422 Paediatric Osteopathy: Threats and Evidence - Transcript

With Steven Bruce and Dr Jerry Draper-Rodi

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Steven (00:00:00):

Welcome to this evening's broadcast. The whole business of paediatric and to some extent, obstetric treatment, at least for osteopaths and chiropractors, has been a thorny subject for many years. Plenty of criticism coming from the conventional medical profession apart from elsewhere about either the safety or the effectiveness or both of those treatment approaches. Now it seems to me that there is a renewed movement in Europe against this approach to treatment. So we felt it was time to take a look at the impact on practice as well as the latest evidence. And I've got Dr. Jerry Draper-Rodi with me in the studio to give his perspective on it. He's an osteopath, his doctorate is in professional practice. He's director of NCOR, the National Council for Osteopathic Research, and he also heads up research and knowledge exchange at the University College of Osteopathy. Jerry, welcome back. As you are aware, I sent out a couple of provocative messages about show, about how there's a movement in Europe against paediatric and obstetric osteopathy, and I gather it sort of raised some interest in the higher quarters, didn't it?

Jerry (00:01:08):

Yes, exactly.

Steven (00:01:12):

Yeah, we had a couple in here. I gather even our chief executive, the registrar himself, has spoken to you about, what the hell is this going on in Europe?

Jerry (00:01:18):

Yeah, Exactly.

Steven (00:01:19):

Is it that significant what you were saying?

Jerry (00:01:21):

I think it's significant. I think there is definitely a movement that seems to be happening, or at least it's sort of culminated at the end of 2024 where several countries, medical societies or groups of paediatricians made statements around paediatric osteopathy mostly and stating

that medical doctors should not advise patients to bring their babies to see osteopaths. So that was in Sweden, in Finland, in France, I think maybe in Germany. And that all happened within a few weeks. I'm not really sure how that was, whether it was orchestrated or it was by chance. But there's definitely a movement that seems to be happening in Europe.

Steven (00:02:06):

Do you know what's the basis of that? Obviously we don't know whether it's coordinated, but on what grounds are they saying don't do it?

Jerry (00:02:13):

So I think it's mostly around safety. I mean if you look at France as an example, the profession was recognised and legalised early 2000 and then there were decrees in I think 2007 if my memory serves me well. And in these decrees there are some sort of limitation of what osteopaths can do with babies. So the wording is quite unclear. So it's been interpreted by the osteopathic profession in a way that allows them to continue seeing babies. But effectively the law says that osteopaths should not do any, I can't remember the exact wording, but any manipulations on babies under the age of six months without a prescription from a medical doctor.

Steven (00:03:03):

Because medical doctors know all about manipulation (not)!

Jerry (00:03:05):

Well, exactly. And medical doctors say very rightly, I'm not going to give a prescription because I don't know what you do. Exactly. And also I don't really understand that, which probably makes sense, but because osteopaths do not use manipulations on babies, they feel that they can continue treating the paediatric population. But what I'm trying to say here is that it's not a new debate, is it? It's been there for quite a while,

Steven (00:03:37):

But every So often it seems to resurface, doesn't it?

Jerry (00:03:41):

That's Right.

Steven (00:03:42):

The poor old chiropractic profession went through hell in this country as a result. I still think mainly because of advertising rather than anything else,

Jerry (00:03:50):

But also the chiropractic profession. I think in 2017 or 2018, there was this case in Australia of a chiropractor doing a video with a newborn, I can't remember how old the baby was, and using a device that is often mostly used on adults.

Steven (00:04:08):

One of the activator devices?

Jerry (00:04:09):

That's the one.

And that was on social media that created quite a big campaign onto chiropractic care on babies because it was considered as being unsafe. So the concern was mostly around safety and that led to the chiropractic profession in Australia making statements that manipulation should not be used on children under the age of two.

That was probably seven, eight years ago. I think something that might have triggered this restart of the discussion was last year there was a systematic review published looking at the effectiveness of manipulation and articulation techniques, or mobilization as it's called in the paper, on the paediatric population. And effectively they made some statements in there which were probably not exactly accurate, including that osteopaths use manipulations on babies. Well infants.

Steven (00:05:16):

Do they actually define what manipulation is because of course lots of people talk about manipulation to mean soft tissue work.

Jerry (00:05:23):

So they define mobilisation as being articulation techniques and manipulations as being what we would call high velocity thrusts

And then they looked at the literature and they found no evidence that mobilisations or manipulations would be effective for managing conditions within the paediatric population. So they looked at whatever was in the literature, but that included for example, asthma, colic and so forth. So a plethora of conditions. So that was around June last year, June 2024 and led the physiotherapists to make a statement, an international statement, saying that they did not recommend using mobilisation or manipulations on children under the age of two.

Steven (00:06:22):

Are we still in Australia regarding that statement`?

Jerry (00:06:24):

So the physiotherapists' statement, that was an international statement. It doesn't mean that people have to follow it, but if he's quite a position from the profession about what they feel should be done.

From the chiropractors, there was a statement that was put out but then removed quite quickly, which effectively followed the same sort of lines that chiropractors should not do any manipulations or mobilisation on babies under the age of two. But I think that was, I may be completely wrong, but my interpretation is because of what we discussed earlier, what had

happened in Australia, there was a bit of a precedent and I think the authorities in chiropractic were taking that in account,

Steven (00:07:10):

But the reaction in Australia was a knee jerk reaction to a video, not because any harm had actually occurred. I'm not suggesting that personally I would want to manipulate a newborn or a small child, but nonetheless it was just a knee-jerk reaction to seeing this video.

Jerry (00:07:26):

But they also, in Australia, I can't remember which exact structure, but they did a report, they sort of looked at whether there were risks associated with manipulations. It's very difficult obviously because there's not much research in that. And research is, when I use the word research, if you think about clinical trials, they're not the best way to look for harms. You would need to do longitudinal studies where you follow a cohort of people for quite a long time and things like that.

(00:07:53):

Anyhow, so we don't really have a lot of that. So it's difficult to know whether there would be problems. But they did this report, which is available online, and they found that they were three incidents of serious harm due to manipulations on children under the age of two that had happened within the chiropractic profession, but not in Australia - it was outside of Australia. So they said while we don't have a lot of evidence that it seems to be doing any harm, the harm that was caused was really serious. We don't really have evidence that it does help babies using manipulations. So at that point we are again around 2017, 2018, they said we recommend not using manipulations in babies. And so that paper and that then statement from the physiotherapists last year led a little bit of reaction within the chiropractic profession, but not within osteopathy, even though the osteopath profession is mentioned in there.

Steven (00:09:02):

Sorry, again, I mean it does sound weird from what you've been saying. It sounds as though we're here to criticise the chiropractic profession, which we are not at all. It just happens to be once again, the chiropractors of taking it on the chin.

Jerry (00:09:13):

Yeah, no, that wasn't at all against chiropractors. I think to some extent the chiropractors have tried to answer that review and the statement that was made against their profession. But I think if something was a bit odd it was more the osteopath profession not really making any statements on that and not reacting to the fact that the profession is described as using manipulations on infants and things like that. And it was just left as it was, which I think can be quite damaging for the profession if that becomes the way osteopath osteopathic care on infants is considered and described.

Steven (00:09:55):

Is it described that way?

Jerry (00:09:56):

Well, yeah, in these papers, yeah.

Steven (00:09:58):

Right. Okay. But not on any official website in this country I'd imagine.

Jerry (00:10:02):

No. So my position is I anticipate that it would be a very unusual thing for osteopaths to use manipulations on infants.

Steven (00:10:12):

Yes.

