Academy of PHYSICAL MEDICINE

Transcript

A Visceral Approach With Jean-Pierre Barral

Cast List

Steven Bruce	SB
Jean-Pierre Barral	JPB
Harriet (Model)	H

SB: As I say, I'm in the studio with one of the legends of osteopathy. I suspect he will hate being given that title; but nonetheless, I'm here with Jean-Pierre Barral— a man who has been an osteopath for 45 years.

He founded the Barral Institute some 15 years ago. He's been a lecturer at the European School of Osteopathy. He has been the director of visceral medicine at the Medical Foundation in France. And he has spent a lifetime pursuing visceral manipulation, and he has the philosophy of osteopathy in his bones. Jean-Pierre, bonsoir!

JPB: Okay, bonsoir.

SB: Welcome. It's a real pleasure to have you here. The first thing I just wanted to address, though, is: I've emphasized you're an osteopath— you've trained as an osteopath; you've taught osteopaths. You've actually taught doctors in France, as well, haven't you? Which is a real success, I would say for our profession. But you don't restrict your teaching just to osteopaths. Also, you're representative in England is a

chiropractor, I believe. And you don't mind who you teach visceral manipulation to, do you?

JPB: Well, first I would like to precise: I'm a manual therapist, and very proud to be manual therapist. I've done a lot of research, but I defend the idea that the hand is more important than the brain.

JPB: And I was a teacher of the Faculty of Medicine of Paris. It was difficult to teach doctors to put their hand, because the doctor is good with a stethoscope, with some drugs. So it was important for us also to be very more direct, because when you are in an osteopathic school, very firm you believe that you have the truth. But when you are in front of 120 doctors each year, new doctors, you try to slow down a little bit to think about what you are, and you are more modest. You asked me before if there is some difference between the... English?

SB: Osteopathy in France and in the United Kingdom.

JPB: There is some difference. Of course, I respect a lot of what they do in your country. The difference for me is that everything of the body is important. So we treat the skull, we treat the teeth; we treat the throat; we treat the lung; we treat the joint. So each cell of the body's important. It's a concept of steel. And it seems that when I was in England, maybe things have changed. The spine was more important, or the joint more important than the other part of the body.

SB: Is that something which has changed in osteopathy since registration— as in, since the General Council was formed?

JPB: Registration in France, or...?

SB: No, no. Since we had the Osteopathy Act in 2003. 1993, sorry.

JPB: When I teach in England, there is a difference for me. There is still a difference, but you know where you're from when you have hot water, cold water. Little by little, the water become a little warm, and it's what will happen because it's very international now. Very international.

SB: So how much time do you spend teaching chiropractors? Is there a difference between the chiropractic approach to visceral manipulation?

JPB: Chiropractors have changed a lot because in America, we have some chiropractors who will take the course with us. On the beginning, remember with spinal, with occiput–C1–C2. Little by little, now they are doing about the same job than us. The new generation is totally different than the other ones. The other one, I remember was

occiput–C1–C2, and that's it. So it's little by little. You know what I say? Chiropractors— we are cousins, somewhere: we have about the same manual therapies, the same goal to help people. So it's why, what I said before, little by little the boundaries become a little softer, now.

SB: I ask the question because I see it as my mission, in part, to try to help bring the professionals together, because I think we have far more in common than we do to differentiate us. And there is still —in both schools, I think, of osteopathy and chiropractic— there is still a small number who despise the other profession; which I don't think is helpful for any of us.

JPB: In France at the beginning, there were a lot of chiropractors, and we say that the osteopaths killed the chiropractors. Less and less. It's curious because in America, there are 74,000— something like that. It's a big number of chiropractors. In France, there are very good recognition, officially— better than us. Better than us because they were maybe, in front, there were so many college. At the beginning, there were 74 different colleges of osteopathy in France. 74. The government has cleared up a little bit. We are about 30 college.

SB: And how many osteopaths in France?

JPB: Officially 32,000. But not officially, certainly not far from 50,000.

SB: That's astonishing because there are 5,000 in the United Kingdom.

JPB: You know why? Because you have a lot of physiotherapists. They have done some doctors, they studied a little bit on the user technique. It's a big difference to use some technique of osteopathy and to be osteopath. But the French government does not know that. So...

SB: Can I ask: I was reading Urogenital Manipulation, one of your books, earlier on. And one of the case studies in there is, I think, a 48-year old lady with knee pain who came to see you. And you addressed her urogenital mechanisms to fix the knee pain. I think you said in the book, you didn't look at the knee, really. You just allowed it to fix itself. Do you have a completely different approach to a new patient to, let's say, a standard UK osteopath or chiropractor? Because we would immediately go to the knee and then work outwards.

JPB: You know in France, first when the patient comes, they take off the clothes; not in your country.

SB: Not all of them.

JPB: Maybe not, no. It's interesting because, in a certain way, we have created something: we have some ladies that come to be checked on the genital system. They come and say, "You have checked my colleague or one of my friend. Can you check me to tell her what is?" And it's interesting because we work a lot of urinary incontinence, dyspareunia; we work on low-back pain connected with the uterus, and so on. So it's why what I say is: a body for me, doesn't stop at the level of the umbilicus. No, it's a new legislation— the newest osteopath, they cannot do internal work. Very curious— they cannot do.

SB: They can't do it?

JPB: No, they can't do it. No.

SB: But you can as an osteopath? Or not in that capacity as osteopath?

JPB: After the old generation, they were very often the physical therapist can do it in France. And it's why the work condition in France was good to be organized in a certain way. But myself, I regret the time we were not recognized, because we were absolutely free to do any kind of things.

SB: Right. The next question for me is: why would someone come to you for urinary incontinence, for any other problems that you might have mentioned? Because in this country, we certainly would not be allowed to advertise treatment for those problems. Is it simply word-of-mouth?

JPB: Because we do it little by little, and it's like the medical doctor. They say there's another way to treat people— they don't need to have operation or to take some drugs. So what I say is a little vulgar: we are created the market. So in a certain way, people with dysphonia or urinary incontinence, adenoma of the prostate. If you are operated, you have more than 50% of chance to be impotent and to have incontinence.

We can do something physically with the fingers. We can help these people. So as you know, when one guy was treated on successfully — it's not always, but successfully— he said to the other people, "Go to see this person. They will do it." When I started osteopathy, people assumed, the term of osteopath was absolutely not known. They say, "Osteopath— what is it? What is osteopath?" In France we say, "The path is the legs." We believe we were specialized in the leg. So we were not known, but little by little, it's because the patient asked to the politician that they must recognize us, that we are recognized. It was the power of the street and the power of the people. So we are.

SB: Okay. We've had a very long question which was sent in before we came on air. Can I start by putting this particular case to you now?

JPB: Yes, of course.

SB: Because that will free up some space on my iPad, apart from anything else. This has come from Robin. Robin is one of our regular questioners, and he's decided to get in early this week, as often. And he says:

"Hello, Jean-Pierre. My 18-month old son, Toby, who is now known as 'the APM Baby' has been admitted three times in the last four weeks with severe bronchiolitis, as a result of respiratory syncytial virus;" which I haven't heard of, I must admit. "Possibly with a brewing bacterial infection. On the first occasion, he also had croup on top of the viral infection, and they were considering an induced coma and a ventilator. Fortunately, that wasn't needed, but he did require nebulizing and salbutamol to keep his airways open. Other than that, his medical treatment has been conservative. Last week, he was admitted twice in 48 hours and ended up exhausted after a solid 72 hours of accessory breathing, with a tracheal tug, and full and exaggerated rib excursion. His breath sounds are now clear and he's off all meds, but his shoulders are still slightly elevated due to mild hypertonia of the accessory muscles. He's being described medically as a happy wheezer."

