Your Mindset When Treating – Ref 272

with Chris Chippendale

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TRANSCRIPT

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Steven Bruce
Hello again. Great to have you with us as always, only five more shows till Christmas, blimey. So that's a total of six hours learning with others for you to get under your belt before the break for Christmas. Today is the first of those shows and we're going to be looking at communication issues and mindset issues with chiropractor Chris Chippendale who's joining me by video link from his clinic in Sevenoaks. We can't do video questions today. But keep your comments and your queries coming in through the chat lines on Facebook and through our website. That's obviously how we get the best from these shows. So Chris, Chris has disappeared. Chris, welcome. Tell us a bit about yourself. There you are. Tell us a bit about yourself and why you're the go-to guy for communications issues.

Chris Chippendale
Hi, thanks for having me. So as you mentioned, I'm a chiropractor. I graduated 11 years ago, my father was a chiropractor. So I was the weird five-year-old kid who didn't want to be an astronaut or racecar driver, I was just going chiropractor, that's what I want to be. And then I've been in practice, run a couple of practices over in southeast, in Kent, in southeast London. And I always knew communication was really important. I was fortunate with my upbringing to see how that was such a vital part of what we do with patients. But then when I graduated, we learned a lot of the technical skills in college, but there wasn't a lot of time left over for communication. And the only people I saw doing communication skills when I first came out, were genuinely like practice management, practice builder. You know, here's how to get people to come back for lots of visits, and certainly many of the ones I saw, they weren't particularly ethical, they didn't really sit well with me, that I started looking for other ways to practice and I worked with a couple of good coaches. It wasn't all bad and started looking outside the profession as well. And it turns out, there's a lot of really, really great stuff on how to ethically communicate and connect with patients, but it sits outside of kind of MSK healthcare. So I spent a lot of time looking at that and studying that, implemented it into my practice, it started making a big difference, started teaching our associates, other colleagues asked for help. And then it just kind of grew from there. And for the last five years, I've been training other clinicians professionally in how to better connect and communicate with our patients. But I'm still in practice as well, I still see patients four days a week, which I really enjoy, because having the balance kind of keeps me sharp on both fronts. I think if I didn't see patients day to day, it would be easy to just start teaching the same things over and over and not evolve. But equally, working with other clinicians helps keep your game with patients as well. So that's the kind of quick summary.

Steven Bruce
It's interesting, you say what you do, because, I say this to lots of my chiropractor friends and colleagues that I think your profession has suffered a little bit because there seems to be a small element who are into that less ethical communication method, which is a shame, because, you know, I personally don't think there's a hell of a lot of difference between chiropractic and osteopathy in the way we handle patients. And I suspect that you get the same people in osteopathy, it just seems that chiropractic is perhaps a little bit more tarred with that brush. So in your case, what is it that's driving your approach to communication? Are you just trying to get patients back? Or are you trying to get your message across to them?

Chris Chippendale
I mean, to me, it was really about being truly patient centred, I learned that word in college and we all said, don't be doctor centred, be patient centred. But the way I was generally taught that, and even coaches who work that way, when I came out, it was sort of, here's how to, like appear patient centred, or here's how to be nice to patients and here's how to connect well, and, you know, seem like a friendly person. And then here's how to kind of convince them to do what you think they need to do. And there was still this element of, you're the expert, you have the knowledge, and you need to somehow get your knowledge into their head and make them do the thing they need to do. And for me, that worked. And that helps. And it certainly helped getting a better understanding of what the patient's true goal was beyond just, get out of pain. Do you want to be able to play tennis again, is it going for walks on weekends with your family, is that what's important to you. So it's partly really digging down into that, but then also, there's a kind of a fundamental shift in the relationship from, you're going to buy treatments from me, or you're going to buy expertise from me. And it's this sort of transactional relationship to more of a transformational one, which is, I think of it more as, I'm sitting down side by side with the patient, a bit like I've got my arm around and going, okay, you've got a problem, we've got really clear on what that is, let's work out a plan together, using my expertise and my clinical knowledge and your knowledge of your own life. And let's see if we can create a plan that gets you there together. So it's much more of a guide kind of relationship versus us kind of sitting across the table negotiating or trading on a transaction there.

Steven Bruce
I suppose that model has been the tradition in all forms of medicine for many years, hasn't it, that sort of, I'm going to tell you what to do, because I'm the expert. What's the key to it as far as you're concerned?

Chris Chippendale
I think the key to it first of all is that change in mindset, it's not feeling like you have to be the only expert. And you have to have all the answers. I've got far more comfortable over the years. In fact, a patient told me this the other day, he's been seeing me ever since I graduated, and he's seen lots of chiropractors, and they'll see different members of the team in the clinic, depending on when they're available. I think of him as a bit of a chiropractic connoisseur. And he said to me, I've noticed you're much more likely to go, hm, I don't know, should we try this and see what happens? Whereas when I first came out, it was much more, oh, I've got to have the answer. Okay, we're gonna do this, you do that, I'll do that, then this will happen. It was kind of a lot more rigid.

