SB: Sally Matthews. So are we saying that McKenzie repeated range of motion to a position of comfort is no longer recommended? Because that would be when I'd recommend extension, if it was a patient's position of comfort.

RL: Well, okay. I'm not going to make a statement about that. The McKenzie book's been out a long time. It's still distributed around. And so, that's up to the practitioner to assess the patient. That goes down all the time, is giving out necessarily a handout or giving out something that's printed or set. Perhaps there's always something for discussion-

SB: Do you know that's what I have a problem with? With the evidence-based approach that the NHS has to take, that they're looking for a single answer to something that they can call a single problem.

RL: If they can.

SB: I suppose they're trying to give guidelines to lots of practitioners and experts.

RL: There's a lot of change in that, from the sort of top-down, to actually look at modifying that approach, I think. It's a desired way to make individualized care come in. And I think that that generally is where things are headed, but it's a bit of a way off yet, in terms of the general NHS structure. Osteopaths, I think, have always done it. And chiropractors perhaps as well in some cases. But I know that, generally, it is like a tablet. You want to make sure that that tablet doesn't do too much harm and hopefully hits the nail on the head for a particular condition. Same with some exercises.

SB: Another anonymous contributor wants to know whether/how often you come across piriformis syndrome, which has been misdiagnosed as sciatica.

RL: Sometimes.

SB: Yeah?

RL: Yeah, yeah. Sometimes. It is the thing that I was taught when I studied. But I think looking at it, we looked at the external rotation of Charlie's hip, and we looked at how that works. So, yeah, there is a component of piriformis in lots of people with sciatica. Again, I don't want to make it the only issue. I don't want to nebulize everything into everything's everything, but the truth is, it may well be multiple components. Bit of lumbar spine, bit of hip girdle, and other muscle groups.

SB: Okay. He's also asked whether you have any thoughts about SI joints contributing to LS dysfunction and discal issues.

RL: Well, again, how much instability is in sacroiliac joints is a big conversation amongst lots of people. But obviously, if there is huge instability and overstrain, and even actually when people have been doing excessive stretching to try and ease the pain as they see it, whether it's sciatica or whatever they've decided to call it, then they can overstrain structures and ligaments that are supporting all parts of the pelvis and sacrum as well. So that sacroiliac element could come and often does. I've treated lots of martial arts people who stretch and stretch and stretch really extremely to the point where in fact they are overstraining, and they're actually adding in other issues in their, can I say, desperate attempt to get better.

SB: Okay. One final observation before we perhaps go back to Charlie, because we're going to run out of time if we don't. Jason just says that if the cobra is done properly, then the elbows are behind the shoulder joints, which lifts the body upward and forward instead of just compressing, which is probably very helpful.

RL: Yeah, you know. Doing it properly is important.

SB: Let's talk a bit more about Charlie, then. He's a chap who's come in to see you. You've found what you found today. He doesn't have any symptoms to complain about.

RL: Yep. Yep.

SB: Would you expect his performance as a top-end cyclist to improve if he manages to overcome the things you found?

RL: There's two measures. There's performance, and there's lack of injury. Or reduction in injury rate. Okay? I actually worked with a team, funny enough, someone in Germany I was talking to who ran an athletics team, and they looked at lots of these aspects between... And they've got measurables. That's the thing when you actually do performance sports of some sort. So that's quite interesting.

And actually, I remember in the paralympics there was a huge change in all the paralympians who'd actually had very little input before, and had

osteopaths and others to help. And for the first time, they were getting not just increments of microseconds more, they were getting a huge change in their performance. So performance change is one thing. Training change and advice might be better, because it's going to lead to less injury and more performance as well. So, for example, if you ran or you did cycling and you want to mix that with swimming or weight training, what would be the best combo to get you the best out of your body?

