Academy of PHYSICAL MEDICINE

Transcript

354R- Chronic Pain Performance Pathways with Ben Adams

Steven Bruce

Good evening. Here we are with the first of this week's Two evening broadcasts. Tomorrow, of course, I have Professor Laurie Hartman coming in at the slightly earlier time of seven o'clock and he's going to be doing a live treatment session here in the studio. This evening. However, I actually have two people joining me. Ben Adams is my guest speaker. He's a BSL graduate UCL as it now is, with a leaning towards classical osteopathy. In fact, he is the director of the ICU, the Institute of classical osteopathy, and he has a particular interest in chronic pain. So Ben, thank you very much for joining us. But I've also managed to convince a second osteopath to join us as well. Now on there is a long standing member of the Academy. He's a friend of mine, I thought it'd be really interesting for us to have an extra voice in our discussion just in case you're getting bored with mine. Now those interest is particularly in paediatric treatment. And he's got some other interesting concerns as well, which I thought might be useful for a future show. The world Your weathers now, and he's interested in paediatrics doesn't mean that he doesn't care about chronic pain. So Neville, thank you too, for coming along. Great pleasure to have you here. It really is. I haven't done any justice I've been because you're not just any old osteopath. You're not just any old that you've actually lecture across Europe and all sorts. Yeah,

Ben Adams

so I've been very fortunate for a number of years to lecture across the UK in Europe. So I've lectured in Italy, Spain, Finland, predominantly in classical osteopathy, but also in genuine osteopathic technique across Eastern Europe as well. And I also was a postgraduate clinical tutor at the London clinic of classical arts. to up the, for about six, seven years, right? And I'm now a clinical director of a healthcare group Atlas healthcare group. So I helped run about seven practices. As part of my part of my role that sounds Busy, busy. Yes, busy is the word, but good fun. Now, I'd like to challenge

Steven Bruce

you came to our attention because of a paper you wrote. Not that long ago. I think you want to tell us about that paper before we get into the details of it.

Ben Adams

Yeah, so I wrote a paper really for for that group, which is a mixture of osteopaths and physiotherapists.

Steven Bruce

So this is the healthcare group. Yes. Right. So obviously, most videos,

Ben Adams

videos are the predominant clinicians that we have. But we also have sports therapists and that sort of thing as well.

Steven Bruce

I'll bet we get some questions later on about you know, the difference between physios and osteo is approach to treatment, obviously, it works or you wouldn't have both in your.

Ben Adams

Myself, I worked in a physio practice for 10 years, and worked with physiotherapists as predominant doing classical osteopathy. So I think it can work really, really well. So the article that I came to write was about pathways, and how we can develop those in ounces, and how we may work as part of a multidisciplinary team, or teams. So

Steven Bruce

I must admit, when I first saw the title for tonight's show, which is you had been picked by the team to come in. I saw pathways and I'm thinking neurological pathways, but your pathways are slightly different

Ben Adams

now. Yeah, so So my pathways will be pathways for for the patient within a within a clinic within a team, how you would structure that treatment, perhaps across a team, or working with different people in the practice. Now, that's not to say that if you're a sole practitioner, you can also take this approach, because we can use a variety of skill sets that we have to develop this sort of approach within a single person practices. Right.

Steven Bruce

Okay. So what is the approach?

Ben Adams

So, essentially, the approach or to develop this sort of pathway is to really build around communication with the patient, understanding where they're at, and looking at, what are they actually asking me? And what goals? Can I help them? Deliver? In what timeframe? But we all do that?

Steven Bruce

Don't we know? We do that? So where are we falling short in this regard? Because we all think that we ask our patients structured questions to get the best out of them to draw the information out in the most appropriate way.

Ben Adams

Yeah, and, and absolutely, and we all do ask these questions. I think the thing is developing a structure around it, and asking yourself the question of, have I made sure have I double checked with the patient, that that is that that is the way forward. And really, it's, it's exploring with them what what they actually want, because the story they may come in with, and they may have prepared to tell you might not be the underlying problem that they that they actually have, particularly with chronic pain. There can be years and years of buildup of injuries, or other sorts of trauma associated with that. And it's important to really pick through that detail.

Steven Bruce

But you talking about the sorts of psychological trauma that might have not caused necessarily their physical pain, but is maintaining it or preventing it from healing or something different.

Ben Adams

Yeah. So so there is an element of psychological trauma with that, I think that there is always going to be a psychological element to whatever patient presents with. But really, it's the there's that and then the buildup of various different traumas that we go through. And how our body adapts to that, that may eventually lead to that that chronic pain state within within patient that we see.

Steven Bruce

I'd love to know about the the structure behind this, this template of of questioning that you may have, and the various sibs that you may use to kind of understand more fully the nature of the chronic aetiology.

Ben Adams

Okay, so the first place I start is really trying to understand what they're looking for in the first place, what is their main driver? So, because although someone may have had chronic pain for a period of time, they may actually come to us in the beginning looking for advice. And is that the case because I can say, I can do this wonderful treatment plan for you and this is 10 treatments or so. But if they're actually say looking for advice in the first place, that's not necessarily meeting them where they're at and He is going to help them in the beginning. Right? So it's establishing that first point of contact. And then what they may want in that process

Steven Bruce

is that you mentioned a 10 treatment plan there, that was probably a throwaway line. Yes. But is that a sort of typical thing that you might suggest to people because I know that many osteopaths and probably quite a few chiropractors as well are actually quite opposed to the idea of prescribing long treatment processes.

Ben Adams

Yeah. So I would say, I, me personally, I take the view of, I would like a review process within what we do. So I agreeing with the patient, or point at which we're going to review whether things are working for them or not, or if certain goals have been met or not. And developing that structure is really important. Yes, the 10 treatment protocol is a bit of a throwaway line, a throwaway line, and it does vary. But I think if we're looking at both short term, medium, and then long term goals, we do have to look at a treatment process

Steven Bruce

as part of that's interesting, what you say there reflects what was what's been said on the show couple of times. But what is lovely chiropractor, Russ Rosen is based in America. So we haven't had him on in the studio yet. But he's saying that it's really a patient is, is maybe they're out of pain, but are they as good as they can get. And sometimes you have to leave it to the patients that will this is what I wanted to be doing. And you got to try and get them there and not just get them to a bearable. State.

Ben Adams

Exactly that. So I think that sometimes we look at easing symptoms as being solving the problem. And that's not necessarily the same thing. And if we can identify those longer term aims with a patient and and work with them towards that, I think we are providing that that better service and potentially helping them their longer term, way back to health.

Speaker 1

Ben, it sounds like you're talking about a best practice recommendation. It sounds like you're perhaps trying to furnish it a solution which I think is totally sensical. A roadmap with a timeline?

Ben Adams

Yes. So a roadmap or a pathway, or it doesn't really matter what you what you call it. But some sort of development of a structure like that, I think is really important and, and often missing in in well, it wasn't in personal practice, but also practices as a business entity as well.

Steven Bruce

When you're lecturing. Are you genuinely lecturing undergraduates? Or Are you lecturing, qualified experienced? Some,

Ben Adams

some, most of my lecturing is is postgraduate. Typically, they tend to be three to five years out, usually. I do do some undergraduate, not in the UK. But yeah, that's predominantly where I'm based.

Steven Bruce

And the reason I asked that question is because of course, we all think we all think we know it all. When we get to the end of our courses, we then realise very sharply that we don't wait three or five years out, we probably start thinking, well, we got the hang of this questioning process. And so obviously, the people who come on your courses, I suspect, recognise that they've got a shortfall there. But do you think that that is common across the profession that we could all improve in our questioning approach,

Ben Adams

I take the view, that is something that we all need to work on all the time. And it's something that, as professionals, we need to really continually develop this process. Because it's at the heart of what we can help the patient do, the service we can deliver. I don't view it as there being perfect communication, and, you know, a beginner's communication, I think it is something that we are all constantly evolving and learning. And that's what's exciting to me about the profession, you know, that constant learning process that we go through. Yeah.

