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Treatment, Research, Context and Innate Healing - Ref 99DN

with Dr. Dave Newell

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TRANSCRIPT

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Steven Bruce
Today we're going to be looking at evidence. We're going to be looking at the placebo, we're going to be looking at the nocebo, we're going to be going to be looking at the specific and the nonspecific effects of treatment. And to that end, I am joined by Dr. Dave Newell from the Anglo European College of Chiropractic, I'll get my words right one of these days, where he is the head of research, director of research. Dave, great to have you with us again, second time for you, isn't it?

Dr Dave Newell
It is yes. Thank you so much for inviting me on, Steve. Just one slight correction there. Actually, I'm head of research, we're now the AECC University College and the chiropractic school is one of our schools we have. We have three schools, one in radiology and also in sports and psychology and physical exercise. So slightly different to the old AECC College, we've moved on to become a fully-fledged university.

Steven Bruce
Yep. But you're still director of research?

Dr Dave Newell
I am. Much to my surprise. After all these years, clearly must be doing something right but yes.

Steven Bruce
Last time we had you on the show we were able to do in the studio instead of Zoom and we were talking about patient reported outcome measures, if I remember correctly. This broadcast, this discussion has been prompted by a paper that you've written about contextually aided recovery. And that was published in which journals?

Dr Dave Newell
I was published in Chiropractic and Manual Therapy, I think back in 2017 now. So obviously this is the end point, if you like, of an awful lot of research done outside of the chiropractic field on placebo, and it was something that I was noticing was increasingly important to articulating - excuse the pun - around some of what the manual therapeutic professions were doing. And had the luck to sort of be relatively new, in the chiropractic literature anyway, to sort of highlight this as an issue in the field, but it obviously has a far greater reach if you like, across not only manual health care and therapeutic options that go with treating MSK, but also generally in healthcare these phenomena are very important. And increasingly we have the research behind it to explain why.

Steven Bruce
And that's really useful and important to all of us, osteopaths, chiropractors, and others, isn't it? Because we do worry that the conventional world doesn't accept that what we do has the effect that we say that it does. But I was going to say that there's probably an assumption on the part of a lot of the people that the placebo effect happens whether you like it or not and there's no way that we can affect it in any way ourselves. Is that true?

Dr Dave Newell
So much to uncover here. I mean, one of the things we might want to do first is just look at the word placebo. So, placebo is a word that has been associated, in a rather negative way for hundreds of years actually, with particular phenomena that people have noticed for hundreds of years and that is that people will often get better and improve from the particular conditions that they suffer from, with all sorts of different weird and wonderful treatments. I suppose things like the sort of snake oil salesman, some of the historical ideas that are associated with what might be called medical charlatans. Placebo itself is a word that means to please and so, really the word itself and the concept has become caught up with this very negative historical viewpoint, which portrays the placebo, any attempt to modulate the placebo, or the effects that might be labelled as placebo, to be somehow non-legitimate in some sort of way, made up purely in the mind of the person, just really pleasing the patient so that the patient then says that they got better because they just want to please you. And so, placebo itself, the idea of placebo comes with a lot of historical ladenness, you know, it's laden with these negative historical viewpoints. And in fact, one of the things that exemplifies this is that it was often associated, the word was often associated with practice back in mediaeval times, where you would pay for mourners to come and cry for you. Which I guess, if you didn't have too many friends, I guess that was a reasonable thing to do. But it got associated with this falseness, this charlatanesqueness. And actually, we now know that it's that it's not really true at all and that the effects that are sort of generated by placebo or the effects that are generated by the placebo mechanisms if you like, are bonafide neurological mechanisms that modify, particularly things like pain, but modify things from performance to the immune system to a bunch of different things. And so, yes, coming back to your question, the placebo effect or the action of placebo, doesn't need people to work hard to do it. So, there are some unconscious and some conscious elements to generating effects that can be elicited by what we might call placebo.

Steven Bruce
I suppose one of the inferences is, in the minds of the people I was describing earlier, that you don't need to do seven or eight years of training to become a doctor or five years to become a chiropractor or an osteopath in order to exploit the placebo effect. So, I guess we've got to be able to show that we offer more than simply the placebo effect and our ability to influence that effect as well, haven't we?