Jerry (00:10:14):

So I'm the chair of the research committee for Osteopathy Europe. So Osteopathy Europe is an organisation of all the professional organisations in Europe, Europe Plus because there are other countries including Brazil, Canada, I think maybe Israel. And so we meet twice a year with all the different organisations and that. But the research committee, we meet monthly and we sort of look at what's happening, but also we conduct some work to support osteopathy Europe. So when that came up to us last summer, this statement from the physiotherapists following this review and stating that osteopaths were using manipulations on infants, the research committee, we felt that it was something that we should respond to. So the choice was either we do a position statement straight away saying that's not what happens out there. Osteopaths do not do this. But the main issue we have, and that's collectively for all manual therapists regarding infant care, is we lack evidence and we felt it would be difficult to do a position paper without providing any evidence to our claims.

Steven (00:11:30):

Including evidence that it doesn't happen because we don't know do we?

Jerry (00:11:34):

Exactly. So saying osteopath do not use them, it's like the black swan, you just need to find one and your whole thing is completely broken. So we went another way and we decided to go and collect data and to ask clinicians and educators in paediatric osteopathy whether manipulation is taught or used in clinical practice for infants, our expectation is that it is not, but we don't know because there is no data on these things. Anecdotal evidence seems to suggest that it's not being used, but that's not strong enough for an international statement. So there's a subgroup of the research committee that is led by Patrick Van Dun who is an osteopath in between Belgium and Germany, Lucas Boer in Germany, Dr. Julie Elwood in Ireland, and Dr. Ana in Brazil who are leading this project working with Dr. Amy Steel in Australia. So we're really trying to have an international view of that so that we can start collecting data. We hope by this autumn in all of the different countries where osteopathy is being taught and delivered as a form of care so that we have then evidence where we can say whether it's used by how many or whether it's not used and not taught. But we feel this

is a critical missing piece at the moment for the profession not to be able to describe what we do.

Steven (00:13:10):

Is there a problem with doing the research in the way you've just described? I imagine that those other countries might not be teaching osteopathy in the way that it's taught here.

Jerry (00:13:23):

And so I think that's a really good point. Again, completely anecdotal evidence. I've been delivering CPD in many, many countries. I go to conferences in lots of countries. I've never heard of any osteopaths suggesting using manipulation - that doesn't mean they don't exist, but the data we'll be collecting will include information about the country that data is coming from and we can look whether there are differences between countries where the profession is regulated or not regulated, whether the teaching is within universities or private schools and all these sort of things. So if we find that there are pockets of practices in different aspects where they use manipulation, we'll be able to describe where these are and suggest whether changes should be made or not. But we will be able to have this granularity in the data to be able to understand these differences.

Steven (00:14:23):

It seems to me that chiropractic has more research behind it than osteopathy. I don't know why that is. Maybe it's partly because there is an organisation out there which publishes research papers and they're all chiropractic papers. Is that the case? I mean you are a rare breed, you're a black swan yourself, aren't you? Very few osteopaths are involved in research.

Jerry (00:14:43):

Yeah, I think the chiropractic profession is much more mature on the academic side for sure. If you look in Denmark, for example, in Canada, they have really well established research centres.

And I think you're right that the fact that they have a really well structured international organisation is really supporting even internships between countries, which we don't really have well established yet in the osteopathic profession. All of that is completely true, but the chiropractic profession has exactly the same issue of lacking evidence for paediatric care. So if we think about the systematic review I was mentioning earlier, I think the first author's name is Milner, that was published in 2023 or 2024 - that looked at the evidence in physio, chiro and osteo. So all of them put together and despite really scoping quite broadly, there was not much evidence suggesting that manipulations or mobilizations were helpful in the paediatric population. I'm not saying it doesn't help because obviously it's a field which is quite under-researched. So it's always this question of not throwing the bathwater with the baby, but it's definitely an area that whichever discipline you're looking at, we don't have a lot of evidence.

Steven (00:16:19):

And a lot of it is just anecdotal, case history stuff, isn't it? I'm not sure how well researched or how well backed up conventional care is for paediatrics. Have you looked into that?

Jerry (00:16:32):

Yeah, so I was very fortunate a few years ago to, that was before my time at NCOR to work with Professor Dawn Carnes, who was the then director of NCOR and Dr. Julie Edward. And we did a couple of systematic reviews and we looked at treatment for colic and we looked at the treatment for plagiocephaly and torticollis. And you're right, the evidence is not very strong again for conventional treatment for anything. So even things which are commonly advised like Infacol, not very strong for colic, anything like that. And these are very common problems that arguably do not have very long-term consequences - they don't have any impact on the life expectancy of people, quality of life for sure, but not on the life expectancy. So you can see why these sort of things are not really researched a lot. But I think the argument which is often made I think, which is a strong one, is that if you look at colic, yes, it does get better within three months. And yes, it's just three months, but it's also a very tiring and difficult three months for new parents,

Steven (00:17:59):

Very stressful.

Jerry (00:18:00):

So even on the top of that, you have your child crying a lot because of colic. That is a very distressing experience for parents. And it is also linked to death in children because parents, some parents, can't cope with it.

Steven (00:18:18):

So I was going to ask, I mean there's certainly some speculation isn't there, that when you're driven to distraction by a colicy child, parents can react in unfortunate ways.

Jerry (00:18:27):

Exactly, exactly. And also in the bonding between the parent or carers and the child within these first three months, it's called the fourth trimester, it is also extremely important. So if you have colic that is impacting on that, it's also very important. So whilst yes, it's rare that children die because they have colic and it leads to the behaviour of parents that will lead to that. Nevertheless it has wider impact on a family starting and all of this. So I think we shouldn't be dismissive about it just because it would get better within three Months, like plagiocephaly and these sort of things. But yes, there's not much evidence. So plagiocephaly was the same. We looked at helmet therapy, whether it was very effective, or repositioning or advice to parents or manual therapy or home exercises. So all of these sort of interventions and we looked at what was working and again, for most of them there is no really strong evidence. So it means that it leads parents, carers to shop around and try to find something that works because they are struggling and they need help and advice. And so they come to chiropractors, osteopaths or their GPs

Steven (00:19:48):

if we leave aside the question of harm, because I don't think there is an enormous amount of evidence that any harm has been done, you could argue, well, it is just as valid to try osteopathy or chiropractic as it is to try helmets or medication or whatever it is that the GP might prescribe for a colicky baby.

Jerry (00:20:07):

Yeah, I ran that question hard. I used to treat babies. I stopped a year ago just because I was not doing enough CPDs for me to feel safe to continue seeing babies. And that was something that would come from parents that it can't do really harm and I don't inherently believe that. I think something that can do good can do harm too. So I think that there's always a risk with any intervention, whether osteopathy, whether chiropractic, surgery, medication, not doing anything. There are also risks with that. So anything has pros and cons,

Steven (00:20:49):

But you might imagine that the risks of let's say cranial osteopathy on a baby are if there are adverse effects, they're going to be very minor and probably no worse than the effects of the colic or the plagiocephaly or whatever the baby's complaining of at the time.

Jerry (00:21:05):

Yeah, I don't know if I can answer that question really, because if I think about the financial impact or the time particularly for parents who are struggling to find time to take a shower because the baby's already crying a lot, I think there are some side impacts that are not negligible for parents when they bring their babies. And I'm not making that statement against paediatric care, that's not what I'm saying. But at the moment, we're in a position for both professions where for some areas of care we are lacking evidence to a point where it's definitely going to be damaging the profession.

So there are areas where I think the evidence is pretty good. If we look at supporting premature babies, there's been fairly large body of evidence coming mostly from Italy, but at the moment being replicated in Belgium, where they found that regarding osteo care, providing osteopathy care to premature babies was helping babies to get out of hospital quicker. So it was saving money and their general health was improving. And so there was some sort of cost effectiveness analysis that was conducted and that was in randomised control trial with placebo groups of large samples. So again, it's quality of evidence, you start thinking it might have an impact. So there are areas like this where we do quite well.

