Shoulder Rehab (How to get it wrong) - RefTA189

with Tim Allardyce

16th September 2021

TRANSCRIPT

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Steven Bruce
Now as you know, my guests are normally either orthopaedic consultants or chiropractors or osteopaths or physiotherapists. We thought we'd try and do a bit of money saving this time and I've got Tim Allardyce to join us, and Tim is both an osteopath and a physiotherapist. Tim, great to have you with us for the third time I think, isn't it?

Tim Allardyce
Great to be here and thanks so much for having me on. I mean, it's always good fun and let's hope we can have some more fun today.

Steven Bruce
Well, I trailed this to my audience as me being quite cross because I was quite cross because one of my contacts made me aware of her pathway through the NHS with a shoulder problem, which we'll come back to in a minute. We were going to talk about knee rehabilitation because Tim is the man behind rehab my patient, he knows lots and lots and lots about how to rehab patients, how to communicate the necessary exercises and so on, we can then get good results. And I think last time we did the hips, so I thought we'd do the knee this time, but because this contact brought this case to me and was given some information by the NHS, I got quite aerated about the way she had been handled. So I thought I would share this with you, put it to Tim and see how it could have been done better. When you logged into the show, you should have been sent an automatic email which gives you access to six pages, with all JPEGs but six pages of exercises which this particular contact was sent. I suggest you don't try and print them because they were on greyish paper, very dilapidated grey looking paper. And of course, your printer will spend ages printing all the grey colours. But these have been taken from an online rehab resource, in this case, Physio Tech, which is an American organisation. There are two sections, there are 11 exercises, sorry, 16 exercises in total, one section with five exercises, one with 11. One of the exercises on this set is exactly the same as the exercise is on this set. And the purpose of the exercise is between the two sets, overlaps as well. And there are various other things which I'll come on to about this. Just to fill you in a little bit with the details of the lady concerned. She's a 34-year-old lady, she's had a long standing shoulder problem. She's not a patient of mine, so I've never examined or treated her or anything like that. So forgive me if I don't know all the details. But this all started in 2019 when she was prescribed Naproxen by the GP for a rotator cuff tendinitis. Fast forward to the end of the lockdown, COVID period and so on. And she waited a month for an online consultation with the GP, was referred to a first contact practitioner and I'm assuming that that's a physio therapist, but she doesn't know. And I think that's quite significant that she doesn't know what the practitioner was, who essentially said, yeah, okay, we'll wait, I think six weeks, three or four weeks for an appointment with a physical physiotherapist and a real face to face appointment. In the meantime, here are these sheets of exercises. So she's been given these 16 exercises of various natures, and Tim will take us through some of those. She hasn't been told how many to do, or how often to do them per day, just told to do them every day. She has also been told, when you go for your appointment, whether or not you've done the exercises, tell them that you have, otherwise you'll just be sent away to do them again. So, Tim have I some, you're laughing, and I just think it's oh, there's so many things in my mind that make this appalling. And perhaps if you haven't opened them on your own website, it might be worth pointing out that this set of exercises is dated February the seventh 2019, this set is dated August the 20th 2018. So to my mind, they're clearly just stuck in a tub somewhere being pulled out and handed over. Tim, what do you think?

Tim Allardyce
Yeah, I think it's really hard to judge, isn't it, exactly what's going on here but I think that there's some interesting points and it brings up around exercise prescription, around adherence to exercises and as well, looking at the model which we're using in the UK, in the NHS and in private practice to support our patients and looking a bit deeper at those models and how we're looking after our patients and what interventions either digitally or mechanically, what we're using to support patients.

Steven Bruce
I tell you what struck me straight away from this is, this lady came to me with these sheets of exercises, she was clearly utterly confused about how she was meant to use them. She had no idea who had prescribed them, and she has no medical training but it was clear to her that these are just been pulled out of a box and handed over and had no bearing on her condition, because she hasn't been seen by anybody yet. And perhaps I should describe the condition, it has all the hallmarks, from what I understand what we would have once called painful arc syndrome, or maybe we would now call subacromial pain syndrome. Yeah, you know, yes. So she's got pain in abduction, pain in flexion. All the other movements are fine.

Tim Allardyce
Yeah, look, I mean, there's lots of things we've got to think about, isn't it? I mean, the first thing we probably want to ask ourselves is, why is the patient confused with what they're meant to be doing? And if they're confused, are they actually going to be doing the exercises? And if they are going to be doing the exercise, are they going to be doing the exercises properly? Or are they going to do the exercises poorly.