Dr Dave Newell
Well, I would just disagree with that, actually. I can see why that's a conclusion that people might make. And I think the reason they make that conclusion is because of this historical ladenness that we see, that it's just placebo. And it's like, well, it's just placebo, it doesn't really mean anything at all. It's not skillful, whatever. But well, actually, we know that the therapeutic encounter is a very complex thing and it brings with it many elements that need considerable skill to get right. And so, actually, what we might call these effects, which are therapeutic effects which are elicited by getting right, if you like, multiple elements of the therapeutic encounter, many of those actually take a lot of skill. So, for example, therapeutic touch, manipulation with confidence, without hurting people. If you move back from that into the psychosocial realm, things like understanding the patient's story, understanding where there might be psychological barriers, understanding

the psychology that might go behind expectation, understanding language, being empathic. All of these things are, to do well, are actually very highly skillful things to do. And in fact, we might talk about this later on, but the odd thing around this is that a lot of good clinicians will do those implicitly. Because they've learned that they are good things to do and they've sort of taught themselves perhaps, to listen very well, or better than they would have done before, and perhaps natural things like being empathic. But we now know that those things could be and sometimes can be done better if you can do them more skillfully. And we may not perhaps do as much of that or have as much emphasis on that in our education as we might have done. So, I would say that no, I think if you're going to elicit recovery, that includes these therapeutic elements, which might be called contextual and you're going to do that regularly and well, you actually need to be very skillful at this stuff, it's not an easy thing to do and it doesn't just happen just naturally.

Steven Bruce
Is it now being incorporated into mainstream training at the AECC? Can I use AECC as a short-term shorthand for university college?

Dr Dave Newell
Yeah, AECCUC is our acronym. So that's an interesting question. I think I had a lovely opportunity to talk to Oliver Thompson on his podcast Words Matter, which I would recommend people to listen to, who's an osteopath at UCO. And we did have a chat around that, about what the manual therapeutic educational curricula do and where they are at this particular moment in time. And I would say that probably, and this is why this area is so fascinating because every time you talk about it unpacks more and more of a Pandora's box around all sorts of issues. But in terms of where the manual therapeutic professions come from physiotherapy to some extent, but certainly osteopathy and chiropractic which are, at very least historically, wedded to the idea of this manual input, then perhaps we don't do as much around this area as we might do. And I think historically, both professions have been dominated with the idea that it's a very, very mechanical type of thing that both professions deliver. And we can talk about whether those mechanisms, those historical mechanisms, have any evidence around them. So, I think that the curriculum really has sort of emerged from that historical viewpoint. And I think it probably still needs a certain amount of catching up. So, I think all curricula need to be reviewed and modernised. And I think that is probably the case for, as it should be for our curriculum in the AECCUC, which is constantly being looked at in terms of modernisation. And I suspect that's probably true of manual therapeutic curricula across the piece, particularly in osteopathy as well. But I think it's a very interesting issue about where we are at the moment with the curriculum and where our focus is and actually where the evidence might be going.

Steven Bruce
Yeah, we've actually had a question from Aiden. Aiden says, do you think that placebo is more powerful in manual therapy as opposed to allopathic? And if so, do you think this might have anything to do with our evolutionary origins as mutual grooming primates?

