Academy of PHYSICAL MEDICINE

Transcript

Multidisciplinary Care A 360 Approach – Ref 291

Steven Bruce
Good evening. Great to have you with us. As always, it's another busy week this week we've got two broadcasts sheduled. In addition to this evening, I'm going to be talking to Professor Bob go in and Simeon, Neil Asha on Thursday lunchtime, about myogenic Thoracic Outlet Syndrome. And you know, I just know that that is going to be a great show, much like the last one that they did with us. Likewise, this evening, another great show. I've got Robin Landsman, with me here, and we'll be looking at how we maximise the effectiveness of multidisciplinary approaches to treatment. And this is going to be a lot about communication, which is of so much importance to all of us. And we'll also be looking at a funky new way to do the bridge exercise. Robin is going to be explaining and demonstrating how to do that and telling us why it's important a little bit later on. Now, I imagine if you're an osteopath, then you're of course, you're going to know who Robin is. He was the senior tutor of sports injuries at the British School of osteopathy as it was for 10 years. And he's also a national media spokesman on a regular basis on a variety of topics. But his most prestigious gig I suppose, was when he appeared on this show for the first time a couple of years back, talking about functional active release and rehab stuff that we will be having a quick look at as we go through this evening as well. He also appeared in one of our lockdown learning shows to talk about collaboration. And Robin, welcome back. It's great to have you in the studio in person. Again,

Robin Lansman
thank you very much for the invitation.

Steven Bruce
We learned a lot about communication this evening way and and you're going to talk about multidisciplinary issues. But I suspect there's a lot of people who are thinking, well, I work on my own in a practice. And so multidisciplinary doesn't apply to me, but I kind of feel you might take issue with it.

Robin Lansman
Well, it's not so much take issue, but I think probably what it is that now and particularly now but perhaps always for osteopaths, perhaps for chiropractors, too. We work in our own

practices. But we get referrals from lots of different people, we see the fallout of perhaps therapies or treatments that hasn't perhaps worked as well as people might have hoped. So we may have seen people who've seen other professionals. And so I think the key to this is really thinking about the messaging and how to handle situations where conflicting advice, conflicting opinions have actually cause the patient quite a lot of suffering and a sense of not knowing which way to turn. So now they're here, here they are with you in new hands. And that can present some conflicts in terms of

Steven Bruce
communication you're going to talk about all about between osteopaths or chiropractors and the other healthcare professionals or is there more to it?

Robin Lansman
Well, I think in my learning and experience of the last few years, I've seen that very much how professional speak with other professionals and how we share information is getting even more important than ever, but also how we connect with our patients, and how we communicate with them, and how they communicate with us and how we encourage that is has become, you know, an imperative really to getting our message across and helping guide people.

Steven Bruce
Yeah. What sort of problems have you seen with communication then with other healthcare professionals? I mean, the the gos see, and the Institute of osteopathy, and imagine the chiropractic equivalents are very quick to point out that most of the complaints and problems in clinic arise between because of poor communication with our patients. Does the similar problems occur with other professionals?

Robin Lansman
Well, I've been working with the NHS with Health Education England recently doing a project which was last year. And it was very interesting exploring with them the way they communicate together as faculties and actually seeing how many of them have conquered these problems, even though they are very multidisciplinary. And it's more about the professionalism and the connection and having practice of actually really expanding some of the myths and actually exploring things in ways that are being professional being another professional. And I think spending time on that to break down these barriers and breaking down the silos creates just a sort of professional connection with other with others. And I think that's that's key. I think many of you work in their own practice, may find that harder feel a bit inhibited about that. And to me, that's something even a long time ago, I was working with the GEOSS running programmes of communication skills with osteopaths around the country. And we did about 19, I think across the country, talking about this exact topic, so it hasn't gone away. And it's still still relevant.

Steven Bruce
I was struck actually recently, as you know, we we get quite a lot of consultant medics in here for our different shows, particularly Orthopaedics consultants, but I was very struck recently how actually, they can be quite. I'm not gonna say dismissive or rude, but they can make it quite clear when they don't approve of one of their professional colleagues. You know, an orthopaedic consultant, he doesn't like another orthopaedic consultant. And they weren't shy about making that clear to me, and perhaps not so much on air. I mean, one of them, he didn't elaborate on it. But in private, he was much more forthright about don't go and see this person. And I said, I wonder if people do need to be just reminded of the

osteopathic practice standard or the chiropractic code that says, We have to be professional when referring to or dealing with our own counterparts, even inside the profession.

Robin Lansman
What indeed, and we are, we are seeing the fallout and I know there were a lot there have been projects around the country, including in Nottingham, I visited a project there that was for many years at the Queen's medical centre there. And, and it was interesting to see, you know, that was very much osteopaths running a service that was the outfall of lots of surgery that hadn't really done what it what it was supposed to this

Steven Bruce
wonderful James Booth was, indeed, indeed a personal there was an osteopathic award to get up there, I think.

Robin Lansman
Yeah, but unfortunately, it's gone. Yeah, it's gone. And that's really sad because it was started. In fact, I forgot the gentleman's name, he started at first, and then they were running it, no chap called Sam was also with him. And they were running a really, and I visited for a whole day, some years ago. And you know, it was really picking up the pieces and really understanding things differently. The sadness was that a lot of these patients weren't seeing perhaps someone else before they ended up having surgery. But the surgeons were referring in large numbers for the ones who kept coming back and thinking, well, we can't do more surgically. And they were doing great things. So yeah, I mean, that's an example where they were, you know, steering a fine line, but doing a great service. Yeah.

Steven Bruce
And I've got James move coming back in here in a few weeks time to talk, I think we're gonna do some one quarter recliner syndrome, in particular, is a new guidelines out in the NHS for dealing with that. But he was, yeah, he was quite forthright himself about the reasons for that osteopathic connection with the Queen's Medical Centre, anything but perhaps that's outside the scope of this evening, isn't it? And what are you going to tell us in about communicating with people?

Robin Lansman
Well, so what I've been learning really is that some of the work that I've been exploring, that I used to do much more teaching undergraduates and postgraduates, and you have a certain amount of time with people to actually explore and expand how things work. And I think that's a good learning experience in terms of working with other professionals. But I suppose communication styles amongst as we were mentioning earlier, amongst professionals, is something working now with some NHS groups and health education, England, it's shown me that they've done a lot of work trying to get that to happen. But in fact, people like osteopaths, and chiropractors perhaps outside the NHS don't have the benefit of that sort of development potential to work with other groups in the same way. And I think that's, that's, that's the sort of thing that I certainly take a lot of time out to actually go to the types of meetings where I'm at an interdisciplinary event, and share opinions because they often do ask around the country if you join various NHS events for allied health care professionals, where we can actually voice things as health professionals, you know, not not to be backwards in coming forwards about

Steven Bruce

that. We used to worry inversely about writing letters to GPS working both when I was in training as an osteopath, and subsequently in practice, because I think we were always concerned that GPS instinctively didn't like osteopaths and chiropractors, and therefore dismissed anything that we wrote to them. And I bet every single practitioner watching this evening has got some experience of being effectively dismissed by either a GP or a consultant somewhere. The ones that you're dealing with, is it would it be fair to say that actually, this is a self selecting audience, because they're the ones who want to communicate with us in the first place? Or is the well,

Robin Lansman
it's making connections and it's getting to know people. I mean, people go and play golf, and they chat about things and they talk about business. And that's how the deal is done. So I think it's not always the obvious presenting oneself at meetings going along to your, what was called a CCG meeting in your area and actually asking questions and being part of the group. I mean, I've done plenty of that. And it's a very good learning experience, certainly in practising communication skills, and being part of that agenda.

Steven Bruce
And those meetings, no stock COVID put a stop to all of those. Well,

Robin Lansman
no, the face to face meetings were public meetings, so they occur in every part of the country. And people including osteopaths are welcome To go along and pose questions and ask the panel of doctors, their local doctors,

Steven Bruce
probably I was thinking back to the CCG meetings which we had as part of our NHS contract, which were just the healthcare practitioners. Oh, no,

Robin Lansman
no, this is wider. That's why doesn't that and you know, and those resources are available online and quite useful pieces of reading to try and work out what's going on in your locality. It's all public information.

Steven Bruce
Okay. So all is well. Communication is wonderful, between the What shall I call it the conventional NHS and the allied healthcare practitioners outside the NHS? And perhaps chiropractors as well? Is that the case?

Robin Lansman
Yeah, I don't know all as well. I think it's a work in progress. And I think, but it takes time and energy. And I think the problem that comes quite often is that, you know, GPS, as an example, are so overrun, and busy. And the time even to spend 10 minutes, having a chat with someone is not as available as perhaps it used to be, I actually find consultant surgeons actually pretty approachable, and actually looking for different ways of working, they seem quite open to that. So you know, and the type of dialogue of letters that we exchange, you know, you're teaching them a bit by the letter you wrote, again, in terms that you're happy that they're going to digest well, and they reply and refer starting to actually talk the same language, you're actually starting to exchange views and ideas, which actually start to come on the same page. So that's what that's encouraging.

Steven Bruce
That's a good point. Because if I write a letter to a GP, based on what I was told by an MSK, specialist GP, at the CCG meeting that I refer to a minute ago, they have, in his words, not mine, zero knowledge about musculoskeletal medicine. So is there a danger that in our efforts to try to impress them with our medical knowledge, we use terminology that the GP doesn't understand. And I didn't want to admit that he doesn't understand it. So

Robin Lansman
I think probably pretty simple language works. It's just making a connection, it's been bothered to do it. I mean, I presented a big piece of work to about 65 GPs who were training in MSK, as a specialism. And I must say, I was surprised on many levels, there was obviously an interest in the topic. But I kind of dug a bit deeper while I was there, and I wanted to find out, partly based on the questions I was getting, and what I wasn't getting, is that quite a lot like MSK, because in a sense, they find some of the exclusions of pathology, easier, life threatening pathology, and therefore actually doing that as a topic is actually slightly, they would say, easier to deal with, and something far more organic in internal medicine that might be might be something really challenging for them to commit a diagnosis to.