Steven Bruce
Is it your experience that any patient will ever do 16 exercises on a daily basis?

Tim Allardyce
It's not my experience, and it doesn't, it's not reported in the literature that patients will have good adherence to doing 16 exercises in one programme. So we know from the evidence, as soon as you go beyond two exercises per programme, you start to reduce adherence and compliance.

Steven Bruce
I thought it would have been four but two, that's very low, yeah.

Tim Allardyce
As a general rule, we try and encourage our team. And we also do some first contact practitioner work. So I want to talk about that, because that's also a factor because this looks like a remote consultation. But look, I mean, we tend to encourage our guys to really to prescribe three or four exercises per go, per session. And then you can build on that you see, you can always review your patient. One week, two weeks, four weeks, six weeks later, and then you can edit an ad and make the exercises more challenging or change the direction or the goal or whatever of the exercises. So I always think, do you know what, if you start with 16 exercises, you might get that one in a 100 patient that is super motivated, and they just

want to do everything. But then I would ask, you know, are they going to be pushing it too hard, are they going to be doing too much, are there dual reasons for doing it, like you said at the beginning, are there too many confusing ideas behind what you're trying to rehabilitate them and why and the goals of rehabilitation. So I personally, I stick to three or four exercises per programme in most cases, there are times when you might want to go above that, you might be working with elite athletes who are full time athletes, and they want to spend a lot longer doing exercises. Yeah. But you have to qualify your patient. The majority, no numbers of exercises is definitely better for exercise adherence. It's an interesting one with all of these that when you work through them, as I said, there's considerable overlap. And you know, one of the exercises is repeated on both sets. But one is using a Thera band for most of the exercises and they are resisted internal rotation, external rotation, flexion, extension. The exercise is given with movements she has no problem with. Now I can understand the need perhaps for strengthening in order to stabilise the scapula or whatever else. But where would you have gone with this? Given that she's got two particular movements which are painful? Would you have gone for passive movement in those directions? Or would you have opted for resistive? Yeah, and this is the big debate at the moment, isn't it? I mean, should we be strengthening our patients earlier than we are currently doing? Now, first of all, I say it always depends on the patient. Because we're treating Mrs. Jones, we're treating Mrs. Smith, we're not necessarily treating a subacromial pain syndrome or a supraspinatus tendinopathy. So we need to work with our patient and we need to find out what our patient is capable of doing. Okay, and a one size fits all does not work with people. You know, we're not robots, we are individuals, we have our own base level of where our movement is or where our strength is. So we need to qualify and carefully assess our patients to work out what they can do at home safely. And I think it's really important that we first of all establish, what can they do? And let's then prescribe the exercise to support their functional gain from our assessment.

Steven Bruce
Yeah. Well then talking in your capacity as a first contact practitioner, what should she have expected from this online consultation, which is the preliminary to a face-to-face consultation in a month's time?

Tim Allardyce
Okay. So one of the challenges in the system in the NHS system is that there is a difficulty with seeing patients face to face. Now that has largely resolved, so we have gone back to seeing patients face-to-face but we are still doing consultations on the telephone, and I shadowed one of my first contact practitioners yesterday and spent the afternoon with him. And we had two telephone appointments, and the rest were face to face. So we saw probably 10 patients face to face and two were telephones. One of those was because the patient didn't turn up. So we converted it to a telephone call. Now the problem is with telephone calls, I think they're really really good when you can't leave the house. So there's a place for them. And they can be put to a video course you can sort of upgrade the telephone call to make it a video call. But that takes more hassle. And we typically see that most doctors and physios don't use the video calls they usually use just a bog-standard telephone. Okay, most and so...

Steven Bruce
I'd love to hear whoever it was assessing shoulder range of motion through just the telephone call.

Tim Allardyce
It's extremely difficult and you have to be smart. So you might ask questions like, is it painful to reach behind your back towards your bra strap? Or, are you having difficulty washing your hair? Or, are you having difficulty reaching up to a shelf that's above your head? Things like that. You can't accurately assess range of movement? Of course not, because you can't see a patient. So you're judging pain levels you're trying to get an idea of what your patient can and can't do.

Steven Bruce
So coming back to what your first contact practitioner of yours would do. She's got a month before she can get her face-to-face appointment. You said we should be monitoring these exercises. Would you expect her to get another, let's call it a video call. I don't know if it was video or not, I might find out later. But would you expect them to follow up each week and see how well she's doing with the exercises and maybe change them or just stick with this 16-exercise programme until she goes into the hospital?