Dr Dave Newell
Ah, I think I hear elements of my own paper which Aiden may have read and that's very kind of him if he has. I think the manual therapeutic approaches to care certainly do have these elements of touch in them. And I think that therapeutic touch and the evolution of therapeutic touch that may have been attached to grooming, so I'll go through that in a moment, but these are powerful primate signals. And my thesis, and it's not only mine but I think it's emerging from the literature, is that safety has big effects on our perception of pain in particular. There are lots of other things physiological mechanisms that can be affected by context and these top-down mechanisms, but I think pain in particular and I think the elements of safety or threat can perhaps be used as a sort of very high-level theory, if you like, around what might be important to modulating pain. And under situations where you're threatened it makes sense to be highly vigilant, both internally of your own internal signals and external signals. And that under situations of safety, that you might turn down that vigilance. And I posit in the paper that one of the very strong levels of safety that a primate may get is to be within the group, safe within the group not on their own in the jungle, and perhaps being groomed by the top guy. And so, I did, perhaps mischievously suggest that grooming might be prototypical medicine and the top guy might be the prototypical medic, the top groomer, as it were, the silverback of our social melieu. In clinician terms might be this top groomer. So, I think that probably touch is very important and I think that maybe in the manual therapy professions, given the fact that there's a lot of therapeutic touch going on, they might very much signal strong safety signals. And so yeah, I think therapeutic touch is very important. I mean, we know this not just in the manual therapy professions, but a hand on the shoulder. If you go to see your doctor often if you're upset, that signalling of empathy is probably very important. And so, it may not be just manual therapy professions but chiropractic and osteopathy and physiotherapy do have the luxury of being able to touch patients and perhaps deliver that very powerful contextual signal.

Steven Bruce
So, is contextually aided recovery all about placebo and manipulating the placebo effect?

Dr Dave Newell
Well, so one of the things I think is important is to try to rehabilitate these powerful therapeutic effects outside of the historical language of placebo. Now, the problem is that placebo has been, as we said before, been associated with a whole bunch of cultural expectations if you like and cultural labelling that has left it with a very negative context, again, excuse the pun. And so, if you are in a situation where something very useful and very real is happening, but unfortunately, the label for that is a label that suggests that it's culturally unacceptable, then it becomes very difficult for people to accept that it's something that they should do well and that is bona fide and legitimate terms of health care with that label. So, you're sort of fighting uphill against that label. So, language is a problem here. So, one of the attempts of doing that is, and there's been multiple attempts from various individuals who have published in the literature, is to try to think about words that are different words that still describe the same phenomena. And so, Dan Moerman, who is one of the guys I read very early on his, in his book called 'The Meaning Effect', tried to do this by positing this idea of the meaning effect. So, a different set of words. But what has emerged is the context. So contextual factors, which are these therapeutic elements that are really important in generating good

outcomes. And so, the context and the contextual factors and the manipulation of these to get contextual effects is a sort of new language that is emerging over and above placebo. And so, the reason that I somewhat again mischievously brought to bear contextually aided recovery is because the acronym spelled "CARE" and for me a lot of the contextual elements are really about powerful care. They're about good care and good carers. Because we know that empathy, listening and compassion and all of those sorts of things are elements that literally modify people's pain that they feel. And so, so yeah, I was quite chuffed with coming up with CARE. But yeah, that's where it sorts of came from.

Steven Bruce
Yeah, I often wonder how long people spend thinking of the acronyms before they actually...

Dr Dave Newell
Way too long, I think!

Steven Bruce
But in that sense, though, you can talk about empathy and you can talk about language and so on, are there less obvious aspects to context that we're also able to manipulate? I mean, does the colour of my wall in my treatment room does that have an effect?

Dr Dave Newell
Well, we don't know about colours yet. But a colleague of mine Christi Bishop and a bunch of other authors, tried to get a handle on the sorts of areas that were important. And some of them are self-evident, I guess. Patient practitioner interaction is very powerful. We know that through things like therapeutic alliance and so on. And there's a whole bunch of research around therapeutic alliance that we can sort of unpack to some extent. There are things such as the patient beliefs and what the patient comes with, we know that has an effect, that's an area. There are the practitioner beliefs, for example, an interesting study was done, where practitioners were asked to give patients a treatment that they didn't really feel comfortable with, compared to a treatment they did feel comfortable with it, despite the fact that their patients didn't know that they were doing that. Patients got better in the treatment that the practitioners felt comfortable with and not so much in the ones they didn't feel comfortable with. So, what practitioners bring to the therapeutic encounter, even unconsciously, can have effect. So that's the third area. So, we've got practitioner's beliefs, patient's beliefs and the patient practitioner interaction. We've also got environment is also important as well. So, the setting within which the therapy is given, we can talk about that as well, a little bit. And we also have the characteristics of the treatment. So, some treatments might be more contextually powerful than other ones. So, for example, the manipulation itself and the sort of therapeutic ritual that goes behind that might be more powerful than simply massage, for example, and then needles might be more powerful than manipulation and so on. So those five things, so the setting, the characteristics of the treatment, the patient practitioner interaction, patient beliefs and practitioner beliefs. Those five areas seem to be the ones that are important.

