Academy of PHYSICAL MEDICINE

Manual Therapy and Modern Medicine

With Dr Stephen Sandler PhD

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TRANSCRIPT

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Steven (SB):

This evening, we're returning to some serious CPD Dr Stephen Sandler. Stephen, third time. I think we've had you on our show. Good evening to you.

Stephen (SS):

Good evening. Thank you for inviting me.

Steven (SB):

Yes, it's lovely to have you with us. How are you coping at the moment with the coronavirus problem where you are?

Stephen (SS):

Yeah. Okay. I mean, myself and my wife are isolated and we're both, well we should have been on a, a retirement cruise, a 70th birthday cruise halfway across the Pacific, heading for South America at the moment, which clearly we're not.

Steven (SB):

Where would a very brave place to be a cruise liner, wouldn't it?

Stephen (SS):

Well, one thinks a lot about that for the future, but that's another, another subject. So we're healthy. I exercising a lot we're doing lots of things with grandchildren by video links with quizzes and things. Yeah. Life carries on.

Steven (SB):

Is the practice still open?

Stephen (SS):

Not at the practice is certainly not open. I made the decision back in middle of March. That's I didn't feel that it was safe. And the reason why I didn't feel safe is because a cough and a fever are not the only signs of Covid 19. Musculoskeletal pain is also a sign because it's a viral infection. The difference between the cold and the flu is it the cold stays in the nose and the flu, you ache all over. So we could have had people coming in and saying, Oh, my back's flared up again, treating them and potentially catching and then passing on the virus because PPE for osteopaths, it doesn't exist. I'm currently discussing this with the GOsC and the IO trying desperately to get us some PPE so that we can go back to work. Well, that's another subject. So, no, I closed the practice. I decided that the risk of osteopaths spreading it and therefore getting a bad reputation because we didn't pack up. Yeah.

Steven (SB):

Are you doing any telehealth consultations?

Stephen (SS):

No, I don't do, telehealth. If someone rings in they're given my cell phone number. In a month, I've had five people phone me and say, look, we got a problem with this, we've got a problem with that. And I give them as much information as I can free gratis because that's the way I think it should be done.

Steven (SB):

Yeah. Well as you've already sort of alluded to you, you are an osteopath, probably one of the best known osteopaths in the country I would say. And we've had you on the show a couple of times before today though. You said you would like to talk about anatomy and physiology, particularly the respiratory system and how you said osteopathy, I've kind of adjusted that slightly to manual therapy can influence people's respiratory system with a view to helping with Covid 19 problems. Is that fair?

Stephen (SS):

Yeah. It wouldn't be so much masses of physiology purely because I've cut things back quite a bit, but you're got to be talking about some fascial anatomies and the

ways, yeah, we can potentially look at a protocol. So once this is over, where is our place where we are going to be, what we're going to be doing? I'm also going to be reviewing how we got to where we are as osteopaths and giving a bit of historical perspective. Now I graduated many years ago and I spent a wonderful life practicing and teaching osteopathy literally all over the world. And I'm going to divide what I'm going to say this evening into two parts. The first one it will be a bit philosophical. Umobably, controversial. Umhe second part is how to accomplish what I aspire to do in the first part.

Steven (SB):

I might be a bit off piste here, but I thought it might be worth just pointing out before we start that as has been raised in social media recently under the general chiropractic council has put this out, we are not trying to get people to advertise that they can improve people's immune systems to the extent that they can beat Covid 19 or anything like that, are we?.

Stephen (SS):

We most certainly are not. And if you just look at some of the YouTube videos about what's happening front line and how these fantastic professors are so knowledgeable in the field, such phenomenal people doing amazing work. Clearly our part is not front line, but I think that when they get back to work, they come in need rehab. And I think us as part of that rehab team I think it's worthwhile saying. When I was first a student, you know, way back in the days when Jesus was a lad, I was taught by teachers who said the osteopathy was another way of practising medicine. Well, people said to me, what does an osteopath do? And, I freely would, would say, well, you know, Still was there in the prairie and he based his principles on treating all and everything including musculoskeletal problems, but not exclusively.

Now that might have been the case in the 1860s/ in the 1870s when medicine, it was really in its infancy. Did you know that in 1860 according to a website that I've been looking at the practice of medicine, it was really about the four humors. The idea of germ theory was very controversial. Yeah. Anesthetics were being introduced. Chloroform was being introduced, anti sepsis came 20 years later, so they would quite happily potentially lifesaving operations, but they would put on a dirty coat to do them to protect their clothing, like your mechanic in the garage, so you wouldn't expect him to see the full range of PPE equipment. We wouldn't there. They didn't wash their hands between patients because germ theory, well it's an in, they were still talking about the stuff from Galen 131 to 199 AD who talks about the four humors and that was in 1860 that was really what medicine was. Nothing you could buy today in the pharmacy existed.