Tim Allardyce
No, we wouldn't expect a weekly. So first contact practitioners are really designed as a one stop to stop shop. So they're not designed as being a rehabilitation physiotherapist. The first contact practitioner is is really to see that patients super quick. And given the right advice, the right exercises, the right support, or refer them to the right person that can see them. And that's a really good plan because it helps prevent chronicity and it means patients can be seen quickly and it's safe GP appointments. So the idea behind it is spot on, I believe, okay, but you see FCPs, first cotact practitioners can't easily see patients on a weekly basis, because there just isn't enough slots and a demand on the system does not allow it. Too many patients, not enough appointments. So we have to see patients every day. We might review them in four or five weeks, but it's like a stopgap, right. Let's get the exercises. Let's follow this advice, do good things with your shoulder, do the right things with your shoulder and we might refer you to physiotherapy at the same time. So while you wait for four or five or six weeks to get to the community physiotherapist,you can be getting on with the exercises.

Steven Bruce
Tell me are all first contact practitioners physios or are some of them osteos, chiropractors, or perhaps even nurses?

Tim Allardyce
So, technically a first contact practitioner could be a physiotherapist or a paramedic. However, typically I mean, so both titles come under first contact practitioner, but actually we tend to utilise first contact physiotherapists. There are a number of osteopaths nationally that do first contact role for NHS trusts. And there's been a big workforce shortage issue nationally with finding the required level of experience within the UK workforce to support the first contact practitioner rollout. And pretty much anyone that's delivered the FCP service will be familiar with that. And so there has been some trusts that have utilised osteopaths, there's a number that I'm aware of. And there are some PCMs utilising osteopaths as well. I've not heard of any chiropractors being used in a first contact role. And there are relatively few osteopaths compared to physiotherapists.

Steven Bruce
Of course. I've just learned that actually this was a voice call, not a video call where she had to consult with the first contract practitioner.

Tim Allardyce
Yeah, the problem with voice is there's a number of problems with voice. I mean, first of all, it's brilliant if you're stuck at home, you haven't got an easy way to leave, you're not well enough to leave the house, or maybe, you're post operative and you're stuck at home and you need that support and you haven't got the domiciliary care, okay. So it's great, but there are a lot of challenges with telephone calls. And one big challenge that we've seen here is exercise plans being prescribed, and the patient's confused. because no one's demonstrating the exercise, the instructions may not be clear, and the instructions passed on to the patient from the physiotherapist or FCP may not have been clear to that patient. So they're confused about what should be done.

Steven Bruce
To my mind, this is a very poor use of resources. And I'm not criticising Physio Tech here, not to detract from what Rehab My Patient does, of course, but you know, we've got black and white, let's do this first one here, which is a passive shoulder abduction exercise with a cord passed over a pulley, and it says here, place a long towel or rope around the shower rod or in a hook fixed to the ceiling. Well, I don't know many people who have hooks fixed to their ceiling, and most people don't want to pull their shower curtains down. And then there's an image of a person with one arm up like that, and then the other image is up like that. But it's not saying, well, how do you get your arm to that position, it says pull the arm up, but forwards, backwards, sideways? It's not being specific. There's no number of repetitions on here at all. And that was particularly confusing. And where this is all taking me, this is having a serious impact on patient confidence in their treatment. She doesn't know, whether she was told or not, and it just escaped her in the conversation, but she doesn't know the qualifications of the person she spoke to. She's got a grey printout with difficult information to follow. But Physio Tech have got lovely full colour videos on their site, much as you have with Rehab My Patient. And if she had been given a login, she could have seen a physical demonstration of this happening and I'm sure that would have helped with her compliance. But the biggest thing is, how many exercises should I be doing?

Tim Allardyce
Yes, so there's so many problems with this program, right? You know, so you say, too many exercises on one program, so the patient is overwhelmed with exercises. Number two, the image quality isn't great. So the pictures are really small. And you know, in this situation, at my page it can make pictures bigger for people who need bigger pictures or smaller for people that don't. But I think a bigger picture is always nicer. Because it's a bit more clear, there's no video link on the exercise sheet. So if there's a video link there, you could also click the video link. If there was a PDF, we have PDF or if you print it out, you can at least type in, you can type in the video link, if you've just got a sheet of exercises sent to you . So there's no video links, you can't actually easily see the exercise, and there's no sets and reps on there. So the patient has no idea, do I do this for five minutes? Or do I do this for 30 seconds. That's a major, major problem. And that's a clear breakdown in communication between the practitioner prescribing the exercises to the patient. And that patient is likely to A, have poor adherence to the exercises, B, get the exercises wrong and C, stop doing them. Or even worse, they could cause themselves more pain.