Steven Bruce
Couple more questions from the audience for you. We've got someone on the Vimeo team who's called 005.6, I think he's part of the MI6 team. He's asked, do you agree with Paul Dieppe's work, he's the author of a rheumatology reference work, his hypothesis about the importance of ritual in the therapeutic encounter for maximising the placebo effect and the overlap of that with shamanistic ritual?

Dr Dave Newell
Yeah, well, I know Paul, I had the privilege of going down to see him in Exeter. He's a professor down there in the medical school and we went out for lunch and had a chat around this when I was actually constructing this paper. And I know he's published quite a bit and some of his students as well, one of his PhD students, can't remember the name off the top of my head and I apologise, has been very influential in publishing some stuff around nocebo, which is a powerful way of making people feel worse. Yes, Paul is a really interesting character, he's a medic, but also apart from that a very interesting and interested academic in all sorts of things, got involved with the theatre. So he got some collaboration with the thespianic elements within the university, in the arts, and in acting, and I think that's where he probably stumbled across this thing about therapy ritual, which is a sort of performance. And I would say that's really important. I think, for example, if I took the manipulation for the osteopathic and the chiropractic professions, I've often said in some of the talks that I've given that if the founders of these two professions had, in fact, stumbled across what they thought was a sort of paradigm which was big toe pulling, then pulling the big toe, even though that might have been something that they felt then they would build a profession on, as a therapeutic ritual wouldn't really be very congruent with people coming in with low back pain, because it just doesn't really make sense to a patient that a big toe being pulled should necessarily stop from being antalgic and in huge amounts of pain and not being able to sit properly. Whereas putting a bone back in place, even though that is almost certainly not the mechanism by which these therapeutic encounters work, does make sense, and the ritual around this, even the language that we have within our society such as "I put my back out", "slipped disc", all of those sorts of languages imply this mechanical idea that you could just put it back. And so, the idea of a sort of clunk, that comes with a manipulation is a powerful story, if you like, that makes sense to the patient. So, in terms of that therapeutic ritual, I think that particular performance is likely be more powerful than a bunch of other performances that that could take place. So yes, I do think that ritual is very important.

Steven Bruce
Christina has come back on the colour therapy business and Christina says that yes, it's been shown in prisons in America, that if you paint the walls pink, you get less trouble from the inmates. Not sure she's advocating painting all our clinic walls pink, but she says colour has an effect.

Dr Dave Newell
Before you go on, on that point, a more important point around the environment is, we know, for example that people who are put in hospital wards to recover from operations, there's some studies, some old studies that have been done around this have shown that people who have a window to look out recover better and more often than people that don't. So, I think it is likely that ambient sounds may have an effect, although

we don't quite know. We certainly know that, there was a wonderful podcast somebody put me on to just recently which was about smell and the neurological mechanisms around smell and we know that for example, what you smell is entirely very strongly based on the context. So, the meaning of the situation that you're in. So, if you're given the same molecule, for example, that is precisely the same molecule that is found both in parmesan cheese and also in vomit. And you label the two vials, which has just got this chemical in, there's no vomit or parmesan cheese, it's just the chemical, label it "vomit" and "parmesan cheese" then people will smell precisely those two things. One will elicit desire to have a pizza and the other one will elicit disgust and so the context around what you smell is very important in the meaning of what you actually see. So I think even things like smell might be important. One particular study, just because it's really interesting, somebody I know called Louise Sandal over in Denmark and she did amazing RCT around looking at exercise for I think it was knee pain. And they divided it into two groups, randomised controlled trial, one that was in a lovely gym with a view over a sort of Olympic style running track with lots of young and very fit people out there and they had this group of older people that were doing the exercises in this environment. And in the other group, they had them do do these exercises in a sort of dungeon down at the bottom of the university, where you had to go down some concrete stairs and follow some ducting to this windowless room that had some bars on it, and they do their exercises down there. Counterintuitively the results came out that the dungeon was much better for patients than doing it in the gym. And when they did the qualitative analysis, so they asked the patients what was going on, the patients felt the sort of dungeon, if you like, they were closer together, so they chatted more, some of them said that it reminded them of their school where they had the gym bars on the wall where they always felt that they went there for a purpose, they were going there to do some work, some exercise. And so, it was this older group and their age that seemed to recognise a particular environment that sent signals to them about some of the positive things around that, that actually helped them get better more than the ones perhaps in the gym, the modern gym, where they felt a little out of place. So, environment probably does have an effect but it's a fascinating area.

