Transcript

Product Review – The Mobiliser

By Back In Action

Taking Part:

Steven Bruce	–	Academy of Physical Medicine
David Newboud	–	Back in Action Director
Len	–	"Patient"

Steven: What we're doing is one of our periodic product reviews. Now, this is not a sales pitch. My aim with these is to get in bits of equipment which we've seen around the shows and the bazaars and how ever else we might here of them, so that we can have a look at them, see how applicable they are in clinic, and let you make your own judgment on whether it's something that would help you in your practice.

Steven: Of course, they're almost always going to be things that I've seen and thought have some promise, and that's definitely the case this occasion. To help us with that, I have got with me David Newbound. David, great to have you in the studio.

David Newbound: Thanks, Steven.

Steven: Now, you're the inventor of this, aren't you?

David Newbound: I prefer to say the developer, because I started with something that preexisted and amended it. But, the concept of using it as a mobilization technique, yeah, that's mine.

Steven: Okay. This is the kit. It's called the Mobiliser. We've got it folded in half so that you can see just how easy it is to pick up and carry around if you have to. It comes in a dirty great big carrier bag, but let's unfold it and you tell us what comes in the bag?

David Newbound: Okay. Actually, the fact that it's already foldable and portable is relevant because we have lots and lots of clients, clients of your practitioners for example, who use these at home in a way that they couldn't use many devices, like a massage chair, for example. Anyway, so what it is, is it's a unit that uses thumbs inside that lift the spine. They also lift the SI function.

Steven: When you say thumbs, you mean knobs?

David Newbound: Yeah. Knobs. We call them thumbs, they're latex, and the way the system works, it comes directly up underneath the spine, lifts the spine and then drops it

again. So it picks up a segment of the spine, lifts it, drops it. Any concept that it rolls through you is just wrong, it doesn't roll through you, it uses a roller as a means of applying a direct lift and a direct drop.

Steven: So each one of those thumbs is going directly upwards and then effectively dropping back off again? Yeah.

David Newbound: Correct. What it creates in the spine is an articulation, and a flexion, and an extension that's really quite large in amplitude. It lifts the spine from a low platform up by about three and a half centimeters. That's much too much for most early users, so we put this on, or sometimes more than one of these, and they effectively pre-lift the spine, so you're decreasing the amount of lift that's provided.

David Newbound: The second thing that we have to do for an early user is we need to raise their head up, so they get no backward arching of the neck. That could be stacking the head up quite high. For an average user, it's going to be just one and a half, like that. But, for somebody-

Steven: Those go under the head, not under the neck? Because the instinct would be to put them into the curve of the neck?

David Newbound: The idea is that this knobbly headrest here has some grip here, and in consequence slightly lengthens the neck, so it turns the upward movement of the thumbs in to a lengthening movement.

Steven: Traction.

David Newbound: Yes. Exactly. It's not a force, it's more a sense of direction. It encourages the neck to let go over the first 5, 10, 15 sessions, and eventually we get rid of this and then the thumbs go onto the neck.

Steven: Okay. So we're going to put those on there. Now, because we're ... This is a 45 minute session, so we don't have a huge amount of time. And the program on here lasts how long?

David Newbound: 15 minutes.

Steven: 15 minutes. Okay. We've got a bit of time to talk about it. But, what I wanted to do was get a patient on here early on so we can see it in action, and you can talk about what it's doing. Shall we do that straight away?

David Newbound: Yeah. We'll do that straight away.

Steven: Let me then introduce our patient for the day. Len, could you come and join us? Just to introduce Len. Len, thanks for coming in and giving up your day.

Len: Pleasure.

Steven: Len, you're 86?

Len: Seven.

Steven: 87. Happy birthday. You're 87, and you've got a very stiff upper spine, haven't you? And your head is a long way forward, which means that you have trouble actually lifting your head sometimes. Which is one of the things I was concerned about in putting you on this device, because I was worried that actually the strain on his neck was going to be too much. And also, his spine was going to be too stiff for this. And a little bit of history, you've also had L4, 5 lumbar decompression at some point, haven't you, a discectomy, in 2003.

Len: Yes.

Steven: So you've got nasty back pain from the lower back, which gives you sciatica, and a little bit of foot drop. You've got pain in the neck, so there's lots and lots going on with Len here. Take it away then, David.