Steven Bruce

The other side of that, perhaps, is that I wonder if, once we're qualified, you find your routine. Yes. And you settle into it. And you think you've got it correct. And maybe I'm speaking purely for myself. You think you got it? Correct. So you you don't develop that communication to the extent that you might?

Ben Adams

Yeah, I think I think that's a fair point. I think that what you will probably find in that case, is that the you come across a cohort of patients that you frequently find that you're, you're not helping perhaps as best as you could. And then that may then lead you on to explore things like communication down the line.

Steven Bruce

So take us a bit deeper into how it affects a chronic pain sufferer.

Ben Adams

So particularly with chronic pain, the way we communicate is very, very simple. Orton, they've often had numerous experiences of healthcare previously, and then may be, or they may feel that there are elements of judgement tied up within that. Things like, oh, it's all in your head, or it's your fault, or that kind of thing. Can be common experiences for them.

Steven Bruce

Just Just a very quick aside. What do you mean when you say a chronic pain patient with the NHS means 12 weeks into their pain, doesn't it? Yeah, so excuse me,

Ben Adams

I would I would broadly agree with that I'm my my sort of definition is sort of six months plus generally of pain, where they have been, perhaps also where they've tried numerous things before as well, unsuccessfully, that tends to be the picture that I would commonly see myself. Okay.

Steven Bruce

Sorry, I interrupted you while you were talking about addressing the chronic pain patient.

Ben Adams

So if we go if we go back to the communication is important to build that that picture, perhaps in more resolution in more detail than than we would with the acute injury. So because we need to really explore that background with the patient. And then I think the other element that's really key to it is, is walking through the patient, what you might be able to help them with, at what timeframe as well, because they might have unrealistic expectations of of what you can deliver, I want you need me to get better into sessions, where they've had something 25 years, I'm sure we've all had that that experience.

Steven Bruce

Yeah. But communicating to the patient, just how long it's likely to take is often difficult isn't?

Ben Adams

It is. But that's why I would suggest something like a review process is really useful, because it enables you to check in with the patient at an agreed timeframe. And then you can reassess at that point and develop your plan further on from that point as well. And also, it allows you to say, well, perhaps this isn't working for you, perhaps there is another skill set that would be beneficial for you.

Steven Bruce

I've had a really interesting communication myself, I've been sitting here, I might mispronounce this name. Someone called Son folk says the computer may have given them that name. I don't know. Good evening wasn't expecting to see Ben, who was a familiar face for my days at the BSA was sitting alongside my old principal, Neville mir. And so you know who that is, but they have no idea you might you might be a name that's been generated by the computer. With your your a welcome paraphrases somebody. Brilliant, brilliant. How have you put this into practice? It's all real talking here philosophically about, we have to communicate differently with a chronic pain patient who's got all this baggage coming with them? Particularly, it's been years in the making?

Ben Adams

Yes. So how you put this into practice is that may differ slightly from practitioner to practitioner, the way I do it is I structure my questions in a way that ensures I don't miss things, I tend to get into too much detail myself sometimes and become quite not narrow focused. So my structure my way of question places, it keeps that wider view. So so how is we've got what seeking what they've come in for, you know, what, what are their main drivers now? Then it is what is this something that I can treat? So you know, all the usual red flag safety questions. And then it's is going into, okay, well, what is the this the tip of the iceberg of? I'm really exploring their, that their background? So if, and what I might do there is start with just exploring, okay, are they historically a sporty person? Are they have they been sedentary for a long period of time? What are their activities and drivers outside of this condition? You know, are they missing doing something? Those Those sorts of things are what I would ask, once I've got an idea of that is then really exploring, how sensitive is the condition? So for example, is there any allodynia or anything like that, you know, what is the degree of that that nociceptive drive that they're experiencing?

Steven Bruce

Do you have some means of assessing that? Have you got a scale that you can measure it against for reference later? Or is it very much subjective?

Ben Adams

So I do, I do try and ask everyone sort of scaling questions. So and this is another thing that can vary because some people find answering questions You know, no doubt 100%? Very, very difficult to answer. So, I might switch that around and try a 10. Or I then might ask them, well, where would you? How would you talk about it? Is it like a middling pain or severe pain or, or a mild pain, so that in some way, I've got a sense of what they're experiencing in a way that they can explain to me, I think often with things like the VAT score and things that are really useful, but there is a cohort of people that it doesn't really seem to work very, very, very well for I have

Steven Bruce

a bit of an issue with that, because not with the whole scoring thing. But it's called a VAs score, but we asked people to put a digital answer to it. And I just wonder, it's probably I'm thinking, my own response to your question. It's hard to put a number on the pane. But maybe I can point to a line and say, I'm roughly there. Yes, maybe I can do that more easily. And then you can put the number to it afterwards or the computer camera.

Ben Adams

Yes. I mean, that's, that's another element to it, if you if you have the physical scale as well. That's, that's something I've done previously, not at the moment, because the clinic where I work doesn't have that. But yes, that could be a way as well, and really is exploring how how they can communicate, because there are the people do communicate in different ways. Some people, for example, a very expressive, and they they may sort of pull faces, or, or sort of physicalize the pain for you, but can't really describe it in a way. And I think it's important to recognise that that element in, in what the patient is saying,

Speaker 1

but what are we right, you're right in asking whether I'm in which I actually I thought I know the answer to my question, but you're attempting to align with the patient. Yes. Exactly. To align and gently redirect, I'd imagine.

Ben Adams

Yeah. So um, attempt to align with the patient, first of all, to really try and understand them. So I think this is where the perhaps me previously, I haven't I haven't done that. What I've learned over the years is that alignment is really, really important in understanding particularly chronic pain due to the complex nature nature of it. And is really spending the time to, to develop that. But also then to double check with the patient. So you said that, what I'm interpreting is this, is that correct?

Steven Bruce

Does this mean your consultations are a lot longer than many? We saw that reflecting the patient back up with a question back means that you're going to have to take more times you're asking the same question twice? Well,

Ben Adams

I haven't found that. I haven't found that How long do you give your patients as a rule, I run a our new patient half an hour continuation. But if I was doing a review, it would still be within that half an hour. unless for some patients, I would really need that extra little bit of little bit of time. So it is it is possible. And I think if we viewed communication is not a separate thing. So right now we're communicating. But when we go to the table, that's the communication over if you've used communication as a, as a process that happens throughout that that entire time. I would say that, then that's perfectly

Steven Bruce

achievable. Yeah, there's a lot of space at the table isn't there for communication. So as Kara has said, most patients with chronic pain need a gradual guided approach. Some get well with a book recovery over a week on a book recovery. But most need a long time to learn the neuroscience and the strategies appropriate to their history, or personality type, etc. Not everyone wants to journal or meditate, but the foundation really needs to be the science.

Ben Adams

Yeah, I would I probably agree with that. I think, you know, these things take time. Some people don't want to meditate or journal or that side of things. But perhaps you can explore Well, what for them might give them a deep sense of relaxation. What

Steven Bruce

some people don't want the science either I imagine and you know, one of the osteopathic practice standards and the chiropractic code has similar wording is that you have to communicate in a way which works for the patient. Yes,

Ben Adams

and exactly that and really, what I'm what I'm sort of arguing is that we do need to really understand how their patient is communicating and really sort of tie in or align to that, because that then opens the door of what's what's possible with with those with those patients, I would argue, but I'd take the point Absolutely. You know, the development, the scientific background, around chronic pain has really shifted in the last five or 10 years. Yeah,

Speaker 1

I think it's going to shift more. Yes, in time to come.