Steven Bruce
I was smiling while you were saying that because there's been an anonymous comment sent in asking if there's any connection between my pink shirts and the behaviour or outcomes or trouble with inmates. I assumed that they were going to ask about the trouble I'm having at the moment with the General Osteopathic Council but that's a different matter. Liz - Hello, Liz - Liz says does the five principles apply to both acute and chronic pain outcomes?

Dr Dave Newell
So, it is really important to say that there's still a lot of clinically based research that needs to be done. In fact, one of the areas around placebo research, which I don't like calling placebo, but contextual factor research, is a call for more of this sort of clinical stuff to be going on. What's the actual effect of these things in clinical encounters and it's a rather difficult thing to do experimentally, but there's more that needs to be done? Acute and chronic is important, I think, obviously, because we will know that chronic pain is considerably more resistant to change than acute pain, although I'm sure that you've all experienced patients where that has not been the case and some miracles that happened. I'm sure there's chronic pain patients

who have had the pain for many years and do get better rapidly. One of the things to think about is that contextual effects are not the only reasons, and why it's an important question, contextual effects are not the only reason why people may improve. We know for example, that natural history, particularly with things like low back pain, natural history accounts for a considerable amount of improvement over time. And there's other things such as concurrent other treatments, for example, patients may be taking pills or going somewhere else as well and you may inadvertently assume it's you. And there's something also called regression to the mean, which is a weird statistical phenomenon which means that if you have a high score, you tend to have a lower score next time you ask the patient. So, all of these things can impact outcomes. But in terms of natural history, clearly acute patients are likely to be affected by that particular variable than chronic patients. And so, if you're going to look at the contextual elements, the specific elements, I don't like calling it that, but the specific elements, the nonspecific elements, which is the contextual stuff, plus natural history, then you might expect natural history to have more of an impact in acute patients than you might in chronic patients. So those changes certainly would be different across those two things. But we don't know and so at the moment in terms of context, whether the contextual elements and how powerful they are with both acute and chronic patients, that research is really only just emerging or has not been done. But I agree it's an important differentiation and clearly, of course, chronic patients are more important in many ways to the economic and health load in society, because they're the ones that cost the most and they're the ones that are suffering the most and the ones that can't go to work the most and so on. So, chronic patients in particular are an important cohort to really be focusing on but yeah, yet to be known, but an important question.

Steven Bruce
Okay. Clive has asked, where do you see the balance between contextual effects being internally generated by the patient, as opposed to externally imposed by the therapist, and where do we have the greatest potential to manipulate the "sensitive dependence on initial conditions" which he's put in inverted commas, so I guess that's an expression which will resonate with you?

Dr Dave Newell
Yes. He might be alluding to complexity theory which is a whole other webinar. But, sorry, first part of the question again?

Steven Bruce
Where do you see the balance between contextual effects being internal from the patient's point of view and imposed by the therapist?