And the other factor is also, as we discussed it with Charlie earlier, was actually a little bit as I was looking at him, I said, "What else are you doing workwise at the moment?" And I could feel that the way he was using his shoulder there on the right side seemed very different and his upper thorax very stiff. And he's been utilizing in loads of heavy lifting and building work. So that goes with "how well does that mix" with, for example, cycling? So if you're kyphosed frozen stiff, being on a bike, doing head down, long distance, even on practice runs, he's going to start to build up tension.

SB: You've got some more things you want to demonstrate on Charlie, haven't you? You were going to do a standing exam on him.

RL: We did that at the beginning. We did the standing exam. I'm just trying to think. The adductor release, I could show you that. And this is actually one of the functional adductor release techniques. The sidelying one, we didn't go into huge detail, but that pressing down onto the QL or lat and using that leg excursion, we could have a little more look at that if you'd like to.

SB: Yeah. Okay. If you're happy to, then, sure.

RL: Yeah. Sure.

SB: Charlie, welcome the intervention?

RL: Yeah, yeah. So if you want to lie on your side again.

C: Side?

RL: Yeah, I think we'll do the same view.

C: Side here?

RL: Yeah. Okay. So basically-

C: Hands in the same position?

RL: Yeah, hands in the same position, yeah. And what we could do here, first of all, is we're going to use that knee straight position. Okay. This could become a little bit fatiguing, but it's part of what we do to get fatigue release. Yeah, so sometimes it is a matter of that. So if I just fix, for example, we were

looking at the lats on this side being quite tight, and now we're going to do that movement extending backwards. Yep. Until I can feel it in here, which I can, just. It kicks in very quickly.

And if you raise that leg up towards the ceiling this time, so this is slightly different. Just a little bit higher. A little bit higher if you can, or is that it? That's all you can do. So the adductors are, when we talk about treating the adductors, the adductors are an issue. Okay, and come forwards towards me without kicking me. So, yeah. And that's... You can feel that?

C: Yeah.

RL: Where do you feel that the most?

C: Mainly in here.

RL: Yeah.

C: Also for your core working to stop you, your elbows from-

RL: Okay. That's fine. Okay, so I'm just going to fix onto his thoracic spine. The more I fix onto here, the more it's going to get tight in the lumbar spine. Yeah, because I'm stopping him moving actually. Yeah. Okay. And back again. So this actually-

SB: What are your fingers fixing up?

RL: They're actually rib heads.

SB: Right.

RL: All the way down. Yep. Yep. You can feel that on there, can't you? Yes. Yeah, yeah. And back again. So if we can do that with a breath out. Yeah. Good. So we'd increase the function through the whole of that drag through here, up into the thoracic spine and back out again. Elbows together, sorry. That increases the tension, of course, which is why he's letting the elbows come apart and back again. Keep the knee locked if you can. That's it. And forwards again.

RL: Now, if we retested... You can see the range is going up already. If you actually rechecked, for example, the straight leg raise, active or passive, much different, isn't it?

C: Yeah, absolutely.

RL: Even the rest, I can see- Well, it's quite intense, the treatment, but it goes off very quickly. So the change, while that was quite hard work-

C: Absolutely.

RL: Was, what? A minute or two and it's gone. And you've broken down a heck of a lot of muscle tension. And you've actually increased the rib function with the breathing, if you're doing that as well, whilst you're holding onto that ribcage. So it's kind of... Yeah, it's teaching a lot of different attributes in a sense to that upper lumbar spine and into the lats as well. That's how I do achieve that on that side. We do the same possibly the other side and see the difference, and see how far the tension spreads and where we need to fix on to start to impede, to start with the leg movement.

C: Yep.

RL: Yeah. And then as we fix on it, gradually, the improvement starts to spread back up into the thoracic spine. So that's what we just did. So the same would be the other way round. If you pop onto your back for a second. What we could do, look at the adductors. Now, the adductors are a horrible place to treat because they're painful. And the groin pain can be part of it, and so on, and even with a hip dysfunction.