Steven (00:22:40):

If I take you down that route on the premature babies, good quality evidence from Italy, so an osteopath or presumably a chiropractor using sacral occipital as opposed to craniosacral techniques could now put on their website, I can help you with your preterm baby

Jerry (00:22:58):

That they can't Steven,

Steven (00:22:59):

They can, if they've got good evidence, if the evidence is good enough, they can defend the position.

Jerry (00:23:04):

The tension is obviously with the ASA, that's why we're talking about, isn't it? And where the tension is, is that evidence was conducted in another country, so whether you could apply that here, because if I look at how it was done in Italy, it was done within hospital before the babies were going back home. So saying that your baby that is back home that was born premature, I can help them. That's not exactly what happened.

So If the osteopath or chiropractor was working within a hospital providing care to babies, yes, but otherwise it's a little bit different. But there are areas where again, the evidence is maybe a bit less strong than premature but still pretty good around plagiocephaly and torticollis and manual therapy. to look at that as a group is doing okay, probably not better than self-management, but we know that parents do find that sometimes difficult because it's difficult to have clear instructions on how to do repositioning, how to do stretching and things like that. So that's something that I think for the paediatric clinicians that are watching us tonight, they should definitely take some of the consultation time to discuss that and to advise parents how to do that. But definitely that's an area of care that we have good evidence.

Steven (00:24:38):

Can I get some of those references from you after the show? Because imagine, yeah, of course if I were a paediatric practitioner, I'd love to be able to say, well, I'm not going to put 'em on the website, but if anyone asks for the evidence behind me saying these things, at least I can say, look, here's what we've got about torticollis and plagiocephaly.

I've got a couple of questions here or a couple of observations I'd like to mention this first one you've already dealt with because Simon says, doesn't it depend on how you define manipulation? Quite often my patients refer to soft tissue techniques as manipulation, but Simon would definitely not HVT an infant. Now you've already said, yes, of course, but those studies that you were looking at, they looked at manipulation as in high velocity thrust. I mention it because it's Simon's birthday. So I just wanted to say happy birthday Simon, and I'm astonished that you're watching us on your birthday, but I'm very pleased. Thank you.

Pip mentions a paper by Tajinder Deora, who apparently did a study with babies, a great study with babies. Pip's never been able to get hold of paper. Apparently came to Cardiff many moons ago and told us in the study she'd done on babies in the NICU (neonates intensive care unit), some treated with cranial and others not. And she's got a biochemist background. So she was able to look at their blood results for markers of information found there was a statistically significant result that those treated cranially were less likely to get infections. Have you ever come across that study.

Jerry (00:26:02):

I know Taj quite well. And we started our PhD together. So I know Taj very well. Yeah, so I think, I don't know about that study specifically. I mean we've talked about it with Taj, but that study had a very small sample if I remember well and also was not published. So that's the thing where again, that is not going to be used. It can inform Taj's work and when she trains

and that's really good, but that's not something as a profession we'll be able to use to evidence.

Steven (00:26:43):

This is So frustrating, isn't it?

Jerry (00:26:44):

Yeah, yeah, exactly. So yeah, that's where we lack this information to be accessible. And also I think where we have failed, and maybe the same for chiropractors, but I don't know, I think we haven't been good as a profession to make sure that others understand what we do. And I think there's a little bit of, it's a bit opaque what we do. It looks a bit magic and unclear and it's difficult for others to understand what the benefits are, how it works. And to some extent we don't really agree with each other how it works, but that makes it even harder for people outside of the profession. I'm not talking about parents or carers because if they've been advised and word of mouth and all that, that's fine, but it's more the outside world. It can be difficult for them to understand what we do.

Steven (00:27:38):

So just talking about cranial osteopathy or the equivalent chiropractic technique, have we got any better evidence for what it's doing now than we had say 10 years ago or further back when I graduated when frankly there was nothing.

Jerry (00:27:54):

So we have better evidence that previous models are obsolete. I think we can confidently say that these models, we need to move away from them again, doesn't mean we should stop the techniques, or we should stop the approach. But the way we conceive them, the way we think they're working doesn't really fit nicely with current evidence. And that comes from preclinical evidence outside of osteopathy. So if you look at how the structures around the brain work, the amount of pressure you would need to create any change, the amount of force that osteopaths tend to use, when you look at the studies that have been published around the validity of palpation and that around the cranium, it just doesn't fit. There are also studies that have been done in osteopathy where they looked at, sorry, I'm going to go two ways. So I'll start with the first way studies where one thing that comes often is that palpation is not reliable and there's a big body of evidence around that. And that to some extent is quite true. Saying that, in cranial osteopathy, there's also some research that found that if you train osteopaths to be quite specific about a technique, then the reliability is excellent.

(00:29:22):

So this idea that no one is doing the same thing or that it is true to some extent, but also we can work to become a bit more reliable between two practitioners or practitioners. I suspect In a research paper you couldn't use this

Steven (00:29:33):

I've often wondered, and I think there's been evidence about palpating levels on the lumbar spine to support this, that although I might describe what I'm doing in different terms to the

ones you use, we might both be effective and we might both be wrong about what we think we are doing and which level, which structure we think we're palpating. That doesn't fit well in a conventional medical model where we want to know precisely which joint you were affecting at precisely which time with how much force and what was the outcome.

Jerry (00:30:04):

And I think also a lot of osteopathic or even chiropractic models tend to be quite tissue-based and you are going to affect for example the fourth ventricle or the gallbladder.

So the models tend to be quite specific and probably we could be a bit more simple in our models and to use the same techniques, but not to be thinking that we are that specific. There's another side which is a bit more recent, and that was done in a school in avenue also south of France. And that was done in an undergrad school and they took a cohort of students who were naive to cranial and I can't remember the whole design, but basically I think they had four groups and they had I think a term of education around cranial where they taught them different things around the rhythm and whether you would find, I can't remember now, eight a minute or 12 a minute or 20 a minute or however many minutes.

(00:31:10):

And what they found is that students at the end would feel what they were told they should feel. So also we are highly informed by the education we have, the models that are taught. So these models it's not that it doesn't really matter. It does inform what we feel. It does inform what we do. It does inform what we tell patients, how we talk to other healthcare professionals, to colleagues and so forth. So all of this understanding I think is really crucial because we need to be harnessed with patients, but also for how we teach the new ones who are going to join our profession post-grad education and all of these. So I think, I mean I'm sorry that's probably too many times used the word crisis tonight, but I think the osteopathic profession and to some extent the chiropractic profession with the subluxation model, we are really hitting a crisis of how our models, which some of them are outdated, how we can update them so that we can…not continue doing exactly what we were doing because we changed through time, but how we can inform what we do with models which are a bit more in line with the way we understand health and the world.

Steven (00:32:26):

So which of the things we have to abandon in our current understanding of treating cranial osteopathy? Are we giving up the term involuntary movement?

Jerry (00:32:38):

So I'm going to talk about another project I'm doing at the moment. So we've received funding from the osteopathic foundation in the UK and from the SOSF, which is the Swiss Osteopathic Science Foundation, something like that, which is the equivalent of the osteopathic foundation, but in Switzerland. So we've received around £45,000 for a one year project, which is called osmosis, which stands for osteopathic model synthesis. And the aim is for us to understand on an international level which and how models or specific models are taught, but also how they are used in clinical practice. So we are going to try to map what the models are, sorry, asking the educators how confident they are about teaching them what level of evidence they feel they need extra or whether they have enough anything

that, so the aim of that project is not to say which model should be ditched and which one should be kept. It's really to be able to see the sort of plurality of models that exist

(00:34:00):

And osteopathy and chiropractic would be different, but chiropractic is not in that project. Osteopathy is different depending on where you work because your national environment is going to impact how you provide care and things like that. So the aim is not to say what should be taught and not taught, but it's to understand what is taught, where there are gaps in knowledge that are affecting education, but also which models seem to be informing clinical practice in different countries. So that's why I'm a bit reluctant to answer which models we should drop because I think it's a bit too early. So I think yes, we're in a crisis, but I don't think we should be too quick and I think we need to take time to analyse what is useful in clinical practise, what do osteopaths use regularly, what is taught, where the gaps are between the two and how we should take this forward.