And Robin says that, while he doesn't think we can treat the underlying medical condition, do you have any suggestions on how we would support a patient both during an acute episode, and during their recovery afterwards? And he says, he thinks the same question would apply for young and old patients, and for any respiratory condition— both acute and chronic. Long question, sorry. But I did let you read that one before we started.

JPB: Interesting. I think because, as I told you, I work in a hospital in France, specialized in lung disease and heart disease. And we saw a lot of baby, and biggest problem —I'm happy that it's better now— we have found we have some what we call surfactant. Very often, the people, the babies are not surfactant enough, which dilates the alveols. And what we work a lot is on the pleura, because the pleura is very connected with the shoulder. Most of the time, it's not the muscle which have a problem, but the pleura. Pleura is attached to the first rib, to the cervical spine, for instance; along with remember, the capsule of the shoulder, of some nervous system coming from C4, C5, and so on. So we will release the pleura on the thorax, on the attachment on the C7— the first rib. We will release the muscle, the subclavian muscle, conoid trapezoid ligament, to free the shoulder.

After, we work on the pulmonary artery on them. It's not so difficult, and the point is to no worries. The rib. We do decompression, in order to stimulate the blood circulation. They have found they have some inflammation around the alveols and the air is difficult for the alveols to absorb. So when we work on the pulmonary venous system, on arterial venous system, on lymph system, it seems that we can help a lot. On the baby, we are find that there's strength inside of them. You always believed that we as a baby are fragile, they are very solid.

SB: Do you make an assumption that there is inflammation in the alveoli?

JPB: Well, we work on the viscoelasticity of the lung. And when we release this viscoelasticity... Because, very often, you have some kind of edema wrong with the lymph system. So we work also with the left shoulder, because you have the thoracic duct, which can help a lot. So you can feel the difference before and after. We use the oximeter that we put on the finger to know the saturation of oxygen. During the session, the patient can see. You put one the oximeter, you work, and you see after the saturation of oxygen. Even after 10 minutes it's better. And that's nice.

SB: And an oximeter costs very little money, isn't it? It's very cheap.

JPB: So if you have a good one, it's about 400 Euro. If have a normal one, is 150. But it's interesting because it gives you at the same time the pulse. And if you have a body carrying on after the saturation of oxygen. And I said to the patient, "Check a little bit. Buy one and you check a little bit, and you'll see it." So the lip, the nail— because remember: when you compress the nail, you see the color is violet; when is violet, you have too much CO2. And you do it several times. I like that kind of treatment.

SB: Do you treat a lot of babies?

JPB: I have treated a lot of baby. A little less now, because I work on some soccer players. So it's... I've treated a lot on what I like for the babies. They are not the social barrier that we have. When I treat you, you will think. The baby, like the old people, they let you do. We are more successful and it's more easy for me to treat a baby.

SB: Do you have problems which you like treating more than others?

JPB: Sorry?

SB: Do you like treating asthma? Do you like treating dysmenorrhea? Do you like...?

JPB: We see people and sometimes they come only for the back pain. And they say, "I have back pain." And when you check, we say, "No, for me it's not the back. There is something, maybe on the ribs; maybe on the lung; maybe on the heart. We work on the atrial fibrillation, also; which was quite successful. Not ventricular. Ventricular is totally different than the atrial. So when you have some people with arrhythmia, you can... And it's important because we are more and more people with transient ischemic attack connected with the heart. So if you can manage the heart beating without arrhythmia, you give a chance to the people not to have this transient ischemic attack.

SB: How do you detect atrial fibrillation? By auscultation?

JPB: Each time when they see somebody, I take the blood pressure of both arms; I check the pulse of both arms; I see the action wide test is positive or not. And after, you can feel easy easily— you count if you have some arrhythmia, dysrhythmia, and so on. We did some research in my hospital, when I was in Grenoble in the French Alps. And it's interesting because with the cardiac monitoring to check a little bit what kind of success we have, and it's interesting.

Myself, I did a lot of research. We have found— not officially, because it's so complicated to prove something. But I did a lot of research with some colleague with the radiologists, with... pulmon... How do you call— people who specialize in lung and heart, and so on. And it was interesting. Very interesting. We have done some research also on the brain, because my next course is on the brain. And we did it in Los Angeles with 10 people, with putting some radioactive drug, very small amount, to see the brain activity; treat the body; see the people one day after to see which parts of the brain was activated and how much it was activated. So it's wonderful. We had three camera turning around sensitive to isotopes— three and it was very interesting. For some parts of the brain we stimulate 15 to 20 percent. So it was important for me to know that we can do something in the brain also.

SB: Claire sends in a question. It's fascinating hearing you describe your approach to osteopathy, because Claire's question is: Do you think that we are losing some of our osteopathic philosophy and some of the original thinking around osteopathy? Are we just becoming more structural?

JPB: The problem is first: in osteopathy, we don't follow the symptoms. Myself, I don't speak to my patient. I put my hand. I say, "You will speak after. I would like to know what my hand is is feeling." So it's very funny because often they come with 30 kilos of x-rays. They want to show everything. Even when they speak a lot, after, they don't say

something. I say, "Voila! What I found is this stuff, this stuff, this stuff, and so on. And after I say, "Explain me what kind of symptom you have." So it permits me to let the body express, because we don't know so many things. You have so many things to to know. The body will tell me, "JP, you go in this way because I need you on this part of the body, on this aliment."

SB: How long is your initial consultation with a patient?

JPB: 25 minutes.

SB: 25 minutes?

JPB: Oui.

SB: You're getting a lot done in 25 minutes.

JPB: Because it's one minute of diagnosis, and 24 minutes of treatment. When I was young osteopath, it was one hour, 45 minutes. I spoke a lot with my patient— what happened, your life, and so on. No need. The body will tell me what happened in your life. So it's a little different. I don't say I'm right— it's what I do.

And you know what interesting? I told you that I worked for some soccer team in Baton. When they buy a player, very expensive player, the ask me to check the player because the player will lie. The club will lie; will say, "No, no, this guy is perfect," and so on. We don't care. And I say to the player, "Voila. What I found is this stuff, this stuff. You can be treated," and so on. So it's interesting.

SB: Do you see a noticeable improvement in their performance after you've treated them?

JPB: Oui, oui. Normally, oui. Normally.

SB: But this is an important aspect of what you do, isn't it? Over here, we as osteopaths or chiropractors, we cannot advertise visceral treatment because there is no evidence behind it that satisfies the Advertising Standards Agency, and other bodies. Where do we stand? Are we noticeably closer to getting good quality evidence for the sort of treatments that you've described?

JPB: No. If you speak about the evidence base, for instance, a lot of the premise were: we tried. We tried a lot and we failed each time, because you are not me, and so on. So you have so many differences. My daughter is pharmacist. She worked one of the big lab, one of the most important lab of pharmacy. They said to me that, "You cannot know our method sheet when they do some research." But if you do

some research in front of people —I did it— they're so severe for everything. But you can do research only in a hospital with some people around you— judged not by your osteopath but only by medical doctors. It's difficult.

I give you an example: one time, suppose you have some inflammation of the sacrum; you have tension of the psoas; and you run, you jog, and you have a sprain. What is the problem: the sprain, the psoas, or the sacrum? I do the listening. I feel the sacrum, I will release inflammation of the sacrum, for instance. And you try to explain to the medical community that the ankle sprain come from the sacrum— well, good luck. Good luck. They will never believe you.