Steven Bruce
We've got a blog on the show a number of times, junk called Nick Burch. And I've always loved reading his letters to copy to the patients, but to the GPS, because he's an orthopaedic spinal consultant. And he has the luxury he can write what the hell he likes and his lessons because no one dismisses his expertise. Whereas they don't know what to expect from osteoporosis and currently, but he put things in lay language, and he wouldn't bother with technical descriptions of what he'd done with people who would just write it as he felt. And it was very clear and very precise, but it was very easy to understand even for the patient, let alone the GPU. Yeah. Okay, so what are we gonna learn from you this evening?

Robin Lansman
Well, hopefully, a little bit about how to have an exchange with your patient that is more meaningful. Something that I've discovered, I think this we will be looking at hands off and topics of that sort, in other words that the patient is now especially after COVID is definitely liking the hands on approach that osteopaths take. And I think what's started to sort of shift is that sort of divide where perhaps what's on offer in the NHS and what's offered with physiotherapy isn't quite hitting the mark in all respects. And we will be exploring excising things a little bit later. So that kind of and how you communicate that and get the buy in, in terms of getting a patient to participate in what you're offering. And give feedback in the process, I think is really important, rather than just giving exercises. So that's something I've certainly noticed in my own sort of progression through career and, you know, patients do like, for example, to have something to take away and read. But at the same time, actually, sometimes it actually switches them off. So it's a different type of learning that I think we're going to explore and a different way of communicating what's needed to them.

Steven Bruce
Yeah, I was going to mention to you, I had an experience with the NHS this morning, which is a lesson in communication. And I don't imagine it would happen in osteopathy or chiropractic clinic or most private physiotherapy clinics, but I had to make an appointment for my father for a hearing test. And I called him yesterday afternoon and he said, Well, we can't I got straight through to his surgery to his GP and they said we can't do that you have to phone back in the morning after state and and then the GP will have to make the

appointment. So I call back at half past eight and I think it was nearly an hour later, I finally got through their hold music, which was a 10 second loop of something with heavy drums and it was just irritating as hell. And of course you can't get away from the phone. You can't do very much else for listening. And I got through. They simply said well, we'll take your number and the GP will call you back when you could have done that yesterday and In some ways, it is a lesson because actually that is the point of contact with the first point of contact with the patient is the receptionist. And if they have a bad experience, then they're going to be grumpy with the receptionist, they'll be grumpy with us as well. And I suspect we do too much better, because we're not under the time pressure that GP surgeries are. But it's something that certainly we've taken on board in my clinic is that we try to make sure that our receptionists are happy, nice people, rather than NHS receptionist standards, and we don't keep them waiting on the phone.

Robin Lansman
But sometimes that is pressure from inside, the receptions are trying but under under pressure from all sides, it's it's all I

Steven Bruce
feel sorry for them, because I really wanted to be rude to this receptionist when I finally got through, because I was so irritated by having to wait for nearly an hour on their hold music. But I had to keep telling myself, it's not her fault. She's been dealing with phone calls all throughout this.

Robin Lansman
But luckily, you're able to look inside and say that, unfortunately, some people probably don't do as well at

Steven Bruce
that. And I suspect you we've read a lot in I know, I'm off the topic, we've read a lot in the press about and whenever you go to a hospital or GP surgery read about me and we won't accept people being rude to our staff when actually, the system is setting itself up to fail in that regard, because it's making people cross before they even get to you. And they're already in pain when they call in most cases, anyway, where we

Robin Lansman
could maybe we could probably bring up the slide we have. That's fine. So this crossover is quite interesting talking to NHS, people who've gone into leadership positions or change their roles is that they've got this kind of say, not conflict, but difficulty being clinical and delivering things with candour and connection, and then actually trying to apply that in other ways. And it's quite interesting that they don't always see that crossover, I've noticed between the two sets of skills now not all osteopath, chiropractors are necessarily in those sorts of leadership positions. But even in your own practice, if it's a bigger practice, some of those things are necessary in terms of how you operate and how you communicate. So the thing about learning about other professions, and that's what we were saying, Have you got time to do it. Now, if you can't get a GP to see you, perhaps you can go and see them. And if you're invited to give a speech, perhaps you could actually share writing it with another professional. I've done that with consultants. And we've co presented and they've actually found it really nice that I wanted to go and sit with them and actually have a little chat for 10 or 15 minutes to plan out what we were going to discuss,

Steven Bruce

you don't strike me as a person who lacks confidence in talking to other professionals. Whereas an awful lot of particularly solo practitioners in the osteopathic chiropractic world will probably be really scared at that. I mean, it's one of those terrifying things in the world talking in public as

Robin Lansman
well, some people find it that but knowing your subject, and be able to explain it clearly and getting an ally really within the room that you can actually share the preparation with. A lot of people perhaps feel the same way. And it's quite a good joined up way of working. So So I think that's something that you know, develops confidence and gives you that chance to practice explaining what you do. And I think what can happen is if you only talk to your group, in a sense, you don't really necessarily get the challenge that you get from an outside group. So you need to have very frank and candid communication. So some of the work I'm doing the NHS is to develop that candid, not clinical candour, but the actual candour between them to give feedback on how that came across how that explanation you gave, worked or didn't work.

Steven Bruce
So impossibly, it's overlooked. But if you can do a two handed talk, if you've got another professional, when you're actually talking, it's very hard to think clearly when someone fires a question at you, because you're under pressure, or really, the other person, on the other hand, can think really clearly and can possibly even anticipate the questions and it takes a hell of a lot of the pressure off

Robin Lansman
to do it. So there's a number of techniques as well about parking questions. And actually also finding out why someone's asking the question is a very useful technique. Because

Steven Bruce
it just goes by you're asking that question.

Robin Lansman
Yeah, under throwing the question out, there's a number of different techniques to use, but passing the question then to the room. So now as you've asked me a really toughy and you then throw it back out? So what do you all think of that question? Or what do you think the answer should be? And then you give you your thinking time, but also you allow others to contribute? And I always think that a good a good question or a question is normally it's not an attack, it's actually just wanting clarity and understanding. And patients are the same. I mean, that going to the difference there is that, you know, a patient's asking questions are merely doing so because they are confused, or they want clarity, or their nervous. There's a project I'm doing, actually, for an insurance company actually funny enough talking about risk. And one of the things that came up that was quite interesting was a lot along these lines actually about talking about difficult patients. And I think one of the answers I gave us was not difficult patient, the patient perhaps is nervous in pain, is finding it tough, embarrassing, all sorts of things. And that's why they're coming across in a particular way. So yeah. So there's different ways of looking at people as you described yourself about the receptionist response, there's lots of stuff going on. So

Steven Bruce

this slide here is as explained clearly and with confidence as your first box. You can't overestimate the importance of confidence. Can you if you don't know your subject, you're not going to be a confident speaker or

Robin Lansman
well, but it's keeping the flexibility. I think because because what can happen as you become a preacher. And what's really important is to allow that interaction back and have the question and perhaps feel in London mind are uncomfortable with that. And that might have to happen. So it's not getting your speech. So well honed that you no one's going to trip you up, I think it's important to leave flexibility in your thinking. And that helps. Yeah. So and then moving on, perhaps, to talk about empowering, which is a term we were talking earlier is a bit overused, and openness, when it comes to connecting with people, you know, there's a difference, I think, and this goes back to leadership and groups in health care about being led, about being mentored or coached? And how much are you willing to be led and how much you've been pushed? And where's the divide line between a suggestion, and something that's being pushed on, you

Steven Bruce
know, I'm, I've not made the connection here, here, I'm here, I'm talking to a group of orthopaedic consultants or GPS, or whatever, male, I'm empowering them?

Robin Lansman
Well, one thing when you're writing to a GP, we have that example earlier, by giving them information that makes them feel good, that makes them feel that they've learned something that makes them feel that they can share with the patients something that you've taught them, but in a subtle way, that it that's giving them some empowerment, that's giving them you're sort of helping their leadership role. You're not diminishing them, you're supporting them. So that empowerment in leadership terms going back to the other work I do sometimes is exactly that message. And it's leadership empowerment, and it's sharing in a way that helps and that openness of dialogue is something to maintain. And I think probably regulators will be very, I think, happy to hear that this is an approach. Certainly, I'd advocate because you get much more from the person you're dealing with.

Steven Bruce
Right? Okay. And you train practitioners in this approach, don't you as part of what you do through a cog, and we're going to talk about that later on.

Robin Lansman
Well, cog is for teams, and it's for, certainly the moment NHS teams and faculties and it hopefully will go across the whole of England later this autumn.

Steven Bruce
And it's the feedback you're getting that actually it has improved the reception by GPS of.

Robin Lansman
So that's not specifically for GPS. Oh, no, no, that's more faculties and allied healthcare professional. But nevertheless, the what it's about is is trying to open confidence and open channels. So allow people to give and share feedback. So whichever way the feedback is going, whether it's in this example, a patient giving you feedback, or you want feedback, for example, patients like to please their practitioners, you know, they want to tell you good news. And some of them actually want to tell you all the bad news only. And picking between

that when you see a patient to find out the light in it rather than just the dark, it's really important to know what is working and what isn't working so well. So that's something that you know, that can come out in lots of different contexts.

Steven Bruce
So, we had a couple of comments. Okay. Well, I was talking about earlier on about professional relationships. Simon says that he gets a lot of patients who come to see him because they can't see someone the NHS because of a long waiting list. And then when they go to see a physio or another practitioner in the NHS, they're told to stop coming to see him because the practitioner wouldn't know which approach was working rather than taking a joined up thinking approach. He reckons that things might change when osteopathy and chiropractic treatments are included in NHS protocols. I don't think that's going to happen.

