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Setting Your Patients Up For Success - Ref 130US

with Ulrik Sandstrom

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TRANSCRIPT

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Steven Bruce
This evening I'm welcoming back for the second time Ulrik Sandstrom. Now Ulrik's a chiropractor. He's had over 20 years of working with elite sport. He's currently the chiropractor for the Leicester Tigers rugby first team. But he's worked in a couple of Olympics. He's worked with athletics, swimming, rugby, all sorts of stuff. He's a senior lecturer with the International Federation of Chiropractors in Sport and apart from that, he also works in two clinics up in Mansfield and Sheffield. Ulrik, great to have you back with us.

Ulrik Sandstrom
Yeah, very good. Thank you. How are you?

Steven Bruce
I'm very well, thank you. Last time you were in, we talked about pain science. And you really appeal to our audience. They like your combination of practical clinical stuff combined with the evidence and so on. This evening, you're going to talk about setting patients up for success. Is there an overlap between the two or is this brand-new stuff?

Ulrik Sandstrom
Very much. So, the lines always are pretty blurred about a lot of the stuff that I talk about, because to me, it's all about essentially managing patients and getting them better and using different tools to do that. So, most of what I teach reflects, essentially most of how I think, and it has to fit together. My brain just doesn't work well, if all of a sudden I pick something in but it then conflicts with something else, there has to be an overall thread through this. And certainly, in terms of managing patients pain science probably was a little bit of a missing link for me that I've integrated over the last two or three years.

Steven Bruce
Yeah, apparently, I didn't quite complete your bio when I ran through that earlier on, because you are also an international lecturer, are you not? In, is it largely sports chiropractic that you lecture in?

Ulrik Sandstrom
To be honest, I'll talk on whatever you want me to talk on. But yes, I speak a lot on sport, I run my own seminars, I'm increasingly talking about sort of pain management and pain science. Because I think a lot of people with regards to the pain science, as we talked about last time, there are these two factions who are going, "No, no, it's all in the brain, we need to just deal with the brain" or "No, no, it's got nothing to do with the brain. It's all about that stuff outside." And I think the feedback that you gave me just before was, again, people quite liked the fact that this is a manual practitioner, who loves manual therapy, but who actually also can see the value of integrating the pain science. So yeah, that's what I'm sort of increasingly being asked to talk about as well.

Steven Bruce
I'm interested to hear you say what you just did, because you're obviously exposed to a much wider audience in terms of lecturing specifics about pain science, I thought everybody now was very much alongside the idea that you can't separate the psychology from the physiology, from the stuck-out vertebra or whatever it might be.

Ulrik Sandstrom
Yeah, it sort of makes a lot of sense now. And if we look back, then, if we look at the sort of biopsychosocial model of back pain that we've heard about for the last 25 years, and sort of paid lip service to a little bit, it's really with the introduction of the pain science knowledge and the ideas of how our brains work, because paint size is just another reflection of how our brains work and the fact that our

brains make stuff up on a constant basis. And we actually havea choice, whether we believe them or not and that to me is a really interesting thing. My daughters just started off a master's in neuroscience at King's College in London and I'm so jealous that I'm sort of looking over her notes when she's when she's doing stuff. And it fascinates me so much, the pictures and the stories that our brains are trying to tell us and how they can be really useful, but also massively disruptive and get in the way of actually living decent lives. And pain science is just another aspect of that.

Steven Bruce
Just as an aside, when is your daughter free to do one of these broadcasts with us?

Ulrik Sandstrom
I'll tack that on the door downstairs because although she's at King's College London, she's at King's College London via you her computer in her bedroom downstairs, which she's gutted about.

Steven Bruce
So, to kick us off, what do you actually mean by setting patients up for success?

Ulrik Sandstrom
So, it essentially boils down to patient management and patient management has always been a little bit of a bad word. And I don't know because I used to sort of, back in the day, there was very much a difference between, in my world osteopaths tended to be people who, if someone came to an osteopath, certainly, when I heard from patients about seeing osteopaths locally, you come, you have a bad back, the osteopath would do some treatment and then you'd be told, see how you go, if it's not gone in a week, come back and see me again. And then of course, you had the other side of it, of the chiropractors going, if you got to a chiropractor, you'll see a chiropractor for life. And there was this whole thing of how do we manage patients and what's ethical, what's unethical. And the problem with the idea of patient management is, it has this sort of concept of, oh, you're just trying to get people back all the time and it's unethical to make people patients dependent. And then I have another slide, I'll probably jump to that in a second, one of my favourite quotes is that, contrary to what a lot of the pain science stuff now does say, Oh, you don't do manual therapy, manual therapy creates dependence. My argument is that manual therapy does not create dependence, manual therapists create dependence. So, it's all about how is this framed? How is this sold to the patient? What's the context in which you provide the manual therapy? And that's the thing that potentially create can create a dependence, but can also very much not create a dependence. So, looking at how we manage patients, essentially managing patients means getting them to do what you tell them and following a plan and because the patients don't follow your plan, then they're not going to get better as much as you felt that they could have. Because surely as clinician, once you see a patient, make a diagnosis and you have in your head an idea of how am I going to best manage this. The idea of the report of findings is to then put that across to the patient, so the patient goes, this makes sense, I buy into this, and I want to follow this plan. And in your head, anything other than the patient following that plan will reduce the positive outcome, that sort of surely makes sense that if you took this patient with a raging disc bulge, according to most of the research, it's going to be two to three months before you clear this, I want to see you fairly frequently initially, and as you get better, we leave a longer and longer gap, we're gonna start doing some rehab and get you on board with stuff that you can do to help yourself. If that patient drops out, after three sessions, we can be pretty sure that patient will not get better as you planned to. So, it's the idea that patients that don't follow the plan are actually doing themselves a disservice. And this is when you sort of get the idea of Oh, well, we're just treating back pain. And we're not just treating back pain, and this is one of the things that I try and get across to people is that, what we do is massive, what we do as people looking after musculoskeletal health has unbelievably wide-reaching consequences for our patients. And particularly in the current situation, we know how much health and fitness is key. If people are healthy and fit, they a) have better quality of life, b) are much less likely to get long term chronic problems, whether that be infections or any of the other chronic diseases. So, mobility and activity is real key. And to most patients who are not mobile, a huge obstacle is musculoskeletal pain. So, what we do and what we say to our patients can, once we get their backs better

or their necks better or their knees better, the effect that has and potentially has on a patient's overall health is absolutely massive. Everyone knows that I'm involved in a little sport and yeah, I love treating athletes. It's really exciting and it gives you some good experiences but to me, getting Mrs. Smith with her chronic low back pain, who's 75 years old, who has now lost her ability to go dancing or go and play bridge or even go shopping on her own, getting Mrs. Smith better to the point where we return her mobility and her quality of life is so much more important than getting someone playing on Saturday afternoon for the team. And very often as a condition it's frustrating because Mrs. Smith probably only got 20% better because of all the other external stuff that's going on with her, but to Mrs. Smith that 20% was the 20% that gave her life back and she can now get fit, she can now stay active. And we know that all the research shows that the outcome for Mrs. Smith's length and quality of life, by her now being able to go dancing and socialise, is absolutely massive. So, I know we're sort of beating ourselves up a little bit here, but it's just getting into the framework of getting our patients to follow our plan. It's not just about getting their backs or their knees or their shoulders better, it's actually about returning massive changes to their quality of life.

Steven Bruce
You said at the bottom of that last slide that what we do is often far more than conventional medicine has any chance of doing, Ulrik. And clearly, we're talking about for specific conditions there. Do you think that conventional medicine is beginning to recognise that more widely?