So we are in another world. They ask us to do some research about sciatic problem between L4-L5, L5-S1. But sciatic problem can come from everything: from the kidney, from cervical spine, and so on. So for them, there is a concept totally different and they have a lot of difficulty. When I say, "Okay, I will treat this patient for a sciatic problem," and they see me doing something on the liver, doing something on the C6, for instance, they say, "No, no. We speak about L5." I say, "Yes." "But it's impossible." Why?

SB: On a number of our broadcasts and in a lot of what one reads, what one hears about research these days, people are talking more about pragmatic research— where they don't specify what you do in your treatment room. They send you a patient who has a problem, or they have a cohort— send them to you with this problem and then they find out whether your patients get better, without worrying whether you're treating C5, C6, or the ankle. Is that something which you've seen happening yourself? Are we likely to get a bit of success with pragmatic studies like that?

JPB: We are pragmatic, of course, because we have empiric... You say empiric?

SB: Yes, empirical.

JPB: Empirical. Absolutely empirical. So it's why I'm very proud to be... When you see in France, for instance, you have any kind of problem: in France, it's cortisone, pain-killer anti-inflammatory drug, for any kind of problem. When you take cortisone, two months after, you have some sore throat, or you have some bronchitis, rhinitis, and so on, because your immune system is a little depressed.

So it's why in a certain way, sometimes I ask me the question: why to prove these people who are doing that kind of treatment that I do something else? Sometimes I prefer to be in my world to work, to

help people a lot, because the people recognize. But to try to please the people who use cortisone for a little part of... Sometimes it's good, cortisone, but for the low-back pain, for some knee problem, it's absolutely bad. Absolutely bad. So yes, we are pragmatic. I was 10 years a teacher, the Faculty of Medicine in Paris— 10 years.

SB: We should point out: it's conventional doctors. It's not-

JPB: Absolutely. Faculty of Medicine is learn only medicine. And when you see what is the treatment: sometimes they are good because the surgery is good. Because they can find if you have some diabetes, it's better to take insulin than to go to see an osteopath. But for the other parts of the body, I went, "Ah!" I was so, honestly, disappointed in Paris.

SB: Do you think you changed their way of thinking? You were teaching conventional doctors. Did they use your approach?

JPB: Each year there were about 30 gastroenterologists that come to learn with me. And you know what they learn? Only to palpate— to know where is the organ, how, and so on. No, they prescribe some osteopathy, but no, they did not change. It's difficult to change 10 years of study. It's very difficult to change.

SB: When you were at the European school, did you feel that enough attention was paid to addressing mobility, motility of the viscera? Or is that something which we pay lip service to?

JPB: When I started in medicine, there were no skull treatment; no osteopathy, visceral osteopathy. So I started in '72, myself, and I tried after to learn to the other student to do it. For instance, when there was a course of visceral manipulations, 50% of the student, they left. Don't say the French or the English, because for them it was not osteopathy, but it was in the old time. Now, it's certainly a change. It was in the old time.

There's something interesting, also. In osteopathy we speak about the cranial movement. Honestly, I don't believe that there is a cranial movement, myself. And we are doing some research now. Because one time there was a guy of 90 years old at the hospital, and I check him and I find flection extension— what we used to find. He died one month after. I did the dissection myself. There was no one suture. The bone was totally calcified— impossible to move, even though the dissection was six hours after. So I believe that there is a change of pressure inside the skull, but not movement like it; and the change of pressure is what we feel— flection extension coming from the heart, respiration, and so on. So it's doing years and years when people,

they learn that there's a cranial movement. Sometimes we must think a little bit, and it was a big problem in France because the medical community did not believe in this stuff.

SB: Yes. I don't practice cranial osteopathy, and frankly, I don't even remember being taught visceral osteopathy as an undergraduate. That doesn't mean we weren't, because my memory is not particularly good. But it does strike me that sometimes in cranial osteopathy, the terminology doesn't help us. When you say to a research scientist or conventional medic, "Well, I can feel flection extension or whatever in sphenobasilar symphysis," I think you may be feeling something and you may be influencing something, but it may not be what is said. And it makes the research a little bit difficult because I believe they've put all sorts of machinery onto test subjects and been unable to find those movements.

JPB: But we are very romantic in our job. So you put your hand, and you feel a little change in pressure, and little-by-little you amplify, amplify. And after, you do believe that you have a big one, and it's why sometimes we must think about that kind of stuff. And if we want to speak a little more with the medical community, we must sometimes think about what we say and what we are doing.

SB: We've had a comment from Tish Reed about evidence-based medicine, and she says she completely agrees with your explanation. And it is precisely the problem that we have with the likes of the general councils —in her case, the General Osteopathic Council— pushing for all our work to be more evidence-based because of the advertising standards that we're subject to. And it makes it very difficult, doesn't it, for us to explain to patients how we can help them if we're not allowed to put it on our websites? Word-of-mouth only goes so far.

JPB: In medicine: Aspirin— 70 years to prove how it works. Aspirin. People, well they'd say, "We don't care.It works." Take some Aspirin. 70 years— so it's so funny. It's why sometimes...

SB: I'm not quite sure who sent this one in, but they say: "Bonsoir, Steven and JP. One of the key things I learned from attending courses with you was the listening." You mentioned it briefly and this person thinks it will be worth asking you to explain for those listening what it is, and it's important in your approach. "The skill explains how you assessed the key areas to treat your patients, and whether the treatment has had a positive effect," which leads us nicely onto our model for the evening, doesn't it? And perhaps you could demonstrate your approach to a new patient.

JPB: Well, I will do it. I like to to put my hand on to feel.

SB: So we're going to introduce Harriet. I'm going to walk in front of the cameras. Excuse me.

JPB: Okay. Thank you for coming here.

SB: Harriet is an osteopath, as I think we explained to you, and has been looking forward to seeing you-

JPB: I start very often in standing position. But now I do it in sitting position. My purpose is to say to the body, "Give me some information to know." So first, I feel something on the right side. It's like my hand is attracted on the head on the right side. So it's one of the parts. I can check what you have learned in osteopathy to check if we have some fixation on the body, on all the spine; what all the osteopaths are doing. You lie on your back.

When I check again, when I put my hand, I check again on the head and I feel something going to the right side. For me, it means that there is something in the teeth or something on the sinus. There is some tension on the face and because it doesn't stay on the skull, it goes a little way forward, okay? After, I can check in listening, normally on the right side, I'm sensitive with the right hand. When I put my hand here and I feel a tension on the left side, which we are not so far from the sigmoid and rectum.

On tension, also, on the genital system, there is a little something precise at this level. Give me your two hands, for instance. I check the two hands. Can I take off the pillow, please? Sorry. Yeah. Okay. Let's check if there is a difference between the two hands. I do the same thing on the two feet to know if there is some tension. It's okay. I have a little tension on the foot, but I'm still attracted by the... Right side. I check the inframamillary. Okay. I have a tension of the trigeminal nerve, 4 meters. I check it twice, trigeminal nerve with a little information here.

Okay. I check the skull. I try to feel if there is something in the trigeminal nerve. I have the same thing here. I have some tension, very close to the coronal suture in connection with what I felt before. But the first thing I will do on her is to release something, the palatine nerve, to release also the trigeminal nerve.

Okay. And after, I will speak to her a little bit to know whether... if we take an example, for instance, you have somebody with a shoulder problem. The patient, he wants you to test the shoulder. On doing all the session, he will speak about the shoulder and little by little, your

brain is totally focused on the shoulder. You will do something on the shoulder.

That's why I prefer to speak after and to say what are the symptoms. For instance, for her it's very interesting because we have this tension. We have, when we feel the infraorbital nerve, you have a little inflammation at this level so there is more for me at the end point than at the beginning.

SB: What we haven't done is to ask Harriet whether she actually has any problems. So when you're ready to find out, shall we do that?