Steven Bruce
It's very hard when you're a new grad, isn't it?

Chris Chippendale
I think it's a necessary part in a way. I think it's a little bit like a mask, you come out and you've got all this impostor syndrome. And we're starting to talk about that now. But it was never talked about when I graduated. But everyone comes out terrified the patient's going to work out, they don't really know what they're doing yet. So you create this mask, you create this professional persona, that you show the patient to hide the terrified look in your eyes behind. And that's what you think a competent expert professional is. And you fake that. And that's okay, because the alternative isn't going to inspire confidence. But hopefully what happens over time is maybe the mask doesn't need to be as thick and as dramatic and

you can start to peek out from behind it a little and sort of be a bit more authentic, a bit more yourself. You know, that's a progression that has to happen over time. That takes experience. But I think that for me, a key part is realising I don't have to have all the answers, but what I really need to do is find out what matters most to this patient and show them, I'm going to make that my goal rather than your goal is to do this. I've got have a better goal for you. And I'm going to ethically try and pitch you my goal. And I spent years doing that, I got pretty good at it. But it always felt like a bit of an uphill battle. And there was always that feeling in my stomach of oh, do they think I'm saying, just come back for the money because I'm one of those chiropractors.

Steven Bruce
We just had a comment sent in by Aiden who admits that this is a massive stereotype. But in Aiden's opinion, it's the American Health Care Model, which is more strong in chiropractic than it is in osteopathy, for whatever reason, I don't know why. Because obviously, they've got plenty of osteopaths in the States as well. And because of the way the professionals have evolved stateside over the last 50 years, you know, that sort of communication that you talked about earlier on, that's perhaps found its way over here. Where do we start in then training people to do this better?

Chris Chippendale
Well, I think the key thing is, like I said, getting that message out that you don't have to have all the answers and talking about imposter syndrome as something that's normal, it's actually a healthy thing. When the imposter syndrome is out of control, if it's like a screaming monster in your head, that's not good. But I still have a bit of self-doubt occasionally, I'll still sit back and go, am I doing the right thing for this patient? Have I got the wrong idea? Have I missed something? I'm looking at it as a slightly paranoid friend on my shoulder going, are you sure you know what you're doing? And that's quite helpful, because then sometimes I do second guess, oh, actually, no, maybe I need to think about something else. But it's not this thing that's driving a lot of fear over me now, so I think talking about that, particularly to new graduates, letting them know, it's okay and it's normal, that starts to normalise this whole thing. So they don't feel oh my gosh, I'm the only one who feels like this. And then, I think a large part, especially for experienced practitioners is learning to kind of start to let go of that mask or let go of this idea that you have to be the expert, because many of us get really good at and then we have this sort of status in ourselves as part of our own, I say ego, I don't mean like arrogance, but it's our own persona, our own idea of ourself, as somebody who is an expert, and has all these things and knows what's best for the patient, and realising that you can know what's best, and you can try and tell them what to do. But often that doesn't really get the best results. Most people's reaction to being told to do something they don't want is to just put their foot down and go, no, I'm not going to do that. So I think learning to relax our own standards of what's a good patient, and how much we need to convince them to do something would really, really go a long way to actually being able to better help them and over time help them make healthier decisions too.

Steven Bruce
I have a comment in here from Christina, who's a tutor to the McTimoney College. She says that they always taught students to connect and be positive with their thoughts. And she remembers having students place their hands on other students' shoulders and think of a particular thing and see what the

patient picked up on. And it was usually very accurately what their practitioner had in their mind and a very good lesson to learn. Does that ring any bells with you?

Chris Chippendale
Yeah, definitely, when we talk about communication, we often think about the talking part. So sat down next to each other talking, but there's so much nonverbal communication going on. And just like Christina is saying, if you're thinking certain thoughts, or you have certain narratives going around in your head, that will impact the way you put your hands on patients. I know for myself, when I've been having a tough time, I've had a lot of stress at home, something's been going on, for example, if I'm not mindful of that, that can start to come across in the hands-on treatment, not that I take frustration out from patients, but I'm maybe not quite so present, and maybe not quite so gentle with my touch. And your patients are picking up so much from you, other than just the words coming out of your mouth. So I would definitely agree with that. I think our mindset really influences so much of what we give the patients beyond just the words we say and the things we think.

Steven Bruce
And I imagine that's probably worse right now, because you know, the times are hard for people. I mean, the economic situation is not good in this country, they might be worrying about their mortgage, or their bills, or whatever it is. And that's very distracting when you're in a room with a patient who wants your full attention.