Dr Dave Newell
So, all of the effects that you're likely to see are all internally generated, because only the patient can report to you less pain. Maybe he's getting at this idea that is there an effect that is somehow independent of the consciousness of the patient, as we might call it the specific effect, that historically has been called specific, and that there are nonspecific effects which are sort of done by the patient. If you're alluding to those two things, then that is a very important question, a very controversial question, I would say. Because what

you're saying is, and I think perhaps it comes down to some misunderstanding again, of what is causing the outcomes that we're interested in, I think you might say that if a patient reports less pain, then what has done that? There are a whole bunch of things that could do that. As we said before, there are lots of elements including things like natural history, but the difference between external internal is interesting. Let's go off on one- so it's about specificity and non-specificity, or specific effects and nonspecific effects, I know this is a very interesting and controversial issue because if you look at sort of pharmaceutical medicine, the specific effect of a drug is something that should happen regardless of whether the patient thinks they should be getting better or not. And it's often underpinned with an idea that the reason it's specific is because it biologically binds to some physiological receptor. And therefore, it's properly biological. It's sort of properly therapeutic. It's almost mechanistic in a way. And therefore, almost regardless of what you did, the patient can't affect for example, glomerular filtration rates just by trying to make their kidneys filter more. It doesn't matter of how much you sit there and try to think your way into increasing the efficacy of your kidneys, it's unlikely that you're going to be able to do that. However, if you give somebody frusemide, then it will change the glomerular filtration rate and you will have more or less urine production. And so, so clearly there are some areas where there are types of physiology that are a long way from the patient's conscious impact, if you like. However, there are types of physiology that are nearer and nearer to what the patient thinks. So things like pain, for example, are probably phenomena that are quite close to the ability of the patient to consciously or psychologically, you can alter what you're feeling in terms of pain by what you're thinking, much more than you can alter your kidney filtration rate by what you're thinking. So, there are going to be some things that are closer. So, when you are being specific, and the problem is that medicine and lots of historical thoughts about what is legitimate treatment and illegitimate treatment have been based on the idea that somehow, if it's specific, it's legitimate, and if it's nonspecific, it's illegitimate. So, the question around what proportion of a treatment is either specific or nonspecific, has the historical problem of saying, well, what you're saying is how much of this treatment is illegitimate and legitimate. And therefore, that becomes a real problem. Because if a treatment or a therapeutic encounter entirely eliminated somebody's pain, but you have done that through contextual effects, which are basically top-down mechanisms from how the patient is thinking about the encounter. If you've done that entirely through that particular mechanism, then you are 100%, contextual. And in the old ladeness if you like around how we consider these things, you are 100% illegitimate, which goes all the way back to, well, it's just placebo. Whereas if you give somebody a drug, and they start peeing more, then somehow that specific effect of frusemide binding to receptors in the kidney is somehow legitimate treatment and some proportion outside of that is this illegitimate thing, If you're thinking about it like that, then it becomes a very pejorative discussion around how much proportion of that is in any particular therapeutic encounter. I don't believe that being specific or nonspecific is particularly important or really a very helpful dichotomy. And there are some reasons behind that. And I apologise if it goes on, but it's a very deep question. The one you might say, if a patient gets better because of this complex therapeutic encounter, including all of those elements which are around belief and around empathy and around safety and so on and so forth, all those cues that you're giving as a clinician, you're doing that really well, if they get better, then one might say they got better and that is legitimate by definition. The other thing is, the problem around that is that you could then say, well, you might elicit that improvement by lying to people. That is a whole Pandora's box around the ethics of the use of context and whatever which is an interesting

one and we could cover in another webinar, but we could touch on at some point. But to go back to the other about legitimate and illegitimate or specific and nonspecific, is that if you look at pain modulation, we know that part of the neurology around pain modulation is a descending pathway that is modified by the patient's perception of what is going on. So the prefrontal lobes, which is where you make models of the world, complex models of the world and cultural interaction, social interaction and so on, what things mean, we know that that part of the brain is connected to descending pathways that impact on nuclei above the spine, that have cells in them that can turn down pain or turn up pain. So how you're thinking about what the therapeutic encounter means can literally turn your pain down and up through a bonafide neurological mechanism. That neurological mechanism uses, amongst other neurotransmitters, opioids and those opioids bind to receptors in a very specific way. And yet, you're eliciting the release of those opioids, which bind to those receptors, by the contextual stuff, which is altering the way that somebody thinks. Now, that is essentially the contextual stuff in the placebo, which, if you're looking at the original arguments about legitimacy, might be considered illegitimate. And yet, if you give somebody an opioid, which turns down their pain, it binds to precisely the same pathway. And yet that is medically legitimate because it's a drug. So this idea about specificity or non-specificity, and it's link to legitimacy and non-legitimacy, is actually a really interesting question. And I would say actually gets in the way of us thinking about, well, what do we need to do to help people get better?