Ulrik Sandstrom
They are. They have to, because that's where the research is going. Last time I was on we talked about the Lancet back pain papers, led by Jan Hartvigsen, and how we're treating back pain wrong, conventional medicine is treating back pain wrong. All the evidence shows that we shouldn't give people long term painkillers, we shouldn't be injecting their joints. We should be essentially doing the biopsychosocial model, we should provide some manipulation, we should provide a lot of education and support, and we should provide controlled and supervised exercise and returning people to activity. And I think, particularly with the current health crisis, people are realising we need for people to be proactive about their own health. Because, with some exceptions, a lot of the people who have very tragic consequences of coronavirus are people who already have very significant health issues.

Steven Bruce
Something else that occurred to me as you were running through that a moment ago. I just started reading a book called Help! by Oliver Burkeman, he's a Guardian columnist, and it is his review of the various, the many, many, many and various self-help guides. And he's very much a cynic about self-help guides. But something you said struck me about this, because he said that a lot of them will talk about goal setting and so on. But there's a counter side to that, which is that when you set goals for people, if they don't reach them, it has an adverse effect. I don't know if that's something that you're going to talk about or you've covered in this. But it was a quite a telling point, to me.

Ulrik Sandstrom
It's a really interesting point. It's not something I've really considered, but I will.

Steven Bruce
I recommend the book. I mean, it's an amusing and slightly cynical book, he doesn't decry all forms of self-help book, but some of the more ludicrous types of self-help book, the ones that say, if you repeat "I'm going to have the Ferrari" 200 times a day means you will get one, that sort of thing. And the spectrum between there and sensible stuff, and does do a reasonable analysis.

Ulrik Sandstrom
I like a cynic. I class myself as an open-minded sceptic, so I'm always curious about things, but I think we do have to have a certain amount of cynicism and scepticism, due to some of the stuff that we work through. Which is why I just love the fact that most of these things that we for a long time have been doing, these things actually the research is now starting to back up. And certainly, in terms of

management, this is key and it is that biopsychosocial model, that we actually now keep going back to, which is what helps patients.

Steven Bruce
Well, sorry, I interrupted you.

Ulrik Sandstrom
No, that's fine. This is a bit of a controversial slide, I'm just gonna pop up here. Why do 50% of our patients just continue care? And by that, I mean just continue care before we've told them that they should?

Steven Bruce
I obviously don't do that, because I'm an osteopath. So, I don't tell them to carry on.

Ulrik Sandstrom
Absolutely. So, this is obviously with my chiropractic head on, but there will be a lot of chiropractors out there going "I haven't got 50% of my patients just continuing care without me telling them to." Yes, you do. Do the stats. We've done a lot of stats over the years. And, again, I'll just run this through these very, very briefly. Essentially, what we do from time to time is we take patients who presented as new patients six months ago, for a month. So, if we did it now, we would probably look at all the patients who came in in May. So, all the new patients that presented to us in May, we now six months later, have a look at where are they? And we put them into four groups. We have patients who are still under care, so we considered that they needed maintenance care, which is something we're going to be talking about it in a minute as well. So, some people will still be under care. Some people will be discharged, we'll go, right there, you're now fine, go do these exercises and give me a shout if you get into trouble again. And then the third group is people who self-discharge, so people who basically you told them to book back in at some point and they either cancelled their appointment and didn't rebook or DNA. Which again, you would argue, is actually someone who didn't follow your plan. And amazingly, about 50% of people, if you go back and look, and I challenge everyone to do this, because we forget the patients who don't come back and then occasionally go, whatever happened to her or whatever happened to that guy. So do go back and look at your files and go, yes, they were discharged, that was cool, or no, I felt they could get a lot better than where they were. Because that surely is the reason why you invite them back, because you think they've got either further improvement to make or you think that it's important that we keep a check on them and prevent a relapse. And when you then start looking at this, and we ring people up and go, just checking. It's not a sales pitch, it's a genuine concern. Hi, it's Ulrik from the chiropractor clinic, I just wondered how you were getting on, I just came across your file and just wanted to ask how are things? And it always feels uncomfortable. But actually, once you've done it a few times, everyone takes it for what it is, it's just a genuine concern. And the good news is that quite a lot of these people who drop out of care, actually drop out of care because they're a lot better. So, they basically decided, no, this, this is good enough for me. And of course, that's entirely their choice. And so, they would say no, I'm feeling great. Thank you very much, you did wonders for me, I'm back at badminton. And you go, that's fantastic. Just make sure you keep doing that exercise. You know where I am, if you need me again, some people do drop out because they get worse. And sometimes there are reasons for that, sometimes we maybe haven't prepared them for the fact that they might get sore. Some people drop out because they can't afford it. My experience is that it's remarkably few people who do that. A lot of people go, oh well, I had to cancel because I had to pick the kids up and then life and stuff got in the way and then I've given never quite gotten back into booking. And actually, a lot of these phone calls end up, actually, yeah, it is a bit niggly and actually I really want to come back in and see you again because we need to see this through to the end. And a lot of them get well enough to manage, we talk about internal and external locus of control. And a lot of your patients do not want maintenance, as we'll talk about a little bit later on, because we talked about the fact that you had Andreas Ekland on your show recently with a fantastic maintenance talk.

Steven Bruce
What did you mean by that internal and external locus comment?

Ulrik Sandstrom
So, people who have an external locus of control are basically people who, they're very much governed by the outside. So, they're looking for advice from the outside, they're looking to the outside for people take responsibility for their actions. Whereas people with an internal locus of control are very comfortable in their own set. And they're the ones who go, I'm happy to cope with a 5 out of 10 back pain all the time. And of course, as a clinician, you go, you're crazy, we can get it much better. But internal locus of control says, that's fine, I can work with this. But once it gets to 7 out of 10, they come and see me. And then literally, after a couple of sessions, when they're back into 5 out of 10, they'll often go, that's fine, thanks a lot. And you're there going, but we can get you pain free or we can get you so much better. They go, no, no, that's fine. That's an internal locus of control and you're literally flogging a dead horse to try and educate them on, we should be doing this. Because as we'll see later on, it's their choice. Sometimes their expectation of what was going to happen is very different to the chiropractor's that may be a reason, or the osteopath or physio or manual therapy or massage therapy. That's your problem, as a clinician, that's your report of finding that didn't align what they were hoping to get out of this with what you're hoping to get out of it, because that, we'll talk about that a little bit later on as well, that's key in that we need to make sure that we are on the same page with what the patient wants out of this.

Steven Bruce
Is that not the same as the next bullet point, then? The expectations are different, then the outcome goals must have been unclear.

Ulrik Sandstrom

Yeah, exactly that. That's where the outcome goals, and you were talking about goal setting in that book, the key with goal setting is has to come from the patient. It has to be patient's goal, not your goal. I want this patient to be able to do this and the patient goes, I don't care. So, it'll only be a meaningful goal, if it's one that the patient came up with. And sometimes they actually need a little bit of coaching to get a decent goal out of them, but it has to be an agreed goal from there. And again, maybe you didn't explain to them how actually groundbreaking, how life changing what you can do for them is going to be. And a lot of that is a matter of confidence. And when we talk about the report of finding, we'll get into this idea of under selling and over selling. Actually, I'll do that now because it's quite an important point. You're always told you've got to undersell and over deliver. That's the key thing. But it doesn't work. And the reason why it doesn't work is because of the whole idea of what we now know about pain science and patient's expectation. And certainly, new and recent grads have this idea of, obviously, they tend to undersell, because they haven't got the confidence level of years of clinical practice, so you're gonna go right, we'll get you better. And that's a tough thing for a new or recent grad to tell someone, we can get you a lot better, we can fix you, we can get you back doing these things again, because of course, in the back of the head of a new or recent grad, they go, but what if I can't? So, it's really important that we don't undersell. We have to feel, this is what I expect to happen. And we have to within a goal setting, do you want to get running again? And they will often go, I'll never be able to run again, I've got a dodgy hip. You go, no, we can get you hip working well enough that we can get you running. And they go, really? Yeah, absolutely. I see no, particularly when this comes after a good thorough examination, you go, I see no structural or mechanical reason why we can't get you running. It's going to take a little while and you're going to need to build some strength and you're going to need to earn the right to get running again. But if that's what you really want to do, absolutely let that be our goal. And that's where this idea of don't undersell it, make sure that you listen to the patient and actually sometimes coax ideas of what would really be life changing for you.