Steven (00:34:53):

Yeah, I think you just made it sound much more complicated to me because I as a parent, as a member of the public, I just want to know if something works and I don't really care what model is in the back of your mind while you are treating my baby, my child, whatever else. And I presume some research studies are still to some extent going on where we simply say you went to see an osteopath and you either got better or you didn't and compare it with people who went for normal standard care.

Jerry (00:35:28):

But I think one of the potential issues, again, I'm going to use cranial osteopathy, I use cranial osteopathy in my clinical practice, not that I need to justify myself, but just saying I'm not against cranial osteopathy, but I think the models are problematic. One of the issues is that we can't expect models not to influence our interaction with patients. And if you treat a baby and you think that the cerebral spinal fluid, the CSF, is impacting how the head bones move or thing like that, and that's the way you verbalise that to the parents saying, oh yeah, the CSF is a bit blocked on the right hand side (I'm making this up and it's a bad expression, so apologies to the cranial osteopaths who are watching us or cranial chiropractors), but that's much better. Now that would be potentially massively worrying for the parent. It could have a nocebic effect.

If we had a model, and I'm not suggesting that would be a suitable model, but there's a cranial osteopath called Marco Gabutti in France and he's the cranial educator at the Swiss institution that teaches osteopathy one of the two.

(00:36:51):

And his model is much more around the mechanics of tissue and how they take lodging and all these other things. And the way he explains how we could look at cranial osteopathy is a way that could potentially be much less nocebic. So I think that's also why models are important because we can frame what we do in a way that can be quite worrying for parents, carers, patients or much less, more empowering and reassuring and things like that. And I think that, so it's on all fronts. Us as a clinician for our students, but also for our patients,

Steven (00:37:26):

It's a hard balance to strike, isn't it? I mean communication is important. Treating your adult patients as well as talking to the adults about their babies that you are treating, and it's probably a lengthy course we could do on how you ignore the stuff that's in your own mind to express it things in a way that they will understand so you don't stress the patients, but you still get the results you're after.

Sarah here has just sent in a comment to say that it's really nice to hear that you used to treat babies. She sometimes gets the impression that people who do osteopathic research only prescribe exercises. We talked about this in the last show, didn't we? That sort of move against the hands-on therapy. So we won't readdress that here, just to say, have we gone beyond that now we are beginning to understand that hands-on does work?

Jerry (00:38:13):

I think so. I don't mean that was a big, big thing. I know we've touched about that last year, but it doesn't seem to be much of a discussion. I think if I think about, there was a big international conference in London a couple of years ago and all the sort of meetings that I have and all that I think there is within the as osteopathic profession, there is no real question whether hands-on should be used. I think it's an expectation and if you ask patients, they do expect osteopaths to use their hands. So I don't think that's really a debate or there were

Steven (00:38:57):

Some prominent voices in the osteopathic world were saying that all the evidence says exercise is the thing. I think were there.

Jerry (00:39:03):

No, well, I don't know. I may be wrong. I think there were definitely voices saying that we should embed exercises within our consultation and I'm definitely in favour of that because the evidence saying that lately the evidence has been a bit more shaken. But I think that makes sense if we want to empower patients and all that. I think where the debate is is more, again, sorry, going back to models, but about somatic dysfunction and whether this is something that makes sense. Is it really a useful model in clinical practice? Anything like that. So while some elements around manual therapy or palpation, anything like that are being questioned, it's not touching patients, treating patients with hands which is questioned. These are different I think questions.

Steven (00:39:52):

Going back to the topic of colic, which you mentioned earlier, Nikki's said that colic’s not a proper diagnosis. The first paper was published in 1958 and we still can't say what it is or what its causes are, it's a term for a range of symptoms. But it's a well-known term and she's quite right to say that.

I think relatively recently wasn’t colic divided into three different types of colic, none of which it was suggested could be treated by osteos or chiropractors. I seem to remember Clive Hayden telling me this a few years ago.

Jerry (00:40:20):

That's possible. It doesn't ring a bell to me. So the definition that I knew about colic was purely based on number of hours of crying and it was something like more than three hours, more than three days per week for more than three weeks or something like that. It was something along these lines,

Steven (00:40:39):

But she's absolutely right. I mean it was just this is what's happening. There was no question of anyone working out why it was happening.

Jerry (00:40:44):

Yeah, exactly. I think and even the word colic seems to suggest is coming from the tummy, but in fact crying can be due to many things, can't it?

Steven (00:40:53):

Of course. Well Rich says, and you mentioned this earlier on as one of the “solutions” for colic, how can Infacol and other similar things be advertised that they’re “colic drops” if there's no good evidence?

Jerry (00:41:06):

I think that's an excellent question and that's something that I wondered how the ASA was not picking up on, I do not have the answer.

Steven (00:41:17):

But I Suppose the ASA isn't going to pick up on something unless someone complains about it. They don't go out looking for things that are wrong, do they? They wait for people to say, this doesn't seem right to me.

Jerry (00:41:28):

Do they? I mean as a profession we had to provide evidence list of conditions that we could treat,

Steven (00:41:36):

But I think that was on the back of a number of complaints, possibly from the good thinking society. I hate calling them that, but possibly on the back of their campaign against us that it was probably, we had to justify it. But I, I'm not aware of the ASA actively looking for problems, but they will react obviously if someone does complain.

So maybe someone should write in and say, well what's the evidence for Infacol? Or something like that

When we talked about them earlier on, you questioned my idea that we can now say that we can treat various things with babies even though the evidence is from another country. I think you could probably argue that the evidence is strong enough for me to say I treat this

and if the ASA says we don't accept it, then you say, fair enough. But it was a good case, wasn't it? And then take it off your website. I would do that, but I'm a bit necky like that.

Jerry (00:42:35):

If I may follow on colic, there was a big randomised controlled trial that was published in osteopathy. The paper was out last year or 18 months ago called the CUTIE trial.

Steven (00:43:00):

Yes.

Jerry (00:43:01):

And that was led by Professor Carnes and what it did is it tested, it compared osteopathic manual intervention with placebo intervention. It found that there was no difference between the two groups. I think that led to a lot of discussions within the osteopathic community, which was very helpful because what this paper did not say was not that osteopathic does not help with colic. What it did say is that when we compare with that type of placebo, we don't see a difference.

(00:43:40):

So if there was an active ingredient is not that. There's something else that might be. And again it goes back to our model, the way you design an RCT or randomised controlled trial is based on your model of your theory and you think that's my active ingredient. I remove this active ingredient in my placebo and I see if I can capture a difference in that trial, they didn't capture a difference. And again, it doesn't mean it doesn't work, it just means that that's not what we thought was working. That is having an impact if there is an impact. And I think all of these things, whilst they are potentially disturbing for clinicians who see babies all day long or maybe not all day long, but they regularly see babies and they see improvement and starting to think what does it mean for my work and my clinical practice.

I think it's also really important for us to start asking these questions if we want to be credible, but also to understand what we're doing and how we could do it better. And it helps us to frame a bit more our work I think. So things are evolving and going in the right direction, but it is a slow progress for sure.

Steven (00:44:47):

It's easy for us to say I suppose, but it's a shame that there is such a confrontational relationship between us and such a large proportion of the conventional medical fraternity who see themselves as defending the public against sharp practice in osteopathy or chiropractic rather than taking a look and embracing what we appear to be able to do for people. Perhaps it's because we have to charge for our services, whereas for a large proportion of the public, they don't have to pay for conventional treatment. I don't know.