Steven Bruce

Mike's picked up on your point about patients having seen a lot of other people associate a lot of patients come to us as their last opportunity to get help. Mike says he sees acute injuries. But there's a lot of patients who have had injuries during COVID and didn't want to bother anyone. And now they're coming out of the woodwork. Yes. Yeah. A long time since COVID. It is still around, obviously,

Ben Adams

I don't know about anyone else. But I found that certainly the caseload that I'm experiencing is become more complex over the last last few years. Using that. I

Speaker 1

am I ABS absolutely, I am. And that, I mean, just that. So I think we still have to bet you know, keep it in mind and consider it. It feels like a long time ago. COVID. Yeah. But it's still relevant. I think, for many people. I

Ben Adams

think so. But but also the knock on effect that the NHS are dealing with, means that perhaps we are seeing a broader cohort of people as they struggled to get into the NHS services and things. Yeah. And do.

Steven Bruce

Would you like to take us through some practical elements of this on a on a model? Live model?

Ben Adams

I mean, if that's okay, yeah, let's

Steven Bruce

go to the practical area. And we're gonna look at how this all works in practice.

This is Greece. Greece is one of our regulars on the show. As far as I know, Grace doesn't have any chronic pain, but she's a good actress, and she will pretend.

Ben Adams

So, assuming that I told you about your pain and that kind of thing. One of the things that would really interest me is your activity levels on what you're doing, and the different different elements to

that. So do you do any sports at the moment or anything? Nice for a No. Any sort of walking or anything like that? So?

Speaker 2

No, not last two lessons at school? Okay.

Ben Adams

And any, any other hobbies or activities you enjoy doing? No, no?

Unknown Speaker

That's fine. Yeah. So

Ben Adams

So what does a typical day look like for you? What would you do?

Unknown Speaker

I'd see I'll just go grab a nap. Okay, and have dinner and it goes bad.

Ben Adams

Okay. All right. All right. So what what I'm trying to do is build a picture of what your what what your life looked like, and that kind of thing. So in your case, you're going to school. But is that sat down? Are you moving around in lessons? What does what does that look like? Two

Speaker 2

out of three are sat down and are not really sat down and moving about? Okay, so

Ben Adams

are you? Are you moving around a lot? Are you picking things up? What does that look like?

Speaker 2

Yeah, like, when I'm doing my projects, I do like fashion. So we can like, dresses and stuff. So I'm not usually sat down? Are you sort of holding positions for a period of time by taking pictures of it somehow to hold them materials? And okay,

Ben Adams

and what what sort of materials would would you be holding, but forgive my ignorance?

Speaker 2

Like different purposes? So Collins, oh, different.

Ben Adams

Okay, all right. No, it

Steven Bruce

was thinking about his lack of knowledge of fashion. And he really shouldn't.

Ben Adams

So, when you're cutting the fabric and doing that kind of thing, are there any kind of positions that you have to hold? Or are you working with a bench? What what does that look like?

Speaker 2

It's not really anything. Okay? Ko is just, however, it's easy.

Ben Adams

Okay, so whatever, whatever's around and that kind of thing. Okay. So do you have to move your body and adapt quite a lot? Or yeah, sometimes

Speaker 2

if I'm moving it and there's like, certain bits up, so like, I'll move with?

Ben Adams

Okay. All right. So what what I'm doing is probably something that we all do, which is delve into the patient's background and explore what sort of positions they might be holding and things like that. The reason why I would ask around activity and sports and that kind of thing is particularly we want to explore, are they doing what we call aerobic exercise? Or are they doing anaerobic exercise? Are they doing lots of proprioceptive movement and that kind of thing. And this is one of the points in the article that I raised is that often when we give exercises, they may focus on one element, so

maybe strength or maybe there may be an aerobic element. So getting patient to walk with back pain or something can be can be seen as good. However, we have to take a broad view to that and see, are we getting all of those elements in when we're building, say an exercise programme for someone. However, as an ostrich, path, I also believe in the hands on as well. So the palpation, the movement of the body, the response would also feed into that. So for example, is there a contracted muscle? Is there spasmodic muscle? How does it respond to the movement I'm putting through it. So I would add those two things together to build up that that picture. And then that would enable me to build that plan with the patient. So I have an example of a really simple thing we can do. So someone has had a history of ankle sprains, and that's led to back pain and that kind of thing. Often, we find that there is a proprioceptive deficit in the knee. So if I just get you to straighten your knee, and back down nice and nice and quickly, yep. And back down. So now, that doesn't really tell us very much guy. So if I get you to really slow that down, nice and easy. We can then get an idea of is there movement around the knee? Is it jerking, or, or moving? What's that muscular coordination like, and that is often something that, particularly with chronic pain, is is missing, or there may be deficits. And so this is something that we can begin to look like to look at, which often doesn't cause them pain. So it is a way to ease into the idea of exercise, particularly someone who hasn't done a lot of exercise, I'm not going to start to tell you to go to the gym and do XYZ, because you'll likely go well, I'm not interested, you know, and this is your thing, finding out what what you enjoy means you're likely to do it more means is likely to be more effective. So, for example, if you were to tell me I really enjoy, I'd know, ballroom dancing or something, well, then we could look at well, how do we get you back to that? And how do we develop an exercise programme or something that reflects that, and enables you to get back to that quicker? So there needs to be an element of specifying what we're doing as well, I think,

Speaker 1

when you have, it seems like you possibly you're using some emotional drivers, you're looking into the patient's life and finding what's emotive to them. Yes. And hopefully, going along that direction. That'd be, right.

Ben Adams

Exactly, exactly. That exactly that really good point,

Steven Bruce

you have a challenge here. Because Greece likes design and fashion and so on, it's hard, is it not hard to build exercise into that if you feel like so as

Ben Adams

it is, in your point of view, where you're doing fashion and things. And there isn't that that that broad activity base, then I would start with something that is going to be easy for you to do, that doesn't take much time. And that that you would be you'd be happy doing on that basis. So I want to find something that's going to be the biggest bang for the buck, without taking you too long to do in

this case. So this is where something like muscular coordination type exercises can be can be really useful. And it's something that we, we could explore with you, however, come a certain point, they're going to be effective, and, and we're going to see really nice, stable knee movement. So at that point, we might need to look at, well, how do we encourage you to do a little bit more aerobic exercise, say, or bring in a strength or anaerobic element. So how I would do that isn't I might talk around the benefits that may bring you in terms of being able to maintain those postures for a long period of time. And what it what it might give you and if you were if you were interested in that, so but the other points thing is I'll get your agreement. So, you know, I because I could say I've got this amazing exercise for you. And you go, Huh, yeah, that's brilliant, thank you. And then you're never gonna, you're never going to do it. Whereas if I engage it and say, Well, how often do you think reasonably you can do that? And what do you think the challenge is, might be, can we explore those to doing it? We can then come up with an agreement as to what what you might want you might do, and you're typically more more likely to do it. So So

Steven Bruce

could you for example, in the case of someone like race, could you say you're not gonna like this great, so you can get off the bus and I stopped earlier when you're going to School get your dad to drop you half a mile down the road and instead of taking you to the front door, exactly, then it wouldn't be even necessarily fun exercise, but at least you'd say, well, no. Yes, an obvious target exactly that.