David Newbound: Okay. So, Len, if we were meeting you as a potential user of this, in our business, i.e., not as a practitioner, but as a supplier of these, because we rent them out to people like you to use at home. We'd be observing that your neck carriage was far forward, we'd be thinking that we didn't want your neck to arch backwards, we'd be thinking we wanted the early introduction to be quite gentle. So we'd be raising the headrest up a lot in anticipation. We'd also be bearing in mind that we might use a second one of these, if you found it too aggressive on your upper thoracic.

David Newbound: But, this is a starting point we're normally happy in the mid 80s at, so I'm assuming we're not going to need the extra pad. We'll modify if we need to. So you need to get your bottom there and your head there, roughly speaking.

Len: Okay.

Steven: Right. Let's get you up there then, if you can.

David Newbound: That's it. Now, we're going to put your head just slightly higher up than that, so move up the bed a tiny little bit. That's it. That's enough. It just gets hold of your head and lifts it a little. And then, we'd be warning you that this was likely to be much stronger than you were expecting. It's going to lift you around, might cause you some concern. If you wanted to lift yourself away from it, brace against it, that's fine. Most people will find after five to ten minutes they start to relax into it, but we want that to happen when you choose, not because we tell you to.

Len: Okay.

Steven: Now you've just pressed a button on here. I presume you pressed auto, didn't you? Which is the top button on it.

David Newbound: I did. Yeah. The auto button gives 15 minutes, it's effectively a measured dose. Because we have practitioners who we are training to use this properly, because we have, at any in time, way over a thousand users who are in touch with us about using it, we need to know what they're doing, so we have a preset level. We do sometimes change that, but it's comparatively rare. What we normally do is to gradually phase out the protective pads and lower the headrest.

Steven: Right. Now, somebody is going to ask us about this in a moment I should imagine, but when those thumbs travel up here, you can see a lot of movement going on in Len's body, and also when they get to the top he's pulling faces, and his head's coming off those pillows. So is that uncomfortable, Len?

Len: No. No, no, just letting it do what it has to.

Steven: You're just pulling faces for the fun of it?

David Newbound: When we were back at the developmental phase, we had the institute at Roehampton attempt by various means to measure the amount of movement that was going to go on at the vertebral joints. They concluded that it didn't get up to 80% of normal maximum range movement. We were, nevertheless, I think in the ... I mean, this has been 17 years now since this was on the market. At first, we would have been concerned more than we are now, because we haven't yet had a single reported-

Steven: Adverse outcome.

David Newbound: Adverse outcome. Yeah. And so many positives. We warn people that it can be extremely uncomfortable at first, we prefer to tell that it might verge on being painful at first, then they're not surprised. And almost always you notice that within the first five minutes the body has begun to move much more easily.

Steven: Yeah. Okay. I've had, perhaps a predictable question come in already, which is are there any contraindications to use of this, and the suggestion is say, spondylolisthesis?

David Newbound: These headrest raisers are also within the manual as means of changing the pressure on different parts of the body. So, with spondylolisthesis we would normally lift up the pelvis by one or two of these pads so that the amount of pressure in the low spine was less. We have many, many, I mean hundreds and hundreds of users with that condition, they've almost always had a discussion with their medic about whether the situation is stable. Almost always they have other issues in their spine, particularly the thoracic where they really need to get it moving, and breathing more deeply, and so the system tends to get used more in those areas, and we decrease the pressure in the lumbar.

Steven: I don't know how many patients have been across this machine, but I imagine that amongst them there will be people with undiagnosed spondylolisthesis. And equally, the fact that you said you raise it by one or two pads suggests to me that you're not overly concerned about spondylolisthesis being aggravated, you're just trying to do a little bit to minimize the pressure.

David Newbound: It's difficult because I want to tread carefully in terms of wording. We have hundreds and hundreds of practitioners who use these in their practice day in day out. Some in the military, some of them might be used 20, 30 times a day. There are lots and lots of undiagnosed conditions that are clearly going on and off this. We, ourselves, run a consultancy system with every one of our users, so we stay in touch with them over days, weeks, months, years. We have not picked up a single negative consequence as a result of something undiagnosed yet. We all live in a world where that can happen to us, but it hasn't happened yet.

Steven: What about, next question, I don't know if it's a different questioner, but what about ankylosing spondylitis?

David Newbound: Yeah. We have long-term users under a study from some of the London hospitals. One world famous sports person has been using it for 11 years now.

Steven: Would it have anything to do with cricket?

David Newbound: No.

Steven: It's not the one I thought of.

David Newbound: No. It's not. Because he relies on sponsorship, he's not willing to have his condition known. But, we have 500 plus regular users with AS in very many states, and a number of those users at first were worried about using it during a flare. Universally, they have reported that that's not a negative consequence. Most of them, they've been able to cut down on some of the drugs they were on, so they're much more mobile. I would say it's one of our most successful conditions.

