Academy of PHYSICAL MEDICINE

Transcript

372R- Basic Neuro Testing and Red Flags with Barry Jacobs & Will Williams

Steven Bruce

Good evening, welcome to the show, possibly you got absolutely no idea just how auspicious this day is our 10th Birthday here at the Academy. In it there were times when we set this business up. But I genuinely didn't think we'd make our first anniversary, let alone our 10th. There's a lot of stories I could tell you about that. But here we are, we're 10 years old. And we're still going very strong indeed. That of course, is thanks to some very hard work by a lot of people behind the scenes and behind the cameras here. APM, quite frankly, is also down to you as well, your faith in us. So thank you very much for that. We do get a lot. And I mean a lot of the messages from our members saying how much they appreciate what we've done for them and, and that genuinely, that's our aim here. What I hope you know is that I want you to take away, I want us to take away as much of your stress as we possibly can, leaving you to get on with being a great practitioner. So I will keep on saying this. But if there's anything at all we can do for you just call us or email but don't whatever you do, don't worry about bothering us because it's what we really want to do. That said, this week we have as they will say on radio fours I'm sorry, I haven't a clue been inundated with a complaint. It's a good natured complaint but a complaint nonetheless. And this is what it is. Please can you do something about this god awful music put on something else. Anything else in capitals? This stuff is just awful. Please, please can we have a change? Something soothing or upbeat? Anything that doesn't repeat every five seconds of my infernal loop, please, I'm on my knees begging you please. It wasn't good nature complain. But this is why we have changed the whole music before the show starts. We had an impassioned plea to change it. So we did in our defence, the original stuff and the new stuff are actually two minutes. So they're not a five second loop at all. But I am like you I hate cheesy hold music that my banks one of the worst. But one worth remembering the music's only there so you can test that the audio is working you we go live bang on time. So you could just mute the volume and set an alarm on your phone if you want to do that. But you might remember in the good old days, we used to pick commercial songs which reflected the topic of the evening so we'd have half a dozen singles on a loop. So that means 20 or 30 minutes of commercial music. We actually had to stop doing that because even though we had a licence for it, Facebook would still

block the stream that goes out to our members group, a Facebook decision not ours, but They won't, we aren't doing our best to make the show as enjoyable for you as possible. So let's get on with the show. I've been talking about pulling music. I have two guests with me this evening musicians. They were both lecturers when I went through my own training as an osteopath. And both of them have been on the show before. Barry Jacobs, apparently a jazz pianist and accomplished jazz pianist was in fact, my first ever guest in June 2014. And that inaugural show was all about red flags, as it is this evening, at least I think that's what we're going to talk about this evening. He was also my guest for a show that we ran from Wembley Stadium. And that was quite exciting. So welcome back, Barry, it's good to have you with so much thing. We've also got well Williams, Willa has been an osteopath for almost 30 years. He's also an NLP practitioner and a freelance composer and musician. So maybe we'll get him to rewrite our hold music for us. He has actually volunteered to do that. So watch this space. Well, great to have you here. Delighted to have the pair of I feel like bloody Michael Parkinson with Peter Cook and Dudley Moore on the show. I really do. Our audience have no idea what's been going on before we went live and see your impressions of their songs. We've

Will Williams

had some jolly Jane

Steven Bruce

we're gonna talk about red flags. First of all, probably was one that was one of them. What's changed since 2014. In your attitude towards red flags,

Barry Jacobs

I think I've become a bit more cynical, because I'm worried about the detection of so called red flags and how red flags have actually become so much more inculcated into our culture, effectively. Apart from the pressure of litigation, I think education has now become more pressurised. So therefore, education has become compressed. And consequently, people are much more likely to be prescriptive. So I can wax lyrical about red flags, as you know, in that I always feel and I think we kind of all feel a bit more experienced and on the to the whole concept of a red flag is is constituted by whatever makes you think it is. And that sometimes can be a real subtlety in primary care.

Steven Bruce

So are there any absolute red flags in your mindset, there's always

Barry Jacobs

there are always going to be red flags. If you look at NHS guidelines, etc, called requirements, the main one, for example, very, very low on the credibility level, and in that it's very rare, but catastrophically critical. So we always ask, don't we, because it's too important not to.

Steven Bruce

We've done a couple of shows on that actually. And for anybody who hasn't seen him really worth looking back James Booth, you remember James from college days, outstanding student in those days on outstanding osteopath went on to be one of the then Bo A's fellowship students at the Queen Mary's spinal unit in Nottingham hospital. We had him on to talk about red flags. And he had some fascinating and invaluable advice on how you deal with it and the questions we need to ask as well, because it's the questions that we don't like asking, you know, how's your sexual function? That's a really hard one to ask of people, isn't it? But actually quite important. Even better, he has some great advice on how to get your patients seen efficiently and effectively if they do get to a&e. Because it's not, it's not always good enough just to send them is it because they will get dismissed osteopaths in the often it's

Will Williams

very important, sometimes to assemble a good letter to whomever it concerns, to help to see the case.

Steven Bruce

His advice, his advice was, and it's brilliant, and it would never have occurred to me and anybody else it was with your phone in the hospital and you say, can you page the on call spinal fellow, I'm sending you someone who has the symptoms, I suspect, quarter recliner, and that person will understand what you're talking about. And they will put the whole process into motion. I've sent letters with patients to hospital and it just been sent off with ibuprofen in the past, and then had to go for surgery two days later. But we're not here to talk about spinal cord recliner. I just think it's so important. We should mention it. Yeah, for sure. So yes, there are some there are some obvious things which you don't treat, which I guess would be red flags. There's no good doing osteopathic technique over an open fracture or something like that. So when you was proved for 90 minutes about red flags when you were in in 2014, and subsequently we did a course on it locally as well. So it gives us some more flavour for dealing with Alright, so conditions which might be cool.

Barry Jacobs

Let me try and just turn that around a little bit. We're in primary care. The thing I'm not particularly keen on, as I said before, is prescriptive lists. So you might not infrequently encounter publications that will list red flags, people worry about aortic aneurysm and rheumatoid and as you say, fractures and pathological fractures the thing, the problem with that kind of ideology is the bits in between. In other words, If I think we try to instil the notion that red flags will be that overt, that obvious, we're going into the territory of pattern recognition. In other words, these conditions are required to fulfil certain criteria. Now, I think I've talked about this before, I remember having the conversation with my 12 year old son about this, actually, he was quite incisive. And he said, Well, maybe it's not about pattern recognition. It's about pattern failure, except the the pattern that we're talking about is one of normality. We are in primary care. And obviously, the more experienced we've become, and this takes me back to what we were saying about education. The more you get to see the more you get to soak up, the more you get to appreciate what constitutes normality. In all its variegated states, maybe the more perceptive or sensitive you will become, about when one pixel in the pattern has

gone wrong. That's very, very difficult, because as I always used to say, when I was an undergraduate, no one signs pathognomonic. No one sign names the disease, there was used to say the first rule of examinations observation, the second was comparison, but frankly, history, history history. And obviously, the more the more detailed, or at least or personally detailed your history can be, then the more equipped you're going to be to start to weigh things up. And it is often very, very difficult,

Will Williams

I should a very important word there. There's important normality. Students, they come to us, they work on each other a lot. And most of the students are normal, in terms of tissue dysfunction. So they're feeling normal, normal, normal, normal all the time, they might find that boring. But it's a great education, because it's only when they touch tissue, and find that it's different from normal, that they can start to become inquisitive. So the the idea of normality is really very important, I think,

Steven Bruce

coming across in education, and you were talking earlier on when we were up having coffee in my office, you were talking about how courses are being curtailed, and students are getting less time with patients or less time in total.

Will Williams

Well, we used to be a five year a part time goes up, I say part time, that's an awful term, because it means that the students are still working. But they have to fit in that study in the time that the this available for them. But we used to be run over five years. And many, many, many times we used to notice, and the students used to say as well. But it wasn't until they got to the fourth year, the penultimate year, that they really started to understand what was going on. At last it made sense to them. At last, they could synthesise from what they've been learning. At last they knew what they all began to know what it was about.

Steven Bruce

It's hard remembering back that isn't it. But I can remember being a bit bewildered through most of my osteopathic training, because as you say, you've got to draw those threads together, which takes a lot of practice, it takes a lot of feeling the normal before you start to understand what it is you're supposed to be looking for. Any apprenticeship is like that. Yeah, you'd like to think, wouldn't you?

Barry Jacobs

That's just a question of practice branch.

Steven Bruce

I get the sense that a lot of students are coming out of college now. Well versed in the theory of medicine. So I'm sure they come out knowing the red flags, they come out knowing the yellow flags, they come out knowing the pathologies, the signs of symptoms, that sort of stuff. Is that then a bad thing? If that's becoming too prescriptive, that they're not thinking around?