Robin Lansman
I don't know at the moment with self referral and first contact practitioner fcp. I think the phrase FCP has been coined very much by physios FCPS first contact physio, but actually, the term is first contact practitioner, of which certainly osteopaths are as well. And I think,

Steven Bruce
what about the term primary healthcare practitioner then? Well, that's also

Robin Lansman
Well, that's also relevant to osteopaths as well yeah, people can come to see us first and not have to see their GP first. But this FCP term is quite interesting because I think what's happening in many areas is that patients are able to self refer and see an FCP physio, as first point of call, they don't need to see a GP and it's covered by the NHS. So what that may do to private practice is interesting. They're not getting the same

Steven Bruce
offer, waiting as soon as it doesn't, which I mentioned, well,

Robin Lansman
they may will get bigger and bigger for the fact that people can go on a list, they may wait to have their triage they first screening but then may not get any actual or may never get any hands on care. But certainly what they get is more than likely to be prescribed exercise, which we're coming on to a bit later. And I think the bridge that I'm looking forward to Well, yeah, the funky bridge. I think there's a number I've created and evolved during my FAA courses that we've actually started to look as assessment tools and to look as remedial exercise tools that are adaptable for individuals. And I think that's that's a big difference in what generally gets prescribed which isn't too adaptable. It's by the printout book

Steven Bruce
you very quickly mentioned fer there was well,

Robin Lansman
so it's functional Active Release function, active rehabilitation, and it's something I was teaching undergraduate It's and evolving, pre COVID doing lots of work in Germany and around doing lectures and and in England, talking about how to actually empower the patient, how to work with the patient, in terms of the assessment and turning assessments into exercises and treatment. So that's kind of what I've been doing for quite a few years.

And that's something I'm coaching people in because I enjoy it. I enjoy doing it immensely. And probably

Steven Bruce
we'll put some more meat on those bones in a little while when we come on to that. So where do we get to on here? We've got to just rip interest.

Robin Lansman
Yeah, a little bit on partnership and trust. I think that the whole thing with new patients particularly is developing trust takes time. And it's not instant, obviously, when they feel results, there's almost a there is a lightbulb moment where suddenly you're trusted. And getting those results is important, but not, in a sense, not without perhaps achieving certain goals that you might want to explore with people where, you know, in a sense, that timeline idea where why they have it wait and get better on its own. What are the maintaining factors, so those kind of things and teaching them the skills, which is what I try and do within the exercises to give you good feedback. And I think good feedback, I mean, accurate feedback about what's working and what isn't. What's changed. What shifted are the exercises you're giving them becoming easier to do is the range of movement improving, because I think it's important that they have ownership. And we'll talk about that more a bit later as well. So they connect to the process and what you're trying to achieve.

Steven Bruce
Yeah, just just to interrupt the flow for a second and go back to what we were talking about. Nikki's just sent it in a comment comment to say that plenty of consultants in her experience like osteopaths, she treats a local rheumatologist who regularly refers patients, often very tricky ones. And over the years, her communication has been regularly with neurosurgeons who also refer and collaborate. It's about forming that bond and then trust, which you obviously just mentioned here, and asking patients to feed back to their GPS as well, which is actually quite useful, isn't it? Because I guess they need to understand that we're getting good results, then that's not something which is often fed back, because so many patients, once they've got good results, they just don't talk to anybody more because they didn't get back to any healthcare practitioners

Robin Lansman
know, well, that word of mouth referral sort of idea with patients who are happy telling other people overseas, how most private practice exists, it literally is that sort of generated in that way. I think the danger is how you communicate why that person has got better, what they tell a doctor may look like magic if they haven't got the insights to work out why they didn't get better before. So that that's the gap sometimes between well, great if you get on with the Osteopath, great if they managed to fix you, but they don't understand why they're happy for you. They're delighted, you've got better the GPS, but that doesn't give you a full understanding of what really happened. So

Steven Bruce
did you find it in your experience? I imagine you've had similar stuff to I have in the past that in 99% of patients come to you wanting to trust you and wanting you to get better. But there will be the few who are coming looking for folks looking to find what you do. I don't know possibly the ones who are more conscious of the money they're spending and they wanting to find a reason to say didn't work. How do you handle those? Well,

Robin Lansman

I think I think that we did a survey, we're doing a survey, it's part of the CPD to actually ask all new patients, in fact, even follow up patients who haven't been for a while, what their expectations are before they come. And not everyone's doing the survey, we are through the practice. During practice, yeah, so we're doing that. And the reason we're doing that is because we wanted to look at referral pathways and the trust that engenders. So if you're referred to me by your GP, that's probably going to engender a reasonable level of trust, if it's by your best friend or your mum or something, again, that's probably going to engender trust. If you've just googled in desperation, maybe, or you're new to an area that takes that's a different kind of line of referral in a different context. So, and we did look at that, and we're now cross gonna cross correlate the source, and the expectations, and particularly why they didn't see us sooner, because quite a lot of people we see are waiting and spending months thinking about it, we found may not be in every practice, but we find people are quite spending their time thinking about it even on recommendations. You know, we're getting people coming in two years after they're recommended even from consultants, months, months, months later that they can do some

Steven Bruce
complicated process for doing this. Or is this a really simple thing is a question when they come in.

Robin Lansman
It's a questionnaire. I mean, we didn't do it on paper, we've done it online, and it goes out to them before before they come. But you know, the uptake rates of questionnaires as we all know, nobody wants to do a great deal. So I probably think we're getting I don't know about five or 6% back. But useful information nevertheless to reflect on. Yeah, before we start,

Steven Bruce
the reason I ask is because this is a this is an excellent objective activity for the osteopathic CPD process. And if you were prepared to share what you've been doing, we could send it out to everybody else as well. You could do this yourselves.

Robin Lansman
Any coming up with five questions and ones that relate to your hunches, I suppose I mean, largely, you know, however you run your practice, you get an idea from patients about these conversations. I saw someone who recommended you And you'll get an idea of how they interact. I mean, the thing is never to underestimate that you still have to engender trust, and you have to build up with every single new patient, you know, because it's it's never to be assumed just because they're smiling and happy to see that, that you know, you've got that going straightaway. So I think that's where the work still has to go in. In fact, if we cover expectations and mutuality, I think that's quite important at that juncture. Because that feeling of expectations and where they're sitting, I listened sometimes to people as they come in, or overhear their conversations, and you know, how excited they are to come as a new patient, because they've been recommended, and someone said, I can fix them. And not that I want to blow the bubble. But when they burst the bubble, when they when they come and see me, I want to kind of bring that down to earth. And, you know, we've got to start, we've got to go through this. And I think the problem also comes a lot of people think that, especially the people from, you know, a search, that, you know, you're offering, the osteo of the pill, the diagnosis and assessment, I think this is very underplayed, in my opinion, in practitioners, you know, where what we're doing is we're not just doing a treatment, that I think that assessment, but that primary care part is still very underplayed or underestimated by people how important that is, when the patient's been through the

process, and you're picking up on stuff they'd never connected, you know, that sort of light bulb moment where the patient will suddenly say, Well, I've never connected that before. And that's really interesting. And that's when they're suddenly getting into why you're asking the questions, you can explain as much as you'd like at the beginning of why we're going to go through this. But it's only when they get that sudden light bulb moment where they connect, how much thoroughness is going into your history and approach before you even touch them. Yeah, yeah.

Steven Bruce
I, I suspect that quite a few patients come along expecting that what we do is typically crack their back or whatever. And that's what they expect us to do. And they don't they don't imagine that we're doing a detailed diagnosis. They don't imagine that we're, we might do other techniques, that racking joints here or there. And of course, they expect that they're paying for the length of time for which they're treated in order the whole process. And we've had a number of people saying, you know, sometimes you just have to point out to them, you know, you don't pay extra, you don't pay the dentist and say, Well, I want you to drill me for a bit.

Robin Lansman
Can I have more? No? Less than three

Steven Bruce
minutes necessary? Yeah. So I think difficult, it's difficult to that's an expectation on the patient's brother, it's hard to offset, isn't it? Because they might have been misled by whoever it was that they saw before he'd been to an osteopath or a chiropractor who gave him an hour's treatment? Did it come to you and you do 15 minutes? I'm not saying you do. But I mean,

Robin Lansman
no, I think when we do the exercise, and we're going to go through that bridge, we will talk about all of these areas within that exercise explanation. So I'm really looking forward to that in a little bit. But just a couple more things, just if we can

Steven Bruce
go into the green one, because we ended on mutual Oh, right. Okay,

Robin Lansman
yeah. So it's then sharing back not just their expectations, but also how I feel about their expectations. So as my example went, we don't as a burst the bubble, but we need to be quite frank, in mutual about what our expectations are on both sides. And I think that's the mutual part of it, really. So it's not just pleasing them, because they were patient, it's finding that mutual around. That's the common ground. And benchmarking and progress I'm very keen on will do that with our demonstration is that we set parameters that we can measure, and they can measure going back to the mutuality, and so on is that they can share in what you're explaining and feel and start to feel what you're doing with your explanations and your examination and your treatment so that you're really on the same page, not not sort of different pages. And I think that's getting them very involved with the, the treatment process is really, really important, other than just doing that to them

Steven Bruce

in the eye. And I'm smiling, you might wonder why because Phil has just sent in a comment here saying put your prices up by five pounds, make him come in early and fill the survey and until they get the five pounds back if they've done the survey,

Robin Lansman
possibly, possibly, maybe maybe I mean, you know, if we did it in person on paper, you probably would get Moore's, yes. But it's another administrative thing. And actually, we're still getting some useful information. So yeah, so I think measuring progress is important and benchmarking all the way through. So you're always that whole thing about providing a diagnosis and providing the follow up information so they can value and evaluate what's going on all the time is something I'm very keen on.

Steven Bruce
Do you do problems, patient reported outcome measures in the clinic? To

Robin Lansman
be honest, we haven't. And that was another thing we did set up this other little survey. We've done another survey also we did ourselves, and it is something that's been on my radar.

Steven Bruce
I'd have thought that problems surveys, they were probably more unreliable than your initial survey because the people who don't fill it in quite possibly might be the ones who didn't do well or vice versa. I don't know. But I imagined that the audience that fills them in will be a particular type of people.