JPB: I checked the lymph node. There is some lymph node on the right side and not on the left side.

SB: Yeah.

JPB: Okay. So there is some lumen difference. Even if sometimes a patient supposedly has a crown with some bacteria, just a little underneath, you don't know yourself. You don't know. But this can give some problems with the shoulder, some problems of the neck, also. Myself, I always clear up what is not on the spine. When I've cleared up after, if there are still symptoms on the spine, I treat the spine.

SB: And do you manipulate the spine?

JPB: Of course. Of course. Because what we call... can you sit up again? Yeah? What do you call the bifixation, so it's... When I check the spine, for instance, okay? Here we have a good side bending. Here we have no side bending. Okay? So if there is just one fixation on one side, definitely don't touch the spine. If on both sides it's fixed, I will do some manipulation with some interest.

SB: Yes.

JPB: Okay. And she has some lymph nodes at this spot. That's why, even if she tells me, for instance, "No, no, I feel good. Nothing is wrong," her body shows me something. I will check the palatine foramen to know if there is a lymph node and I will release the nerve in order to relieve, and after check again to know where is other things.

SB: Okay. So, Harriet, I'll give you your microphone back. Tell us what's wrong with you, if you don't mind.

H: I have some inflammation in my sterno-clavicular joint on my right side. I have a prolapsed disc at C6-7 in my neck. I don't remember which side it was. I think it was my left. I have a problem almost where he, you indicated after a Cesarean section where some of the

stitching started to come apart and I have an actual gap where I put my fingers in almost like you said, there.

SB: Okay. A lot of you, even here, you were talking about treating internally and your hand placement is in areas which could give rise to complaints from patients if they're not properly informed. Do you have a chaperone in when you are treating? Do you get consent through written paper or-

JPB: No. Nothing.

SB: Nothing at all?

JPB: Nothing at all, because they trust me, they come and I treat them. You know when I feel nothing, I say to the patient, I feel nothing. Don't spend your money with me, you have something else to do. But you know what is interesting, she has a side bending on the right side which is not good. Similarly on the left side. Okay, lay on your back.

My finger is very clean. I just wash it. Open your mouth, open your mouth. You bite a little bit. Bite. Bite more. Okay, release. Bite. Release. Voila. Voila. Underbite a little bit. Voila. I release the nerve, okay? I release the nerve of the skull. Voila. When you start to bite, just as short time I follow the listening means that, voila c'est bon. Okay, you sit up. You sit up here. And after, so I check a little bit the spine when I see... Okay, well we have about the same on the left and the right.

SB: Does that feel different to you, Harriet?

H: A little bit freer.

JPB: After we'll do something else. But you know it's... I don't treat it. It's what I do in my office and because sometimes when you have some interview you try to look very smart, intelligent. It's what I do. I'm very clear myself. When a patient is not better, I say you feel not better and I try to find another solution. But for her will be the first step and after we check again. Lay on your back.

Harriet. So I check along, I learned no more, no more. This problem on the coronal suture here. Okay. I will note, there are two things. There is a dilatation of the venous system on the sigmoid as this level, and also the genital system, we have a little scar. You don't know what it is, but a little scar here and some venous congestion also. Okay, so it's all, this area is way tense and create some problems on the spine. Voila.

SB: Well, you were able to tell that with a very, very brief outpatient. Is that just the benefit of 45 years of doing work?

JPB: You know, at the beginning it took me a long time to check people. I was always wrong. I was very bad osteopath at the beginning. You're not people who will tell this, it's because you need time. And I was bad, but I was very nice with people because as when you are bad, you are nice. How are you feeling, so on and so on. And little by little I see. No, I don't want to stay to be nice and bad all my life. I'll never work a lot.

I'm a fan of anatomy because honestly, until now I do three hours of anatomy a week, each week. Because without anatomy, osteopathy for me is hand-on anatomy. Voila. When you have the hand you have the anatomy to me it works quite well.

SB: Why did you go straight to this inguinal area rather than the diaphragm or elsewhere?

JPB: When you put your hand, okay. What is listening? You have a tension on the tissues. Okay? You put your hand and you feel your hand going attracted by the tissues. I put my hand here, at this level and my hand is turning. When the hand is turning means there is something as a stricture. When it's just gliding like it is on the function, if we have a dysfunction so for her is turning. That's why I know that I have some stricture which have something on it. Yeah.

SB: So what should Harriet do about the problem she's described with stitches giving way in the cesarean section?

JPB: As for me I will do something internal because there's some damage there.

SB: Okay. We're not doing that on camera. You'll be pleased to hear that. I am intrigued by this because constantly in England, in the UK, we are being told if you want to do anything which might be perceived as any kind of sexual contact, you must get consent. It must be explained. If you want to do internal treatments, you have to give them 24 hours to consider it. So you can't bring them in and treat them. Is this not the case?

JPB: Viva la France! In America, the same thing. When you, when did you do a cross of people, they likely must sign something saying they will not sue you because... You know you are registered, which is very rigid for me. They are rigid and they will kill your job. Because the issue asks too much. The patient will be very afraid, can you send me this stuff off. Can you sign again? He said, what is it? Oh no, it's not dangerous. In France we do it. You know, I've seen a lot of patients in

my life. I've done maybe not far from 3,500 internal work, more on ladies, and men also. So never one person sue me. Never.

SB: Never one person?

JPB: Never sue me. So, you can do it.

SB: Okay.

JPB: Because it's so natural for me to do it. They feel it sometime, for you say what comes in next time. Maybe it's the end of the day. You have some problem. But they never say no because the patient, they want to be treated. On one, you put a lot of limit. You know in America, the two people in one hour, they spend 55 minutes on 5 minutes of treatment, they are so afraid to be sued. So afraid. Yes, I pay 300 euros of malpractice a year. In America, I paid $15,000. What is the difference?

SB: Well, it varies. There are a number of cases going through in this country at the moment of practitioners who are being accused of improper conduct in the treatment room.

JPB: But those are the patient... You are sued by the patient?

SB: Yes. And some of these go back many years. Do you record in your notes that you have consent?

JPB: No, because not consent required. Because after you read your note on, you always find the same thing. And maybe I'm not a good example from us. I don't record, I work with my friend and she's the same physician as me. She writes a lot of things. But not me.

But you know, I work with a... I give some courses to two veterinarians. So because the vets are interested, but several languages on the listening. American I cannot speak. There is something with an animal that there is some connection at once. It feels as if you're doing something good on it. For the people, the same thing.

SB: Yeah. You treat animals?

JPB: I'm not very good at it. I have three horses. Okay. They like me, but honestly, no, because I never did some dissection. I never learned the anatomy of the horse and I know it's not a good thing.

SB: Okay. Harriet, we will leave you for the moment. And you can stay there or you can sit down again and we may come back to you later. I

don't know. But Jean-Pierre, lets go back to our seats, we have some more questions already. Thank you, Harriet.

H: Thank you.

SB: There's a couple of questions that came in earlier on. One from Matt Walden who you may know, he's a very well known UK osteopath, and he's asked whether you think that the pressure for evidence-based medicine is actually in the patient's best interest.

JPB: So the question is evidence-based medicine?

SB: Do you think that the pressure that we are under to provide evidence for our medicine, do you think that is in the best interest of the patient?

JPB: I suppose that the French people are very different than the English people. And honestly we've known since a long time. But they never ask for evidence based. If a patient asks for evidence based, the doctor will trust us, and we never ask evidence base because you know what happened?

I remember when I was at the Faculty of Medicine of Paris with the Dean, there was somebody saying, what is evidence based? You do something very effective, you treat me, you do something very effective but with no evidenced base, you cannot use it. You cannot. But to know if something is useful you must do it.