Steven Bruce
Yeah, I've just actually noticed that on this particular set of exercises, this is the set of 16 or the group of 16. Numbers two and three are effectively the same exercise to all intents and purposes and there's just no thought being put into this at all. There are two other exercises which are repeated between the two different programs here.

Tim Allardyce
Yeah. Now what I'm wondering as you see some organisations are printing generic booklets. Yeah. So they said, okay, all our shoulder pain patients will get this booklet. So there's no real specifity to adapt the program to the patient. And I think that's what maybe happened in this case, because the programs are dated 2018 and 2019. But she was only recently prescribed this. They've just given her a generic program. And it might be dated, which is why there's no video link. And I think this is why then you need to have an active subscription with this software because this stuff works together. You can't rely on simply having a sheet of YouTube videos or a sheet of exercises, or a booklet necessarily because there's not specific for that patient.

Steven Bruce
Well, I suppose I mean, we picked apart all the things that are wrong with this particular manner of prescribing a program of exercises for someone. Okay, and then we can move on to rehab itself.

Tim Allardyce
Yeah, I think so. A lot of it is also, we've got to really motivate our patients, haven't we as practitioners, because we know that a lot of patients won't go and do their exercises. I mean, we just know that and patients will come in and they will say yeah, I've been doing the exercises. I was in a GP surgery a couple of years ago in North Croydon and a patient came in and I'd seen him two or three weeks before and they came back and he said, I'm in pain and nothing's working and I'm not getting any better. I think it was a back problem they had and I said okay, run me through the exercise, it's always a little thing I do to see if they've been sort of really doing the exercise and I said, run me through the exercises and show me what you've been doing. So the guy, he stood up and he started doing this sort of thing with his leg. I mean, he literally had no idea what he was doing. And I had the exercise plan that I prescribed and it was completely different, there wasn't this hip extension thing that he was doing. And so I sort of had to really sit down with him and really spend more time going through it because sometimes patients just don't quite get what you're trying to tell them or don't follow the program or we've not communicated well enough what they need to do.

Steven Bruce
Yeah, and it is a big issue of communication because, I don't know what the evidence is but I'm pretty sure there is good evidence out there that if you don't communicate well you don't get patient confidence and if the patient's not confident in what you're doing, regardless of what you do, the outcomes are not going to be anywhere near as good. There was one other aspect of this which I did mention to you, part of the recommendation from her first contact practitioner was that five hours before her face to face consultation she should apply heat to the shoulder. Now I think she went over with a whole lot less

confidence after she spoke to me because I was in turn aghast and amused by what she told me but heat five hours before an appointment?

Tim Allardyce
So I guess the theory behind this particular advice is, maybe if we get some heat, it can help sort of warm the joint up a little bit which can make the joint a little bit more mobile.

Steven Bruce
If you accept that and I do accept that heat can be beneficial, you'd expect to say, well, apply heat every day.

Tim Allardyce
Yeah, I mean, I'm not sure why it was so specific, make sure you do it five hours before your appointment. I mean, there's not that much logic in that, I mean, if it was an intervention, you would you would prescribe it probably a little bit more regularly or encourage patients to do it as a process rather than just a one off heat treatment.

Steven Bruce
And if it's intended to make the appointment easier, to make the movements easier during the appointment, I would have thought five hours is way too long.

Tim Allardyce
I wasn't sure whether it was five hours of heat or whether it was do it five hours before you come?

Steven Bruce
No, no, it was heat at least five hours before you attend, put some heat on this.

Tim Allardyce
Yeah, I mean, you need to be super careful with that, because you can cause some skin damage by using heat for too long. I would be really, really, really cautious with that. And we've probably all seen patients come in that have had hot water bottles on for too long, even with covers on and they've become mottled over the skin. The skin comes in mottled and discoloured. And because they've been heating and heating, and we have to be super careful with skin damage in these situations. So I don't know the reasoning behind that. I don't know why they would do that. But I would usually prescribe a maximum of 10 minutes of heat if I was recommending heat. And I do recommend heat in some circumstances.