Chris Chippendale
Yeah, absolutely. It can be quite distracting. And it's important to, I think, acknowledge that but also cut yourself a little bit of slack that it's normal to have these thoughts. I am not 100% present with 100% of my patients, there are days where I'm off my game, and I get distracted by other thoughts and things like that. And that used to really bother me and I was beating myself with a stick going no, be better. Don't do that. But recognising your own limitations, I think is really important. And that's something that I see with more mature, I wouldn't say experienced necessarily, you hope they go hand in hand but that level of emotional maturity to give yourself some slack and understand that maybe I'm not going to be at my best today. But maybe that's okay, I only have to be good enough. I don't have to be perfect all the time.

Steven Bruce
Yeah. So I know you run courses, so it's a bit cheeky to ask you to give away some of the stuff that you charge for. But that's why you're here. So I'm going to do it anyway. Have you got some techniques that you can advise people on? We talked about, you know what you said originally there, but some practical steps they can take to improve their communication skills.

Chris Chippendale
I mean, good communication always starts with listening. And many practitioners come to me saying, how do you explain this? How do you say this? Or how do you get the patient to get this into their head, I always tell them, if you haven't done a good enough job listening, it, that's not going to work. Because if you haven't listened to them, they're not going to listen to you. One of the things I love most with listening is what's called reflective listening, which is a skill that comes from motivational interviewing, and originally counselling, where the patient will say something, and you reflect it back to them. So they're

telling you about this back pain they've had for some time, it's been getting worse lately, it's really sharp, and they're getting worried that it's going to affect their ability to play sport. And you reflect back something that you said, so I might say to him, ah, okay, you're really worried about this impact on your sport? And the key thing with a reflection is that it's not a question, because you can do that once or twice that, oh, you're worried about sport. But with reflective listening, you can use this regularly throughout the conversation, it shows them that you're listening, it encourages some momentum, you can be skillful in what you choose to reflect. If you want to know more about the sport, you might reflect that. If you want to know more about the onset, you might go ah, so it started when you woke up three weeks ago just out of the blue, even if they said some other things, but if you make it a question, question after question after question, they can start to seem a bit challenging. You know, imagine if like, for those of you who are parents, if you have a teenager, and they come down one day and say, oh, I cleaned my room, if you went from oh, you cleaned your room. That's a statement, that's, oh, that's good. But if you went, you cleaned your room? It's going to imply a little bit of disbelief. And sometimes that can happen without us meaning to if we just keep questioning them, it might sound like we're a bit skeptical. So using it and having basically your voice go down at the end, if the voice goes up, that's where it implies a question. And just sprinkling those throughout conversation. If you haven't done this before, just try it once or twice. If there's a natural lull, rather than firing the next clinical question, just try reflecting something that they've said. And you'll see, usually what will happen is that will then encourage them to say more on that topic, and you'll get some more useful information. That's probably, if I was going to think of all the communication skills I've learned over time, that would probably be my favourite.

Steven Bruce
I suppose there's a balance to be struck here, isn't there for a lot of people, they'll say, well, we're not GPs with a limit of eight minutes on our appointment times. But nevertheless, quite often, we have patients who will take up all of that appointment with talking if we give them the chance, but still expect you to run on and give them their treatment and their advice and everything else, and then write your notes up, thereby delaying everyone else. And as you say, you've got to be quite judicious in the amount that you reflect back to the patient.

Chris Chippendale
Yeah, definitely. Actually, there's two whole lessons on talking with patients in my course, because I get asked about this a lot. And the reaction to reflective listening is often practitioners go, well, I don't have time to sit and talk all day. And that's true. Certain talking to patients, we may need to manage that. I think that there's two approaches to this, though, there's first of all, there's letting our own preconceptions just relax a little bit. Because I found that instead of asking sort of repeated closed questions, like when did it start? How bad is it out of 10? Have you had this? Have you had that? If I asked more open questions, and then reflect, they often give a lot more information that I didn't have to ask for. So I feel like personally, opening at the start of a history, letting them talk will often answer the majority of the questions on your form that will need to be answered anyway. And then you can come in with some targeted, more closed yes, no questions. Red flags, I haven't found a way to openly ask about red flags, I need to know has this affected your bowel or bladder function, I can't go tell me about your bowel and expect to get the right sort of information there. So I would say start more open. And then you can start to narrow down on those questions if you need.

Steven Bruce
How long are your appointments?