SB: Yes.

JPB: So there is somewhat of a paradox. A very huge paradox.

SB: I think this may not be a problem you've encountered, but Bob Allen has asked again about evidence-based medicine, says another fascinating discussion. But his question is: "How do you deal with the people who are very pro the evidence based and to refuse to accept if a treatment works if it hasn't been proven using a randomized double-blind controlled trial. Are they convinced that your treatment approach works without the evidence to support it?" I'm guessing that from what you've said so far, yeah, they're happy.

JPB: There's a patient who come to see us, they have tried so many things there and because my appointment we have a long waiting list. So they wait a long time, and they don't care about it. Honestly, I never, I've heard one patient telling me. Even the doctor I treat what evidence-based medicine.

I worked in a faculty of medicine where, as I told you, there were some group of doctors who want to pull a lot of things. What happens when you manipulate them? When you do a twist, what happens exactly? When you do a twist on the spine, you're on the capsule, you're on the synovia, you're on the facet. You're on the nervous system and the vascular system, so on and so on. So you never know. Nobody knows.

What you do when you hear a noise you have a stretch reflex certainly on the small muscle but also on the capsule. At once we have a dilation of the smooth lateral and the spinal lateral also, is very difficult. Even the stuff is very difficult. I did some research where the vary color objective. That's why it's difficult. When we treat an organ, we treat an organ with...

I've done about 600 researchers with Doppler effect. Okay? Arteries are easy. And so on. You cannot check very often or wherever. If you have done something, 600 is nothing. And I say to some people doing some research if we can use this research and no, no. It was not done by doctors, was not done in a hospital. It was not done by a faculty of medicine.

SB: Yeah.

JPB: Okay. I say we are very effective on the vascular system. That's it. For me, that's it.

SB: Well a lady called Katrina has is asking for some advice on a case. I think people are very keen to get your opinion on their actual patients since you're in our studio. She says she's an English osteopath who recently set up practice in France.

She has a new patient recently who's a little bit concerning; a 29-year-old nurse, single mother to two children, one born by C-section, the other vaginally. She presented with mid right back pain that's episodic and moves around and is not easily reproduced in clinic. She has abdominal pain in the right lower quadrant which is quite acute on palpation around the ileocecal valve. She had her appendix removed as a child. She also complains of night sweats, which is obviously a red flag. She otherwise appears and describes herself as very healthy but she's stressed. And she acknowledges that this isn't really very much information for you to work on, but she'd like to know your immediate thoughts.

JPB: Well when you have that type of person it says the same thing. When somebody come to see me with any kind of pain, standing, listening, sitting position, listening. I do the listening. For there certainly is

something on the inguinal canal. Because, some nerves on the inguinal canal which are very tight and we have the inguinal nerve with you femoral nerve and so on. So she must check the inguinal canal.

But it's not a good answer, what I say; because the good answer is to say to the body and very deeply modest myself. I want to say deeply modest because I know what is to fail. I know what is to be successful, and I know that we have a big limit. We try to know what is in the person but we will never know totally the person. We will never will know totally the physiology of something so it's why we are modest. But what I say the body must know better than us. For the body, it's easier.

Honestly it's easier when my colleagues, I taught some colleagues. At the beginning, they took a lot of notes, a lot of notes, a lot of notes. And after they have notes, we are not trying to list. The premise, what you say, manual therapist. And I push them to use more of the hand and to know first what the hand is doing. Always repeat the same thing. What the hand is doing. And I try to check what the patient is saying.

Most of the ladies, for instance, when they are in menopause, they are different. They have no more elastin, which is very connected with progesterone. They have capsular syndrome and some a right shoulder problem. If you want to work on the shoulder you will increase the pain. Most of the time we work on the liver because it's very connected with the liver. So we don't touch the shoulder, we don't touch capsular syndrome, despite I know where I differ myself. In the school of osteopathy to say we from, we want to have people good with the hands on what kill osteopathy is university, the university.

I did a lot of university. You sit and you speak, you speak, you speak and so on and so on. You speak. But we still palpate, palpate, put you hand, what is underneath the several level and so on. It's adrenal.

SB: For how many years were you a bad osteopath?

JPB: How many years I was a bad osteopath? I would say, let me check. Four years? Five years?

SB: Okay. So now you run courses across the world, but you run courses in England teaching visceral manipulation. How long-

JPB: Not only visceral manipulation-

SB: Indeed. But for how long does it take somebody to be competent? The sort of things-

JPB: They are better than me because honestly, because at this time osteopathy was only interest. Okay. There is a new generation now. I say you are better than us because of the chance to have some people, like you, like me are teaching. So you start not from zero one certain way. They will nursing above the skin, nursing above the organ. When you take off the organ of a person, you cannot leave. You cannot leave.

The brain... I'm doing some research on the brain since '81. And I do now courses about the brain. I will start in January. So it's so interesting. You have so many things to do. Incredible on the brain, on we work on the brain. So it's incredible.

SB: What is the purpose of the research? What's the aim?

JPB: The course for the brain, we work for instance on the vascular system. We work on the vascular artery. Then we work on the pressure and talk on your pressure a lot. We work on the functional area.

For instance, we have several... You have a person after transient ischemic attack, he cannot speak. You have just one word, two words. You check. You ask him to speak. And you check where there is a discontinuity between the language center, okay the vocal center on the other part on where you feel this discontinuity. You work with density relief and so on. You stimulate. And there is a guy who wrote a book, "The croissant in the Head". Did you read, no?

SB: I haven't read it. I saw it and I liked the title.

JPB: It's a funny story because during a course they asked me to. Say, somebody cannot speak, aphasia since three years.

SB: Yeah.

JPB: So why not? So I check it. I do something and suddenly the guy started to speak. Everybody was surprised, myself also. It was interesting because the shape of a croissant because you have some radiate fibers. It was a shape of a croissant. I said to my colleagues, that is not normal. I work on this shape of the croissant. And suddenly he started to speak. In Grenoble, I organize some free treatment for disabled kids during 30 years, okay? And sometime we are very surprised and sometime, nothing. Okay? And sometimes a kid, not able to move, started to move after the session. So it was interesting.

SB: So the purpose is to look for example where with transient ischemic attacks it's to look at rehabilitating patients after a stroke but not preventing the strokes. Or are you doing both sides?

JPB: Preventing where we spoke about the fibulation for instance, but we have a lot of young people now with that kind of disease. Very young girl, 40-45 years old. So they are treated by medicine which certainly is good also. And they come after because they have a lot of stuff. We try to reconnect some fibers in the skull. It's interesting. And also to work on the arterial system because most of time when you have some this kind of dyskinesia, we can stimulate the basal vertebral artery, by the internal carotid artery. We can stimulate the blood circulation.

SB: I need to address some of the questions that have come in so far. The comments. Somebody who has not given their name has a comment about your approach with hands-on first. It says they understand why you would use your hands-on first and ask questions later, as we can often be blindsided as they put it by the patient. We can be distracted by them. But they make the observation, "It plays havoc with the consent and communication that we are required to ensure we practice here."

JPB: That is very political. The premise of what I say where we are looking in France from because the government doesn't say exactly what osteopath? We are recognized. I'm still surprised that we are recognized but they don't know what you are doing. So we have the chance to be totally free from them.

SB: I'm curious by this because what is the level of regulation of osteopathy in France? Is it a government body like it is in England?

JPB: You must have a diploma recognized from some school. That is a rule. Officially, you must have a diploma. You go to the prefecture here and your diploma is registered. You have a number and after this number, you can work. If you're not this, you cannot work.

SB: The prefecture is a specific region is it not?

