Multidisciplinary Care – A 360 Degree Approach – Ref291

with Robin Lansman

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TRANSCRIPT

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

Robin Lansman
Thank you very much for the invitation, Steven.

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

Robin Lansman
Well, it's not so much taken issue, but I think probably what it is that now and particularly now but perhaps always for osteopaths, perhaps for chiropractors, too, we work in our own practices but we get referrals from lots of different people, we see the fallout of perhaps therapies or treatments that hasn't perhaps worked as well as people might have hoped. So we may have seen people who've seen other professionals. And so I think the key to this is really thinking about the messaging and how to handle situations where conflicting advice, conflicting opinions have actually caused the patient quite a lot of suffering in a sense of not knowing which way to turn. So now here they are with you in new hands. And that can present some conflicts.

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

Robin Lansman
Well, I think in my learning and experience over the last few years, I've seen that very much how professionals speak with other professionals and how we share information is getting even more important than ever. But also, how we connect with our patients, and how we communicate with them,

and how they communicate with us and how we encourage that has become an imperative really to getting our message across and helping guide people.

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

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

Steven Bruce
I was struck actually recently, as you know, we get quite a lot of consultant medics in here for our different shows, particularly orthopaedic consultants, but I was very struck recently how actually, they can be quite, I'm not gonna say dismissive or rude, but they can make it quite clear when they don't approve of one of their professional colleagues. You know, an orthopaedic consultant, who doesn't like another orthopaedic consultant. And they weren't shy about making that clear to me, and perhaps not so much on air. I mean, one of them hinted at it on air, but in private he was much more forthright about don't go and see this person. And I wonder if people do need to be just reminded of the osteopathic practice standard or the chiropractic code that says, we have to be professional when referring to or dealing with our own counterparts, even inside the profession.

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

Steven Bruce
That was the wonderful James Booth wasn't it? He got some osteopathic award to get up there, I think.

Robin Lansman
Yeah, but unfortunately, it's gone. And that's really sad because it was started in fact, and I've forgotten the gentleman's name who started it first, and then they were running it, a chap called Sam was also with him. And they were running a really, and I visited for a whole day, some years ago, and it was really picking up the pieces and really understanding things differently. The sadness was that a lot of these patients weren't seeing perhaps someone else before they ended up having surgery. But the surgeons were referring in large numbers for the ones who kept coming back and thinking, well, we can't do more surgically. And they were doing great things. So yeah, I mean, that's an example where they were steering a fine line, but doing a great service.

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

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

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

Robin Lansman
It's making connections and it's getting to know people. I mean, people go and play golf, and they chat about things, and they talk about business and that's how the deal is done. So I think it's not always the obvious. Presenting oneself at meetings, going along to what was called a CCG meeting in your area

and actually asking questions and being part of the group. I mean, I've done plenty of that. And it's a very good learning experience, certainly in practising communication skills, and being part of that agenda.

Steven Bruce
Have those meetings now stopped? Did COVID put a stop to all of those?

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

Steven Bruce
Sorry, I was thinking back to the CCG meetings which we had as part of our NHS contract, which were just the healthcare practitioners.

Robin Lansman
Oh no, this is wider than that. And those resources are available online and quite useful pieces of reading to try and work out what's going on in your locality. It's all public information.

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

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

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

Robin Lansman
I think probably pretty simple language works. It's just making a connection, it's being bold enough to do it. I mean, I presented a big piece of work to about 65 GPs who were training in MSK as a specialism.

And I must say, I was surprised on many levels, there was obviously an interest in the topic. But I kind of dug a bit deeper while I was there, and I wanted to find out, partly based on the questions I was getting and what I wasn't getting, is that quite a lot like MSK, because in a sense, they find some of the exclusions of pathology easier, life threatening pathology, and therefore actually doing that as a topic is actually slightly, they would say, easier to deal with, and something far more organic and internal medicine might be might be something really challenging for them to commit a diagnosis to.

Steven Bruce
We've had a bloke on the show a number of times, chap called Nick Birch, and I've always loved reading his letters, copied to the patients, but to the GPs, because he's an orthopaedic spinal consultant and he has the luxury, he can write what the hell he likes in his letters because no one dismisses his expertise, whereas they don't know what to expect from osteopaths and chiros. But he puts things in lay language, and he wouldn't bother with technical descriptions of what he'd done with people, he would just write it as he felt. And it was very clear and very precise, but it was very easy to understand even for the patient, let alone the GP. Okay, so what are we gonna learn from you this evening?

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

Steven Bruce
Yeah, I was going to mention to you, I had an experience with the NHS this morning, which is a lesson in communication. And I don't imagine it would happen in an osteopathy or chiropractic clinic or most private physiotherapy clinics, but I had to make an appointment for my father for a hearing test. And I called him yesterday afternoon and I got straight through to his surgery, to his GP, and they said, we can't do that you have to phone back in the morning at half past eight and and then the GP will have to make the appointment. So I called back at half past eight and I think it was nearly an hour later, I finally got through their hold music, which was a 10 second loop of something with heavy drums and it was just irritating as hell. And of course you can't get away from the phone and you can't do very much else while you're listening to this. When I got through, they simply said, we'll take your number and the GP will call you back. I thought, you could have done that yesterday. And in some ways, it is a lesson because actually the first point of contact with the patient is the receptionist. And if they have a bad experience, then they're going to be grumpy with the receptionist, they'll be grumpy with us as well. And I suspect we do it much better, because we're not under the time pressure that GP surgeries are. But it's something that certainly we've taken on board in my clinic is that we try to make sure that our receptionists are

happy, nice people, rather than NHS receptionist standards, and we don't keep them waiting on the phone.

Robin Lansman
But sometimes that is pressure from inside, the receptionists are trying but under pressure from all sides.

Steven Bruce
No, I feel sorry for them, because I really wanted to be rude to this receptionist when I finally got through, because I was so irritated by having to wait for nearly an hour on their hold music. But I had to keep telling myself, it's not her fault. She's been dealing with phone calls all throughout this.