Ben Adams

So you're, you're looking for the easy hanging fruit. So, you know, it doesn't have to be going to the gym, it doesn't have to be doing exercise is what works around your life. Now, because I could say, well, if everyone goes to the gym, they're going to be healthier. And that is true, but is not really much benefit for you. Around what what what you're doing. So really delving in and being specific about what we're asking and understanding the patient is really key to developing an effective approach with the patient,

Steven Bruce

this might be a bit of a stretch, is there a potential negative effect, and if you say to a patient in chronic pain, who's probably got some psychological maintenance, maintaining factors Anyway, you've got to go to the gym and do this, and they think I don't want to go to the gym, where they're gonna get more stressed and perhaps even exacerbate the problem.

Ben Adams

I would say quite often, my experience is that they wouldn't, they just wouldn't engage with it. So they might tell you that they've done it when not, or they would just not engage with that element of treatment. And this is the other thing in some people, exercise is not going to be where where you can start with them. So you might have to start with a solely hands on approach, and gradually

move them to something where they where they're doing more, you know, so you gradually shift the locus of control to, to them, rather than as as the

Steven Bruce

practice how are you getting every one of the incentives? Is the patient, realising they've made progress? So how are we how are you setting these little targets or benchmarks are the patient.

Ben Adams

So my little trick is to borrow their phone and video them doing it? Right? And say, okay, that's you doing the exercise? Okay, well, then, we'll then when we review it, we'll see what that looks like in a in a few weeks time and things. A, they've got it on their phone, they can, they can watch themselves doing it. So if they forget, then it's there for them. The other thing is, they can then see progress, you know, week to week, as they can watch back the videos and things.

Speaker 1

And that's one of the hacks that we often have as well, it's so good to use people's phone, their own phone, yeah, you will have their permissions. And it's such a great way to keep up with the progress. Right?

Ben Adams

Exactly that because if you give someone a sheet of exercises, with the best will in the world, I'm gonna look at that and think, Well, I can maybe remember how to do one, or how much do we learn after after a lecture or in a lesson, maybe 10% 15% at the most. And the same holds true for for exercises and that kind of thing. And I think this is something that we we often forget it and we need to build in structures that allow that take that take not advantage of that, but take account of that. So that they have that and built in. And it doesn't have to be fancy, you know, just just videoing a phone thing.

Steven Bruce

Interesting. Grace. If you were in my clinic, I'm doing this examination on you. You're wearing shorts and sports tops, I can see all the bits moving stuff like that. And I say I want to film you on my phone so I can send you pictures of that. Would you feel uncomfortable

Unknown Speaker

about that? No, I don't think so. I'm curious

Steven Bruce

to know, because we we all know, great revelation is used the patient's own phone rather than us have those records on our infant. I'm just exploring whether that would be an issue for some,

Speaker 2

not for me, but my friend is

Steven Bruce

definitely not worth risking it.

Ben Adams

That's my sort of clinical director hat going GDPR. And yes, absolutely. It's just much better for them to have it on their phone. Now there is there is a downside in the clinic wouldn't keep records of that. So you wouldn't have the reference. However, you could always make a note of what progression is occurring in the video and that and that kind of thing. So it's a little hack, and I'm glad to know that someone else has come up with a hack as well. But developing that having that alongside that review structure can work really well.

Steven Bruce

In terms of looking at groceries like a moment ago, you were looking for the smoothness of expansion. Yeah.

Ben Adams

So it gives me an idea of the muscular coordination. So if I just get you to do that nice, nice and slowly, really, really simply, I'm just looking for what is that coordination like in three forms of movement, one muscle contraction specifically. So obviously concentric isometric and eccentric. What what is that like? Often in the it's with the eccentric where that control starts to break down? And you see shaking. So that's often where the patient will often just let the leg drop. And so that's where you need to engage with training around that to, to develop that control. Now, if someone has chronic pain in the area, typically that is, you're going to notice a big difference one leg to the other, you're also going to notice after you've done a few repetitions, that you'll come to a point where everything shakes. And that there's a, there's a big sort of wobbliness in the knee as it were. And that's really the sort of total volume of exercise that that that can take at that point. So what you might do is say, Well, you can see that you can only do three repetitions at the moment, there's no point trying to push further, particularly with the with the chronic pain patient, you why you want to do is gradually build up tolerance and increase so over a few weeks that make that shaking point where you get a exhaustion, that might be six repetitions, say so. And that's what you're looking for. So quite often when they say, Well, how many repetitions should I do? I say, well, it as you can see, you want to want to do around three, but sometimes in some days, that's going to be more other days, that's going to be less, because with stress and other things, our exercise tolerance is going to be higher and lower different days. So that that point is going to occur, a different repetition. So

perhaps a sort of static number, or amount of exercise isn't going to be of benefit, or the most efficient way of helping that person in that case. So

Steven Bruce

your guidance would be do it until you can't control it properly. And

Ben Adams

as long as as long as they can, as long as they can see it and feel it. If they recognise it, then yes, if they can't, and some people can't, I would use repetitions within that. So although you're losing some potential efficiency with that, if they don't recognise it themselves, then the danger is they do too much. And whereas

Steven Bruce

I'm going to ask how you deal with the person who's approaches, if he stopped me to do three than 30 must be better? Yes, I would talk

Ben Adams

them through the reasons is why not something you know, like the the novel stimulus effect, if you introduce something new, you're going to have a big vision, logical response and overshoot the mark somewhat. So I talked to them around that and say, you know, really, you're gonna get the most benefit from doing that. If you overshoot it, it can be quite sore. And you might really feel that for a few days afterwards. If that happens, you know, stop what you're doing and go go back to the two or three repetitions, say that they recommended. So and sometimes, if someone is really driven and really doing a lot, you have to have that conversation with them about what is the purpose of exercise and training. So you might talk them through your stress response and adaptation curves and, and that kind of thing, I find that works really quite well. If they get an idea of that you're generating a stress, and then you're getting a response, which enables them to train better, then they can they, they can see that more, quite often they're not aware of that. And often, in that population of people that have chronic pain, they frequently have really become quite advanced athletes, but they're training like beginners. So the more advanced you become, the more specific you might have to be in what you do. And you might have to pick your priorities. So, you know, after a certain point, if you're a marathon runner, you're not also going to be able to do you know, heavy squats and the rest of it because of the competing demand. So, but if you try and do lots of weightlifting, say, that's going to add to your general stress pool in the body, your general Allostatic loading and that kind of thing. And then that might may result in in pain and inefficient training, or overuse type injuries, which can become chronic in

Steven Bruce

nature seems in some ways to conflict with evidence that we've heard good evidence, and we've had discussed on the show before, which is that if let's say you have knee pain, then strength

training, yes, proper strength training, which means training to failure is proven to give you good results in that. But of course when when we give that sort of advice to people, we're not dealing with a chronic pain patient. Oh, yes,

Ben Adams

exactly. So this is where there is a difference between the acute and the chronic, and where we have to be aware of what that background of the patient may be that is not the strength training is bad. But you might not start there. So say you had a chronic knee patient where they had those proprioceptive deficits, do you want to train strength training to failure within that, where they don't have the appropriate control, I would argue that you're much better off starting with that proprioception approach. And then building in strength training, which is going to be much more controlled, and therefore efficient at that point, so you

Steven Bruce

call to mind for me anyway, of course, I once did with Al Lindemann. And he did a lot of similar sort of things for people who had lost proper proprioceptive control after possibly surgery or recovering limb injuries. But he will be challenging that movement, and getting the patient to resist what he's doing with the limb as well as sort of trying to push it in different directions while they correct it. Is that something you incorporate into this? As a sort of you call it a novel stimulus? I think,

Ben Adams

yeah. So it, you can do is not something I do. Because of the how I how I would engage with would generally be passive. I'd be looking to establish nice coordinated movement through the Lumina in a passive manner, looking at different leverages, and things as well. But sometimes active engagement in that way can be can be really beneficial, but it's not something I'm, I'm an expert in so

Steven Bruce

so where do we go next with this poor suffering patient here?