Steven Bruce
I've got a question for you from one of our audience, Tamara has asked whether you find your own language creates better compliance in patients? She says, for example, adapting to the patient's style, as in

visual, auditory, kinesthetic, or other cues. Doing that she says she's noticed a huge difference in how her patients understand their diagnosis and expectations, which seems to affect their compliance and outcomes. Thank you, Tamara.

Ulrik Sandstrom
Yeah, thanks for that great question. And yes, absolutely. And I've got a slide later on, that basically has a picture of a chameleon. Because that's what you need to be, as a clinician, you need to be a chameleon. I've not done any NLP, I'm a little bit uncomfortable with whole idea of, patient crosses their arms, you cross your arms, patient leans forward, you lean forward. I think there may be some good value in that. Because I'm not comfortable, it's gonna feel odd. And once it feels odd for me, it'll not be genuine. But no, you absolutely do adapt your language, I think a lot of it is subconscious and a lot of it is driven by listening first, because by listening and just sitting down and just letting patients talk, you get a vibe for where they're at. And I think good clinicians subconsciously will meet the patients where they're at. And obviously, if I have someone crying and in 8 out of 10 constant pain and they've been everywhere, their life is misery, I need to tone my voice down, I need to sometimes put a hand on their shoulder and go, I know how hard it is, I know how difficult this is. And if Rob the builder walks in and he's pulled his back yesterday and he comes in and he swears at me and goes, this effing back is gone again, can you fix it? I'm not going to put a hand on Rob's shoulder and go, Rob, I know how difficult this is for you. That isn't gonna work. I go, sure we can get that moving again. So yeah, Tamara, absolutely. And certainly, adapting that and being conscious ofadapting that, there's no doubt that that improves outcome. Because what it improves, it improves the patient buying into what you're telling them. So therefore, improves their compliance to the plan. If they comply with a plan, they're going to get it by a better outcome.

Steven Bruce
Where did we get to in your slides?

Ulrik Sandstrom
So, let me just change to the next one here. So, the whole idea of if they discharge themselves before you have actively discharged them. What mindset did we leave them with? Sometimes even with the mindset, well, that didn't work. And this is the classic, someone's had chronic back pain for two years, you treat them four times and they're pain free and they go, this is amazing. And then you had in mind that they were going to come in next time for a little bit of manual therapy, but then shifting on to more active care, giving them a lot of exercises, guiding them back to the gym again and all that sort of stuff, and then they don't pitch up. And then a year later, you hear, no, that didn't work. It was sort of better for three or four sessions but then it came back. Despite the fact that they were pain free after two years. But if you haven't explained how back pain works and what the research shows us about recurrence, then they may very well genuinely think, well this chiropractor's rubbish. It was better for a couple months, but then it came straight back. Sometimes, they're also then really embarrassed to return. Because sometimes they'll go, I know, he said, I should be coming back and I never did and now I feel a bit bad because I didn't follow his plan. So actually, they may be too embarrassed to pick up the phone and be afraid that you're going to be telling them off and go, yeah, I told you, why didn't you come back? Now you've gone and ruined it all again. Or they may just be living with a little bit of pain. So, this is the problem sometimes with that self-discharge that it leaves this vacuum. So, to me, we need to reduce the levels of self-discharge as much as we possibly can. And even if that's a phone call, once they haven't shown up after two or three weeks, it's a much, much nicer way of leaving it. We'll talk about how we can do that and what sort of vocabulary we can use for that.

Steven Bruce
On the subject of patients cancelling, which you were covering a little bit ago, David has asked whether you have any estimated or documented data on how many treatments the average patient has received before they cancel?

Ulrik Sandstrom
I haven't. We actually sometimes subcategorise these self-discharges into people who've sort of had three

or less treatments, because they generally were the ones who probably got somewhat minimal effect and really didn't buy it. If someone cancels after maybe five or six or eight treatments, chances are they're probably going to be quite a lotbetter and they may well give you a ring. But the people who self-discharge early on, generally, you're unlikely to see again, and it may just be a personality thing or other stuff happened in their life. And as we see on the slide, I'm just going to pull up here, I can live with the pain, it worked, I'm now fine and I'll ring you if I'm in trouble. That may very well be where you left them. But it's this whole idea of this therapeutic alliance, which is a sort of buzzword at the moment, that we're working together to get the patient, and the better a collaboration, and obviously, if the patient drops out, then there may be a vacuum and you need to make it easy for the patient to pick up the phone. Even if it's just saying that, I completely realise sometimes life just gets in the way. Absolutely fine. Make sure you keep active, make sure you do this exercise. You know where I am if you need me again. And that's sometimes really all they need.

Steven Bruce
I wonder whether we should throw that back at David and say, David, we will await the results of your clinic audit when you can tell us what the average is. It's difficult because as you say, there are different categories of patient. Can I just interrupt with another question? I don't know who asked this one. But whoever it is, says that they find that they're more elderly, male patients are harder to get going with exercises and commitment to getting better and do you have any tips for that particular demographic? I suppose I should answer that question, since I'm in that category now.

Ulrik Sandstrom
Yes, Steven, why don't you? Yeah, I think it's true. And we'll see a little bit later on, a lot of it boils down to the goals, the goal setting and making sure that you don't apply your goals and your thoughts and your beliefs onto a patient who actually just wanted to feel a little bit less stiff in the morning and who doesn't really want to do exercise. And it's a free country. It's our job to go, these are the benefits and this is what could happen. It's the old adage about leading a horse to water, but you can't make them drink. They're not going to do the exercises just because you say, I'm really clever, I've got a degree and 30 years of experience, you should be doing exercise, because I say so. But if you go well, if you do some exercise, actually that stiffness in the morning is likely to disappear. If you did a little bit of that core stability and a bit of strength and strengthen your hip flexors up, I think we could actually get you back playingfootball again. And all of a sudden, they go, oh. And now the exercise is a means to an end. And, and that to me, is real key. Because to be honest, I'm one of those unfortunate people that don't get an endorphin release. I get on my bike, I go for a run, there's no part of my physiology that goes, *explosion noise* Ulrik, you feel amazing. It doesn't happen. Exercise, it's fine, I don't mind it. But it's not a big buzz for me. But I know it's really good for me and enables me to do lots of things that I probably otherwise wouldn't be able to do. So, I think the goal setting is really important in this,

Steven Bruce
What you've just said, there is actually in itself, quite important, isn't it? Because again, and it comes back, perhaps similar to what I just said about the self-help stuff, if people expect that they're going to get an endorphin rush from doing exercise, and they don't, again, they'll be disappointed with themselves and that will adversely affect their outcomes as well. So maybe it's worth explaining to them. Yeah, some people get the endorphin rush, some don't. But the fact is that they're all gonna get benefit from the exercise.