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

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

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

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

Robin Lansman
Well, some people find it that, but knowing your subject and being able to explain it clearly and getting an ally, really, within the room that you can actually share the preparation with. A lot of people perhaps

also feel the same way and it's quite a good joined up way of working. So I think that's something that develops confidence and gives you that chance to practice explaining what you do. And I think what can happen is if you only talk to your group, in a sense, you don't really necessarily get the challenge that you get from an outside group. So you need to have very frank and candid communication. So some of the work I'm doing the NHS is to develop that candid, not clinical candour, but the actual candour between them to give feedback on how that came across how that explanation you gave, worked or didn't work.

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

Robin Lansman
There's a number of techniques as well about parking questions and actually also finding out why someone's asking the question is a very useful technique.

Steven Bruce
"Why are you asking that question?" Is that the first you say?

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

Steven Bruce
This slide here says explain clearly and with confidence as your first box. You can't overestimate the importance of confidence, can you? If you don't know your subject, you're not going to be a confident speaker.

Robin Lansman
But it's keeping the flexibility. Because what can happen as you become a preacher. And what's really important is to allow that interaction back and have the question and perhaps feel a little undermined or uncomfortable with that. And that might have to happen. So it's not getting your speech so well honed

that you no one's going to trip you up. I think it's important to leave flexibility in your thinking. And that helps. And then moving on, perhaps, to talk about empowering, which is a term we were talking earlier, is a bit overused, and openness, when it comes to connecting with people. There's a difference, I think, and this goes back to leadership and groups in health care about being led, about being mentored or coached. And how much are you willing to be led and how much are you being pushed. And where's the divide line between a suggestion, and something that's being pushed on you.

Steven Bruce
Now I've not made the connection here. I'm here, I'm talking to a group of orthopaedic consultants or GPs or whatever. And now I'm empowering them?

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

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

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

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

Robin Lansman
Sorry, that's not specifically for GPs. That's more faculties and allied healthcare professionals. But nevertheless, what it's about is trying to open confidence and open channels to allow people to give and share feedback. So whichever way the feedback is going, whether it's in this example, a patient giving you feedback, or you want feedback. For example, patients like to please their practitioners, they want to tell you good news. And some of them actually want to tell you all the bad news only. And picking between that when you see a patient to find out the light in it, rather than just the dark, is really important to know what is working and what isn't working so well. So that's something that can come out in lots of different contexts.

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

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

Steven Bruce
Whatever happened to the term primary healthcare practitioner then?

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

Steven Bruce
It doesn't change the waiting lists either, does it, which are immense at the moment.

Robin Lansman
They may will get bigger and bigger for the fact that people can go on a list. They may wait to have their triage, their first screening but then may not get any actual, or may never get any, hands on care. But certainly what they get is more than likely to be prescribed exercise, which we're coming on to a bit later.

Steven Bruce
The funky bridge that I'm looking forward to.

Robin Lansman
Well, yeah, the funky bridge, I think there's a number I've created and evolved during my FAR courses that we've actually started to look as assessment tools and to look as remedial exercise tools, that are adaptable for individuals. And I think that's a big difference in what generally gets prescribed which isn't too adaptable, it's by the printout book.

Steven Bruce
You very quickly mentioned FAR there. What's FAR?

Robin Lansman
It's Functional Active Release, Functional Active Rehabilitation, and it's something I was teaching undergraduates and evolving, pre COVID, doing lots of work in Germany and around doing lectures, and in England, talking about how to actually empower the patient, how to work with the patient, in terms of the assessment, and turning assessments into exercises and treatment. So that's kind of what I've been doing for quite a few years. And that's something I'm coaching people in, because I enjoy doing it immensely.

Steven Bruce
And probably we'll put some more meat on those bones in a little while, when we come on to that. So where did we get to on here? We've got to partnership and trust.

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

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

Robin Lansman
No. Well, that word of mouth referral sort of idea with patients who are happy telling other people, obviously is how most private practice exists. It literally is sort of generated in that way. I think the danger is how you communicate why that person has got better. What they tell a doctor may look like magic if they haven't got the insights to work out why they didn't get better before. So that's the gap sometimes between well, great if you got on with the osteopath, great if they managed to fix you, but they don't understand why. They're happy for you. They're delighted, you've got better, the GP is, but that doesn't give a full understanding of what really happened.

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

Robin Lansman
We're doing a survey, it's part of the CPD to actually ask all new patients, in fact, even follow up patients who haven't been for a while, what their expectations are before they come.

Steven Bruce
Who's doing the survey?

Robin Lansman
We are, through the practice. My own practice. And the reason we're doing that is because we wanted to look at referral pathways and the trust that engenders. So if you're referred to me by your GP, that's probably going to engender a reasonable level of trust. If it's by your best friend or your mum or something, again, that's probably going to engender trust. If you've just googled in desperation, maybe, or you're new to an area, that's a different kind of line of referral and a different context. And we did look at that, and we're now gonna cross-correlate the source, and the expectations, and particularly why they didn't see us sooner, because quite a lot of people we see are waiting and spending months thinking about it, we found. May not be in every practice, but we find people are quite spending their time thinking about it even on recommendations. We're getting people coming in two years after they're recommended, even from consultants. Months, months, months later.

Steven Bruce
Do you have some complicated process for doing this or is this a really simple thing, just a question when they come in?

Robin Lansman
It's a questionnaire, I mean, we didn't do it on paper, we've done it online, and it goes out to them before they come. But the uptake rates of questionnaires as we all know, nobody wants to do a great deal. So I probably think we're getting I don't know about 5% or 6% back. But useful information nevertheless to reflect on.

Steven Bruce
The reason I ask is of course, this is an excellent objective activity for the osteopathic CPD process and if you were prepared to share what you've been doing, we could send it out to everybody else as and say, you could do this yourselves.

