Academy of PHYSICAL MEDICINE

Transcript

390R- Manipulation Techniques with Laurie Hartman

Steven Bruce 34:00
We're going to sense lately that safety is a real concern for practitioners in all our professions. So we thought we would address that specifically. It goes to the heart of a lot of our osteopathic practice standards, the chiropractic standards and more and and it's very important, but we want to get it in perspective.
So I have got one of my favorite guests back in this evening. Probably needs no introduction, but I'm going to do that anyway, obviously, it's Professor Laurie Hartman. Laurie has been an osteopath for 60 Years and clinical practice himself for probably 50 years, he's run numerous courses for us here and elsewhere in his real area of expertise, which is what is, I don't know, perhaps incorrectly known as minimal leverage technique. He is the master of high velocity thrusts. He's renowned across the world for his techniques. He teaches across the world, and he is an absolute genius when it comes to teaching and practising hvts, which, of course, is why we've got him here. Laurie, it's great. It's a real pleasure to have you on the show again. It's always such fun having you in here. Do you think I'm right in saying that there's an increasing concern about safety, and therefore a growing reluctance to use hvts in practice.

Laurie Hartman 35:45
Yes, I think you're right, because the pendulum swings. At the moment, it swung right towards being safety. And so many people, they hate manipulation because they've had it done on them and it hurts, yes, and they don't like it,

Steven Bruce 36:00
yeah, but it's still taught in colleges, isn't it? And if it's not, if it's being taught, then people should leave confident in their use of hvts, but also knowing when not to use them and safety is paramount.

Laurie Hartman 36:13
Yes, yes. When I was a student, there were 16 students in my year, and now there's 120 in the year. Well, you can't teach 120 like you teach 16. And we were told 16 you can't do it. It's

too big a class. So because the tutor went round, did it on everybody, right? Which was interesting.

Steven Bruce 36:35
Now we probably can't get into the detail of whether you think thrusts hvts are being taught properly or correctly at colleges, because that might get us into dangerous territory. But I suspect you'd probably agree that maybe they don't go into the depth that they could to make sure those thrusts are safe and targeted. Well,

Laurie Hartman 36:56
no, I don't think they do. People that are teaching technique are usually people that are good at it, and they get involved with teaching. They're not they don't understand all the ins and outs of it, because most of them haven't been doing it very long, usually a year or two. It takes longer than that to be better at it, and that's part of 50 years, something like that. Yes, all the

Steven Bruce 37:19
shortcut, of course, is go to someone who's been doing it for 50 years and doing it well. And doing it well, and learn some stuff from them. I was struck. Sorry to you about say something. I was struck. I think we were at dinner last night, and you said this that you had, you'd come across a practitioner on a course where you had taught your method of using HBT, and that practitioner had said, well, was using a much more brutal technique, one which you said, that's dangerous. And they said, well, it works for me is, is that a common problem?

Laurie Hartman 37:45
This is, this is the problem. We see this sometimes on these courses that we do here, where somebody's been practicing 20 years and they say, Well, I don't do it like that. I do it like this. And the answer to that from my wife is, you're here to learn, learn, don't, don't fiddle with what you normally do, and start from the beginning.

Steven Bruce 38:07
So what is the business of minimal leverage? Then

Laurie Hartman 38:11
this was taught to me by Clem Middleton, who was my I worked with him for about four years at the BSO. And he said, Well, you can do this better than I can. And he retired, which was a bit of bit of a shaker. And he said, in America, they teach three levers, rotation, side bending and thrust, and that's it. And he said, No, that that's the, that's typical chiropractic method. That's the method they use in the states, if you put you want

Steven Bruce 38:40
to be rude to our chiropractor members here in the States, that's what they

Laurie Hartman 38:44
in the States, that's what they do. In this country, most chiropractors are very good at manipulation. They use a lot of force because they only go in once, but they're accurate and they don't often cause problems in the States. They do this is half the thing. It's

Steven Bruce 39:00
kind of I think I get the sense that chiropractic training in the States is very different to chiropractic training in in the UK, and I don't know about elsewhere,

Laurie Hartman 39:09
I think it is. It's much more commercial than anything, particularly in this country. British people generally don't like that, so it's not so good.

Steven Bruce 39:19
I'm hoping that we're going to get lots of feedback from the osteopaths and chiropractors and maybe physios who are watching this evening who do manipulation as well, on their experience of how they manipulate and how safe they think it is. But one of the things that struck me about the person you mentioned on that course was that that person might have been doing their technique that way for 20 years with no problems, but you only need one problem. And you know, there have been numerous instances of accidents reported as a result of high velocity thrust techniques, particularly to the neck. My sense is that the studies that looked at those statistics or found those statistics are. Not only considering highly trained osteopaths and chiropractors, they're also looking at people from other disciplines who've done very short courses in manipulation and don't know the sort of stuff that you know that you teach, or even the bog standard osteopath like myself hopes the practice. Yeah, yeah. So where do you go beyond your three levers? Or you mentioned two levers there? Well, one was

Laurie Hartman 40:21
the thrust. They only use two or three. In this country, we teach people little rotation, then side bending, then compress it that way, then side shift it, then tip it into extension. And you're adding things all the time. And when I say extension, people think, oh, it's dangerous. We're talking about the neck here. It is dangerous, but if you tip it in a small degree of extension, the facets become closer, and it's so easy to slide them. Yeah,

Steven Bruce 40:52
Robin has just sent in an observation here. You probably know Robin. I'm not going to give his surname, because I try not to give people surnames on the show, but he says he's seeing an increase in patients who are looking for the brutal techniques that they might have encountered on YouTube. And have you seen him? Robin's calling it the Y strap adjustment, which I think, if Robin will correct me, perhaps, yeah, I strap around the neck, and it's almost, it's almost a running jump with the strap. Where do you think that's come from him. And how do people get away with it?

Laurie Hartman 41:22
I don't know. And the chance of causing subluxation with that is enormous, but people still use it, and chiropractors lean back and they give enormous pull. American chiropractor, yes, yes, it is mostly Americans. I have

Steven Bruce 41:37
to keep saying that we have got a lot of chiropractor members, and all of the chiropractors that I have met in the course of running the business here, running APM, have been to my mind pretty much the same in the way they practice as osteopaths. And all of the chiropractors I've met despise that part of the profession that practices in that American way

that you described. And I know that there are a lot of great American practitioners out there too. We've had some on the show, but there's that. There's that very well known bunch with the horrible adverts and the, you know, the business model, which we all think is abhorrent, yeah. So, yeah, we don't want to be like those. I think

Laurie Hartman 42:12
British people generally are much more gentle with what they do, and they're much nearer to what our stoop has to do than anything. And the people I've seen on these courses that we run here, when the chiropractors, they're all good at manipulation, and they're very happy to find ways of reducing the force they use, they love it. Yeah, yeah.

Steven Bruce 42:33
So in terms of safety, then maybe we don't really need to rehearse what the worst dangers of cervical manipulation are, do we were talking about cervical artery dissection or potentially causing a CVA, a stroke, maybe, if we've dislodged a thrombus, perhaps, what are the other problems that you've you've heard about or seen in other people's purposes?

Laurie Hartman 42:57
I discovered a little while ago that if you take a piece of wood and you bend it over your knee and you're going to break it, you push it once, the chance is very small. If you push it once, twice, and then three times, and you're increasing the pressure, eventually, if it's going to go, it'll go, and you can feel the tension. And if you take your hands off and start again. You're then having to start again. Now, why are you starting? There's something in the tissues. If you wind it up once, back off. Wind up again, back off. The third time, you can feel the resistance increasing. It's not active from the patient. If you stop and then start again. You have to do this again. And this is what I do with most manipulations on the spine. Always, I wind this up two or three times. And on the third occasion, if it's going to go it almost goes itself right, and I'm not using a lot of force, and I in the lumbar spine. Now, wind it up, hold it back off. Do that two or three times, and you feel the tension accumulate. If you don't feel it, you don't trust because it's not going to go, you just injure the patient.