Steven (SB):

Yeah. It's funny. I remember seeing something or reading something somewhere that in that period you describe, it was almost heretical to say that anything Galen

had said was wrong. Absolutely drummed out of medical school. You couldn't, you couldn't tolerate a new idea. Could you just, I just want to reassure the physios and the chiropractors watching today that this is what you're going to say although you are an osteopath, it isn't all only applicable to osteopathy. You've worked with chiropractors and physios in the past a lot

Stephen (SS):

And you can only work with people if there is mutual respect. For me, you know, our professions are different. Everyone is valid. It's just, it's like languages. There are different languages in the world. We've all got to learn to speak a common language and I think that's, that's where we should be. And the more people that I've spoken to in my life more that becomes valid and important. So back in the day, medicine was, was crude. Still was a doctor. We think he was trained by his father who was a doctor. We think he graduated from Kirksville, but there was a fire, the records were destroyed. We're not sure. There's all sorts of digging to be done in, in this. And there's people like my very good friend and colleague, Jane Stark in Canada knows more about this than anybody else, but by 1860 things are changing and if we look at osteopathy today, it's obvious that we can't be anything than a modern, therapeutic practice supporting acute modern medicine. Medicine has moved on and so should we, if we're going to have an independent place in the future. Look at the Covid 19 there's a huge argument going on between the people at Imperial and the people at Oxford as to whose statistical modelling is correct You know? Yeah. It's all about evidence based medicine and that's where it's important. But the debate is, it should be challenging, but we should be part of that debate. Evidence is the future of osteopathy.

Steven (SB):

Interestingly, we've already had a question in on that very topic. I thought it was Galen for a minute, but I thought he's a bit bit past his time is actually Keith Galer who says, from an advertising standards point of view, would you say we would be allowed to say in our marketing and our websites, whatever we are, we can help with respiratory issues.

Stephen (SS):

Yes. Because we treat the ribs because we treat the thoracic spine, we should treat the diaphragm. We treat the fascia. Yes, we treat ribs because it all comes down to the fact that we treat motion. Yup. No, from the cell right there up to the macro organism. We treat movement.

Steven (SB):

And we've actually done a number of broadcasts in the last couple of weeks involving stuff with breathwork as well. And osteopathy is not just about poking muscles and wiggling joints is it? It's incorporating all those things. The same with chiros and physios and in answer to Keith's question, my answer almost always is if

the advertising standards agency doesn't say you mustn't say it and you believe you've got evidence, then I would say do it. Because the worst that can happen is that someone will complain and then you'll have to take it off your website. But nothing worse than that will happen to you. Certainly as an osteopath. Chiropractors, chiropractors, the GCC has got a little bit slicker at dealing with spurious and you know, nasty claims made against them. But again, it's not a, it's not a big deal.

Stephen (SS):

I think it's about we have to redefine our place. We can't any longer rely on the, the medicine of 1860 to define what osteopathy is.Yeah, we're, we're way beyond that now. We should be actually engaged in this debate and I think, yeah, this is absolutely ideal. For us now it's the best time because you're going to have literally thousands and thousands of people recovering from this disease. So if you want to set up big time trials to compare the efficacies of what we do and what other people do and find the route out of this mess and get people back to work in the quickest possible way, now's the time. At the very end of this, I'm going to ask Justin to show some slides that were done that that relate to the epidemics of pneumonia in the States in the early part of the 20th century. Yes, they need updating, but there's still sort of valid stuff in that. So I feel that our part is in recovery. I thought that whatever we do now, we need to have evidence based so that the people we're talking to will respect what we're saying. It's no longer good enough to say, well, I'm doing this because my patients wants it and if they weren't happy, they wouldn't come back. Right. That's nonsense. You can't do that. Not anymore. The world is changing. Yeah.

Steven (SB):

Are you seeing parallels in what we've got now with your research into the Spanish flu epidemic of in 1917?

Stephen (SS):

Well, again, if, if you, if you look at the stuff that's been published. So this is where it comes from. It's an, it's a useful tool and it's, it was published as you can see, 2014, so it's not that old. It's, it was a well researched trial. Next one please. This is one which looks at the treatment of pneumonia. And this was, was published 2008. It's been shown to reduce patient's length of hospital stay, duration of intravenous antibiotics incidence of respiratory failure when compared to convention care alone. Next one please. Okay. And this is the use of spinal manipulation for pneumonia. Back in 1918, patients treated with the standard medical care had an estimated mortality of 33%. In the osteopathic institutions that went down to 10%. Okay. It's old. It's 1920 but it needs re-evaluating.

Steven (SB):

Just going back to one of those previous slides there and we've already established that we're not being precious about this. It, the previous slide said osteopathic manipulative technique is effective, blah, blah, blah. What the hell is osteopathic

manipulative technique as opposed to manual manipulation on the subsequent slide? I surely there is no osteopathic manipulation. Most of the opposite is a philosophy rather than the what you do with your hands.