Jerry (00:45:14):

Yeah, I mean saying that I think in the UK we work fairly well with other professions. I mean in academia for sure, collaboration is very easy. Whatever your background. And I

collaborate with many physios, gps, psychologists and so forth and it's never been a problem. In my clinical practice, I work quite well with my local GPs and all that. So I think that's fairly easy.

Steven (00:45:40):

But equally in recent shows we've had people saying that a patient has come to 'em and the GP has actively told them, don't go near an osteopath. An osteopath in that case - it could have easily have been a chiropractor. There is certainly a body of opinion in the conventional world which says that we are charlatans

Jerry (00:45:57):

And I would respond to that, that there are probably quite a few osteopaths who say do not see a consultant and get medication or get surgery. So I think it's a bit of a two-way street and if we want that relationship to be better, very anecdotal evidence, I used to have this relationship with my gps. So what I did is I went to them and I did a CPD to them about the new NICE guidelines when they were published. And at the end of the talk they said, but why are you doing that for us? What do you expect from us? And I said, nothing, I am full. I don't need more patients, but I'm really fed up of patients telling me that they can't tell you they are seeing me because you are going to tell them that doesn't work. At the end of the day we work for the patient's benefit. That's not in their benefit, the fact that they can't share this sort of information and I was not coming to get business, they could see that I was not talking nonsense. And since then it's been fab. Really fab. So I think we also have to accept that we are a tiny profession.

(00:47:05):

vMedical professionals will not have met any of us. They will have heard things about our profession and we need to create a relationship. And if there is trust, it would be easy. But it's five and a half thousand osteopaths in the uk, three and a half, maybe 4,000 chiropractors in the uk. So what they're going to hear is from the Daily Mail and “oh, what the chiropractor did” and it's going to be this sort of information that they will have received. So we also have to work to build these relationships, so they trust us. So I think we have to work a bit harder on that one.

Steven (00:47:42):

And I don't know how you managed to get into the GP surgeries to do that CPD.

Jerry (00:47:47):

The Practice manager. I sent an email to the practice manager and she said yes.

Steven (00:47:51):

Right, okay. And they presumably organise regular CPD sessions In the practice.

Jerry (00:47:54):

That's right. So they have once a month a lunch CPD thing and I was a slot on one of them

Steven (00:48:00):

I guess they're probably looking for things to talk about as well.

Jerry (00:48:04):

On that note, if some people want to do that. MSK, it might have changed now with some of the physios being first contact practitioners, well osteos too, but it used be, I think it used to be 35% of GP appointments were MSK-related. And we know that the GPs' knowledge in MSK is quite limited because their training hours are limited and so forth. So I think there is appetite for CPDs on MSK best-evidence guidelines and stuff like that. So I think we have a way in which is quite easy.

Steven (00:48:40):

Yes, I mean you have an advantage in that you are a very academic sort and you clearly retain knowledge of research papers, which the bulk of us wouldn't do. And knowing a lot of doctors as I do, they are equally good at remembering the details of research papers. I suspect you can argue your case in a CPD session with them better than many of us.

Jerry (00:49:02):

Yeah, it wasn't at all confrontational that meeting and they were quite happy to hear about the changes about before and now what it means and like that.

Steven (00:49:12):

Well, I think that's reassuring for people. I think a lot of people would find the idea very scary of standing in front of a bunch of gps who we know are extremely well educated in medicine, Well informed.

Simon says that the NHS says "hold or cuddle your baby, hold them upright, wind your baby gently rock your baby, give them a warm bath, use white noise to distract them and feed them as usual. Don't put gentle pressure on the spine or skull". Which is cranial osteopathy. "There's little evidence this works and it could hurt the baby". But anecdotally, Simon says he's found cranial has appeared to help a colicy baby. Now we've all heard plenty of anecdotal evidence to that effect. What I find striking in there is the idea of using white noise to distract the baby. Now it's no secret. I have a military background and I've been exposed to white noise and I bloody well, wouldn't want it used to me on me to distract me from pain. But there we go. Have you heard that advice?

Jerry (00:50:05):

So not that least exactly, but regarding white noise, I think there is evidence around that

Steven (00:50:14):

At the end of it, the baby will tell you anything!

Jerry (00:50:16):

I don't know very well about it, so I'm not going to try to go too much into details, but unsettled infant behaviour, which effectively is a little bit similar to colic - hours of crying per day, per week and so forth. It is related to some extent to a lack of sensory stimulus. And so sometimes parents, because the baby cries a lot, they don't dare go outside because they think people are going to judge them because the baby is always crying and all this other stuff. So they end up having the baby a lot inside and not being stimulated to light, sounds, leaves moving and all this other stuff. So there are things that can be done at home like putting the baby in front of a washing machine and seeing the stuff moving and stuff like that. But white noise

Steven (00:51:10):

Just for the benefit of the audience - in front of the washing machine.

Jerry (00:51:13):

Yeah, not inside. Not Inside. So the white noise is also part of the sort of stimulus.

Steven (00:51:21):

Wow. Groose says, I think current models of health should incorporate aspects of osteopathic thinking. If osteopathic thinking has to change to be in line with current fashions, it's no longer osteopathic. Is that what you were saying?

Jerry (00:51:33):

No, that's not what I was saying. And I think, yeah, that's a difficult one, isn't it? So I think that's my position. I don't think we can treat patients as we used to treat patients in 1874.

(00:51:51):

I think the world has changed. I drove to come here, I've got a smartphone in my bag and a laptop in my bag. I do very long hours, but in front of a computer - that's quite different from a farmer in Missouri in 1874. So I think there is a change in society and if our profession wants to survive, it has to adapt to society. So yes, the profession is going to change. Our models have changed tremendously in 150 years. So there is a change that operates automatically. We understand microbes, all these sort of things. So we have adapted to that. What that doesn't mean, it doesn't mean that we have to fit with other models that do not work well for our practice or way of interacting with patients. And I think potentially one example that might explain that is if we look at patient-centred care or person-centred care, which used to be called maybe holism in the past, that is a key feature that has always been a key feature of osteopathy and potentially a chiropractic too, I don't know, but it's quite likely that David Palmer also. I mean there was lots of similarities between the two, but I think the osteopath profession hasn't been very good at putting itself forward as a profession that is person-centred care taking in account the person's context. And I'm far from being good with history, but if you look at Andrew Taylor Still, he had a sanatorium outside of Kirksville that used to be a psychiatric hospital and he took over the psychiatric hospital. So if you go there, it's really worth a visit. So I went to Kirksville and you go there and it used to be cells where psychiatric patients would be locked. And Still said, no, come on. They need to have good food, they need to have exercise, they need to be included with the local community. I mean, that's really person-centred care. That's really holistic thinking, it’s about more than just

bones out of place. And I think as a professional, we haven't really been good at promoting ourself as doing that. And healthcare has caught up with us massively and now person-centred care is everywhere. Does it mean that we shouldn't do it because others are doing it? I think that would be a big mistake because obviously that's been a cardinal aspect of osteopathic care for a very long time.

(00:54:41):

But saying that we don't really understand what is person-centered care in osteopathy. So at the health sciences university where I'm an associate professor, we are launching a PhD in person-centered care in osteopathy to understand what do we do that is person centred care. So we're currently recruiting. If people are interested, they can go to the HSU website and look and apply if they want to do that PhD. But I think there are elements of care that are intrinsically important to us. And I agree with them that we shouldn't drop them to fit with other stuff, but also we need to understand them a bit better for our own benefit and maybe for other professions benefit. But a bit like what we said with the GPs, I think we need to go to others to explain what we do so that we have a better relationship. We also have to understand, be better for ourself, our own benefit, what we do to understand better.