Barry Jacobs

I think you've got to have a framework. And absolutely, it's critical to understand what the prescribed red flags are. All I would like to try and convey is that they exist at the extreme end of red flag for many people in primary care. You know, heaven forbid, you do see some significant things. But what I'm not pleased about is the notion of excluding conditions. I like the idea of trying to incriminate a condition based on the weight of evidence that you might be able to glean, but absence of proof is not proof of absence. Right. And I think it's important to put in mind the patient we saw last year, man in his late 50s. And he was actually a full time entertainer with a big band and quite successful actually in within his kind of circle. And he was complaining of a couple of weeks of what he described as excruciating back pain. Now, a lot of people will say it's excruciating. If she was there that he was walking around perfectly fine, but it looked like it was comfortable. He was not really interested in issues of knife pain. He didn't have any real major constitutional conditions but what he was doing was drinking a great deal to affect his pain. And he was drinking a substantial amount, multiple units. But he would tell us this with a smile. He had an entertainer smile. And we saw on the first time I thought, you know, and you can, you can try buying things and you can try vibrating them with a tuning fork. Maybe there's a pathological fracture. Who knows, you know, I've got spinal pain. And I remember we wrote a letter said, look, you've really got to get an MRI, you know, we're not happy. There's nothing really much there. He said, Look, it's fine. Just make my back pain go away. I probably did it. You know, I think he was trying to take out a tree stump, of course. So there was a reason I've been trying to pull out this downed tree stump and then my back started killing me. And it's really agonising, really can't sleep with it, you know, but or during the day or anything, it was not particularly as I said, anyway, eventually, he didn't turn up on one of his appointments, because all we could do was say, Look, just follow up if you're not doing anything, but we are really trying to push you into getting through, he just wouldn't go eventually, he just didn't materialise. We rang him up, and he had a huge mass in one of his lumbar vertebrae. You just don't know. Even in retrospect, I'm not entirely sure what it was. That made us think this is not right. Probably just because he was so peculiarly wedded to this notion of exquisite pain that you had to quell with alcohol, or anything else,

Steven Bruce

no interesting expression you use there, because it's something we use on the first day training course that I run, because it's a first aid training course for clinicians, you know, so at some point, when there's a first aid emergency, you have to switch to first aid head rather than clinicians head. And it's when you get that sight that that feeling there's something not right here. And it's a little nagging voice that sometimes you've got to listen to it. That's the pixel. Yeah, yeah. The Missing pixel. Yeah. And but it's hard, because of course, we are brought up were schooled with drilled into us that we've got to try to find the answer. We've got to do something for this person. That's what we're for. We're here to help. Yeah, it's hard to get rid of it.

Will Williams

As long as we know that an answer needs to be found. That's equally important. It goes back to the normality thing, you know, what's normal, and we must never ever lose our instinct. You know, how much research we do, how many books we read, by how many cases we studying, if we have a bad feeling about something, we should trust it. Obviously, we don't work in isolation with it. But we should always trust about feeling, you're

Steven Bruce

going to spend a lot of time with undergraduates and people who aren't just about to launch their careers. Do you think that the fear of litigation is affecting them much?

Will Williams

The fear of litigation, I think, you're always trying to do your job properly. And part of that is taking a good case history to do a good examination. So if that's what you do, you know, law or no law. So I'm gonna think about litigation, to be honest, in terms of taking a good case history. It's what I do. Yeah.

Barry Jacobs

Yeah, who knows what's going to happen? Heaven forbid. But the I think one of the most important instructions I have absorbed over the years is the criticality of communication. And I only hope that I can try and keep up standard to which I aspire. I have attended as occasionally as a witness brought in and so on, and been involved in, in, in, in post litigation situations, nothing. I'm pleased to report so far affecting me directly, but it's about communication. If you can try to convey your idea to the patient saying why you're doing what you're doing. And effectively, it's about transparency, I suppose, isn't it? Because if you yourself understand why you're doing what you're doing, you have a better chance than of conveying that. Because an i i fear for what I sometimes don't realise I've admitted, when I haven't written now, and again, you know, it's often said that recording negative results is important. I looked at that. I did that. Yeah, did you? It's

Steven Bruce

I think it's hard to it's hard to keep up. Those are the hard to be conscientious throughout your career about writing down things that where you've got a negative result isn't. We had somebody wrote to me the other day, and I don't have permission to give the practitioners name, but of the case sounds very similar to what you were describing. But a patient came in and with back pain, wanted treatment desperately wanted treatment, and the long and the short of it is that the patient then turned out to have metastases in the bones. And, but a complaint was then raised. And the sorry, the complaint hasn't been raised. And that was the critical thing. What the solicitors have done is send a fire a letter I imagined to everybody, including the Osteopath saying, Give us your notes. And they will either pick the most likely culprit at the end of the day, all of them to complain about in a in a desire for this patient to get compensation. Now, there are, there are occasions when that will be legitimate. And the patient, I believe, feels that the signs of this, the Council of Ministers

were overlooked. But how many times you write in your notes, what you should write, advise the patient to go and seek a further opinion on this and that was done. But the number of times that they said this and the patient still came back hoping that an osteopath would fix the pain and feels that the suggestion is by the solicitor that the Osteopath should have known that there was malignancy there. But of course, he didn't have X ray vision. That's why you're telling him to go somewhere else.

Barry Jacobs

But I think context is the key there. context, context is very much the key. Yeah, we always want this is exactly what we always worry about, you know, have I actually got the full grasp of this history of the context. So you've just reminded me, this is going to obviously, I think ring more bells or wave more red flags for people but effectively, I remember seeing a patient it's probably about 15 years ago now. And thankfully, she's still with us. Now she had a history of a lumpectomy, small mass one breast. Consequently, I think she had radiotherapy, but it was a small, localised lumpectomy, they got a clear margin around it. 18 years later, she's got a persistent low backache. Now, what really helped here was I knew her of all. So I've already privileged to have some insight into what's normal for her and what she might say. And again, this is something that I think people sometimes remark on in the NHS, GPS don't get to see the inside of their patients kitchen anymore. So they're not as familiar with the patient as they like, yes, you can compare that individual to the rest of the population. But it helps to know the individual who has their moods and up and down sons idiosyncrasies is critical. So I thought this is not right. This pain is not going away. It took a few minutes. And I wrote to the GP, GP x rayed, which I suppose is useful for excluding if I can use the term because it was an x ray, bony fracture, pathological fracture, that sort of thing. Nothing going on. And I really cannot tell you how I even came to the conclusion. But there was something about the X ray I didn't like. And I hate even having to admit that because I can't somehow form that into a tangible form of processing unless it was some sort of subconscious processing, where I was comparing her pixels to everybody else's pixels if we can extend the metaphor. And I said to the luckily, I knew the radiologist, I called him up and said, Look, I don't know what to do here, because I just don't like the look of it. And I don't even know why I look at it. And he said, Well, why don't we just get an MRI? So it was easy for you to say this is NHS? Says on the Nash, he said, Look, speak to the GP again. Tell him I said they should have an MRI and in those days, the GP could do it. And she'd had a secondary one.

Will Williams

If the MRI had come back, and they'd been nothing more fun, then you can say at least I look what would you have regretted sending him for half an hour, you know, I'd rather err on the side of caution and I have in the past absence of proof is not proven

Steven Bruce

to build up that sort of relationship with a radiographer. They'll radiologists there, isn't it? You can try but it's very hard to get

Barry Jacobs

especially nowadays. Yeah. And that was again it was on the Nash it's very rare for that sort of national health

Steven Bruce

or the Nash Nash distraction here I've got some there were comments coming in. Nobody's sending in questions for you just at the moment but well, maybe who is Sharon says hi will and Barry she's one of your Norfolk students. Cheers Yes hello share who she is she what you described earlier was normal for Norfolk poor sharing you got discovering you says Barry You still owe me for working all those hours in your bagel shop.

Barry Jacobs

Wow. Okay, well in that case I want to dock your pay short shortchanging people I'm still getting complaints.