Robin Lansman
It's only coming up with five questions and ones that relate to your hunches, I suppose. I mean, largely, however you run your practice, you get an idea from patients about these conversations. "I saw someone

who recommended you." And you get an idea of how they interact. I mean, the thing is never to underestimate that you still have to engender trust, and you have to build up with every single new patient, because it's never to be assumed, just because they're smiling and happy to see you, that you've got that going straightaway. So I think that's where the work still has to go in. In fact, if we cover expectations and mutuality, I think that's quite important at that juncture. Because that feeling of expectations and where they're sitting, I listen sometimes to people as they come in, or overhear their conversations, and how excited they are to come as a new patient, because they've been recommended, and someone said I can fix them. And not that I want to burst the bubble, when they when they come and see me, I want to kind of bring that down to earth. And we've got to start, we've got to go through this. And I think the problem also comes from, a lot of people think that, especially the people from a search, that you're offering, the osteopathy pill. And the diagnosis and assessment, I think this is very underplayed, in my opinion, in practitioners, where what we're doing is we're not just doing a treatment. I think that assessment part, that primary care part, it's still very underplayed or underestimated by people how important that is. When the patient's been through the process, and you're picking up on stuff they'd never connected, that sort of light bulb moment where the patient will suddenly say, wow, I've never connected that before and that's really interesting. That's when they're suddenly getting into why you're asking the questions, you can explain as much as you'd like at the beginning of why we're going to go through this, but it's only when they get that sudden light bulb moment where they connect how much thoroughness is going into your history and approach before you even touch them.

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

Robin Lansman
No. Can I have more? No, less is more.

Steven Bruce
You get the treatment that's necessary. That's an expectation on the patient's part that it's hard to offset, isn't it? Because they might have been misled by whoever it was that they saw before who'd been to an osteopath or a chiropractor, who gave him an hour's treatment, and they come to you and you do 15 minutes. I'm not saying you do.

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

Steven Bruce
Go onto the green one, because we haven't done mutuality yet.

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

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

Robin Lansman
Possibly. Possibly. Maybe. If we did it in person on paper, you probably would get more response, but it's another administrative thing. And actually, we're still getting some useful information. So I think measuring progress is important and benchmarking all the way through. That whole thing about providing a diagnosis and providing the follow up information, so they can value and evaluate what's going on all the time is something I'm very keen on.

Steven Bruce
Do you do PROMs, patient-reported outcome measures in the clinic?

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

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

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

Steven Bruce
It's very hard to come up with a PROMs questionnaire, which is likely to be filled in by patients, isn't it? If you look at the online research or the research in the journals, they have these great lengthy questionnaires and no patient's going to sit down for half an hour filling in all these questions.

Robin Lansman
Well, clearly five questions is beyond a lot of people. But just to go on to prognosis and management, if we may. Unless I'm driving forwards too fast?

Steven Bruce
No, not at all.

Robin Lansman
So prognosis and management. I think what's also quite confusing for people is that question when a patient says, when can I go back to work? When I can I go back to the sport? And it's having a method, and if you don't do the benchmarking and progress measures, it's very hard to be very confident about where that question goes. And I think we have the term working diagnosis, which is a very acceptable term. I had a chat with someone the other day exactly about this from the General Osteopathic Council, just to kind of go through that idea, that not making a diagnosis is a case that comes up sometimes where people get into difficulties with their regulators. But having a diagnosis, that's a working diagnosis, that's adaptable to how things are progressing, is a reasonable approach. At least you're working with some theories based on your evidence and what you've been doing. So I think that prognosis and management phase is also part of the communication. Where's it going next? Where's it come from, but where's it going next? And how does what you're offering in terms of exercise and advice fit with that progress plan?

Steven Bruce
So when you say balancing or measuring your prognosis, or adapting your prognosis and your feedback in clinic, are you saying, "well, you can go back to sport when you can do this" with exercises in clinic?

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

Steven Bruce
The trouble with you, Robin, is you were the senior tutor on sports injuries at what is now the UCO for 10 years, so you know lots and lots about this. Most practitioners, I would say, have shakier idea of when it will be safe to return to say high level football or rugby, based on the exercises in the clinic. How do you overcome that?

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

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

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

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

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

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

Robin Lansman
And I think the problem is a lot of people use off the shelf Pilates or yoga exercises, but they're not specific enough.

Steven Bruce
Or they just say go off and do Pilates.

Robin Lansman
Yeah, exactly as a prescription, just go off and do it. And I treat lots of Pilates teachers and yoga teachers, and people who've been doing planks for years, who are so locked up in the upper thoracic area and in their shoulder girdles, in their neck, because they think, and this is the counterintuitive point, how do you break down the belief that what you think you've been doing for X years is helpful and actually, it's been doing harm? And when you keep getting told it's a good idea, it's very confusing to think that, in fact, it's the other way around. So breaking that down is really tough for people psychologically to deal with that. And you are damaging trust on some levels, because people believe and trust that what they think and they've been told is good for them is good. And now you're saying, well, actually, do you know what, this actually is part of the, in a sense, the maintaining factor in why you still have a problem. And that's hard for people to swallow to start with.

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

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

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

Robin Lansman
Okay, so COG we've talked about and that's really the team building training?

Steven Bruce
What's it stand for?

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

Steven Bruce
So how do people get involved with COG?

Robin Lansman
Well, there's an application form on the coguk.info website. So basically people are connecting in to do that. And as I say, mostly at the moment, it's been faculties for the NHS. I'd be very keen to do it with groups of osteopaths.

Steven Bruce
Don't exclude the chiropractors.

Robin Lansman
And chiropractors. I've had plenty of chiropractors come on FAR workshops and that's been no problem at all. And I think that the COG idea really is to produce, what we've been doing is producing podcasts. So what we do is it's an interview technique process, where one of the exercises is to produce a communications podcast for your team or about your practice, and develop that as a team. So there's ownership in that. And that's something that we've done a lot. So that's that project. And the FAR, which might come along soon, maybe. Okay, well, that didn't, but that's okay. So one of the things that I think with osteopaths, and I know, the do not touch bit has been very much where people have been to the NHS, had physio exercises, but had no hands on at all. They do want hands on, but I think the thing we're going to do with our demonstration in a minute is very much look at how you can mix the two and make that productive.

Steven Bruce
It does seem to have become almost a mantra in NHS physio that you don't put your hands on the patient these days. I don't know if it's universal in the NHS system, obviously, I don't think it's the case in private physio practice. Do you know, is it something they're being told not to do, just give you exercises and leave it at that?

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

Steven Bruce
We're having a problem with that clicker.

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

Steven Bruce
I do. We didn't bring up the FAR slide. Do you want to talk about that some more? We can do that when we come back if you like?

Robin Lansman
We can come back to that. Should we do that?