Ben Adams

So it what what I could do is show you perhaps how I would use hands on treatment, and how the two were combined. So if I can ask you to have a lie down on your back if that's okay.

Steven Bruce

One grace is doing that we got to make so didn't we have Letterman telling us that walking was a great exercise and all this prescriptive exercise? isn't that helpful? I didn't realise somebody already told me commented on a sales training. I don't recall that I remember him coming into studio. But does that ring any bells with you?

Ben Adams

But yeah, I I take the point walking achieves a lot. However, I would argue that often there can be specific deficits, where if we identify them, one or two quite simple exercises can help the patient get better, quicker. And that would be my main tip. But I agree, walking is a fantastic exercise. And but if they're not keen on walking, then again, you know, that patient isn't going to do that. So how do you how do you square that? Grace is going to be made

Steven Bruce

to get off the bus early now. Before you go on, I've got a couple of other things in here. One is that son focus identified himself. I don't read out surnames on the show, but it's Andrew and he graduated in 2007. And worked for you soon afterwards. Yeah, hello, Timothy ambo says he really liked the communication between nabble and Ben, right over to you then. He says me as well. But these two are so clear and concise with question and answer, YouTube. And as a parents of neurodiverse children, as well as working with a diverse patient base with varied and complex issues. He finds that patients and communication is key. Yes. Yeah.

Ben Adams

I think it's something we, we often underestimate. So for example, if I look at myself, I'm a lecturer in classical osteopathy, I can think Well, the main thing that we do is, is the treatment, the hands on and that kind of thing. And I can talk to you at length about the the sort of artistry within that. However, there is also a huge communication element. And I think it's tempting to skip that bit sometimes. And if we were viewing the the person as a whole, we have to engage with that that side, man,

Speaker 1

it's a vital part of the patient's experience. Yes. And I think it's the patient experience the patient journey itself and the hands on isn't it? Most of it, but isn't all of it at all?

Ben Adams

Exactly. done exactly that because I'm hands on is can be incredible. But you have to also create the environment for the hands on to be efficient to the stage. Yeah, set the stage. Exactly that. And if we don't set the stage, well, what what play are we going to be performing? You know, and that's the that's the question. I think that we need to think about some time

Steven Bruce

so as to other great mountains and osteopathy would would echo that. I mean, Simeon Neil ASHA has been on the show a number of times and one of the things he's emphasised on his courses is the importance of touch, because it works both ways. So What you get from that, but also I'm very

struck when I said earlier on, we've got Laurie Hartman in the studio tomorrow night. And on his courses, he says, it's not just about that it's about how are you touching? Yes. And he will do a demonstrate that people do handshakes and sort of do it differently. And how do you feel when you have your hand shaken that way, you know, and when he's touching a patient's back, he'll have one hand on the shoulder, while he's palpating. And that feeling of security that it engenders in the patient is very important.

Ben Adams

Yeah, exactly, that, I'm hopefully going to show something very, very similar. In I would, I would love to try and create that security. Where, and I just started, so nice and relaxed, nice and loose, I'm not going to do anything sudden, okay, what I'm going to do is just gently, right, backwards and forwards like this. So all I'm doing is just getting a sense of the, the traction, and then the release through through the soft tissues in the beginning, trying to make sure that it's nice and secure for the patient. And I've got soft hands. So what I don't want to do is, you know, grip really tightly, because that's that the patient is going to pick up on that. And that that that tension in the hand. So for me, creating that environment is so important. And just that that soft movement and the use of the body and rhythmical approach, comm feedback or a wealth of information. So in this case, really, I'm just getting a sense of how soft tissue in the leg is moving to begin with. And then there's the quality of movement in the ankle. So I'm not, I'm not assessing range, I would I would do that, that separately, if I needed to. Now what I'm looking at is the coordinating movement through the, through the whole lower leg. I'm also starting down here, because it's going to help her to let go and reassure her, she can feel my my touch. And hopefully, that will enable her to to let go more as I've progressed with treatment and things.

Steven Bruce

The astute viewer is going to say, why are you working on the other leg now, but of course, it's the one near the cameras, and it's a demonstration? Yeah,

Ben Adams

so I'm gonna be I'm gonna be swapping around and moving around. So I've been told to work in a certain way for the cameras. So again, we're just, we're just getting a sense, a sense of the quality of movement. So, um, one of the things that we often don't consider is the actual axial loading through the leg, in, in injury. So we might think, say, of the rotation, and that kind of thing, but how is it also dealing with the compression and releases, we walk and run and things as well. So this gives a really good feedback as to what that can be. And I'm just trying to keep my hands soft. And using my hands to feedback Well, what's what's the tone in those muscles? I'm not seeking to, to do do anything at this point. I'm really just, is there any spasm or any any tension? Is there any pain? You know, sometimes, as we know, even when we pick up a leg that can be painful? Okay? If it is where, how is it painful? Where are they experiencing it? Is it that they're just holding really, really tight, in which case, I might just slowly just persuade them to just gently let the leg drop, like the lead drop. So I'm trying to engage everything in that passive way. And that enables that coordinated movement to occur through through the leg.

Speaker 1

I think anyone who's like we will have been working with patients for years, will know that if you put your hands on someone, you will know if they want you to touch them or not. Yeah, and I think it's almost like this gentle engagement almost like a dance to some extent. Exactly that. Yeah. Whereby actually confidence and all of that is infectious. Your patient feels it to us. And I think that will just add to a nicer experience. odour?

Ben Adams

Absolutely, absolutely. So you want the experience to be pleasant, pleasant for the patient. I think what I was guilty of as a student and as I graduated and developed was rushing in, okay, you've got a knee problem, I'm going to, I'm going to rush in and examine your knee whereas often that can be painful and sensitive for the patient. Whereas if we if we take a step back and just explore what are the global mechanics going through a limb say to begin with, it also allows them just to relax and let go. When

Steven Bruce

we get done with after all our years of doing it to each other that there are a lot of people out there who are not used to strangers putting hands on knees or other parts of their body.

Ben Adams

Yes, it Exactly. And if we rush and if we grab, exactly like you say, they'll, they'll feel it, there'll be an instinctive contracture, or holding, and then the treatment isn't perhaps going to be as effective as it could be. So, I would say is really important to start with that, that distant view, you know, if you're, if you're setting up the stage for your play, you want to walk on, and gradually just cajole the audience, you don't want to go in and make them jump, you know, you want to gradually get them to soften with you now. So we've, we're just getting a sense of that loading, and then I can explore rotation through the lag, age, keeping everything nice and nice and loose and relaxed, I can then engage with rotation through the leg, and I'm gonna have my hand here. And that's just supporting leg and allowing them to let go. So if there's any sort of resistance, I'm going to, I'm not going to push or pull through that. I'm just working, working around that point. So it's really what I want to avoid is any sort of nociception, any sort of nociceptive drug, particularly in the chronic patient, because of that idea of sensitization either of the periphery, or that central sensitization. So, because if we, if we're too firm, and we develop no nociception, then arguably, again, the treatment is going to be as effective as it could be, whereas we won't sign

Speaker 1

up and you become aware of unconsciously obtain informed consent as you go along. Did you give a narrative as you go along? Yes.