Steven Bruce
Dave, I feel really, we were just getting going in this discussion right now and we've come to two o'clock already. But if I can take just a couple of seconds, a couple of minutes to just run through a few things that have come in, one of our viewers has asked what you meant by natural history. Now I think it's a slightly confusing expression, but I'm assuming what you mean by that is the natural course of events which cause a problem to get better?

Dr Dave Newell
People get better anyway.

Steven Bruce
Yeah. Salame Olivia - hello to Salame - She asks, does the white coat help with the effects of a treatment? Or does it affect rather than help?

Dr Dave Newell
I do believe that there is some preliminary research, older research, that suggests that the white coat may have impact but that's a study yet to be done well, and it's a really interesting one, but I suspect that it will have some effect.

Steven Bruce
Could you give us a quick recap, what are the five principles that you talked about?

Dr Dave Newell
Yeah, so the areas where you might be thinking about concentrating, or thinking about noticing in a therapeutic encounter, and trying to mitigate or do well, would be: the patient practitioner communication, interaction, so including therapeutic alliance and empathy; picking up on patient beliefs, bad beliefs will get in the way of them getting better, such as I can't move or it's never going to go away, and good beliefs, such as self-efficacy, I can deal with this, are the sorts of things you could be concentrating on because they will help; your own beliefs about the treatment, whether you are thinking that this is something that you shouldn't be doing or you don't feel comfortable with it, that's an important area and perhaps something that you could think about and perhaps widen your viewpoint of what you're doing; the environment, which we don't know much about, but probably does, and I think a lot of clinicians already are onto this and probably try to modulate their therapeutic environment in such a way as to make it comfortable and safe and so on; and also the treatment characteristics itself, such as touch perhaps being more powerful than non-touch.

Steven Bruce
Dave, that's been brilliant. Thank you. I apologise to those people whose questions I haven't had time to ask. Robin Moody says we need more lunch. I think he says we need more than a lunchtime to cover this particular problem. But maybe I was distracted because I know Robin. It would be great to talk more about this and some of the other things that you've mentioned in that. Can I just ask one final and hopefully quick question, you've talked about a lot of characteristics of treatment, a lot of the context of treatment, is it sufficient for us to know these things are important, just from this discussion, or is there somewhere people can go to be specifically trained on how to enhance those aspects of training?

Dr Dave Newell
Well, yes, it is very important to be aware, I think that's the first step. I think it's important to realise that what you bring to bear as a clinician is much more than what you think you're doing. And therefore, as soon as a patient walks in through the room, then things like active listening, you're listening to the whole story, not interrupting, and being able to recognise key elements of the story that appear to be quite important to the patient, just as one of the areas that we've talked about, is very important for you to realise. So, remember that you are much more powerful than you think you are and you're much more powerful outside the elements that you think you're delivering, you're actually delivering a lot more. In terms of where you might go, there's a bunch of training around pain science, I think the pain science area is a very interesting area. And there's things like the cognitive functional therapy, there's a bunch of stuff that's coming out of Australia with O'Sullivan. I don't know whether there's training there but there might be. There are areas if you look, off the top of my head I can't give you the websites but there are. The Royal College of Chiropractors, I think, in their pain faculty have put on some seminars around this and of course, some Oliver Thompson, who is one of your guys, has got a brilliant podcast, Words Matter, which is predominantly talking around these areas, stuff outside of the manual therapeutic elements. Soplenty of CPD around there, I suspect as well.

Steven Bruce
Dave that's been really informative. Great pleasure talking to you again, thank you for coming on the show. But that's all we got time for today, I'm afraid.

Dr Dave Newell
Thank you so much. I really appreciate you inviting me on. I'm happy to come on again at any other point.

Steven Bruce
Thank you.