Ulrik Sandstrom
No, absolutely. It's like, I don't know about you, but I've not found many patients who, you show them the bird dogand they go, oh, bird dog, brilliant. I love my bird dog. It's not fun. Doing strength and stability and core exercise is just not that entertaining. But if done appropriately and under good advice, it's actually fairly quick and that leads to other benefits. And it's this phrase that I love doing: You need to earn the right to get running again. If you would love to be running brilliant, but you need to earn the

right. The bird dog and your hip stabiliser exercise and your monster walk and your side plank, that's where you earn the right to get back to running again.

Steven Bruce
Okay, so the next anonymous question, I'm afraid, and I apologise, I like to acknowledge who asked these questions, but they've said, how do you get the patients to commit to their goals, do you get them to sign something, do you talk to them about what will happen if they don't commit?

Ulrik Sandstrom
Not generally. Also, because one of the things that we have, life changes, you know, shit happens. And sometimesyou've got to keep your frustration as a clinician out of the way, you are there for the patient. And it's the patient's goal always. And just as well as the patient has a right to more than one complaint, the patient also has a right to change that goal. And I have to bite my tongue sometimes when you do this amazing work and getting someone who, on their first visit, said, my dreams would come true if I could run again. And then after four r six weeks of treatment, you've got them more mobile, you actually start to build some strength again, you go, right, now we start with a little walk, jog exercise. So you walk for two minutes, then you do a little jog for two minutes and then you go back to your walk, and we do Couch to 5k and you get super excited about getting them running again. And then they come in next week and go, oh, I never really got around to doing that walk jog again, but no, I probably will next week. And then after two or three weeks, you realise actually, running sounded like a really great idea two months ago, but actually, it's not really what they want to do. And that's their choice and we just get much better rapport, much better if you go, that's cool, that's fine, anything else I can help you with, anything else that will change your life or will improve or that you want to do in terms of the fitness? And the beautiful thing about exercise is that we now, we all used to go, you should go swimming, because swimming is really good for your back. Or you should definitely not run because running is bad for your knees or running on concrete is even worse for your knees. And of course, we now know that that's completely rubbish. There was a recent study done that actually running on concrete is actually less knee loading than running on soft ground because the time of impact of contact is much, much less. So actually, overall the load through the knee over a 10k run is less when you're running on tarmac.

Steven Bruce
The shock is not more significant?

Ulrik Sandstrom
Yeah, certainly the in terms of the data, the research is suggesting that actually, you may be better off running on a hard surface. But again, it is just that example that what we used to say about exercise, well, this is good for you, this is bad for you and of course all the research shows, exercise does good for you. And it actually doesn't really matter what. Even in terms of back pain. In terms of most pain, exercise. Yeah, we want to do some core stuff and we want to do this, but at the end of the day, exercise is beneficial. All the research shows that exercise is good, probably doesn't matter so much what you do. And that's where, when people start going, right, what exercises should I do? My first question is, what do you enjoy doing? Now what would you love to do? Because they might go swimming because Ulrik says I should be going swimming, if they have hate getting their face wet, they're never going to be swimming for the rest of their life. And they go, I do love Zumba but my back sort of gives way. Great! Zumba is the one! Let's get you strong enough and working well enough that we can get you back into Zumba. Because if they enjoy Zumba, they might go, I want to go line dancing because I meet up with my mates. Brilliant. Let's get you line dancing. So, it's this whole idea of exercise has to be driven from what they want and they goal.

Steven Bruce
Ulrik, I'm going to set two challenges right now. One is to you and one is to Justin in the production booth. Because both Sylvia and Catherine have asked what a bird dog is. So, his challenge is to put a camera on the floor and your challenge is to talk me through the bird dog. While we expose the horrors of our studio to everybody. Justin will have to tell me where I have to be. What do I do?

Ulrik Sandstrom
Yeah, I'm just gonna say I'm even more disappointed now that I can't come sit on the sofa with you. Because obviously that was the plan all along. But with COVID we're still very distant. So, you basically get on down on all fours, hands immediately underneath your shoulders, knees under your hips. So, knees hip width apart. And then you just sort of hold your stomach muscles nice and tight, so almost like a brace, like someone's about to punch you in your stomach. You just hold it nice and tight. And then you push one leg straight back to about horizontal. Very good. And now you lift the opposite arm up.

Steven Bruce
I've always called these Supermans.

Ulrik Sandstrom
I tend to use the Superman one as well. But yeah, if we sort of go on the McGill's stuff, then yeah. Very good.

Steven Bruce
We're gonna go back to the normal camera but I've got to let Justin get back in the booth before I can do that. Right, good, I'm glad we managed to get that out of the way. I've also been asked whether you do motivational interviewing? And I'm not entirely sure what that is, either.

Ulrik Sandstrom
Yeah, really good question. The real answer is, I don't know. Because I don't know enough about it. My suspicion is that probably part of the way that I talk to patients, I may well do. But it's certainly on my list of things to look into a lot more. There are some really good people out there talking about motivational interviewing and listening skills. There's certain people out there, there's a chiropractor called Chris Chippendale, I've been on one of his courses, he does some really interesting stuff with that. I don't know enough about it to know whether I do it or not. But it's certainly something that I'm really interested in. And I think anyone who's looking at improving listening skills, improving ways of getting patients on board, because it's this classic dichotomy of, you know, if only people knew what I knew, they would do what I would do. And of course, we know that that's rarely the case. So, it's something that I'm really interested in. And I think it would be a really useful adjunct, and it would fit nicely into all the stuff that I already do.

Steven Bruce
I've been told by Claire, that nobody's now watching us, they're all busy doing the bird dog/Superman thing. I meant to ask you about that bird dog, though, and it's something that I think I know the answer to, but you're the expert on this. It's easy to get the opposite arm and leg out for most people, but where does the head go? Are you looking straight down at the floor or looking ahead?

Ulrik Sandstrom
I tend to look halfway in between. So, I tend to have patients just focus on a spot a little bit ahead of them. So, I don't have the head tucked in, I probably have very slight neck extension, but certainly not looking up.

Steven Bruce
The temptation is to want to look straight ahead along your Superman arm, isn't it? And that can put a lot of stress on the neck, obviously.

Ulrik Sandstrom
Yeah, and particularly when I tell my patients that obviously I expect within three to four weeks to see them levitate slightly. That's an outcome goal for me.

Steven Bruce
Let's get back on track, shall we? Where were we?

Ulrik Sandstrom
I was, as a young chiropractor, looking at report of findings. We were very much told, there's three things that a patient wants to get out of report of finding. They want to know exactly what's wrong with them, they want to know exactly what you're going to do to them and they want to know exactly how much it's going to cost. And what I've realised over many, many years is that patient don't give a monkeys about most of those things. They don't actually want to know exactly what's wrong with them. And also, what we have to be realistic about is, that in most cases, we have no idea exactly what's wrong with them. It's this idea that we could send a chronic low back pain patient to three physios, three chiropractors, three osteopaths and three masseurs and we'd get 12 different diagnoses. And we'd all help the patient, we'd all be able to get the patient better, research suggests that, but the ways and the thought processes and the ideas and the diagnoses may well be very, very, very different. And actually, we have no way of knowing who's right. So, this is a completely different topic, but I call it the diagnosis illusion.

Steven Bruce
Well, I think we talked about it last time. And I think I said, then I'm probably guilty of it in that I want to display my great knowledge by giving them technical, medical, biological detail, which actually they don't care about and probably didn't understand either.