Robin Lansman
So what we're getting is, as you say, the preemptive strike, not the outfall of what works and what didn't so that's that's probably why it appealed to me to do what I did. Because I really want to know what what where we sit before we even meet

Steven Bruce
those Right, it's very hard to do a prompt question or to come up with a promise questionnaire, which is likely to be filled in by patients, isn't it? If you look at the online research or the also the research in the journals that were these great lengthy questionnaires and new patients going to sit down for half an hour filling in all these questions,

Robin Lansman
well, 25 questions is beyond antimony emails and so on. So, but just to go on to prognosis, management, if we may, yeah, yeah. Let's, I'm driving forwards to you. Okay. So prognosis and management. I think what's also quite confusing for people is that question when a patient says, When can I go back to work when I can I go back to the sport. And it's having a method. And if you don't do the benchmarking and progress measures, it's very hard to be very confident about where that where that question goes. And I think we have the term working diagnosis, which is very acceptable to them. I had a chat with someone the other day exactly about this from the general osteopathic Council, just to kind of go through that idea that not making a diagnosis is a case that comes up sometimes where people get into difficulties with their regulators. But having a diagnosis, that's a working diagnosis that's adaptable to how things are progressing, is is a reasonable approach, at least you're working with some theories based on your evidence and what you've been doing. So I think

that prognosis and management phase is also part of the communication, you know, where's it going next? Where's it come from? But where's it going next? And how does what you're offering in terms of exercise and advice fit with that progress plan?

Steven Bruce
So when you when you see balancing or measuring your prognosis, adapting your prognosis and your feedback, including us saying, Well, you can go back to sport when you can do this with great exercises in clinic? Yes,

Robin Lansman
well, so when you've got your remedial, and your rehabilitation exercise, remedial is at a different level than then rehabilitation. There's a crossover. And it's giving them exercises that give them confidence to use their bodies in ways that going back to full contact sport, for example, would be a completely different ballgame. But once they're able to demonstrate that they're able to do the exercises with a robustness, that is a good indication that they're starting to get more able to return to activity. That's what they were they want to

Steven Bruce
trouble you, Robin is you are the senior tutor on sports injuries at the what is now the UC over 10 years. So you know, lots and lots about this. Most practitioners, I would say have shakier idea of when it will be safe to return to say high level football or rugby, based on the exercises in the clinic? Well,

Robin Lansman
yeah, have you overwhelmed because what we've got to do is reproduce something in clinic that replicates something that's useful, we can't all go and watch them play, we can't all go and you know, watch them run. And indeed, you know, even a treadmill test for 10 minutes or less than two minutes, three minutes to choose the new trainers doesn't give the person who's just run their problem starts at 10k when they've already started to fatigue. So you're getting an idea on which trainers are good for you, but not at the right time when you're tired. Yeah, yeah. So there's things like that are measured and made as absolutes. Whereas we need to find methods of sort of assessing people, which, which is what I like to produce in sort of my assessment techniques, which have evolved over quite a period of time to give to give that idea where you're also I mean, a large part of, you know, protecting pain and are you over protecting the pain? And it's finding out what's legitimate protection? And what's obviously illegitimate what what in the mind has become an issue and a habit that we want to kind of unpick with the patient.

Steven Bruce
I expect that your experience is more with osteopaths and chiropractors, but as judging the profession as a whole, how good do you think we are at the whole rehabilitation process?

Robin Lansman
Well, from what I gather, you know, a lot of undergraduate training doesn't have a great deal of it at all. People pick things up as they go, it's really coming up with a protocol. And that's kind of what I've been trying to work on for myself, because to be honest, it drives my work programme in a way that makes it much easier for me to interact with my patients. Because we set up a dialogue, we set up a tool, a communication tool that we can use between us to find out how progresses because asking the patient sometimes doesn't get you an answer. That's very useful. Not always,

Steven Bruce
when you were a tutor at the BSO was there a section on how to devise a rehab package? I'm guessing there must have been

Robin Lansman
not a great deal, I have to say, I mean, it's something that I tried to bring into what I did, I was I was kind of doing, running, running the clinic once a week and basically having students in who were watching what I did, and working with me, and you know, presenting ad hoc little lectures to how to work that process. And over the years, you know, I'm like to think thinking practitioner I've reflected on how I work and and try to adapt that and actually change it over the years. I don't think I do now, what I did 20 years ago.

Steven Bruce
Now, I'd love to hear from whoever's watching this evening, what they do in terms of rehab as as well as some anybody who watches the recording later on because, frankly, I think we were horribly under trained in it when I went through my osteopathic training. And most of the people I speak to they'd be Yes We all know of some exercises. But I, I want to know, how do I know that this is the right exercise? And when is the right time to run?

Robin Lansman
And I think the problem is, you know, a lot of people use off the shelf Pilates or yoga exercises, but they're not specific. And they just say go off and do or they go off and do Oh, yeah, exactly as a prescription, just go off and do it. And you know, the people, I treat lots of Pilates teachers and yoga teachers, and people who've been doing planks for years, who are so locked up in the upper thoracic area and in their shoulder girdles in their neck, because they think this is the counterintuitive, but how do you break down the belief that what you think you've been doing for X years is helpful. And actually, it's been doing harm. And when you keep getting told it's a good idea, it's very confusing to think that, in fact, it's the other way around. So breaking that down is really tough with people psychologically to deal with that. And you are damaging trust on some levels, because people believe and trust that what they think that they've been told is good for them is good. And now you're saying, well, actually, do you know what this actually is part of the the, in a sense that maintaining factor in why you still have a problem? Right? And that's hard for people to swallow to start with?

Steven Bruce
So okay, yeah. Before we go and do some practical, did you want to talk some more about functional active rehab? Or,

Robin Lansman
well, we can do that as we go. If you want on the practical, I just probably wanted, if we can bring up a couple of other slides just to do those. I think that would be useful. And we have our jack is going to be helping us as the model in a few minutes. So we will be doing the bridge. And I do want to make it practical. So people can do that. So we can move on. I can move on. Can I move on one more slide?

Steven Bruce
If the thing hasn't gone to sleep, if it has just press it again?

Robin Lansman

Okay. Okay, so called we've talked about and that's really the the team building was training? Well, that's a good point we did. We did it because in fact, we were linking patients and professionals as a cog system of different groups and teams. So it was more that than the actual meaning of the word cog. But we brought it out during during lockdown times. And we're thinking about this quite a lot and making a difference. And that communication skills is what we're doing for teams of the NHS, and even osteopathic small groups, so that they can speak to patients and other professionals with more confidence. So that's that training package.

Steven Bruce
So how do people get involved with kg? Well,

Robin Lansman
there's an application form on the kg info dot info website.

Steven Bruce
Which www.com dot info. Yeah, yep.

Robin Lansman
And yeah, Coggan k dot info. And that's so that's basically people are connecting in to do that. And as I say, mostly at the moment, it's been faculties for the NHS, I'd be very keen to do it groups of osteopath, so people don't use we exclude the chiropractor, and chiropractors, none of that when I've had plenty of chiropractors come on fer work. And, you know, and that's been no problem at all. And I think that the core idea really is to produce what we've been doing is producing podcasts. So what we do is it's an interview technique process where one of the exercises is to produce a communications podcast for your team or about your practice, and develop that as a team. So there's ownership in that. And that's something that we've done a lot, right. So that's, that's that project. And so the FA R, which might come along soon, maybe. Okay, well, that didn't, but that's okay. So one of the things that I think with osteopaths, and I know, the DO NOT TOUCH bit, has been very much where people have been to the NHS had physio exercises, but had no hands on at all. They do want hands on, but I think the thing we're going to do with our demonstration, and it is very much look at how you can mix the two and make that productive.

Steven Bruce
It does seem to have become almost a mantra in NHS physio that you don't put your hands on the patient these days. I don't know if it's universal in the NHS system, obviously, I don't think it's the case in private no practice is, do you know, is it something that I've been told not to do just give you exercises and leave it at that?

Robin Lansman
It seems there are protocols and packages of care. And I guess some of the evidence based says this exercise or that exercise depends on you give it to but those exercises are acceptable and useful. And so that's what they've been given. So it's it's a very strange process, it's become more and more hands off, totally hands off. Which is, which is a shame. And I think just, that's the other

Steven Bruce
problem with that clicker.

Robin Lansman

We are having a problem with a clicker. But that's okay. We have to bring up the first slide. There you go. So yeah, so the bit that comes here is minding that gap between communication that's going on between the patient getting an exercise and not having a dialogue about the exercise. So the demonstration we're going to do in a minute is very much looking at reducing that gap and making that communication with the exercise altogether. Right. So we can do that if you'd like to

Steven Bruce
do that. Just wanted you We didn't bring up the SAR slide. You want to talk about that some more.

Robin Lansman
When we come back if we can come back to that. Should we do that? Yes.

Steven Bruce
Okay, so where's the slide, bring up the thing, so it was a lovely one. All right. Okay. we'll just walk. He's gonna do it for us. There we go. Okay, I want to bring up planning is a lovely slide. So this is, you know, it's a well used and it is water exercise, isn't it? It's the breach, which is what we're gonna talk about. But you've overlaid this with communication and patient partnership, and safety and quality and practice, which are two of the osteopathic practice standards, which have their counterparts in the chiropractic code. Yeah. Why is that? Why do we put those? Well,

Robin Lansman
I think the thing is, giving an exercise just on a piece of paper is not really communicating and sharing. And getting that connection is so so important to actually get compliance and people to understand why and, and to follow it through. Otherwise, they as we all know, when you give exercises, a lot of people stopped doing them after a short while for a whole list of reasons. Certainly not just because it isn't working, but perhaps it's too painful. So what I'm going to show you in a second is not the Pilates version, as shown in this picture, but an adaptive one that's global. And the reason is, because though this is using lots of different muscle groups and joints, we can make it even more powerful as an exercise. And it's a very useful exercise done recumbent because, again, you're taking all the pressure off, particularly the lumbar spine, and making it a very effective exercise. And it's looking in different principal ways at activating muscle groups that are missed out. And particularly interesting, perhaps, I think, since locked down on people walking more and more and more when they do is that that exercise is tightened up people's legs a lot, putting more pressure oddly onto the low back than ever. So we need to, we need to do something about that.

