Academy of PHYSICAL MEDICINE

Transcript

374R- Research and EDI - Dr Jerry Draper-Rodi

Steven Bruce

Good evening and welcome. Tonight's show is a very static one, no practical, not even any slides to distract you, but it is nonetheless a very important topic I think you'll agree. Although my guest is himself, an osteopath, and a very well regarded 1am I said, things we have on our agenda are very relevant to all physical therapies, I suppose, in osteopathy. We're fond of highlighting the lack of good research into the profession itself. And I imagine chiropractors do the same. But I do wonder sometimes whether that reflects a lack of support for our own particular brand of therapy or our own preferred techniques. Personally, for example, I've always felt that the reliability of those studies into let's say, joint manipulation is a bit questionable. And perhaps this evening is a perfect opportunity for us to get all those questions answered. With me here this evening is Jerry Draper Rudy. He is, as I said, an osteopath. He is also the director of emcor, the National Council for osteopathic research, and He's an associate professor at the University College of Osteopathic Research Centre. The agenda is pretty much whatever you want to want it to be in terms of research. But we do have on our list of topics so how our interventions influence pain relief, pain prevention, as well as you'd say, the effect of mental health on mental health and what the research tells us about equality, diversity and inclusion in practice. One thing before we get rolling, though, there are aspects of research and these topics which I know lots of people find quite contentious. What I don't want to do is to have the show devolve into a mudslinging contest. So it would really help if everybody is allowed to have their say, especially in the chat rooms. So I guess what I'm asking is that you'd be friendly and tolerant in there, even when someone says something maybe you don't agree with. Anyway, Jerry, it's great to finally have you on the show, because we've been trying for some time to get you on the show. I know. Thank you very much for having me. I'm really happy to be here. And we've had your colleague Dan on the show before to talk about research as well. But I know you've got other things you want to talk about.

Jerry Draper-Rodi

In terms of yourself. You do still practice as an osteopath, one day a week you told me earlier? What sort of osteopathy Are you? Well, I'm a fairly broad osteopath. Until recently, I was still doing some

paediatrics. But I decided to stop that because I don't see enough to feel that I was probably safe anymore. But apart from the paediatrics group, I tend to see a quite, you know, the whole community. So I see older adults, probably most of my patients are going to be around the sort of 50 Plus, I guess, and in the sort of management and really around, you know, trying to work out what's going to be the best for them. And really the stuff partnership collaboration with the patients. But I noticed you haven't used the word structural, when you haven't said cranial. And the reason I'm asking is because I know that those are sort of those little areas within our own profession, which are mirrored, of course, in chiropractic, which people often sort of, kind of pigeonhole themselves into. So I guess I've got issues with these terms. They are very mechanistic, in a way, you know, cranial and all that. So I put my hands everywhere on the body, well, where obviously, it's appropriate with patients consent and all that, but I put my hands on patients heads on their abdomen, around, you know, their spine and everything. I don't think I find using words, cranial, visceral, very comfortable, because I'm not confident in the models behind them. But nevertheless, I apply techniques are would usually be, you know, described within those terms.

I use evidence as much as I can. But I think, you know, everyone here is going to be aware that evidence is lacking for most of us. And that's not unusual. And I think that's fine. But trying to navigate how we, you know, manage patients when evidence is lacking is something that I quite like, you know, having these conversations with patients. Yeah.

Steven Bruce

I said in the introduction that we're you know, we're very fond of saying that evidence is lacking for what we do.

A lot of people who are watching this evening or watch the recordings ever will be saying, well, frankly, they don't care. They're only interested in whether their patients get better. And I can remember thinking at college, and for years afterwards, we had been taught some cranial osteopathy and I remember thinking, I'm really sceptical about what I've been told here, but I wasn't sceptical about whether it worked. I was only sceptical about the mechanisms behind it as they were explained to me then is that for you, is that the problem? The the mechanisms possibly aren't what we think they are. Oh, yeah, I think there's there are many issues with the fact that these models are probably obsolete, but we continue, you know, teaching them or using them to explain what we do with patients or the healthcare path.

Jerry Draper-Rodi

regionals I think, you know, it's problematic on many levels. I guess, these arguments that it doesn't matter whether it works or doesn't work, because he works with my patients is something I'm quite, I'm quite uncomfortable with.

Just because I think all of us, you know, ultimately, we are aiming at helping our patients getting better. And always doing the same thing is a lack of opportunity. You know, there are ways where

we can probably enhance our outcomes, they are things that probably we do very well, but no one knows about it. So it's not going to help other patients know about what we can offer. And, you know, all of us all the time, we use some form of evidence, whichever it is patient's feedback, you know, previous experiences all of that to inform our care. So it's not to replace all of this by this randomised controlled trial said this, of course, no one hopes that anyone would work that way. But he's just having a sort of broad source of evidence that is going to inform the sort of, you know, complete, complicated discussions that we have with patients, I think the it's really the complexity of clinical care, that, you know, is sometimes a little bit simplified by evidence based practice is going to be this or that. We know it's much more muddy, you know, than that in real life, and possibly getting muddier. When we talked earlier to before we came on here, we talked about the difficulty of tutors at university accepting written work, because it's now AI is getting so much better at generating things worse. Richard Horton, the editor of The Lancet, is very well known now for having said that you can't trust peer reviewed peer reviewed papers, because sometimes the evidence is manufactured, the data is manufactured, the biases and allegiances of the authors are not disclosed, and so on. Yeah, I think what he was saying was that

the position before was we trust unless we find something wrong, now we have to notch trust, and then find evidence that we can trust it. And that's, I think that message was partly to peer reviewers. So when you do a peer reviewed has to be thorough, but also for readers, you know, even though it went through peer review, and we talked also about that, but predatory journals, we have to remain really, really careful about what we read and how it's going to inform practice or what we advise to patients. Yeah, yeah.

Steven Bruce

Yeah, I kind of sympathise with Richard I mean, when a man who runs that, who is the editor of the biggest medical journal, certainly in this country, one of the biggest in the world, when he says he can't trust research. That's that's a very significant statement to make. Is it? And I like the spin you put on it that,

Jerry Draper-Rodi

but I think there's, there's still a body of people who believe that the peer reviewing is the end of the process. Whereas it's probably not is it the peer review is what gets it published. And after that it's open to scrutiny by the rest of the academic world and professional world and others? That's right. But also, I think we have to accept that, you know, research is not going to be a final answer. You know, it's little bricks of knowledge that you build, and you have a bit more and a bit more. And a paper will never be able to settle a debate, it's just getting a bit more weight on that side, or that side of an argument or you know,

and that you can see movements, for example, the BMJ

very recently said that they were only going to accept clinical trials published in the journal if the research team was providing the whole dataset, right, which is something that has been a very big problem. So open science has been asking for that for a very long time, open access, open science, open data are all these sort of, you know, open movements.

But as long as journals are not pushing there, there was not really going to happen. Now to publish in the BMJ you have to give me a data. Well, that is good. There was also an agreement.

Steven Bruce

At least 10 years ago, I believe that all research had to be pre declared the outcomes had to be predicted not the outcomes, the intention had to be predicted, which I don't think has been adhered to by the papers as it was. Yeah, so damn good idea, because it meant you couldn't hide the stuff that didn't suit your purpose. So it's, it's mandatory now for systematic reviews and for randomised clinical trials. But now with this movement of open science, everything should have a protocol pre registered that can be modified. So that is basically stamped with the journals don't necessarily do they do they certainly do humans because they want to get the money for the publication and and for publishing info, then disseminating those papers. It's quite a big business isn't it is yeah. So you know, up and up and accessing predatory journals, they're not going to be really interested about protocol being, you know, published and all of that, because that's not exactly how they're sort of Moodle is made on the we've had a couple of comments coming in already. And I think we could probably have predicted this this, this thought chain because most of us think along

These lines. Mica says anecdotal evidence is still evidence. And Kim says the evidence is if the patient gets better within a certain timeframe. And I think that's great. That's what we want. We want our patients to get better. I suspect that there are complicating factors in that they weren't there in terms of

Jerry Draper-Rodi

Yeah, and I, I quite agree with the first comment about, you know, anecdotal evidence. And that's right. No, that's completely true. And as I said, we need a broad range of sources of evidence to use and that would be part of it. Regarding the second point, I guess, I'm maybe a little bit uncomfortable with that, as a clinician myself, because when a patient comes back, and they get back, they feel better. It's really difficult for me to pinpoint why, you know, is it because of what I did? Is it because of what I said, because of what I advise, is it because just time happened, you know, Dima has passed. And that's it isn't because they took some painkillers, you know, all these sort of things. And maybe I over complicate things, but I, I quite like to understand why someone gets better. And we know that natural history is a very big component, why people get better. So if you take low back pain, the last data that we get from a systematic review, it's around 80% of patients will have their low back pain episode getting better within a week for a new episode. So again, if we say them at day two, we see them a day two, and they come back in a week later, and it's much better. Yeah, but it was very likely they would have got better on

Steven Bruce

their own. Awesome, give me a review for the clip.