Stephen (SS):

Well there, there are various different discussions in that. I would maintain that osteopathy has a number of techniques it has cranial techniques it has visceral techniques. It has soft tissue and myofascial techniques and it has bone techniques.

Steven (SB):

And so do chiropractors

Stephen (SS):

Yeah, no. Yeah, but what I'm saying is that, is that the way it's taught, it relates to individuals no. The diagnosis I think we have to be very careful about because the way the diagnostics are taught across all of the disciplines, it's slightly different, but analyse the difference and therein lies the truth. But in terms of technique, the public associate osteopathy, chiropractic, certainly with the click getting the cavitation, Well that isn't true because the vast majority of patients, it takes five seconds to crack a joint and half an hour to treat the patient 29 minutes, 57 seconds -that's the essence of what is osteopathy or chiropractic or physiotherapy. So I think that we've got to get out of this manipulation idea into the idea of looking at the body and how we approach it. And then it's just a question of of using the spanner or a screwdriver.

Steven (SB):

I wholeheartedly agree with that. It's just that the slides both referred to manipulation, which as you say is a relatively small component.

Stephen (SS):

If you look at the history of it was talking about specific vertebral manipulation,

Steven (SB):

Have a couple of questions in both from Elsbeth. She says asking whether we can help with damaged lungs. First; Isn't the damage done by Covid 19 greater and or different than that done by flu. And also do we know the extent of that, that damage done by Covid19 and can we be sure that we can help with it?

Stephen (SS):

No, we don't know the extent. Medicine doesn't know the extent, medicine is still trying to find out how the things spreads. What we do know is that, it's been stated that those patients that recover, will take at least three months before they're able to work for a full day, and a year before they're able to assume normal life without any restrictions whatsoever. Certainly the pictures that one sees about this are

astonishing. I have a friend he's in hospital at the moment. He's got massive diabetes, grossly obese. He's only got one kidney that works. Okay. and he is suffering from right heart failure. Well, we all thought he was a gonner when he got covid five days later and he's sitting up in bed talking and complaining about the quality of the scrambled eggs they're producing, you know, please. The [inaudible] the why people are treating this and understanding this is based on an influenza model is based on pneumonia model. Okay. it's the, the lung beds are literally hot, red, painful, swollen and useless. And that's where the, the drugs are coming in. You don't need a bacterial infection as well as a viral infection. So antibiotics intravenously are introduced. The breathing, whether it's a C pap machine or whether it's, it's a, a full tracheal intubation, will be used to keep the breathing to keep the blood gases flowing, monitoring almost minute by minute how thats responding on how the tissues are responding. That's clearly nothing to do with us, but that is very, very, very much to do with acute medicine. And when the patient gets discharged and he comes back and he's still having his breathing difficulties, just as we treated patients who are asthmatic patients who are bronchitics, patients who are emphysematous in the past, we should be part of this attempt at getting the patient back to health. Osteopathy to me is looking for health. Medicine is looking for disease. If we can push this patient towards health by mobilizing his fascial systems by mobilizing his muscular systems, getting him to breathe better, using all of these tissues available. The chiropractors can do it with their model and the physios can do it with their model, then we will be able to see these patients,I hope, getting back to full strength, not in a year, but maybe within six months.

Steven (SB):

Hmm. Do you know what the difference is in terms of training? Because obviously the physios are heavily involved in respiratory work throughout the NHS at the moment, aren't they? I mean they obviously get trained specifically to do that, whereas we get trained more generally in mobilizing lungs and releasing soft tissues. And so any idea what the specifics of their training is?

Stephen (SS):

Well, as I understand it and I'm full of, be fully prepared to be, that I'm speaking now out of the air, I understand that physiotherapy has a very good basic training and then the postgraduate training will be respiratory care, women's health, sports medicine, manipulation, medicine, et cetera. So to actually have a physiotherapist that's got two or three postgraduate qualifications would be very rare. Whereas osteopaths I know are trained across all of the different disciplines and are applying osteopathic principles within each discipline that there is. I think the trainings are very different and that's why I don't think we could be part of the acute treatment because it's physio therapists, who are dressed up like spacemen, who actually working on the acute patient once they, they're off of the ventilators. Yeah. That's not for us, but we are there in practice once they've been discharged, getting them back towards this model of health,

Steven (SB):

Pip's sent in an observation saying that she's read that you can get up to a 40% loss in lung function after Covid 19. Are you, is that sort of thing that you've seen?

Stephen (SS):

I'm not aware of it, but I'm not surprised.

Steven (SB):

Mm. And we've had a question about the, the papers in particular one about the, the slide that's behind me at the moment. There's two groups of patients mentioned there. One way you had 33% mortality and 10% when treated by osteopaths. You, do you have any feeling for the quality of the research in those two groups? Were they comparable? Was there any other bias in that unit?