Ben Adams

So I would say, my clinical director, it's important to maintain continuous consent as you go along. So I'm constantly talking to the patient about what I'm doing and why and, and that kind of thing is really, really important to do that, as well as consciously as well as was unconscious sometimes, like you say, you can you can feel, Oh, they don't want you to touch them. And that's, that, that's okay. Well, when

Steven Bruce

it's one thing to talk about what you're doing to a patient, it's a different thing to say, I'm about to do this, is that okay? Well, I imagine that's what you're you are doing.

Ben Adams

Yes. So what I would do for for this sort of thing is I explained to them beforehand, generally what I might do with the leg, and then say I'll do something very similar with with the arm, or, or with the other leg, for example, so that they're aware they that they can get a feel of it. But just explaining what I'm doing as I as I go through. Particularly, if you want to use any stronger techniques, or any any, anything like that, obviously, that is really, really important to do, what

Steven Bruce

you were doing on the hip that you were operating in a very narrow range of motion, that would you gradually build that up to the patient's tolerance or the full range of motion depending on

Ben Adams

so it depends. So if I wanted to assess that I would do Orthopaedic and of range. If I'm looking at this idea of coordinated movement, I would, you will find that will probably change as I was doing it, but I wouldn't seek the the the end of range barriers as it were. Because say for example, if the hit there's a reflex change a sort of neurogenic reflex change in the hip, I then might want to go and have a look at the the leg or the ankle again, equally, I might want to have a look at the lower back or the the pelvis as a ring. How is that adapted to that to that change? is the part of this painful sites that's a knee is that a carrying on its own osteopathic Lee, I would argue that it's the tip of the iceberg. And we're gonna have a whole bunch of other stuff going on through the body that that we need to look at and assess as well. So really, end of range can be really useful. It's what your aims are and treatment, is that how you want to do it so that the model that you're using will influence how we use a technique. So, for example, like I might want to assess the orthopaedic and arrange for hip absolutely, you know, but if if I'm trying to get a sense of this coordinated movement, I'm going to miss it. So if I if I have the have the leg here, nice and loose. And also she's she's quite tense. So where where she relaxed, that's quite a narrow window. Okay, but what I'm what I'm getting a sense of as well as, as as the leg moves is the I'm moving a carrying down through the leg down by the fibula as well, not just through through the hip. Wherever I take that to end of range and start to explore, that tells me something different. But I'm not going to get that coordinated movement that I'm,

Unknown Speaker

I'm looking forward. So that's quality versus quantity, right?

Ben Adams

Yes, yeah. So it really what I'm what I'm suggesting is looking at the qualitative impact of what we're doing, that there is absolutely a need for quantitative assessment. And but that is that qualitative feel that we're looking for, not just in terms of range of motion, but also what does the muscle feel like. So there's a big difference between a chronically Fibro used muscle and a spasmodic muscle, you know, they, physiologically there are different things occurring there. And they're going to feel quite different to the touch. And I think it's important to try and pick up these differences. For example, quite often, we find that the property is in the back there might my spasm, as we just gently move the fibula and things, because we can pick that up with our fingers. Whereas if we have, typically we get sort of chronic fibrosis on the on the outside of the thigh, and the iliotibial band and the vastus lateralis. That feels very, very different. And the response we might get in the tissues is is quite different. So, again, I'm not looking to sort of impose upon the tissues. But listen for a sort of reflex response.

Speaker 1

Really, it seems as though almost you're you're extrapolating what you feel, and perhaps extrapolating further along muscle chains, joint chains, fascial chains, so on and so forth. Yes, would that be wrong? Or

Ben Adams

no, I absolutely do that. So you're, I'm trying to build up a picture, not just of the local area, but also the global thing. So muscle chains, fascial, chains, all that side of things as well. Because we know for example, if you have shoulder pain, if you do work with your your core, and that kind of thing, actually, the gold standard evidence shows us that that's going to help with the with with the shoulder pain, same sort of thing, but with the hands with the and feeling the response in the body. Using those, those leverages to to get an idea of not just what's occurring here, but also more globally as well. And if we think about it, whereas the nerves apply from from the knee coming from, well, it's coming from the low back, you know, so we have to have a look at the low back we, we have to have a look at the sacrum, you've then also got the sympathetic nervous system, which we know often when knee injuries, you do get atrophy of the sympathetic nervous system, particularly on the medial side. So where does that come from? Well, that might come from higher up in the in lumbar spine, or your hypogastric Plexus, down, down through, down through the nerves and things. So there are different connections that you have to consider when looking at as well. If you have swelling, chronic inflammation around the knee, that's quite different to acute inflammation. So how is that? How is that potentially draining? What are we what are we thinking of? Well, I would argue we have to look at the lymphatics and other sort of research in modern lymphatic movement really interesting. But it tells us that if you stretch the lymphatics, you actually encourage peristalsis. So by engaging with these long leverages, we're helping to engage with the peristalsis of the lymphatics, and they radically helping with a sort of chronic congestion around the knee as well. So it's bringing all of

Steven Bruce

the indirect way of addressing the lymphatic system, as opposed to trying to mess up along the course of the lymphatic. Yes,

Ben Adams

yes, I want to try and achieve that peristaltic neurogenic effect, as opposed to fizzy massaging light. Because I want that to hopefully stay there for a period of time. So because you can get peristalsis that lasts for hours, if you if you stretch. I don't know I haven't done the research into direct massage. So I don't it might be the same. But certainly the when I've looked at peristaltic movement back by a stretch that that can last for for a period of time. If we're using a long lever we're also getting In that squeezing stretch through the soft tissues and through the, through the lymphatics as well. So arguably that's, that's what I'm what I'm hopefully trying to achieve at the same time. So getting a, getting an idea of, of that coordinated movement can be, can be really useful. My hand here, I'm feeling the fibula, but also round underneath the puppeteers and things. So I'm getting an idea of what is the response? What is that lag telling me? What is the, what is the communication? Now, I can then if it's, if it's comfortable for them, then lift up and then look at the look at the SI, obviously, if they have a knee problem, I might not want to induce the flexion. So I but I can then carry on with that process, and have a look at the pelvis and things as well. What that does, is, is not just the state that I feel but the how it responds in forms, what I might then do for a, how long it might take. So is there a is there a quick response in the tissue? Or is there is there nothing? You know, we've all had that feeling where it feels like the tissue is leathery? Or and there's no no response to it? Well, if that's the case, then then perhaps that's going to be take longer than something that is you can feel the contracture but it lets go. So there's still that neurogenic element to, to what's going on. Whereas if we have that, to leathery feel to the tissues and things on there is no response, it may take a period of time, or it may, in fact, never respond, we have to be have to be aware of that, I think, and then that can influence how long treatment may take. So I think the hands and the hands on are so important to what we do. I totally get an understand why there is this drive for exercise based treatment and and the rest of it. But I would say that we we are missing out on something if we if we let that go, if that disappears. Over the years, there's a whole wealth of information that we're potentially leaving on the table. And there's a whole effect of treatment that we're potentially leaving on the table for the patient as a craft, isn't it the craft? We need the art history, I would argue, you know, there is and I think it can be it's really tempting to focus in on the on the detail and science. And absolutely, we need that. But how we interpret it, how we use it, how we develop and build our artistry, it can be informed by that I would argue. And if we lose that, then if we're building a play, we were no longer Shakespearean, you know, we've lost that artistry that comes in in writing a play. So that can be really, really useful to pick up all that information from from the leg. Often, in chronic pain patients, I would personally treat the whole body and I would treat the whole body because I'm aware of that sensitization that might be going on. So well, as I'm sure we all know, we have the idea of peripheral sensitization and central sensitization where stimulus that would normally be non nociceptive becomes nociceptive. I would argue that if we can move the body so that it isn't experiencing pain, and we're getting those reflex changes, we're hopefully trying to dampen down that sensitization. And if you read into a lot of the pain science, if you don't really want to be pushing into the area that's painful, because you're feeding into that, that sensitization picture, you're adding fuel to the fire. Really what you want to do is dampen that

down a little bit. So as a because I typically do classical osteopathy and we tend to wiggle the whole body around. That really appeals to me, and that that sort of model really appealed to me. Not to say it's always right, or it's the only way or, you know, but for me personally, there's a really beautiful artistry to that. And, and really using the body and simple leverages like that can be can be really useful. Connect

Steven Bruce

certainly worked on the leg, where do you go now.