Jerry Draper-Rodi

You see, so but then, you know, we can be we can look at their risk factors of chronicity. There are lots of things we can do about this. But just using patient outcomes as a fact that he would say that's basically, you know, what we do is effective, I think is probably missing some of the factors that will influence why someone is getting better.

Steven Bruce

Yes, and of course, that comment that came in from Kim was, if the patient gets better, actually, if you've got a lot of patients and they're getting better, and hopefully that they aren't all getting better, just through passage of time, someone who will be chronic back pain sufferers or whatever, then you can begin to say, what I'm doing one way or another is working. But isn't, isn't that what's known as a pragmatic trial, you don't say you adjusted L to L three, you say you went in and saw an osteopath or a chiropractor. And after this period of time, we reviewed it, and you had got significantly better or completely better, and we checked again, after six months, and you were still better. And we don't necessarily care what you did in the treatment, we just knew that the patient got better.

Jerry Draper-Rodi

That's right. So without getting too technical, there's a spectrum of clinical trials. On one end, you have the pragmatic trials, like you define. And the other end is what we call explanatory trials, which are placebo controlled trials. So it's not binary, either, or it's really a spectrum. And so you can have some features which are more pragmatic, and others, which are a bit more explanatory. But if you are comparing to real world interventions, so you use chiropractic and osteopathy, I wouldn't recommend doing that as an RCT, because I'm not sure that they will be the most useful, but you know, it could be that saying that there are a lot of similarities. So there might be things interesting that would come up from that. But then using two interventions that exist in the community that you can access, and then you compare outcomes, which might be cost effectiveness or whatever, yes, that's really problematic, in essence, and therefore the clinician, it will be at the discretion of the clinicians, which would be called providers in your trial, it will be at the discretion of the providers to decide what they do.

Steven Bruce

Right? Wouldn't the normal comparison be say osteopathy or chiropractic with normal medical care, which might be sit and wait for a couple of weeks, take some ibuprofen, and maybe do some exercises,

Jerry Draper-Rodi

it would really depend on what the condition or the symptom is, if it was something like, you know, nonspecific low back pain without getting into the sort of what does that mean, but you know, if it was something that is part of the scope of practice of these professions that you don't need to have usual care alongside, you know, you can be you don't have to, then no, you don't, you don't need to have an usual care group. You could, as a control if you want it to be, you don't have to.

Steven Bruce

So I'm smiling because someone called Groucho calling himself or herself Groucho resyncing this, so a quote from the training in the 1980s. Some people get better, even if you throw sausages out. Which is true, isn't it? Sometimes it doesn't matter what you do. You just you're just there. There were three strands to what we were going to talk about tonight, one of which was the impact the impact of physical therapy on pain prevention. Where do we stand in that research? I'm presuming there must be some.

Jerry Draper-Rodi

Well, so we've just published a couple of weeks ago, a scoping review, looking at prevention in Muskoka. He's old pain for in chiropractic, osteopathy and physiotherapy. And I expected that there would be a lot of literature in that, because, you know, anecdotally, I think a lot of us do that. We see patients who don't want to develop any problems, they want a checkup, or others who want an MOT, because they have that in the background, maybe, you know, low back pain, or neck pain or whatever. And they just want to make sure there's not going to get worse, and then we're going to have another episode. So they do they come for these emojis sessions. But also, if you look at sort of, you know, the policies from the government, the NHS, there's a big move towards prevention, because, of course, you know, with these lifestyle related disorders, like you know, type two diabetes, high blood pressure, cholesterol, which are having, you know, very large negative effect on interval integrals, but also in the city. There's a big push towards. And we went in the literature, and it's not much at all for, you know, for the three professions together. So, I was, I am

Steven Bruce

surprised, I thought that physiotherapy at least would have an awful lot of evidence behind it. And there is a tendency I feel for us to see our professionals, if not all three, in competition with each other chiropractic, chiropractic and osteopathy, in competition with physiotherapy, because they are the big professionals.

Jerry Draper-Rodi

So we found 21 papers on the topic. I mean, that's ridiculous. Yeah, that's really small, I think we should really place ourselves as key professionals, who can really, you know, take part in this movement around prevention, you know, wherever you stand, you know, if you want to look on a sort of physical, philosophical point of view, it makes sense for our professions. You know, I'm thinking about carrying us to here, if you think about patients patient care, the sort of principles with which we want to, you know, do some form of treatment prevention is really core to our principles.

But nevertheless, and I suspect, it's probably a lot of what we do in practice and some of the problems data and the surveys, we've done it with that it seems to suggest the case the problem, those are the patient reported outcome measures. That's right. That's right. And we can see that a lot of our patients who come to us they've had persistent pain, and they might be coming for a new episode, or because they don't want to own up. So. So I think that probably is a good is what happens in practice. But we don't have any evidence of that. And therefore, if you have the government, and they want to fund whatever sort of project or anything, we can't really say, We're here, we're very good at what we do, because we don't have that evidence. And so I think it is important for our professions to really move towards prevention to demonstrate that we are safe, where effective, we can, you know, mobilise that knowledge into preventing MSK problems or any other sort of issue? How do we do that?

Steven Bruce

I mean, that sounds to me, like it's a massive, prospective study of some sort, where you've got a huge database of patients who don't have any problems, and you're just trying to show that they didn't get any problems in the future.

Jerry Draper-Rodi

Yeah. So you can do that. And so we mentioned problems, the patient reported outcome measures, that probably wouldn't capture that very well, to be fair, but we have the infrastructure to start capturing some of that data. And as you mentioned earlier, Dan, Dan Bailey came in December or January, here to discuss the practice based research network. And so we have now 570 osteopaths in the UK, which otherwise probably 500 clinics, who have agreed to being members and start, you know, supporting collecting data. So, we are building that sort of infrastructure to be able to do the sort of, you know, quite large international studies to start capturing some of these elements. And, you know, of course, private practice, NHS work is completely different. We're doing a study on around osteopaths working in the NHS at the moment, although many, I can't say because we are doing a qualitative study. So we are interviewing people who work so I don't have sort of, it's not really, you know, numbers as such. What I can say is the people we have interviewed are loving it. So you know, and I think, you know, people went there, people were interested. So I'm not saying it's for everyone, but the ones who are interested. Definitely love it.

Steven Bruce

So can I ask those the ones that you've spoken to? In what capacity? Are they working within the NHS? Are they taking referrals from GPS or are they working inside hospitals or

Jerry Draper-Rodi

all the different walls so from primary care? Sorry, I forgot the name that is not coming together. I've got the name, secondary care and a different bands. So from bands, I think we've had from band six to eight. So from you know, the sort of delivery of care up to sort of more management level and all of them worked very closely with lots of different professions. including other osteopaths. But not

only. And they all said the caseload is much harder in the sense that they are patients with more comorbidities, who have had a person in pain, who might not be in the capacity of working. So a few of them were during both private and NHS work. And they said, you know, the sort of type of patient that we're seeing were quite different. So, you know, I think if we do manage through the practice based research network to get data, but prevention and all of that, we have to accept that it will be on the part of the community, but not the whole community that is out there.

Steven Bruce

I think, I like to think we've been instrumental in getting quite a few people to sign up to the practice based research network. What we'll do later on in the in my follow up email tomorrow, we'll make sure that people are reminded of how they can participate in that, because it's no good sitting on our collective backsides. And complaining that there's no research, if we don't do anything to help ourselves, but

Jerry Draper-Rodi

also sitting on our data, we all have loads of data in our clinics. And if we bring all of that together, that's how we are going to get power, you know, power through communicating with prospective patients power through, you know, discussing with the government. And the way I see, you know, our profession, and our work is very through collaboration. So, the practice based research network is really about us as academics, working with clinicians, and patients and agreeing what is important. So it's not the academic saying, oh, we need to know more about for this for prevention, maybe clinicians don't care about prevention, and then we won't look into that. So we are currently doing a survey with our members to decide what will be the first projects we will be running so that it is meaningful to them, it will help their practice, and that we have something that is really useful for the profession.