Ulrik Sandstrom
No and I do not bring a spine out now. I don't point to facet joints, I don't do any of that. I just basically tell them, your back isn't working very well, is pretty much the extent of my explanation of what's wrong with them. You've got some joints that are stiff, you've got some muscles that are really tight and sore, and that nerve's a little bit irritated, which is why you're getting the pain tracking into the back of the thigh. That's what's wrong. So, what we need to do is we need to get the joints freed up, we need to get those muscles relaxed so we can build some strength back in to them, which is going to take the pressure and the irritation out of the joints, so we can get more mobile, so we can get you back doing what you want to do. Basically, what I found out after a lot of soul searching and realisation is that actually patients want to know three things, but these are the three things they want to know. They want to know you care, and this is where some of the listening skills come in, they want to know that you genuinely understand and care about them. Not about their L5 S1 facet syndrome and not about all your certificates on the wall and you know how clever you are and how clever you sound when you bring the spine out. They want to know that you actually understand who they are and what they're looking for. Then they want hope of where they could get to and this is where the idea of you need to instill this in them. And this is where don't undersell the hope, don't hold back on how good these people could actually become if they follow your plan. And then of course, they need a plan. They need to know, okay, so how are we going to do this? They've realised you care about them and that you understand them, and we're going to surely look at how we can make sure that our patients get on board with this, then they need an idea of where could I get to in life, how much better could my life be if I do what this chap tells me, but now we go, okay, this is how that's gonna work. This is the plan, this is the outline, this is what I'll do, this is what I expect you to do. And these are the progress and this is how we're going to going to build that up. So, these together are really the three key things and in terms of the care aspect, this is a classic little slide. I'm in the way of this one.

Steven Bruce
No one cares how much you know, until they know how much you care.

Ulrik Sandstrom
Apparently, Theodore Roosevelt, if you Google it enough, you'll find another three authors also said this particular quote. Gandhi and Einstein probably said it too if you search long enough, but it actually is true. And this is where the listening comes in, and this is where the understanding and just the sort of phrases, I know how hard this is and this is where the chameleon comes in. And this is where the rapport is super, super important. We need to listen to who it is we've got in front of us because we have a person, we have Mrs. Smith, we have Mr. Jones, we don't have a chronic disc derangement or a labral hip

tear, we have a human being. And that's actually where our focus needs to be. And sometimes there's the idea that, certainly to surgeons, the human being around this L4 L5 disc prolapse just gets in the way. Because that human being has concerns and questions and you just want to get in there and operate on it and we need to be better than that. We need to look at that wholly, again we're back to holistic treatment, we're back to the biopsychosocial model of treating that whole person. And you can only treat the whole person, if you understand who that person is. And, again, this is the idea of building rapport. You can go back to this, to the idea of the care. Because one of the phrases that I sometimes use, when we talk about pain, in particular chronic pain patients, the ones who are kinesiophobic, their life has been completely taken over by pain, they don't sleep, they're stressed to their eyeballs, there's so much wrong with them, they will often have, it can cause other to health problems as well. And one of the phrases that I sometimes use, after going, I know this really hard, this completely takes over your life, it's a horrible, horrible place to be. And I go, a colleague of mine came up with this phrase that I've now stolen, I say, you've got chronic pain and you've got sleep deprivation. That's against the Geneva Convention. What you're going through is torture. And once you point that out they go, oh, God, he actually does understand that this is pretty bad for me and he doesn't just see a bad back, he actually sees the person behind it. And this is when you get that rapport. So let the patient's talk, meet them where they are and let them know with just simple phrases that I know this is hard, and I know you shouldn't have to carry on like this. And sometimes when you even put little phrases in their minds, obviously not being able to play with the grandkids must be horrible and they go, yeah, yeah, yeah. Just those things. Or if you can't go for a 20-minute walk, then obviously, you can't control your weight. You'd be struggling with getting fit and getting exercising, and doing all the things that normal people do and they go, yeah, no, absolutely, this is why I finally need to get something done about this. And so, it's just preempting, what's going on with them and really focusing on, yeah, I understand I know how bad this is, we need to find a solution for this.

Ulrik Sandstrom
Yeah. Ulrik, can I just drag you away from this point of your discussion back to the Supermans, because they're still occupying some people's attention. Pip has said that she was told by a yoga teacher that when doing the Superman, you should try and stretch your neck lengthwise, as if you were stretching your head towards the wall you're facing. Does that make sense?

Ulrik Sandstrom
Yes, it does. And it's one of my progressions. So, to be honest, initially people struggle enough, people with chronic back pain, they struggle enough even balancing, let alone worrying about lengthening their neck. I know a lot of yoga and some pilates will be looking at make sure you hollow and zip, don't brace, hollow and zip. Most of the research now includes muscle activation through the abdomen. So, we can't exclusively activate tiny little muscles on their own. So that actually the brace is a really good way of stabilising yourself. And it's much easier because some people, like a 60-year-old overweight bloke with no core, you ask him to hollow and zip, he has no idea where that is. So, I just go, right, just brace, imagine I'm about to punch in the stomach. What would you do with your stomach? Yeah, no, that's cool. So now do that, and still breathing. And then once they're comfortable there, then I will lengthen, I will also ask them to lengthen their neck, because obviously the longer the less stability you get, so the more activation you get. I will often sometimes, when they get comfortable to be able to do three times 30 seconds on the Superman, I go, now to get into Superman position and reach your foot and your hand as far away from each other as you can, because again that's going to destabilise and make those core muscles work harder. So yeah, no really, really nice point but I will tend to use it as a progression rather than my initial goal.

Steven Bruce
You remind me of something I mentioned on one of these shows before and it was about pelvic floor muscles. I don't know if you've read Adam Kay's book, 'This is Going to Hurt', which is a very, very funny and poignant diary of an obstetrics gynaecologist consult or a senior registrar. But he said when telling people how to tense their pelvic floor muscles, he would advise them to imagine that they were

sitting in a bath full of eels and they had to try and stop them getting in. Not quite the same as being punched in the stomach but it's that way of teaching people how to brace those muscles.

Ulrik Sandstrom
Yeah, absolutely. So, can we put the Superman to bed now? Anyone else?

Steven Bruce
I can't promise that no one else is going to ask about the Superman.

Ulrik Sandstrom
Let's have a five-minute Superman amnesty. So, we talked about this idea of hope, but in order to give patients hope they need to believe in you. And this is where the sort of the initial, they need to know that you care. Also, you need to have explained the problem in a way that makes sense. And therefore, you have to explain the solution in a way that makes sense, in order for them to buy into this guy seems to have a plan and seem to understand what's going on. And again, it is back to that very simple idea of, you know, your back isn't working, your joints are stiff, your muscles are really tight and irritated, that's now spilling over onto the nerve, which is getting irritated as well. And that's where you get the thigh pain from. Probably the muscles are tight because they're weak, so they're trying to protect everything, you hit so many vicious circles. Vicious circles is a word that I use a lot, because the joints are stiff, then you can't move the muscles so they get deconditioned, when they get deconditioned, as soon as they get loaded up, they panic and spasm up, you now get worried about that, that causes them to panic even more, and again, we hit another vicious circle. So the way that we're going to work around this is we're going to hit it from all angles, we're going to hit that vicious circle from all angles, we're going to get your joints free and mobile, I'll be doing some manipulation in order to do that, then we're going to work on your muscles, I'll give you some massage, I may use my little instrument, I've got some needles I might poke in you as well, and getting that free and mobile is gonna make your back work better, once your back works better, that nerve's gonna get less irritated and you're gonna start to feel some relief. Once that happens, we're going to start building some strength back up to make sure that this doesn't happen again. There was my report of findings. Pretty much for whatever the patient, whether that's a neck problem, a shoulder problem, or a mid-back problem. That's because I know that to be true. If I go into much more details, I'm actually into realms where the research is going, yeah, but wait, can you know that? And a lot of the time we can't and a lot of the time the patient just doesn't care. Well, most of the time, I would argue the patient doesn't care.