Steven Bruce
Yeah, let's do that. So where's the pink slide, bring up the pink slide, it's a lovely one. All right. He's gonna do it for us. There we go. Okay, I wanted to bring it up because I think it's a lovely slide. So this is a well-used and taught exercise, isn't it? It's the bridge, which is what we're gonna talk about. But you've overlaid this with communication and patient partnership, and safety and quality in practice, which are two of the Osteopathic Practice Standards, which have their counterparts in the Chiropractic Code. Why is that? Why have you put those up there?

Steven Bruce
Let's go and work on Jack,

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

Robin Lansman
We will, thank you. Hello, good to see you again.

Jack
Good to see you.

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

Robin Lansman
No competitions. But we had a little chat earlier and we did go through a little bit because your work is incredibly heavy, if I'm right in saying?

Steven Bruce
What do you do?

Jack
Steel work.

Robin Lansman
So that's pretty heavy. And so that has an effect on the body globally, because it's pretty heavy going, and you play football, how often and how intensively?

Jack
Three times a week.

Robin Lansman
Right. So both very physical, both quite different, but both very demanding. And the crossover in a sense that is important in this exercise to see how do they work together? Or do they actually aggravate each other in different ways? And I think part of this, and the FAR approach we were talking about, is a little bit looking at assessment, moving into exercise, and then potentially treatment. And that will guide you'll see in a minute, hopefully. So imagine we've got an acute low back. Okay, now the bridge exercise generally is done, if you just bring your legs up, with the feet fairly close together. Yeah, in fact, in a Pilates exercise. And so if you just lift your back really, yeah. And what that does in a traditional pose, which is actually quite hard to do when someone's back is very stiff and yours is somewhat, pop it down again slowly, right. So what we see, we see a level of excursion, Now in someone very acute, they probably wouldn't get two centimetres off the ground, because it would just be too painful to do. And then in someone very stiff, they'd also find they wouldn't get to that sort of diagonal between the knee and the shoulder. Okay, so even with you, that was a little bit tough at a point. Now what we want to do is make exercise easy and effective. So communicating that with the patient is really important because nobody wants to do painful exercise, even if it's helpful. So what we're going to do is, just for the time being, just pop your hands just up just on your front, that's fine. So the way I'm going to do it that's quite different is to actually put the feet in this instance, and you'll find that quite difficult because your adductors are quite tight and the hip girdle's are tight, get them quite wide to start with. Now that's quite different than the original start position we had. And if you just put your hands down now, just flat down, what we're looking to do is to bring your heels towards your fingertips. So that sort of distance back. Now what happens the further back you go, the more rotation starts to happen, because of the glutes, so you want to just turn the feet in so your feet a parallel. Which is quite hard for you to do, puts strain actually in lots of areas, and we can't see from that side but puts lots of areas on to these peroneae as well. So now, we want you to do that same bridge, but differently, I want you to actually use the thigh muscles and your calf muscles to do that bridge, not your back muscles. Okay, so pushing up. Okay, and now you should find that a little bit easier to do, less effort, because now the legs are doing the work and the back, just drop down slowly, is actually basically doing less work.

Steven Bruce
But it's still working?

Robin Lansman
But it's still working. And your pelvis needs to stay quite free. Now, most of the time with so called core exercises, which we're not doing here, and we don't want to do, is that the core gets so engaged with the lumbar spine that you're peeling the back off the ground. And that is exercise a lot of people do for core strength, but the trouble is you're developing tension, as well as anything else. A little bit about this setup, and it's quite a complex exercise, but the patients quite enjoy that kind of in depth kind of connectedness that we're going to bring into this. The thing we have to be respectful of, obviously, quite a lot of people may have kneecap or knee issues, so the amount of flexibility they've got to bring the foot back even further may be limited, or perhaps different between the two sides, if they have a knee problem one side and not the other.

Steven Bruce
I take it you want the feet evenly drawn back?

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

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

Robin Lansman
We want the whole chain down to the foot to encourage the calves to actually engage and actually push as well, the shins and calves. And what we can do to make it, well, we'll see there's two options on this, is to actually put the feet onto the heels. Yeah, just pop the other one onto your heel. So now, we're in dorsiflexion, which tightens up and stretches. And now do your push up again. But not using your tummy as much, which you now are, because it's harder. Yeah, it's much harder, so you're trying to use your abs to help you. But you now find how hard that is, because his calves and shins are not doing much at all, because they're so tight. And the big conundrum comes that the difference between a tight muscle, a tight muscle basically fails and doesn't give power, the longer the muscle is, the more flexible it is, the more power it can give. So training these muscles to get stronger, is defeated if they're stiff. So a lot of this process of activation is all about getting things to work more efficiently get up the blood flow, and then everything starts to work. So what we wouldn't do at this stage, because that was harder, and we

don't want to make it tough, is we would do this on flat feet, because you do that better. So until the back's better, there's no point trying to make it harder by putting the feet up. But some people oddly, depending on how they walk, or how they run, in fact, find that it's easier up than down. Depending on how their hip mechanics are working. So you can play between the two as to how that might improve or how that might hinder the actual excursion of the pelvis.

Steven Bruce
In terms of progressing this exercise, came in with acute back pain, doing this exercise as you've described, he's still likely to have some discomfort here, isn't he?

Robin Lansman
Well, actually, even people who are very acute, if they go wider, we will afterwards do this on the floor on a mat and get the feet even wider, and the wider they go, within the limits of the adductors, the better they get at doing the bridge. So the whole thing about rest, if you rest too much, you get stiffer, and actually activating muscles and doing more movement actually starts to free up the function. So that that will be the kind of thing we need to do. So the bit we haven't done, and this goes into the upper body and neck in a moment, so it becomes very global, is we're going to talk about the breathing mechanics with this exercise. A lot of the breathing out and the breathing in and getting that right, makes the diaphragm engage thoroughly. And what that does with that breathing is it gets the upper lumbar spine that you'll see in a minute with the breath, it's going to make it harder or easier depending on when you get the timing going. And the upper lumbar spine is getting articulated, where the the diaphragm attaches. So what we're going to do is you're going to do a breath in as a preparation before you do the exercise. So breathe in, big breath. Okay, and I want you to now do the exercise breathing out, during a whole breath out. Breathe, breathe, breathe up to the top. Okay, good. And then slowly breathing in on the way down, slowly controlled to a count of four roughly. So the breath lasts about four. Ideally, it's pursed lip breathing, tight lips because you're pushing out the air, and that makes the diaphragm engage even more.