Steven Bruce

It occurs to me that we are in danger of entering a sort of a vicious spiral in some ways in our profession, because we talk a lot about evidence based practice. But because there isn't any evidence, that means that we have to accept what there is, which means we limit our scope of practice to that evidence, and people are not getting involved in wider. But now I'm thinking here, of course, there is. I'm going out on a limb because I didn't know correctly. There is a body of evidence or body of the profession, which says spinal manipulation, weather manipulation is ineffective. And the opposite end of the spectrum is that exercise is all you need to make people better. Now, that's a bit controversial in all sorts of ways, which we can come onto later. But if you say all of the evidence supports this end of the spectrum, whichever that is, it means that we stopped doing the other end, and therefore there is no evidence for it. So yeah. I was a long winded question. Sorry about that. No, no, I

Jerry Draper-Rodi

really, I think I get where you want to go. I think we have to differentiate social media with evidence. And, you know, 10 years ago, there was Adam Meekins is probably the person who was driving a lot of these discussions against manual therapy, much more around exercise. And that was really some sorts of social media influencer during that sort of work. And, you know, that's their prerogative, they can do whatever they want. But that's never really been in the research. And then he was been around research, he's saying, but research never really said that. I think it's quite clear now that, you know, without being too nearly stick, you know, whatever intervention, you're looking at, the effects, the effectiveness, when we called effect size is going to be the same. So if you look at psychological care, manual therapy, whatever sort of intervention, manual therapy exercise, if you look at mindfulness, acupuncture is quite similar. All of these, they have, you know, fairly small to moderate effects, which means that's why if you're in pain today, in the streets, you will see lots of different practices, offering lots of different professional services. And all of these people make a living because they all do the best they can, but there's not like one winning sort of, you know, intervention. So the spectrum you're talking about against manual therapy and for exercises, there's really good evidence, saying that, you know, giving exercises to everyone doesn't work, you know, patients who have been in person pain when you do qualitative work, I haven't done that. But there is a qualitative studies out there, asking them, how do you feel when your healthcare professional says you should be doing exercises? They hate it because they've tried it? It was really painful. And maybe they have, I remember some participants who were overweight and they said, You know, I can't really feel the weight. You know, the idea of me putting your life on and then going to the gym is just, you know, a no no. And so having an approach which is much more personalised to the patient, and yes, trying to promote them becoming autonomous and being physical The active Of course, that's really important. I think no one would disagree with that. But saying that, you know, manual therapy is going to be the opposite of I think it's really well, that's social media sort of narrative. And one final thing I'm going to say on that, because I feel passionate, as you can see around it is often the argument that he says is that many therapy is going to make patients dependent. Yes, and that's a big argument from people who are all about exercises. And the only troll, as far as I'm aware that looked at that. And they did exercises which were framed within a biopsychosocial model, versus manual therapy, which was framed within a biopsychosocial model. And then they looked at how many sessions these people had outcomes and all that basically, they found no differences. In the sense of same number of sessions, I think it was between four and six I can remember outcomes and everything. So there is no evidence out there that suggests that if you do manual therapy, then the patient is going to come for a very long time. I'm friend as people can probably hear, and in France for a very long time, and still now but a bit less, if you went to the physio, you would have hit lamp, you would have 20 sessions, you would go back to your GP, you'd get another train session. And that was really coming. That was the sort of way in physio it was working. To me, that is dependency that is where, you know, it's really pointless as okay, you know, it's a waste of resources, it's moving away from that, you know, physio is really wrong. So everyone in France is really improving. So, just saying it was a long time ago, what I'm talking about, okay. But if you compare that sort of passive care that doesn't really give anything compared with manual therapy, which I disagree is passive care, I think patients are involved during, you know, manual work can be involved during manual therapy. And if you add advice and you know, reassurance and exercises, no doubt, you know, within a few sessions, they feel better, they go back into the, to their life and all that, you know, to me, I can't really see the sort of dichotomy of passive and active being very useful.

Steven Bruce

I have seen there Well, I mean, there is quite a well known paper, which raises some hackles in our profession, which criticises osteopathy for being biomedical and not not approaching things through a bio psycho social lens. And I just wonder whether that's whether that is supported by evidence, because I can't I don't think I could see a patient and not apply a bio psychosocial analysis to it. Maybe I might not have the skills to address the psychosocial elements of it. But I've been thinking about that. Where should we be going? What does the evidence tell us about?

Jerry Draper-Rodi

So the evidence says, so the old evidence, which is around 10 years ago, says that we were as bad as physios and GPS. We were quite biomedical in our understanding of pain and stuff like that.

Steven Bruce

Now, could you just explain what we mean by biomedical for anybody who So pain

Jerry Draper-Rodi

is due to a specific tissue in the body, if you are in pain, you shouldn't be active. bed rest is good. All these sort of, you know, what is against current advice or guidelines for the management of nonspecific musculoskeletal pain. I did a small study recently, again, around low back pain and bicycles from management with osteopaths who had been in practice for more than 1520 years. And it was a small pool of osteopath, but their levels of biopsychosocial management were much higher than what we had 10 years ago. So there might be a shift, I think there is a shift out of them. What I would say is, we discussed earlier about a patient I saw today. And that patient had seen a another health care professional before me, which would fall into the category of many threat feeds you it's, I was just confused. I've already mentioned visuals and I don't want to sound like I have anything against visuals. You know, it's not that at all. But they had seen a physio who had given them and lots of biomedical biomechanical explanations, and they got a spine that's a DS getting your disc is inflamed is pushing on the nerve centre. And the patient was hitting me today how anxious they had felt after that appointment. And I think probably that physio might not see that as biomechanical. You know, they were providing education, but they knew that the patient was anxious. But it's also what we say and what the patient is going to retain that is quite important. So I think there are quite a few layers of how you're going to interpret whether someone is biomechanical or more bio psychosocial. Well,

Steven Bruce

your name is on a paper about the no SIBO effect, which is what we're discussing here. If you tell people this nasty red thing here is poking on a nerve and patients can get quite alarmed by that. What what do we know about the no SIBO effect and the way we as osteopath chiropractors treat our patients? We don't

Jerry Draper-Rodi

know a lot so we did the position paper, which was really to try to start a conversation with chiropractic, osteopathy, and physiotherapy,

Steven Bruce

and mercy bow in case anyone's in any doubt is the opposite of placebo, it's that selling somebody that's going to make them sick, and it doesn't make them sick, I had no intention. And

Jerry Draper-Rodi

I think, you know, as clinicians, we see that all the time, you know, oh, I've seen I know, the orthopaedic surgeon, and he said, with that, sort of, you know, X ray or MRI in 10 years, I will need total hip replacement, there is no data, saying that with that sort of imaging, that you will know, whatever outcome the vision is going to have, we know that it's not the X ray that you do surgery on, it's the person and you know, their beliefs and their needs and all of that. Nevertheless, you still have lots of practitioners who have the sort of an that's going to plant a little seed in someone's, and therefore that's going to change their behaviour that might become much more protective exercise later. And that's where all the sort of negative health outcomes are going to happen. Could

Steven Bruce

it also make them more dependent? Because they'll suddenly think, well, I've got to keep coming back to you to make sure this doesn't cripple me from

Jerry Draper-Rodi

Exactly, exactly. So in the paper, we make the argument that it's very likely that in this profession, when that happens, is not done on purpose, we don't think there's a sort of commercial, you know, need that make them think, Okay, I'm going to tell them that, so then they're going to come for 20 sessions instead of three. But nevertheless, because of poor part of the training, or different aspects, the sort of language, language or semantic is used with our patients, and that can make them really scared. And that's going to have a negative impact. So whilst evidence is quite limited on the topic, I think, thinking about our communication, thinking about the sort of advice we give about investigations are the sort of things where we can act, and we make a list of recommendations of you know, future research. Sorry, but also implication clinic in clinical practice what it means.

Steven Bruce

Do you manipulate patients yourself? I do. Right? So what do you say to those people who argue that one, it's more risky than not doing it? Until there's no evidence for it working?

Jerry Draper-Rodi

Well, I think that would be quite an intriguing statement, I'd like to know where the evidence, where's their evidence? Because I'm thinking about a few things. I'm thinking about, for example, the chrome study that was done here in the UK a quite a long time ago now, that looks at adverse events, following osteopathic treatment, and they didn't find any differences between manipulations and the other sort of techniques. I'm thinking about the meta analyses that and we have lots of them being published, you know, every so often, but either they find that they don't really have it any effectiveness, or that they have some effectiveness. So yes, there's a bit of debate there. But regarding the the arms, the harms, that you know, it's very little, yes, any intervention has any risks, you know, and that's part of your consent talk that you have with the patient,

Steven Bruce

we do worry an awful lot about vertebral artery dissection, or, and so on. And

Jerry Draper-Rodi

I think we should, you know, I don't think, you know, if we look at the I formed framework about psychological dysfunction. You know, the evidence seems to be quite strong, suggesting that it's not about the manipulation. It's the diagnosis that was wrong. And the pain was not musculoskeletal. It was vascular. Yeah. It was referred pain from vascular issues that were mimicking musculoskeletal pain. And then, you know, the practitioner decides to do a manipulation. But with or without manipulation, probably the outcome would have been the same. So I think our problem as clinicians is more in the diagnosis and you know, dream, cranial nerve testing, hybrid pressure, testing for blood pressure, all the sort of testing that may be not done routinely before doing spine manipulation. I don't do many spine manipulations. I have to admit, just to replay it fully to your question. But the evidence about the manipulation, doing harm to the arteries, is not very strong, to say the least.