Steven Bruce
Let's go. Let's go and work on Jack,

Robin Lansman
we will thank you. Hello, thank you. Good to see you again.

Steven Bruce
Jack is becoming a regular model. He was he's a footballer he was here and a week ago from that world. And we're gonna find out from him later, whether he thinks you're better than that.

Robin Lansman

No competitions. But we all said that we had a little chat earlier. And we did go through a little bit because your work is incredibly heavy. If I'm right in saying you do

still work. So that's pretty

Robin Lansman
heavy. And so that has an effect on the body globally, because it's pretty heavy going and you play football, how often? And how intensively three times a week. Right? So both very physical, both quite different, but both very demanding. And and the crossover in a sense that is important in this exercise to see how do they work together? Or do they actually aggravate each other in different ways. And I think part of this, and the FA our approach we were talking about is a little bit looking at assessment, moving into exercise, and then potentially treatment. And that will guide you'll see in a minute, hopefully. So imagine we've got an acute low back. Okay, now the bridge exercise generally is done. If you just bring your legs up with the feet fairly close together. Yeah, in fact, in a Pilates exercise. And so if you just lift your back really, yeah. And what that does in a traditional pose, which is actually quite hard to do, and someone's back, so the very stiff and yours is somewhat or and pop it down again slowly, right. So what we see we see a level of excursion, I mean, someone very acute, they probably wouldn't get two centimetres off the ground, because it would just be too painful to do. Yeah. And then some are very stiff, they'd also find they wouldn't get to that sort of diagonal between the knee and the shoulder. Okay, so even with you, that was a little bit tough at a point. Yeah. Now what we want to do is make exercise easy and effective. So communicating that with the patient is really important because nobody wants to do painful exercise, even if it's helpful. So what we're going to do is just for the time being just put your hands just up just on the front, that's fine. Okay, so the way I'm going to do it, there's quite different is to actually put the feet in this instance. And you'll find that quite difficult because your abductors are quite tight. And the hip girdle is a tight, get them quite wide. Okay, to start with Now that's quite different than the original start position we had. And if you just put your hands down, now just flat down, what we're looking to do is to bring your heels towards your fingertips. So that sort of distance back now and just bring your big toe, what happens the further back you go, the more rotation starts to happen because of the glutes, so you want to just turn the feet into your feet a parallel, okay, which is quite hard for you to do put strain actually in lots of areas, and we can't see from that side but puts lots of areas on to these Boronia as well. Okay, so now, we want you to do that same bridge, but differently, I want you to actually use the thigh muscles and your calf muscles to do that bridge, not your back muscles. Okay, so pushing up. Okay, and now you should find that a little bit easier to do less effort, because now the legs are doing the work and the back just dropped down slowly, is actually basically doing less work. Okay, still working, but it's still working and your pelvis needs to stay quite free now, most of the time with so called core exercises, which we're not doing here and we don't want to do is that the core gets so engaged with the lumbar spine that you're peeling the back off the ground. And that is exercise a lot of people do for core strength, but the trouble is you're developing tension, as well as anything else. Yeah. On the other day, a little bit about this something that's quite a complex exercise. But the patient's quite enjoy that kind of say in depth kind of connectedness that we're going to bring into this, the thing we have to be respectful of, obviously, quite a lot of people may have kneecap or knee issues. So the amount of flexibility, they've got to bring the foot back even further, maybe limited, or perhaps different between the two sides, if they have any problem one side and not the

Steven Bruce

other, or totally, you want the feet evenly, drawn

Robin Lansman
evenly, evenly drawn back, if possible, but if we can't, we'll compromise at the position that they can manage. So we may have one slightly further away from the beginning till they get a little bit better at it. The point is, we're trying to stop the recruitment between runners and other people get a lot of tension in the quads lower down onto the kneecap. Yeah, and what we're trying to do is actually start recruiting much higher up the thigh into the upper quad. Okay, so by putting the foot back in this way, we're getting more upper quad recruitment, which doesn't happen enough. And this is not stretching, this is activation, we're actually activating the muscles in different ways. Okay? So if we think about the pelvic tilt and the pelvic roll, because the quads are very tight, or the hamstrings are very tight, this starts to actually activate those muscles in a very different recumbent way, under less pressure.

Steven Bruce
You mentioned the calves as well, how much work are they doing? And why you particularly engaging them, right? So

Robin Lansman
we want the whole chain down to the foot to encourage the calves to actually engage and actually push as well the shins and calves, okay. And what we can do? Yeah, to make it, what we'll see there's two options on this is to actually put the feet onto the heels. Yeah, just put the other one onto your heel. So now, we're in dorsiflexion, which tightens up and stretches. And now do your push up again. But not using your tummy as much, which you now are, because it's harder. Yeah, it's much harder. Yeah, so you're trying to use your abs to help you. But you now find how hard that is because his calves and shins are not doing much at all, because they're so tight. And their big conundrum comes that the difference between a tight muscle, a tight muscle basically fails and doesn't give power, the longer the muscle is, the more flexible it is, the more power it can give. So training these muscles to get stronger, is defeated if they're stiff. So a lot of this process of activation is all about getting things to work more efficiently get up the blood flow, and then everything starts to work. So what we wouldn't do at this stage, because that was harder. And we don't want to make it tough is we would do this on flat feet. Yeah. Because you do that better. So until the backs better, there's no point trying to make it harder by putting the feet. But some people oddly, depending on how they walk, how they run, in fact, find that it's easier up and down. Depending on how their hip mechanics are working, so you can play between the two as to how that might improve or how that might hinder the actual excursion of the pelvis. So

Steven Bruce
in terms of progressing this exercise, you remember that acute back during this exercise, as you've described, he's still likely to have some discomfort here as

Robin Lansman
well, actually, even people in a very key, if they go wider, we will afterwards do this on the floor on a mat and get the feet even wider, and the wider they go within the limits of the adopters, the better they get at doing the bridge. So the whole thing about rest that we know, if you rest too much, you get stiffer, and actually activating muscles and doing more movement actually starts to free up the function. So that that will be the kind of thing we need to do. Okay, so the bit we haven't done, and this goes into the upper body and neck in a moment. So it becomes very global, is we're going to talk about the breathing mechanics with this exercise. Okay, now, a lot of the breathing out and the breathing in and getting that

right, makes the diaphragm engage thoroughly. Yeah. And what that does with that breathing is it gets the upper lumbar spine that you'll see in a minute with the breath, it's going to make it harder or easier depending on when you get the timing going. And the upper lumbar spine is getting articulated, where the core of the diaphragm attach. So what we're going to do is you're going to do a breath in as a preparation before you do the exercise. So breathe in big breath. Okay, and I want you to now do the exercise. Breathing out during a whole breath out. Breathe, breathe, breathe up to the top. Okay, good. And then slowly breathing in on the way down slowly controlled to account for roughly. So the breath lasts about four. Ideally, it's pursed lip breathing. Yeah, it's a tight lips because you're pushing out the air. And that makes the diaphragm engage even more. Okay, very good feel to you.

You feel different? Yeah, easily with when you do the breathing feels a lot easier,

Robin Lansman
right? So you're recruiting muscles you weren't using before. And you're articulating your upper lumbar spine as well. So you're getting a benefit in flexibility terms. Okay. So as this progresses, this exercise is got a number of levels, you want to make it adaptive, because you want to not let people be in pain while they're doing the exercise. So there is a bit we'll do we could do on the floor and that have the upper body. Should we try that? Just continue? Let's

Steven Bruce
do that. Just before you go. Darcy has asked Well, what's this exercise for and and suggested is this disease or whatever else? When would you

Robin Lansman
Well, to be honest with you, anyone who is afraid or won't move their back? This is a very safe way of examining and checking and exploring their function, and it then turns into the remedial exercise but as I was explaining, you want to make it as easy as possible. There's very little You could cause injury or damage during this exercise to anyone, just because they're in pain is not a reason to be scared of their pain. It's a matter of finding a way around that. So they can give them a bit they can get mobility, but without aggravating the symptoms.

Steven Bruce
So if you're using this as an examination, what are you going to find from it? What are your what are the what are the things you might take away?

Robin Lansman
Okay, so right, we've added in a couple of other factors the feet, and we found that makes it harder. Yeah, we've found where his fifth seat position are, makes a difference to how much effort he has to put in with the glutes or how tight his glutes are. So we can start adding up a few things about what is contributing towards his back. Where are the structures when they're under loading, that are hard to examine during a standing exam, because they can't move. They're in agony. They can't move. But this is actually something even someone in some substantial pain could start to do. And quickly, you know, within the first session,

Steven Bruce

we've had a few questions, we deliberately removed the pillow from his table. A lot of people have said apparently, or a couple of people asked whether you'd normally have cushions for the patient, right. And Claire's mentioned to them that she'd pinched all the APM pillows recently for the clinic. It might be hurtful, but actually,

Robin Lansman
we took them. Okay, we took them in? It's a good question. I think he's if someone were more kyphotic, or couldn't lie as flat as Jack can, we would put a pillow in. But as it's gonna come up in a few moments, the demonstration will include things to do with the neck position and things to the upper back. So we wouldn't want a pillow in less. They couldn't lie flat.

Steven Bruce
Yeah. And of course, we had to put him here because there's a hole in the table. Every clinic we've lost all the things that go in the hole.