Steven (00:55:42):

Have you heard of Joyce Miller, a chiropractor?

Jerry (00:55:46):

I don't think I have.

Steven (00:55:47):

Nikki recommends a book called Evidence-Based Chiropractic Care for Infants written by Joyce Miller. And there's no reason necessarily why you would know it. Again, no offence to Nikki or Joyce Miller here, but I always worry that we all have our favourite textbooks and they will be written sometimes on the basis of personal experience of that practitioner. And there is, there's a big difference in that. And having the evidence to back up what they say, I'm prepared to believe that what Joyce Miller says is quite probably very, very good and very, very useful and very beneficial to her infant patients. But of course what you are focused on most of the time is finding the evidence to support what we do. Is it not?

Jerry (00:56:27):

Yeah, I think so. Whilst I'm a clinician and I am promoting osteopathy as a form of care for patients, and I'm an educator, so I teach osteopathy at undergrad and postgrad level. So I've got lots of, one could say conflicts of interest. Saying that, when I conduct research, I don't try to do research to prove something, but I want to understand. So whatever the answer is, whether it's positive or negative, I don't see that as a problem. I see that as a way of understanding what we do and making us think differently. Okay, maybe we thought that way, doesn't mean that way. And I don't see that as a sort of a dead end. Oh, there is no evidence, therefore we shouldn't be doing it. That's not the way evidence works. So I don't think I'm doing things to prove it, but more to try to understand and explore and practise.

Steven (00:57:27):

And just to reiterate on that, I'm worried that I've now sounded as if I've said, no, this book's a waste of time because it isn't a research paper. It may well be backed up with lots of research and I'd be interested to take a look at it, especially if I treated babies, which I don't. So that was evidence-based chiropractic care for in Infants by Joyce Miller - also open to osteopaths. Tom's just sent something in here. It says, I'm grateful that Jerry and others are at the forefront of osteopathic research and cooperating with other practitioners, and they're putting us on the map as a profession to help our standing with other healthcare professions. I'm always happy to hear that he's holding us as a profession to account with our outdated ideas and yet doesn't lose faith in our profession as a whole. And Tom says that you are a legend, which is very kind of Him. That's very kind.

Steven (00:58:13):

I was wondering actually, I know that geographically it hasn't made a lot of difference, but now that University College of Osteopathy has come under the aegis of the University of Healthcare Science,

Jerry (00:58:24):

Health Sciences University

Steven (00:58:25):

The Health Sciences University, which is effectively the Anglo European College of Chiropractic, as was, I think that now is part of the university. Does that mean there is better cooperation between the two professions or has it not affected it?

Jerry (00:58:37):

No, not that it's not good cooperation, it's just that there was already quite a good cooperation. So what used to be UCO, university College of Apathy and the AECC University College in Bournemouth, so London and Bournemouth, we were working alongside quite a lot. So the research teams, we were collaborating on projects and each institution was supporting the other one in different processes. And so there was already quite a strong relationship before the merger. So the merger was effective in August last year, I think on the 1st of August. And so now we are one university with two campuses in London and Bournemouth. And so there's definitely much more collaboration between the schools. So we have four schools within the university, one of them being UCO, the school of Osteopathy, but there was already there four schools.

So we have AECC, the school of Chiropractic, UCO the School of Osteopathy. There's one, I won't be able to say the name. It's something along the lines of School of Rehabilitation and something else, which is, I'm terribly sorry, I shouldn't know that. But it's physio, podiatry, radiology, speech and language therapy, dietetics, I think. So within the university we teach 10 of the 14 allied health professions. And the fourth one is the school of health business,

Steven (01:00:07):

The 14 allied healthcare professions. Chiropractic isn't one of them, is it?

Jerry (01:00:11):

No.

Steven (01:00:11):

Why is that?

Jerry (01:00:14):

I think that there's a bit of a story behind that, but I don't think I would share that tonight.

Steven (01:00:18):

Oh, okay, fine. Over dinner!

Claire has just sent in some information about Joyce Miller, who we talked about a moment ago. Currently retired from overseeing the busy AECC infant practice, the interdisciplinary breastfeeding clinic and University of Bournemouth's master's degree in musculoskeletal health for paediatrics. This is obviously taken from the internet. She continues to do research to add to the evidence base. She's an author of about 75 peer reviewed, published research papers and resides in Scottsdale, Arizona and Bournemouth England. So there we are. That's Joyce Miller who clearly has some considerable credibility.

Kerry says, I think learning to communicate with parents is an important part of paediatrics training. I try to explain in terms of bits being tight or stiff as that is something parents can understand. I also say, assuming it's true that this is very common and I see it all the time, it's my job to make them comfortable and to reassure that development is as it should be at the moment from what I've observed, or there are a couple of developmental things that the baby isn't doing, but it may well be that he just isn't showing the right things. Now she says she'll keep an eye on it and monitor development so it doesn't scare them. And it's exactly what you were saying earlier on, isn't it? That business of some of the terminology we use can be very scary. I think when people, an adult patient is told, you've got a herniated disc, that's a very scary thing to hear, isn't it? And of course, people's definition of a herniation varies depending on which radiologist has reported it, which doctor's talking about it or which osteopath is talking about it as well. But when it's your baby that's being described to you, possibly even more Emotive

Jerry (01:02:00):

completely. And I fully agree with what was said.

Steven (01:02:09):

Kerry said it's an important part of paediatric training. I can see that it ought to be, is it actually part of paediatric training?

Jerry (01:02:18):

So I do not know the answer to that question. But what I was going to say about what she said is that I fully agree with what she said. So I trained in France for six years full-time. A large part of our training was paediatrics,

(01:02:35):

But one thing that we didn't have was basic red flags in the paediatric population because we see mostly functional problems and therefore it's healthy babies. In France, all babies would see their paediatrician several times a year. So there was this assumption that if there was something nasty would be caught by someone else, which I think is, again, that was a long time ago and might have changed a lot, but I don't think that was a very mature vision of placing yourself as a healthcare professional. Putting that aside, when I came to the uk, I became aware that UK paediatric osteopaths were pretty good on red flags and screening, which I wasn't. So obviously I trained in that and I was much better. But I think going back to the comment, I think someone delivering paediatric care needs to be strong on these things so that when it's not that then all the reassurance can come, all the positive communication can come. Yeah, that's normal. We see a lot of that, but you need to be sure that it's safe to say that and so that you do not make them miss opportunities of seeing someone else getting proper care for something.

Steven (01:03:53):

And this is something that Kim has just brought up in the chat here as well. Kim says that the thing is to know what the diagnoses are and that's difficult in a baby. You might think it's colic, but the differentials could be more serious. And as osteopaths or chiropractors in this age of litigation, we've got to cover ourselves. Well, yes, we have to do that, but actually you've got a baby's welfare at your fingertips. That's even more important, isn't it? Kim always asks the parents, have you seen the GP? checked the baby hasn't got a temperature and gets a thorough case history, which goes without saying, I imagine. But it is difficult. I mean, conventional practitioners clearly don't know what's going on with babies half the time. If you're just calling it colic, that isn't really saying what's going on, it's just saying when it cries a lot. So yeah, I dunno what led us onto that one, but clearly that business of communication, yes, communication, wasn't it? It's hard to be certain what's going on in a human being that can't communicate with you.

Jerry (01:04:52):

And I think to be fair, in the uk, there is good quality CPD training and I'm sure also potentially undergrad training, I don't know. But around all these sort of triage and screening aspect, which then gives you confidence or at least knowing when you need to safety net parents just in case that happens or whatever. So I think that's something where we're getting pretty good in the UK on that.

Steven (01:05:23):

Yeah, so we're pretty good in the uk. But let's go back to Europe, which is where we started this whole thing. I think you said Finland, Sweden, France. A number of countries have suddenly become rather more opposed to paediatric treatments by our professions than before. Is that something which is being counted effectively by the professions?