Steven Bruce 44:11
Yeah, and I think a lot of us come out of college thinking that we're failures if a manipulation doesn't work, so we found something harder to try and make it work. Yeah, I am speaking for myself here, when I when I left college, and you know, you feel under an obligation to make something go pop for the benefit of the patient, yeah, which perhaps is, is not the way we should be practicing. Well, I think you've in the you in the past have come up with guidelines of when, when to manipulate and when not to manipulate. Yeah,

Laurie Hartman 44:36
when I think of what I did in the first 10 years, I was really heavy on patients, and then I found I could reduce that as the work increased, I had to reduce the effort I was using, and my results got better and better. They all get reactions, because the tissues have changed. Even though I'm doing very little, they get a big reaction. You mean an adverse reaction? An adverse reaction. Afterwards, things are really sore. Yeah, but they come back three or four days later and it's all settled down. They're not better. Do you

Steven Bruce 45:04

think people going to college these days hope or come out of college expecting that patients won't have any adverse reaction to treatment? You know, thinking that this should be completely pain, soreness, stiffness free afterwards.

Laurie Hartman 45:18
I think they do. And I used to think the reaction was, was using the wrong technique. Sometimes it is, but often the tissues that everything changes, the flu begins to move. Everything starts to free up, and they're a lot. They do get reaction, but it lasts a day and they're much better. Yeah.

Steven Bruce 45:35
Now what people really want to see here this evening is an example of how you would go through your not just your diagnostic process, but your safety analysis with the patient as well. And we've got a patient in now. You've met this person before, and we've had to give Laurie a little bit of time with this patient, because we are dealing with, you know, safety issues here. So we have to know that Laurie is we have to know whether or not Laurie is going to treat the patient, what he might find, how he needs to do his examination, but we're going to go through the whole thing again with a patient that I came across when I was the guest on his radio show. His name is Ian Griffiths, and he is the host of beetroot radio in Northampton. And when I was on the show, he was just talking to me, as you would expect, because I'm an osteopath, he was saying, Well, I've got this problem. And I'm guessing he was thinking I was going to fix it for him then and there, but I've grown wary of doing party trick osteopathy. But he's the perfect candidate to come in and take us through some very interesting safety concerns, diagnostic concerns and potentially some some treatment options as well. So Ian, can I get you to come and join us on the stage? Please? I think I just woken him up. It's really kind of you to come in. And obviously we've given you some time with Lori to start with, and we have been through some of the clinical things that we would do for real in clinics, such as consenting to treatment, consenting to be videoed while all this is happening in front of a bunch of other healthcare practitioners. But as I just said, what I'd like you to do? Could you just start off with your your particular problem, your case history? So far,

Ian Griffiths 47:16
as best as I can remember it, it's my first indication to it was I was trying to solder a speaker fitting back onto a cable, and I found it's something I've done a lot over the years. And I found I couldn't keep the soldering irons still in the same place I could feed the solder in, because I couldn't keep guesses hot enough. So then I thought, Okay, I'll be clever. Swap hands. I'm not ambidextrous, but give it a try. And so I found, oh yes, the soldering lines nice and still now, and I got sold, and I couldn't keep solder still, so I gave up on that and gave it to somebody else to do. And then some weeks later, I noticed that I was getting a tingling sensation like pins and needles in my fingers, and then it gradually spread down the arm, and also started getting quite intense pain in between that part of my arm. Don't know which camera's on it, but round about here and whatever was happening on this side, about 30% of it was happening on this side.

Steven Bruce 48:22
I'm just just from the audience's point of view. Be interesting if the audience could feed in to us at this stage where their own thoughts are going, in terms of, you know, what they would need to do with you, whether they need to refer you somewhere else, or whether they're

thinking, we'll never look at this particular aspect of the body. But if you carry on when we might get a few comments coming in

Ian Griffiths 48:41
So then this pain here and again, 30% about on this side. And I put it down to (being a great doctor as I am!), that this is where I've been having all my covid and flu and everything else that they wanted to stick in injections. And so I thought, I just put it down to that. Then it started to get worse, and I started getting pain from that knobbly bit there so highly skilled, all the way down the arm, inside

Steven Bruce 49:18
of the arm, to the last two fingers

Ian Griffiths 49:20
to the last two fingers. And I also noticed that this hand often gets colder. There's a difference in the color there, that one's pink, that one's not. And so off to the doctors I went, and straight away, went for the prescription pad here have cocoamol, which I refused, because I'd had an issue with opiates, prescribed opiates once before, and I certainly didn't want to go back down that road

Steven Bruce 49:48
remind me how that went, because that was an interesting story I heard earlier on. I think the audience will be really interested to hear about it

49:55
A friend of mine is a neurosurgeon. Yes, I've got some in. Intelligent friends. That is hard to believe, but we were all out one evening, and I didn't realize I was doing this. I kept doing this and rubbing the back of my head. And he asked me what it was I was doing, and I said to him about this pain, I guess, in the back of my head, and it's there. And then if I take some tablets, it goes away. And he looked at me and sternly said, Yeah, you're addicted to the gear. Yeah, by the gear, by the way, as I'm an exiled Scouser. So So anyway, he said, he explained that it was opiate addiction and that this was one way that my brain was playing games with me to tell me to take more. And so he said, You'll hate me for six to eight weeks. He said, But I want you to just stop taking it was cocoa. Cocoa. Yes, so is the 50 milligrams, 500 gram tablet. And he said, you know, six or eight weeks, you'll hate me, but you will find at the end of that time that not only have the pains in the back of your head stopped, stopped there, but you probably don't need the cocoa mole for the reason you were taking us in the first place. And there was a wager, and I had to pay off.

Steven Bruce 51:25
But that's interesting. I mean, I wouldn't have known that, and any others, I wouldn't recognize that as a symptom of addiction

Ian Griffiths 51:34
. So I have been given several prescriptions for naproxen now, which I take and as I said upstairs, I often get the mouse and think, Do I really need them? Are they actually doing any good?

Steven Bruce 51:48

Have you relieved any pain or relieved any of the tingling or any other well,

Ian Griffiths 51:52
the only way I really know that would be to stop taking them again and see what happened over the course of a week, I assume. So my guess is I could probably stop taking them and not notice very much difference at all. Yeah. Okay, so, so anyway, we back to the doctors and oh, it's a rotator cuff, rotator cuff injury. So off. Now again,

Steven Bruce 52:18
I really interested. This is the thing that got me really intrigued when I was down in your studio, because I thought, rotator cuff. Where the hell did they get rotator cuff from? These symptoms, these signs, and maybe the audience will be thinking

52:32
the same ideologies

Steven Bruce 52:35
the audience is thinking. And I always make this very clear, and I've done it on your show as well. I am not here to put down GPS. GPS do not profess to have great musculoskeletal knowledge unless they are particularly trained in that area, and a lot of them will, they'll conjure up diagnoses from things they've heard about because they're trying to help. Yes, and

Ian Griffiths 52:54
I feel very sorry for GPs in the amount of time they actually have with each patient, because it's minimal, yes, and I guess they adopted to a layman like myself. Gets measured. If I've got pain, I go in to see a doctor, and they give me something that stops the pain. Then that's a win in my mind. But yeah, so anyway, we, I don't want to alienate any GPS, especially my own, but so we, we then moved on to an MRI scan, which showed damage in was, I Think it's c7 and five, six and c6, seven

Steven Bruce 53:39
We've had some diagnoses sent in, right? But you were you? Your doctor said he thought you had a rotator cuff and sent you for an MRI. This was the one you had in July, I think couple months ago, yes, right? So I've got the report - this was compared with your previous MRI in 2003 but it simply says that c5 - six, c6 - seven, disc protrusion causing bilateral foraminal stenosis and neural compression more marked on the right side. Now, foraminal stenosis means that the holes where the nerves come out are a bit narrowed, so therefore they could be compressed. We, he says, Some neural compression, so some compression of those nerves. So that could be a culprit. You've had nerve conduction tests,

Ian Griffiths 54:33
yes, I had conduction tests, which was all came back as normal, and then I was sent to see the physio, right? That went really well, he was quite upset with me and asking, Why was I being sent to him? When, when the GP had said it was rotator cuff. He said, when it's quite clearly not it's your neck.

Steven Bruce 55:03

Yeah. Well, good for the good for the physio. Great. Question, asking the wrong person. But the answer is, actually, is actually clear. It's what I said earlier on. GPs are not musculoskeletal specialists, and many of them don't know. So he sent them to someone, sent you to someone who does know - a physio.

Ian Griffiths 55:15
However, he then decided to do an examination where he hurt me. He worked his way down the back of my neck, found a little lumpy bit, gave it a push, and my arm instantly went very numb and almost almost with like a burning sensation. And I said, Please, don't do that again. And at that point, I feel he sort of had his thumb on this, put his hand on it, and gave us a really good push, which made me jump off the table. As you as you can see, I'm not exactly a small chap, and jumping up. And straight away, he went for, I can call security, you know, I'm not violent. I wasn't going to attack.