Bend the knee, if you would. So what we do with this, and I've sort of modified. I don't know if you can see properly from the camera point of view, but basically, the adductor belly, though people may report pain further down in the groin, is normally shortened. And a lot of people if they're doing, for example, external rotation for squats, they're starting to develop a big imbalance between the external and internal hip rotators, and the adductors and gracilis, which is right down here.

So what we do to make it slightly more tolerable, it's a little uncomfortable, but it goes quickly. You put your foot on your heel to start with, which actually kind of destabilizes the hip a bit and actually puts the treatment, instead of just being in one line, which I'm going to do what I call cross-fiber soft tissue or fixing onto the muscle belly. The way we locate that is if you come back out and just slightly out this way into adduction. And then you actually push slightly against me, going in towards the opposite direction. So we find a bite point.

Now, with the foot, having got that instability, you're getting a three-dimensional aspect to the way you're releasing that muscle. Okay? So what happens, what we call... Well, the best muscle activation is what's called multiplanar. It works in all planes, easily in all directions. Now when you see footballers practicing all their warmups, you often see them skipping sideways and doing all sorts of stuff to try and break that down and to give them all sorts of weird options to the muscle. So this is doing that as well. It's very three-dimensional.

Putting the foot onto the heel. And then, as I said, you're actually going to, oddly, I'm going to fix here but you're going to stir the foot like you're stirring the porridge into a circle. Now we're going to go in both directions, because you're going to compare which is the easier one. And you're going to find one is quite a lot harder than the other. Yeah. Tight.

C: That's the hard one.

RL: Yeah, yep. So we worked with the hard one. So we work with the most difficult circle. I fix onto the gracilis and to the adductor magnus.

SB: How uncomfortable is that?

RL: Out of 10.

C: That, I'd say, is about six.

RL: Okay.

C: Pull in this way is a whole lot more.

RL: Yep, yep. You're adducting slightly that direction. So if you pull slightly that... Yep. So there's a little bit of him adducting. I'm slightly putting the pressure on, but very little, just focusing it, and you're doing those circumductions. Okay.

Now, the interesting point about asking how much, and that's exactly how I score it, is that we work on your score out of 10, not mine. Because I can't feel it. But I can feel the tension, and you give me the score that you're going to score it, which is six.

C: Yeah.

RL: Yep. So what we then know is, when we go down from six to five to four to three to two to one, that we're getting a change. We're getting a release of that muscle. So functional, active release. And I can feel it as well. So what's interesting is I know where your score is. I can tell you your score now is two. And it's-

C: The circle becomes a lot easier.

RL: The circle becomes easier. Yeah. So the way... No, no, you're absolutely right. And thank you. So what's interesting here, and we haven't done this at all before, in fact, today.

C: No.

RL: So what's interesting is that circumduction... So if you think again about gait and rolling gait and how people are running and moving, yeah? That whole circumduction movement, if you can watch that, is actually spreading from the ankle, almost like a pumping action through into the knee. And actually, we could even use the hip in that as well to start stirring it even slightly in a bigger movement. So you're actually starting to engage even more muscles as you do that. And that could be also remedial homework. It looks like not a lot of work, but actually, if you get it quite intense and get that dorsiflexion up, it becomes harder, yeah? So if you start stirring that around, keeping quite a tight... I was going to say dorsiflexion, but quite a tight circle upwards with the foot. Yeah. Yeah. And that starts to engage the calf more, because I can see it and feel it.

SB: Yeah, yeah, yeah. Holding the knee still?

RL: Holding the knee... No, and allowing the knee to roll with the foot and ankle movement. Yeah. So you're starting to move a lot of muscle groups together. And you can try the opposite way, yeah, which is difficult. Yeah. No, it is. It is. But what you'll then find is that if we then went through some other tests, which we're not going to do today, but if we did, you'd start to feel that the whole leg movement comes freer and it's easy to engage the muscles. And the fatigue rate would drop as well. So that would be quite a useful cycle. If we did the same, the other side. So that will release quite quickly.