Jerry (01:05:56):

I think there are attempts. So osteopathy Europe as a structure is there to support countries when they face this sort of political crisis. So Spain had a similar problem, not in paediatrics, but a couple of years ago where osteopathy was described as being a pseudoscience. So

Spain has a list of pseudoscience practices or therapies and osteopathy was put on that a couple of years ago And osteopathy Europe, the research committee that I chair, we worked on producing documents to provide all the evidence that exists. So that side of my work is much more political. It's not then that I come as a researcher and I'm neutral and I see what happens, that side is really advocating for the profession.

Steven (01:06:49):

Coming back to the thing I said earlier on to you though, who is it provoked that? Somebody's clearly taken a decision to put osteopathy onto that list and that won't have been a politician. They won't be thinking much about that sort of stuff. Or not a pure politician.

Jerry (01:07:04):

Yeah, I think I may be wrong, but if my memory serves me well, I think in Spain it was related to the physiotherapy profession. I think there was a movement from the physiotherapy profession to try to have osteo as an add-on competence to physiotherapy. A bit like you have in Denmark, for example, in Denmark, to be an osteopath, you need to be a physio first and then to train in osteo

Steven (01:07:29):

Is it the same in France?

Jerry (01:07:30):

No, in France you can be either a full-time or what we call exclusive osteopath like I did. So after your A levels, you go into a private school. Now it's a five year full-time training, and it used to be six year for me. So that's one way, which is probably the biggest bulk of osteopaths in France. Or you can be a healthcare professional. So physio and medical doctors are the biggest ones. And then do a part-time training. Right. But yeah, so I think that there is a group of people who flag up an issue and that leads to some sort of consequences. So Osteopathy Europe support these countries to try to provide evidence to counter some of these arguments. But in the recent statements made in the different countries, we've already said it hasn't really led, no, it's not true: In Finland, it led to a round table with a representatives of the paediatric association, the osteopathic association. And so I think the paediatric association recognised that there was evidence there was not much risk, but they said they were not prepared to change their statement. But at least this conversation that has happened in Finland. So potentially that will lead to something at some point.

Steven (01:09:00):

I have a couple of other observations here. Now, this is an interesting one. Pip says, I had a three-year-old who had a blocked tear duct and was due to have surgery three treatments later. He no longer needed the Op and was taken off the list. How much money did that save the NHS and stress from mum and baby, which is a nice anecdote. It's a nice story, isn't it? But of course it doesn't prove that Pips, I'm sure, pip, that you did do great treatment on this child, but it doesn't actually prove that this wasn't a natural course of events. And that's one

of our great challenges, isn't it? In saying that it was the treatment that had this effect. It wasn't natural development.

Jerry (01:09:40):

Yeah. So there's interesting work in a positive way. When I say that it sounds judgmental, but there's good work being done in Quebec at the moment by Professor Chantal Morin osteopath and, occupational therapist by background, and she did her PhD around work on the temporal bone and otitis media and, so if I tried to summarise the work she did initially, she looked at whether osteopaths were able to diagnose a dysfunction. So I use the terms that were used in her research: dysfunction of the temporal bone and whether that dysfunction that was felt in babies could predict the occurrence of Otitis media. And she found that it was a reliable way of testing, but also it could predict the intervention. So now Chantal and I and other people are supervising a PhD student in Quebec who is going to do an RCT that will start recruiting babies this autumn, because obviously that's quite seasonal. It's related to the season to see whether the intervention, spreading intervention can prevent otitis media.

(01:11:13):

So there are things happening which will help to build a better body of knowledge. Maybe it won't work, I don't know, but at least these things do happen. So I think we all have evidence in clinical practice, and that is useful evidence. And I don't think we should dismiss that because that's evidence we can use to inform what we tell other patients and explain. But obviously if we think about policymakers, people who buy bulk of care, and that's not going to be enough for them. So I think for us as clinicians, it's useful, but for us as a profession, we need more.

Steven (01:11:49):

So how does Pip and how do other practitioners like her, many of whom will have similar case histories, anecdotes that they could share? How do we make use of this to add to the body of evidence?

Jerry (01:11:59):

I think there are two easy things to do. One of them, if there are paediatric osteopaths here tonight, I mean there are looking at the questions, if they're not doing it yet, the PROMs patient reported outcome measures, from NCOR. In the PROMs we have a paediatric PROMs. So for the ones who see babies, there will be questionnaires that will be filled in by the parents or carers. So it doesn't take time on the appointment during the appointment, but it will provide them with their own data that they can then use on their website to describe the sort of population they see and how better they get and stuff like that.

But also for us as a profession, it means that we start collecting data. So that's really important. That's free for osteopath to do. That's really important for the profession, for us to start building this sort data. For more information, they can go on the NCOR website and we have my colleague, Dr. Carol Fawkes's email address, and they can contact her, they would get the code straight away. It's very easy to implement.

Another thing I would recommend is for any osteopath in the UK listening to us is to join our practice based research network. So it's called NCOR Research Network. We launched that last year. We have more than 600 osteopaths who've joined us

Steven (01:13:20):

And we promoted it after your last show. And I think we helped to Generate Some of those numbers.

Jerry (01:13:25):

And we started doing projects, quite a few projects with the research network. And one of them that we are hoping we are waiting for ethical approval, but we are hoping to do this year is to start implementing a tool to collect data directly from Clinico. So Clinico is the main software being used in the UK by osteopaths. We did a survey to check and Clinico is definitely the bigger one at the moment. So we have worked with an IT company to develop an extension on Chrome so that when osteopaths fill in their form, the data will be extracted automatically with the patient's and osteopath’s consent, obviously,

Which means that, again, it won't take time from the osteopath to provide that Data,

But instead of having data lost, and we see thousands of patients daily, all of us collectively, that's it. Now, we'll be able to collect that data and to turn that into research and therefore produce papers and therefore use that as a way of informing others where we do. So again, practice based research network, if you've go on the NCOR website, there's a form to fill in, and so you become a member

Steven (01:14:39):

In terms of the data that it collects. I'm curious here from a research perspective, is there any vulnerability in that data in the way that sometimes you only get data from people who are happy with treatment or the other way around? Or is this you ask people before the outcomes are known, whether they're prepared to share the data and then it's automatically uploaded, uploaded from that point onwards?

It sounds like a fabulous way of gathering Data.

Jerry (01:15:06):

Exactly. I think it's such a waste. So many treatments delivered and we have no evidence about that. We don't know what osteopaths do in the treatment room, which techniques they use, which group of, we have some ideas about the patient groups they see. We have data about that in the uk, but the outcomes, we have a bit with problems, but there are missing pieces. There are quite a few of them.

So that will definitely be a big one regarding your questions about satisfaction and whether that would impact recruitment, I don't think that would be a risk because of the way the recruitment of participants, patients, will work. We'll definitely have a section of our community that is the one that goes to a osteopaths or it would be the same for chiropractors, so people who can afford private care, but it will represent the patients we see on a daily basis that would be real world patient, which is quite different from some of the

randomised control trial that may be conducted in hospitals in a setting, which is really different from a community-based clinic.

Steven (01:16:14):

Claire, my Claire has just come back in and said, this sounds like the April fool that we wrote for people a couple of days ago because we said that the new diary that we are offering free of charge to osteopaths, we said, we've got this new extension which watches you in your clinic room and analyses your body movements and your interaction with the patients through video cameras and all this. And it will recommend what CPD you should do and where your vulnerabilities are. It's not true. We haven't got anything that films you in your treatment room. But I think you were saying earlier on that there was a chiropractic equivalent to the practice-based research network, which has now been discontinued.