Steven Bruce
Yeah, I think that that reflects the insecurity that we, osteopaths and chiropractors particularly, labour under because if we were to write a letter to a GP about a patient, we want to demonstrate our great medical knowledge and we want to demonstrate that we can use the right terms and we know precisely what's wrong with the patient. And yet, of course, you know, a GP might get an MRI report back from the local lab and would see some things on it and have no better idea of what's going on than we do.

Ulrik Sandstrom
No, absolutely. And the great thing with, I keep going back to this, the great thing is that all of the research is backing us up. Let's stop making a diagnosis out of just giving an MRI finding a Latin name or giving a source of pain a Latin name. You have a shoulder impingement, it hurts when you do this, you got a painful arc and it's tender when I press on your supraspinatus, I think you have a supraspinatus tendinopathy. And then we get an ultrasound scan. Oh, yes, you have supraspinatus tendinopathy, as do most people over the age of 50, who have got no shoulder pain whatsoever. And again, it's just that realisation, at the end of the day, we're not treating the supraspinatus tendinopathy. I can't treat a supraspinatus tendinopathy. I can treat the function of the shoulder, I can get their neck free and their shoulder stabilisers working better and I can get the mid thoracic spine better and we can start doing a rehab programme that's going to load that supraspinatus tendon up in order to make it stronger and make it heal. That's what we can do. But you know that tendon itself is not what we're actually even working on. But yeah, I digress.

Steven Bruce
Philip has said, Mr. Bruce- Philip, you're very formal. I appreciate that. Thank you very much- Could I ask the speaker how long a treatment session is with him?

Ulrik Sandstrom
My treatment sessions are 15, well, they were 15 minutes until COVID, I now do a 20-minute session.

Steven Bruce
That's an admission which could spark a lot of controversy amongst people, isn't it, about how much you can do in 15 minutes? I don't say that intending to be critical. Just that many people will say that they can't do all the things that you've described in terms of building up an empathetic relationship and so on in such a short space of time.

Ulrik Sandstrom
That's why my new patient appointment is an hour.

Steven Bruce
New patients are an hour, I see.

Ulrik Sandstrom
That is because your new patient appointment is where you set this up. I often say, delivering a good report of findings and a new patient rapport means all of the rest of the treatment plan gets so much easier. We'll go through in a minute exactly how I do this, but no, my new patient appointment is an hour and I would say about 20 minutes of that is the case history, about 20 minutes is examination, and 20 minutes of that is report of findings. And most of that report of findings is not, this is specifically was wrong you. It's more, this is how the plan is going to work and asking questions, does that sound okay to you? Does that sound like the goals that you were wanting to get to? And then once you have that in place, we will look, I've got a couple of slides later on, on specifically how we can then reinforce that as we go along. But yeah, it's really important in subsequent treatments, that you still keep this fire burning. Your report of findings is never done. You're always reinforcing, you go, oh, no, that's really good. Yeah, that L5 is moving loads better. And remember, those muscles that we talked about, they're really relaxing down, which is why they don't spasm when you get out of the chair. Again, linking these things to what patients feel. You know how much better you are getting out of the chair now? That's basically because all of this is a lot freer and your muscles aren't panicking every time you try to get out of the chair. And they say, oh, yeah. Brilliant. That makes sense. Do you also remember how we talked about now that everything's more mobile, now, in order for it to start stiffening and getting loaded up again, we now need to start building some strength in there? So, there's a little mini report of findings at the end of every treatment, I will go into that a little bit more detail later on as well.

Steven Bruce
Okay, just before you move on to the plan stage of this, Joe has asked actually a really relevant question, I suspect, for lots and lots of practitioners. Do you have advice for dealing with patients who don't think you understand because you, the practitioner, are a young fit active guy, so how can you possibly understand their pain? And you and I have both been there at some stage in our careers.

Ulrik Sandstrom
Did he just call me young?

Steven Bruce
I said at some stage in your career. But very definitely fit and active.

Ulrik Sandstrom
It is a good point. And again, it sort of comes back to that whole idea of meeting the patient where they are. And understanding that just because this is who you are and where you are, that doesn't mean that the patient needs to be there. And a lot of that is that initial dialogue in the case history, that you start to

get a little idea are what would change your life? And that, to me is the key, it leads us into the goal setting really nicely. It has to be their goals and some of the phrases, you know, what would tell you that you are getting better, what change in your life will tell you that you're on the right tracks? And that actually becomes a really nice, early goal for you. And sometimes the goals aren't oh, what would you love to feel? Where do you see yourself in five years? That's not what you're talking about. Sometimes, it's just the idea of what would you let you know, that we're on the right tracks and that this treatment is working? That's another really nice little early goal. But it's a very, very good point that's being made that we have to be careful not to try and impose our, who we are and our beliefs on to the patient. And sometimes most of that comes with language, so I guess to answer the question is that most of it is language and body language to a certain extent and using words that I understand that it's difficult to be where you are and I want to work with you, in order to try and get you to where you want to be. Not to get you to where I am or where I think you should be, but to where you want to be.

Steven Bruce
Interesting too, I remember when I first started my training as an osteopath, I already had grey hair by then and I was told that was a distinct advantage because even though I knew nothing at that point, having grey hair conveyed that air of wisdom and experience which I had absolutely no right to have, but it doesn't help the younger practitioner, does it, who's straight out of college and maybe has never experienced serious back pain themselves and is trying to convince some elderly bloke that actually they will get better and they do understand.

Ulrik Sandstrom
It is hard and it's a classic recent grad gripe, when you get experiences it's a lot easier to be very confident and convincing in, I know we can get this better because I've seen it a million times before. When you haven't seen it a million times before you've got this little thing going, but what if it doesn't happen? And I might just do this now just in case I forget it. I've got a nice little tip for you recent grads out there, who are afraid to go to patient, right, here's the plan, this is what's going to happen. So, I'm going to do this, you're going to feel this and by this time then I'll expect this to happen, I'll expect you to be able to do this, I'll expect you to be able to sleep at night, and you should be pain free at least 75% of the time, and give it another three weeks, we're going to be looking at getting you back running. And I realise that they're probably new grads sitting out there going, I could never say that, because what if it doesn't happen? And this idea that then they undersell and then we get into this classic- Again, I'm not picking on the new guys, but I've mentored enough new guys over the years that I know this happens- you get the classic, right, so what's going on, you got this facet syndrome and then you have the golgi tendon organs and the muscles and the ligaments and the tendons and all these other things, and you get all this stuff going on. And the patients now lost. And they go, so anyway, we're going to do a bit of treatment- And it's always this a bit- we're going to do a bit of treatment and we going to do a bit of massage and we're going to do a bit of manipulation, we're going to do few adjustments. And then we'll see how you're going and hopefully you're going to start to feel a bit better. Well, that didn't instill me with any confidence in anything whatsoever. But of course, it's driven by the Oh, but I daren't promise them things just in case. So, you're almost building up this protective layer around you, that you don't dare promise too much. But the problem with that is that it doesn't then tap into this whole thing that we know about patient confidence and how much patient expectation drives their outcome. I mean, all the research shows this, the patient expectation at the end of the first session drives their outcome. So, if the patient goes, right, he really knows what he's talking about and I'm really expecting that actually, we can get this better. Massively, massively affects their outcome. So, if you under promise, and they go, that didn't sound that great. You've actually now hindered the patient getting better. And the research shows this, so the way that I caveat that is to go, right, this is the plan, this is what I'm expecting, and then I wrap it in a nice little positive where I go, the great thing about what we do as manual therapists, I use the word chiropractor, because that's what I am, but it works equally well with everybody else, is that what we do is usually really effective. Which a) means that you're going to get better pretty quickly. It also b) means that in the unlikely event that you don't, I will know quite quickly. So, if for some reason within four to six treatments, I'm not seeing these changes that I expect, then obviously we need to find out why that is.