Stephen (SS):

We're looking at 1920. Yeah. Okay. So you're certainly not looking your antivirals. You're certainly not looking at modern medicine. These are from the American osteopathic association. So therefore these will be doctors in osteopathy. Okay. I'm, I'm a doctorate, I'm a PhD, but I'm not a medical doctor. These are medical doctors and these patients were admitted to medical facilities and those that had the standard care plus the osteopathic approach were the 10% group, those that just have the standard care with the 33% group.

Steven (SB):

Okay, well that's encouraging then. So what should we be looking at in terms of addressing patients who are coming out of the, their intensive care out of their hospital wards and looking to recover then Stephen?

Stephen (SS):

Okay. I think that's a a good question. If we go back to the slides I'm just, I'm looking at, okay, if we go to slide 10 please. Yup. We're looking there and where it just suggests immediately that this is a protocol that might be applicable. A protocol is a protocol. It's a series of steps to take, but it isn't gospel. You don't do this to every single patient. But you do some of it to most patients, and we look at a fascia release technique to the front and sides of the body to the lungs on the mediastinum, an unwinding technique these can be functional technique as in Bowles- Hoover, they can be met techniques, they can be Jones' techniques. But these are fascial release techniques unwinding because these patients have spent their time desperately trying to draw in to their mediastinum. Stretching techniques, the intercostal muscles. We've all done these. These are the sitting and techniques. These are the sidelying techniques, applied through appendicular skeleton through the shoulder and, the parascapular techniques and these are very effective techniques, but don't forget these patients are going to be very weak. So all techniques are done really only as much as the patients stand. That's what I've started with this idea of fascial

release because it's very un-challenging. And then so the stretching techniques, the accessory muscles of respiration. So we're looking at guiding us into a bigger picture. And then the fascial release techniques to the CD junction. The root of the neck, first and second ribs. Because if the a sympathetic nervous system has got a part to play in this, that's where it's going to be found. And then lymph drainage techniques are very, very, very important. And these are techniques that should be taught in every school in the country so that these protocols are saying, well actually, you know, I'd like to be involved in the care and in the rehabilitation of these patients, but I'm not sure what I can do. The answer will always be what have you done in the past? Beause most of the stuff here is available is there, but the difference is our hands on Our thinking about what this is and why it's going in in the same way. If we can have a look. Slide three please.

Steven (SB):

This is the fascial system. I'm not sure if it's that clear on, on the screen. But it shows that the fascial system excellent starts right up in the head and goes all the way down through the neck, down through the thoracic openings, around the pleura of the lung, the endo- thoracic fascia, all the way down through the renal fascia, right the way down to the plantar aponeurosis in the feet. Now, all of these fascial restrictions will be restrictions to fluid flow restrictions to lymphatic flow and restrictions to venous flow. They won't be restrictions to arterial flow as such, because the arterial pressure is much greater. But if you take away the restrictions to fluid flowing, then the organs themselves approach more towards health, away from the disease. These poor souls that are laying having their breathing done for them in intubators aren't using any of this Very interestingly I saw one particular doctor who was talking about how it was very important to have these patients in the ICU laying face down with their arm above their head. Yes. Because that was a position that they'd found for greater oxygenation. Who would've thought that? Yeah. You know,

Steven (SB):

And, and we had a, we had a, a breathwork demonstration with Kerry Dowson a week ago. And she was talking about getting people into a prone position and doing various sort of a yoga based breathing exercises basically to encourage the cough and help them to drain their lungs.

Stephen (SS):

Well, you know, I think that once they're up, we need all the techniques that are, are at our fingertips literally

Steven (SB):

How funny. You mentioned the chap, he was lecturing I think doing a live lecture for the Royal college of medicine and I think it wasn't, and I was, I was astonished cause

he said that the lungs actually increased their capacity at the early stages of this, which will increase their flexibility.

Stephen (SS):

Desperately trying to get the air across. It's like taking an asthmatic - they'll take a deeper and deep breath, but they can't breathe it out.

Steven (SB):

Well, I've been sent a reminder by Claire and I, and I did mention this earlier on, but we're talking here about what we can do to help with respiratory problems and most people will probably be aware that Edzard Ernst and the good thinking society are out to get anybody who claims to treat anything that can't be backed up by evidence at the moment. So saying you can treat covid 19 would be a big no, no. Saying you can treat pneumonia would probably be a big no, no. But you have pointed out that there is some reasonable evidence behind us if we say we can improve the function of the lungs or the ribs or anything else, as long as we don't claim to be treating these diseases, but we've got to be careful.

Stephen (SS):

I definitely don't want to claim that. But I want to be part of this rehab system. And I think that with so many thousands of patients who are coming out of this disease needing help to breathe. I think that we have a part to play and I think history shows that in past that part made a difference. Now we need big term trials. Now we need all the osteopaths volunteered to be part of the volunteer system support in the NHS. We all need those people now back in large scale trials, treating thousands of patients over the next two years and saying, well, look at this. This is quite interesting. There's no difference between this group, this group and this group or Oh, there's a huge difference between that group because it's using these parameters to measure, they improve. This is the way we have to go forward by evidence.