Steven Bruce

And Robin says best best days in clinic involves Barry and we've got a lot of love for these guys. And he gives you he gives you a little kiss anyone between the two of you but we're happy to share. I think people really really like hearing the sort of the cases that you talked about because it's what puts a smile on case based discussions are quite apart because everyone wants to hear how it works in other people's clinics and you know, what did you You found that was unusual. What did you do that I might not have done? You got any more? Yeah,

Barry Jacobs

for sure. Because I was just put in mind of the occasion of a couple of weeks ago. Will and I will recruited to a was it health? Fair? Did

Will Williams

we call it exhibition Men's Health Awareness? Exhibition? There was? Yeah, it

Barry Jacobs

was a local, a local exhibition in, in alum Hall, which is the local kind of venue, one of the locals. Yes, yeah, that's right. You want to have a cream egg story? I'll tell you that, I'll tell you. So they set up a lot of different stores. And we'll get there early, of course, chomping at the bit. I went, because I was persuaded. And I'm not going to name names here. But I was told I could go home early. So I thought Great. What I hadn't realised of course, is you missed lunch. So I had to go without doing my shopping. Anyway. So we set up all this we'll set up so I just walked in, of course at the end, and everything had been set up beautifully. And they'd set up a lot of other stores, local GP surgeries,

which was fantastic. And I had a walk around because I was getting a bit kind of boarded or I walked around and it was just terrible thing to admit, but nothing was had much of that happening. Except for people who live locally and knew me anyway and came outside walked off. And I was talking I saw our stalls or the city, they'd set up their own macaron self management, blood pressure machines, and then the nurses and all these different surgeries, they all have the Omicron thing is unfortunate in the current climate, but and stores local GP surgery, which I won't name those saying hello, how are you? Yeah, nice to see you kind of thing. And they had, it was around Easter just a few weeks ago. And they had a load of so to be thematic. I dare say they had a lot of cream eggs set up on the table. And I said, I looked at these cream eggs. I looked at them. I said, I said are you having a drive on diabetes today? And they said, Yeah, okay, yeah, how to get those that they're going well. Wouldn't let me have one after that. They checked me out. But anyway, so later on another afternoon, a person came up and was asking questions and so on. And actually he said, Look, I've got a really painful knee because you have a look at it. Now I don't even know, you know, in a non committal sense if we're permitted nowadays even to build to kind of offer an opinion. But I can say in a non committal way, and you can't hold me to this, I'm more than happy to have a look. So we were with a couple of students who were really great on the day certainly better than me. We took the chap to the side took him to a private areas, of course, we'll have a look just first aid context, if you like. And, actually, he'd had it was a man in his 40s. I can't know what he did for a living, but he'd he'd had an injection in his knee a few weeks away the week before. And it was warm, and it was swollen. And didn't like it. He could low bear, he could bend a bit. It was uncomfortable, wasn't terrible. We found out he had an injection because he doesn't genitive condition. But I didn't like it. So since him to just advise we can send him and write a letter. I said, Look, I don't like look at that. Why don't you go to hospital and just asked him to have a look at it. He was. And it turned out it was a septic arthritis. And he we heard the following week, he was very pleased that we've said that I don't know if I'm opening myself up to prosecution for having done something. Or if it had if he'd spent five hours in a&e could have been written and complained. But the same thing happened last week, last month, to me in practice. It was an 83 year old patient and again, knew him of all and had virtually identical symptoms. Now I didn't know if it was an effective condition if you're a septic conditioner rather, or he had gout, or it was just osteoarthritis, but it was sudden onset and it was hot and he couldn't bend it. Now, as it happens under those circumstances. I treated him for a mechanical condition. But I said look, I just think you should go to any anyway because a person in races with a sudden onset swelling in their knee, you don't take any chances. And I was worried and amazingly he wasn't very happy spent five hours in a&e and by the time they saw him, he could bend his knee again. Apparently I'd worked a miracle right which was great because it means I've wasted his time.

Steven Bruce

Well, did they examine him at all or they just say Wait

Barry Jacobs

a sec, just go home take some ibuprofen and you'll be fine. Thank you very much didn't even do a blood test which at least I would have done just in case you know, but he was fine. Now, as I said, you know that to me was a red flag context. Yes. You just can't know and should you should you not always err on the side of it

Steven Bruce

is an interesting one is that I mean, did you take a formal case history for that? In the alum Hall? Yeah.

Barry Jacobs

Yeah enough.

Steven Bruce

You can you can say we act Be professional. I haven't documented it. Right, you haven't documented?

Barry Jacobs

Right undocumented? I said, I don't like to look at that, I think, but what was the alternative? Don't bother me. I'm sorry. You're negligent. You know, you should have known you could have seen what was wrong with that person I couldn't. And also as a question of compassion, at least you can offer somebody some advice at a time,

Steven Bruce

where you use the term first aid that, didn't you and one of the principles of first aid is that, you know, if you're acting in the best interest of the patient, then you've got a strong defence for whatever reason, even if you get it wrong, if you think you didn't, we're not saying you did that.

Barry Jacobs

Well, he was obviously very grateful he ran, he ran to college. And he was saying, well, thanks so much, you know, because it could have had serious consequences. But

Steven Bruce

as Yoda brows here says, There's a saying that if it isn't written down, it never happened. So you are where you are standing yourself into danger, aren't you? If something happens in your clinic treatment, or when you don't put it in the notes, it'll be the thing they complain about. As far as while you're working hard for this patient. You've got this nagging feeling that it's not your area of expertise, but you're trying to do your best to fix them. When you forget to say, I asked them about these symptoms. You

Barry Jacobs

can only recognise your own limitations, hopefully and be aware of them. And I think that's a fundamental principle.

Steven Bruce

It was interesting when we had Jonathan Goldberg, who's a barrister, a defence barrister on the show, when we were down in Swansea, we did a live show from Swansea. And we were talking about if someone complains about you, should you write to the gos C or the GCC and say, This is what I did without bothering a solicitor which is expensive and all respect. And he said, No, don't. Don't ever do that. Because he gave the example if someone comes to you, and you think they've got cord recliner, and you and they complain that something went wrong, and you write and say I asked this question, and there was no saddle anaesthesia. If you don't write that you asked all the other questions in the quarter Aquinas pathway, the National pathway doesn't assume you didn't and they'll say that was negligent, and you usually don't see you will be so careful about what you put in your notes. But I'm not aware. I was accused also, when we were down there drove scaring the pants off the students at Swansea. And I suppose the purpose of the lecture was to talk about complaints, but it's what made me ask my question about whether people are scared of litigation. Partly there's a new saying that the colleges are scared of litigation these days in what they allow to be taught how that the tutors and students pay. And

Barry Jacobs

finally say there's that does make me mindful of a particular situation this encourages because i don't know i was write down every question I've asked I will say patient denies called recliner. You know, we'll I'll ask them. One of the key things actually I just talking about is, is you know, I say to people, can you if it's a woman, can you sit down and initiate the way you always say In plain terms? Can you wait? You do it can you start because as you know, with cord recliner with the key things as they get written, you only retain your nutrition retention, and then overflow, incontinence and so on. And that's really important. Numbness. But one of the problems with that kind of attitude to litigation, unfortunate, which is now unfortunate. With us, is it encourages the use of lists. What you can think of as an unthinking audit? Yes. Now I'm thinking audit encourages you just to tick boxes. And again, the reasons I'm thinking is because a are you thinking about what the patient is saying to you, and therefore asking an appropriate question, appropriate directed inquiry based on what they've told you. And secondly, what then if you're using it tick boxes, why aren't you asking

Steven Bruce

them some questions? Well, with you well, Sara is getting back to red flags, which we were talking about. Sarah says she had a patient where the only red flag was an increase in night sweats. He'd had odd night sweats since a child and she instinctively knew to refer and the patient confirmed a fractured disc and needed immediate surgery. So a subtle change.

Barry Jacobs

But he's had night sweats since she was a child. Well, was

Steven Bruce

that she hasn't revealed that I'm gonna say it's an adult. Yeah.

Barry Jacobs

Well, then if that's normal for him, I'm amazed and this has been any change

Steven Bruce

in the well that's what she said there was a bit it was an increase in nights.

Barry Jacobs

I see. There had been an increase Sorry, I missed that.

Steven Bruce

Sarah wants to know what the peer review uses initial case history as your initial case history. Is it the same one you use when you were at college? Or you added more questions?

Will Williams

Oh, it's it is under revision all the time. They hope for the best but I hope it's still under revision. Yeah, it in fact, I the first case history I ever came across was when I was trained to be an osteopath. And I thought it was very good. So I took it home. And I use it myself and built up on it changed a few things and

Steven Bruce

built up on it. Do use people So electronic ones,

Will Williams

I use paper notes, I will always use paper notes. And I have a good reason for that. I can remember where things are on the paper, I can remember whether it was in the left hand or the right hand. And it's always visible. As soon as I take the notes out, I can see in one gulp, what's going on. I do see advantages in computer notes. And I suppose that'll come to one too. But I hang on to my paper notes for as long as I can.

Steven Bruce

Yeah, I was wondering, Barry. And based on what you said, there, there's a, perhaps a danger that electronic notetaking drives you down the lists process because you have set templates on the on the notes, which you can have on your paper notes, where you take off, patients report responses to questions.

Will Williams

But there are things that always fall between the stools, here talking about prescriptive tick boxes. And so there will always be questions that the tick boxes don't ask, which could be relevant, yes.

Barry Jacobs

And you have to learn, I suppose the subtle art of making the patient understand what you're asking, and the breadth of what you're saying,

Will Williams

it's absolutely essential that they should understand what you're after and why you're off. So

Barry Jacobs

you may say, Have you had any operations, for example? And they will say, and they may think they're only asking about my spine? Yes. And you want them to be able to tell you everything, any form of procedure, Operation investigation, anything and sometimes therefore, you can actually very economically ask a question that opens them up, as long as you give a few examples, you know, have you had any other symptoms? You know, nothing to do with anything, any chest pain, any breathlessness anytime, before anything, anything changed? Changes the thing? I think, any changes?