If we retested that sideline, it was the other leg doing the leg excursions, that would then improve that extension range and that flexion range of the whole of the hip and the whole of the leg. Yeah. So that kind of tripodal, whatever you want to call it, hip girdle going downwards, yeah. The way all those muscles attach to the pelvis and through, to the issue of tuberosity as well, coming forward, it's quite a weird one that the adductor is not so much medial but wraps around and back to the inside, the issue of tuberosity. So it's kind of a spiral almost, as it comes forward.

So it's got quite a lot of complexity and if we looked at, as we've talked about, the piriformis syndrome someone was talking about, that rotation can be fighting, in a sense, this sort of muscle tension buildup as well.

SB: Right.

RL: And can give you groin pain. A lot of people end up saying, "I've got groin pain. A lot of it's emanating from much lower down," and they don't realize it at the time. So that's another useful technique that I use a lot.

SB: So just quickly, if you were to summarize it, what can people take away from this and use directly in clinic to treat their next patient with sciatica, whether they're sporting or-

RL: Well, it's really a matter of broadening their examination. It's trying to get the patient understanding how their body is moving. It's capitalizing on some of the respiration mechanics, actually, which I really enjoy. That's actually what we're doing at Istanbul. That's going to be heavily part of the course. And it's really trying to, again, always... And it's really difficult being a practitioner when a patient is passionate, "I've got sciatica and that's what I've got," is to kind of just step away from that and keep stepped away. Take that view that, actually, this is about lots of other things.

It may be the disc is prolapsed and that's what happened, but it's a fairly rare case that there is a full prolapse that's caused it. In fact, it's probably... I think it's three out of 300. A surgeon I was talking to you sometime ago said, on scan, on referral from doctors, GPs, so 300 people referred with sciatica and disc problems, only three out of 300, 1%, are actually finding a prolapse that really is attributable to their sciatic nerve problem. So it's kind of misdiagnosed often to start with.

SB: So when someone presents to you, first of all, what are the criteria on which you would say, "No, you need to go and get scanned now"?

RL: When we've gone through these cycles and we're actually starting to provoke things quite easily and quite quickly, obviously, there's a pathology. I've seen a few, unfortunately, tumors and various things that have been missed by, unfortunately, other doctors. And it is very much then that you're actually finding everything provokes everything, and that's quite quick to tell.

Looking at their medication, actually, is also an interesting measure. So I would go into quite a lot of detail about obviously the duration and the effectiveness of the medication. So like we asked Charlie, "How much does it hurt out of 10?" I would actually ask people, and that's a useful measure, "How effective are the pills that you're taking if you're still taking them?" And if people tell me they're taking a pill that's fairly potent and it's giving them a one, a two out of 10 benefit, there's something else going on potentially that needs to be investigated.

SB: Right. Charlie, we're going to leave you now. You can get yourself dressed and relax. And we'll get back and just take a few final questions. Thank you for your contribution, Charlie.

RL: Thank you, Charlie. Yes, Thank you.

SB: Fascinating stuff, this. Robin's asked a question. Would you do these exercises before or after mobilization or manipulation if it was indicated?

RL: Okay.

SB: Or instead of, or before and after?

RL: Sometimes instead of, but actually another interesting question about scoring. I actually look at the quality of manipulation in terms of not how much pressure I'm using so much as how easily did the joint, for example, mobilize. So if I score that in my head and say, "Well, that went too easily," if I thought it was relevant, that is actually a very easy measure to find out that this is a lot more myofascial than it is joint-related.

Ideally, if I'm out before you do the manipulation, which is how I use these techniques, to work out how much is myofascial and coming from where, then that determines in a sense what I need to do next. So if I feel it's joint-related, I may will manipulate and then retest using some of these myofascial techniques to see the benefit.

SB: We have another question from an anonymous contributor. They recently had a client who was diagnosed with an L5 disc prolapse on the right by a private consultant by MRI, but his neurological symptoms are on the opposite side on the anterior thigh. The consultant offered him a nerve root injection at L5 on the left, not the level relating to the symptom, and this person advised him that the disc prolapse on the right may be an incidental finding. And actually for him symptoms were reproduced from psoas on the left and improved with exercise addressing the left psoas. Any comments from you on that?