JPB: Administration kind of center... Administration center.

SB: Does that mean if you move away from Paris where you live to somewhere else, you have to go and register again with the prefecture there?

JPB: Mais oui. So it's when you have your number, you can work, you can work on all France. All France.

SB: And the complaints procedure in France. If a patient doesn't like what you're doing, can they complain in the same way as they can here to the prefecture?

JPB: No, he complained to the front of the courts.

SB: Okay. So it's a directly legal approach?

JPB: We have not a lot of complaints. We have some complaints of people sometime with sexual harassment, but he do something that they must not do. They try to seduce a person and that is totally different.

SB: It's very French.

JPB: We have no complaints about somebody when you do something for some internal work and so on. You have some people complain because sometimes they feel they have some sciatic problem when they came only for low back pain. Something like it.

I just know one person paralysied after a cervical manipulation, not by an osteopath, but I know the person because we have heard of many things. This patient, he create a problem with the vertebral artery dissection. Okay.

The patient was not able to leave, but we're still working on the end of the day was to paraplegic on the lady. And you know why I know this story because they call my office, I was too much busy to see, and they went to see somebody else. And this lady that have paraplegic since 15 years now. So we are not a lot of complaints. It's why we pay 300 no more. I said maybe we'll come. Maybe we come a little later because some people maybe they come to make some money and not… For the moment, no.

SB: Some more questions. Claire P. I'm not sure who Claire P is, but she asks about adhesions. Do you think we can do anything to help people diagnosed with adhesions between bowel and uterus?

JPB: But you know, adhesions, a lot of the time it's.... There's a guy in France Gambert et al. a surgeon. He has written a book and he has done some research about adhesions. And it's interesting. Because you know, for instance, you have several layers of the skin. You have the epidermis, dermis, hypodermis, and so on. And we try to work on the several layers.

And what I noticed, for instance, for some illnesses, important illnesses, that you should do it... Strongly doesn't work. You should do it with a light pressure for the fibers, what we call induction. For instance, you put your hand. Your hand is situated what we say in

some problem. You go after, you move your hand and your overtake the limit of the listening, what we call induction, on this, what we do on this, we're better with our resistance.

With Crohn's disease, for instance, I've seen a lot of Crohn's disease. We can help not on the cause of the illness, but a lot on the consequences.

SB: Really? Would you care to put a figure on your success rate with Crohn's?

JPB: So, so we are not.

SB: Would you care to put a percentage on your success rate with Crohn's?

JPB: No, no. Because I have to... I'm not modest this time. I've treated about... more than 100,000 different people in my life. Okay. So I've seen certainly 200 people with Crohn's disease. It's not so many, but it's not so bad. The there are some is different for me to do some study, because sometimes they have a lot of people coming from America, from Crohn's disease on the unit. Sometimes it fails, sometimes we're fortunate.

I would say on the symptoms and not on the cause, a little more than 50% maybe. Little more than 50. It's not bad because the symptoms are not easy to accept for the patient.

SB: How does the medical profession regard that? Because most people with Crohn's disease, getting conventional treatment still have many symptoms. They have an uncomfortable life, don't they?

JPB: You speak about the conventional medicine? Okay, so the problem in France, we are the world champ of antibiotics, of anti-inflammatory drugs and... Because there is some culture... I'll give you an example. Funny, I was in Grenoble. Grenoble is... We have 60,000 students, and maybe 20,000 researchers. And the people was... That kind of population was quite easy to treat because intellectually, they understand very well. Now, I am in Clamart. Clamart is a French Cowboys. So they don't think so much. They don't think so much. They want to feel better.

SB: Yes.

JPB: But sometimes they don't understand. And I say, "Don't take Cortisol. Don't take anti-inflammatory drug because it could be dangerous for..." Now, the doctor say, they see the doctor, they take the drug, it

doesn't work, they come to see us. In Grenoble they refuse to take this drug.

SB: Really?

JPB: Very often. When you know the side effect of Cortisol you'll fear them.

SB: We've got a clutch of Claires asking questions this evening. This is yet another Claire. What do you think the cause of Crohn's or ulcerative colitis is?

JPB: Difficult because we suppose it's an immune system. There's some genetic, there is some part of population for instance, New York, the Jewish part, they have some problem. So genetic is very important on the massive and very modest they work not on the cause, on the consequences. With some help the people but sometimes the cause is very different. You know very often... When you have a name an illness, very often there is no treatment. On the one, the name is very complicated. You are sure there is no treatment.

SB: Yes. Interesting observation has been sent in. My wife Claire as you know, as an osteopath and she, with several other anatomists, runs regular courses dissecting horses. And you've had the hugely beneficial experience of dissecting fresh human corpses, which is totally different from an embalmed corpse, of course. And somebody's why we haven't invited you to come on one of our horse dissections. Would you come?

JPB: But to see what? To check what?. Sorry. So it wasn't interesting for me. You know it's-

SB: I think it would be more interesting for everyone else to be on this. To hear what you would say.

JPB: I saw some of the operation, the horse one time because it's... But no. It took me a long time for the anatomy human being, it's really long to to learn on what is important. I would like to explain something about inference. When we treat somebody, we have what we call macro treatment. You treat nasal, fascia, septum and bone and so on. On little by little thanks to the big stuff, you go to some structure a little more tiny. On this structure, do I use something a little more tiny on some. At the end you can treat the cells, you start from something macro to micro.

So it's why it's interesting for us, for the brain, for instance. The brain you have what is important. The pressure system is attached to the base part of the brain following the artery and the vein and the nerve.

So when we work on this fascia, you have a lot of influence on the nervous system. The cranial nerve, you have a lot influence on the arterial system, the vascular system. So it's interesting, but you must know where to put your hand.

SB: Yes.

JPB: So if you don't know where the anterior tubercle or frontal tubercle, you will never do it so sound. Sometimes you can do it with the instinct, but you must repeat after. So it's why the only... One advice to say to somebody. Work anatomy, work anatomy.

SB: Right. So one of the points that Claire and the others who run the horse dissection courses, which they do because they are much easier to organize than human dissections, is that the anatomy is in many respects, very similar to human anatomy. The feet are different.

JPB: The most similar anatomy is a pig.

SB: Right?

JPB: The pig, you put a pig like this. Okay. It's exactly the same shape of the organs. So for the horse it's, for instance, the leg are totally different than our legs on the... But you know, I knew that you have very good people in your country. Some of them are very well known on the... They come in France to treat the horses. Also, you have some English people who are coming in France now.

SB: Yeah.

JPB: Very good. But myself I say I'm good in the... For diagnosis. But treatments, zero.

SB: Yeah. Okay. Liz has asked a question about the peripheral nervous system. The vagus nerve is very long. How would you treat inactivity or failure of the parasympathetic system to dampen down the sympathetics?

JPB: The vagus nerve is interesting. They have a lot of research about the vagus nerve. There are some place where you can do something on the juggler foramen. You can... Between the carotid and the jugular vein, just between you have the vagus nerve. With the heart you know what is important? It's the vagus nerve. Slow down the heart, slow down the blood pressure. Is the only proof that we own the vagus nerve.

So oximeter, blood pressure, you work and normally you on supers, under jugular foramen. You work, you massage, your blood pressure

diminish or your pulse diminish. So it's maybe 70-60, 60-50 50 you are sure to be on the vagus nerve. That is... I work a lot on the vagus nerve myself, but also very often with a light to do it with the oximeter to know a little bit because sometimes for instance, you have a fascia which surrounds the common carotid and the jugular vein, internal jugular vein. If you use the technique a little different, you will stimulate the sympathetic system, just on the side. Okay, so sometimes it's wise and it's interesting to check second after second if you are always on the vagus nerve.