Steven Bruce

you rightly point out communication is a really key issue in what we do. Have you come across maybe more so in recent years, difficulties in communication, for

Barry Jacobs

sure. Now, the the gentleman with the knee, he is profoundly deaf. And we do spend usually half an hour a few weeks shouting at each other. And that I also think he's might well be not as sharp in the memory department as he used to be. And he, he's funny enough, his his partner, became very concerned. And the trouble is, he wouldn't give me consent to speak to her at that time. And there came a point pretty quickly. I said, Look, your your welfare is now in question. And I was wondering whether I might need to take action anyway, even without his consent, because at that point, I was getting quite concerned about something else. And eventually, he said, All right, all right. You can speak to that kind of thing. She's driving me mad. And I spoke to her very reasonable woman. And

the response was, he had a fracture, as well, I don't know if he had a fracture, but he had a fall. When did he have a fall? Well, you know, months ago, 83 year old man fell down, off the bed onto his backside, straight down as it and he came in with symptoms. Did you see the bruise? I thought he hurt his hamstring. She said, No, no, no, the bruises all the way down. I think there's a possibility you may have had a fracture. And that was why it was taking so long. But in a sense, even though I became a bit concerned about have I had the truth that he remember, the truth is, he's been a very sharp individual, but the edge is just going you think if he isn't what I forgot about that.

Steven Bruce

You're almost certainly going to provoke questions. I'm going to ask you in anticipation, you said you thought you might have to do something without his consent. So On what grounds did is be specific about this patient? But on what grounds? Would you say action without the consent of a patient? If

Barry Jacobs

a patient really isn't if I'm not having if I'm not getting enough information? And I think there really is a case where the patient's welfare or somebody else's welfare for that matter in those circumstances arise is in question. Yeah, persons a danger to themselves. There are circumstances where I think one is empowered to be able to either approach a third party even without consent. But that's not really happened in this case. Okay. And I wouldn't want to be pressed on that because I don't have the expertise to talk about it at length. Those

Steven Bruce

situations, I think we have discussed it on some shows in the past. Okay. Concerned about what at what point can you make that decision and

Will Williams

even if even if we had a couple of cases, three, half a dozen cases, to say why we might reach that point. They would be different from the cases anybody else would have. They are all unique. Every single case is unique. And as Barry said a lot earlier on, you know, must be the decisions must be taken. You In the context of what's going on that context, context, context is so important. That's why history is critical.

Barry Jacobs

As much as you can gain, as you say, so communication is vital.

Steven Bruce

And I think if I thought I were acting in the best interest of the patient, I would think hard about it, but someone's gonna report they're gonna complain to me to the General Counsel, well, I'll take that

hit. And I will stand out stand up in front of the Professional Conduct Committee. So I was acting in the best interest of this patient because of this. They would probably be sympathetic to that argument. You

Barry Jacobs

just have to be, I think you'd have to be in a situation when you think the agent really is in danger. Yes. Or someone else? Or someone else's are endangered from them. Yeah.

Will Williams

We don't sorry to interrupt you. You've got a fantastic question that needs to be answered. But we don't have to do we can come up with the answers on our own all the time. You know, we have most of us have good friends, good. associates that we can run it by, which helps a great deal. Yeah.

Steven Bruce

And I like to think that this forum APM is one of those as well. Because even being not a case based discussion, people can phone us and say, I've got this dilemma, I've got this problem. I'm not likely to know all the answers myself, but I've got a lot of people I can call and say what do you think? And we can get answers to people. It's not going to help in the, in the in the immediate nature of a treatment, or an appointment. But we can get back to people because they got other patients to see,

Will Williams

it's good to come back to the solicitors with a consensus of opinion, isn't it?

Barry Jacobs

I think that's exactly what you've been saying, as well. Stephen. Where possible, colleagues should consult if they can, yeah. You know,

Steven Bruce

when I was a lonely profession, generally, isn't it?

Barry Jacobs

I think it can be I think it can feel very lonely. A lot of the time, actually, but we don't have your problems.

Steven Bruce

You got a few goodwill.

Barry Jacobs

So now now, the rest of the

Steven Bruce

longer column. Sally says, Barry, obviously not interested in wills point, this is for you. Could you talk us through how you approach? So Michael HBTs. Do you have starter questions? Do you have questions you always ask? I seem to remember you. I seem to remember you asked more heart runners than I had been taught. But I might have remembered that wrongly. Okay,

Barry Jacobs

I thought this actually might be a setup. Where it's not not on my part anyway. Now. Okay. Back to the loneliness of the long distance osteopathy, I think, because I now and I'm not going to be trying to set off a wave of hysteria here. This is just my personal view, sorry, for touching the microphone. I try to stay away from cervical manipulation as much as possible. The reason being, is that for me, I think the therapeutic benefits are not sufficient to justify those tiny, but nonetheless potentially catastrophic risks. I find if I see somebody with a neck problem not dying or not, I'm not necessarily divesting myself of the notion of a survival diagnosis. But I find because of the what I reconcile to being mostly somatic referral, when we manipulate something that shares a common route, with another structure, I can intervene with something low down upper thoracic spine, and I find it's almost as effective. I don't think I like to go through it. But for those people that are interested, I think avascular history is critical. And that means all the inflammatory conditions, it means a potentially a migrainous instability scenario. So again, anything that may make me worried about vascular status is Yes, something even for lower cervical. Oh, for sure. For sure. Yeah, for sure. So I try and stay away from it as far as I can. One of the things that actually seem to come to light years ago, never did finish, or even start the paper, actually. But I remember having a bit of kind of casual Association discussion with a vascular surgeon about this. And one of the interesting things we found out is that damage to the intima, which is what everybody worries about in blood vessels, occurs as a result of cross sectional force. So it's not actually necessarily for it's not actually the traction that does it. It's actually a force of the perpendicular. So the vessel and this happens sometimes in road traffic collisions with the lap belt, you see a leaflet and an aortic leaflet formed because of the Southern shearing force. So it's to do with we think it's to do with speed. This is not published, it was just ideas that we were throwing around. But one of the things that we found to be very interesting, actually was that and you do talk you were talking or pertaining to the upper cervical spine is the high velocity rotation and then a sudden stop implies vessels that go with them. In the circuit, those that provide survive that supply the circle with the verticals and crosses, actually go through a rotational force very rapidly and then stop, which means that one called the love pile, the super max point stays where it is, and the upper Park wants to carry on because of this rotational momentum acceleration really. And it's a massive cross sectional force. So it might actually be that it's all due to rotation rather than anything else. So, you know, I heard enough, I didn't need to, I've probably been corrupted, too much. So personally, I'm, I'm happy to proceed

without actually doing so like poverty, manipulation? I mean, if you're going to them, if you're gonna do it, do it inside bending. That's my fear.

Steven Bruce

Okay. Just out of curiosity, I mean, presumably, students are having to practice these in clinic on patients. And you're right, okay, where else that

Barry Jacobs

I know, I say to them, I say to them, seriously, look, you know, that's part of the syllabus, if that's what you want to do discuss with someone else. I've got my own views. And, you know, I've got to stand by them.

Steven Bruce

Curiously, when we've had Laurie Hartman in here, teaching, manipulation, of course, a big part of those teachings of Michael manipulation, the first thing he does on virtually all of his demonstrations, as you said, Well, the next not moving very well. Middle of the thoracic neck suddenly joined, yes. doesn't mean he doesn't then manipulate the cycles. But of course, he calls it minimum leverage, as he has many masses of leverage there, but there's only tiny movement. So he's not rotating very far, which might be lightspeed. But it's mostly Yeah, absolutely. It's got to be very honest.

Barry Jacobs

I wouldn't want to say anything. And actually, Laurie Hartman is the reason I became an osteopath, actually. So I think he

Steven Bruce

hasn't actually said you're the reason he stopped.

Barry Jacobs

Sometimes some people need a lesson.

Steven Bruce

We're gonna get on to some questions. This is this question is almost superfluous given what you've just said in what you've implied. Well, Gary, says, Barry, do you have an upper age limit that you would not perform a survival et on?

Barry Jacobs

I'm sorry, I thought that was going to be rhetorical off.

Steven Bruce

Do you have an operation? And I'm guessing us they're doing?