Steven Bruce 56:05
This is a show about safety, and we're building in some communication and consent issues in this as well. Laurie, give him, I'm jabbering away. You're the expert. I mean, some of your opinions on how this was handled.

Laurie Hartman 56:16
If I heard that history that I heard before upstairs, I would, for the first 20 years, I would have said, You must have an x ray before I can do an x ray or mri scan, which is a lot better. And he's done that. Nowadays. I would say, I'm going to put my hands on it see what's there. And if there's no reason why I can't manipulate. I would go ahead and apply the techniques I normally do, which involve lots of different levers, and therefore it's getting to those joints without straining them. And I've looked at his neck, and it is very tight, and I think I can free that up quite a lot, but not by ripping it around, by using lots of tiny levers and very gentle thrust.

Steven Bruce 57:06
So what do you think about the way this patient was handled by physio?

Laurie Hartman
I think that's awful, frankly.

Steven Bruce
And I'm sure the whole of our audience would agree, and it's an NHS physio, yes, and physios are bloody good practitioners. They've got really good knowledge, different knowledge to osteopaths and chiropractors, but every so often you can get bad treatment. I could tell you some stories of my own treatment, along in the past with physios, but I find that quite difficult to believe, almost, because if you specifically said, Don't do that again. We're not allowed to do it again. It's assault if we do it again. And to do have done something which caused you pain, which you said, took a long time to recover

Ian Griffiths

from three to four weeks to get back to where it was, which wasn't in the great place anyway. I

Steven Bruce 57:54
I mean, that's, that's, that's caused you some significant distress, shall we say. And so in terms of handling a patient, if you had examined a patient and they had said, well, that hurts, what would win your approach there,

Laurie Hartman 58:10
I would have backed off and stopped straight away. Yeah, there's a reason why it's hurting, and that's why everything I do is applying very slowly the forces. If there's any pain, I stopped straight away.

Steven Bruce 58:22
We've had some diagnoses sent in. One says right, c8 paresthesia, plus a c4 deltoid tubercle. Pain. Yeah, okay. One says ulnar distribution, impingement somewhere. Another one maybe. Intention tremor. We're going to scare the willies out of you now, aren't we? Intention tremor with the soldering. So what's your take on the tremor with the soldering? Laurie,

Laurie Hartman 58:58
well, I think that the muscles are weak and there's an imbalance between the extensors and the flexors. And if he's lifting something heavy, he can do that, no problem. It's the fine things he's shaking with and but having had the hands on his neck, just have a look at him. It's actually C 67 that's in trouble on that right side. It's not c8 but it's in that area certainly,

Steven Bruce 59:23
which is odd, isn't it? Instinctively, when you spoke to me in the studio, in your studio, I thought, Oh, that's a c8 problem because of those two little fingers, right? But of course, imagery and theory falls apart when you have your actual hands on a patient and feel what's working what's not.

Laurie Hartman 59:40
There's certainly some ulnar nerve distribution. We did part of the problem, and I looked at the elbow and there was nothing I could find there.

Steven Bruce 59:49
One comment is, a least-to-most invasive approach may be advantageous, peripheral nerve examination followed by specialized tests to rule out myelopathy, vascular involvement, disc, etc. Would you? Would you be thinking maybe some Thoracic Outlet Syndrome here? Or

Laurie Hartman 1:00:09
no, it's something that crossed my mind. But on side bending there's an immediate increase in the pain. Side Bend the other way, and it disappears. And the vascular component that could be but my hands on that area, there was nothing to find.

Steven Bruce 1:00:29
Okay, is there anything else that you'd like to talk about in terms of what you what you're thinking as a result of the case history before we go over the treatment table?

Laurie Hartman 1:00:37

No, I'm going to examine him properly this time, not just a quick look, and I'll test the nerves with the patella hammer, we should see some diminishment there, even though the nerve tests were negative, yes, and, and it's very much a question of what I find, then I treat it accordingly

Steven Bruce 1:00:56
One of the questions I have to before we go over is that we have the benefit of an MR Report that we wouldn't necessarily have had in our own clinics. So if a patient came to you with Ian's symptoms and you hadn't sent him for an MRI, you probably wouldn't have been so worried about disc bulges, would you and that must be the case with so many patients that we see. Having got the report, does that influence the way you now have to treat it?

Laurie Hartman 1:01:29
No because at his age, the disc bulge, if it is a bulge, is not an active thing. How old are you now?

Ian Griffiths
62

Laurie Hartman
Yeah, so they're going the disc bulge, I'm not too worried about, because I'm not going to be straining that at a minimal point with a tiny force that's not going to cause him problems

Steven Bruce 1:01:48
right now. Final thing before we go, a couple of comments in the in the list here for some time, Scott has said that when you use the word force, he wants to remind us that it's mass times acceleration, and a chiropractic HVT is very fast. Observers can't see the move, but the movement is minimal, thus with little risk. And that's what, of course, you're talking with yours. The movement is limited, so therefore the damage to the local tissues is going to be minimal. And Dee has sent in a comment saying she's had two new patients this week who've been told not to let any osteopath manipulate their neck, otherwise they can cause a stroke. And she wonders if it's becoming a common warning to the public from surgeons.

Laurie Hartman 1:02:29
I think it is, yeah, because they've seen one or two and they assume every manipulation is going to do that. Yeah, it's not,

Steven Bruce 1:02:37
no and well, it does fascinate me is that patients even having been told that, even by us in our own clinic, if I say to someone like I have to give you this warning, there's a very, very small chance that I could cause a stroke by this manipulation. And I'll give them some context for them, and they're still prepared to go ahead with it. And these patients have clearly come to see Dee, even though they've been given that warning by somebody in the past. Shall we go for the table and you can do your wellness?

Laurie Hartman 1:03:03
When I qualified, No, we didn't have to do all this precautions. You just if you're going to treat them or not treat them, if you're going to treat them, you never said anything about what

could happen. The patient's scared stiff, and they have to do it now. They're very worried about it, but, and I think it'll turn around again. Well,

Steven Bruce 1:03:21
I think it's absolutely essential that it's the patient's decision. Is it which they can only make if they know that there is some degree of risk. But as you say, I mean, I think perhaps maybe we'll get to a stage where you put more context on that risk.

Ian Griffiths 1:03:35
Also think, if you don't mind me, it's having trust in the person you're talking to and just listening to Laurie and listening to yourself, I have trust when I went to see the physio, and he straight away got on his high horse, should I have just turned heel and left?

Steven Bruce 1:03:53
Well, you know, on your courses, Laurie, you often start them with how you greet a patient. And I have said to you in the past, as well as other people. I just wonder how much of your success with patients is just due to the way you handle them. Because they from the moment they enter the room, they are full of confidence that you know what you're doing, because you do know what you're doing. And when you see somebody like that, immediately your brain is not set for success, isn't you're thinking, oh God, who am I with now?

Steven Bruce 1:04:26
Annabelle says totally sounds like a c7 nerve compression. She had a c5 six posterolateral disc bulge with relevant radicular issues, loss of c5 and six reflexes, numbness and parathesia. It took weeks of gentle soft tissue before she could even tolerate the activator, which is a tool that chiropractors use, particularly chiropractors, let alone an HVT and Annabelle is 38 years of age, right?

Laurie Hartman 1:05:15
Can you sit on the table from that side?

Ian Griffiths 1:05:17
Yeah.

Laurie Hartman 1:05:21
Sit there, please. All right. Now, let's just have a look at this, and we'll see anything I do gives you any discomfort, you tell me straight away.

Steven Bruce 1:05:32
What are you looking for?

Laurie Hartman 1:05:33
I'm looking for differences. I'm doing the tapping that's interesting. Something there that's probably the one that has triggered this. Now

Steven Bruce 1:05:43
you teach that on your courses, tapping technique, and you do it properly, you feel, you hear a difference in tone. As much as anything, there is

Laurie Hartman 1:05:48
a difference. You're not going to hear a lot with him, but that's different. It's, I don't know if you're hearing that, but if I keep tapping that, he doesn't like that at all.

Steven Bruce 1:06:01
And you, Ian, are you feeling anything from that?

Ian Griffiths
No.