Steven Bruce
Yeah, well, I mean, on the subject of heat and/or cold as I understand it, there is a bit more evidence so on cold therapy, cryotherapy than there is on heat therapy, but it's still pretty thin. When you try to work out how much should be applied, when it should be applied. You know, all that sort of stuff. What do you know about the evidence behind heat therapy?

Tim Allardyce

So I'm not up to date exactly recently. However, when I studied my Master's in Sports Physiotherapy at Bath university, I did a project on this. So I really drilled down on it. So I did a big project on ice and heat for sports injuries, and whether you should ice and whether you should heat and how long should I ice and how long should I heat and what are the protocols and what are the ideas so I looked at all the evidence and really drilled through and I got a really good understanding of it. And the amazing thing was there was no, that I could find, there was no consistent evidence on things like, how long you should ice for, how long you should heat for, whether you should use ice and heat or ice and contrast bathe or just ice or just heat, and you know what, all the research contradicted. Every other research and in a lot of cases where there were research studies on using ice and heat for a particular problem, like back or for a knee problem, they didn't actually detail number of times you use the ice or the length of time you use the ice for. So I had to conclude there was no obvious research based explanation for how many times you should do one or other, or what you should use. And, so there may be something out there more recent, but I'm not aware of it. Of course, there will be stuff that supports ice, there will be stuff that supports heat, there will be. But there's no clear consistent agreement on what should be used.

Steven Bruce
I kind of guessed that's what you would say. And to some extent, again, there's a bit of headology goes on in this, isn't there, because if a patient says heat really helps, well, it probably helps to encourage them to apply heat, it makes them feel more confident about it. And I don't know. And there is some clinical evidence, isn't there, the big money spenders are never going to do research into heat and ice therapy because they want to sell drugs. They don't want to sell heat and ice which anyone can apply.

Tim Allardyce
I love prescribing ice and heat. I love it. I believe and yes, you can tell me it's not an anti inflammatory fight. Some people do say that, but I believe that it reduces inflammation. I love it because it's really natural. Yet there's no drugs. It's non invasive. It's not a it's not an injection. It's not a drug that goes in your system. It's free to use. And it's really easy to use if you've got the motivation to do it. And I think that's why so many physios and osteopaths and chiropractors love prescribing ice and heat, because you know what, we find it does work.

Steven Bruce
The feedback is that it helps.

Tim Allardyce
Yeah, it helps and you know what, patients seem to say positive things about it. And when you use it as part of our treatment program, when you use it as part of an exercise program, it's another intervention, it gives patients more control over their own recovery. So there's so many benefits I can see for the use of ice and heat. And it's FCPs and you know, I'm in it. I'm an independent prescriber, so I could prescribe Naproxen. Okay, do I want to prescribe Naproxen? Not really, because there's risks, what are the risks, lots of GI issues? Some patients don't tolerate Naproxen very well. What are our options? Well, I could go, Naproxen are stronger. As an independent prescriber, I never prescribe Naproxen. I just don't do it because of my routes to physical therapy and physiotherapy and osteopathy and my roots are, let's go as natural as possible. And let's use natural solutions, ice and heat where we can.

Steven Bruce
This came up a couple of days ago when we were talking about rheumatoid arthritis, because so often nonsteroidals are prescribed in conjunction with a proton pump inhibitor. And we've had so many people on the show saying, talking about the damage which PPIs can do, that I would be very loathed to go down that route. But I have got some questions in the audience who won't forgive me if I ignore their questions. This one came in a while ago from Chandra, who says, are isometric exercises better if pain occurs during active range of motion? And how often do you use them?

Tim Allardyce
There's a place for them. So yeah, they can be pretty good. So it's sort of applying an exercise against resistance. And I think they're good for strengthening but they're not the complete answer. They're one part of an exercise program that can be useful for rehabilitation. So I support their use, and they're really controlled. So they're really easy to use. So I think there's a place for them.

Steven Bruce
Yeah, okay. And Adam sent in an interesting observation here, because Adam says he thinks it's fairly simple. If a patient believes an exercise is going to benefit them, then they will do it. And he said he had himself an epiphany a few years ago, when he decided he would never prescribe an exercise that he wouldn't honestly do himself. And if he was in the patient's shoes, and since then he says he's had excellent compliance.