Steven Bruce
How did that feel to you? Do you feel it is different?

Jack
Yeah, it's easier, when you do the breathing, it feels a lot easier.

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

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

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

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

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

Steven Bruce
We've had a few questions. We deliberately removed the pillow from this table. A lot of people have said apparently, or a couple of people asked, whether you'd normally have cushions for the patient? And Claire's mentioned to them that she'd pinched all the APM pillows recently for the clinic and it might be her fault, but actually, she didn't get them all because there's one over there.

Robin Lansman
It's a good question. The thing is if someone were more kyphotic, or couldn't lie as flat as Jack can, we would put a pillow in. But as it's gonna come up in a few moments, the demonstration will include things to do with the neck position and things to do with the upper back. So we wouldn't want a pillow unless they couldn't lie flat.

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

Robin Lansman
Yeah, so that's kind of coming next. But it's a good question. So we've got some of that going on. What I'd like to do, Jack, if that's okay, we'll just do the lying on the floor bit and then bring you back onto here. So if you put yourself down and we're gonna also pop down here. So basically, the exercise now is the same bridge. But in someone who was finding it really difficult, or couldn't bring their feet far enough back to get some purchase on the pressure downwards, we're going to use more than the width of the mat. So if you go wider and wider. So even if you can't come much closer to your fingers, as we had before.

Bring your big toes pointing inwards if you can. And obviously, we've got some abductor issues here. And what we're going to do is get you to do the same exercise using the breath exactly as we did before on the couch. Breathing out, a bigger breath out if you can, audibly. Now how does that feel to you, Jack, compared to the feet being closer?

Jack
It feels easier.

Robin Lansman
So you can play with that width, a bit like sumo wrestling, you can go wider and wider to get more stance, more purchase, more pressure. There'll be a limit to where there's a benefit, and it depends on how tight the adaptors are. But this is a way, if the pain is happening at all, even at the width of a couch, that you can actually start to adapt that by putting the feet wider and wider. And that gets you the chance to actually do the exercise. The only downside of this sometimes is people get hamstring spasms, cramps, because they're not used to doing exercise in this position. But actually, once they shake those off, and they can tolerate them and come back and try again, shake it out, try again, they get better and better and their hamstrings start to actually release because they're working the antagonist group, the quads, harder and harder, which actually releases the hamstrings. And that then starts to free up both the hamstrings and the quads.

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

Robin Lansman
Well, we're going into sort of neutral, really, we're not gonna go into extension. So we're going from the lying flat position to that angle between the knee and the shoulder maximally. It may depend, if someone's got a very high lordosis, it may be a different set of circumstances. And this may not suit everybody. But for most people, with the average sort of kypholordosis that people have, this will be fine. And I've used it very, very widely, and use it with a lot of my patients. And in fact, the patients who come to see me want to demonstrate this and this becomes their kind of big piece to share with me, what's improved, how it's going, how much further. I've had people with massive spinal surgery, who've had all sorts of pain for years, who were very kyphotic and suffered pain for years, who now do this every single morning, and they do a set- And I'm going to show you the next bit in a second how we make it stronger and even more useful. That wouldn't be the first step. That's where we are now- and they do a set of 20 slowly, or sets of five slowly, up to 20, and it's all about the breath rhythm, and the slowness and the mindfulness really of the exercise.

Steven Bruce
The next question was obviously going to be how many and how often, but you're saying once a day, five to 20. Depending presumably on pain and tolerance.

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

Steven Bruce
Any people you wouldn't do this on? Who would you avoid?

Robin Lansman
Well, the knee issues. If someone has got a severely arthritic pair of patella, whatever it is, or compression of the patella, this could be painful, but adapting it, I mean, there's nothing wrong, I mean, it's harder the further you go away from the body because the lift is harder. But what you then do is, if you bring in the heels here, yeah, at this position, just try and do that, Jack, if you can, pushing up. At that position further away, it becomes easier again. Is that fair to say?

Jack
Yeah.

Robin Lansman
So depending on, this is an adaption by actually being further away from the centre, which actually would hurt the back more, but doing on heels, suddenly using the calves more, it encourages more use of the calvess, you get more strength from the lower end and that starts to help things. Jack, can we have you back? So if you pop yourself in the same position. Are there any other questions or is that good? Okay, that's fine. So what we're doing now is we're going to do something that adds a bit more to this. And we know, in fact, Jack earlier said that there was a bit of a shoulder problem which I detected during actually, this procedure, just to let us know about that, but that actually does come into the mix now. And you're gonna see. So if we just put the arms, both arms, up into the air, and what we do is we tighten both fists tight. And what that does is gives a little bit of tension spreading from the hands, fists, down through the arms into the shoulders. And if you press those shoulders a little bit, using your back muscles, your intrascapular, between the shoulder blade muscles, rather than just the chest, you start to engage the whole upper thorax. All the periscapular muscles are now saying, hello. You've got them firing. And now if we do the same lift, breathing out.

Steven Bruce
He's brought his feet closer together.

Robin Lansman
Yeah, the feet are too close. That makes it really hard. And that was hard to do, wasn't it? Okay, so go nice and wide. And on the floor, this would be even easier, but we're gonna do it on the couch for now. And push, breathing out. Okay, that's harder, because your shoulders are very stiff but you managed. Where did you feel that pulling?

Jack
My shoulder, my left shoulder.

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

Robin Lansman
Does that remind you of anything, Jack?

Jack
Yeah, very similar to last week.

Steven Bruce
Yeah, Matt Wallden's middle crossed syndrome, it's that special sling across there.

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

Steven Bruce
So having seen it manifest in the individual, is this something you're going to try and fix now? Or are you just going to keep doing the exercise until it resolves itself?