RL: Yeah, it happens a lot. There's a lot of findings that are erroneous findings that are not definitely related to the presentation. We know that. And it happens all the time. Does that answer the question? I'm not sure it does. What was the first part of the question, sorry?

SB: The first part was the lead-up saying that the consultant had diagnosed prolapse on the opposite sides of the problem, of his nerve root injection on the wrong side.

RL: Well, you know. Again, it's hard to know without seeing the scans. What I would say is always, always, always, my tip is see the scan and the report. And what you tend to find is that the reports are harder to find, because the medical legal document is the report. The scan can be done by anybody, and there's no inference-

SB: So you're not talking about the radiologist report.

RL: Yeah.

SB: Oh, okay. They're usually fairly short, aren't they?

RL: Depends. Some of them are longer, and some of them are better and shorter and more in-depth. But actually, that's the kind of, if you say, inference knife. The person has seen a consultant. The letter you often get to see is the consultant's interpretation of the scan and the report from the radiology.

SB: Yes.

RL: Yeah. So if you really want to see what's really going on as the osteopath in this, or the other practitioner in this, you need to see the report. And then that kind of helps you when you look at the scan to see whether they correlate properly in your head or not. Because the inferences by the consultant may be completely different again. And his decision of what to do, therefore, is different again.

SB: Okay. We've got a few minutes to cover a few more things. Diana Rowlands has said that you started by talking about sciatica initiating in the lumbars or as a traction sciatica. Is this active release aimed to release sites of tethering throughout the lower extremity, or aimed at improving general recruitment and function with the idea that that will resolve the sciatica as a byproduct?

RL: All of those. Both.

SB: Good. The follow-on for that is you've given us a snapshot of what you do.

RL: Yeah, yeah, there's a bit more to this, but, yes.

SB: And you don't run formal courses at the moment, you said. So how do people learn more about this?

RL: No. What happens, I used to run quite a few in London and I get invited, if you like, by places, like in Holland and in Germany, and now in Turkey. And in the UK as well. So I've done groups in Northern counties, for example. I did a course up there. So people will say, "Come and talk to us," and that's how it goes these days. I think it's just easier that way. I think you've got to request for me to come here, from someone.

SB: It was from me, wasn't it?

RL: I don't know. I don't know. Oh, thank you.

SB: No, when I set up-

RL: But I don't know-

SB: I didn't realize that you would do that sort of small group consultation. We can get you into a clinic and do a day of CPD, for example, and learn more about what

RL: Yeah, I think small groups, what people have said in the feedback is... I've got quite a lot on YouTube with feedback from osteopaths all over the place, and it's been great, that they've even put it on their websites. They've done the course with me and actually happy to say so, so that's really nice. But I think

the big thing is getting the feedback, using it in practice. It's quite lovely to have that happening. Yeah.

SB: I mentioned to you earlier on, actually, that we've got a small team of people who are answering, handling the questions and dealing with everything else that goes on. And Claire has just sent in that they've had some really interesting questions and comments tonight, but they've been so busy dealing with all of that, they've not been able to watch it. So could you just go through it all again?

RL: Okay.

SB: It is, of course, going to be recorded.

RL: Yeah, yeah, yeah. Absolutely.

SB: Even Claire knows that. Someone else has just said, "It's so nice to hear you to talking about different sorts of exercises. I've always thought they were different, but not many people actually distinguish between them."

RL: Okay.

SB: That's good?

RL: Yeah, I'm happy.