Barry Jacobs

I just, I will do them. But look it again, it's contextual. You wouldn't get me doing it on somebody? Probably. The research used to say that the highest frequency of risks I've no idea this is excellent. Now, but the highest frequency of risk gates used to occur in people under the age of

Steven Bruce

30. Yes. And as you got older, the arteries became more robust. Exactly. Or

Barry Jacobs

or fragile. Yes, more friable brittle. Exactly, exactly. Yeah. Where's that crack coming from? I don't think I'd want to necessarily put an age limit on anything like that. Again, it's about context. But I think you'd have to be sensible and look at the history. I'm

Steven Bruce

going to read two more of these and then we're going to do something that I know you don't want to do. Very, we're going to do some neurological tests. Great. I don't know why you don't want to do because I know you're bloody good at it. But anyway, Juniper says a company called VISTA health. And they're offering low cost MRIs across the UK at various locations, where patients can refer themselves on the website. Having seen the MRI reports, they seem very thorough now.

Barry Jacobs

They're very good. I've been struck

Steven Bruce

by the varying quality of the radiology reports that you get back with MRIs, though, and how the terminology varies between radiologists. They're talking about the same thing, but they use different terms. Yes. Very confusing. So many things have different names.

Barry Jacobs

I think, I don't know if you've heard the same thing. I've not had it verified. But from what I understand. Some companies have a quick turnaround by sending the estimation out across the globe. So of course, they will get the report done somewhere where everyone on when we're asleep kind of thing.

Steven Bruce

Yeah. And it's one of the reasons where we've had Rob shanks and Darren Chandler on the show to talk about interpreting MRI. So said he's always worth looking at the imagery, because sometimes the radiologist will look specifically for the thing that they've been told to look for, because they're on a very quick turnaround time, and they might not look more widely and there might be things in the future a bit of practice that you can you can find, yeah, for sure. I

Barry Jacobs

think a lot of the time. A lot of radiologists when it comes to looking at spinal architecture are very wedded to the notion of neural compression might be abutting the root or it might just not be a bad thing, or it might be indenting the route all the people or whatever. And I think the issue is to actually highlight especially when you're speaking to students and that helps to remind ourselves you It may not be the route that we're interested in the disc is a horrendously pain sensitive structure, the annulus often has injury and some radiologists are really very, very capable at reporting on those minutiae. There's a particular radiologist I'm always keen to refer to, because I know and even with something that's already been reported, are sometimes saying, Look, you just have a look at this place and see what you think. Yeah, and just review and then very helpful to have that sort of relationship free pages will come back, as opposed to a single site. Gosh,

Steven Bruce

I will normally a paragraph so we see. So

Barry Jacobs

yeah, well, unfortunately, it may well have to be in the private sector. So we're fortunate that if you can speak to people in the in the NHS in the mesh, and you know, you're doing well, why not?

Steven Bruce

Before we go across to the the treatment area and BOCES, with concern over capacity, is there not a case to contact the GP and record accordingly, regarding mental health or capacity to make informed decisions and consent? We were talking about communication, communication and capacity to give consent earlier on. I'm not quite sure what ambo means there. But I think, think he's saying, If you are worried about a patient's capacity, then should you then contact the GP? I think if I can start by answering myself, I think if you if you're concerned about capacity, then you shouldn't be treating because without capacity

Barry Jacobs

that you can't get consent. That's the binders. And then are you obliged, and I are not really an expert in this at all. I certainly know people that are. But to my mind, I think again, you know, they if they don't have capacity, have they brought somebody with them? Yes, I saw a patient today, for example, the college, and he he's English wasn't bad, but it wasn't his primary language. So it wasn't his first language and his son came with him to interpret. And between them we could speak. But again, you know, there was a facility to gain consent or direction and so on. And we really had to change direction and get get them back into being investigated that sort of thing. But

Steven Bruce

it's, it's still a difficult it's a minefield in ways, isn't it? Because actually, if you can't understand the language, you can only take for the word of the analysis.

Barry Jacobs

And it's all about again, as you say, It's about transparency about consent,

Will Williams

and consistency. Of course, it might be a different story next time.

Barry Jacobs

Again, I'm sorry, we're not really providing much assistance here.

Steven Bruce

No. And I was thinking, consent and capacity are such a topic in their own, which we usually did 90 minutes with him, we come up with loads of different examples, but a legal expert to give us their

Barry Jacobs

opinion. I think so. Yeah. Absolutely. And also, again, going back to that issue about endangerment, you know, and the judging whether or not a patient is in danger. And if you do start to see somebody, slightly different example, if you see a patient for example, you've known for a few years, and then you start to feel that they are developing dementia. It may well be in their interest to speak to the relatives especially think they're going to crash the car, which is often happening in dangering. People absolutely.

Steven Bruce

Quick one from Gary. I don't know if it's the same Gary as before. Gary says my red flag was high blood pressure, which really wasn't obvious looking at morphology of the patient, who was presenting with headaches. palpation was unremarkable. And although she was insisting on a neck manipulation, you love it when patients tell you what you gotta do, I get that a great deal. They're all medically qualified by the the blood pressure would have partially would have made it inappropriate. Anyway, he talked her into an MRI scan with which revealed bone cancer in her upper cervical vertebrae. Sometimes, we said only one sometimes you just got to trust your instincts. When you think something isn't right. The GP was saying nothing wrong until the scan. And then of course, you can't blame the GP, they're not musculoskeletal experts. And they haven't got X ray vision either.

Barry Jacobs

And if the patient's not telling them everything, and they we have the privilege sometimes have a lot more time and repeat. And even we and we still don't know

Steven Bruce

why I stopped beating around the bush what's new in neurology than very? What's

Barry Jacobs

new in neurology? I think, if I may, I'll rephrase the question. I don't know. I hope nothing is new in neurology because it's not. I'm not the main neurologist here, but I do have an interest in it. And I think one of the things we can do today is possibly just to recap on technique. I'll just brush her muddle through a few ideas. I was very fortunate because when I was an undergraduate, a lot of our neurology teaching went to membership level. It's like postgraduate, medical level, and for some of it, and we were very, very fortunate and I did some elective neurology and so on, but I would not purport to that to be the expert by any means. But we can have a little muddle through technique just to demonstrate

Steven Bruce

Claire and I, my wife Claire and I have been talking for years about doing In just basic neurology. Yeah, for sure, because I think I certainly speak for myself when I came out of college, I was quite fiercely with the opinion that once we'd been taught it, we should have been made to do it on every single patient regardless of whether they need it until we could do it blindfolded. And then we can start doing the same and working out whether this is a necessary pathway to follow. Absolutely,

Barry Jacobs

absolutely. You shouldn't be thinking about the device, the instrument, the process, we should be thinking about why you're

Steven Bruce

employing it. But you can only do that it's a bit like playing an instrument, isn't it? Once you've learned which note comes out, then you can start thinking about how you interpret. And

Barry Jacobs

you should know all the notes and in the right order.

To preview right.

Steven Bruce

I have to say that I wasn't at all sure where the conversation was going to go this evening and whether we were actually going to get any sense over these two whatsoever. Unfortunately, we are getting a lot of sense. But unfortunately, I have to be the patient for today. Right? I'll have my man undress me for the next part of the show. He

Will Williams

just did.

Barry Jacobs

Let's just have the shoes and socks off. If you would Williams, there's nothing else

Steven Bruce

keeping my trousers

Barry Jacobs

taking off, you could just tell her to do give me

Steven Bruce

the quick polish and quick polish.

Barry Jacobs

He takes his time. Remember, don't forget the socks either. Please.

Will Williams

Hold.

Steven Bruce

So you said the the principles of this box observation, comparison. He's not even listening to me now. Sorry.

Barry Jacobs

I thought you were giving a recap. Yeah, so obviously, yes, history, history history. So I drifted off there.

Steven Bruce

Remember, actually, and this is this is true. A number of students saying that during their college days, given the history to bury, he will be fast asleep. That was sorry if I woke you up. No,

Barry Jacobs

no, no, it's very true. I can remember it may well be new, I can remember that's exactly right was when my children were very young. That evening, and I was probably getting even less sleep than usual. And I remember somebody started off saying and we didn't talk much about history, taking my idea. But funnily enough, nowadays, it's about name, age, occupation, and then main surgical history. Because anything that could be eclipsing diabetes, history of cancer, that sort of thing and medication. Then I go into the main history, and I remember who got as far as the medication. And the steel was really quiet. I thought unnecessarily abrupt and said hello. I said, What did you do that for? And I said, You were asleep? You know, you were asleep? I think I might have been, but then again, you know, a lot of student history is I think our scintillating and keep us completely wide awake. Anyway. So can I just remove that important? Well, I think anything could happen now. Okay, so effectively, all I'm going to do very quickly

Steven Bruce

ask you to hold that. Don't fiddle with it.