Robin Lansman
Yeah, so that's kind of coming next. But it's a good question. So okay, so we've got some of that going on. What I'd like to do, Jake, if that's okay, we'll just do the line on the floor bit and then bring you back to here. Yeah. So if you put yourself down, yeah. And we're gonna also pop down here. Okay. So basically, the exercise now is the same bridge. But in someone who was finding it really difficult, or couldn't bring their feet far enough back to get some purchase on the pressure downwards, we're going to use more than the width of the mat. So if you go wider and wider, yes, even if you can't come much closer to your fingers. Yeah, as we have before. Bring your big toes pointing inwards if you can. And obviously, we've got some abductor issues here. Yeah. And what we're going to do is get you to do the same exercise using the breath exactly as we did before on the couch. Breathing out a bigger breath out when you can, audibly now how does that feel to you Jack compared to the feet being closer through the knee feels easier, okay. So you can play with that with a bit like sumo wrestler, you go wider and wider, to get more starts more purchase more pressure, there'll be a limit to where there's a benefit, and depends on how tight the adaptors are. But this is a way if the pain is happening at all, even at the width of a couch. Yeah, that you can actually start to adapt that by putting the feet wider and wider. And that gets you the chance to actually do the exercise. The only downside of this sometimes is people get hamstring spasms, cramps, because they're not used to doing exercise in this position. But actually, once they shake those off, and they can tolerate them and come back and try again, shake it out, try again, they get better and better and their hamstrings start to actually release because they're working the the antagonist group, the quads harder and harder, which actually releases the hamstrings. And that's then starts to free up both the hamstrings and the quads.

Steven Bruce
She was asked a question, I guess related to a certain degree. She says she's really cautious about putting an acute low back pain problem into extension, because you've only aggravates it too much. What's your thoughts on that?

Robin Lansman
Well, we're going into sort of neutral, really, we're not, we're not gonna go into extension. So we're going we're going from the lying flat position to that angle between the knee and the shoulder maximally, it may listen, it may depend, if someone's got a very high lordosis, it may be a different set of circumstances. And this may not suit everybody. But for most people with the average sort of kofler dosis that people have, this will be fine. Okay, and I've

used it very, very widely, and use it with a lot of my patients. And in fact, the patients who come to see me want to demonstrate this. And this becomes their kind of big piece to share with me What's improved, how it's going how much further, I've had people with massive spinal surgery, who've had all sorts of pain for years, who were very kyphotic and suffered pain for years, who now do this every single morning, and they do a set. And I'm going to show you the next bit in a second how we make it stronger and even more useful. That wouldn't be the first step. That's where we are now. And you know, they do a set of 20 Slowly, or sets of five slowly up to 20. And it's all about the breath rhythm, and the slowness and the mindfulness really of the exercise. It's not done sort of blind with you,

Steven Bruce
just because the next question was obviously going to be how many and how often you're saying once a day five to 20. Different Yeah, presumably on on pain and tolerance.

Robin Lansman
Well, yeah. And you know, what if they can do a few now and again, even if it's five or three, better to do that a few times a day, then why they're doing absolutely nothing, because this activates their muscles and starts to get them moving. And you'll find after doing this, even with someone for a few minutes, they'll be able to turn over more easily on the couch and you'll suddenly find they get up a bit better. So you're starting quite quickly to make a difference. You know, so it's effective.

Steven Bruce
Only people you wouldn't do this on who would you avoid? Well, the

Robin Lansman
knee the knee issues. If someone has got a severely arthritic, you know, pair of patella, whatever it is, or compression of the patella, this could be painful but adapting it. I mean, there's nothing wrong. I mean, it's harder the further you go away from the body because the lift is harder. But what you then do is if you bring in the heels here, yeah, at this position, just try and do that, Jack, if you can, pushing up that position further away, it becomes easier again, that we went it was closer. Is that fair to say? Yeah. So so depending on this is an adaption by actually being further away from the centre, which actually would hurt the back more, but doing on heels suddenly using the cars more, it encourages more use of the cards, you get more strength from the lower end. And that starts to help things. Okay. Yeah. So Jack, can we have you back? Yes. Okay. Yeah. So if you put you put yourself in the same position. So are there any other questions? is good? Okay, that's fine. So what we're doing now? Yeah, is Yeah, we don't need the headaches, we're going to do something that adds a bit more to this. And we know, in fact, Jack earlier said that there was a bit of a shoulder problem which I detected during actually, this this procedure. So just to let us know about that, but that actually does come into the mix now. And you're gonna see, so if we just put the arms, both arms up into the air, and what we do is we tighten both fists tight, okay. And what that does is gives a little bit of tension spreading from the hands, fists down through the arms into the shoulders. And if you press those shoulders a little bit, using your back muscles, your interscapular between the shoulder blade muscles, rather than just the chest, you start to engage the whole upper thorax. Yes, all the Paris scapular muscles are now saying, Hello. You've got them firing. Okay. And now if we do the same lift, breathing out through his feet closer together. Yeah, the feet are too close. That makes it really hard. And that was hard to do, wasn't it? Yes. Okay, so go what? Thank you to go nice and wide. Okay. And yeah, and on the floor, this will be even easier, but we're gonna do it on the couch for now. And push breathing out. Okay, that's harder, because your shoulders are

very stiff. But you managed? Yeah. Did you feel where did you feel that pulling my shoulder, my left shoulder, right, your left shoulder is a bit of a problem anyway. Okay, now we can palpate that underneath. Yeah, just to check whether he's engaging the muscles or if he is, yeah, by getting the whole flat palm across the back there and just getting him to do the exercise, you can start to also see some rotation coming through his thorax because of the difficulties of that shoulder. Yeah. And if you translate, if I can just pull my hand, if you translate that twist from the top, we you noticed earlier, we did have a little practice run, but you start to get on the way down a curve coming in to the way, the two, if you like, the hips, and the leg muscles are controlling that descent down, there's a sort of slight twist in the way you control those muscles. Just do that, again, breathing out from the beginning, push arms long. Right, and if you have a look, and it's subtle, and down, slowly, especially on the last moment of landing, if you like, there's a slight twist, and that twist will go all the way through from here you have a rest, that will go all the way from that shoulder girdle, which again, you're doing heavy steel work, and this shoulder is a problem you told me earlier at work, that diagonal line, if you like through the muscle chains is something that we haven't done the standard exam, but there may be some of that with squats and other tests that we could see. And that is causing a problem diagonally across through to this left.

Yeah, very similar to last week. Maulers middle cross syndrome is like that's, that's special sling.

Robin Lansman
Okay, so that that the thing about learning these it's not a matter learn, it's, it's in a sense, seeing it in the example we've got in front of us. So how it manifests in the individual is particularly what I'm trying to identify here.

Steven Bruce
So having having seen manifests in the individual? Yeah, is this something you're going to try and fix now? Or are you just going to keep doing the exercise until resolve? Well, so

Robin Lansman
Okay, so what we can do is we can get him to either with his lower body start to control that twist. And so you actually consciously start to tighten and prepare the muscles, so you know where the landing problem is. So you start to just slightly adjust the tension in the glutes or in the in the quads. Yeah. So try and maybe do that, just to give that a go. Yeah. And it might be gone. Yeah. So if you take out that twist, and if you look in that position, through your knees as the horizon line, if you can just you might need the pin over this, this bit, you could do the Philip. Because you can actually use that visual line to the knees to see it. And if we still have the Yes, over Yeah. So you can basically look through the not the knee line to actually see that the way that actually moves and how those legs are not being controlled as easily. Yeah, so thank you. So that's an interesting sort of way of observing those chains. And actually seeing them in action, in a sense. And we might say, you know that Jack's probably may have some back issues and so on. But maybe the primary driver of everything is the shoulder which is perhaps left in abeyance, but come in now with an acute back but actually the big result might be to get the shoulder fixed. Yeah, if possible, or do things differently at work. Yeah. So just try and do that. Again. If you can just about from that angle not to flex with the neck and head. Just have a look have three knees if you can just about see that. Yeah. And yeah. Can you feel that? Yeah. And what's interesting for you palpate, if I can just go to the forehand? Yeah, just for a minute, sorry. Yeah, we'll do a nice neat switch, if you want to. And this is something I do quite often as well as to see just let your

head go into my hand is to do the same exercise, get your heels apart, just a little, your heel. Yeah, that's right. So let's see, do that push breathing. And I'm going to feel just push how much tension and I saw it, his head rising off the pillow earlier, is coming into his neck muscles, you can actually palpate suboccipital, you can palpate into the neck and see where these tension lines are coming from his upper to lower body, and his lower to his upper. So how that bounce goes between the two. And obviously translating heavy work into football. Yeah, and you can feel that rising, you could even turn this into he can do the exercise, and I can actually treat his neck at the same time and actually release his upper neck. So functional X release, this starts to become why it is what it is that we're using functional exercise. And it's very profound, because the fascial tension that I'm getting through his scalenes and through his traps is massive. And he's kind of controlling it using his body movements.

Steven Bruce
Not quite sure how this exercise is functional.

Robin Lansman
Well, okay, how is it functional? That's a good point. And it is a good point. And I do like, I do like the question. So how is this functional, in terms of getting out of a chair, it isn't getting out of a chair. But using that midriff to turn in bed to get up from, from lying down to sitting is where a lot of people get a lot of pain, getting out of a car. So getting this whole connection between upper and lower body is a useful thing. A lot of people when they get disabled, the first thing that happens, you know is they can't use their legs to lift themselves. So they use their arms. And when their arm doesn't work, they've got nothing to push themselves up with. So that's kind of how it connects. I think doing it. Recumbent Lee is putting all the pressure off the spine. And that's the main reason for doing this way.

Steven Bruce
Claire sent me an another follow up saying yeah, a lot of people are really worried about this idea of putting the spine into backward bending, because at the moment, it's effectively in forward bending, isn't it? As you said, what you're doing is straightening it.