Chris Chippendale
So my appointments, I do an hour for an inpatient consult, and then follow-on visits are 15 to 30, depending on what they need. I'd say a good 20 to 30 minutes of my initial consult is the history. But I'm going through more than just getting their history. It's also about finding out what's important to them, what their goals are, how this is affecting them emotionally. I'm often running them through some of my pre ideas if I have some clinical suspicions already, seeing what they think might be going on. So we're exploring it a lot deeper than just, let's fill out this history form and go on with the exam. But I have found that taking the time to do that at the start, really pays dividends down the line. Because if you do that really well, you don't get patients who visit 2, 3, 4, 5, are peppering you with questions, asking the same question every time. You know, if they say to me at visit three, so what's actually going on, I consider that a failure in my communication, because I will have told them that, but they haven't heard it. And I could go, they weren't listening. But that doesn't really help the situation. And the more effort you can put into that at the start, I would say the less frustration you'll get down the line there. But there are obviously some strategies you can use with talking to patients as well. The nice thing with reflections is you can actually use them to interrupt without interrupting. When you see really skilled practitioners doing this, there's times where it seems like them, and the patient is saying the same thing. They're sort of talking over each other a little bit. But they're using it to guide the conversation. Because if you reflect back a key topic that might get them off the holiday in Dubai, they had three weeks ago that you maybe don't need the details of and back to how it felt when they got off the plane when they came home. So you do need to redirect the talkative ones. But I would say if you go into the interaction, worried they're going to talk too much, you're going to start interrupting them early. And in studies with GPs, they've shown the average interruption time is 17 seconds into the appointment. And then the patient will self-sense, they will start to go and I have patients coming to me already doing this because they're worried about being a bad patient. And they go oh, wait, you don't need to know about that. And oh, sorry, I shouldn't be telling you all this. And I'm often going no, tell me more. That sounds quite important. Because they're not qualified to make that decision. That's why at visit five, you find out oh, I had this massive operation three years ago. And you're thinking, why didn't you tell me? They're gonna go, well, it didn't seem important. You're not qualified to make that call. So we don't want to be interrupting and making them feel like they're saying too much at the start because we could miss a lot of key information.

Steven Bruce
Yeah, sure. Andy has sent in a comment saying that a book called Consulting With Neuro Linguistic Programming by Louis Walker is a very good book on this subject. Is that the basis of a lot of the things that you're talking about here?

Chris Chippendale
No, I don't do a lot of NLP, I just haven't really studied it a lot. I think there's a lot of value in it. And I know a number of people who have found it useful. My first exposure to it just kind of biased me a little bit because it was used by some of those practice management people for like, here's how to subtly influence the patient, here's how to make them think certain thoughts. And I know you can use it completely ethically. And that's not how most people would use it. But that kind of turned me off a little bit. And they

talk a lot about, at least they used to, maybe it's changed, learning styles, like visual, auditory, kinesthetic learners, that's been shown to not really be the case. It worked, I used to use it, and it worked quite well. But I realised over time, what was working wasn't the fact that I was giving an auditory learner lots of sounds like I'm hearing that kind of words, but it just made me really focus on the patient, really put my attention and try to mirror and match their behaviour. So there's a lot of utility in that. And I certainly don't mean to disparage it. But it's not one of the topics I've focused on a lot myself, but I think there's a lot of value in that. And offer when you look at a lot of these different methods and modalities, often they're doing a lot of the same things. And often the things that are working are pretty common across them, really put your attention on the person, you know, pay attention to the words they use, really give them your focus. Often, that's enough for people to feel really listen to the first time and to get that key information. So I'm not familiar with NLP in any detail. I wouldn't want to speak on that. But I think there's a lot of value to it certainly.

Steven Bruce
A lot of us, I suppose, one of the key challenges or two of the key challenges with what we do is, first of all, trying to relieve patients' fear about whatever it is they've come in with. Because as we all know, if you've got severe back pain, it can be terrifying because you think it's more than simply mechanical. But also then there's the simple stuff like getting patients to do the rehab exercises, which we think are better best for them. Are those sorts of challenges which you think you address better now?

Chris Chippendale
Oh, absolutely. I think in terms of the fear, I'm much better at confronting that head on now, of just asking, I'll often ask them outright, what's your biggest concern about this? What are you most worried about? And I do see, quite often I'll mention this to practitioners they'll be worried about yellow flagging the patient or reinforcing catastrophising. But if you just try to be relentlessly positive all the time, a, it can seem a bit insincere because no one's positive all the time. And be the patient feels like their real fears and worries aren't being heard. There's a big difference between instilling fear, if you don't do this, you might end up in a wheelchair and all that kind of nonsense. But not doing that but actually exploring what's already in the patient's head. I quite like the phrase don't leave things in the fog. Equally if there's a patient who seems a bit dissatisfied with their results so far. I used to sort of shy away from that and try to reframe all the time go, oh, okay, so that's two out of 10 improvement, that's already something and then reassure it can take time, don't worry. But now I'm much more likely to go. It seems like you're not that happy with progress so far, could you tell me a bit more about that, and they didn't get a chance to share this, often, they then share it, feel heard and go, maybe I am being a little bit impatient here. But if it's a fear about their back pain, they can know that they've been heard. And that I understand that. And then hopefully, I can come and reassure them and say, well, listen, everything you've told me suggests we don't have to worry about it being cancer or a fracture or something like that. But if I try to jump in and reassure too early before they feel heard, then it won't land because they'll think no, he didn't get it, he didn't listen, and I'm still really worried. So exploring that stuff, being fairly direct with that I found really makes a difference. It's a bit frightening when you haven't done it before. And when the imposter syndrome is really high, but practising it over time, I would say just ask patients, what are you really worried about with this, you'll often see it's a real relief for a lot of patients just to be able to share that. So that's a big thing I focus on a lot more. And then when it comes to encouraging them to do the exercises, the lifestyle changes, that sort of thing. There's a whole number of strategies, I go through loads in the course,