SB: Okay, so the answer is that it's not as straightforward as we would like it to be?

JPB: Well, there's no measure. I love vagus nerve, I work a lot on the, for example, the digestive system and the heart. Because the heart is under the domination of the vagus nerve.

SB: Phil in Woking has asked about trigeminal neuralgia. Do you have an approach to trigeminal neuralgia? How would you-

JPB: The trigeminal nerve with the optic nerve is the most important nerve of the cranial nerve. We work on the trigeminal nerve. And we work on the cavernous sinus. We work on the infraorbital foramen. Supraorbital foramen. We work on the palatine. The greater palatine foramen, for instance. We work on the inferior dental alveolar nerve, so we have many things we can do on that. Look what the center what is the interesting with the trigeminal nerve is a nerve of a migraine. The nerve of the headache. Without trigeminal nerve you have no headache.

SB: Interesting. Salome Olivia has also asked, what do you do about migraines? Do you have success with migraines? What's your approach?

JPB: The real migraine, the genetic. A female because they have a female problem more than male problem. We slow down. Difficult to make disappear because it's hormonal dependent.

SB: Right.

JPB: Okay? For instance, when a lady have normal headache during pregnancy, you are sure there's a hormonal problem, very difficult to fix. On for the other one with the cervical spine and so, we have a lot of results but the trigeminal nerve reacts very well to our weight on corner level we have good effect. Very good effect.

SB: And of course, the question which came in ages ago is where do people go to learn more about this? You said you run courses in London with Ale Letterman, do you run courses elsewhere in the UK?

JPB: When we have the burn Institute there're some courses in London, in Scotland, we have also around England, some courses also. We have the... We have done something very original on the peripheral nerve. We treat the peripheral nerve. We treat on the intra neural pressure a lot. Because the peripheral nerve, inside you have what we call the nerve internal, the nerves, the arterials, and so we work a lot on this fascia. It's interesting. Very interesting because without nerve, you have no result in a job.

SB: Yeah.

JPB: If you have no nerve you have no result. You can't do what you want. So it's why the brain is... What is so interesting with the brain? The brain without the body is nothing. The body without the brain is nothing.

SB: Yeah. So people should contact the Barral Institute in this country?

JPB: Barral Institute, yeah. So we have a lot of courses. We have maybe 30 different courses now and it's-

SB: Are they tiered or can you go in any one of these at any-

JPB: Mais oui. We have about 80 teachers because I'm not young now. Myself I just go two weeks in America, no more. I have no time. So it's... We started in America. Why? Because the osteopath. American they don't use osteopathy. Okay. They don't use osteopathy and it's a pity because they have the money, the research, the Academy of medicine, they have every things but they don't use it. When you give the program to somebody to use drugs is finished.

In the faculty of medicine, Paris, the Dean asked me to... Demands me to do medicine. I say, "No. I'm not interesting to... I'm Interesting with the hand. Some of my colleagues accepted to do medicine, no infiltration of cortisone and little by little they stopped to work with their hand.

SB: So, I imagine then that where the argument about whether osteopaths or chiropractors should be allowed to prescribe, you would say they should not because it will distract them from the-

JPB: Honestly, because we don't know. What would be good is to prescribe tools to stop some people to work, to give three day four days, not to work maybe. But when you put your fingers on the drug you are lost.

You are totally lost because we have not the education to know what kind of drug to give. And after it's so symptomatic it's difficult not to be symptomatic. Took me 10 years not to be symptomatic. It's difficult. Very difficult on you. Sometime at the end of the day you have a little tired, you have a tendency to come back to the symptoms. It's why it's not so easy. So we must defend our culture, our background. So it's important.

SB: Yeah. Somebody you talked earlier on about treating the baby, Robin's baby. And you talked about the lungs there, and somebody has said do you do much work on the lungs because they missed the start of the talk? Do you treat other problems and the one described with the pubs with Robin's baby? I mean what's your approach to lung problems?

JPB: For the lung?

SB: Yeah, you work on the diaphragm?

JPB: But as we work a lot for that, we have a lot of baby with asthma. We try to see if it's genetic. There's something very interesting for my colleague at the level of the right second rib, we have the right bonkers, which is very connected with asthma. There is a right Finnic nerve, the right vagus nerve on the... As I go to caverbend junction. So, if you can walk on this part is very important.

You release on this very often genetics, so we work, diaphragm. But the diaphragm is secondary. We work on the vagus nerve, which is important for the sympathetic system on the T4-5, T6. We try to work... What else? On the mediastinum and so on so it's… we can have better. On the real asthma, genetic with a family with asthma to get a real results is difficult. We help them but there are plenty of some asthma that's so difficult. And there's false asthma, coming from gastro esophageal reflex disease. That one is very easy to treat.

SB: Are you seeing more diagnoses of asthma now because it seems over here it's become more common? Either the diagnosis is becoming more common or the condition is more common.

JPB: You're right then because they tried to, you know myself I saw in the hospital people dying from asthma with a heart or 200 240. So it is something they table so they are doing some research with the vagus nerve also while with like a pilotas with the vagus nerve. They're doing some research. And that is a good part of medicine because they tried not only to put the cortisone on its own. They try to check, weigh on what is difficult, what is genetic. Genetic is very difficult to treat

SB: Someone called Ian's asked another question about medication and asks what your view is of patients continuing to take their medication while they're having visceral treatment.

JPB: Alors. For instance, we see people with stomach ulceration. We see a lot of people with problem of the intestines. When suppose that when I treat somebody I feel is not enough. We, I have some people specialize in France in microbiology. Microsystem. They work a lot with mushroom. Natural mushroom and also some of the treatment, very light and not difficult. And sometimes I send to these people.

But what is... Myself I try to release the information of the gut, for instance. I try to work on the vascular system, for instance, superior mesenteric artery, which is very important. To work on the root of the mesentery, to work on the spine. So we help a lot, we help a lot. On some people, sometimes they're not, not easy on symptoms these people-

SB: That actually leads into this question, which is how do you assess the abdomen? Do you use different levels of pressure or is it just more instinctive? And I think you demonstrated this on Harriet earlier on but-

JPB: Different level of what?

SB: Pressure.

JPB: Pressure. Well, alors. The problem with... What we see with listening. If you put your hand on somebody, you feel a gliding. Gliding means as a dysfunction. There's just bad day at... Something like it. If your hand turn, I'm like it. Okay, good. Little deeper. You have a tissue which has something very real. Okay. It could be a cyst, a tumor, inflammation, adhesion or so on.

So it's way you work a little deeper. We never use the... It's not painful what we do. It's not painful what we do, but what is interesting, we must feel a difference after. It's not because the patient tells you that is better. We don't care what he's saying. We sit with, he tells me he's better now and when is good. You have no more listening. That is interesting. So the body give you the answer because some people that try to please you.

SB: Yes.

JPB: Oh, Yes. Thank you very much. You were so nice on. So, some of them try to ask you to do more. "No. I feel still some things." They want to push you to do more.

SB: Yeah. Part of that question was about whether it's instinctive, what you do. Do you think that you have a particular talent or particular sensitivity to this? Are there people who could not do what you do?

JPB: My talent is to be a hard worker. No, I'm not very talented. Myself I'm curious. I like... I don't like to see people suffering. That is true that I don't like this. To see people... Because sometimes in life people have no chance.

SB: Yeah.

JPB: I saw a lady a short time ago, she has still some, she was operated, but for chorne or something. On the nose, she has about one meter, 50 centimeters less of her... She has always something. And I told her, "How do you feel yourself? Life was good with you, yes or no." "It's not good for me. And you know why?" I said, "I don't know why, but help me please help me."