Steven: Okay. Which I suppose bears out the normal physical therapy protocols, doesn't it? That quite aggressive physical therapy is good for ankylosing spondylitis?

David Newbound: Yeah.

Steven: This is effectively what this is doing. And a lot of us in clinic might be doing something similar to this with our own thumbs, but we're not going to be doing it for 15 minutes, because it's bloody hard work.

David Newbound: The big thing with the use of this being a portable device that we can ship to somebody's home, and they can be using it within two days is they can use it

when they first wake up in the morning. Now, the use of just as they get out of bed is our preference, and just before they go to sleep at night. What they get from that is in the morning they get their body warmed up before they do their activities, and they start to break their habitual repeated use of their body. So they may be getting up as a 50 year old when they're actually a 40 year old, but that's become their habitual way of dealing with their body.

David Newbound: If we can warm their body up first, then they start moving in a freer way. They then do more activity during the day, then in the evening they give themselves the gift of it just before they go to sleep and they start the next day. It takes maybe three to four weeks before they're now finding themselves getting to the evening and their more spontaneous, amplified movement has persisted without them feeling too tired.

Steven: Okay. Are there any published trials on this, you know, that would stand peer review and so on, that say, "Here are the measured outcomes between different groups"? And I'm not going to hold it against you if there isn't, because we all know that that's very difficult to do.

David Newbound: No. I'll explain it in detail. When I was going from prototype stage upwards with this I had a relationship with Dr. Redgrave who's a surgeon and an osteopath. She was loaned many, many units to do her own trials because I felt I wasn't insured to be doing that. She argued that it wasn't necessary to go ahead and do trials because each of the modalities that it offered was already well researched and known about. I thought that was perfectly feasible. If I could go back now and change my view then I probably would.

David Newbound: What happened within about two years was the military starting buying units in order to do their own research, because the prize for them was getting people back into active service more quickly, particularly prolapse. They were very interested in that, were concerned that there was no research, so they just simply decided to do their own. That research came out extremely well. They bought units for each of their rehab units. It went through the NATO medical committee as being safe and effective on low back prolapse, although they use it for many other conditions.

David Newbound: Sadly, they won't release the trial data. So they've allowed us to make the statement that they did the trials, which was run by two GPs and two in-house physios. But, they won't release the data to us.

Steven: Quite bizarre, isn't it?

David Newbound: I think in a way it's understandable. That's the culture within the military. The only thing that exists is the physio that did the original pilot study, published it as part of her qualifications, and we have that, and we issue it within the manual, and we will issue it to anybody who wants it.

Steven: Okay. Before I take up these questions that have just come in, could you explain what these thumb ... there's two sets of thumbs going up and down here, right?

David Newbound: Yeah.

Steven: What exactly are they doing over this 15 minute protocol?

David Newbound: Right. It's incredibly simple. They effectively lift the person on four points, and drop them.

Steven: No. But, they're going up and down, is there a pattern to it?

David Newbound: The only reason there is a pattern is in order to make an early user find it more difficult to predict it. One of the things that, amongst the many things we're

tackling ... Bear in mind, this is aimed predominantly at chronics who regularly go acute, who aren't responding well to treatment, time, or drugs. It's not a great sample set if you want success, but that's our target. What we're looking to do is to overcome their over-defensiveness that might inhibit their recovery. So we randomize the movement of it so that they get to feel that their spine is stronger than they thought it was, that they can't go, "Oh. I'm moving out of the way. This is being done to me, and I feel good about myself that it could be done, and I didn't collapse." The randomization of the program is really not particularly important.

Steven: But this is covering the full length of the body, isn't it?

David Newbound: It is. So because really frequently we'll have somebody get on this where their legs are behaving completely differently, not because their legs are different, but because their thoracic is different, or because their lumbar is different. We work on running through the backs of the calves, and eventually maybe week three, week four onwards if they were using it twice a day, we would apply weights that would pin those parts down and start softening off the leg muscles a lot.

David Newbound: For a very more advanced user, particularly dressage riders, they'll have this across their SI function in order to equal up the SI. A very, very advanced athlete will probably have five or six of these all over them from the top down. So, in GB rowing they're usually using three of these, and they're using the system three times a day, whereas a person who's in their 80s with Parkinson's is probably going to be using an extra softening pad, and would never dream of putting this on their body.

Steven: Yeah. We have been asked if you can adjust the speed and intensity. And although I know the answer to the next question, I'd like to say can you also alter where these thumbs are operating?