Steven Bruce

No, but you only need one case in the press.

Jerry Draper-Rodi

Yeah. The chiropractor I think, yeah, of course. Yes. And

Steven Bruce

who I bring up on every first aid course we run, but I also know to osteopaths who have had patients die on their premises, not as a result of manipulation. But again, if the press gets hold of that, I'm sure that they would draw inferences which may or may not be justified. Yeah. So I've got some questions that have come in here. Hannah says evidence informed practice as opposed to evidence based might be a useful concept. What's the difference? Yeah.

Jerry Draper-Rodi

Because I'm a bit simple, I guess. Maybe I like if I guess,

Steven Bruce

I guess you have a symbol from all those letters after your name Jerry.

Jerry Draper-Rodi

But I like simple things. I like evidence informed. Yeah, it's an it's a good word. And I agree, because you're going to inform your practice from lots of things. What I find is a bit difficult is that we start having several concepts or several words for the same concept. And therefore, if you were doing, you know, trying to sort of scope the reach on the topic or whatever, you have lots of different synonyms. And so, on the principle, yes, I think evidence informed practice is really good. But I think rather than creating new terms all the time, it's not new and evidence is what has been around for a long time. And but I think, just to simplify, I tend to use evidence based but I don't have any problem with that evidence informed.

Steven Bruce

The difference, I guess, is that if it's evidence based, then you have to have evidence to show that what you're doing works, as opposed to I'm using the evidence. But

Jerry Draper-Rodi

no, because, you know, if we look at the evidence based model, Sackett, mid 90s, it was about the best available evidence, the practitioners experience, and then the patient's preferences and values. So it was really all there from the beginning. So evidence base doesn't mean you have to do what is in an RCT, it's really, you know, using all of that, to make sure that the best decision is taken for that specific patient in front of you. Because you will never have an RCT that had a 62 year old who smoked for 20 years, and now looks after a dog and you know, your patient in front of you will be the end of one, it will be that patient that is quite different. So you can't say I will only do this, you will have to inform your decision by

Steven Bruce

any conventional surgeon or whatever would I'm sure say that their intervention works provided you put the right patient on the table, which means that you know, you have to select your intervention to suit the individual. And

Jerry Draper-Rodi

it's hard to know sometimes. And as you might know, you know, orthopaedic surgeons are going through a very tough time at the moment, because a lot of their interventions for pain are

demonstrated as not being effective and having obviously lots of arms and very, very expensive. And so there are lots of really exciting trials happening in Orthopaedic Surgery at the moment in Australia, in the UK, looking at fusion, lumbar fusion, looking at I'm not going to find the word now, when you do laminectomy. And they are looking at, you know, the whether they are effective, and they are doing true placebo control, but it's it's on the sort of mythological point of view, it's a nightmare. But they have done amazing stuff.

Steven Bruce

But they do a similar one on knees,

Jerry Draper-Rodi

shoulders, and they found that there are no differences between placebo and all that I don't know, for the ones I've just said, because they are being conducted at the moment. But you know, the sort of issues of no SIBO placebo doesn't really work. And with that, it's not just in manual therapy. In psychology, they go through the same conundrum, the same crisis, where they have contextual factors or contextual effectiveness, what we call placebo, if you can, which is good, you know, you're going to attach to your therapies for 45 minutes every week. And so that, you know, oh, you know, Steven, he's so warm, He's so kind, he listens to me, and all this, I've never said that about me. And that's going to be really important. But then when in psychology, they measure the specific effects of using Acceptance and Commitment Therapy, CBT, whatever sort of approach you have, it's tiny, really small. So it's not just in mania therapy, that is a massive problem in any sort of approach for nonspecific symptoms like pain.

Steven Bruce

We go through some more of these, Lauren says, He recalls chatting with an osteopath and mature osteopathy emphasises, well, of course, a couple of years ago, in her training, she spent a day with Laurie Hartman, his clinic, the main thing she took away from that experience was that you can't help everyone.

Jerry Draper-Rodi

And I think this is something that, to me, is a sign of the maturity of a profession, accepting that we're not going to be able to help everyone. Not every symptom, or every patient can be helped with your approach. Obviously, triage all of that, but also, we might end up understanding that we're really good at some stuff, and let's good i love this stuff. And that's fine. I think

Steven Bruce

this is another it's a very difficult decision to make this particularly I think, because as healthcare providers when someone walks into our treatment room, we want to help them we don't want not It's not that we don't want to admit that we can't it's that we don't want to let that patient down. And there are a number of cases I can think of when we weren't talking about them here which have

gone to complaints against osteoporosis because they've tried hard to do something despite the fact that really they should have said I can't do anything for this

Jerry Draper-Rodi

and I think this is where having a really close you know, professional network around you is really important. I can

Steven Bruce

recommend the Academy of physical medicine for them. Yeah, but no, but I'm thinking about you know, look at each

Jerry Draper-Rodi

you know, your ot your psychologist You know, sports court where all these sort of things, you know, having these people there where you think you know what I think these specialists would do you know, they've had a couple of sessions with me, we got where we could, but now they need x y Zed, and having these people around you is really important. Why

Steven Bruce

don't you I'm slightly joking about the academy. But as we were talking about, again, earlier on, we run regular case based discussions. And actually having those is a great way of getting input from a lot of other people who might just be able to think, well, maybe this particular approach would be helpful, and it's a suggestion to throw into the mix, isn't it? Darcy says, All the workup re effectiveness of Osteopathic and chiropractic manipulation for simple low back pain compared to physio or acupuncture was done in a massive paper published by the government called the CSA G report in the mid 90s. It informed the NHS on how our osteopathic services might be used effectively. Bottom line was that HVT is the business end of managing acute facet joint strain. Does that ring bells with you?

Jerry Draper-Rodi

No, not really. I'm afraid so. Apologies. I'm aware of the UK beam trial that was done. But that was probably a bit later in the late 90s. I guess. But no, I'm not sure about that. Sorry.

Steven Bruce

I think when Darcy says all the workup really effective isn't what we do. We there have been lots of trials, a lot of inquiry into chiropractic. I think a lot of them from America or Canada that I've seen also

Jerry Draper-Rodi

a lot from Nordic Europe, North Northern Europe, they've done lots of really, really, really nice, really elegant trials into low back pain, but also musculoskeletal

Steven Bruce

pain. But an awful lot of them I've thought have been, what's the effect of manipulating this one lumbar joint? Patient. And I always think to myself, That's, first of all, I wouldn't trust very many people to make the joint they're actually I think they might be to identify one with a finger on his bonus process. But the one that actually, whatever it is difficult, but he also seems too limited to me. And one of the criticisms, again, is that we're not holistic enough, despite what we think.

Jerry Draper-Rodi

And I would fully agree with that. But I think we have to go back. Why did they do that trial? Where was the research question? Right? If your research question is to see whether that approach works for managing that symptom, that will be bonkers to be doing this really will be not helpful at all, do you know whether manipulation of C three helps with diaphragmatic mechanics or with you know, shoulder pain or whatever, we don't work like that, you know, we are going to be much broader, it's much more complex of intervention. But if you want it to understand what could be the mechanisms that are involved, when you do that sort of technique, one might be the processes or our models currently, you know, correct, then that sort of trial is perfect, you want to do something quite specific, you remove one ingredient in your control intervention, and you see whether it makes a difference or not. And, and but quite often you write these trials are seen as you know, it doesn't really help practice well in mind to try it and see what happens. But also it helps education. It helps when we talk to patients and all these sort of things. So for example, we did a systematic review recently, with a colleague of mine in New Zealand, Kesava Sampath, we submitted published a meta analysis, looking at the biomarkers following spinal manipulations. So again, you could think doesn't really matter doesn't you know, I'm not going to measure cortisol levels with my patients before and after in the in the clinic. But it's, you know, if you read a book about spinal manipulations, you're going to have everything happening there. You know, it's all it's all going to happen. But what is really happening, and you need to measure that, and we had some studies, and now we have some evidence suggesting what might be happening. But it doesn't mean that tomorrow we're going to treat any inflammation, but with bone manipulations, you know, it's not that but it's really what happens when we do experimental prediction, and that's really working that what, you know,

Steven Bruce

fancy human says, Did the lack of evidence between manipulation and other techniques causing problems and not quite sure I'm reading this correctly? Did the lack of evidence between manipulation and other techniques causing problems include C spine manipulations?

Jerry Draper-Rodi

And recycling?