because there's many you can choose. I think one of the biggest things, though, is just making sure they can see the link between that behaviour change and their goal. Like if you're going to give somebody a bird dog exercise, make sure they know why getting better at a bird dog is going to help them swing the golf club on the weekends. Because I never want my patients go, oh, I'm doing a bird dog to keep my chiropractor happy. So he doesn't tell me off, you know that that's extrinsic motivation. That kind of works. But it doesn't last, but as soon as they don't need to see you as often, they'll drop it. But if they go, I'm going to do this every day, because it's going to help me get something I already want. And I've probably clarified my goal through talking to my chiropractor with that, I'm far more likely to stick with it long term.

Steven Bruce
What do you do about measuring compliance?

Chris Chippendale
My approach is, I try to just stay approachable, really, I tried to let my patients know that if they can't do something, and I'll tell them this, if they're struggling to do it, or they're just not doing it, to let me know. Because I'm not going to give them a telling off and have a go at them and this sort of thing. But if it's not working, I want to know, so that we can adapt the plan accordingly. And maybe that will mean, you know what, I've given you 20 minutes of exercises to do five times a day, maybe that's a bit much for you. Maybe if you did two minutes, three times a day, that's gonna get a better result. Or it may be if they're just not doing anything I give them to do, I need to adjust the prognosis and their expectations. And maybe they'll need some more treatment as a result. But if I let the patient know, look, these are the options here. You know, I can see you five times this month and you do the exercises, or I can see you seven times and you don't, what would you rather do, and some patients will choose, I'd rather pay more money and do less work. And as long as they know what my expectations for the outcome are, I don't particularly mind, it's not my job to force them to do things they don't want to do. It's my job to give them the options, let them know where I think that each option will lead and then help accompany them as best I can. So you can use things you know, we use, like fizzy track, and there's a lot of these things that will track adherence. My experience with that, and maybe it's because I don't frame it something I expect them to use. But patients forget to fill it in all the time, and then often come in to see me and say I did do it on Tuesday, I forgot to press the button on the app, but I promise I did my exercises and it seems to instil this sort of power dynamic, if they're doing their homework, or they're gonna get told off by the teacher. Being the bad cop does work for some people. It's just not really my approach. It's not something that's worked particularly well for me. So essentially, I try to keep it informal. I just try to make it as clear to them as possible. But if they're not doing it, they can tell me, and we'll find a solution for them.

Steven Bruce
There's a curious question that has come in from someone who I can only identify as PI. But who is definitely an osteopath. Now, he or she says that they understand that some, they're saying chiropractors, but it could be anyone I guess, chiropractors don't do any manual therapy until the third appointment. The first appointment is case history and X rays. And the second is explaining the report of findings. And then this is explained and justified as being more professional, and apparently may give the impression of being more listening. I've not heard that myself. Is that a way of practice that you're familiar with? And is it something that we all ought to look at?

Chris Chippendale
I'm familiar with it. It's kind of come over from the US. It's part of that sort of here's the way we're going to set things I mean, the US, a lot of those chiropractors, particularly in the 80s, they were paid by insurers and the insurers had no limit on what they pay, and the patients just had to turn up and get the appointment. So, it's much more lucrative, if you say, right, come back every day. And each day, I'm going to give you a different technique. And I'm going to space out the initial onboarding process to four visits, because then I get to build the insurer for four visits. So there was a lot of advantage taken of that. There are some advantages to it, three days is a bit of a stretch. I don't know many people over here that do it, but I am aware that it has been done. I know a number of practitioners who space it over two, so you go up to the exam, and then they come back for what we call the reported findings, which is really just letting them know what the plan is. And then, that will usually include treatment at the end of that second visit. I don't practice that way. There's pros and cons to each. I know people who are decent ethical practitioners and get great results who do that, there's an argument to be made that the patient has a chance to think about it, really take it on board, it's quite overwhelming when you do a lot in one visit, the examination itself can flare people up. So they may need a break for a couple of days for the system to settle down before you treat. I don't do it that way myself. But I'm aware of that. I think as long as the expectation's set before the patient books the first visit, I don't have a problem with it. We just find a lot of our patients call up and they'll say, does that include treatment. So for me, if I can do a little bit to help fast track that result, I'll still take more time at the second visit to go through things in a bit more detail. But my personal approach is if I can do something on day one to start getting them feeling better sooner, then I'll do that. But I don't have big problems with it done the other way. The patient needs to know what's coming up. Otherwise, it's a bit of a bait and switch and you're just gonna annoy people doing that, right?