David Newbound: Yeah. Absolutely. If you wanted to set it to within a six inch zone, or if you wanted to drive it completely, then you can do that. You can also set it to work on the whole body, and as it goes past a particular area, to give that area extra attention and then to go on its way. All of that's possible. The fact is the vast majority of our home based users will use it on the 15 minute program and fall to sleep.

Steven: Okay. So you can adjust the intensity in that you can say, "Work hard on this bit here." You can't make the thumbs stick in any further?

David Newbound: Well, at the moment bear in mind for an early user we've taken away ... Well, if we did pressure mapping, we're at less than 1% of its full intensity. But, the intensity goes up very greatly as you increase the lift a little bit.

Steven: How do you do that?

David Newbound: This pad is pre-lifting Len. So gradually we phase that, and then by changing your body position you change the intensity in different areas. By lowering the headrest you put the weight of the head onto the upper thoracic.

Steven: How much of that has to be practitioner guided? Or, could you say to a patient, "Just get on with it, and after a few months do this, do this, do this"?

David Newbound: Most practitioners, if they're using this in practice will be having a conversation with the user about useful stuff like diet or lifestyle whilst this is occurring. Some practitioners use it before manipulation, some after, during the training that we give them they find out which they like for which type of patients. Now,

there's a completely separate set of users, which is the ones where a practitioners has said, "You should get one of these and put it at home for a month," and we've hired it to them. In that particular case we set up a consultation system, and our advice will be different for every single user.

David Newbound: But, it rarely involves localizing the system. It usually involves changing the time of day that they use, the body position they're in. Most people will still stick with just pressing the one button and running it for 15 minutes.

Steven: Okay. Obviously, people are interested in outcomes because you've mentioned the military study that says it's good, but you can't see the research. Which answers another of the questions, is where do I get the research paper? Which is, presumably you can't get the research paper.

David Newbound: You can't get that research paper. You can get the pilot study easily from us. The pilot study was run by a physio, it passes muster in terms of whether it was a good trial, but it was a very small dataset.

Steven: Okay. But, it's a private study, so that's what you expect, isn't it. I didn't mention when you came in, your organization, your business, is Back in Action, isn't it?

David Newbound: Correct.

Steven: And backinaction.com is the website?

David Newbound: .co.uk.

Steven: .co.uk. I beg your pardon. So backinaction.co.uk, so you can find this stuff there. Right. More questions.

David Newbound: Can we just say, the Mobiliser is a part, a very significant part of what Back in Action does, and it is on the Back in Action website, but it has its own website which mobiliser.com.

Steven: Mobiliser.com. We'll put these all up on our website so that people can see where to go. Lee.

Len: Falling asleep.

David Newbound: Good.

Steven: Lee has asked where he gets the research paper, which you have just answered. Steve has asked, is there any data that demonstrates tangible greater flexibility in the spine after a period of usage? Which I guess is a similar sort of question.

David Newbound: That was within the military pilot study. They measured things like the change in thoracic expansion. Within 20 uses they had approximately 31% increase on their users. We, ourselves-

Steven: Sorry. 31% increase or 31% of users had an increase in-

David Newbound: No. 31% increase.

Steven: Wow.

David Newbound: Yeah. The pilot study was exceptional, which is why they commissioned other studies because there was some skepticism as to whether the results would be repeatable. The people that were involved in those trials are contactable, completely independently. Major Nell Mead has left and now runs a private practice in Liverpool Street, she has a Mobiliser within the practice. She's used one in the military for many, many years, ran the original pilot study, helped on the subsequent trials. She can be contacted any time.

David Newbound: Wing Commander Chris Beach was the head physio for the RAF. He's the one who commissioned the other trials, and he recruited internally the GPs and the physios. He's also left the military now, he works in a hospital for those with MS

in Amersham area where he's put Mobilisers in for people to use there. Again, he can be contacted. They can both speak of the trial data in a way I can't.

Steven: Okay. Sue has sent in a question saying, "This doesn't seem to be contacting the thoracic spine, is that a problem?" She says.

David Newbound: I would say it is contacting the thoracic spine. It's lifting the thoracic spine quite a lot. The more we lift the head, the less the weight of the head is applied to the upper thoracic. For us, for people like you, Len, our first 20 uses, we're really only aiming at the thoracic, we're trying to get the thoracic moving more. If we say that the thoracic is between here and here, would you say it's been applying itself to that area?

Len: Yes. I can feel it lifting that part of my body, stretching the spine as well.