Laurie Hartman 1:06:07
No. Turn to one side with your head, please. As far as you can go, my word, yes, right, and the other side, yeah, okay. Now. Side, bend in one direction. Side, bend your head one ear on the shoulder. That's it.

Ian Griffiths That's making pins and needles. Down, okay?

Laurie Hartman 1:06:26
And the other side,

Ian Griffiths yeah, that's fine.

Laurie Hartman And tip your head backwards as far as it'll go comfortably. Back then under my arm, yeah. And what about the other way? Into flexion, forwards. Yeah, that's all right, that's good. Okay. Now I'm going to put some gentle pressure here. Now try that turn to the right. Now, let's have a look. Still producing the symptom in your hand,

Ian Griffiths 1:07:08
no - slight tingle in the elbow, yeah.

Laurie Hartman 1:07:10
So you've reduced that by doing what I'm putting very firm pressure on the test most of sign and trapezius, a big muscle there. Now try the rotation. Now that's amazing. That's why I think we've got to work down here, not into the neck, because the neck is the result of this. It's not coming from

Steven Bruce 1:07:38
there. So often in the past, you've demonstrated that if you adjust something in the thoracic the limitations, the restrictions in the cervicals seem to disappear.

Laurie Hartman 1:07:49
That's two fingers. Yeah, right. Try tipping the head backwards. Now crunch. I Yeah, that's good, right now, come along to your back. There's a few tests I just want to do with Yeah, thank you. Let's have a look at this one first, let's let the arm go loose. Nothing. Much there. That's reasonable. There's nothing much there. Let's test the other one to see. There's not a lot there either. There's a little good, right? Let's have a look at this arm first, so you you don't get many symptoms in this arm at all. No, no, let's have a look at the elbow, feeling the the ulnar nerve. It's good. So look at this shoulder.

Steven Bruce 1:09:11
What are you checking for?

Laurie Hartman 1:09:12
I'm just looking to get the idea of what is normal is because it always changes a bit, and that's reasonably normal. Now, let's have a look at the bed. See what's going on on this side. Look at this wrist first. And this obviously wasting on the flexor aspect there, particularly on the the ulna side. And that's that's not brilliant at all. What does that mean? The muscle, because the nerves been pressured, is wasted away if we get the pressure off the nerve that should recover.

Steven Bruce 1:09:58
None of this is uncomfortable by the look of it.

Laurie Hartman 1:10:05
what happens if I press there? Does that hurt?

Ian Griffiths 1:10:09
It doesn't hurt.It's not pleasant.

Laurie Hartman 1:10:13
Let's look at the shoulder.

Steven Bruce 1:10:42
what were you actually feeling there?

Laurie Hartman 1:10:45
I'm looking at the range of motion and shoulder, then pushing that down a bit to see if that triggers, and it's worse if I've got pressure on there. So this, this points to the upper ribs on that side as being the key problem. Let's help you lying on that side first, please. Now I'm just going to do some very gentle work here.

Laurie Hartman 1:11:26
Just try and let it go as much as you can, just taking this round in a gentle circle. There is that causing you any pain? No, no, let's get in here.

Steven Bruce 1:11:40
What are you contacting there?

Laurie Hartman 1:11:41
This is on first and second rib.
first rib, principally because this has been there so long the rib is is elevated. And if I can take that down a bit, that will make some difference.

Laurie Hartman 1:12:10
That's pretty solid. Yes, very tender. That's his second rib. That's partly the cause.

Steven Bruce 1:12:20

Is that what you had poked by the physiotherapist before?

Ian Griffiths 1:12:23
No, it was more so it was in central in my neck

Laurie Hartman 1:12:27
right, turn onto your back again. Can you fold the arms like so just that's fine. And let me just come under here, see if I can free this off, pulling that rib down. Is that hurting? No. And lift your head off the pillow just a little and drop down and again and drop down last time. Good, okay. Did that hurt as I did that?

Ian Griffiths No, not at all.

Laurie Hartman Good, right, sit up again. We're facing this way.

Steven Bruce Did you get the effect that you expected and wanted?

Laurie Hartman Yes, the rib freed very nicely on that side.
Let's have a look now, try the side, bending of the head to one side. Yeah, no problems, now on the other side, yeah, that's good. Try turning the head to one way, and the other way

Steven Bruce 1:13:45
That was a lot better.

Laurie Hartman 1:13:50
okay, so that's part of it. And I haven't touched the neck. Got to do that, right? I'm going to free this one up down here, because this could be part of it

Steven Bruce
this is a thoracic

Laurie Hartman
Yeah, that's too full. Can actually just hold yourself like so that's it. And just lean back on me.

Laurie Hartman 1:14:13
Just let your head drop forward. Okay,

Laurie Hartman 1:14:23
drop the hands down. Let's have a look at the neck side bending now. Yeah, that's better. What about the side bending

Ian Griffiths 1:14:35
doesn't feel as bad

Steven Bruce 1:14:37
it's always a difficult maneuver,

Ian Griffiths 1:14:39
I think going further than it was doing earlier.

Laurie Hartman 1:14:42
Is that producing pain?

Ian Griffiths
no, it's not.

Laurie Hartman
No, right - Turn onto your back.

Steven Bruce 1:14:47
(ironically) So it's definitely a rotator cuff then,

Laurie Hartman 1:14:54
If I can just get. This to release. I'm doing a little bit of very gentle soft tissue here. Tell me immediately, if this produces anything, is that affecting the hand?

Ian Griffiths 1:15:13
Can't tell, so I'll say, No, yeah,

Laurie Hartman 1:15:21
that's the thoracic outlet that they were talking about pressing there that's not affecting

Ian Griffiths
I can feel it in the back perhaps, on the right, just on the one side. Yes.

Laurie Hartman 1:15:32
What about now?

Ian Griffiths 1:15:37
No, nothing. So

Laurie Hartman 1:15:39
it's the neck that's the problem. Let's see if I can free this off very gently. That's some rotation, little side-bending, side-shifting, tiny bit of extension, 123, is that causing you problems? No little push

Ian Griffiths 1:16:01
That, crunched.

Laurie Hartman 1:16:04
Lets look at the side-bending.

Steven Bruce 1:16:11
Yeah, that's significant, significantly
different, yeah, which in itself, I mean, the ability to turn your head is a valuable improvement as well, isn't it?

Laurie Hartman 1:16:21

Let's look at this side. I'm going to take this very slowly. Tell me if you get any pins and needles, that's rotation side, bending, extension, side, shifting compression. Is that hurting?

Ian Griffiths
No.

Steven Bruce 1:16:43
What did you feel then? Ian,

Ian Griffiths 1:16:44
it felt like bone rubbing against bone, yes, but it wasn't unpleasant,

Laurie Hartman 1:16:52
right? Sit up again. Back to here. That's it, right. Now, try the sign bending of the head. Now,

Ian Griffiths 1:17:06
in my head, I'm seeing all these things in the movies of the preacher healing. It's

Steven Bruce 1:17:12
a little bit like that, isn't it? Yeah.

Laurie Hartman 1:17:16
What about the turning of the head? Yes, that's better.

Steven Bruce 1:17:21
(ironic) See what the audience don't know is we switched the patient, just quickly there. So we've got a completely different person.

Ian Griffiths 1:17:26
You found another good looking bloke…?

Laurie Hartman 1:17:30
just doing some very gentle soft tissue here. I think this will start the change going, because I think the work you've had done on it in the past has irritated it, it will blow up, almost certainly, but it should carry on getting better. When you say blow up, it'll be a little bit sore, possibly tomorrow, but not a lot. The hand will take at least two months to recover the strength or the tremor. Strength and the tremor should go, yeah, and we'll see,

Steven Bruce 1:18:06
Because I'm sure you'll try some soldering, you know, every absolutely

Laurie Hartman 1:18:11
yes, just grip those two fingers as hard as you can. Grip really hard, fine. And now this one the same. That's better. Yeah, that's good. And once again, do

Ian Griffiths 1:18:24
I do carry heavy cameras in that hand?.

Steven Bruce 1:18:30

I know you did that power test before you treated here. And is that different?

Laurie Hartman 1:18:37
Yes, there's a lot more strength there. That's working. Yeah, so the muscles, yeah, as because we're taking the pressure off, the muscles have to get better, and that'll take time, obviously, yeah, right. It's a little more I just want to do here. It's just,

Steven Bruce 1:18:55
what are you thinking at the moment?