Barry Jacobs

I think that's an instruction for both. So alright, so all I'm going to do is this is actually a routine that I was shown, again, when I was an undergraduate and was in a position to to exploit as an undergrad and funnily enough, I actually was talking about this this afternoon to a student I think, because in the old good old days, but even before the G c existed, and we had the GCR we used to have very big, scary final exams and a whole horde of examiner's in three piece suits and so on and twin sets would come in, and it just kind of knock on the door and barge in and just what you're doing

something so you had to perform for a few seconds. And I remember just thinking, oh, I'll just go through a neurological examination. Just Good afternoon. So the thing was just doing an examination on the left. It was brilliant. That's probably what got me through the exam. So again, this is a very artificial circumstance because I'm not really acting on the history, you know, we're not going to talk about Steven's previous history, you know, he's one of one of being in and out of various clinics and so on. But you know, what, we won't talk about that now again, but they do some of them have neurological consequences of course, as we know, I just refer you to Churchill senior so I'm going to assume that he's not gonna I'm gonna assume that maybe you know, he's complaining of, of symptoms in one extremity, you know, maybe he's got a tingling or he's got panels, so let's just assume that he's perhaps suggesting a root irritation, some radiculopathy in the leg. So I'm just going to test and as you said, you're quite right. We took the history. Observations, the first thing I don't need to run through Everybody I hope watching will be aware of the aversive signs of of motor or lower motor neuron issue, because that's what we're talking about. So lower motor neuron because I'm thinking about the lower motor neuron I'm not doing as tested generally, assess everything I'm interested in understanding the integrity of that structure. Remember, when a patient presents with a symptom, or a sign that symptom or sign is simply the effective, effective manifestation of corrupted or altered behaviour. Right. So structure governance function, if the structure has changed, the function has changed, I'm going to assess the function and see if that function does what I'd expect it to do. Now, in order to know what it does in the context of the individual, I want to find out what's normal for him. So I'm going to write I am therefore going to justify looking at the upper extremities, even though I know nothing is wrong, because then it gives me a better idea of understanding what's going on with it. Now, in fairness, again, I'm going to have to judge this. So if Steven screams, it may be because I've hit a bony prominence, because I can't see his his bits. So here we go, I'm just going to do a few tests, I also have to tell you that Stephens reflexes are not particularly brisk. I'm sure they were in a different life. But in this case, they're not set up. So we may not see a great deal. So this is how I would do it. So always stretching the tendons I'm starting off up here, everybody at home should be saying what level it is, if it's gonna be C five, or six, in this case, or whatever. Not a lot happening. Now I have to tell you, but I can feel a very slight, very, very slight jerk and probably imagining it, I'm moving down there to the wrist, there, we're getting a little bit something a little bit more explicit. Thank heavens, the prop didn't fail entirely. And I'm comparing so side to side, side to side side to side, I'm now going to use gravity. Let that go. Please, Stephen, thank you very much. And I'm going to tap the triceps. Normally, I would look for evidence of a of a joke there just in muscle contracture because I'm certainly not getting much there. Same thing again, I've changed hands. I'm running parallel to them. And that's it. And I've finished pretty much finished reflexes up there, I can do power, I'll come back to power in a minute when I when I kind of got a bit more stamina, right and moving down now. Don't have to sit him up, don't have to change the position don't have to do anything extreme. I'm now going to see if I can get a I'm really having to bash this. But I think you can see that that's actually working, I would only normally once. And the important thing is just to let that 10 and hammer just drop. So the as it were, the energy goes into the limb, there we go. And I'm managing to elicit something. And even if you can't see much of a jerk, you can certainly see a contraction in the muscle belly. Right. Now I'm going to move down here now, you probably expect me to go to the ankle jerk, which I'm going to do. And you'll notice I'm just tapping my own hand. Patient said to me yesterday is something terribly wrong. I feel like I can't actually detect you hitting me with my numb. Now, we saw an intact ankle jerk in this case, because I was thinking of roots. I'm not going to start talking about the upper motor neuron, we're going to talk about a focal lesions centrally, I'm only interested in this case, because of his history, which we haven't developed. We're only worried about what was going on locally. So I was happy with that. But the key thing here is and I haven't rehearsed this on Stephen. In principle, every

tendon has a reflex. Every tenant has a reflex. So in this case, I was looking at the foot. Remember, we went from up here from a knee jerk down to the ankle jerk. So we missed out L five. And in some cases, you can and there we go look at that we can actually elicit by tapping the EHL extensor, hallucis, longus, beginning and l five response. Absolutely fantastic. Thank you very much for that you came through in the industry. And so having done that, I'm not going to do a plant response because I'm not, in this case particularly worried about that. I could have done power. I'll come back to this in a second. So for the upper extremities, if we want to do this in order, can you just stop me doing that please? Then Q Can you stop me doing this please? Thank you stop me doing that. And everybody should be saying at the moment, probably well, biceps, C five, C six, perhaps C seven pushing away. You can do it over here. It's not me doing that in queue. Next C eight. That forms an eight. In theory, figure eight. So give that a good grip. can do it together. If you want to go on enjoying. Thank you I'm sure. fingers apart. Please stop me pushing them together. Stop me doing that. So there's two one is the number of calls intrinsic muscles hours. Thank you very much. We could have done the thumb as well for two ones. Well, I suppose. push push push into production. That's fine. That's that law. Interpreting

Steven Bruce

that in a lot of the textbooks. You know we get we're great at 12345 and you know you're supposed to have this ideal measure where every patient is a woman that they're all feeling the same, but it's not. And

Barry Jacobs

that's the thing. That's why comparison is such a critical thing. You really cannot easily grade things like that reflexes are a little bit more explicit. But if a person's got brisk reflexes all over the damn place, then that's no and they've always been like that, then that's normal for them. But yes, I know that some disciplines like to try and grade things, and they think it provides a level of objectivity. And if anyone's had to fill in our Booper form, or they ask you for specific outcomes, you know, I do struggle with that sometimes, because I think, well, you know, we need to describe this, it can be very difficult or that you know, it's weak for them. If something is very obviously not one of the forms of comparison other than being this idiosyncratic side to sign up and down comparison and a temporal comparison, in that some people are different on day to day depend on tired they are and so we do also still have the benefit of the bigger picture. So one pixel being out, they are different never met you before. But you are particularly weak in this limb compared to everybody

Steven Bruce

else. You haven't talked about reinforcement for

Barry Jacobs

you're about to talk about. I wasn't actually because it wasn't necessary. But I suppose we can

Steven Bruce

always wondered about reinforcement if you need to reinforce to get this one but not that one. That's a different

Barry Jacobs

again, because everywhere and everybody is it is Socratic blood pressure's vary, sometimes enormously from side to side as well, sometimes 20 millimetres of mercury symbolically between the two sides. Everything is that everything can be varied. And you can only gauge this in the context of multiple tests. No one test is pathognomonic. or very rarely, is very difficult. We can look we can show this off if you want to. So let's Stephens talking about I'll take the this, this reflex here and see if it went away went actually I'll tell you what, let's see if this one, this one's probably better on screen, isn't it so I can hit it. So look, we've got our muscle belly contracting there. And Steven, if you could get into the reinforcement position. So Steven, in a minute on command is going to perform an isometric contraction. If we had a drum roll, it would be very useful. Okay, so I'm going to tap when I give you the signal. So 123 go, there we are. And that was exaggerated. So we try that just once again. Don't Don't go yet. 123 go. Look at that. Thank you. He's actually wired into the plug down here. And then we'll just thank you. We'll fantastic valet for this afternoon. Thank you very much. Wonderful. Okay, so we've looked really in a very brief just turn a turn through these reflexes 123456. And then when we did those, right, I can't remember if I did, I was about to do power was untie. So this is where I was taught to do power. So straighten, please. Lovely. Very, very nice. Same thing again. Look, it's easy, easy, gone. Do that again, for me easy. Thank you just wrapped it to my extensive, right? Stop me doing that push, push, push, push, push, push. Now, I didn't do it in the order of gone again, because I just didn't do that. So that would have been in in the case of a route that would have an Alpine. Right. So done all that. Again, the inquiry in this case was the lower motor neuron, the nerve root. Now, sensory testing, and this is a this is a area to feel a bit more confident in, in talking about today. And you've asked me what's new? So I'm

Steven Bruce

also I'm asking again, because it's one of those areas, which I think is left a bit woolly in a lot of the teaching that I received, it was a long time ago. And it wasn't you weren't guilty?