Ben Adams

So I have to remember, so I might have a look at the limb. So have a look at the limb here. So again we're doing is just picking the arm up. And just a show it's nice and relaxed. And again, I'm just soft hands soft. If I buy if I, if I grip, it feels quite different. So if it's soft. So again, I'm trying to engage with the the sort of fascial structures through here, and just get a sense, what is my, what is my hands telling me here? You know, there is the is there resistance. I'm not sort of pulling and pushing. It's just seeing how it responds, well, let's go again, it's quite a narrow window where I get that that passive

Steven Bruce

movement, you're developing testing like this into treatment at the same time where you're going to come back and do that subsequently.

Ben Adams

So I Yes, so I'm testing and then I might attend to training where I might just add a little bit of pressure here or there. And just ease through that. So one of the big influences for me, has been the work of stucco, and the fascia and the superficial and deep fascia. So if we think of the fascia in the trapezius, you know, the big binding fascia, blending into the nuchal ligament, and then how that blends down into the arm doing something like this, where we're taking advantage of that fact. And we're just easing through the fact that, again, I'm looking for that neurogenic response. I'm not trying to create a physical response underneath my hands. Could

Speaker 1

it? Could it be the examination is a therapeutic experience? Or verging upon that? Could it be that your examination might be one that is almost therapeutic?

Ben Adams

Yes, well, so there can be the blending or merging of examination, and then the the therapeutic effect of it. Really, what we want to do is create that therapeutic effect through the whole

experience. So from the moment they walk through the door, ideally, I'm going to pick up the phone, right the way through treatment, to to, even then if you think about it, the whole plan of treatment, you want not to be have that therapeutic effect. So in here you want to I'm deliberately trying to create a calming, easing, gentle environment for the patient, and I want them to be almost asleep when I'm when I towards the end of treatment.

Steven Bruce

Guessing Because grace didn't squeak at all that it was all very comfortable.

Ben Adams

Yeah. Good, good.

Steven Bruce

We had an observation from Sarah, who loves your expression, wiggling the whole body around? Is that a great expression? Describing what we do? But Sam actually has asked the telling question, and that while most of us know about classical osteopathy, we actually know what to do with this we only one, this is the way you use what you've demonstrated so far is that typically what a classic was diverse fields?

Ben Adams

Yes. So what what, what may define a classical osteopath, I'm not entirely happy with the term. But essentially, we do this whole body wiggling. So we would typically try and treat the whole body in every every session, not always. But most of the time, we would look to try and treat using long levers. So using the whole leg into the lower back, using the whole arm into the neck, or, to move a little bit further down,

Steven Bruce

we say well, just for the cameras, so just

Ben Adams

about about, yep. So are using the whole whole arm into the thorax, the neck as a long lever means the pressure, but I have to produce my hands is a lot less. Whereas if I have a short lever, I have to produce a lot more pressure on the hands. Now that's not to say, surely the techniques are wrong. It is just how we how we define what we do in Glasgow last job. Now, I found that when I work this way, my hands don't hurt as much. There isn't as much tension in my forearms, and all the other things that come with with lots of soft tissue and that kind of thing. That's not so don't do soft tissue. I do. But I will predominantly look to try and use these these long, long levers. I was I was giving a talk in BSL UK. And I was saying to them, you know, there's this thing of there is the one way there is

right and wrong. I really I would suggest moving beyond that to what model are you using and is what you're working in form by that model. So with classical apostrophe osteopenia, yes, we would use those long levers, and we look for that gentle wiggling, could I get you to turn on to your front? That's okay.

Steven Bruce

I'm gonna stick a pillar on your middle again, you hear me? There we go.

Unknown Speaker

Don't have my hands like that,

Ben Adams

yes, let your arms dangling nice and relaxed there. So what we would do is typically, what I did there to the arm and the leg, both sides, then we would do something similar with the neck Bada, I will come come back down. And then just let your legs relax there if you can. That's it. And again, I've got very similar sort of leverages, I can really explore movement in the feet and the ankle as well. And I'm just getting a sense of what is that? What is that movement through through the leg, into the lower back and into the pelvis doing. And again, I'm looking for a listening for response in the in the tissues and things. Now, I might be that I, as I'm working, I find that there is stiffness, say in the ankle or in the foot, and then I can come and look at that. But I can then go back to that global global approach. So I might look locally, but then come back and look globally. Yeah. So I'm, I'm always trying to integrate those those two things together. So movement based, and sometimes, I then might focus, you know, where I might use short, short lever, and then again, but take that into that wider pattern again. So I'm not just looking to treat one bit in isolation, but try and have effect through the whole thing. And this sort of whole body wiggling is what that's trying to achieve really. Quite often I find, as we treat people and the different patterns emerge of what what they may have experienced. Actually, you realise Oh, there's there's quite a lot of tension or stiffness around here, which I didn't really realise was there before. And this way of working enables you just to constantly sort of double check your work is it where

Steven Bruce

Kim's asked why you don't check the pelvis first, as she says, Now the transfer of weight from the spine to the legs is crucial. If the pelvis is out of line, the transfer will be compromised, leading to compromise with the sacrum, having an effect on the lumbar spine above and the knees and gas drops below.

Ben Adams

Very good point, I may well check their pelvis first. So I often start down here, if I get the sense that they're apprehensive, or if they've had chronic pain, so I may well assess the pelvis standing or sitting, first of all, to see what what's going on. If it is a sort of primary element in what's involved.

But yeah, nothing sort of set in set in stone. Really, it is, where do I think for that patient, the best place might be to start. And because this is about chronic pain, typically, I will start the furthest away. Because I want to produce that, that soothing settling environment for them. Now, sometimes I might, I might look directly at the pelvis and see, but again, imagine for the non osteopath, you you're going in and then someone all of a sudden is pressing into your pelvis and you've got knee pain. So you have to be very careful how you explain that. And that's not to say I would never do it, but that there is an element of caution now with that perhaps

Steven Bruce

you've got five minutes left or a bit more treatment. We're okay. mination.

Ben Adams

So once we've Halak that you can, you can then use this hand here, to get a sense of any tension in the tissues. How is that responding? Is Is there any sort of spasm? Or? Or is it is it nice and easy?