Steven (SB):

Imogen has sent in an observation that of course patients are all different and so it's going to be very hard afterwards, isn't it? Or you already mentioned somebody who's got diabetes cardiovascular problems and so on. And is right as rain nearly after five days. Other people with no apparent co-morbidity diseases or other, problems that would complicate the issue, seem to very quickly deteriorate and, and possibly don't even come out at the other end, you know, young doctors and so on. And so she's saying, well, what I'm leading this is that, it's very hard to compare patients at the end because you don't quite know what's going on inside them, but the damage may be totally different in different groups.

Stephen (SS):

You've got to ask the right research question and this is why some of these doctors are, are dying because there was one thing I saw yesterday that talks about a genetic link that we haven't yet discovered, but some people are genetically predisposed to viruses like Covid 19, whereas others aren't.

Steven (SB):

It seems to come as a surprise to everybody, didn't they, when they discovered, I think that the, the black and ethnic minority communities are more prone to this. Well, actually there were lots of diseases which affect one particular group of society more than others.

Stephen (SS):

And men are suffering more than women. Yeah. No. What's that got to do with it? Is it oestrogen is it something else? We don't know. The one thing that, this has brought up is that there are a number of research questions it's gotta be huge. It's going to be huge.

Steven (SB):

But as you said, at least if we've got a big enough database on which to, to base our research hopefully all those confounding factors can be sort of ironed out in the process.

Stephen (SS):

This is the job for the professional researcher getting, I mean, having done research myself to get my PhD. I know how difficult it was to get the right research questions and if you ask the question properly and if you're guided into that questioning in a careful way so that you set up your trials with good methodology and therefore you've, you backed that good methodology with, with a good data collection and statistical analysis. You'll come out at the end of it with gold star research.

Steven (SB):

Yeah. So you might not know the answer to this, but Keith Galer is in again and asked about ventilators. He says, it's been hypothesized, I'm not sure by whom, the ventilation is actually making people worse and that the oxygen deficiency is down to a lack of binding ability rather than to lung capacity. And he says that's not his experience. But how much of this do you think could be down to poor nutrition poor immune system, lack of sunlight, and could we address, could we help in any way other than by addressing breathing mechanics

Stephen (SS):

Again, the whole subject of ventilation and whether it's positive ventilation, C-PAP, or whatever it's being looked at in an amazingly rapid and developing way. The good doctor that we referred to before talked about overnight development along with the Royal Navy using re-breathing apparatus in a, low pressure system. I mean,

wow, that's just astonishing. The more we know about the disease and the way it works, the more we can address the questions that it poses and yes, sanitation and good health and all the rest of it. It's all very important. But you have to have a living patient to work on. And I think that this is why I'm, I made the big difference with acute medicine and what we do. As far as acute medicines is concerned, it's capable of getting people like my friend back from the abyss. Whereas what we can do after that is to support them when they're gone from the black disease to the bright lights of a of health if we're brave enough to accept that challenge.

Steven (SB):

Are you aware of any damage that's physically done by forced ventilation? Pip's mentioned that she's read somewhere that that forced air pressure damage the alveoli.

Stephen (SS):

I have no knowledge of that.

Steven (SB):

Okay. Okay. So back to what we can do about it then.

Stephen (SS):

Well yeah, say it's a, it's a question of of adapting the sort of techniques, but we have show that we know at least we have a place to play. I think what's it going to be interesting also is the fact that in the future the whole, question of PPE is a, is going to be very important. I think that in future when I go back to work, I will be treating patients with a mask and gloves for a very long time. I think that, so you don't lose any palpatory ability by wearing a pair of gloves. But I think the idea of having plinth covers the cloth covers or a towel over the plinth. Gone completely. It's a wipe down plinth. On a piece of paper at the top of it

Steven (SB):

We actually bought some new face rings for ours as well, which are there are a plastic squishy stuff which are again, they're wipe clean,

Stephen (SS):

But I think that's, it will be the least we can expect of ourselves and our patient and expect of us. Hand gels will be all over the place because, you know, we'll wash our hands very carefully, but the use of hand gels and even spacing patients apart in the waiting area is, it's something we've never done, but maybe we'll have to look at it. Again.

Steven (SB):

I think there's always astonished me Stephen, you go to your GP, they have packed waiting rooms with people cram shoulder to shoulder and there people are

expecting to go in with transmissible diseases unlike us where normally it's a musculoskeletal problem for most people. Bet that changes.