Steven Bruce

We talked about this earlier? It's about the lack of evidence between manipulation and other techniques causing problems. You said there wasn't any evidence. Did that. Do that including?

Jerry Draper-Rodi

Not very clear, sorry. So what the evidence seems to be subject I'm far from being an expert on that. And Roger Carey and Steven Vogel provide courses on that and they are much more elegant than me in explaining that. So I'm just explaining what I heard, you know, that in from the afferent guidance, but what is clear is that extreme movements are what are causing problems, extreme rotation, extreme extension and stuff like that. When you look at an age which Usually when they're done, they're not done in full rotation of full extension, there will be a bit of rotation, a bit of extension, but not much that is going to affect the vascular tissue. So there is evidence, which was not very good initially categoric evidence and stuff like that, but you know, where those, and now there's much more in sort of living tissue evidence around that. So the evidence of strokes or, you know, post manipulations, tend to show that there's been another incident that led to that. So, you know, picking reversing and turning them made or things like that. But the manipulation being the sort of onset of that stroke. I think there's good evidence that No, it's not that it's more that it was brewing in the background, and it was missed by the clinician. Fortunately,

Steven Bruce

it's been a concern of mine in the past that investigations into manipulation, particularly, let's say C spine manipulation, have included evidence from a whole swathe of practitioners. And it could be argued that and again, I'm not anti physiotherapist, let's say a physiotherapist has gone on a weekend manipulation course, it could be argued that they might not have the skill of an osteopath or a chiropractor who's been doing this for years as a student, and then yours as a as a trained practitioner. And that would distort the effectiveness of the research because they won't be doing as well, I'm going

Jerry Draper-Rodi

to be the devil's advocate. That fees, you'll probably see the placement in neurology, and they've done a lot of work around your G and during cranial nerve assessment and stuff like that. And therefore, if the manipulation is not what matters, but it's the pre screening, that is really important features might be much better than others. So I am not really sure that this sort of difference between professional is very meaningful in these sort of discussions, because I've read,

Steven Bruce

but you did say that it's the extreme movement, which is like, those people who are less well trained in manipulations are likely to use much more movement, much more rotation than those who have done in depth training.

Jerry Draper-Rodi

But perhaps, the evidence doesn't really suggest that when you look in very experimental conditions, about I think it's cervical manipulation, but also thoracic manipulations. And you look at experts and they will come to the expert, I think with probably like 20 years of clinical experience with novice, which were just graduated. Many therapists, I remember what the background was, I think it might be in chiropractic. And they looked at the specific effects of that manipulation. So it's a little bit different from what you were saying, it was exactly the same, right? So this idea that our specificity is getting better with time, our perpetual rescues, and all of that is a narrative that is really important in our profession. And I'm not saying it's not true, I'm just saying the dividends, he's not really suggesting that's the case.

Steven Bruce

I suppose partly, I was driven by you know, I keep mentioning Lori Hartman, we've run a number of courses with Lori here, we'll probably get one every time every year. It's his final course. But he can't quite give it up. But he, he calls it a minimal leverage course. But actually, it's a maximum leverage course, because he's putting, you know, anything like 10 levers into the setup, and then a tiny movement with speed, but very tiny movement. And I suspect that there are a lot of people who've been in practice for 20 years who haven't done any training since they were undergraduates. So the technique won't be any more refined, it will simply be 20 years old.

Jerry Draper-Rodi

Yeah, in that study. I can't remember for sure, but they were educators, they had been providing CBDs for a long time. So they were not the case, not negating what I'm saying, but the sort of average osteopath, they were probably considered as sort of, you know, quite experts in their fields. Okay. But you know, you talk about complaints, and that's something that we do every year, we look at the constant complaints against your path. And clinical care seems to be something that has been plateaued for a few years. So we need to look into that. But obviously, the main one,

Steven Bruce

so clinical care has been plateaued. What do you mean? Well,

Jerry Draper-Rodi

it hasn't. So, okay, let me rephrase, restart the main issues for complaints and concerns, as I'm sure you're aware, it was around personal relationships. And it included issues around communications around informed consent, with obviously all the sort of unprofessional behaviours on top of that. So that led God to change the CPD scheme and we all had to do every three years something around comes and consent. And what we have seen is since then, it hasn't went you know, down and now there's almost no complaint. So you potentially was effective, the change of speed. What hasn't really changed is around clinical care. And that has been the same if you put 2020 out because of

COVID You know, we closed our practices for a few months and blah, blah. But if you put 2020 aside, it's been the same for the last whatever, six years. And that includes misdiagnosis. Error and diagnosis, more pain after treatment, complications after treatment and all of that. So I think that's where, to me, that's where I want us to, to look into, you know, what can we do better? You know, what can we learn from our mistakes because we will make mistakes. That's normal, you know, we will never do zero mistakes, but there may be mistakes. We do a bit too regularly that we can learn from.

Steven Bruce

Yes, yeah. You mentioned that as osteopaths, we have to do some training in communication and consent for our tri annual triennial CPD. Chiropractors are required to focus on equality, diversity and inclusion, haven't you just done a study in that

Jerry Draper-Rodi

I have with a very broad team of mostly osteopath, but also a physio fantastic physio. And we looked at Egi in undergraduate training. So I'm gay. And during my undergrad training, it wasn't very easy to be gay and to sort of be in the treatment room and not knowing how to behave to make sure that you train when you qualify. I finished my training in 2007. Okay, so it was a six year full time training in forms. And so yeah, 17 years ago. And it wasn't very easy, but I thought, you know, it was early 2000, and blah, blah. But then there was a report by Stonewall about LGBT community in universities in the UK, which was awful, really horrendous. So I thought there might be something interesting to look in us, I think, educational institutions. And so I had this idea that it was going to be quite small around LGBT and organise, and then, you know, I became aware that it was a little bit silly to look in something isolated because of interest. intersectionality, you have to look at all different characteristics. So it became this huge study where we, you know, I was not equipped to look into ethnicities, disability. So that's why this sort of, you know, team grew and we've had people, the sort of interesting Genuity of that

Steven Bruce

was, what was the question you were trying to answer, but we wanted

Jerry Draper-Rodi

to know, what was the experience of students who are from underrepresented groups during the training in osteopathy. So the sort of, we started with a systematic review, which we found there was nothing in osteopathy. There was somebody trained in Cairo and physio about bullying, harassment and discrimination. And then we did a survey of all the students in the UK asking about their experience, whether they had been bullied, whether they feel they're under within an underrepresented group and all that the response rate was not very high, like it tends to be with surveys. But there was really unfortunately, good evidence that it was not rare for that to happen. firmus

Steven Bruce

any small group, whether it's people with ears that stick out, or ginger hair or anything else, all of them will have experienced some sort of persecution in their childhood or whatever. Yeah,

Jerry Draper-Rodi

but that was not during childhood that was in an institution where you had clinicians, by future clinicians, and also clinicians, most of them clinicians teaching them. So technically, we could expect there will be a nurturing environment with people who are caring for others and all this stuff. You know, that's, I know, I sound idealistic, but that's what you would expect. And obviously, that wasn't the case. So then we did focus groups with we included women, LGBT people, people with disability, and people from ethnic minorities. And we learned from that experience, and you know, what they shared, it was shattering. You know, it was really, really horrendous, the sort of experiences we heard. But we learned a lot from that. And then we brought that back to the IO G or ask all the different schools and colleges in the UK, we did a big forum day. And that led to sort of action. So you know, things are moving and people are really proactive. So you know, it's really fantastic. But yeah, I think it's difficult for

Steven Bruce

an equally interesting study to be done about attitudes to the lb LGBT, LGBT, and all the other letters community in clinic. Yeah,

Jerry Draper-Rodi

so they've done that in, for example, in the US, they've done that with lots of professions. I think I can remember if it's 1700 or 17,000, clinicians, and they looked at attitudes around LGBTQ plus patients groups. In osteopathy. There's been a study, which to my regard is not a very good study, but looking at Italian osteopaths opinions around trans patients. In chiropractic, they've done a study quite similar Recently, and I've just finished supervising a master's in Switzerland. And the students looked at the experience of Swiss trans and non binary patients experience of healthcare when seeing an osteopath. So you know, it is what did we learn? Well, we learned that patients tend to try to find an osteopath, or chiropractor or a therapist, or clinician, who seems to have positive views. So it can be simple things like, you know, having a message on your website saying, We will come everyone, we're inclusive, and we've done training and all this other stuff, that having your forms, you know, your history cases, reforms, not having sort of binary box, but where patients can enter that themselves, like pronouns, or their title, all these sort of things. And now I use the sort of online clinical notes system, you know, that's you can activate that very easily. So these things can be done quite easily now, but obviously, you know, if some of us are still on paper, you know, obviously, paper notes. So it might need a bit of tweaking, but these sort of things. So just to be humble, and asking patients, how they want to be called, and what is their sex, which is their gender, all these sort of questions, and I guess, getting a bit of training to feel comfortable asking these questions. And I've been doing that for a very long time, obviously. And there's an old,

Steven Bruce

there's an old guard in our steel with you. So what I'm going to offend a lot of mine. Exactly. Normal patients, if

Jerry Draper-Rodi

I answer this question I've never had any patient saying was that. And the only comment I had one day was a fairly old female patient who said, know what your questions now understand. I never understood what was all these first around gender and sex, but no complicated. And I wasn't here advocating or anything, I was just asking the questions. But by asking the questions, it's sort of, you know, yeah. So yeah, I've never had any negative comments on that.