Steven Bruce
I guess there is a mood amongst many practitioners to say that the patient has got to get value, health value out of every visit with you, therefore it must include treatment. But I was actually thinking about this the other day when two patients sent in their MRI discs for me to look at, well, actually, looking at those MRIs takes a bloody long time. You have to bring them up on the computer, in one case, I had to get in touch with the hospital and get them to send the results and all this stuff and then trying to interpret MRIs when I'm not a radiologist. So I've got to try and contrast what the radiologist has said with what I think I need to know. And all that takes a lot of time. And of course, the patients expect you to do this free of charge. And sometimes we have to bear in mind that it is okay to charge for our time.

Chris Chippendale
I completely agree. I had a patient, I think if it wasn't yesterday, it was the day before, he came in as a new patient. He had had an episodic low back pain for a while before, he kind of said, look, my brother in law's a chiropractor, I don't want that clicking thing. I'm really just here to find out what's going on and get some advice about what I should do. So we did the whole consult. And at the end of it, I said, Well look, the main thing to do is we need to get you strengthening your back more, here's some exercises, it had already calmed down at that point, I said we could do some hands-on treatment, if you wanted. It sounds like you're not that keen on it. But if you are, this is what that might look like. And he left it and said no, actually, I'm gonna leave that for now, I'll do these exercises. But I'll let you know if anything comes up, left perfectly happy, attended the other day because he had had an MRI. And he just wanted

to chat through the results with me and he booked the appointment and he came in and we talked through it and I said okay, based on what we found here, this is how I would alter, the answer was not a lot. But this is what's going on. This is why I would recommend this and that and he left perfectly happy, happy to pay for the visit. You know, it never occurred to him that we were going to be doing some treatment because he didn't want it. And I think often we don't realise the real value we provide on top of the hands-on care that we do. Often when I review a patient, we'll have the first course of care, first few visits, booking a review to have a progress update, reassess, reexamine. I have a lot of patients, like, we do the exam, I sit down, I talk them through, this is where we're at so far, this is the plan and they're going great. And they're putting their shoes and belt on, ready to walk out the door. And I'm going, well we haven't treated yet. So I think a lot of the time actually patients are happy to pay for just more than the treatment. There's a lot of value to our expertise and even just reassuring a patient sometimes.

Steven Bruce
Yeah, just so you don't think that we're having a go at chiropractors here, somebody, and I think he's an osteopath, has sent in another comment saying, actually, physio therapists quite often will get the patient in for an appointment to discuss what's going on, then they'll give them their exercise sheet. The next appointment is just to check they've been doing the exercises. So again, no hands-on treatment from many of them. And I suspect that osteopaths think we're a little bit holier because we always like to think we get our hands on but sometimes, as you rightly said there, hands-on isn't what's needed or what's wanted by the patient. And there's a lot we can do by good communication, which brings us back kind of to the topic that we were here to discuss. You've got some slides there, does that put some flesh on the bones of what you were saying about communicating well?

Chris Chippendale
Yeah, definitely. I mean, we had a couple here. There's just little illustration I quite like of that transaction versus that transformational relationship. This is how I think of it. I used to be like the former where the patient comes in, tells me about a problem. And then I'm going to tell them, okay, you give me X money, I'll give you Y treatments. It wasn't framed like that. But this is what we thought the relationship was, was they give me money, and I will give them treatment. And changing it to that transformation one, where sort of, I come around the side of the table, I'll sit with them, workout, plan together. So it's much more as equals, it's less oppositional. So that's just an illustration, I quite like that. So I tend to think of it with patients and making that shift alone changed the way I communicate in a lot of subtle ways, because it just changed the way I approach the interaction, even my goals for the interaction as well.

Steven Bruce
Yeah, yeah. And I can think back years and years ago, when, if you visited a doctor or you visited a consultant, you were generally at the opposite side of a desk rather like the cartoon characters in your slide nowadays. I don't know anybody who does that, of course, we sit sort of, maybe not next to the patient, but we don't have the desk between us any longer.

Chris Chippendale
Yeah, exactly. I think that's the way you set up your room as well is really important to the kind of encounter you're going to have, how you're going to make that patient feel. And there's balances to that as well. So like one of the things we talked about, I actually have a slide here for what I heard as the trust

equation a while ago, I really like this, it was a nice way to think of a simple way of building trust. You have trust comes from authority, and empathy. So the authority is your expertise. And the empathy is, you're a nice person who cares about the patient, you can have all the authority in the world. But if you don't care about the patient, why would they listen to you? The stereotype of the arrogant consultant is that kind of person. Equally, though, you can have all the empathy in the world. If you don't have any expertise, why would they listen to you? And you can do this in ways you set up the room. So setting up the chairs, do you have the desk between you? Can you sit facing each other a bit more? Can you sit next to each other, that can really help the empathy. We have, for example, my front desk team show some of these pictures you can't really see, they're spinal anatomy models, but they got flowers all over them. And we have comments from patients all the time about how nice that is. And it actually helps them feel a little bit more taken care of. What you can't see in this corner, though, is my certificates. And I have those up on the wall because it shows the patient that yes, we've got the empathy side, but also authority. I am an expert in this field, and you're in the hands of somebody who knows what they're doing and is qualified. I think some of us shy away from hiding that because we think it might seem arrogant. I don't have them sat, so the patient has to stare at them all the time. But if they're looking at me by my desk, that's in the background, so you can really build trust with that trust equation, obviously, and in how you communicate but in how you set the room up as well.