Tim Allardyce
Yeah, because it goes down to what is really helping our patients get better. And you and I, we get five practitioners, all prescribing the same exercise program for the same problem. But you know, if we're really passionate about the exercise, and we do the exercise ourselves, or we've used the exercise, and we can really encourage the patient to do it, then we've got the added placebo, haven't we? We've got a reinforce placebo, this exercise is going to help you. I mean, look, you've got two options. Steven, you could be my patient right now. I could prescribe you an exercise program for your shoulder pain. Okay, there you go, Steven. There's your exercise program, go and do it. There's clearly the sets and reps on there and come and let me know. Or I could go, hey, Steven, here's a great exercise program for you, we're going to work on your range of movement. This is what the exercise plan is going to do. This is how many times I want you to do, I think this is going to help reduce some inflammation in your shoulder, also we're going to strengthen your shoulder. So I put some strengthening exercises. So I'm reinforcing it. And now you're more likely to do it, and you're more likely to benefit from it. So we've given the same exercise program, but we've got two very different results, we've got a reinforced supported one. And we've got, go away, do your exercise program.

Steven Bruce
I have to say as well as that in terms of reinforcement, the passionate nature of the practitioner as it were. These sheets of photocopied black and white images don't inspire confidence. And it costs a few pence more. But actually, colour images convey a more convincing impression to the patient, I would say. Better still colour videos or online demonstrations, such as you've got with Rehab My Patient, which leads me nicely onto some questions about Rehab My Patient and other online systems. Because Vicki has said,

do we need written consent in order to put a patient's email address into Rehab My Patient, and that would apply to any other system, honestly.

Tim Allardyce
So I've, again, really drilled down on this. So we hired a GDPR lawyer to look at all of our GDPR processes. And I went into some detail with this. So it's a really interesting topic. And I won't bore you too much. But I will say that we have just been notified that GDPR is going to be redesigned post Brexit. So we're now obviously, we are out of the EU. GDPR is an EU thing and it is going to be redesigned because it is thought to be too much box ticking. So let's wait and see what happens with GDPR. Because I think they're going to make it more sensible, more logical. But look, the situation is, technically if you want to be belts and braces, then you need to ask permission to put your patient's email address into a software. Okay. Now, and that's, you don't need written consent for that in my opinion, but a lot of people do put it on a consent form. That is just my opinion. Why do I say that? Well, there's something called legitimate interest. And the legitimate interest is look, what are you using this email address for, you're not sending them marketing information, you're not spamming them, you're not sharing their email address with companies that are going to sell them products, you're simply putting an email address in to support their recovery. So it's a bit like the question about, do I need consent to put my patients' email address into a, when we do a COVID vaccine? Or, do I need consent from my patient if I phone an ambulance because my patient's fallen down? It's not, of course not, there's a grey area, which is legitimate in this.

Steven Bruce
There's also, I mean, you're singing off the same song sheet as me when you talk about this. This legitimate interest allows you to do that. The only thing people have got to be assured of in clinic is that the software platforms that they are using are themselves GDPR compliant, and you will make that clear on your platform, I'm sure. And other than that, it then comes down to what I would call the commonsense factor, is that no patient is going to complain unless you start trying to sell them double glazing. They're not going to complain, they've always got the option to unsubscribe and so it's something I just wouldn't worry about. And if they did complain, the legitimate interesting would cover you and nothing's going to happen the ICO will simply say, stop doing it, or okay, whatever.

Tim Allardyce
So we've prescribed over 2 million exercise plans and are not aware, not even once of a single patient complaininh to one of our practitioners that uses a site.

Steven Bruce
That's not 2 million exercises for one patient, is it?

Tim Allardyce
No, no fortunately not. But I've never heard of it been happen. I've never heard of it and you know what, because it's just one email that goes to that patient. They're not on our subscriber list, their details are never going to be used for any other reason. And patients kind of, they appreciate actually that you've taken the time to send them an exercise program, they know you're trying to help them and they expect an exercise program.

Steven Bruce
Here's one that is intriguing from a GDPR perspective as well as from a rehab perspective. Franker says he always videos his patients with their own mobile phone when he demonstrates any exercise, it only takes five minutes. So there's no GDPR in that, because he's videoing them with their phone so they've got something to look back on. I imagine you're going to say, that's a very useful thing to do to reinforce to them, how to do the exercises correctly, but the other thing is, if you're doing a video conversation, if you are videoing them in some way, we'd have to be careful how we stored that video.