Steven Bruce

We have done a couple of shows with Simon, who surname escapes me for the moment, but he's, but he was fronting up gendered intelligence in London. And I found them fascinating. And anybody who knows me will know that I actually am quite irritated that we discussed this, because we shouldn't have to discuss it at all. It shouldn't matter to anybody, what their patient in front of them does is behaved, how they behave. But he was very, very good about how we should approach those questions. And also, he said just how much it's appreciated by but it hit particularly the trans community. And in his experience, how just a little bit of knowledge about the trials and tribulations of that way of life is, is affecting them. But also, he said, It's okay, if you know, they've given you their pronouns, that it's okay, if you get it wrong, as long as they know, you aren't deliberately trying to go down that route, which is you're going

Jerry Draper-Rodi

right? And I think, you know, if we want to be holistic with our patients, and if we want, to me, it's really important to understand their previous experiences with healthcare in general, with industry. Have you ever seen, you know, this stuff? Yeah. And as soon as we know that, if you're black, if you're LGBT, if you have a disability, if you're Jewish, then it's very likely that they have been discriminated against by other healthcare professionals in the past. So their experience is probably quite negative. And they come to us. So if we want to build a rapport, you know, therapeutic alliance with them and all that, in maybe I'm not saying we should do that all the time. But there may be patients with whom you know, discussing these topics will really help them to feel more comfortable and confident in trusting you and invent math.

Steven Bruce

We have had a lot of questions, again, there's possibly more than I can cope with. And they will go back to what we were discussing before. Lauren says, surely gaining evidence based results always requires an underlying belief system or model. Models are all very nice as a left brain exercise. Sadly, though, something will always come along that doesn't fit the model. And I guess you were saying that, reflecting that in what you said earlier on that it's the patient in front of you, you're dealing with not the generality of a trial.

Jerry Draper-Rodi

Yeah. And I agree with that comment, you know, because a modal is false, by definition, is never going to be a true representation of what happens out there. But it's a way of mobilising what might be happening so that we can try to use it, we might be able to test it we can convey that model to others. So it's it you know, as a society where we live with others, it's really important concept. But I fully agree there will never be a model out there, which is true, because models do change. We learn that they don't work so we adapt them and that that's part of how We all work.

Steven Bruce

And Simon has said surely the importance of our profession, but the important thing in our profession is to know our limitation. It's probably an important thing in all professions, particularly medical professions, we must be able to refer on if we can't treat someone, which is all very well. But when we have the biopsychosocial model, there's an awful lot of people we can refer to in this wider context, isn't that? And you've just said that actually, in the psycho, psycho analytical, psycho analytical or psychotherapeutic world, actually, the evidence is not strong for different interventions, it's going to be quite hard for us to say to this patient who is paying privately to see as well, I want you're gonna see another private practitioner, don't know if what they do is effective. But you need psychological help of some sort. Yeah,

Jerry Draper-Rodi

you're right. It's a it's a very big challenge even more for, you know, in private practice, I guess, what I find useful is to see what these other professions say, they should see when they should be referred patients. So for example, pain psychologists have made statements about when manual therapies should be referring patients to them. And the list is quite short. And it's for things where I think all of that, or all of us unless, you know, people have specific training, would feel ill equipped facing these patients. So patients who have voiced that they have suicidal thoughts, patients who have, who use drugs, to or whether they can't control patients who had severe depression. And I think the fourth one may be post traumatic stress disorder, but I'm not sure about the fourth one, that there are four, there's a list of four, it's not that long, at least, we do see lots of patients with anxiety, depression, stress, that's very common, but it doesn't mean we need to refer all of them to psychologists, but they are, you know, patients who can't deal with that level of depression or stress or anxiety. And obviously, they should get help, and we're not the best place for that. So there are tools to help us to know to screen to you know, and I think that's really important. I completely concur with that person where, you know, there's the first line of triage red flags, but then all of these psychosocial factors. Is that for us with the pain better, will they get better? Will they get less anxious? Or is there something more to that which men can't really help with?

Steven Bruce

Well, I kind of infer from what you were saying earlier on that what we do can very often help with me a little bit. And what this person does can help me a little bit, put them all together, we're probably going to get a much better outcome is, is there a way that we as osteopath or chiropractic

colleagues can develop our own skills to perhaps be better at the psychosocial elements of what we do? Yeah, I've got

Jerry Draper-Rodi

a few thoughts fighting with each other in my head, which one is going to win? Well, so my, my doctorate was in the bio psychosocial management of nonspecific low back pain. So that was eight, eight years ago, what I did was to develop an elearning course to equip osteopath who hadn't really been exposed to the basics, remote all into that management. And we tested it, that was good. It seemed to work. That's great. And so we tested it again, looking at patient outcomes, where they would help. And so that was updated so that elearning is available, and you know, people could take it and you know, and all that. So how

Steven Bruce

do we find that? Because it sounds very interesting to me personally, let alone do any of the other. Yeah, it sounds a

Jerry Draper-Rodi

bit of a marketing term. So I do apologise for that. But it's on the Uco CPD website. And the elearning is eight hours long and it's 100 pounds. Right?

Steven Bruce

Okay. Well, it's only marketing if you bring it up if only bringing it okay. It's not

Jerry Draper-Rodi

if it's useful training, yeah, we should I think there's there's that which is, you know, there's lots of content and stuff and the feedback has been amazing and it seems to be very effective. Another aspect that I was going to bring to your question was about bicycle you

Steven Bruce

improve our psychosocial skills in in dealing with our patients. That's right,

Jerry Draper-Rodi

and the

Steven Bruce

umpire remembered what I questioned.

Jerry Draper-Rodi

I can't remember what the second thought was about it we'll come back in a minute so

Steven Bruce

Okay, Kim says I might take issue with him on this and I do so in the in the nicest possible way and she knows that what it needs is a GP that can join up all the dots. A medical doctor will give a pill a surgeon will operate a psychologist will analyse and acupuncturist will stick pins in and a physio will give exercise. The osteopath and chiropractors look at a patient on all levels and make an informed decision on the basis of their training and experience. This is when you decide whether to treat or refer. Do you think that generalisation is fair?

Jerry Draper-Rodi

I think I And you know, that's definitely getting outside of my expertise. But when I see GPS, or physios who have time with patients, yes, I don't think that's a true representation. But I think

Steven Bruce

the NHS physio is almost directed in what they will do by

Jerry Draper-Rodi

any of us, if we had, you know, very limited time with patients, of course, you have to do the sort of really important triage and then provide some sort of intervention quite quickly because of not knowing that. And, you know, I think there are some sort of structural constraints that can limit how much one can interact, I see my patients for 45 minutes. So I've got, you know, a luxury of time with them. And therefore, I can do a to spend it over time to understand the expectations that concerns, you know, provide some form of treatment, all of that. But I think it's really related about from the environment in which I work, right, rather than the profession. Okay.

Steven Bruce

Let me go back to what I said about weekend manipulation courses, because Dave here has sent in this the point over weekend manipulation courses and skill is a very interesting one. As I understand it, the research suggests there's no level of expertise or specificity and manipulations. I think there's a danger from taking this research and ending up with a piece of watered down application of such techniques. I've been manipulated by those who have done a weekend course, and those who've done much more training and a demo manipulation from Lori Hartman, I can tell you absolutely, there is a difference in feel and comfort from these manipulations as a patient. So while we may be able to argue against specificity, specificity in the evidence, I'm concerned, if that then leads to

people thinking just a weekend course is fine, because there's no specificity expertise, and thus leading to unskilled and unsafe practice.