Barry Jacobs

When it might have been we could have had it we could have had around you with but you did shout at me after all. So it may well have been mean good. Right? So I'm going to talk about a very specific example now to illustrate a particular technique, which I found very useful. And then afterwards, we can go through them terms briefly. Or I can just point at the dermatomes. I'm not really interested in doing that. And I don't think anybody else is because we know where the dermatomes are, and you're quite right. Nobody's actually explicit necessarily about specifics, at least in the textbook, Garrett Fuller, for example, you know, it was a wonderful authority in in neurology literature, often route values will be offered over a number of different levels, and one will be in bold, or the others will be in brackets or something to say it's probably going to be you know, when we do this, it's probably going to be all three, but it could be L four, l five, but they might have slightly different wiring and embryologically. We know they're great variants aren't there. Alright, so what I'll do is I'll

talk about a particular use of sensory testing now. If, obviously, if a patient has sensory deficit, you might be able to pick that up in the history. But then again, you might not and I talking about red flags again, I can remember one case where a colleague was actually actually castigated by a POC tribunal. Fortunately, because they didn't believe that she had performed the tests even actually recorded because they all came out as negative, right. And the patient did have a lesion that was a disc injury, and the patient pursued it as a complaint. But sometimes these things that don't show up, and you can do a test and the test may will be negative, you just get an audio, nada, at least, you may not find anything. So you really have to recognise that there's a scale, it's a spectrum. So we do a lot of tests as if they're black and white, which is probably a failing, sharp and blunt, for example. Now, just contemplate that for a second, because for sharp and blunt test, you'd really have to be really quite definitive in your loss of sensation, not to be able to tell the difference between one and the other. And patients do have that sometimes been a lot of conditions, these injuries are subtle, they vary, and they deteriorate. So rather than just a qualitative test, it would be very useful to have a quantitative test. Now you were asking before, can we quantify reflexes and it's very difficult, but it is better, as I said before, if you can compare the patients themselves, so if I thought, Well, okay, your reflex up, there was a was a five out of 10, that and the others rule of five are attending my views expressed that one's a one out of 10. But that's for you. So from a sensory perspective, one of the things that I remember being taught in a very humiliating session, or all free, interesting a many, many years ago, probably about 30 years ago, was that a lot of the neurologists there weren't implying sharp and blunt for obvious reasons, even though that's something that everybody's taught, but they did use comparison. So you compare one dermatome to the other one day and 20 other, but this can be further refined. And what I'll do is I'll just let me just get a pen. Sorry. Well, anyway, just got a little pin here. And one of the things we've been exploring over quite a while actually is and I say we and I'll explain a little bit about that in a minute is that if you can establish a normal sensation for a patient, if you can actually find out what's normal for them, I just hope we've got enough time. So thank you very much. I'm gonna go for a cup of tea now and sit down, lie down, I think sweet tea, please. If you can establish what's normal for a patient, which in itself is quite difficult, then you are in a position to be able to compare that to the site you need to explore. So for example, in this particular case, I'm going to just change over from the root scenario, which you'll see a lot. And I'm going to change to diabetic neuropathy only because diabetic neuropathy is convenient for us, because as we all know, it affects the longest nerves first. And therefore, very conveniently, we have exposed feet here. So I'm going to show you an example of this, this same technique can be applied in other scenarios like route or whatever, of course, it can, because we again, exploring the function of a particular structure, and it's anticipated behaviour. So what I'm going to do in a minute, I'm gonna show technique where we hopefully demonstrate or actually demonstrate to the patient, a normal level or a, if you like a control level of sensation for them, then I'm going to say right, with that in mind, I'm going to compare it, I'm going to take that normal for you, and then I'm going to ask you what you think elsewhere. So what to do, I've got little pin. And what I'm going to do is I'm going to use the rest, and this area is planned to rest here has a very similar nerve density to that other toe, which is very convenient for us, because that's where we want to test. Now conventional testing would say even if you use a pin, and most of the time people don't, but does involve a pin used on the dorsal hallux here just between the nail and knuckle. So I'm going to apply multiple applications or multiple stimuli to the wrist here. And I'm gonna do it like that, Stephen, and I'm going to say to you, I'm doing a few. And you'll notice I'm doing them at more than one a second, it's got to be at least, though, and it's slightly more than one a second. And the purpose of that is twofold. The reason for the timing is because if you apply sensation that a great one a second, you induce a phenomenon called wind up. This is a form of temporal summation. And summation means that the average is out the stimulation for the patient. So I'm doing that. So for

you, Steven, that is a five out of 10 Let me know if that's a five out of 10. Do you mean the Talk or the stimulation that was just a process called wind? Okay. All right. So this is a very manly attempt to show these not in pain. So that's actually, exactly. So that's getting that's yeah, this is not supposed to bleed either. But anyway, so you've now got to keep going. So that's a five out of 10 for you, right. So how long would you do that for as long as I know that you have actually established that. Okay. All right. And this is a really, really good point that you make, it's not necessarily a set number. It's to be clear, and you can keep coming back to it. It can be repetitive, I can say to you look, that's a five out of 10. Okay, got it five out of 10. When I go down here and you get confused, which might happen most of the time it doesn't but because I'll come back and say you sure, there's no set number and in fact, it was it was the principal at the College of Osteopathic was Pat Hamilton, who actually coined that because I say, How do I express that? You know, is it number is for a number of seconds? How long is it? Is it number of applications, or just as long as the person gets used to and that's exactly what happens. And this is the point. People love to be involved with this and involved in their own care and treatment. So you say I'm gonna go back again. Right? That's a five out of 10. Steven, that's a five out of 10.

Steven Bruce

What's this? New screams roar?

Barry Jacobs

What's that? Three? Is that really a three? Yeah. Okay. Compare it to that one, too. Okay, um, I'm not on hard skin. Or if I do it there. Yeah. So we know it's intact. Is that definitely a three? As can go again? Yeah. See, this is all right. So that's fine.

Steven Bruce

More more severe, similar. It's similar enough for you to stop.

Barry Jacobs

So was that still three or four? Was that less than it was?

Steven Bruce

It was more or less the same? Okay, fine. All right. So

Barry Jacobs

I'm sorry for the flippancy apologising to your audience not, not you. So. So those are roughly the same. So what we've done and I can keep going back and forth to reestablish? Yeah. So the other said there was a two fold reason one was because of the windup summation. The second is that you don't, if you only touch once, you don't necessarily know you've necessarily hit a receptor and your

pressure can change. And that's the problem. And sometimes people have tried to establish a normal I shall we say, a standardised stimulation by using a spring loaded device or a device, especially a diameter and so on, and it just doesn't work with every patient is different. And I remember seeing this study that really at the Royal Infirmary and how, and they used a kind of spring loaded device versus a handheld one, and there's no difference. Can we get up can standardise it? I haven't quite been quite haven't quite finished with you, Mr. Bond. So what I was going to talk was, I really even in your case, I don't want the alternative. So so what I was gonna say was that was looking for diabetic neuropathy. In that particular case it is specifically because diabetic neuropathy affects small fibres, a Deltan and C fibres, they go first. And what's normally done in the National Health actually, is a large fibre test, which is done with touch, which is a monofilament. And they use a little use a little 10 gramme piece of looks like fishing line. It's only another one and they say to the patient, can you feel it? And before people cost too much doubt on this idea of this, this quantitative, this relative quantification technique that I've used, I'm pleased to say that it's actually been trialled in North Cumbria, the NHS Trust there over the last year. And they were very pleased with its capacity to diagnose neuropathy earlier than conventional. Brilliant. So that may actually go on and they're now going on to do a new study over the next three years based on what would you

Steven Bruce

regard as a significant difference? If that was genuinely a five on that was a two? Oh, that's

Barry Jacobs

a good question. Thank you very much. Well, so what would I that remains to be seen what I think we need to try and demonstrate and that's what the next study is going to do. Is is okay, this is a very, this is a very important question, actually. A real game changer in the last couple of years, or even the last 18 months, actually, last couple of years has been recognition that you can actually reverse diabetic neuropathy detect it early enough, right. Yeah. And this is a combination of things like HPA one C control, you know, sugar control, lipid control, weight loss, et cetera. There's a few things hypertension is one of them as well. So if you pick it up early, and if the patient says you will, I have got a three and by the way, they probably would have had like touching tax because that's a large fibre situation, then you know, that's yet to be explored. But it's the idea is to know, let me just be explicit currently, that's not common practice. Common practice is light touch. However, Louise, I haven't finished with you yet. Everybody probably remembers using one of these has had a one to eight tuning fork, but having one Exactly. Now, I as a rule, tend not to use these because if like most neuropathy, or most damage seems to be relatively you can't it's not really useful for doing a dermatome because of course it doesn't actually confine itself to specific parts of the body. It is the other standardised test for diabetic neuropathy which is a pity because again, it's large fibre The problem with large fibres is they tend to deteriorate with maturity. So as people get older, they go anyway. So it doesn't help you. It's the small fibre that you really need to be looking at. But I saw a particular case yesterday, and we can talk about this if you want to get up now, we are enjoying enjoying the post. I saw a patient as you stay there for a second please thing. I saw a lady yesterday and she she asked me to have a look at it because she was experiencing. She was experiencing a peculiar sensations in her feet bilaterally and alike. She felt like she was wearing tight boots. But what was really interesting is that she was saying that no lady in her late 60s fit horse rider, that sort of thing. No real constitutional rules. But then she said, when I think I should be correcting something, if I trip if I step I was on a catch myself on a tilt. Most people would know how to correct

that. I fall over. And she was referred to a fourth clinic, but then she couldn't go NHS constraints, the clinic of clothes and so on. Could you have a look. And the interestingly enough, that made me think that she was a tactic. Now the thing about large fibres, as opposed to small fibres is that they can affect motor function and sensory function. So that was where the tuning fork came in. And that may well be a B 12 deficiency. I don't know I read Margie people, we need glasses to find out what it is. Otherwise, she needs to see neurology and indeed,