Tim Allardyce
Yeah, I mean look. So he's saying, well, I take the patient's phone, and then I use their phone to video them doing the exercise, and it only takes me five minutes. Well, that's fine. In FCP world, we haven't got five minutes to prescribe an exercise plan, we're on 20-minute slots, and we've got to do an examination, a history, a management plan, and write the notes and everything else that's involved in that program. So we need something that does work quite quickly. So this might not be so, so useful. And the other main issue you've got with that is, there's no clear record of what you've prescribed. So unless you're going to write down the description of the exercise, the name of the exercise, how they did the exercise, the sets and reps, which is going to be very time consuming. Yeah, you've got no record of what you gave that patient. And that's a bad situation, because you need that record for your notes. Because if they come back next week, and say, that exercise really aggravated me, and you go, well, I mean, how many times did you do the exercise, tell me more about what was wrong. You know, you've got risk. I can go, there's the exercise, there's the instructions. This is how many times you're meant to do the exercise, if you'd follow that, there wouldn't be any problem. And there's no record if you've done it on their phone.

Steven Bruce
You've slightly touched on this with what you just said. But Georgina asked the question about how long an FCP appointment was, you said 20 minutes. And I imagine that's standard nationwide, is it?

Tim Allardyce
That's standard nationwide, there are some in small areas, a handful of places might be 15-minute appointments.

Steven Bruce
She says it doesn't look like best practice. But the question is, why, is it just time pressure that's leading us down this route? So tell us why we have FCPs?

Tim Allardyce
It's absolutely time pressure. I mean, look, what is best practice? Define best practice. Because you know what, when I did my rehabilitation training, we could spend two days doing an assessment. Okay, so if we had all the time in the world, and GPs, the same, if they had the time, they would much rather do a 20-minute slot rather than a 10 minute slot. And we as FCPs would rather do a 30-minute slot than a 20 minute slot. But you've got to weigh up the system, the pressures and demands on the system with delivering a service. I think they've got it about right with 20 minutes. I think that 30 minutes would be too long, and you wouldn't see enough patients. And 15 minutes is too short.

Steven Bruce
Yeah, okay. Ian's asked whether interferential treatment helps.

Tim Allardyce
It helps if you believe in it, it helps if you reinforce it. It's a good placebo. It helps if the patient wants it. And it helps if you combine it with other interventions, like exercises and/or manual therapy, and encouragement and motivation. I'm not sure there's much evidence to support it as a standalone intervention. But I think as a supported intervention, I think there can be benefit with it. And if the patient wants it, and they've had previous good results with it.

Steven Bruce
Well, I'll tell you what, I mean, I had Tim Watson on the show. I've had him on the show several times and I think in one of the first shows, he was considerably more concise than you about this because I asked him to tell us about interferential and he said yeah, it doesn't work. There is no evidence, there was then no evidence to show that inferential had any benefits whatsoever. However, as you rightly said, placebo can be very, very important in these things. And one of the great benefits in my view of interferential over say ultrasound is you can feel something, so you think something is happening and maybe that has an effect. But Ian, we have Tim Watson back on the show on the sixth of October, I think it's an evening show, we've got him in the studio so hopefully we're going to be doing some demonstrations of stuff. I have no idea which particular bit of electrotherapy we want to look at, but we can certainly ask him then what's the latest evidence for interferential because I think there has been a bit more over recent years. Let's just finally turn back to, I think we better stick to shoulder rehab and not knees because we only got a few minutes left. As a first contact practitioner you had the lady I talked about earlier on come in, she's got this sort of painful abduction and flexion. Which of the exercises would you have given her to see her through to her first face to face appointment?

Tim Allardyce
So first of all, I would have examined her, so I would have liked to have seen her movement and seen what she can and can't do. So in an ideal world I would have really, and I prefer face to face appointments so I would have had the patient in face to face and based on that examination, those findings I would have then prescribed the exercise program, but as a general rule of thumb, I love starting with gentle, simple passive exercises. Why do I start with gentle, simple, passive exercises? First, do no harm. The simple, the gentle ones tend to be the safest ones. Number two, the patient gets them. So I start patients off on something simple so they start to get the movement back or they might start to reduce some inflammation or they might start to build some strength or some stability in the shoulder joint, depending on where the patient is on their rehab journey. I start simple. So I might start with some gentle passive exercises and build up from there into some stabilisation and some strengthening and then into some functional exercises. I love that approach because patients seem to get, it seems to work for my patients. I don't necessarily jump in straight away with strengthening. I qualify the patient to see what they can and can't do. And in some cases, I do prescribe strengthening stuff earlier. But I always prescribe stability before I strengthen. And that's just a principle of rehabilitation that I follow. And I think it's a principle that's often missed.