David Newbound: Was it Sue you said asked that question?

Steven: Yes.

David Newbound: I would say to Sue that the issue is that what you perceive when you're looking at is nothing like what you perceive when you are using it, and that's why, and we'll probably come on to this later, that's why we have a program where we'll loan them to practitioners and they can experience it themselves.

Steven: I have to say, my own experience of trialing this when I came across you at two exhibitions, I think one was the Institute of Osteopathy and the other was at the MCA conference. I tried it, on both occasions, because I've got a very poor memory, I was quite surprised at the intensity of this. And I certainly felt it going through my thoracic, I mean that's the bit where you feel, "Gosh. This feels quite uncomfortable."

David Newbound: Yes. If I go back to 17 years ago when I was taking it to lots of my friends who were practitioners, and saying, "There's this prototype, what do you think?" Universally, everybody said, "It's too strong." So Sue's reaction as an observer is different to the reaction as a user. Now, I'm satisfied now that it's not too strong, and the vast majority of the people who thought that would no longer think it now. But actually, it is, I can promise you, Sue, it's really quite intense on the thoracic.

Steven: I'll come back to these questions in a little while. I was going to say that very few people at home have got a treatment table that they can put their Mobiliser on, so presumably they're going to use it on the floor, they won't use it on their bed or something really squashy, will they? Does that actually magnify the force of the thumbs?

David Newbound: Yeah. When I first drank wine I thought [inaudible 00:23:16] was the best thing in the world, and now I've got all sorts of distinctions. When people first use-

Steven: That was early experience of the floor was it?

David Newbound: Yeah. Thank you. An early user of this just thinks, "God, this is intense." And, "Is this okay?" Putting it on a coach like this, slightly decreases its intensity. Almost all of our users are having it delivered to their door and they fold it open and they put it on their spare bedroom floor, and that's where they go to use it first thing in the morning, first thing at night. And it will therefore, be slightly more intense than Len just experienced.

Steven: Yeah. Has he finished now?

David Newbound: Yeah. We've gone through 15 minutes.

Steven: You can stay there for a bit, and we'll talk to you in a second about your experience there, Len. Great question here which I'd love to answer myself, but

I'm going to let you do it. How does this differ from those massage chairs, because they've got thumbs that move up and down?

David Newbound: Yeah. Okay. It's a fundamentally different design concept. Within a massage chair there is a deliberately designed way of avoiding bending the spine so that you can apply a massage chair to a very broad spectrum of users without doing any checks as to whether they're suitable or not. So inside the chair mechanism there is a rocking head that always spreads the load over around about six inches. If I wanted to break a stick I would put it ... Let me use this. If I want to bend something, I create a point of leverage.

Steven: You hold that thing, saying I'm going to use this, and Len's looking really worried. Because I was worried about what that was for as well.

David Newbound: This is representing what's been happening to you.

Len: When does the torture start? Now?

Steven: Yeah.

David Newbound: Yeah. A massage chair is designed to apply itself over a long length, and in consequence it creates almost no leverage.

Steven: Point it to the camera so they can see what's going on.

David Newbound: Right. It makes virtually no leverage, so you get minimal flexion and extension in a massage chair. You get lots of massage, but you don't get any mobilization. The idea of this device, which is why it's conceptually different, is to use its force to create movement of the vertebral joints.

Steven: Yeah. Okay. You mentioned the fact that they don't have to do any checks for a massage chair before any old person can get into it. Which actually takes me back to that early question about contraindications, because we talked about ankylosing spondylitis and spinal problems as spondylolisthesis, are there absolute contraindications to using this?

David Newbound: Well, let's deal with the one that a lot of the time people don't really know why they restrict it, which is somebody who's pregnant. We don't have a view as to whether or the use of a mechanical massage device is or isn't safe, so we advise against its use. We advise against using it if you have had a procedure applied to you, deliberately designed to prevent movement of a vertebral joint.

Steven: So if you ...

David Newbound: Yes. Rodding up in some way. However, let's be clear, we have hundreds and hundreds of users with those conditions, but they have come to us with a letter from their medic that says, "The procedure is stable and we can now treat this one joint, or these two joints as if it was one vertebral bone, and we can mobilize on either side of it." But we don't make that decision ourselves, we would eliminate that group of people, part them to one side and say, "Now you have to discuss that with your medic."

Steven: Okay. Sue's asking again about osteoporosis this time.