And sometimes some patients are just more stubborn in responding than others. Sometimes it's because there's something else going on, that wasn't obvious on my initial examination, but then we're gonna find out, okay, where do we go from there. So, a) it makes the practitioner feel more comfortable. I've got a get out. I haven't promised them 100% but I've told them what I would expect, but I've still given myself that get out and you've actually turned it into a positive. And patients even go, obviously, nothing is 100% in life and unfortunately not 100% of my patients respond to what I do. I will always wrap that up in, from what I've seen today, I see no reason why you wouldn't respond as I expect. However, we put little stop checks in and if at some point we're not quite getting to where I was hoping we're going to be, we'll need to find out why. either do some more investigation or refer you for a scan or to see someone else. So that's one of the things that certainly for a lot of my young grads that I've mentored, they find much more comfortable because they can then go, this is the plan, this is what I expect. And then they have a little get out at the end. But their whole report of findings isn't seeped through by oh, I'm hoping this is gonna work.

Steven Bruce
This is a related question. It's not quite on the track of what you were you were planning to talk about today. But Pip has raised a couple of really, really valuable points here. We were talking to a barrister a few weeks ago, Jonathan Goldring, and we had the Advertising Standards Agency on our show. We are all of us more and more aware of the chiropractic code and the osteopathic practice standards, all of which hold us to being absolutely honest with patients and not promising what we can't do and things like that. And she raises two points, first of all, how do you keepyourself on side with Advertising Standards and honesty with the patient but also in building up that rapport with the patient? Presumably you have to make sure you set some clear guidelines for yourself on when you might be overstepping the mark or making the patient think that you've overstepped that boundary of intimacy, if you like.

Ulrik Sandstrom
Yeah. In terms of the Advertising Standards Agency, that's a really simple one. Because whatever I tell my patient during a clinical encounter has got absolutely nothing to do with the Advertising Standards Agency. That's only what I put on my website and what I what I may put in an advert. What I tell them in a clinical encounter, obviously, has to be genuine but most of it is, and, again, it's wrapped up in the "I expect this to happen and I see from my examinations today, I see no reason." And the great thing about the evidence-based triage is, clinical experience is one of them. So, 33% of everything that we suggest to the patient, actually, we can put down to clinical experience. I've seen lots of patients with similar issues to you, normally I expect by this time this will happen. And that to me is fairly clear cut. And I think sometimes we have to be careful that our concerns about promising stuff, and at the end of the day I'm not promising, I'm outlining that this is my expectation of where we could get you to.

Steven Bruce
Tell me, Ulrik, your patient notes, you rightly said, obviously, that we cannot know precisely what's wrong with the patient. Are your notes that unclear, if I can put it that way? You don't write L4/5 facet irritation, you would write lumbar spine dysfunctional?

Ulrik Sandstrom
Yeah. One of my favourite words is pathomechanics.

Steven Bruce
Which sounds suitably...

Ulrik Sandstrom
Sounds really cool. And basically, just means exactly what I told the patient in their consultations. Your spine isn't working very well. Yeah, that's exactly what it is so I go lumbar spine pathomechanics causing compensatory hypertonicity around the lumbar erector spinae and glutes.

Steven Bruce
Have you got that on a rubber stamp?

Ulrik Sandstrom
Actually, one of my good friends, a sports physio that I worked with at the London Olympics, we got on very well, there was a lot of physio chiro banter. And he ended up basically just going hashtag L5/S1, it is always L5/S1 with you chiropractors. That's all it is.

Steven Bruce
We've not got much time left and we've got more questions coming in and we still haven't dealt with the plan and the goals or your case history that you were going to discuss.

Ulrik Sandstrom
Yes. So, we were just wrapping up on the hope. So again, we talked about this a lot. I'll just briefly skim through this, again, these are phrases, what would you love to be able to do again, and that's such a powerful insight into who that patient is, and again, sort of negates the idea of, I think you should do more exercise or more swimming. We're making this about the patient. We're making our therapeutic alliance about the patient, another buzzword "patient centered care." You tell me what you like to do and I'm gonna try and facilitate and help you with that as best I can. It doesn't get much more patient centered than that. And sometimes patients have a very low expectation because of what they've been told about their spine and their crumbling discs and all this sort of stuff. That they go, Oh, I guess just being able to walk the grandkids to school would be great. Good. That's good for a start, could we push that a little bit more? What about going out and doing a five-mile hike in Derbyshire? Oh, no, I can't do that with my meniscal tear and my degenerative disc. What if I told you, you probably could? Would that be life changing? Would that be something you'd want to drive or aim towards? And if they go, that would be the best thing in my life. Brilliant. And if they go, no, not really, I'm happy walking the grandkids to school. Also cool. Sometimes I can get really, it may come as a surprise, but sometimes I can get a little bit over enthusiastic. But this is where you can help them and go, I think we can get you to walk and they go, that would be amazing. If I could meet up with my old mates again and do five mile in Derbyshire on a Sunday afternoon, that would change my life. There we have our goal, right there. Have we now changed this patient's life? Are we about more than back pain now? Have we changed their mindset for social interactions, their activity levels, their overall wellbeing and health, reduced their chances of cardiovascular disease, probably reduced their chances of infection because of their increased immune system? Absolutely. We know this. The evidence is there. So just by setting that goal of getting him on board with, wow, that'd be amazing, we literally have changed their health and their life by just a couple of simple phrases. And again, another one of my favourite questions: If you woke up tomorrow morning and you had no pain, you're completely pain free, and you know that there's nothing you could do to damage your back, what would you do? And again, that's a really interesting thing for patients to start mulling over and again, it's this whole idea of getting insights into who they are and what their goals are. So, we're now on to plan. Because obviously, whenever you want to get a really important point across, you need a black and white picture of Yosemite National Park to put it on. So, you know, this is an important point. Manual therapy does not create dependence, manual therapists create dependence. And again, we talked about this earlier, it's all about that envelope. But let's get back to the plan.

Steven Bruce
For everyone watching the recording, we'll have that in the quiz afterwards, what do you need to reinforce a point most of all? A black and white photograph of Yosemite National Park.

Ulrik Sandstrom
So, in terms of the plan, I generally put it down to three phases, this is for chronic pain, this is not for Rob the builder, who tweaked his back two weeks ago and has no history of low back pain. But this is for most chronic pain. Sorry, this slide is so important, it just wants to keep cropping up. And I go through this, this is my report of findings, this is those 20 minutes. So, this is the plan of how's it gonna work? Phase one, we need to get you working again. I'm not going to give you any exercises yet. People go, what, but I need exercises? And some people go, thank god. I go, well, you can't walk around Tesco without exceeding your envelope of function, how on earth do you think that you can start doing