Laurie Hartman 1:18:56
I'm just checking through to make sure that's working properly. I didn't get a good manipulation. I got a little, yeah, right. That's all I'm going to do with that, because I think if we do more, we will start to stir it up. You've seen significant change, and that's good

Laurie Hartman 1:19:21
It should start to improve from that, it should carry on improving,

Ian Griffiths 1:19:27
Is it something that'll return to where it is.

Laurie Hartman 1:19:30
Idon't think so. I don't know it should.

Steven Bruce 1:19:33
But if Ian were your patient, what are you going to say? Come back in.

Laurie Hartman 1:19:37
I want to see him. I give it about a week to settle down and then see him again, and it will stir up, and then it'll settle and if it comes back, we're not going to get very far, but I think it should improve, right?

Steven Bruce 1:19:50
And if he doesn't come back and see you again, well, I mean, what I mean here is, I'm not trying to build a custom for my own clinic. I'm just saying, if he doesn't go and see anybody, will continue to improve

Laurie Hartman 1:20:01
I don't know. Frankly, I think it will, but it's a question of getting that pressure released.

Steven Bruce 1:20:08
It is sometimes hard to explain. I think to patients, isn't it? Because they think, Well, you've done this, I've got this improvement. Why do I need to come back? Actually, it's been like this for two, three years, you've said already. So it wants to go back to where it was, and it needs, perhaps some encouragement, but

Ian Griffiths 1:20:21
that's why I was asking, Will it just go back to where it was?

Laurie Hartman 1:20:26
If I shout at you, you jump, and then you relax, if I put a strain in you like that, and it stays there until somebody puts the hands on it in the right way, and it goes and there's nothing clever about what I've done, I've just hit the right point, and that's released

Steven Bruce 1:20:51
So could you just, particularly for the cervical adjustments you did there, remind us - you put in rotation, side bending, two compressions, a side shift, an extension. Yeah, we're getting up to the seven components that you put on the screen back there. And I know on some occasions you tweak the fingers as well

Laurie Hartman 1:21:14
I've got the finger just pushing even more compression, a very firm pressure, so the patient feels secure and it focuses

Steven Bruce 1:21:25
It's a good job of coming back to teach a course in a month and a half? Because this is not, I don't think this isn't stuff that you can learn instantly from an online show like this is a little bit of supervision.

Laurie Hartman 1:21:36
Most people would look at this case and think, I can't touch you. I'm going to make it worse? Yes, that's right, but as you can see very

Steven Bruce 1:21:52
You probably won't see the GP again about this. I hope you won't, but you know, it will be nice to feed back to the GP that the diagnosis that we've come up with here, that Laurie came up with here, was actually effective. I'm trying not to say that the GPS diagnosis was wrong, because that sounds that sounds bad. But so far, so far, we definitely haven't addressed your rotator cuff, you know, and going for sonography on your rotator cuff will probably show that you've got a tear in one of the one of the tendons there and but then so is everybody everywhere. You won't learn anything from that.

Laurie Hartman 1:22:28
If I saw you again, the next time, I would do more or less the same. I'd do firm pressure on that second rib. I'd also work on the shoulder a bit, because if I do the lock now, you don't know what's producing with change. We've got change. I'm not going to do any more.

Steven Bruce 1:22:48
And yes, and I had the same years and years ago. For two years at least, I went around unable to rotate to the right with my neck, until I got an HVT from somebody, and suddenly I was very angry with the NHS, because I thought, what's happened to my neck in the two years, how have I compensated? How was everything else adjusted? Because I can't turn my neck, and it made my driving that much more difficult. Whole body. Thank you, Ian, we'll release you back into the wild now, and if I can release you to your seat over there, we'll speak to you again after.
So we're going to do just a little bit extra. Some people who are watching this evening have probably heard me say this before, but I first came across you when I had just qualified in the year 2000. We've done our final exams. You came on to do one of those little post exam

courses that the colleges used to fill up time when they could have been doing other things, and you were going to demonstrate an OA manipulation, and you wanted a volunteer, and I was the volunteer, and I wonder if perhaps you could talk us through that seated OA manipulation that you did on then, because I didn't think it was going to work. Yes, and I might explain that later. But where would you like me, sir?

Laurie Hartman 1:24:06
Well, let's drop this table down. I hope you sit and sit down. Yeah, drop it down a fair bit. Actually, any particular side you want done?

Steven Bruce 1:24:18
Oh, no, I don't really need for it done at all.

Laurie Hartman 1:24:22
When I was a student, I learned about the occiput and there were eight possible lesions. It's forwards, it's backwards, it's up, it's down, and first of all, you can't feel it anyway, and what you can feel is not giving a lot of information. And I struggle with the supine techniques, and some of them, I got to work. Mostly it didn't. And then I was doing some work with Barry Savery, and he had a visitor from Canada

Steven Bruce 1:24:48
Barry Savery was the principal of the ESO, that's right, a long time, wasn't he? He's a very, very well regarded osteopath.

Laurie Hartman 1:24:55
Yeah. And we were both students together at college. We were both in the same year, and. Canadian chap showed me a manipulation I've never seen before. And I thought, That's brilliant. That's not straining anything. And if you get it right, it's going to work. You pull the Atlas back, you take the head, you put pressure on and little side bending and extension, and then you just do that. You're pulling the Atlas back, and top of their head, round.

Steven Bruce 1:25:21
One of the things just to stop you, though, I really like about the story, which you missed out there was that you had been told at one conference that you were not allowed to do any cervical manipulations, and I think you did this one on your wife, and somebody in the audience said, Oh, that's okay. Anything else is unsafe, but if that's manipulation, that's okay.

Laurie Hartman 1:25:39
That was in America where manipulation on the upper neck has been banned in lots of states because they use full force off the end of the table. This one is not and it's the only one I know that you're doing it in mid range, right? And if you don't grip firmly enough, it doesn't work. You've got to grip really firmly to make that work.

Steven Bruce 1:25:58
Should we have a little demonstration? Yes, I'm going to take this earpiece out. Was never using it anyway, right

Laurie Hartman 1:26:05

there. Let's drop this down a bit more.

Steven Bruce 1:26:12
Talk us through it again as you do.

Laurie Hartman 1:26:13
Yes, I'm looking at your occiput with the fingers there. And yeah, that side bends that way. It doesn't go that way. So there is a little tension that's fixing in front of the Atlas, turning the head just a little bit there. Now your age of neck, I'm not going to do is more than that. That's pulling that do you mean?

Laurie Hartman 1:26:36
if I pull that back, that's rotating that way. This one comes around here, and I'm gripping you, chest, upper arm, forearm. That's side bending. That's extension, pulling back on the others. See there's no, no way on earth that's going to go. No, it's not locked. No. Okay, so that's the tension going round in circles there, gently pulling back,

Steven Bruce 1:27:03
fucking hell. Excuse me, exactly the same reaction before actually. Laurie, you know, I thought that's never going to go and there we are!

Laurie Hartman 1:27:12
And what I'm doing, I'll show you this again. I'm pulling back there, side, bending extension, pulling back on the Atlas. Take you into circles, and then both elbows coming back. I'm not gripping the head with that hand, I'm gripping just there. And this one is open there. It's not there. It's there because I want you side pin. That's the position elbows pull back. And then

Steven Bruce 1:27:38
the amazing thing is, there's absolutely no strain on the patient in that technique. Is there none at all. Yeah. So thank you. Yeah. Does it move better now let's have a look.

Laurie Hartman 1:27:58
Now, that was the mid range manipulation, not end of range. And that was using compression, side bending, rotation, extension, pulling back and then around there, both hands working together like that, and that was nowhere near your end of range. That's why this is so much safer. But you need to be fast.

Steven Bruce 1:28:31
As Scott was saying earlier on about chiropractic manipulations, they are so fast that people, he says, can't see the movement. Let's go back to our chairs, and we'll take a few more questions and observations from our audience. Now these will come in random order, I'm sure an interesting one from Joe here. Joe wants to know what neurological findings would you have? Would have caused you to avoid a cervical HVT altogether.

Laurie Hartman 1:29:07
If I'm using the type of technique I'm using with using firm pressure, and unless I'm causing increase of pain, I would carry on. And most people would wouldn't want to touch that neck. They say, Oh, it's terrible. I'm going to work on it, because I don't care what I do, because I know it's safe. Yeah.