SB: And obviously, we're getting other feedback, which I'm not-

RL: It's not trying to be different for different's sake. I think the point is I've investigated, explored, and run these ideas with lots of groups and lots of osteopaths as well around the country. And, actually, chiropractors and Pilates teachers and a few other people who've come. And it's been really intense. I like to get from the presentation that I'm giving a lot back from the others in the group. That's more-

SB: We have a Pilates teacher who comes in here and does regular lunchtime shows and exercises which might be helpful for this, this, or this. And I know she'd be fascinated to come and do this sort of thing as well. She's very knowledgeable. She's part of the orthopedic consultants CPD group that we're also part of as well. Very good. I suppose, first, I should reassure people that everything that we've done is recorded. It'll be up on the website. Your original presentation will be up on the website. The NICE guidelines. We didn't talk about the FABER test, did we?

RL: No.

SB: But the document that-

RL: Well, some hip checking depending on whether it's arthrosed and so on and so forth, I put that in because I thought it was important to balance the whole hip-leg function in. Because everything is multifactor in the end.

SB: That's actually part of the presentation, which is downloadable, for looking at that.

RL: Yeah. There's a few things.

SB: There's also the related paper on the FABER test that they can download as well.

RL: Yes.

SB: So there's lots of stuff there. And I've also put your contact details on the site.

RL: Thank you.

SB: So your website, your email, your Twitter, your LinkedIn handles or whatever they're called.

RL: All of that. Yeah, there were-

SB: Some of these people are interested in doing some training with you, or for you to come train them.

RL: Well, if they can get a group together. Obviously, it's time out of practice. I need to do that, and I enjoy doing it. So it's not a problem. People do, as I said, book and get a group, and then we go into it.

SB: What size group is ideal for you?

RL: Well, it's interesting. That's come up. That was actually what I was about to say earlier, is that actually, people like the hands-on. They want the intensity and what I'm giving them one-to-one. We've done groups of 36, that's too many, in Germany and places. Actually, I think in Northern counties it was like 45 people. Slightly different topic, thoracic outlet, but still a big group. So to get the practical and to get the practice, I think, 10 is a good number in a group. And they work well together. I think that's quite a nice number. 10 to 12, rather than more. But, yeah.

SB: And if people are going to do that sort of course and they want to get you in to do it, do they need a facility where they can put five separate treatment tables out for 10 practitioners? Or is it okay to have you demonstrating one, then they will disappear off to different rooms and practice? Or...?

RL: No, I think it's useful together, because we change round a lot. So what we try and do is have different students or whoever they are mixing it around and checking different people's bodies. The whole thing is they need to experience through their palpation. It's quite easy palpation and building the dialogue with the patient, so the other osteopath, in this case. They're training each other in communication skills as they do it, which means they're actually practicing how to explain it and how to put it clearly and so on as they learn the techniques. So they're getting quite strong ownership of it. And I think that that's part of the strength of it.

SB: Yeah, as well. Well, it's been a great, it's been a fantastic, a very lovely evening chatting to you. Thank you. I presume that you will keep us posted, will keep the world posted about your advice, your expert advice to Public Health England through Twitter, and there's a website?

RL: There's a new project, which I'm working on heavily at the moment, which is going to be interprofessional. And I think osteopaths may be engaged and interested with that. Perhaps we'll talk about that another time here. But I think that's-

SB: Like chiropractors, or is that...?

RL: Anybody who wants to join, actually. It's really about health professionals and reaching out in different ways. And I think I've had a lot of uptake from a number of people I've been speaking to who want to contribute towards it. I think it's going to be very exciting.

SB: So what's the best way for people to keep in touch with what's happening from your perspective?

RL: At the moment, Twitter and Body Back-Up. The hashtag #bodybackup. We're launching new things, but that's the current way in. I'm on LinkedIn as well obviously. If people want to make comments or whatever, nice ones I hope, then I'm more than happy to.

SB: And be happy if they ask us further follow-up questions on this, that we can send them on to you?

RL: Sure. Sure, sure, sure. Totally. Totally. Why not? Yeah.

SB: Good. So thank you very much-

RL: Steven, thank you very much for inviting me. So nice.

SB: It's been a pleasure. And hopefully we will get you back again here sometime.

RL: Thank you. And thanks to Charlie.

SB: Indeed.