Stephen (SS):

I remember my wife talking to her midwife and, and saying she was in labour, is it time to go to hospital? And the midwife said, what do you want to go there for? It's full of sick people, you'll catch something. Yeah. So, yeah, the idea of us operating our practices in a slightly different way I think is, is, is going to happen. And I think that, well getting back to what I was thinking in terms of the, the, the, the, the actual techniques, I'll be very happy once we're out or our isolation as I come back and do an evening session for you, demonstrating these techniques on, on subjects so that we can actually see, what we're doing. I don't envisage it being, a huge challenge. I can talk for the osteopaths, I can't talk for anybody else. But you know, cranial techniques that are used to treat horizontal diaphragms and increase the capacity of ventilation within the chest and mediastinum, these are apparent, the techniques of Barral that are used on the segments of the lungs and the mediastinum. These are apparent. And if needs be specific, manipulation techniques, yeah. They can be used because they have a part to play. Whether that part has got anything to do with people's autonomic nervous system is still to be examined properly or whether it's just a question of the fact that these patients have been stuck in one position for a long time and their musculoskeletal system is suffering because of it. And then manipulation playing a sound part. So my appeal is more evidence base, a better understanding of what osteopathy can do post-Covid and don't be afraid to use the techniques that you've got because they're, they're applicable as they've always been.

Steven (SB):

Yeah. Sarah Oliver sent in a question for me actually, which is, could I share the link for the face rings that I mentioned and I'd love to take credit for these wonderful wipe clean face rings. But actually of course it's my wife who does all the sensible stuff in the clinic, in fact everything in the clinic. So I will get Claire to give me the link for those things and we will send it out as part of one of our next emails that everyone has access to that Evelyn O'Hare has said, that she actually hopes after there's something that's quite close to my heart, but I suspect will never happen is that our professions get closer together because we do so many similar things and we've got so much to offer. But there's a, there's an awful lot of parochial, foot stamping in our, in our different professions. And yet I think maybe this maybe do you think it will maybe bring us together? Maybe we'll all recognize that we've got similar things to offer or

Stephen (SS):

I don't mind if it brings us together what I don't want to happen. And I go back long enough to remember the times before 1993 when each of the professions were striving to get its own independence. Yes. I remember the times when the profession at one point was being offered a professional supplementary to medicine

as a branch of physiotherapy. And I pay credit to those osteopaths who work very hard. People like Simon Fielding Collin Dove who actually fought and fought and fought and eventually got the osteopaths act through in 1993 and the chiropractors in a similar way. Now having got that independence, I don't want to lose it. I don't want to go back to the times when we were a profession thought of as a profession supplementary to medicine. I think that we've got a lot to offer because we look at health as opposed to disease. I think that each individual profession has got its differences and those differences are significant. And you know, maybe a large clinical trial, will show up the differences between the groups in which case, fine. In 10 years time we may very well be doing something different, but please let's start. Let's not, let us lose our independence. There are roots whereby physiotherapists can train to become osteopaths and chiropractors. I'm not aware of any route where it goes the opposite direction. And I think that's because we've got our independence, we've got our act in parliament and we've got our, our head held high.

Steven (SB):

Yeah. I'm not entirely convinced that we couldn't manage with just one general counsel for osteopathy and chiropractics since they don't do anything for the profession. They simply protect patients. We could probably do with them combining and maybe we saved some money, but then I doubt that I, I suspect they'd find more ways to spend the money, but it's, I'll take what you, I'd take what you say there, there is value in, in that sort of tribalism in terms of perpetuating your, your, your own form of excellence and your own philosophy. Isn't that

Stephen (SS):

I think that the, that each has its place.

Steven (SB):

There's a, I mean, lots of stuff coming in. I've got one specific for you from Ams Koa, I hope I pronounce the name correctly. He reckons he's got a family member who has covid 19 so how can he help to treat them? They've had a range of symptoms for three to four weeks. I think it means that possibly days, mainly nausea and breathing and vocal difficulties. So what would you be doing with someone in those situations?

Stephen (SS):

I will be always seeking to make sure that he's in the recovery phase. I'll be having conversations with him or the have conversations with his medical team. And if the medical team are happy, for you to start doing the sort of stuff I've been suggesting. Fine. Carry on and do so, but I think you, you have to be guided by the people at the sharp end.

Steven (SB):

Yeah. What about the, the sort of the prone breathing techniques that we talked about earlier on?

Stephen (SS):

Yeah. I mean these are techniques that are being used in ITU departments in patients that are laying in in the wards. I think that when it comes to treating the patients post-covid a lot of these patients are going to be best treated sitting because it's less challenging. Certainly I don't think they'd be treated very much flat on their back, but maybe be propped up at 30 degrees. Because the studies say that the lungs work better in that position.

Steven (SB):

Yeah. Rafael's asked us a question about transmission and we were talking earlier on about how we might modify practices in future. And he's questioning how, how can you have any idea whether you've got clean air in a waiting room or a treatment room? How do you know when it's clear? How often, what time period?

Stephen (SS):

I don't know. What I do know is that after every patient, my couches are going to be wiped down. No, the paper over the top of that will be disposed in a way that is essentially putting it into a yellow sack, not a black sack. So it's a hazard. That's one thing you say about PPE. We haven't got any PPE at the moment. And those that have got PPE are saying well okay I'm covered. I've had nothing from the GOsC or the IO that tells me how to dispose of PPE. Go look on YouTube because they have a lovely video about how to take off your PPE and not get re-infection so you know, this is a big subject. As far as I'm concerned, the PPE that I'll be using in the practice is the minimum standard that I personally we'll feel comfortable with. Well, I think that my associates will be doing the same and we'll be throwing that away in a sack. And if needs be the GOsC or the IO will show me how to dispose of that sack. You can't just leave it to the dustmen to pick up.