Steven Bruce 1:29:33
Dare I ask this question, have you ever injured somebody through a cervical manipulation? No, no, no. And I suspect you've done one or two over the 50 odd years of your clinical practice. I think at one point you said you were doing 34 patients a day.

Laurie Hartman
So yes, I came across a few!

Steven Bruce
when you do your courses that particular sitting OA technique is, I think, is a little difficult to master. You remember the course we did two or three courses ago, and everybody's on the course, and the only person who mastered it was a fifth year osteopathy student, so we gave him a prize at the end for the HVT technique. So it is a little bit tricky. Lawrence says for the OA adjustment is the point of fixation on the anterior of the c1 TP,

Laurie Hartman 1:30:21
yeah, fixing in front of c1 pulling it backwards, and then you've taken the head the other way.

Steven Bruce 1:30:28
When you do the course, you explain that, if you press on that with your finger, it hurts, doesn't it?

Laurie Hartman 1:30:34
Yeah, yeah.
The funny thing is, if you take a nice grip, then you squeeze the head, the pain disappears. Yeah, there's something about squashing the head. That's why you've got to hold that really firmly. The final movement is a tiny twitch. It's not a big range movement. Yeah,

Steven Bruce 1:30:53
I think that the business of compression is perhaps one of those which is often overlooked. Because I think doing lumber, lumber manipulations there's probably two different compressions that you put into the manipulation, don't you?

Laurie Hartman 1:31:06
I've got a finger on the lumbar circle. I'm putting downward pressures at the table and then into me. And eventually The Movement is tiny because the joint is ready to go. If you're doing from a distance, the force is going it's not going to the way where you're aiming, right? Yeah.

Steven Bruce 1:31:24
Matthew says this trend to go through every possible adverse outcome with patients in advance is really not appreciated by most frequently. He says he gets asked not to frighten them, but I have to tell them. I'm required to obtain informed consent. We all know where this originates from, and as Laurie says, Matthew thinks it will change eventually? I don't know. We have to give patients that information, don't we? We can't, we can't go through with a technique, particularly in an especially vulnerable area, let's say the OA, without at least having given them the option to say no, I think, yeah. I don't know how we phrase things, so

that we're being fair to the patient, but at the same time not frightening to be Jesus over them. Yeah,

Laurie Hartman 1:32:07
I think it's a problem. And most surgeons will say, Oh, if I do this, you may get a stroke. And we're not doing that, but we're almost going that way. And I think, I think it's wrong. Well,

Steven Bruce 1:32:20
it's an difference in frame of mind, isn't it? If I go to a surgeon to have a disc decompression, actually, I, as the patient, probably think this is the only option, and the surgeon knows what he's doing, I can understand the mechanics of this, so I can take his warnings with not with a pinch of salt, but I can accept that he's gonna do the right thing. When they come to an osteopath or a chiropractor and they're given all that sort of detail, they're probably thinking, well, maybe I should go in a surgical route where someone's gonna cut through endless bits of tissue and risk all the consequences of that. But they think there's obviously no reason for you to do this when there's this level of risk. And we've had people on the show talking about how you explain that level of risk. And I sympathize with what Matthew says, because it's very hard to say the word stroke without causing people to get very upset, very worried. We talked about this before. I've had somebody saying, there's been a number of comments about how calming your voice is. Well, there's more than just the voice. Isn't there because you talk about that whole physical contact thing which inspires confidence in the patient, the way you put your hands on them, you know, the way you shake hands when you meet a patient and things like that. Where do you put the emphasis on this? Or is it all just part of a blend for you now,

Laurie Hartman 1:33:42
I think it comes from the way you're brought up. I was brought up to very calm with people, and in the normal circle social circumstances, I'm terribly shy, but when I'm working on a patient, I'm there, they're there, and they usually accept it very no problems. It's funny, and if they don't, I just say, Look, I'm not the person to treat you. And they get quite a shock when I do that. I don't often do that. That's

Steven Bruce 1:34:15
an interesting conversation they have with a patient, and probably easier for somebody as experienced as you are than it is for somebody who's relatively recently graduated when they they think that in every circumstance they've got to do something with that patient in front of them. But it's an important lesson to learn, isn't it, then that you can say no, there are reasons to say no, and sometimes it might just be that gut feeling that says this isn't where I want to go with this. Another comment here that says quite a few viewers seem to think you're quite good at this.

Laurie Hartman 1:34:52
I should be by now.

Steven Bruce 1:34:54
Sarah says, can you tell us what the OA technique technique felt like, Steven, now we've heard your response, but not really why you responded like that, Sarah, I do apologize for my rather barrack room language, but then I have a military background, as you know, this was exactly the same when Laurie did this on me, 25 odd years ago, I remember sitting on

the treatment table while Laurie went through that procedure, finding the TP, giving a compression, a little bit of side bending, a little bit of rotation, a little bit of extension. And I remember thinking, God, this is going to be really embarrassing, because there is absolutely no way - What the heck just happened. And there was an enormous crack on that occasion, and it is just so unexpected to me as a practitioner, because I know what techniques ought to feel like. I know what it feels like when you've locked up a cervical spine, and it just doesn't feel locked - well It does when you know what you're looking for in a mid range technique like that. But when you come out of college and you're used to wind it up here and side, bend it there, and, you know, it's a totally different approach, a totally different approach to manipulation. And I don't think it would surprise a patient, because they don't know what to expect anyway. It surprised me because I thought I knew what to expect, and I thought I was quite good at manipulations. Oh, God, the hubris of youth.
Nick says, do you always stack vectors in the same way for each technique?

Laurie Hartman 1:36:30
Yes, I probably do, rotation, side bending, side shifting, and then I play with the other bits to get that to focus.

Steven Bruce 1:36:38
Does it matter?

Laurie Hartman 1:36:41
It probably doesn't I put a bit of a little rotation and try and hold that firmly, then side bend until it bites the hand, then side shifting and playing with it afterwards. I think you got to put some of the rotation that's your primary movement in to start with. But after that, if you rotate it a bit, and that's it, you don't need much else. But if it doesn't lot with some rotation, then you start adding the other bits. So maybe I'd never thought of that. Yes, maybe I do. Yeah, yeah.

Steven Bruce 1:37:17
Okay. Rob says, having attended your minimal leverage manipulation course, it's given him the skills to treat effectively and safely and with confidence. Watching you work, Laurie, and being under your guidance is something every osteopath should do. And he says, Thank you to me for allowing everyone to benefit from your knowledge and wisdom in the art of osteopathy. And again, I always say this when anyone mentions osteopathy. I mean, we're talking about manipulative therapy to a degree here on we and yes, you've got a background as an osteopath, and you have that osteopathic philosophy, I suspect that, well, you've taught courses of chiropractors. How different you find them from osteopaths.

Laurie Hartman 1:37:58
I if they, if they come on the course, they want to learn, and they're very keen to learn, and I know they've got the manipulative skill to know when they're at the end. I don't have to say, push it until you feel the resistance. They know that, and they can feel it. And it's in some ways, it's easier to teach good chiropractors than good osteopaths, actually, because they know what they're doing.

Steven Bruce 1:38:25
You mentioned this earlier on, but you know, I've been present for a lot of your courses, because you've run a lot here and for us elsewhere, and I am always taken aback by the

number of people who come watch you, listen to you, and then just do exactly what they've always been doing before with the patient they've got on the table and the table in front of them, instead of doing what you've told them, there is, you know, there is so much to learn from your courses, and I don't think you can learn it all in one course. To be honest, most of the people I know who've done your course have always come back for a second or even a third, and then still say, I'm remembering 60% of what Laurie said.
Matthew says, But Stephen, we're even required to quantify the specific risk. And if we're honest, we all know how meaningless that is. Quantifying risk based on published figures which seldom relate to what we're doing or might find ourselves doing as the condition reveals itself as we work. Yeah, I'm, I'm going to disagree with that, I think, because I don't think we are required to quantify things precisely, because actually to quantify the nature of injuries that might occur as a result of a lumber or cervical manipulation. It's very, very hard, isn't it? And I think the person we had on the show years ago, the first person we had to talk about communication and consent, she put up big scatter diagrams and said, you know, this is a diagram showing all the manipulations and that tiny, little red dot down there, that's the one where adverse consequences occurred. Which is quite a, quite a useful way of something's being buzzed, yeah, quite a useful way of putting the risk into context, perhaps. But I don't think we're required to give statistical analysis of the studies that we've seen. I think that's going you a little bit too far, because, frankly, patients don't want it to do they patients, they said, Well, get on with it.