Steven Bruce

we've done a couple of shows on B 12 deficiency. So it's a great topic to explore, isn't it? Yeah, for sure. We

Barry Jacobs

have a light. Can I have a lie down here and

Steven Bruce

get back over here? Thanks. We haven't got one left. And I've got a lot of questions. So we want you to know I'm okay with bare feet for the rest of the know, the camera work, we'll make sure that they're not exposed. Cameron wants to get oh, no, I won't. Release. Okay, I'll be says you don't. You say don't just do the process with neuro exam, but it doesn't take long. And as long as you're also thinking about what you're doing, I'd argue far better to have lots of ticks on your notes to see you've done a thorough neuro exam than to have to argue or explain why you didn't feel it necessary to do X, Y, or Zed. Unless you've got Barry's ability to argue the case. You are pretty good at this stuff, aren't you? So it

Barry Jacobs

will from what I'll be saying he is then doing the process, isn't it? Yeah. So I don't think he has any contradiction there. He had a good reason for doing what he did. But the one thing I wouldn't argue is it doesn't take long. I think if you say well, it doesn't take long. I would say I did it because I was able to discern what was normal in the patient. The

Steven Bruce

shifting between foot and hand that you would or risk that you were doing earlier on? You did it for quite a long time. Would that be a sort of normal length of time would entirely depend

Barry Jacobs

on I did that for demonstration purposes? How long did it take you to establish a normal?

Steven Bruce

The first time you did it? I think I can say that. I say I understand you're gonna call that a five. I'm going to tell what's

Barry Jacobs

the five one and then bang, that's it. And that's probably a lot quicker than would be done in a national house for sure. And they really are under constraints. So it's very, very quick.

Steven Bruce

Claire says she had a patient who was a radiographer training to be a report, a reporting radio or an MRI. She always had me in mind when she was writing her training reports and what I would want to know she was told she was reporting too much information and had to reduce it. Just a bit sad.

Barry Jacobs

But it depends on whether it was relevant or not. But The

Steven Bruce

radiographer, the reporting radiographer radiologist might not know might be the

Barry Jacobs

one who was I'm confused who was actually saying too much.

Steven Bruce

radiographer was the radiography. radiographer who's thinking of clear when she's writing the reports is thinking, hang on. All right, what I think Claire wants to know, but he's being told by her supervisors, ma she's training.

Barry Jacobs

So what we don't know maybe Claire can tell us is whether that was because she really was a training and didn't know what was relevant. And we've all been guilty of that and providing too much information. Or was it that the supervisor just had a particular idea about the extent to which osteopath actually studied medicine?

Steven Bruce

Yeah, I do. I wonder if

Barry Jacobs

they won't understand that.

Steven Bruce

I suspect it might have been that she in her training. She was writing reports which she knew Claire would appreciate but they weren't intended for Claire, they would just report on this imagery that we've given you and tell us we just don't know do we know you don't. Robin This is barefoot Robin. I'm pretty sure says he. Robins always got a comment about barefoot running or wakeboarding or things like that. And you won't mind me saying that because he's a very, very lovely member of the of the Academy. He says he learned the history taking lesson with an elderly gentleman who asked if he had any who I asked if he had any CVS issues, which he answered no. burying you differently as he knew the patient. I think he enjoyed the look of terror that crossed my face when the patient removed his shirts. that triple bypass. Apparently, yes,

Barry Jacobs

I do that on, which,

Steven Bruce

you know, there's another lesson in that in that a lot of people these days are saying, well, we don't need to undress our patients. And, you know, we had somebody who said, you know, they suddenly realised they looked at the sort of the muscle disparity between left and right, which they couldn't see with the clothes on, or in this case, if you wouldn't have seen the scars or whatever. And it's all down to that business or litigation that we talked about earlier on, isn't it that we don't want people saying, well, you made me take my clothes off, and I was standing there and my brown pants for 15 minutes. I've

Barry Jacobs

got to be honest, increasingly, I make a window where I have to now and things have changed dramatically, haven't you? But if you need to look at something you need to look.

Steven Bruce

I've always been puzzled by the issue of gowns, though, because I've always thought, what's the point of taking the clothes off? So you put a gown on? You feel worse with the split down the back than you did with no clothes on at all? I think. Yes. Have you ever contemplated using gowns? Or do you just undress what you need to address when you dress it again? No.

Barry Jacobs

I thought the Osteopath was supposed to wear the girl. I was not what you remember, I remember. Yes, when the circumstances in which we were wearing a gown and not something we want. But I can remember locally in a practice where they did that they had cubicles to change in opinion came out. And again, I wasn't really comfortable with it.

Will Williams

I'm not comfortable.

Barry Jacobs

I just didn't like it very much.

Will Williams

But they got to accept the fact that some patients to modesty or religious reasons, don't want to undress for her when she's have to work around it. But we mustn't assume that they then want to take off this, if you explain it properly, a lot of the patients are very cooperative, but

Barry Jacobs

the climate really has changed. And in our practice, I have to say, and I'd like to take credit for it is my esteemed colleagues who do this, they have been extremely thorough and diligent in matters of consent. And recording, the patient has agreed online, you know, in advance, they've actually provided not only informed consent, they know what they read the form that says that what to expect. And last but obviously, which is a something we've kind of put together what if they've never been to ask you about before, that they have a sense of their own autonomy, they can have a chaperone, all of these things, you know, all of these things are valuable, you know, so that patients can be as much part of the process as possible in partnership, I suppose, as we say nowadays, but that sensibilities have definitely,

Steven Bruce

we got time for one more question apart from I'm gonna read this one out. I didn't know who it was. Somebody said I normally get my patient to remove their own shoes and socks. Is that old fashioned? I mean, we have to point out that it's just I'm used to having someone do it for me.

Barry Jacobs

I think we can dispense with the silver platter.

Steven Bruce

Probably is old hat here. We're asking you for your exposure on neurological knowledge here very. Lucy says you used to treat her when she was a child after falling after she had been falling out of trees and our forces. And when you did a neuro exam, you observed that the extensor hallucis longus. Power testing the HL the E, the second digit would raise and she's never understood the connection. Why if you're testing the hallucis would the second digit raise? Can you explain?

Barry Jacobs

I don't understand. I'm sorry. Could

Steven Bruce

you say you're testing the big toe? When you test the power test that the second one lifts? Why?

Barry Jacobs

I couldn't tell you I don't know what that is. Okay. Sorry, Lucy. I it's been

Steven Bruce

for another question.

Barry Jacobs

I don't know what that is. I mean, some people are just idiosyncratic, I guess. Yeah. Or it may have well been, I guess that is the although it's the HLN effects, mainly the big toe speculating, you know, dorsiflexion of the toes may well well be multiple wiring. And it may be that there had been damaged to that particular tendon or that particular branch of the nerves depending upon what had happened and maybe everything else moved in that didn't.

Steven Bruce

I don't this is lengthy. I don't know if it's going to turn into a question or whether it's just an observation, but it's from Sarah. Services. I don't know if these cases help. She had a lady aged 60 who had knocked the back of her leg and presented with a red and inflamed lower right leg. For me, he's a lady. So 6060 For me, instinctively her skin looked to read but hardly any heat on palpation. I told her to see a GP that day and it was a DVT and another lady aged mid 50s with low back pain after wearing heels but was feeling nausea, which she put down to a virus she was getting over. And movements were too good for the level of pain she was experiencing and I referred it was identified as breast cancer that metastasized to three places in her spine. It's not a question. Sarah says I've learned to trust my instincts and if something just feels wrong It's always best to have it checked. osteopathy is key chiropractor, of course, which of course is little consolation to those who are just graduating because I still want to build that experience. But

Barry Jacobs

it makes me worried actually, because I just wonder how much I've missed.

Steven Bruce

Yeah, and I imagine that every medical practitioner has that same concern, because you're gonna miss a lot, aren't you? And hopefully it doesn't turn into anything serious or we pick let's pick up any final takeaways for people before we close?

Will Williams

Well, I think, yes, we've been doing it for a very long time. He's been doing it longer than I have. But I think we're in the same boat as the students. We just don't know everything. And the most important quality is the reflective quality to learn and learn and learn. Things

Steven Bruce

are really good. Yes, absolutely. Well,

Barry Jacobs

if you've got a WhatsApp group with colleagues, that's fantastic, unfortunately, multidisciplinary practices a few osteopath, a couple of physiotherapist and we sometimes say look, look what I found or look at this MRI or something, you know, any ideas or anything, but you can do that with other practitioners. You don't need to be on the same place physically,

Steven Bruce

gentlemen, it's been a great sharing stage with the folks again. Steven, I hope you enjoy 10th anniversary show our 807 live broadcast.