Steven (SB):

I say, would you say that because the only research that I've seen on this says that the bug will only live for 48 hours on most surfaces. I think it's 24 on plastic. No, 24 on a steel. It's 70, 72 hours on plastic or cardboard. But I also saw a research from the newspaper industry saying that newsprint doesn't transmit the bug because it's porous, I don't know how that logic works, but,

Stephen (SS):

Oh dear. But I think at the end of the day you know, I take off my gloves that I've been used to handle the patient. I take off my mask. Potentially there's a pathogen on the gloves or on the mask, so I need to throw them away in a way that's that's acceptable. Yeah. Their clinical waste.

Steven (SB):

Yeah. The other thing I saw in that same research was that the bug is no longer transmissible or no longer detectable in air after an hour.

Stephen (SS):

Well, we don't know is the answer because tomorrow you can have something along comes along and says, Oh, it lasts for a week. We don't know.

Steven (SB):

Hmm. But given that it's impossible to cater for all those things, I guess we have to go with whatever research is currently available, don't we?

Stephen (SS):

And we have to be able to make sure, not only do we protect the patients, we're protect ourselves and I think that this is why masks are very important. I don't think we need to go the full thing with the visors and and gowns. I think that when we get back, we'll be safe enough with a face mask an appropriate face mask and, and plastic gloves. Where do we get the masks from? Don't know. Whether we pay for them ourselves or we get given them by the NHS don't know. This is, this is [inaudible].

Steven (SB):

Oh, I bet I can answer that last question for you. Yeah. The NHS isn't going to pay for them for us, are they?

Stephen (SS):

No, but the department of health might, if the GOsC or the IO make enough pleas on our behalf and that's what they should be doing.

Steven (SB):

Amanda's asked an interesting one, when would you ask the patients themselves to wear face masks given that the WHO currently advises that they might be better for Covid carriers, coronavirus carriers rather than for recipients as you might put it.

Stephen (SS):

I haven't thought about it, but it's a perfectly good suggestion. Yeah,

Steven (SB):

Of course. You don't know who in many cases we don't know who the carriers are. Do we, because people are asymptomatic before they actually start.

Stephen (SS):

They come in with backache as I said before. Yeah. We all know what it feels like to have the flu, you know, it's essentially different than having a cold. Your muscles ache. If you've got a preexisting, i don't know, you've got a pre-existing spondylolisthesis for example, and it's normally you know, jogs along quite nicely. You get the flu. That's the first thing that's going to come in and say, ouch, look at me. You go in and treat that patient not knowing. So that first symptom is Covid.

Steven (SB):

Keith Galas just talked about, people disposing of their PPE. He says people are throwing rubber gloves or latex vinyl gloves all over the pavement after they've been shopping.

Stephen (SS):

Yup, I've seen it.

Steven (SB):

There's an interesting observation. I made myself feel the day I was in the queue at Waitrose and I was, there were a number of people who were wearing one. I think they're all wearing latex gloves, but of course it's entirely valueless unless someone's told them how to do it. The lady in the, in the grocery shop up the road, wears them, but actually they were of no value if you use the glove like a hand and the lady in the supermarket had her phone to her face like this with the glove and was then brushing her hair away and then touching the shopping trolley and everything else. The lady in the shop with the groceries, I mean she's handling everything with these gloves as though it's somehow going to protect her from Corona virus. But then she's touching her face with the gloves.

Stephen (SS):

I think the best you can say is at least they are, they're putting the glove on. It's nod in the right direction as opposed to to maybe not. Certainly. when we go out for our morning walk and we might pop in and get a pint of milk or something on the way I make sure when I come home, the first thing I do is wash my hands with hot water, sing happy birthday twice and then put on some gel..

Steven (SB):

Carol Baker asked about immunity. Does anybody know whether there is immunity gained from having had Covid19? Have there actually been, has anybody been tested who's been re infected? Are you aware of anything

Stephen (SS):

I'm aware of one conversation that was had with somebody who was a BBC broadcast. And it said specifically just because you've had Covid19, it doesn't mean to say you've got rid of it and that's what they're worried about in terms of the second peak is flattening. Thank God for that. You know, we're getting to where we

should be getting to with social distancing. That's fine. But they're looking for a second peak and that's, that's, that's entirely a possibility which may be patients with already infected with displaying the second set of symptoms. In terms of social distancing. I saw a very interesting thing. The, the television, somebody who was saying that a jogger went past them in the park and she could smell the garlic on his breath, that's too near. That's way too near. We make a big thing, not only when we're walking of keeping a distance, but if I see the person coming towards me moving in the opposite direction and saying thank you and that's happening more and more people are acknowledging, Oh, Oh, that's all right mate. Thank you. And then now people are saying it back. Maybe that's another little thing that we can do in terms of social distancing., I don't know.