Robin Lansman
Yeah. But bring it into neutral again, rather than actually trying to extend it to, there shouldn't be an extension. Some people, when they try this, do start to want to over lift because they're trying to use their abs too much. And they're trying to do an extension exercise, which it isn't at all, you possibly think that more is better. And probably think more is better and stronger is better. And holding it for a time is also better, which it isn't. It's all about function. It's all about movement. So it's really controlling the movement and going through a full range, and back and down again. And using that breath rhythm. And speed really is about the right pace for the exercise. So there's a little bit more. That's okay, just a moment. Yeah, we can we can we can swap around again. Yeah. So basically, we take the pillar out again, yeah, so we've had a look at that. So what we can do now, we've got the arms and we've added in the arms. Yeah, and we've talked about the feet position. So if you, for example, bring the arms back up into that fifth position, what tends to happen when people who are chi fo kyphotic, and very stiff in their shoulder Hills is as you lift that you tend to people tend to want to do that, because that's the way their arms go. So what you need to do to get them to actually resist that. Okay, so in other words, they don't move anywhere. And that's the difficulty. And you have to use some muscle effort to do that. And that will stretch your work further and further up into the thoracic spine. So this spreads from being a lumbar spine exercise to a thoracic exercise gradually, as they get looser, and as they get

better at it. Okay. And what you can also add in is, depending on how your shoulders really, is to add in a number of different options crossing the arms. Yeah. And now try to do that breathing out. It's tough, isn't it? Yeah. Much harder to lift. And I can see it looking at your face that there's some struggle with it. Yeah. And if you cross the arms the opposite way. Yeah. elbows locked, if you can. Keep them out. That's it and try again. Well, that's a bit easier than the other way around. Yeah, yeah. And that's because that spread attention, the shoulder is going all the way around your shoulder girdle. And it's being dissipated one way and aggravated the other. Yeah. So you could say, I mean, that turns into perhaps an exercise for the shoulders. To some degree, you don't need it for too too long and keep the shoulders in the air too long. So in this case, you may want to as we're doing, let you have a rest now and again in between, there's nothing wrong with that, and then go up into as you do the exercise. So if we want to make it really work, just go from here, up into the up into this as you lift and then down again. Yeah, so you're starting to use a completely different sort of movement. I mean, I know swimming and this are not the same. But you know, there's something about doing stuff that keeps the body in line and uses the limbs and so on. That is a very useful exercise to do. And a lot of people can't be bothered to go and get wet in the

Steven Bruce
same time. Of course, I presume that you're trying to trying to make sure he's not switched to using his arm

Robin Lansman
Indeed, indeed, indeed. And so someone who is for example, carrying some weight and hasn't got much abdominal quality of time, which you obviously have is we sometimes add a weight. Yeah, so not too to literally make it harder, but actually to engage the muscles in the ABS a little bit more strongly. So what we could do if I, if I sort of pretend my hand pressure on your abs is, say a kilo or two, and you lift through that, that should, and people who haven't got muscle strength actually give them a little bit of bracing and a little bit of support. It's not about the weight, it's more about the bracing, but actually, you want him using his core, it's not 100%. But you but just keeping the spine a little bit engaged, it helps without without adding any force. And people find this makes it a lot easier to do when that when they're suffering. And then the last little bit is okay to move on to is to actually have the chin tuck in. Because what we were palpating, when I was sitting at the other end some of these neck muscles, what we can do, and it's a bit to get your head around, is to do that chin tuck as you do the lift, it's not fixing the chin down. But it's actually doing that bridge to bring the feet back just back to the hands. So the fingers will leave, we'll leave that the feet, the the the arms out of it for a minute. And what I want you to do is do the breath out, but actually do the chin tuck as you actually do your bridge. Breathing, don't lift your head, just tuck. That's it good. Can you feel that? And so what that does, that actually starts to meet in the middle. So everything from the back of his neck down and the traps start to meet with the lumbers function going up into the thoracic. And where they meet becomes a stretch point. Yeah, so that's kind of useful as extra, if you like therapy moving on from back into other parts. So you might say, well do the simple bits just for the acute backache. So, but when you're looking sort of globally, as I like to try and do, yes, you know, this starts to spread into all sorts of other areas. And if they're having a bad week or a bad day, and it goes into a bit of a flare up, which things can do. You still want them to be able to do some of it rather than give up the exercises. And I think one thing that often happens with exercises, as soon as there's a flare up, people just stopped doing them altogether.

Steven Bruce

We have been asked as well, what do you do about compliance at home service centre and say, Well, how do you make sure they're doing them correctly at home? Do you do video monitoring?

Robin Lansman
No, no, we sometimes do a video of the patient on their own phone. Yes, they can take that and watch it. The truth is, their body's changing all the time as this exercise is working. So when they come back, the first thing I'll do apart from saying how you doing is look at them do the exercise. So my regular if you like, I mean, amongst other exercises, this is what I use, I would then get to monitor where it's improving where they're finding difficulties. So it's not really imperative they get it perfect the first time, or second time or even third time, but they're starting to progress with it and are getting more and more confidence with their body. And the ability to bring in these other vectors with the shoulders and the neck and the feet positions and so on. gets easier to bring in.

Steven Bruce
Okay. What about your geriatric patients who might struggle to get down on the floor? Or worse still get back up from the floor? Can they do this a different way?

Robin Lansman
Well, I think doing I mean there are other exercises are probably given maybe first depending on but but actually, this one even done on the bed, which is not ideal. A very soft bed, probably not. But if they can lie on the foot end of their bed, which is the hardest, normally the hardest problem, because it's least used. That can be a method that at least they can start and as I said better than doing something than certainly doing nothing. So even on the harder end of their bed, or finding how to bed that's definitely better than not doing it.

Steven Bruce
And Tim's asked whether you can exercise on off on all fours at all,

Robin Lansman
not for an acute back now. I always do it recumbent because most people are fairly comfortable to low recumbent. So doing this position is I mean, so there are the cat and the cow on the other yoga exercises that we would all know. And I know they're prescribed still quite often. But a lot of people if you ask how compliant they are doing, I'm not quite convinced they are. And then if they're done properly, well if they're done properly, and the probably the people are fit enough to start with, then probably but we're dealing with all sorts of issues here with quads a dysfunctional quite often people with chronic backgrounds, we all know the way they've been walking in the way the pressures are their hip girdles, their leg muscles are probably quite a problem part of it, their upper body component is definitely a part of it. So so this gives them control and allows them to work broadly with their body.

Steven Bruce
If we were really quick, you might have time to go through the straight leg exercise you were talking about.

Robin Lansman
Yeah, if you want. Yeah, we did that last time some time ago. So what I use this is this is again, part of this or can be go from this into the straight leg raise. It's an active straight leg raise. It's not about testing for static weather. It could be we can run that cushion, but

because yeah, let's give him a question. If you Yeah, if you just put your legs out flat, both one and two, right. So what we're going to do, we're going to do a leg raise this is more to see recruitment through the hips into the back and vice versa. So if we tighten both feet tight, yeah. And what you're going to do is pre tighten your quads. So the quads are kind of activated and tight. And you're very slowly going to lift this leg, using a breath out or on a breath out or with a breath out. Just try and do that lifting until you find the back of your knee just begins to pull and says That's far enough. I don't want you need to bend. So just try and do that. Have you raised, breathing out through the belly? So you're getting a nice belly breath out? And keep going until me or Knodel? Do something. Yeah, that's about it. Yeah. So you can see how little excursion you're getting in your hamstring. Let's do the same with the other leg slowly, keeping the tension to the very last moment. Yeah. And we're going to do the same exactly with this leg. Okay, breathing out as you lift. Okay, and just go to that point where, which is really doing better than this. Yeah. Okay. So that's a good assessment of how your hamstrings are either letting go or not letting go. And it's also an indication of how well you're recruiting the quads, how powerful they are, but also how much recruitments going on? And where

Steven Bruce
it's a difficult question to answer how far you can rest. If you want to do, how far would you expect a patient with good quality hamstrings quads to be able to get well

Robin Lansman
considering age and fitness, I mean, you're not doing too well, in terms of range, but at least 45 degrees. Yeah. So what we can also do is find out is the component, the hamstring and legs, or is it more the low back. So the second part of this, depending on how you want to pull it together, if you just put both hands up out of the way, and I'm just gonna put my hand under your lumbar curve, you don't even have to lift it because it's a little bit of an arch. Yeah. And basically, I want you to do the same again. And I'm palpating really both sides of the lumbar spine between the middle to the lowest lumbar joints, okay, and breathing out, breathing out, and the more you breathe out, just want to see there's very little mobility in his low back at all, I mean, that's, I can still get my hand out relatively easily and down. Okay, and try the other leg. But when you recruit more, it does help the leg lift. Breathe. Yeah, so now you're a bit more focused on your back because my hands and your legs are going high. So so just drop down again. So that would say that he's lumbar spinal function a great, and His muscles are not recruiting too well, when we try and get them a little activated not too much. Because they're stiff, it helps the leg lifts. So that lumbar roll that lumbar functions coming in. And the more he gets the lumbar function, the more he's getting the leg lifts. So that's, that's a useful test. It's a useful exercise could be with someone sciatica as well for that matter, but, but it's a useful thing. And that could become a remedial exercise as well. That, you know, there are other ways to do it. But that's the beginning of it. And actually just repeating that looks like you're not doing much, but just doing that exercise, say 2010 each side, that would build to release the hamstring without you stretching it because stretching your hamstrings just makes the hamstrings go no, thank you. Right. And actually, people do quite aggressive hamstring stretching and rolling. And actually, this exercise by recruiting is switching off the opposite group. So your muscles are getting better at the front. And the hamstrings are saying like, Oh,

Steven Bruce
can you can you improve that in any way if you provided something under the lumbar spine to give proprioceptive feedback, so these people are pushing

Robin Lansman
people say a coin or any of anything flat, you can feel you know, would give you some connection, but it's not all about the core. It's about everything working together to get that function between the legs, the hips, the hips, just the when you put your Yeah, absolutely. So yeah, people do put something small, nothing big, nothing to lift it. But just something that you can sense is a useful way to check your getting that contact point. Yeah.

Steven Bruce
Jack, thank you very much. We're really showing.

Robin Lansman
Thanks very much.