David Newbound: Yeah. It's an interesting one. Ann Redgrave originally, Dr. Redgrave originally wrote the contraindications, and she didn't include osteoporosis. I was concerned about that. She still doesn't think it should be included, and we certainly haven't ever had an incident, and I think it would have come up by now. But, we chose to take contraindications off our website because we received legal advice that by putting some contraindications on there implied that we had thought of everything, and we have never intended to think of everything, we can't, it's just not possible. We can't think of the implications of

telling somebody to go for a walk because they need more exercise, they could trip or whatever.

David Newbound: We do advise anybody that says that they are very osteoporotic to go and get advice as to whether or not this type of mechanical force is suitable. But, we don't take responsibility for that ourselves.

Steven: Let's get some feedback from Len on this. Len, would you be happier sitting up, or are you happy staying down where you are?

Len: I think I'd like to sit for a bit. My neck is killing me.

Steven: If you swing your legs over that side. Okay.

David Newbound: Can I just say, we would advise anybody who's just use this to go from being lying down, to being on their feet, but still leaning against it, or leaning on a good chair. Because typically, we've softened them up, and one of their issues is normally that they sit badly, so Len will sit badly like this, and I'd prefer that he was on his feet and just leaning against it. Would you be happy to do that?

Len: Yeah. Just let me get off of that for you. There we go. How's that.

David Newbound: Yeah. That's fine. So we're usually wanting to wait 15, 20 seconds just to make sure somebody is not giddy if they've got off of a table.

Steven: Yes. Okay. How did that feel, the treatment, Len?

Len: Well, it's very comfortable. I found it very pleasant when it gets between my shoulder blades and my neck. The lifting and movement there feels very good.

Steven: Yeah. And you've always responded quite well to traction of your neck, so that's possibly part of it, if these pillows are actually applying a little bit of traction as well.

David Newbound: I don't want to create the illusion that this applies traction. What it does is it gives the neck and the head a sense of where up is versus your thoracic. So because my background was Alexander Technique, I'm interested in the idea that this encourages the neck to let go and lengthen. It's doing that as a direction, but if it had any great force it would simply slip under the head. But, I do think it has a very good effect on the neck, it does cause quite a lot of lengthening.

Steven: Now, I haven't explained this already, but I've already had Len on this device in the past. Now, Len's been to see me on numerous occasions, he comes on a weekly basis, and I can relieve the pain in his neck for two or three days, at the most, before he comes back. I haven't been able to do very much about the continuing the chronic low back pain, for which he's on three Tramadol a day, and has been since 2010 or something like that. So far too much Tramadol for a normal person. His sciatica, I'm not doing anything about that. Len, do you remember when you first used this?

Len: Yes. I do.

Steven: How did you feel after that particular session?

Len: Very comfortable.

Steven: Right. Did it have any effect on the drugs? Did you continue taking the-

Len: Yes. For a day or two I found I didn't need as much Tramadol as I would normally need.

Steven: Okay. Why only a day ... it's just a day or two after the treatment?

Len: Yes.

Steven: But that was, you were coming to see me once a week, and you were seeing this in clinic, so it wasn't as though you were using it every day at home.

Len: No, no. I've only used it-

Steven: And I have to say, I was quite startled, because I was quite worried about putting you on this device given that degree of kyphosis, and the amount of rigidity I felt in the spine. I was really startled when you fed back that information. I actually lent this to you for a couple of weeks, didn't I, one of these devices? It wasn't quite so effective then, was it?

Len: I didn't use it properly.

Steven: What happened?

Len: I was using it the wrong way around.

Steven: So you had your head up this end?

Len: I had the head at the wrong end, yes.

Steven: Which isn't your fault. That's my fault. I only mention that because I thought as a practitioner it's worth remembering that sometimes you've to make sure the patients ... because it looks the same with the pads on, doesn't it? You've got to explain to the patient this is not the pillow.

David Newbound: Can I also just remind. There are two different ways of using it. When it's taken by a practitioner either for evaluation, or because they decided to become an owner, they may take our training, they may not. But, they use it with their patient the way that they think is appropriate. The moment that a practitioner says, as you might have done in Len's case, "Right. I think it would be really useful if you were using this in the morning and wake your spine up, and then let's see what changes. And then, let me see how my treatment of you modifies in, say three weeks time."

David Newbound: The moment you're going down that route, the responsibility for guiding the patients is ours, and we have a daily interaction with them. So we would have picked up instantly that Len was using it the wrong way round, we would have been discussing with him the best way to use it, the best time of day, and so on.

Steven: I feel bad enough already.

David Newbound: Yeah. Sorry.

Steven: Len, thank you very much. Do you want to go and take your seat again, rather than you leaning there, and we'll carry on our discussion about this and some other things, because there's a whole load of questions have come in as well.