Jerry (01:16:53):

So in the UK in Bournemouth a few years ago, they started a PBRN, practice base research network, called Crunch. I can't remember what the acronym stands for. And I think what they decided is to stop it and run some studies to work out how it would be best for that one to work, which is what we did with NCOR. So before launching our PBRN, I mean there's been years of work in the background. We did a series of focus groups with the osteopaths across three of the four UK nations to understand what would make it work for them if they were joining. So we understand, we understood the stakeholders and what could be done to support them. So there was a lot of work in preparation for that to function. And I think it's working extremely well. But there are good chiropractic practice-based networks around the world.

(01:17:54):

The main one I know is ACORN in Australia. I think there's a similar one maybe in New Zealand and ACORN is being updated at the moment, I think. So there are examples of PBRNs.

I think probably even more active one is the one from professor Alice Kongsted, in Denmark. I don't know the name of the PBRN there, and it might be just the Nordic group, I can't remember the name. They have a very active research network in Denmark that produces very good high quality articles.

Steven (01:18:34):

Do you have any feel for, it wouldn't be fair to ask you about chiropractors, but any feel for the percentage of osteopaths who have participated in the PBRN?

Jerry (01:18:44):

So in the UK we have recruited 600. My numbers are probably out of date because that was sort of last autumn, last time I checked, but so that's a bit more than 10% of the profession, 10, 12% around that, which is good because I have to say, so some of the practice-based research networks have 50% of population of the profession. You need 15 clinics to build a practice-based research network. So we're well above the minimum threshold, but also

because of the size of NCOR, we're a very active group, but it's quite a limited team. I think 600 is a good number and we're very happy to have more. So please join us.

Steven (01:19:30):

Well, no, I was just thinking that there are lots of osteopaths, myself included. They've forever bemoaning the fact that we haven't got enough research to justify what we do. Well, here's the chance to do it. And possibly without too much effort on the part of the practitioners concerned

Jerry (01:19:44):

And lots of free CPD and ways of learning skills. For example, something I hear a lot is “I see all these papers, but I don't know how to read them. I don't know how to know whether it's something I should trust or should not trust. How do I gain these skills?” And that's something that the people and I can really provide them.

Steven (01:20:03):

Yeah, a few things about research have come in Kerry saying the OCC, the Osteopathic Centre for Children, was very big on teaching red flags, which were taught multiple times during the course and reviewed periodically in clinic. And I'm sure you are familiar with that. Lou says Craniosynostosis needs to be diagnosed very early, a red flag, and we need to be decisive in referral if we suspect. Now, I know nothing about that, but I imagine that if you are a paediatric osteopath, it would be one of those things that you are taught about early on. And again, not knowing anything about it. Is it something that a parent might come to an osteopath with before they've seen a conventional practitioner?

Jerry (01:20:46):

Well, Craniosynostosis is a good one because it basically looks like plagiocephaly. I mean, if you know the difference, they look quite different. But as a parent, your baby has a bit of the head being a bit flat or a bit of a funny shape and someone has said the osteopath is great for that or the chiropractor is great for that. So yes, they are patients that you are quite likely to see in your clinic. For adults we see axSpA or Cauda Equina syndrome and stuff like that. Quite co syndrome, not regularly, but axSpA very regularly. And if you've never seen them, it's probably because you haven't really looked for them the same with these conditions. I think that's definitely a basic skill that all paediatric clinicians should have for sure. Yeah.

Steven (01:21:33):

Okay. Lucy wants to know what sort of study you would recommend to satisfy the sceptics

Jerry (01:21:39):

In any field?

Steven (01:21:41):

Well, Lucy hasn't specified, and I didn't want to presume, but I guess we are talking a lot about paediatrics here. We haven't really talked about obstetric osteopathy, but there's probably no time left now.

Jerry (01:21:53):

Yeah, so regarding, I mean obstetric, there is some evidence. Regarding paediatrics, there's been studies looking for example, at parents' experiences of bringing their children, and I think that's really valuable, asking parents, why did you decide to, what was the benefits? It doesn't tell us that it works or doesn't work, but we also understand a little bit more about what we provide. We might be providing more than just the hands-on treatment and understanding all of that is really good. So I think that's great. I think ultimately it depends what sort of group we want to target. What audience are we talking to.

(01:22:34):

If you are talking to policy makers, it will end up being randomised control trial. That will need to be that sort of evidence that will be required for us to have a say on care. But for us to be able to do randomised control trial, you would need to have £500,000 or a million pounds. So it's very expensive. So you need to look at national funding. And for us to get there, we need to have this sort of launch data. So again, sorry to plug that in again, but PROMs, paediatric PROMs. If we have a large body of evidence suggesting that there is improvement within a few weeks and stuff like that, we don't know whether it's natural history like you mentioned earlier, but if there is evidence of that then we need to do an RCT and you go to a funder, then if there seems to be something there, We need to test it.

Steven (01:23:30):

So half a million to a million quid for the trial. Why so expensive?

Jerry (01:23:34):

So it depends. It depends how you do it. So for example, CUTIES, which was the RCT for colic that was funded by the OEF, which was the Osteopathic Educational Foundation, which is what was prior to the osteopathic foundation and the OEF gave, I think if my memory serves me well, a hundred thousand pounds to NCOR and that paid for the trial. But that was, I think quite a tight budget to do that trial. And it was done in osteopath clinics. Patients were paying for their appointments, whether they were receiving sham or real osteopath care.

Steven (01:24:18):

Is that an important part of the trial that the patients continue to pay for their Treatments?

Jerry (01:24:21):

Yeah, yeah, because otherwise you have always the ethical concern that it would be parents from more modest background who would accept to take the risk and you have this sort of dilemma.

Steven (01:24:35):

Isn't the counter argument that if they're paying for treatment, you don't get to examine a specific element of society. You don't know whether it works for everybody in society.

Jerry (01:24:44):

Yeah, I think that's a really good point.

Steven (01:24:46):

Just the guardian-reading fraternity who like osteopathy and Chiropractic.

Jerry (01:24:49):

No, but I think the counter counter argument to that would be that currently the groups that bring their babies to osteopaths are likely to be from a specific group socioeconomic group. And I think that's not entirely true. Someone mentioned the OCC and the OCC have clinics within the community where, I don't know how much it costs for treatment, but there are sort of discounts. That's not the word I'm looking for, but it's less expensive than going to an osteopath in a private practice. So there are definitely accesses depending where you live in the uk, where you can get treatment for less or in osteopathic educational institution clinics and stuff like that.

(01:25:38):

But yeah, the cost for an RCT is very high. But if you look at the NIHR, the National Institute for Health and Social Researchers, I'm not exactly sure about acronym which is one of the main funders, I sat on a panel to assess awards or applications for funding, and that line of funding was the RFPB, so research for Patient Benefit, and that one was specifically for allied health professions. So we had lots of applications from paramedics, from physios, from lots of different professions. It was fascinating to read the gaps in their knowledge and what they want to do, but there were none from osteopaths, which is a big shame. And I think that will start developing because we have more and more people able to do research now in the profession, which is fantastic. But what I'm trying to say is that there is now funding accessible for our professions.

(01:26:41):

So chiropractors were not included in that one because it was for AHPs, but there's another NIHR RFPB, research for patient benefits, which is for, I can't remember how they're called, non-AHP healthcare professionals or something like that. The deadline is next week, so it's too late for our audience, but I know that chiropractors were included in that one. So just to say, chiropractors are not excluded, it's just that it's different streams of funding that exist and everyone can apply. So these types of research we need to build up. We need some sort of foundation evidence so that we can go higher up and yes, it will take time. But I don't think that, not that anyone has said that in the comments or you mentioned that, but the rhetoric, we used to hear that it's big pharma, we don't have funding coming for osteopathy, that's not the way it works at all. There are good and big, these awards are huge, amounts available.