Steven Bruce
You know, I like what you just said there. We had a speaker on the show some time ago now who was saying that, we need to consider whether spinal models and pictures of spines and things like that are actually a little bit intimidating for people who are not medically trained, because they're not used to looking at those anatomical diagrams, and they find them a bit scary. You also got flowers on them, which makes them a lot more interesting. And I hadn't really thought, I mean, we put our certificates up, but I hadn't really thought about how that is a subconscious contributor to the patient, accepting that we do know what we're talking about. So, it's worth doing clearly. So I thought I had a new question, but I haven't, it's the same one I just asked you. Yeah, so carry on please.

Chris Chippendale
Well, you mentioned models and I think that's an important one as well, because models are a great education tool. But often, a lot of them come with bits wrong. And I used to have, back when I started, this sort of spinal degeneration model of, here's a healthy lumbar disc, here's one with a bulge, here's one with osteophytes here's one nearly fused. And I had that sat on my desk. And it never occurred to me that some patients were going to look at that and go, I hope that's not me. And you know, I didn't pull it out to scare patients or anything like that. And this is back when I trained, we had more structural understandings of these things. We assumed that that was what was happening with everybody in pain. I've now hidden, you can't see them, but they're in a cupboard there, hidden right at the back. I pulled them out for this patient the other day, he just wanted an explanation. But I don't have them on display the whole time. And a lot of the full spine model, there's this bright red angry disc bulge sitting at your side. And I'd say to my team members, if you're going to use that, be aware the patient's eyes are going to go right to the angry red bit, even if you're talking about their neck, and part of them is going to go I hope I don't have that. So you want, if there's an elephant in the room like that, you want to draw attention to it as well and people misinterpret things a lot. I had a neck model a while ago that had the deep neck flexors all over the scalings. I remember a patient who went, oh my god was that supposed to be blood

if someone like breaks their neck, he's got this red stuff coming down here, so that model got put into the cupboard as well. I think we need to be mindful because they are very useful tools, but just having them sat on display the whole time might not be the best idea because you won't know who it's scaring. And the vast majority who are scared by it probably won't bring that up. So I think being mindful of the potential risks to those things as well as the benefit of them.

Steven Bruce
Yeah. So what are the other contributors then to getting the best effect in your patient? We've talked about listening properly, we've talked about accepting that it's a partnership, and that we're not just an authority figure, establishing our credibility, what else would go on in your treatment?

Chris Chippendale
I think a key part really...

Steven Bruce
Sorry, was that a good way of reflecting back to you what you just said?

Chris Chippendale
Yes, that was good reflective listening, it's more of a summary as well, as the specific type. So you've got the right answer. I think a large part is just keeping in touch with the patient about how they feel things are going day to day. So you know, when they come in, they'll tell you well, this is what's happened since last time, I'll reflect that back to them, then they'll get on the bench, and I'll do my assessment or tell them what I found, or do my treatment. And then at the end of that visit summarising. So, this is what we found today, this is what we've done, this is what that's going to be doing. And we're going to see you again next time. This is when that will be, here's what to do or keep doing in the meantime. So you keep just reminding them of all these things at every visit, you know, you remind them of their goal, I bring up their goals somewhere every single visit to keep reminding them, I'm working on what you most want. I'll keep checking in with any rehab and things like that, obviously, but even just what I found what's going on, because you can share all this stuff at the start. And I think as practitioners, we're often guilty of trying to do a mind dump in the first couple of visits of, you need to understand everything I need you to understand now. Because otherwise, you might not come back, and I'll lose the chance to educate you. But we throw all this stuff at them. And we can give them things written down, the rule in my practice, if it doesn't leave the room in an email or on paper, I'm not allowed to expect the patient to remember it. Because they'll remember bits, but they'll forget most of it. And then just dripping it back in, checking back in, you know, asking questions if they seem unsure, but also just reminding them, just bringing things back into conversation so that you're always just reinforcing the things you want them to know. And to me the goal for care is always one of the most important things there, I want them to really get the, I'm not here to just get rid of your pain. I'm not here to give you a biomechanically perfect spine, I'm not here to change your lifestyle and make you super healthy. I'm here to help you get what matters most to you. And as long as we do that, we're on track. So reminding them of that I think is key because otherwise they can forget, it's not what they're used to with healthcare practitioners.