exercises? Your function, your tolerance in your spine and your ability to cope with load is so poor, that we need to get you working first. So, phase one, basically is this idea kind of, we talked about this last time, but the idea of tolerance. So, part of my report findings, this idea that tolerance is essentially how well you're working. So, if your joints are free and mobile, your muscles are relaxed and strong, and your nervous system is activating and supplying you appropriately, your tolerance is out here. You can do whatever you like. Once the joint gets stiffer, your muscle gets tighter, and your nervous system stops working properly, this is where your tolerance is. And this is why whenever you do anything too funky, you break down. Our job is to get you out here where you can do what you want to do. And, and a lot of people go, oh, that makes sense. So, to me, right, phase one, you're here, this is where you are today. You've got very little movement and tolerance to load. So, I'm going to do some stuff to you. So, phase one is generally me doing stuff to you. I might give them bits and pieces to do but generally, phase one is my job. When we get a lot of pain science in overlap, then obviously there'll be a lot of involvement in that too. But phase one, I'll be doing some manipulation to the joints to get them mobile, I'll be doing a lot of work on the muscles to get them relaxed, I may put some tape on it to help you stabilise, and I would expect within and, I normally go, the first couple or three sessions, don't put too much into how you feel. You may feel better, you may feel worse, you may feel the same. That's fairly normal. We're moving the goalposts, we're trying to get movement into areas that haven't moved for a while. Sometimes muscles don't like that so much. By four to six treatments, I would expect you to be significantly better than you are now. Almost regardless of what I treat, I tell patients this. Because I think most of us would agree, if by six visits with a patient we haven't made a significant change to some of their symptoms, we're barking up the wrong tree and then there's something else going on. And I tell patients this so they know there's a stopgap, they know that Ulrik's just gonna keep treating me, and again, a phrase that I hate when anyone uses, particularly my recent graduates who go "and we'll see how you go." No, we won't see how you go. We will make a plan and we will make sure that that happens. So generally, for most patients, phase one is somewhere between four to eight treatments. And then I normally say right, once you are happy that you're feeling better, once you come in here and go, Ulrik, I'm feeling better than I've felt for months. Great. Now we've got some functional capacity to start working with. This is when I start putting my feet up on the desk and go, right, I've done all the hard work, now it's your turn. And then we move into phase two, which is me doing less and less to you, and then focusing on you building up strength and building some exercise. And then we go, depending on your goal and of course, the reason why we do these exercises, this is where you earn the right to go running again, to go fencing, to walk the grandkids to school, to walk with your mates in Derbyshire. So, we're going to leave you longer and longer gaps in between. Phase three, and again, this depends on the patient and we talked about how Andreas Eklund has got some really good ideas of who we should be looking at in terms of maintenance. And the phrase I often use is right, we will be doing a lot of work over the next month or two of getting you working as best you can. We know that you have five-year history of chronic low back pain, we know that I can't fix that. All the research shows that I can't fix five-year chronic low back pain, no one can. Five-year chronic low back pain is a chronic condition that needs managing, I'm pretty sure we can manage that at a point where actually you're pain free most of the time, you may get the odd little relapse, but we can keep top side of it. Phase two basically gradually develops into phase three, which is the maintenance programme. And this is led by patient goals and targets. And what I always say is that my aim with my maintenance is to treat you as little as we can get away with. And I go, the good news, or the bad news, is that most of that depends on you. And so, the more good stuff you do and the less bad stuff you do with your back, the less frequently you need to see me for your maintenance care. So, if you keep doing your exercises, if you keep active and mobile, if you keep taking a little break on your long-distance journeys and make sure you don't sit for eight hours in front of a computer, I probably only need to see you every four to six months. If you don't do this and you don't do your exercises, I will probably need to see you more frequently in order to maintain that mobility that we've achieved. So, it's up to the patient, so the patient can't now come back and go, why do you want me to come back in two months? I thought we were going to move to three. Have you done your exercises? Have you? Oh, yeah, no. And of course, this is back to patient choice, and some patients will go Oh, great. No, I'm onboard. And some patients go. All right, I can't be arsed. Can I just see you every month instead of doing my exercises? I go, it's a

free country, you can do whatever you want, if that makes a meaningful difference to your life, absolutely. I'm here to do that. And at any point, you want to spread those out further, just ask me for that advice again, what I was telling you to do. But the great thing is, it's the therapeutic alliance, it's the agreement between the two of you of how are we going to work this? What do you want out of this? That's what leads it. So that pretty much is my plan.

Steven Bruce
Ulrik, I can't believe this. But we're very nearly out of time. And I wonder whether you, instead of doing that return to play, you talk us through your case history because people love to hear about how this has worked in practice.

Ulrik Sandstrom
Yeah. So, my case history, obviously I want to get a good idea. My opening question sort of varies a little bit between, what can I do for you? Or, tell me why you're here today. Or tell me your story. And I deliberately try and keep it very open. And we sometimes do get the, well I'm here for my back, aren't I? And that sometimes comes back at us. But just keeping that open question and allowing patients to talk, to me in terms of my case history is really important. And I will delve in and I will ask about the kids. Oh, how old are the kids, oh, are they at school or at university or what they're studying. Because it builds a rapport. It tells the patient, he's actually interested in not just my spine. And it's those little things, I often think that the first five minutes of a case history is actually just getting to know, it's almost like I'm at a dinner party and someone's sitting next to me and I want to find out who they are.

Steven Bruce
How did that all work with this young lady, Gemma, that you've got in your example?

Ulrik Sandstrom
Yes, we may need to leave that one because it's a bit of a long story. But no, Gemma was broken. I'll just very briefly pull it up here. Yeah, Gemma was broken, she was 25 years old. And she sat and cried in my office, because she'd been told that she, since the age of 15 that she had a bunion, and that she'd been taking co-codamol forever since. She'd been programmed to learn that she was broken. So basically, what we did was, I realised that there was a massive amount of pain science and perception going on in here. And basically, I examined her fairly briefly and enough to say you are not broken. I see nothing significantly wrong with your foot, your knee or your spine, you definitely haven't got an 11-centimeter leg length difference, to be honest, I struggle to see a leg length difference at all. And I said, unfortunately, your brain has lived for the past 10 years with a notion that you will never be better. I'm going to put things in place and give you a programme. Luckily, she was a very intelligent girl so I gave her some really interesting, good stuff to read on pain science. And then I said, we're going to put little things in place to show your brain that you're not broken. So, I want you to walk 200 yards and you go, Well, I can only want 100, that's fine. Walk 100. And the next time walk 110 and then next time walk 120. As long as the pain doesn't get to any more than 5 out of 10, work with it, we need to reintroduce the concept of pain is not damage. Pain is something that your brain can actually work with. I assure you, you're not breaking anything, you're not disturbing anything. You're basically just gradually getting your brain used to walking. And that was the programme, little baby steps to capture five key principles to the point where she basically said, I spoke to her dad and she's still out in Switzerland, she's going on 12- or 15-mile hikes in the mountains around Geneva.

Steven Bruce
Just before you go while you were off air, I read out the comment from Jennifer, who's a newly qualified osteopath who's found this very, very inspiring and reassuring. Barbara says, you're a great model for your method and she feels energised by your explanation. And several other people are thanking you for sharing some of your scripts, because that's very kind and we don't do enough sharing of scripts with each other, probably because we spend so much time very often working in isolation. As always, great, thank you. And you and I were saying how nice it would be if we could do this in the studio next time. Perhaps we won't have to worry about the zoom connections and also we can go for a beer afterwards.

Ulrik Sandstrom
Yeah, absolutely. Could I just I actually, I forgot to clear this, would it be useful if people get an email for me if theyhave any questions?

Steven Bruce
Yeah, I'm very happy to facilitate that. And, of course, if they want to know more about you, they just have to look for Sandstrom seminars online.

Ulrik Sandstrom
Yes, that's right. Yeah.

Steven Bruce
The trouble there is finding the symbol on their keyboard for an O with a line through it.

Ulrik Sandstrom
I should have said I have a really easy way to get onto my mailing list, but I haven't yet, I am planning to actually potentially do a full one-day full seminar, integrating a lot of what we spoke about today with the pain science and actually looking at actual scripts and formulas and what are the stats we need. It's one of the things that I've planned in my head for a long, long time.

Steven Bruce
If you send the details to me, I will send it out with an email which has the slides in it from this evening so that people have got that handy. And then they can make the decision whether or not to sign up or not. Obviously, I can't forward their details to you without their consent. It's been great talking to you again, it's been it's been great fun.

Ulrik Sandstrom
Thank you. Yeah, you too, Steven. I hope to see you soon in person