David Newbound: Sure.

Steven: Okay. I think this might be Sue. Her previous question was specifically about the upper thoracics, T1 to 3 isn't being contacted, but something about clarifying that. I see, they've put the questions together. T1 to 3 isn't being contacted, says Sue.

David Newbound: I don't know where the camera is looking at the moment.

Steven: The one from the side here. Yeah.

David Newbound: So this is being set up for an early user, and it's being extra gently set up for a user in their 80s with a large amount of kyphosis. Now, even for any early user, this area here gets no attention, and this zone, going to be seen on me, doesn't. In my view, because we have made measurements of the vertebral movement, the upper thoracic is being moved, but it may not be being pressured. As this gets lowered, and as this gets moved down gradually, I'm exaggerating maybe 20 uses here, as this moves down and down and down, then the thumbs are coming right the way up, and they're going right the way up into the base of the

skull. It's a completely different beast, but our job or the practitioner's job is to get that progression to occur at the right rate for each user.

Steven: Somebody's asked, what about patient's who are clinically hypermobile? Surely mobilization wouldn't be appropriate for them?

David Newbound: Right. Okay. It's not going to move any of the joints beyond a normal range of movement, and let's remember that back from our original measurements. With hypermobiles we warn them that if they're paying us for the use of the Mobiliser they should know that they've got about half of the measured success rate that we normally get. We advise them that they must progress much more slowly than all of our other groups of users, because as they let go with the tension in their spine they've got to take up active control and they've got to wait for that to be able to build up.

David Newbound: But providing that, they use the system progressing much, much less, and they don't go as far, the results are usually very good. We have to stop hypermobiles from using it too intensely because they want to get rid of the symptoms.

Steven: Right. One thing that went through my mind when I started using one of these myself for a trial and lending it out to Len, was that as the thumbs go along your spine, actually there is a tendency to tense, to stop your spine from over-flexing, over-extending. Which is actually not dissimilar to many of the exercises that we use in order to stabilize the spine by exercising the postural muscles, the [inaudible 00:35:00] and so on. I wonder actually if that's part of this, is actually in a hypermobile person it will be making them tighten those muscles up, which is ... exercise is beneficial [crosstalk 00:35:10].

David Newbound: The tightening occurs until for whatever reason, and I think we could debate lots of different logics as to why the reason changes. But, the tightening occurs until the person allows the movement to take place. Now, what's changed, we could debate. I think most of our practitioners say what they observe has changed is beneficial, but it happens when the spine believes it's okay to let it happen. So the effect you're describing is an early effect, but would drop off with time.

Steven: Now, a lot of people have asked about cost and availability, and what you do with them. We will get on to those questions, but one thing that I'd like to ask is, how you would expect a practitioner, an osteopath or chiropractor to use this in their own clinic? If you look at Ann Redgrave, Lady Redgrave's site, her website, she says that she will give it to patient's 15 minutes before treatment and or 15 minutes after treatment to get the spine moving.

David Newbound: Depending.

Steven: Yeah, depending. I seem to recall you saying that wasn't how you envisaged it being used when we spoke at the McTimoney Conference?

David Newbound: Okay. Can I go back a stage? More than 50% of all of our practitioners who have purchased a Mobiliser don't have it in their clinic, they have it at home, and it's for them and their family. They're very happy with the way that their practice works, they're not very happy with their own view of their own longevity as a practitioner. So the first thing is to recognize that practitioners are not immune from the problems of our normal everyday customers who come to see us with back pain.

David Newbound: The second thing to say is, when we loan them to practitioners, which we do for up to three months so that they can just have a long hard look at it, we will

encourage them to have it in their home not in their practice, and to use it the way a home based client would be using it. Use it when you wake up in the morning, use it just before you go to sleep at night.

David Newbound: Now, when practitioners put it in their practice, the difficulty in answering how they put it in is because some of them have a spare bedroom, some of them have a six room practice scheduled by a receptionist with online booking. There are such a wide variety of ways they work. I think if you want to see a small practice that doesn't have room to leave it out all the time, then I'd suggest going and looking at the video on our website made by Richard Gubbay, a chiropractor in Exeter who's used one for seven or eight years now. He gets it out, maybe five or six times a day and puts it on the floor, and he uses it for that subset of his patients.

David Newbound: I think the real skilled use of the Mobiliser is when you recognize the patients where if they used the Mobiliser, either in practice or at home, they would make a leap forward in their situation. And that would also inform you better in terms of where to go with treatment. That's a very positive cycle. I can't think of any practitioners who would use this universally on every patient.