Laurie Hartman 1:40:21
Yeah, yeah. But why did I put my hands on his upper thoracic first? Because I wanted to see if there's anything tight there when it's been like that, and he side bending with pain in his arm, and he can't side bend. I'm looking below the area, looking for what's possibly the primary lesion, and that second rib, I thought was, was the key to that, yeah, and that's why I released that. And that meant very simply, with a tiny thrust, but put my thumb on that really hard, just I found the right point, and then he could side bend. So that's what made me look at that, get that out the way. The neck, I know was the problem, and I could do that, not touch the neck and to be better, but I freed the neck from one side, then I came in the other side, got it in position, pushed that quite hard, no irritation, and that tiny Twitch with no more rotation that's putting the force in very sharply. And the thing released.

Steven Bruce 1:41:22
McTimoney chiropractor friends talk about the thrust that they use, which is very, very fast, and they emphasize the speed of that. And maybe what we were hearing about earlier on, you always emphasize the speed of the manipulation, which is quite it's quite different from the amplitude of the manipulation, isn't it? I mean doing it fast Doesn't mean doing it to end of range or through end of range in some cases. Is that? How easy is that for people to master?

Laurie Hartman 1:41:46
I think it does take time, because you need to be aware that you're not taking the joints end of range. You look for mid range, and you're trying to put that force in really sharply. Now I'm doing that, I'm not hitting that hard. I'm just there. If I'm doing that, that's completely different. I'm trying to put the force in, and there's a sudden isometric tension. Everything tenses, and then it relaxes, but you can't see that. You're just seeing the hands, but that everything tenses as you're doing that.

Steven Bruce 1:42:18
And I suspect there is a psychological component in this isn't there because, for example, we had a course recently, and not with you, but one of the students was practicing the dog technique, which I'm not sure if we're allowed to call it the dog technique anywhere. That's what she was doing, and she wasn't getting it. And one of the other osteopaths on the course was suggesting this and this. And then I said, do this and this, and then I tried your version, your refinement of the technique on her and her own thoracics released, very, very, very easily. She practiced this on me. And I just thought there was some psychological block to her putting that speed into it. It was almost as though she would put all the levers in and then and not try to put that short, sharp thrust into the technique, gut feeling of, how many people on your course go away better at this percentage wise, do they all manage to improve?

Laurie Hartman 1:43:16
They're all better on the one manipulation that they were nearly getting. Then they're getting it, and then they gradually go from there. But if you look at the dog technique as an example, you've got one hand on top that's adding compression. Underneath, you're lifting up. That's the same thing. Then you're rotating, rotating side bend, side bend. And then push that that way, that that way, and then it's a tiny thrust in that direction. Everything's focused both ways. It's like taking a piece of wood. You're doing that with it. It's not one hand doing it. And when you don't see that, when I'm analyzing, that's what I'm doing.

Steven Bruce 1:43:57
Lawrence has asked another question, were you demonstrating? Scott there. SCO double, T, now I don't know what Scott means, do you? I don't Lawrence, Lawrence, you have to come back to us and give me a bit more information about that, because I've got somewhere in the back of my mind, I think I've seen the abbreviation before, but I can't remember what it is at the moment.

Simon, says too much emphasis spent on pointing out the reasons why we shouldn't manipulate. He says he used to teach and found the students became terrified to manipulate at all, and thinks we've gone too far in the wrong direction.

Laurie Hartman 1:44:49
Absolutely right? I'm sure that I've spoken to students from various courses or new graduates, and they've come out and they just think, yeah, we know how to do it, but we don't like it. We're not going to do it. To do it.

Steven Bruce
And do you think that affects their ability to resolve problems in patients?

Laurie Hartman I think it does. This Saturday, I was doing some work in Hatfield with a clinic down there. There's a lady from Barnett who was qualified, she knew what she was doing, but she won't use manipulation because it hurts. Come out the front. She came out the front. You've got this - bang, that - bang. She then said, Oh, that's all right. I can now do it. I know what I'm doing, because I'm now looking at the final thing, not the wind up. The final thing is getting that tension. This takes time to feel it. And she completely changed her approach after,

Steven Bruce 1:45:24
presumably, if she stayed in business, she was getting results without doing manipulation, yeah,

Laurie Hartman 1:45:29
working 10 times 10 treatments to do what I'm doing the first session.

Steven Bruce 1:45:37
Interesting. You say that because, of course, one of the things I've heard you talk about is how you in a court of law afterwards, justify the fact that you use this technique on a patient. Now, have you been in the situation of having to justify it or as an expert witness for somebody else

Laurie Hartman 1:45:54
I've acted as an expert witness with a few people. And that's one query that the lawyers, who are very good at what they do, ask them, Why did you do a thrust? And you've got to have the reasons. A, it's quicker. It saves a lot of time. B, you're putting an impulse into the tissue, even very gentle one which you get reaction to. C, the patient thinks it's better. Lots of different reasons why you do it. Okay, and if you don't do it, you don't get the same change. You can work on that tissue for ages. There's something about that that makes a change.

Steven Bruce 1:46:28
Yeah, yeah, a lasting change. And you know, I mentioned this when you were looking at Ian earlier on, that in my case, I went for two years. I woke up one morning with this neck, horrible neck pain, and I couldn't rotate to the right, which did affect my driving. I was, you know, a very active job at the times. It was affecting that as well. I went to hospital, where they x rayed me, and of course, found nothing. Gave me ibuprofen, which was fine for a few days, and over a period of time the pain disappeared. But as I said, you know, I was left unable to rotate the neck, which means that you've got to compensate in all sorts of other ways. And even though I wasn't an osteopath, then I was still thinking, how is this affecting the rest of my body, that I'm having to compensate for this problem? And that one manipulation was all it took. And, you know, I was, I was so angry after that, it took that one manipulation, and I was fixed, and I'd had this, all this stuff from the NHS and others, just saying, Well, you know, you got to put up with it.
I do like this. Sarah wants to know whether you introduce lots of levers in peripheral hvts. And of course, peripheral hvts are slightly different to axial

Laurie Hartman 1:47:38
yes, if I'm working on the peripheral spine, I discovered on the spine, I apply three times. If I feel the tension accumulate and it's not hurting and I'm in the position, I go ahead to the manipulation on the peripheral skeleton. I'm going to do nine or 10 repetitions, one, two. I'll do this 10 times, and you feel it building up about the sixth or seventh. I'm not counting them, but I'm doing them. If there's no build up, I don't do it. And if it doesn't build and then my successor in peripheral joints is much higher. Was in America that I asked for somebody with a foot problem couldn't be manipulated. 500 people watching this. This chap limped over. I thought, this will be fun. And he lay on the table, and I wound it up 10 times, and bang it went. Everybody said, Oh, it's miracle. It's not - it's just doing it 10 times. And it went, I'm not going in hard. I'm just teasing it repeatedly. It's gonna happen.

Steven Bruce 1:48:38
You have a bit of a record with conferences about startling things that come out, including, of course, one technique where you said you couldn't fix a problem, and a physio, I think, came out and said, Well, let me have a go. It was a hip tech which, you now, of course, teach on your course. We've got a video of that on the website, I think somewhere, of you teaching that when we were on a course somewhere, and we did that as a live. That's right. Tell us about that one.

Laurie Hartman 1:49:03
Yeah, the they asked me to look at one guy. He was 58 I think at the time. He had a tight hip. And I got about the front 24 people watching this, and I looked at it wouldn't rotate in internally at all. And I said, you've got quite bad arthritis. Said, looked at it. Had very limited rotation. And I said, you need surgery. He said it's booked next week. I said, Well, I think that's what you've got to do. And I said, anybody in this audience know what's going on? One young chap came out said, Let me have a look at it. And he tried shifting it. One hip would slide forward, the other, wouldn't. He said, Oh yes, the hips too far backwards, lay on your side, tap, tap, tap, and immediately it rotated all the way. And I sent the chap an email two weeks later. I said, How's your hip? Oh, I've canceled surgery. It's all right. I'm playing golf now, perhaps. Seen him since, and he's still playing golf. The hip was tight, and how can you shift it? I don't know.

Steven Bruce 1:50:06
And I quite like that. I mean, it's actually a really simple technique to apply, isn't it? And as long as you get your communication right, because you are smacking someone on the bottom, so yes, careful about your communication right. You can try it, and it will often have a good effect.