Robin Lansman
Okay, so what we can do is we can get him to either with his lower body start to control that twist. And so you actually consciously start to tighten and prepare the muscles, so you know where the landing problem is, so you start to just slightly adjust the tension in the glutes or in the quads. So try and maybe do that, just to give that a go. So if you take out that twist, and if you look in that position, through your knees as the horizon line, you might need the pillow for this, because you can actually use that visual line to the knees to see the way that actually moves and how those legs are not being controlled as easily. So that's an interesting sort of way of observing those chains. And actually seeing them in action, in a sense. And we might say, that Jack's problem, he may have some back issues and so on, but maybe

the primary driver of everything is this shoulder which he's perhaps left in abeyance, but come in now with an acute back, but actually the big result might be to get the shoulder fixed if possible, or do things differently at work. So just try and do that again. If you can just about from that angle, not too flexed with the neck and head, just have a look have through your knees. If you can just about see them. Can you feel that? And what's interesting if you palpate, if I can just go to the far end, just for a minute. And this is something I do quite often as well, is to see, just let your head go into my hand, is to do the same exercise, get your heels apart just a little. So let's see you do that push breathing. And I'm going to feel how much tension- and I saw it, his head rising off the pillow earlier- is coming into his neck muscles. You can actually palpate suboccipitally, you can palpate into the neck and see where these tension lines are coming from, his upper to lower body, and his lower to his upper. So how that bounce goes between the two. And obviously translating heavy work into football. And you can feel that rising. You could even turn this into he can do the exercise, and I can actually treat his neck at the same time and actually release his upper neck. So functional active release, this starts to become why it is what it is, we're using functional exercise. And it's very profound, because the fascial tension that I'm getting through his scalenes and through his traps is massive. And he's kind of controlling it using his body movements.

Steven Bruce
I'm not quite sure how this exercise is functional.

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

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

Robin Lansman
Yeah. We're bringing it into neutral again, rather than actually trying to extend it at all. There shouldn't be any extension. Some people, when they try this, do start to want to overlift because they're trying to use their abs too much and they're trying to do an extension exercise, which it isn't at all.

Steven Bruce
Yes, and possibly think that more is better.

Robin Lansman
And probably think more is better and stronger is better. And holding it for a time is also better, which it isn't. It's all about function. It's all about movement. So it's really controlling the movement and going through a full range, and back and down again. And using that breath rhythm speed really is about the right pace for the exercise. So there's a little bit more. So basically, we take the pillow out again. So what we can do now, we've got the arms and we've added in the arms and we've talked about the feet position. So if you, for example, bring the arms back up into that fist position, what tends to happen with people who are kyphotic and very stiff in their shoulder girdles is as you lift people tend to want to do that, because that's the way their arms go. So what you need to do is to get them to actually resist that. Okay, so in other words, they don't move anywhere. And that's the difficulty. And you have to use some muscle effort to do that. And that will stretch and work further and further up into the thoracic spine. So this spreads from being a lumbar spine exercise to a thoracic exercise gradually, as they get looser, and as they get better at it. And what you can also add in, depending on how your shoulder's feeling, is to add in a number of different options crossing the arms. And now try to do that breathing out. It's tough, isn't it? Much harder to lift. And I can see it looking at your face that there's some struggle with it. And if you cross the arms the opposite way. Elbows locked, if you can. That's it and try again. And that's a bit easier than the other way around. And that's because that spread of tension in the shoulder is going all the way around your shoulder girdle and it's being dissipated one way and aggravated the other. So you could say, I mean, that turns into perhaps an exercise for the shoulders. To some degree, you don't need it for too long and keep the shoulders in the air too long. So in this case, you may want to, as we're doing, let you have a rest now and again in between, there's nothing wrong with that, and then go up into as you do the exercise. So if we want to make it really work, just go from here, up into this as you lift and then down again. Yeah, so you're starting to use a completely different sort of movement. I mean, I know swimming, and this are not the same, but there's something about doing stuff that keeps the body in line and uses the limbs and so on that is a very useful exercise to do. And a lot of people can't be bothered to go and get wet in a pool.

Steven Bruce
But all the time of course, I presume that you're trying to make sure he's not switched to using his abs and he's using his quads and calves?

Robin Lansman
Indeed. And so someone who is for example, carrying some weight and hasn't got much abdominal qualityof tone, which you obviously have, is we sometimes add a weight. Yeah, so not to literally make it harder, but actually to engage the muscles in the abs a little bit more strongly. So what we could do, if I sort of pretend my hand pressure on your abs is, say a kilo or two, and you lift through that, that should, in people who haven't got muscle strength, actually give them a little bit of bracing and a little bit of support. It's not about the weight, it's more about the bracing.

Steven Bruce
But actually, you want him using his quads, not his abs?

Robin Lansman
100%. But just keeping the spine a little bit engaged, helps without adding any force. And people find this makes it a lot easier to do when they're suffering. And then the last little bit is to actually have the chin tuck in. Because what we were palpating, when I was sitting at the other end, some of these neck muscles, what we can do, and it's a bit to get your head around, is to do that chin tuck as you do the lift. It's not fixing the chin down, but it's actually doing that bridge. So bring the feet just back to the hands, to the fingers. We'll leave that the arms out of it for a minute. And what I want you to do is do the breath out, but actually do the chin tuck as you actually do your bridge. Breathing out, don't lift your head, just tuck. That's it good. Can you feel that? And so what that does, that actually starts to meet in the middle. So everything from the back of his neck down and the traps, start to meet with the lumbars function going up into the thoracic and where they meet becomes a stretch point. Yeah, so that's kind of useful as extra, if you like therapy moving on from back into other parts. So you might say, well do the simple bits just for the acute backache, but when you're looking sort of globally, as I like to try and do, this starts to spread into all sorts of other areas. And if they're having a bad week or a bad day, and it goes into a bit of a flare up, which things can do, you still want them to be able to do some of it, rather than give up the exercise. And I think one thing that often happens with exercises, as soon as there's a flare up, people just stop doing them altogether.

Steven Bruce
We have been asked as well, what do you do about compliance at home? Sarah sent in to say, well, how do you make sure they're doing them correctly at home? Do you do video monitoring?

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

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

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

Steven Bruce
And Tim's asked whether you give exercise on all fours at all?

Robin Lansman
Not for an acute back, no. I always do it recumbent, because most people are fairly comfortable to lie recumbent. There are the cat and the cow and the other yoga exercises that we would all know. And I know they're prescribed still quite often. But a lot of people if you ask how compliant they are doing them, I'm not quite convinced they are.

Steven Bruce
Do they have a benefit, if they're done properly?