Steven Bruce

Could you do that on the other leg? Just I think the cameras might find it easier to pick up the exactly what you're doing again. So

Ben Adams

is that is that better? Yet? Yeah. So is there is there any spasm, you know, also is is the pelvis moving? You know, what is the what is the tension in that? So again, I'm not I'm not sort of grabbing with my hand or, or pushing, just getting a sense of what's of what's going on. Now, I then might take that into treatment by then. Actually just just adding a little bit of pressure through my hands and seeing if if I need to. But again, I'm trying to use that, that long lever into where my hand is. So I'm not, I'm not sort of pressing with my thumbs, and I'm creating that short lever there. I can then do this similar thing. But we can look at gently oscillating the body. So where you might use the leg to just get an idea of movement through through through the spine there. So I'm just bringing my hand over here, because it's easier to generate the movement. But in a real life patient, often I would start here, because that would often create the movement through the spine to to assess what's going on. So just getting a sense of how that of how that's moving. And seeing, and then thinking, how does that reflect what I felt below? And potentially above as well? Is there nice movement through the, through the spine? If I left the arm, you know, what does that what does that look like? Does that also transfer through the spine? And so looking at different leverages, and saying is there? Okay? It may, it may, cause you may get coordinated movement through the spine this way. But if we try a sort of top down lever, how is that working? And

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like the improv that you have the improvisation you you improvise and adapt, right? Yes,

Ben Adams

yeah. So there's no such thing as a standard patient. So I think this is one of the things where we can look at is the principles that we're using. If we're coming at it from a principle of base point of view, as in, we have a principle of what the technique is trying to do, we can then mould it and move it as we need to, to be effective in that patient. So rather than saying, Oh, we stand here, when we write that there's not really working in this lady. So we can see where a similar movement might be effective in that case. And it's, it's appreciating what we're what we're trying to do. i That's why I really like these long levers, because it gives you that scope, those options, that perhaps, if you're looking at a smaller area with direct pressure, it is difficult to have as much scope or options there. I think this way of working gives you lots of different possibilities and things as well. So

Steven Bruce

should we leave grace to snooze? They're generally in the the table and go back over to our seats for questions. Thank you. Great to be on model again. Thank you. We did have an interesting thought from Kim again, earlier on, but not so much about the way you're treating but just she mentioned that we've seen so much in the press over recent years about bullying in elite sports, particularly your athletes, either by their parents or their coaches to achieve things. And of course, elite sports, one of the sort of we're likely to get themselves into a chronic pain pattern of some sort. Now, I don't know if you treat elite sportsmen but is that a factor? Do you think in in their well being,

Ben Adams

as in the sort of emotional background

Steven Bruce

or the emotional or sustaining factors of chronic pain? Yeah,

Ben Adams

I don't treat a lot of elite, sport sports people myself. But I would say that, absolutely. We have to consider those sorts of things in the background. I mean, we can see if we think of say, perhaps teenagers who may be very good at a certain sport, and they can very quickly develop overuse injuries, and they're pushed by the pirates and that kind of thing. So you can you can see that, yes, they have problem there. But actually, the there is a potentially an underlying issue there as well to, again,

Steven Bruce

it's outside the scope of today's discussion, but I suppose there's a role for us in our in our requirements to do as much as we can for safeguarding our patients to recognise that there might be one of these nasty underlying factors in there. Absolutely.

Ben Adams

And I would strongly encourage everyone to do a safeguarding course and get safeguarding trained. It isn't done very much in the profession. And I strongly recommend that you do. Going through level three safeguarding, I think should be mandatory for every practitioner, because it really, really makes you aware of those things. Yeah.

Steven Bruce

Just coming from Philip. This is the general ba routine body adjustment. Seeing up through right side then up left side supine, first and then prone. Neck looked in the supine neck looked in supine position, looking for subtle tension, subtle changes in joint shape felt while moving, treating as you feel very holistic and brings in all systems. No question in there just an observation about what you were doing. Yeah.

Ben Adams

So certainly, yes, that's that's what body you're just moving or trimming our body from a classical osteopath would look like. I would argue that it is also a principle that you can take into different positions. So you don't necessarily need to be supine, prone and that you can apply the same principles in different positions and things as well. Yeah.

Steven Bruce

You haven't come on here trying to sell courses or anything like that. But I did see one question in earlier on, which has somehow disappeared at the moment, which somebody saying, Well, where do we go to learn all this stuff?

Ben Adams

Good question. So I'm a, I'm one director of the Institute of classical osteopathy. We run courses in the UK, we also run courses with other schools in Europe and things as well. So depending on depending where you belong, the courses the course we offer is 18 months, I believe. Don't quote me on it. But that's not full time. Obviously. No, no. So it's postgraduate. And it's based around four day seminars. And I think we have what, five, five or six of those, as well as online tutoring and things as well. We did have a clinic, but unfortunately, they had to shut up because of the pandemic and things. pandemics over there. Yes, yes. Yeah. Maybe that's something we will look at doing again, for now online is, is what we can do at the moment. Okay.

Steven Bruce

So for those of us who are too lazy to go on an 18 month course, yes. What do we take away from what you said today and quit and incorporate it into our otherwise very structural hivelocity practices,

Ben Adams

I would say, what I would encourage people to take away is the idea of communicating with the patient, both in terms of verbally, but also through touch. And really building that atmosphere. Setting that stage is so important in with the chronic pain patients do that. And it's, it's so tempting to want to get them better, that we tend to rush it. And that's what I would, I'm cautioning at take that step back. Take that, that moment that that deep breath and build that stage, because that's what's going to be so important. Patient a

Steven Bruce

couple of very final questions very final. Let's think of some grace was in her tracksuit, while you were using demonstrating your technique, would you leave your patients fully dressed? Or do you undress them to underwear or sports clothing? Or it depends

Ben Adams

on the patient. So if if they're comfortable, they often undressed a sports clothing. But if they're if they're not comfortable, I'm perfectly happy to treat them clothes as well. It's really, if you go back to create an environment is what's going to create that environment for that.

Steven Bruce

But then it begs the question, if you can treat with clothes on Why'd you get them? Partially?

Ben Adams

Because you can't was certainly a maybe my my patient is rubbish, but it's only I can't feel I can't feel the detail

Steven Bruce

as most of us would say, you certainly feel you're getting better results if you can palpate this joint.

Ben Adams

Yeah, it gives you more feedback, more information, I would say.

Steven Bruce

And the other one of those two questions was uh, we did touch on the issue of consent while you were over there. I kinda I like to bring him consent wherever I can, because it is such a such an

important topic. And I was actually I was talking only a few days ago to Jonathan gold ring, a very prominent barrister who we've had on the show a few times. And he's an expert, absolute expert in defending osteopaths and chiropractors when they find themselves in front of the committee. But how do you record your consent? Because it is an ongoing process? It must be an ongoing process, do you have a single thing at the end of your treatment loop that says that you've got informed or valid consent for the whole thing? Well, this

Ben Adams

is where I might be doing something that the barrister said is not a very good idea. So I would defer to his judgement, but the way I tend to do it currently, is I would say that I've gained verbal consent to that. If there's any areas where I feel I need further consent, I would say a time further consent at that point. So for example, around more adjusted measures, or or HBT or

Steven Bruce

something, but so therefore, you would although as you were moving around your patient's body, you will say Oh, I'm about to do this. Is that okay? Or is that okay? You'd have one record of you gain you gain consent orally for the treatment. Yeah. So

Ben Adams

I would, I would, I would have one one record and I would talk the patient through that continuously. I don't know but I'm not. I'm not an expert in that. So perhaps that is something I need to look at. And

Steven Bruce

it is something we all need to be really on top of. And when we hammered home every time we have these broadcasts, and I'm concerned about recording everything significant in the notes, even if it's an absence of finding, in some cases, yes. And on shows in the past, we've had people saying, well, what's the best form of what's the better written form I can use to get consent? And my answer is there isn't one because it's a useless form of consent. Yes. It's by definition, not ongoing. Yes. You

Ben Adams

need ongoing consent.

Steven Bruce

Exactly. That so all it shows is intent on your part. Yes. Consent. Yes. Yeah. Gentlemen, thank you. That's you cope very well with the boys in blue. interrogated. Thank you. Thank you so much for coming in. And we've had 476 people watching, which is a very good number for an evening show.

So clearly, what you had to say was of great interest. Thank you. No, thank you for coming in as well. Steven, people obviously referred you to me, so ashamed in front, not coming in here. But thanks a lot. Thank you. Thank you and for taking part in the show. It's been very useful and good night to you