Jerry Draper-Rodi

I agree with that. And I think I wouldn't recommend, you know, going forward just to date or that I would have also concerns I'm not sure exactly the same, but I would definitely would have concerns. I guess what that statement or you know, a testimonial says is that the best person to whom we should be asking that question our patient, and it's been sorry, it's going to sound extremely judgmental, but maybe a little bit navel gazing, where, you know, we've been wondering whether that technique is better than that one and all that. And that's been us clinicians sort of arguing with each other. By the end of the day, you know, lying on the bed, eat all the planes that is a patient, you know, so asking them, I'm thinking about Mandy Banton, Amanda Benton, Dr. Benton, she's done her doctorate in the experience of patients receiving cranial treatment. And so it was what is called a phenomenological study. And it was all about the experience of patients receiving care. And, you know, we learned so much from asking our patients, why, you know, what happens? What is your experience during and all that? So, you know, them saying, you know, it was much more specifiy was much more comfortable. Yeah, we don't have evidence of it. I wouldn't be surprised that we might find that. But, yeah, we need more.

Steven Bruce

Does this relate to the concept of, I'm gonna say collaborative decision making, which I, as I understand it, is that you have a discussion with the patient over what they think and you feel is going to be the best technique, which I felt a little bit worried about, because I thought we were always told that just because the patient says I want my neck manipulated doesn't mean you do it.

Jerry Draper-Rodi

Yeah, that's right. So yeah, that's shared decision making. So that's the one. There's a beautiful model of shared decision making that I really like. And that's what I tend to use in clinic from Elwin that was published a few years ago. And it's around three talks, which I'm going to miss represent and bastardise. And I do apologise, but basically, it's about an initial talk. And you understand, you know, this basically your case history, your you know, your chapter initially, you understand why they're here, but also what their concerns may be. And then after your examination, you have an option talk. So you describe that would be your sort of informed consent. So benefits, the risks, the alternatives, you know, what happens if you don't do any treatment, and here you would prison, maybe a couple of options, you know, that you might be able yourself to offer, which might be, I don't know, some form of hands on and all self management or whatever sort of acupuncture if you do that, whatever. And then there's the something around like choice taco. That's probably a better word than that. But where the patient is going to say, You know what, I'd like to do this. And that's where the patient might say, you know, I'm 103 and I'd like you to crack my neck because when I was 20, that's what used to work. So you might need to revisit some of the options you discussed earlier. You know, it doesn't mean that the patient is going to share it, you decide. It's shared decisions, you bring the evidence, you know, what do we know what would seem to work and then

the patient say what they will Like, and then together, we try to work out what's the best option for them?

Steven Bruce

Right. And so that shared decision decision making, as I understand it has gets good reviews in terms of overall patient outcomes, and is there a placebo effect? Is there a psychological effect in that patient feeling engaged in the treatment?

Jerry Draper-Rodi

Yeah, I mean, when we look at the effectiveness of treatment, as I said earlier, you know, there's not a treatment being more effective. And another one, if we look at pain outcomes, though, we do know that if we use a technique that the patient prefers, then the effectiveness is going to be much bigger. So if you patient comes in, says, I love manipulations, and you decide, I'm not going to do any manipulations, because I'm the boss in the room, and I'm going to decide, well, that's a shame, because you are losing a lot of the effectiveness that you would have got from doing that technique. Obviously, maybe hiring appropriate drew that technique on that patient, and then you need to explain it to discuss. But if we can provide some form of treatment that aligns with their previous positive experiences, then the effect might be contextual, by be specific, we don't know the effects will be getting that patient for sure.

Steven Bruce

It's curious. And most practitioners will have a similar story, but I can remember a patient coming into my clinic many years ago now. I forget what the problem was. But the patient said, I've had ultrasound for this before and it worked. And I could see absolutely no mechanism whereby ultrasound could possibly influence this. And I explained that to the patient. And I said, Okay, we'll do this. And it worked. Which is yeah, as you say, if it's what the patient wants, then maybe there wasn't mechanism for it. It wasn't just psychological. But it's it's definitely going to enhance the outcomes. As

Jerry Draper-Rodi

long as there are no risks, as long as we're not making the them waste time or money. That is not a missed opportunity to get proper treatment, if they had could Equina Syndrome, for example, we're not going to discuss whether, you know, many, sorry, you go to a&e, you know, you have to get that sorted straight away. If we're not in that sort of pathway, and it worked well for them in the past, you know, then there's probably a good case to

Steven Bruce

raise that issue of money. And of course, that is a concern, isn't it? Because if we, let's say we've seen a patient 20 times, that's probably grossly exaggerating any normal course of treatment, but they haven't got better, but they've spent 50 quid per treatment on us. And, and they say, this idea

grumpy about that, it's gonna be very hard to justify it, if we can't show that there's some evidence behind the approach we've taken. Yeah,

Jerry Draper-Rodi

we have evidence around. If you look at us to better your chiropractic, you know, and now we are to a level of evidence where we have meta analysis of good quality, we have quite a few of poor quality, but I'm thinking about one from, again, sorry about the mispronunciation back as your low I think the name is Italian, I think woman who did a systematic review, not to meta analysis that was published in the BMJ open probably a couple of years ago. So if people wanted to find that, you know, they should find it with that. And they looked at, I think it's a systematic review of systematic reviews. So that's the sort of level where we are at now. Now, still lots of gaps, things we don't really understand, around Guinee, abdominal pain, headache is a bit better MSK we're getting there. So you know, we have some evidence. So if one had to justify why they did, you know, that sort of treatment for shoulder pain, or wherever, we can have some evidence to suggest, you know, what, it wasn't completely, you know, an evidence or, you know, lacking any form of evidence to do any of that. But you're right, there are forms of treatment being delivered currently, for conditions for which there is really nothing at all. And I'm not for cancelling culture in any way. I'm not saying that people shouldn't be doing any of that. But I do think they should have an open conversation with the patient saying, you know, what, we have no evidence about it. I've seen patients with your condition in the past and they seem to have responded well, it's a little bit unclear whether you will be responding we don't know who and responds, who doesn't respond. I would suggest if you're happy with that with maybe we try for a couple of treatments, and we'll review them if we see no improvement, then we stop you know, and then you don't end up in the sort of 20 sessions of not effective treatment and then leading to a complaint against you all these things.

Steven Bruce

We had some lovely shows with a chiropractor American chiropractor might read us on the show. And and he talks about maintenance care programmes, but it's it's very much not one of these I want to see you 40 times it's very much what goals do you want to achieve now are we getting anywhere closer to those goals would you want to get anywhere closer but but all the time? He's measuring the improvement and showing that by reference to the patient's feedback, progress is being made. So it is a lot of it is about honesty, isn't it? So we're getting off the topic of research. And we're getting

Jerry Draper-Rodi

I was going to follow with the Nordic maintenance programme, study that was done in. I shouldn't know, but I'm not sure. I think it might be Denmark, natural. May, geography is not great. At least homestead is the fantastic researcher, she's amazing. And they looked at that, whether it was better to give treatment dates in advance, or for the patient to come whenever they needed a follow up. So to play by basically, I loved their study that it was really clever, really elegant. But what they found is that it depends on patients who are at high risk of chronicity, they greatly benefit from having appointments ahead, and they know when they're going to come patients who are fine, you know, easy life, they're happy in their life and all that they get much worse if you give them dates,

and they get much better if they come on a sort of ad hoc basis. And that was for patients who had a history of personal low back pain. So I

Steven Bruce

want to differentiate between the two types of patient Yeah,

Jerry Draper-Rodi

they used a can remember which tool they use with our many of them the overbroad start back, and I can remember which one they use to decode a made between a risk of chronicity and no risk of

Steven Bruce

start back simply determine the degree of psychosocial issues, or psychological issues. Yeah.

Jerry Draper-Rodi

And so you have three categories. In the start back end, you have low, medium, and high risk of chronicity. Okay, and it measures some sort of physical stuff, like, you know, I can walk and save these like nine questions, if I remember well, and some are sort of physical questions, and others are more psychosocial,

Steven Bruce

I think these questions, five to nine are all about your anxiety levels, and so on. Yeah. Darcy says a new patient in acute agony from acute facet joint irritation cannot possibly offer a rational insight into whether you manipulate them or not. Of course, you have to ask get permission. And I'm not sure what prompted that observation from Darcy, maybe it's the patient can't make rational decisions or shared decision making because they don't really understand the problem.

Jerry Draper-Rodi

Or they can lose my you know, what I would say to that, remember, the last time you went to a&e for your own health, or you went to your GP for acute problem? Were you able to make a rational decision? What sort of information did you need? Did you get it, I remember myself, I didn't. Last time I went, I was told what to take as a treatment. That was it of Hugo. And for one of my sons, I had to go to the hospital. And there we got loads of information. And my son, who then was round seven was able to make a decision. So I think not all patients are similar. Not all patients have the same levels of health literacy, of course, but I think, you know, for most patients, if they are provided with the useful information in a way that they can understand and retain, then they can make a decision, even if they're in agony, I think, yeah.