Laurie Hartman 1:50:24
Yeah, sometimes it does, but you've got to hit it hard and slide off

Steven Bruce 1:50:27
You said, tap, tap, tap. Actually, you weren't tapping at all

Laurie Hartman 1:50:30
You it one, then again. And then you really go for it. You got to put everything into that.

Steven Bruce 1:50:38
Soph says she's a recent graduate and she's terrified of HVT, not least because they've been taught to explain the risks quite explicitly, also using statistics. Now, obviously I'm going to say Soph needs to come on one of your courses so that she can learn how to do these things safely and effectively and so on. But I would also argue that I don't believe the law requires you to go into that depth. The colleges might teach it, but they don't require. The law doesn't require you to go into that sort of depth. When you're explaining risks to a patient, I've been for numerous surgeries, and no surgeon has ever said to me, there's a 3% risk that I can do this, this or the other, they'll just say there is a risk that this can go wrong. These are the sorts of things. They're all small risks, but I have to warn you about them. And you know, people then enter into it then with a degree of understanding, don't they?
So is a new graduate suitable for your courses. Do they know enough to be able to improve.

Laurie Hartman 1:51:39
I think the new graduates are the best because they're in learning mode and they're prepared to change. Once you've been doing it for 10, 20, years, it's difficult. They're going to struggle with what they're doing. They go back to what they know, because it works. So I think the best people are new graduates, really.

Steven Bruce 1:51:59
Soph followed this up, saying, doesn't the research show that it doesn't matter where you manipulate, you'll still achieve an analgesic effect. It's providing a passive input into the nervous system, and that's down regulating and producing natural opioids. So technically articulating soft tissue have the same impact. I can be perfectly honest, it didn't have the same impact with my neck.

Laurie Hartman 1:52:17
I think it does. But why did what I did on that neck work so well? And people look at that and they think that's incredible. You can't do that, but that's something I do every day, and how does it work? And I think if you're in exactly the right place, you hit the right point, it'll work. But if I do manipulate the wrong point, it won't work. And some of it works because I'm giving confidence, but you've just got to be so accurate with what you do. I think if you put an input in, you've got a tight neck, and you come in and you tap it, immediately it turns better. There's something about the tap that does it. There's something about that impact which makes a difference.

Steven Bruce 1:53:02
Yeah, yeah. So that's definitely a role for manipulation. Yes, knowing when to do and how to do it is a critical thing. You've talked about Ian's neck. JoJo says, Could you remind her please, what was the diagnosis and what was the rationale for your treatment? How did that relate to the presenting symptoms?

Laurie Hartman 1:53:24
The key thing was C six, seven on the right, which was sticking. The second rib was elevated, and that was part of it. That's why I put pressure on that. That was better. I released the rib, did some gentle soft tissue, worked on the scapula. I can't do side bending, so I didn't try that. And then I freed that the other side first, which was easy, then I came to the bad side, introduced the side shift, and I got that in position, and then a tiny rotation, and that freed immediately. And that's the point that I'm not going to do more, basically, just what was specific, and that's why only takes a few minutes to do it.

Steven Bruce 1:54:07
How long typically would you spend with a patient like Ian? if he came to you as a new patient in clinic, then

Laurie Hartman 1:54:13
I used to have an hour with new patients. Then it went to 40 minutes, and eventually half an hour, I would take the history, examine them, explain what's going on, and treat them. And I never let a patient go without treatment. The first time to me that that's crazy to examine and say, Come back tomorrow. That's ridiculous. So 40 minutes. If I had to do it quickly, I'd do it in less time, but I'm taking risks there. I don't like doing that.

Steven Bruce 1:54:44
Was it y ou telling me, you know of a practitioner who takes the case history on the first appointment, has examination on the second appointment, and then does treatment on the third appointment?
Laurie Hartman
Only one manipulation, only one manipulation.

Steven Bruce
I don't know. I mean, there are all sorts of aspects of the osteopathic practice standards and the chiropractic code where you could think, Well, are we really delivering an ethical treatment when we do that? I mean, so that's a discussion we can have. Of course, we've got time for a couple more. Lawrence says that SCOTT is “standard classical osteopathic terminology and technique”, which he recalls as the five columns of flexion, extension, side-bending side-shift, compression, etc, as you were demonstrating.
Tim says, Do you think that your expertise in martial arts, particularly with regard to high velocity, acceleration, deceleration, has helped in your approach?

Laurie Hartman
I think it has,

Steven Bruce
Well, we can't train everybody to be a black belt in karate.

Laurie Hartman 1:55:46
No. So I spent 20 years training, and after three months, I suddenly realized we're using the same stances. We're using whole body to generate the force, and we're doing exactly the same when we manipulate. And very much like karate, you're not coming in hitting you're stopping short, just a slight touch. And we're doing the same. You're coming with a tiny force. Everything focuses. Then you relax

Steven Bruce 1:56:09
With a lot of not a martial arts, if you're going to be good at them, there's an economy of effort involved as well, isn't there? And you've got to keep going all day while you're doing these things to people. And I've seen some people on your courses. You've picked them up for it, but you know, they're wound up with tension themselves when they're trying to do things, they're knackered after that first model that they've practiced on.
Simon says, The Wardle family sent their greetings to the professor, my father in law and his daughter Joy, have fond memories of you work in Finchley.

Laurie Hartman 1:56:40
That's right, I worked for him for about two years!

Steven Bruce 1:56:44
A long one here from Dave. Dave says I potentially needed a procedure in hospital, and was given a sheet with a list of adverse events from pain through to death, listed as one in 10 on each one, but it was presented as a sheet not explicitly communicated person to person, I found the general discussion of adverse events in the general medical world much, much, much less than what we're asked to do, or at least as he, I think rightly, says, we’re led to

believe we must do. And I think that is that is one of our problems that our general counsels - they feel so vulnerable, they're so determined to be better at this than everyone else that they've gone over the top in some places, haven't they? It's very important that patients are safeguarded, but there's also a balance to be struck with making sure that practitioners can do their jobs effectively and efficiently. And you know, you could take issue with the chiropractic code, but the chiropractic code says that before every manipulation. I might have got the wording wrong here. I can, I can look this up a little bit later. It says you have to record consent before every aspect of treatment. Now record means you actually got to put it into something, which means put that into the computer, and then later on, you can't do that. It's just you can't treat a patient like that. Can you? And the chiropractors are about to, if their proposed document is accepted, the poor buggers are about to have their standards increased from 29 to 81 I think. And I bet you you can't recite the osteopathic practice standards, and there aren't very many of those. How does anyone expect us to know all of these things, except when we come to court and some lawyer will walk us through them to make sure we can answer? Sorry. I'm going off on a bit of a rant here. Well, you know, I just sympathize with all these practitioners, particularly the new grads who are coming out being told that safety is paramount, and all these things we've taught you are dangerous, don't do them. That's that's almost the message that they're coming out of college. Obviously, I have mentioned your course on a number of occasions. We've we are running a course with you, a two day course over a weekend of the 16th/17th, different. Thank you to the man in my ear who gave me the dates. So we're running a course with you. You take undergraduates on the course? Do they have to be of a particular level of training.

Laurie Hartman 1:59:25
Preferably third year or above. But I'm not bothered.

Steven Bruce 1:59:29
And as we know, one of the undergraduates we had on one course was better than everybody at that particular time. So yeah, they can, they can still learn, can't they? I think we have 13 people booked already. So we have 11 places on it. And we actually, this is really the first time we've mentioned the course. And I suppose, honest, this is this program, to some extent, is promoting that course, but promoting it, I think, for a very good reason, because you hear the concern about safety, and then you watch Laurie operate, and you realize. How you can make those manipulations so much safer. In practice
Claire's sent me a comment saying that she thinks I'd like to hear this from Alistair regarding Sophie's comment about the risk of cardiovascular incident following HVT is one in a million. Risk of cardiovascular incident in the population is 101 in 100,000 in other words, statistically, it's 1000 times safer to have your neck HVT than to be alive. That's an interesting manipulation of statistics there, because, of course, the risk of a stroke doesn't go away just because you're having your neck manipulated, yeah, but, I mean, it does put it into context. The difference, of course, is that we are actively doing something to a patient, whereas if a stroke happens to them just out of the blue, no one's done anything to cause that. Laurie it's been a treat. We've had 623 members watching this evening. So thanks to you, and thanks to Ian over in the background there sitting on the in the studio waiting area, and we'll see you soon.