Steven Bruce
See you for the next one. Take care. So somebody has made an observation. Jason has said that this seemed quite similar to an approach taken by Josephine Elphinstone who came in sometimes I don't, you might not be familiar with her. She's not an osteopathic chiropractor. But others might want to look at that one. Can we just, we would like to talk about the courses that you run the coaching courses. I think your website is www dot body. backup.co.uk. Yeah,

Robin Lansman
practice.co.uk. I mean, that's the practice website. But we've now put in the coaching option, because patients actually quite liked the approach as well. We get people telling other patients about it, but also, the thing I was teaching undergraduates and postgraduates all over all over the place of pre COVID. You know, is something now that actually, it's quite nice to do with small groups. And so initially, the preamble stuff, the things we've been doing now and more, you can do quite easily online. And in fact, we're doing it. In fact, linking people up with a video call. And, and in terms of a team, it could be someone in, you know, in the same practice, or even individual friends, colleagues, osteopaths, whoever, who wants to connect to do the course together. It's quite useful to do in the same room with someone, not me, but them so we can, they can practice on each other and actually palpate and we go through that in quite a lot of detail. Okay, so we're gonna run with the treatment table. Perfect. Yeah. And we've done several sessions so people can go away and try the ideas out in practice, and then come back and ask questions and actually have that chance because obviously went sometimes you know, you do a course roll day or two. You can't the question comes up two weeks later, not not so this gives them the chance to have that inner sense coached approach.

Steven Bruce
Is it better to do this face to face in a room with with other practitioners doing?

Robin Lansman
Well, I think what The way I manage it, I think is reasonably close in terms of our connection. And we also do some questions first to get an idea of what people need and what they want, and get some feedback on that.

Steven Bruce
I'm just asking, because I'm just wondering whether, if if we could put together a bunch of people, would it be a good idea to get them in studio? And do

Robin Lansman
I'd love to, I think some of the treatment techniques and some of the rehab techniques, if it's a group and, you know, an interested group is always lovely to work with. So, you know, I think I've done it with small groups. Partly people's logistics sometimes, but I think actually doing it would be great. I'd love to, why not?

Steven Bruce
And who, who would you take them out? Or CEOs, chiropractors? I'm assuming sports therapists physios?

Robin Lansman
Yeah, yeah, we get I mean, you know, when I've taught it before, we've had that in Germany, particularly lots of physios. Yeah, and personal trainers, and all sorts of people came actually, you know, people who were running athletics teams, and

Steven Bruce
we found out whether it was interesting. Yeah, if there is, yeah, you know, we've got this wonderful space here. I love running, I'd love running hands on courses. And so if we can get a suitable number of people together, well, on

Robin Lansman
the website, people do not we've got feedback from previous delegates on video that we shot at the time, a few years back. And I must say, people have told me even now, I get emails saying, I'm still using this in practice, it's saving my hands, but I'm feeling very connected with the patients. So the treatment techniques were kind of move on from this. But as we did that last bit with the neck, in a sense, the palpation, and traction and treatment that was linking the treatment to the functional movements, so that that would be sort of where you go next with it becoming a hands on technique as well.

Steven Bruce
I wonder to my own approaches, and I'm kind of for years, I've been quite resistant to the whole idea of exercises that that sounds weird. I know what because we're so familiar with hearing that people go to a practitioner given a sheet of exercises and disappear. But actually, getting exercises which have a purpose is a totally different thing, isn't it than just the standard sheet from the box? Well,

Robin Lansman
ownership is really, really key. I mean, I know, I heard a surgeon up in Scotland, I was speaking up there once and the surgeon from Strathclyde was talked about hip replacements and engagement with people doing exercises prehab. And it was really hard for people to do until they've been promised surgery to actually do the exercises. When the surgeon said, you got to do these, they often did that they did least well, when they got the printouts. Right, far better experiential. In fact, one of the slides if we can come on to it, can we do that? Yes, yeah. Because I think if we might be able to share this one, we've got a little bit about how the ownership Yeah, of if we can put this on the main screen, that'd be great to share. So this way of learning, I think, is something that's worth summarising on in basically, people learn stuff from their own experience, they get stuff from external experiences, but owning it personally is really powerful. And so what I'm really keen to do, and people say, Gosh, you spent 50 patients, that practitioner sets, we bet you spent half the session going through an exercise, or even a whole session going through an exercise. But what they've taken away is a personal experience. So when they get that feeling, and I want

them to sense and feel the exercise while I'm with them. So when they go away, and I even say to them, you know, apart from the video possibility of them, but when they go home, they should practice it when they get home just to kind of bed in when they're in their own space, how it feels and how it felt, and ask questions when they come next. And we can modify that and that link. I think that peer also linkage, you know, people can certainly ask you pass learning this can share and discuss and learn. But I think that personally experiences is something that doesn't just come from a leaflet doesn't just come from reading or watching a video on YouTube. It's not the same as feeling it. So it's very important to get that buy in, and that sort of sense from patients. And that's what I try and give my patients I love to teach that approach. So are

Steven Bruce
you happy for us to share the slides as a handout after this? There were very few, but it's always useful to have a bit of reminder, Mike has just said he qualified 20 years ago, and this wasn't a thing that was taught in any great detail. He says he finds it very interesting for his sports injury patients. But it's not just sports injury patients is

Robin Lansman
anyone who wants to perform better. I mean, I think probably what it is, is even elderly patients who've been told, you know, there's not a lot we can do type of line, which unfortunately, what a lot of them hear this approach and I use it for all age groups. And I think it's it's, you know, useful to activate muscles and to find different ways of exercising, that are not just about stretching, I did a whole presentation for arthritis section some time ago for their one of their London groups, and gave them some quite different ways of doing exercises, which were not the standard that were given for arthritis. And I have to say, quite a few came to me actually. And they were they were very happy to try something completely new. Yeah. So it's

Steven Bruce
something that is worth US covering at some point. Was that different exercises for arthritis?

Robin Lansman
Well, I think so I mean, a lot of the things that are taking pressure off joints and making things work more effectively, more efficiently. And actually taking people's mind is part of it, but certainly seeing that they are more able than they thought they were with bits that they weren't using. They've all that capacity and in fact the capacity to get well it's all about finding the bits that work and helping the bits that don't but people don't necessarily do that they become very folk As on symptoms, and I have to say, I think quite often, practitioners can fall into the trap. And I've certainly heard this from, you know, what patients have said into treating where the pain is and what they're told the patient needs. So that patient centred empowerment becomes a little bit damaged, if you only get driven to do what you're told to do by the patient. And sometimes pleasing your customer seems a bit like going to the headrest and getting the haircut that, you know, that you tell him that you might have some advice, he might have some ideas. But you know,

Steven Bruce
if we have a case based discussion about this, sometimes patients coming in determined that this is the treatment they wanted. And there were various approaches to that sort of patient, you know, you do something to placate them, but then get on with what you really want to do for them

Robin Lansman
as well, well, going back to expectations in the survey, it's really handy to know, in a sense, we'll get that upfront as to whether the expectations are where they're placed. Because otherwise the trust is broken, because you're not doing what they want. And some people see the world that way. And people who are very wedded to their pain and have suffered for quite a while very hard to shake, that, that you may have something else to offer them. And I think that's that even stops people coming to see a practitioner privately at all. It's not the money it's Is this worth spending? Is this worth doing? When I've been told by too many other people that there aren't there aren't options here. And that's actually probably the hobby horse of my career is realising you know, that there's so many people out there that are not accessing something that could really help them because their belief has been set up, normally externally by by miscommunication and misunderstanding. And, and even when someone says don't see them, they're gonna fix you, which I know is a very strong promise. You know, they're very reticent to actually to actually go ahead and do that. I've had conversations with many patients, they've taught six or seven people, you've got to go and see him. And yet he's heard back from it's not the money, it's they've been told that really, there's nothing anyone can do. Right? And therefore they're stuck in that rut.

Steven Bruce
We've got just a few minutes left. Something that struck me earlier on in the discussion is that we are about to start running as part of our CPD offering here multidisciplinary team meetings in the studio on a regular basis. And we'll see how often it's it works out. And there'll be run with the spinal consultant. I talked about Nick Burch because I used to go to his multidisciplinary team meetings. And they were attended by Pilates instructors, physiotherapist, hydro therapists, chiropractors, osteopaths, everybody, and Nick used to refer people to all of these people as he thought it was appropriate. But it was great because he would bring up the cases and he'd give us the MRIs and tell us the interpretation on the MRIs and ask everybody's input on how we could deal with this. And a lot of what you've said, this evening makes me think that this is a great opportunity for that improve communication between the teams, might be that we would like somebody else to come up and join that multidisciplinary team on an occasional basis. Sounds interesting. Oh, yeah, I think it might be you might, you might enjoy it actually, because great opportunity to share the sort of wealth of experience that you've got that anyway, I'll put that to you over a bit later and see if you're more amenable,

Robin Lansman
know that it's interesting. And certainly the work I've done recently, the Health Education England all those projects, in the way that they've transcended professional silos in all different ways, is about the communication style and the professionalism and the wanting to go forward with a team approach. And I think the ownership in that is really key. Beyond the minutiae, I in a sense,

Steven Bruce
Robin, we've let you down and see we had 420 people watching and I was hoping for over 500, but second, I'm okay, but there will be lots more that will watch the recording. But yeah, it's been it's been fascinating and certainly has given me a lot of food for thought for patients with my own just taught listening through in watching you. Oh, hang on here. Guest number 4363 years. So do you advise patients they might eat after doing the exercise essential? Final question.

Robin Lansman

Yeah, well, while the experience goes for while they're with us, that takes taking the time it takes to go through and explore, they will feel sensations that they can share almost certainly with us at the time. So you're not going to give them too many surprises. But obviously, yes, you know, the bits. We've just talked about the quads and sort of areas that may go into cramping spasm, so there will be some messaging there to share. Yes, to preempt that. Okay.

Steven Bruce
Brilliant. Thank you very much. Thank you. That's it. That's all the time we got for this evening. Apart from a couple of things I wanted to share.