Steven Bruce
But in terms of providing stability exercises, surely that does mean introducing some sort of resistance into various ranges of motion.

Tim Allardyce
Yeah, because when you're using range of movement, you typically will be using the muscular contractions, you're typically strengthening the muscle. And with stability, I think we're also looking at the smaller muscles that support the joint. So with stability, I kind of think of things like scapular stability or rotator cuff stability. So we might look into smaller muscles rather than strengthening which might focus a little bit more - you can of course, strengthen rotator cuff but you know, typically when we're strengthen, we might look at bigger movements, which will typically target the prime movers, say the pectoral, or the deltoid, or the trapezius. And so I don't ever forget the stability phase. Because the stability and the stabilisation around the joint, if the joint is unstable or hyper mobile is super important. And stability is different to strengthening. When we look at stability, we're looking at the stabilisation around the joint which could be small muscles and ligaments and other tissues. When we're looking at strengthening, we're typically more focusing on bigger muscle groups, prime movers. And that's how I think of rehabilitation.

Steven Bruce
And I'm guessing from what we discussed a few minutes back that if you're prescribing exercise, each patient will have their own login to Rehab My Patient. And when they log in, they will see the program that you have currently prescribed them. So it is all very clear what they have to do.

Tim Allardyce
Do you want to see it? Yes, let's share my screen. Let me just show you. Hopefully you can see the screen. So I've just got a test account here. And so we'd create our patient. So let's add our patient. Let's just add Mr. Test Simon, let's create an exercise plan. So let's look at shoulder. Let's just go to shoulder all. So let's say, first of all, we've got an inflamed shoulder, it's a very sore patient, doesn't really want to move it. They're not really ready for strengthening because they're a little bit too acute in the shoulder, they probably haven't got the confidence yet. We might prescribe some really gentle passive exercises. Now pendulum. Some people love it, some people hate it. When it's done well, I think it can work, but it's often not done well. A simple abduction like a rock the baby is great, you might just do a simple flexion exercise like a passive arm lift. And if you want to do some stabilisation exercises, that's fine. So do we want to do scapular stability? Or do we want to do rotator cuff stability, it really depends. We could do something like a wall press up, we can do something like a four-point kneeling hold, we could do something like a sitting stabilisation, where you just simply hold a position or you're going to a four point position and hold a position, that's also a strengthening exercise as well. So you can essentially you can maintain stability for a joint, okay. And let's also say, in this particular case, the patient had subacromial pain syndrome. So let's add our subacromial pain syndrome. Let's add our subacromial pain syndrome advice sheet and let's put in our shoulder rehab. We can track it if we want that's been in our sets and reps. I like that there's big pictures, clear description, video goes in there as well in a minute and fit in your sets and reps. And let's put that 10 times twice a day. And hold for 30 seconds and repeat three times twice a day and press save and then email them. And I've done that. I've assessed my patient, I prescribe the exercise program for them. And then I have emailed it and in a perfect world I will have

gone through the exercises with them. That depends on whether you've got the time or not. But ideally, you'd go through the exercises to make sure the patient knows what they're doing as well.

Steven Bruce
True. We're out of time. I'm assuming that when the patient logs in they see that exercise plan, they don't have to navigate through menus and things like that or get confused by different exercises. They just see what you told him to see.

Tim Allardyce
Yeah, exactly. I mean you can favour the exercises so that, yeah, we all love to prescribe what we love to prescribe, right. You know, we will have our favourites and there's nothing wrong with that because there's certain things like the comment from James, I think it was, that said, I do the exercises and I want to prescribe the exercises that I've done. And so you could favour the exercises and so you know where to navigate. So it makes it a lot quicker and a lot easier. And I just would add as well regarding shoulders, so we've just been very kindly allowed by Joe Gibson to film her whole, I know she has been on your show.

Steven Bruce
Yes, fantastic shoulder rehab expert. Yeah, really, really good.

Tim Allardyce
You know, what I love about Joe is that she can really walk the walk as well as talk the talk because you know, what I realised by spending quite a lot of time looking in detail and really drilling down on her exercises over a long period of time. And I've probably filmed now about 250 of her exercises is that she backs up what she says because she's pretty much EMG muscle tested. She's muscle tested everything on EMG and so she's seen the activation of the muscle during each particular exercise. So I think she really knows what she's talking about. So she really is super, they'll be coming on once we finish processing them.