Steven Bruce

Dave has, has sent in this observation that if we need to understand our limits, and know when to refer where does that line start or stop between improving our own skills in bio psychosocial management? Again, saying no. He says, we're saying no, I'm not actually not best placed to manage the BPS elements in this way. So go and see another practitioner. I guess that has to be down to the individual practitioner, doesn't it? Yeah,

Jerry Draper-Rodi

I think that's an excellent question. And, and, you know, going back to what we said earlier, you know, the psychologists have said, when they should be referred patients, on our side, we have to be clear about our professional boundaries, or our scope of practice, I guess. And, and that is when we are going to be able to know whether, you know, a patient's presentation is for us or not. And probably it's not a question not for us or not, for us, it's a question for us only, or us with someone else on the side, you know, health psychologist, a clinical psychologist, I mean, and I think, you know, it's working in partnership, and a lot of that will be much more easier to do if we work with, as we said earlier, you know, a close community of other clinicians around us, and then we can have a chat, or, you know, maggot, you know, so this patient, I wasn't really sure. And they said, Well, you know, let's wait, I know, it sounds quite critical, you know, they should see someone quite quite quickly. So having these sort of multidisciplinary discussions, you know, the case of a discussion that you were discussing earlier, I think are really crucial for us to sort of understand a bit more our own limits.

Steven Bruce

I've got to read this one because it's from Claire short, my wife. And I know what I'll get if I don't read her question. She says, Jerry, I first asked you to come on the show a few years ago, when you were frantically busy and couldn't fit us in. Thank you so much for joining us this evening, it's been great to listen to what you have to say. And I suspect that that is the feeling of most of the people watching, we've got time for a little bit more. And I also want to know, you know, what we can realistically do to improve research. But first of all, Morgan says, maybe a question on forms or prior to attending such as Is there anything you want the practice to know prior to your visit to make your experience easier or more comfortable? My friend is deaf. And she was recently asked a similar question, and she really appreciated it. So an open ended question like that, maybe is that

Jerry Draper-Rodi

I think that's a really lovely idea. That reminds me of some work, that the geoscape deed around shared decision making. And I don't know if you know, people are aware, they developed these resources that no one really used because I think they were going to launch them and COVID happened. So obviously, that will not launch. And they were launched 18 months ago. So I went to a conference in Oxford for the launch of that. And following that, Professor Don Karns, did some research looking at Dyads of patients and osteopaths and how they were interacting with using them. I think the short answer was most of us were not aware of these resources existed, but they were providing what this person was saying about, you know, providing some sort of a form for patients to write, basically, to prepare for the appointment. Well then start thinking, What do I

expect from that? What are my sort of expectations, but also to be able to write down these sort of things. And I also use sort of online forms patient's feeling before attending, and I've got this sort of poems for up and things. And I don't have many patients putting things in there, but some do, and it's always quite valuable.

Steven Bruce

Yeah. And I guess I'm thinking back to that question, which may be over exaggerated in my mind. But I don't want to offend anybody who is irritated by the long list of pronouns that you now offer to people in a drop down mess. But if you offer an open ended question, is there anything I want to know, they'll ignore it? They won't think anything of it. But those people who do want to tell you that they are, they're trans, or they've got a particular issue that you haven't thought of your case notes, then they will be forefront of their mind. Yeah,

Jerry Draper-Rodi

but regarding the pronouns, instead of having the sort of drop down menu, that would need to be updated on a regular basis, because the least does change regularly, it's probably easier just to have an open text, and people can write down whatever they want in there. So someone who might be a bit more sorry, it sounds judgmental, but conservative or old fashioned or whatever, they wouldn't see a problem to put em are in that box. And someone else might be really delighted to be able to put an x and you know, and then everyone would be happy. So I think that ways not to make people feel rejected either way, because it's too modern, or because it's too old fashioned.

Steven Bruce

I'm leaving very little time at the moment for us to talk about how we get involved in research, which is clearly very, very important. This looks as though I ought to ask this question before we get onto that. So this is gonna be the final question. Dave says, I find a lot of patients really offload the decision making on to me as a clinician, not all but some, they tend to almost zone out at the discussion of options and default to yes, you do what you think is best? Have you got any tips for how to address this and bring the patient back into that shared decision making process fully

Jerry Draper-Rodi

agree with Dave, that happens to me all the time. And you know, of course, they come to see us because we have an expertise, and they think we are better players, but also because we come from a very paternalistic healthcare model where every healthcare professionals you've seen in the past probably told you what you were supposed to be doing. Take these antibiotics, do these exercises, you know, all these others. So that's the model they've been used to. So when you ask them, What would you like? I don't know. You're the one who knows best. So that's, I think that's why it's sort of, you know, that sort of background of Whitecap. What I tell them is, I usually use the same sort of chat, which is, well, you know, what, all of the approaches I mentioned, they all work exactly the same, they, they have the same effectiveness. But if there's one that you like, better, you're more likely to be relaxed during the technique. And if you responded, Well, you're likely to respond well,

this time. So if to you there's something that seems a bit better, that will help us to get better outcome, and I can't take that responsibility, you know, they are the ones who need to decide. And usually that does the trick. And they say, Okay, well in that case, I have to say, you know, I had that before I didn't really like it. But there's still this belief that you know, manipulation is better than that or soft tissue is better than you know, the soft stuff, and other women will do We'd have any evidence of that. So, you know, I'm happy for them to decide. And

Steven Bruce

for the patient who has never been seen by anybody for this problem before, it's never been manipulated or explain

Jerry Draper-Rodi

what it means, you know, soft tissue is a bit like a massage. And many patients, when you hear a click or pop, you know, you can simplify to people who haven't had any experience in the past. Right,

Steven Bruce

so we have a little while, very few minutes left, but what do you suggest that we how do we improve the evidence base? How do we get meaningful results that we can use in our practices? Well,

Jerry Draper-Rodi

there are a few things, I think, a project that we've run for a long time is problems, patient reported outcome measures. It's a system that will get even more simple in the next few months, where osteopath will be able to send that to all of their patients without without having some specific code and all that. So the process will be very simple. The more data we have around nearly 8000 patients in our database, now we're just good. Well, we can do better.

Steven Bruce

And we explain how this works. I mean, in in my clinic, say I want to take part in this.

Jerry Draper-Rodi

So you contact us. So Dr. Coward, folks is the person leading the project. On the N co website, we have a page with her email address, and you come back to us you get to code and at the moment, you will need to send a specific code to your patient, but that will change in the next few months, it will be streamlined, your patient will feel that before coming for the first appointment. And that's quite important. And then they would feel that after the appointment, week one, week six, and we will see the sort of change. We don't know whether it's specific, whether it's contextual, you know, all of the sort of things we discussed earlier. But what we see is that patient satisfaction is to the roof. patient outcomes are excellent. And you know, we use tests, which are using the NHS, like the

family and friend tests, you know, you receive a text and they say, if you had a friend or someone of your family, would you recommend the service. So we use that, again, it's fantastic. All that is really, really good. And I think as a professional, it's things which are important to demonstrate that we're safe, we are effective, even though we can't really understand exactly why. But that sort of methods. So that's, that's something that is quite good. And in parallel for the people who are interested. And this practice based research network, I think this is where we will get the most meaningful data by capturing what happens in real world in our clinical practices. So not in a hospital in a sort of laboratory setting, which is fine is good. We can learn a lot from that. But what we do with our patients, who are they? What do we do for how long? What do you know, what are the sort of outcomes is comorbidity, something that is affecting the outcome, all this stuff, we have this huge data set that we're all sitting on to. And if we start sharing that, you know that will help so for people to join the PBRN. Again, they can go on the website. And that will so we have around 570 osteopaths already in there, which is great. And it's that's where we are going to be able to do that. So we've developed an app. I'm using the wrong word. It's called a extension I think so that osteopaths can who work currently with clinical can extract some of their data automatically and we're going to expand to other providers. And so we are sort of facilitating so that it's not taxing on osteopath time, because we're all busy and and all anonymized, of course. And as soon as as long as the patient consents, and the Osteopath, consents and all that. Fantastic.

Steven Bruce

Well, unless all 509 Other people watching this evening are part of that, then hopefully we can come in some more to join. And I'm sorry that obviously what you said about getting involved in the research pertains mainly entirely to osteopaths. But I hope the chiropractic, the chiropractor

Jerry Draper-Rodi

have a practice based research network, which is called crack. Ouch. I can't remember the acronym. I think you might think it may be crack. So they have a practice based network. And also they have problems that they've been running for a very long time. I've lost the name of their problems. I looked at the website a couple of days ago. So I should remember, we

Steven Bruce

had a couple of academics from the Anglo European college on the show some time ago who talked about these things. I'll try and dig out the data and we'll put it out on the email that I send out tomorrow. But we run out of time, Jerry, I'm afraid. Thank you very much. It's been really enjoyable talking to you. Thank you. Well, there you go. That's it for this evening. Thank you for taking part as well.