Steven Bruce
And I think we probably need to remind ourselves occasionally that the words we use can be just as scary as the models, can't they? An example of that is a chiropractor guest who I had on the show who was talking about her own breast cancer. So she's a healthcare professional who was diagnosed with breast cancer. And she said that once that word had been said in her consultation, she didn't hear another thing. And of course, we're generally not using that word with patients. We'll be saying you've got a herniated disk, you've got a disc bulge, things like this, which patients might not fully understand but which will terrify them. And then we have to perhaps look for subtle ways to explain these things without scaring the hell out of patients.

Chris Chippendale
Absolutely, there's been a big move for this. It's nice to see it's even happening in medicine now with GPs to sort of think about the language they're using. Maybe you don't explain all the tiny things on the MRI report. They just, you know, age related changes, the phrase that they often use, I think that's really important. I'm really glad that's happening. Because we often don't realise what might scare some patients more than others. Maybe they have somebody who, a family member who had a slipped disc and has had crippling sciatica ever since, if we're not open to them maybe having that fear in their head, then we can just use disc as a throwaway line. We wouldn't even say slipped, but they might still hear that. So being mindful of that language is really key and taking the time to explain what we mean. I really like as well, I think it's called the Kieran O'Sullivan test. It's not related, but works at Petro Sullivan, where at the end of the visit, he will ask the patients, so when you go home and your spouse or your friend or family member says, oh, what did they say? What are you going to tell them? And that can be really enlightening because you'll think you've done this great job explaining it and they come out with something completely different because the words that you thought came out of your mouth and the words that went into their ears weren't quite the same, and at least you can catch it and address it then, rather than try to deal with the fallout after that's been cemented in their head for a few days.

Steven Bruce
Yeah, fascinating, I've got a family member who is very guilty of that.

Chris Chippendale
Yeah, I think it's easily done. But we need to just be mindful of what we can do to help prevent that in the first place.

Steven Bruce
Yeah, we don't have very long left, Chris. And I was just thinking, clearly you've got a lot of stuff to share. And I think when, before we came on air, you said you've got some free material that people can make use of, how do they find that?

Chris Chippendale
Yeah, absolutely. So I think we've got a slide with that, I put together, this is very new, actually, it's a three part video series on the trust formula, or the trust equation. So if you go to my site, patientcentre.co.uk/freetrust, I'm not sure if they'll pick up the QR code from there, but...

Steven Bruce
We'll send it out to them as well. So yeah.

Chris Chippendale
Yeah, so you'll get a free weekly newsletter that I do, which is just me sharing tips. So you can use the patients right away. But you'll also get three video lessons on how to use that trust formula to build better trust with your patients as well. So how to really turn the empathy right up, how to build authority without seeming arrogant, and then how to put it all together there, so they can access that there. I'm sure send this out. I've got loads of free videos on YouTube, I'm on Facebook and places like this, I have a tendency just to think of something all that might be helpful and just throw it out there on a video. So, there's lots of other stuff in there as well. And I do you have the course, the happy patient project if somebody wants to take a real deep dive. That's a much more in-depth course, we go through pretty much everything I've been teaching for years for clinicians on that. I'm going to be doing a Black Friday deal on that soon. So if you're on the newsletter list you'll hear about that. I'm only going to do that for a select few people that I'm actually going to close the roll in for a bit whilst we tweak it a little bit. So if people really want to take a deep dive, they've got that as well. But there's plenty of free content I put on there too.

Steven Bruce
Chris, that's brilliant. Thank you. I hope you've reassured some of the horrible osteopaths watching the show that, you know, chiropractors are decent people and that, you know, we're all about getting the best for our patients. You're either extremely good at the soft sell, or you're just a bloody good practitioner. And I hope people will take up the offer of all that free material at least. And hopefully we'll see you again sometime in the future and maybe get some more information out of you then.

Chris Chippendale
Yeah, absolutely. Look forward to it. Thanks for having me.

Steven Bruce
Thank you for giving up your time today. Well, there you have it, we're out of time, I'll send you a handout of the slides that Chris has used a bit later on. But don't miss out on the remaining five and a quarter hours of CPD between now and the Christmas binge. The first one is next Tuesday. We've got a lunchtime Case-Based discussion. And then another lunchtime show on Monday the fifth with Dee Bell and we'll be talking about Tongue Tied babies. And after that I've got two evening shows in a row, the first one with Claire Minshull and Serena Simmons on Wednesday, the seventh of December, they're going to be talking about the psychological aspects of patient compliance. So there'll be some more communication stuff in that, but I can guarantee it'll be a great show. If you've seen any of the previous shows with Claire, you'll know what a Livewire she is. And Serena is very definitely in a similar mold. Another great team is Nick Burch and John Graham, Nick is a fantastic spinal consultant and John a superb rehab physio. They're both in the studio on the evening of Tuesday, the 13th. And we're going to be talking about chronic pain and neurofeedback training, expecting from them a lot of great science and some really useful practical stuff for you to take away. That takes us up to our Christmas break when my team will get a very well-earned respite from all the work they put in to bringing such a great service to you. But that's it from me today. Thanks again for joining us and enjoy the rest of the week. Have a lovely weekend. Bye for now.