When you see these people, you want to help them a lot. To be modest... I saw a lady a short time ago, cancer. Of course, I never have treated or healed cancer in my life, but I was able to help them. She died a short time ago. She told me, "Jean-Pierre, you can help me no more?" I said, "No, no more." She say, "You know what happened?" I said, "Well, I know what happened." And she'd say, "Oh well, I do."

So, it's when you have that kind of experience, you feel some of that stuff in your life. I had the people coming, I am stoked, but you kill these people and so it's way. It's a modesty. Something very important for me because we have a limit that we never overtake, but it's not something which discouraged me. You see, I must go further, further to help these people.

SB: And more questions I'm afraid. Somebody who is anonymous asks about gastroesophageal reflux disorder. Do you have any experience? Well, I imagine you have a lot of experience.

JPB: Which disorder?

SB: Gastroesophageal reflux.

JPB: Something that we see very often. I've seen thousands and thousands of people with this stuff. The point after is to know it's allergy. Sometimes you have some allergy, which can give this. That is very difficult to treat because allergy is... When you have allergy very often you are more and more allergic. What we call bacteria proliferation in the... What you call gasteropalarision.

You have these micro little lazy, difficult to empty very quickly. So you gastroparisian You have some bacteria, these bacteria you haven't suppose helicobacter.this helicobacter will attack your stomach and so on. We can help a lot with the vagus nerve. We a pilaris okay to stimulate the palaris to to, to help the body to evacuate a little more and to have less for proliferation of bacteria. So we have good results, good results.

SB: Another anonymous question. Do you find any other practitioners or books very helpful in gaining knowledge for your approach or is it anatomy, anatomy, anatomy?

JPB: But you know, if you're not sensitive, you don't do our job. If you don't know the anatomy you will have a big limit. Anatomy is not enough because in must of the hand on the hand is not enough. Because you know, for instance, sometimes when you take your... Sometimes I feel not so good myself. I say, "My goodness, you must work a little more." I open my book of anatomy, and I can tell you that I have a lot. I open on sometimes the little detail you will find is massage. I find something with this stuff. No I'm, sure that we cannot do our job without anatomy.

SB: How do you actually measure patient outcomes? Because on the one hand you say, patients will try to please you so you can't trust what they say, but on the other hand it's not. It wouldn't be acceptable to the medical community here to say, well, I think they're better. Therefore they must be better because surely there has to be some way of measuring their quality of life. The improvement after all?

JPB: They come... First, he has something to say. We never heal somebody. We help. We permit a better compensation adaptation. For instance, if you take somebody, you have seen genetic problem, maybe birth problem, maybe intra fetal problem, vaccination problem, infection problem, physical trauma... Nobody's in good health. Okay, because we have all a lot of stuff, but sometimes you have in good composition at the station. You feel good. Myself I feel good. I touch wood. I have no pain for the moment. Okay.

But sometimes... What we try to do is to treat one part, another part and so on. Our new permit to have a better general adaptation compensation when we understand our job. You have somebody with a knee problem, you work on the knee and the knee's, much more better. But you have done more than the knee. Maybe you have done some things to somebody depressed because depression with knee with low back pain, with bad digestion... All this stuff. Do I have you to have a decompensation or sometime to do something intelligent on

the knee on the spine will help more the people that you believe yourself. And that is good. That is our job.

SB: A question about prostatic hyperplasia which came in some time ago because you mentioned it. And I don't know who asked the question, but they're asking for a friend, not for a patient. So they don't have the full case history but he's 35 years old has been diagnosed with prostatic hyperplasia. And the first, the question or I heard about this was when he saw him recently and he went to the toilet about seven times in the space of an hour. It's affecting his bladder and sexual function and the consultant has already mentioned surgery and obviously the person says he's recommended he sees an osteopath. Would be... We'd be interested to hear your perspective.

JPB: But for instance, you know when somebody has some hyperplasia of the prostate, we have no effect on the size of the adenoma. We have effect in the intra adenoma pressure on this apartment because what happened? The pressure simulates the urethra. The guy must go to the bathroom many times, and you said he had some venous congestion which had some effect on the erection and so on. It's why we do something internal.

You can work on the sacrum on the, on the other part on the hip. It's important also on we work internally and we try to soften the prostate middle pathway. There's the ureter, you have two lobes, you work on the two lobes. And sometimes it works very well. Three station works. Sometimes they don't work but when it works it's fantastic because the guy is not operated. He has not the risk.

You have some surgeon right now which are more much better than before. Normally operation of the prostate is... Do it in 45 minutes. 45 minutes in impotency and incontinence. You have some surgeon it takes a long time. They are very miniatures. They try to to respect the nervous system on the people. I'm not that kind of them. So it's where you, you must ask always the surgeon our how long we last a surgery.

SB: Yeah. And Robin, I'm not sure. I think it's the same Robin. Has asked, you talk a lot about hands on and releasing nerves and soft tissues. How do your techniques influence things? Is it a direct... Is it a tissue state, fluid dynamics, direct mechanical release or, dare he say, energy?

JPB: Alors. I've chose the prem. So vascular scissors, sure. And vascular, nerve, lymph system is sure. And because they are very sensitive to manual pressure. Nerve system also. Okay. Viscal elasticity is sure. And I suppose a little magnetical because I did some research about

the editorial medical field around a person. We did it in America. We failed, but I did it with the French nuclear power agency people, not the romantic like us. We do it with the infrared. Is a part of the editorial medical field.

We did some research about the infrared emitted by the body when there is something wrong and we were very successful. These people, we specialize in gun. Okay. Infrared gun. So we are not the same job I understand. With the hand you can feel a difference of one 10th of a one degree. Okay. And when you treat very well a person, very often the degree diminishes. So we have some effects on the medical. What is energy that is difficult to understand? What is energy? Because we have a lot of definition. Energy is power to do a work.

I suppose there's something, when we speak about motility. It's not clear, not really clear. We feel it. But I would like to do a little more research because we are not only flesh, we know we have something else, on the better. Try to have the two feet on the ground. I'm doing some research and we do some research. But this is motility again. Right?

SB: I suspect most people do understand what you mean by motility. Would you like to just make sure we understand.

JPB: For instance, mobility, I moved my hand, my arm, everybody can see you or some little moment of the organ for instance, which are not due to the diaphragm because the diaphragm when you move, you move all the organs. And so you ask somebody to stop to breath for a short time and you can feel little movement, which are not seem to see with the mobility. It's a little bit what people felt or saw on the arms around the skull. It's why I would like to do some research to see if is not due to the vascular system which... The vascular system with the heart and so on. So it's easy to stop the diaphragm, is not easy to stop the heart. So we will do it without the diaphragm.

We have some people doing some scuba diving. They can stop to breath, doing four or five minutes. Okay. When I have the patients I would like to do some research with them. Because motility I'm sure with them where we can find a little more motility.

SB: And this is more than just the pulsation of blood flow.

JPB: Invisible movement. Okay. I suppose it's a maybe a combination of vascular-lymph system. Also it's... I suppose... Well, speaking about the skull for instance. The ventricular system is this... You have some cilia inside.

SB: Yes.

JPB: The same rhythm that people feel with the hand. Maybe there is something also I would like to do.

SB: Yeah. Fascinating stuff, Jean-Pierre. Thank you so much for coming in this evening. I have a great job. I get to meet some really wonderful people doing this job. And this has been one of the highlights for me, so I'm so glad you able to spend the time to come and see us to see, and I hope that people will take the opportunity to attend your... The Barral Institute courses and put into practice. We're all, I think very envious of the fact that you practice in France where you can do things which we would regard as being classical osteopathy.