Robin Lansman
Well, if they're done properly, and the people are fit enough to start with, then probably. But we're dealing with all sorts of issues here, with quads that are dysfunctional. quite often in people with chronic back problems, we all know the way they've been walking and the way the pressures are their hip girdles, their leg muscles are probably quite a problem part of it, their upper body component is definitely a part of it. So this gives them control and allows them to work broadly with their body.

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

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

Steven Bruce
Shall we give him his cushion back?

Robin Lansman
Yeah, let's give him his cushion. If you just put your legs out flat. So what we're going to do, we're going to do a leg raise. This is more to see recruitment through the hip into the back and vice versa. So if we tighten both feet, tight, yeah. And what you're going to do is pre-tighten your quads. So the quads are kind of activated and tight. And you're very slowly going to lift this leg, using a breath out or on a breath out or with a breath out. Just try and do that, lifting until you find the back of your knee just begins to pull and says, that's far enough. I don't want your knee to bend. So just try and do that. So if you raise, breathing out, through the belly so you're getting a nice belly breath out? And keep going and tell me, or nod or do something. Yeah, that's about it. So you can see how little excursion you're getting in your hamstring. Let's do the same with the other leg, slowly, keeping the tension to the very last moment. And we're going to do the same exactly with this leg. Okay, breathing out as you lift. Okay, and just go to that point, which is already doing better than the other one. So that's a good assessment of how your

hamstrings are either letting go or not letting go. And it's also an indication of how well you're recruiting the quads, how powerful they are, but also how much recruitments going on and where.

Steven Bruce
Perhaps a difficult question to answer, how far would you expect a patient with good quality hamstrings and quads to be able to get?

Robin Lansman
Considering age and fitness, I mean, you're not doing too well in terms of range, but at least 45 degrees. So what we can also do is find out is the component, the hamstring and legs, or is it more the low back. So the second part of this, depending on how you want to put it together, if you just pop both hands up out of the way, and I'm just gonna put my hand under your lumbar curve, you don't even have to lift it because it's a little bit of an arch. And basically, I want you to do the same again. And I'm palpating really both sides of the lumbar spine between the middle to the lowest lumbar joints, okay, and breathing out, breathing out, and the more you breathe out, just want to see there's very little mobility in his low back at all, I mean, I can still get my hand out relatively easily and down. Okay, and try the other leg. But when you recruit more, it does help the leg lift. Breathe. Yeah, so now you're a bit more focused on your back because my hands and your legs are going higher. So just drop down again. So that would say that he's lumbar spinal function ain't great, and his muscles are not recruiting too well. When we try and get them a little activated, not too much, because they're stiff, it helps the leg lifts. So that lumbar roll, that lumbar function's coming in. And the more he gets the lumbar function, the more he's getting the leg lifts. So that's a useful test. It's a useful exercise. Could be with someone with sciatica as well for that matter, but it's a useful thing. And that could become a remedial exercise as well. There are other ways to do it but that's the beginning of it. And actually, just repeating that looks like you're not doing much, but just doing that exercise, say 20, 10 each side, that would build to release the hamstring without you stretching it because stretching your hamstrings just makes the hamstrings go no, thank you. And actually, people do quite aggressive hamstring stretching and rolling. And actually, this exercise by recruiting is switching off the opposite group. So your muscles are getting better at the front and the hamstrings are saying, let go.

Steven Bruce
Can you improve that in any way if you provided something under the lumbar spine to give proprioceptive feedback, so that he can feel himself pushing down?

Robin Lansman
People say a coin or any of anything flat, that you can feel would give you some connection, but it's not all about the core, it's about everything working together to get that function between the legs, the hips, the hamstrings.

Steven Bruce
It was just that when you put your hand there he got better.

Robin Lansman
Yeah, absolutely. People do put something small, nothing big, nothing to lift it. But just something that you can sense is a useful way to check you're getting that contact point. Yeah.

Steven Bruce
Jack, thank you very much. We'll release you back into the wild again now.

Robin Lansman
Thanks very much.

Steven Bruce
See you for the next one.

Steven Bruce
So somebody has made an observation. Jason has said that this seemed quite similar to an approach taken by Josephine Elphinstone, who came in some time ago. You may not be familiar with her, she's not an osteopath or chiropractor, but others might want to look at that one. Iwould like to talk about the courses that you run, the coaching courses. I think your website is www.bodybackup.co.uk.

Robin Lansman
That's the practice website, but we've now put in the coaching option, because patients actually quite like the approach as well. We get people telling other patients about it, but also, the thing I was teaching undergraduates and postgraduates all over the place of pre COVID is something now that actually, it's quite nice to do with small groups. And so initially, the preamble stuff, the things we've been doing now and more, you can do quite easily online. And in fact, we're doing it, in fact, linking people up with a video call. And in terms of a team, it could be someone in the same practice, or even individual friends, colleagues, osteopaths, whoever, who want to connect to do the course together. It's quite useful to do in the same room with someone, not me, but them so we can, they can practice on each other and actually palpate and we go through that in quite a lot of detail.

Steven Bruce
Okay, so in a room with a treatment table preferably.

Robin Lansman
Yeah. And we've done several sessions so people can go away and try the ideas out in practice, and then come back and ask questions and actually have that chance, because obviously sometimes you do a course for a whole day or two, the question comes up two weeks later, so this gives them the chance to have that in a sense coached approach.

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

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

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

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

Steven Bruce
And who would you take on that? Osteos, chiropractors, I'm assuming. Sports therapists, physios?

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

Steven Bruce
Well, we'll sound out whether there's interest in doing it. We've got this wonderful space here. I love running hands on courses in it, so if we can get a suitable number of people together.

Robin Lansman
Well, on the website, we've got feedback from previous delegates on video that we shot at the time, a few years back. And I must say, people have told me even now, I get emails saying, I'm still using this in practice, it's saving my hands, but I'm feeling very connected with the patients. So the treatment techniques were a kind of move on from this. But as we did that last bit with the neck, in a sense, the palpation, and traction and treatment that was linking the treatment to the functional movements, so that would be sort of where you go next with it becoming a hands on technique as well.