Steven: Right. Okay. What do they cost?

David Newbound: They start from £2,200, they'll have been used within our hire fleet, and they go up to £3,300 and they'll be new and have a long five year warranty.

Steven: Any warranty on the used ones then?

David Newbound: Yeah. One year. In practice they're not going to go wrong, but that's the nature of we're selling them when they're already three, four years old.

Steven: Are there lease options?

David Newbound: Yeah. We have lots and lots of people who are paying, say £130, £140 a month. Some of them will have put down a small deposit. But, the majority of our clients, they just say, "I'm going to have one for a month." We have a minimum package of a month. It's sent to their home, they use it, they report to us their background, how they're reacting, their relationship with their practitioner. They can invite us, and we will willing carbon copy in their practitioner, so their practitioner can join in with the conversation.

David Newbound: Quite rapidly, most practitioners are very happy with the way we handle it, and don't want to have that involvement. We're not talking to them about medical conditions we're talking to them about an effective way of using it for them and their lifestyle.

Steven: The email that I sent out to people telling them about this broadcast mentioned the fact that you do this three-month trial, and we've told them that you've got 50 of these available for people to try at the moment. This is not a sales pitch because I've got no vested interested in whether these things sell or don't sell. You're not giving me any kickbacks or anything on this, and I wouldn't take them if you offered them.

Steven: What impressed me about the trial, which I took up, was that I didn't pay for anything. This thing arrived in my clinic one day, and we unwrapped it and put it on the table. We used it according to the regular emails, or texts and emails that we got. There was no pressure on me to buy it at all, and when it came to return it, your team are quite happy to come and collect it, and take it back. There was absolutely no cost whatsoever to people doing the three month trial.

Steven: I admit to being very skeptical about this. If I confess, the only reason why I didn't keep it is because I don't actually think that my back was bad enough to merit it. So personally I didn't feel that I got the improvement that probably someone like our patient, Len, would have got with this. Nevertheless, I still say that it's an offer that people really ought to take up. There were lot's of skeptics out there, and I think what have you got to lose? If you've got space to put this on the floor in your house and then just fold it up and put it against the wall when you're not using it, then it's something which ... it's a useful thing to know about, even if all you're doing is saying to occasional patients, "Well, you might want to have a look at this."

David Newbound: As a company, we started on the basis that I was disillusioned with the whole sales process which seemed to be forcing people to do things that they wouldn't otherwise have done, and didn't want to do. We've had a very gentle trial it and see approach from the very beginning. You want to buy a chair? No, we're not going to let you buy a chair, you have to borrow it for a week, because before you pay for it we want to know that you're going to be a happy customer, and that we've got it right. And from that, we learnt lots.

David Newbound: With the Mobiliser, when we first put it to market we did the same, we just kept loaning it to person, after person, after person, until we learnt the best way to teach them. With practitioners, we used to go to all the conferences, such as the conferences where I've met you before. We would market it, we would say, "It's this much money to hire one, it's this much money to buy one."

David Newbound: But, from the conferences, we get to talk to 15 people in two days. So we just decided instead we would put our money into having a group of them and just loan them, and if somebody doesn't like it, it doesn't work for them, that's absolutely fine. They know that they were given every opportunity to have a look at it fair and squarely. But, a really large proportion of the people who take up this free scheme do, in fact, fall in love with it.

Steven: Well, we're at the end of our 45 minutes now, almost. What I would say is, that I'd be really interested if as many people as possible took up the offer of borrowing one of these. If you'd like to borrow one yourself then just drop us a line, either by email or use the chat facility on the website, or comment on Facebook and say you'd like it. We'll arrange for David to get the kit to you. There's 50 of them, so get your name down quickly because otherwise you might be a bit disappointed. But, it would be also really useful for us, because we'll know who's got them and we will stand aside from this, but we'll also seek your feedback when you've had it and find out just what you thought about it. Is that a fair thing for us to do?

David Newbound: Yeah. And if people are interested they can schedule it ahead, so there's holidays coming around at the moment, for example. So you can say, "Yes. I do want to take up one of those 50, but I want it to be in two months' time," or whatever.

Steven: Well, whether or not it works for you personally, it certainly won't work for every patient, because some people it's not entirely relevant, it's certainly something worth knowing about. And I would really urge you to take up the trial. And David, thank you very much for coming in and going through all that with us. A long way to come for 45 minutes, I know, and thank you for bringing the kit and so on.

David Newbound: Very welcome.