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

Robin Lansman
Well, ownership is really, really key. I heard a surgeon up in Scotland, I was speaking up there once and the surgeon from Strathclyde was talked about hip replacements and engagement with people doing exercises, prehab. And it was really hard for people to do, until they've been promised surgery, to actually do the exercises. When the surgeon said, you got to do these, they often did, but they did least well, when they got the printouts. Far better experiential and in fact, one of the slides if we can come on to it, because I think if we might be able to share this one, we've got a little bit about how the ownership. Yeah, if we can put this on the main screen, that'd be great to share. So this way of learning, I think, is something that's worth summarising on. Basically, people learn stuff from their own experience, they get stuff from external experiences, but owning it personally is really powerful. And so what I'm really keen to do, and

practitioners have said to me, but you spent half the session going through an exercise, or even a whole session going through an exercise. But what they've taken away is a personal experience. So when they get that feeling, and I want them to sense and feel the exercise while I'm with them. So when they go away, and I even say to them, apart from the video possibility of them, but when they go home, they should practice it when they get home, just to kind of bed in when they're in their own space, how it feels and how it felt, and ask questions when they come next and we can then modify that. And that link, I think that peer also linkage, people can, certainly osteopaths learning this can share and discuss and learn. But I think that personal experience is something that doesn't just come from a leaflet, doesn't just come from reading or watching a video on YouTube. It's not the same as feeling it. So it's very important to get that buy in, and that sort of sense from patients. And that's what I try and give my patients and why I love to teach that approach.

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

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

Steven Bruce
Is that something that is worth us covering at some point? Different exercises for arthritis?

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

Steven Bruce
We had a case-based discussion about this some time back, patients coming in determined that this is the treatment they wanted. And there were various approaches to that sort of patient, do something to placate them, but then get on with what you really want to do for them as well.

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

Steven Bruce
We've got just a few minutes left. Something that struck me earlier on in the discussion is that we are about to start running as part of our CPD offering here multidisciplinary team meetings in the studio on a regular basis. And we'll see how often it works out. And there'll be run with the spinal consultant I talked about, Nick Birch, because I used to go to his multidisciplinary team meetings. And they were attended by Pilates instructors, physiotherapists, hydrotherapists, chiropractors, osteopaths, everybody, and Nick used to refer people to all of these people as he felt it was appropriate. But it was great because he would bring up the cases and he'd give us the MRIs and tell us the interpretation on the MRIs and ask everybody's input on how we could deal with this. And a lot of what you've said, this evening makes me think that this is a great opportunity for that improved communication between the teams. It might be that we would like somebody else to come up and join that multidisciplinary team on an occasional basis.

Robin Lansman
Sounds interesting.

Steven Bruce
Well, yeah, I think you might enjoy it actually, because it's a great opportunity to share the sort of wealth of experience that you've got. Anyway, I'll put that to you over a beer later and see if you're more amenable.

Robin Lansman
No, it's interesting and certainly the work I've done recently, the Health Education England, all those projects, the way that they've transcended professional silos in all different ways, is about the

communication style and the professionalism and the wanting to go forward with a team approach. And I think the ownership in that is really key. Beyond the minutiae, in a sense.

Steven Bruce
Robin, we've let you down, we had 420 people watching and I was hoping for over 500, but there will be lots more that will watch the recording. But yeah, it's been fascinating and certainly has given me a lot of food for thought for patients of my own just listening to you and watching you. Oh, hang on here, guest number 4363 has said, do you advise patients they might ache after doing the exercises? That's your final question of the evening.

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

Steven Bruce
Brilliant. Thank you very much.

Robin Lansman
A pleasure. Thank you.

Steven Bruce
That's it. That's all the time we got for this evening. Apart from a couple of things I wanted to share. First of all, one person asked whether we were still selling Clinic Armour couch covers, nothing to do with this evening's discussion, but yes, we are. I think we are the sole distributors for Clinic Armour couch covers in this country. Those are the covers that you saw on the table while we were working with Jack earlier on. And if you need some of those for your own clinic, then just send an email to anyone here or call us at the Academy. But it's Elaine that deals with that and her email address is elaine@apmcpd.co.uk. So that's Clinic Armour. You heard me mentioned the multidisciplinary team meetings. I'd be really interested to have your feedback on whether you think that will be useful. Effectively you will be looking over the shoulders of a lot of people in the studio here, while we discuss specific cases, but of course you have your opportunity to contribute, and your own opportunity to put your own cases to us as well. And hopefully, we will have, not just our spinal consultant leading that discussion, but we'll have very experienced osteopaths, he says, glancing briefly at Robin here, it doesn't necessarily have to be Robin, it could be all sorts of people. But I think those can be a really useful development from the case based discussions that we run normally. Anyway, as I mentioned earlier, on Thursday lunchtime, we have a show 13:10 to 13:55, 45 minutes of superb CPD with Simeo NIel-Asher and Professor Bob Gerwin, the subject will be Myogenic Thoracic Outlet Syndrome. I mentioned that earlier, I know. But they'll also be in the studio for a face-to-face course over three days in May. And that's going to be all about dry needling. And I've said it before, I'll say it again, this must be the best course on dry needling that you're ever likely to go on. So whether you've never needled or whether you've got years of experience, do consider it. Bob is a professor of neurology from John Hopkins medical school in Baltimore. Simeon's a world expert

on trigger points. And between them, they demonstrate how to absolutely nail treatment with dry needling. And of course, they're all over the safety aspects of it as well. It's just brilliant. That's 19th to the 21st of May, there's a link on the screen to the booking page, and you can still pay in three instalments, if it's cash flow that might hold you back. But the course is now well over half full, so don't hang around. One other show to trail for you. Quite an important one. We've got a case-based discussion on Tuesday the 21st, so a week from now, again at lunchtime, and we're going to be looking at headaches. And we've already got a couple of cases lined up. But let us know if you've got any interesting ones of your own. I think we've actually got Elizabeth Hussey joining us for that show. I could be wrong. But she is a master of headache disorders. And that's an academic description, it's not just me bigging her up. She is one of the leading lights of the EdACHe trial, which we've mentioned on several shows and the online course which emerged from that is now open. And that's all about building your confidence in assessing and treating headaches. And the link to that course is on the screen and I can thoroughly recommend the course. So there you are, enough from me. Have a good week. See you soon. Thursday lunchtime for Thoracic Outlet Syndrome, I hope, and then next Tuesday for our case-based discussion on headaches. That's it. Goodnight.