Steven (SB):

Another question that occurs to me that you, you may not know the answer to this either, but it's often struck me that if you, if you're walking along a pavement behind someone who's smoking, you can smell that cigarette smoke for a very long way away. Now, while I wonder whether that, those sorts of particulates actually help in transmitting diseases like flu or covid 19 because does that keep the particles, the, the respiratory particles airborne for longer?

Stephen (SS):

Steven? I saw a thing on, I think it was BBC again, somebody sneezed. Okay. And they had chicken pox and he sneezed. That went under a door, under another door and was detected three rooms away, wow. You know, this is, this is the stuff of nightmares. So I didn't think we realize about spread just how much these things can spread, but certainly the idea of coughing and sneezing in to your elbow? Great! It's just going to stop it from spreading through the world. And a slightly humorous level, someone suggested to me that the best use of the face mask when you were in isolation is that it stops you eating too much.

Steven (SB):

Observation from Tisch. The pandemic's big mystery is why it affects people in so many ways from those with no symptoms to those who need intensive care and scientists in the UK are turning to biobank to find the answer. Scientists are turning to UK biobank to find the answer. Apparently this is a project which has collected genetic material from half a million people and followed their health for more than a decade, will also track those with covid 19 and apparently there'll be looking for variations in genetic codes and they want to see if there are differences and make it easier for the virus to enter into cells and examine how the genes respond.

Stephen (SS):

That was on the news last night. It was very, very interesting. Very, very interesting. But you know, these are, it's, this is a, again, looking for the cause and effect and this is something that modern medicine is really fabulous at.

Steven (SB):

Yeah. Carl Norris has asked about treatment. Do you have any specific considerations for areas to address and treat in someone who has suffered covid 19?

Stephen (SS):

Well, I would be very conscious. Looking to see firstly in diagnosis, which areas have been overused. I mean we talked about the accessory muscles of respiration. There's a clear example of, of, of, of a system that's used to aid the breathing system. Also be thinking in terms of the mediastinum the lungs and the way the lungs are supported inside the chest, the various visceral ligaments that connect the pericardium. The whole of the heart lung system within the mediastinum itself. And then looking at that fascial chain that you saw before, which again, anybody wants those slides more than welcome to have them just follow those fascial chains all the way from the cranium downwards, looking at fascial restrictions which have come up because these patients have overworked them. And then if you want the treatment to include techniques that are easy to apply. Um no, let me re reiterate, not easy to apply but which can be applied and which are unwinding techniques which are non challenging. Certainly these are the sorts of techniques that I feel a very applicable in these sort of cases because you're only ever going with the tissue tells you to go and you're working very lightly in a non challenging way. Then as the patient starts to improve, they can start to do the more of the rib stretch techniques. And then you start to look at the rest of the spine and the connections that go through the four diaphragms throughout the diaphragm in the head, the diaphragm at the entry to the chest, the diaphragm itself and the pelvic floor and looking for the balances between those using craniosacral techniques or fascial release techniques and all the time if the patient needs it. And if the patient can stand it, if you use direct specific manipulation techniques, they're always done in very minimal leverage with the least possible stress to the tissues. Certainly certainly would never use a dog technique where you're literally squeezing the life out of the poor guy. Yeah, there is very gentle techniques are, are applicable. And I would probably be using more of the accessory techniques or the other ways of looking than direct manipulation as such. Okay.

Steven (SB):

Carrie wants to know what your magic bullet would be. What's the most important, important concept you'd want to share with patients too, to help them recover?

Stephen (SS):

So to me the most important concept is slow. This is a disease that gets out of the acute phase very quickly one way or the other. And the recovery has got to be slow because we're constantly breathing. We don't stop breathing and take a rest. We constantly breathing and that recovery will be at so many different levels within the body. Again, encouraging the all the accessory dietary and nutritional advice that we

can and gentle exercises. Sure. I'm sure nobody in the physiotherapy world is, is looking to treat these patients in the same way they would treat an athlete recovering from, from an injury. But I think that's a, it's going to take time. And as long as we're working within the capability of that patient, we should be able to see results.

Steven (SB):

Yeah. Now somebody asked whether you think that cystic fibrosis rehab techniques would be useful for patients post discharge. Now I don't know what they mean by those techniques. Perhaps you do.

Stephen (SS):

I don't, I'm afraid. I think if I had a case of a patient with cystic fibrosis, I would probably recommend them to a postgraduate physio who deals in lung disease.

Steven (SB):

Right. Okay. Oh now, hang on. Someone sent me a long one here. Paul says, referring to the chiropractic code he says that the code States that they should put patient's health first as does the osteopathic practice standards, practice stems, respect them, and ensure that you promote their health and welfare at all times. Yeah. Okay. So we're going all through that. I'm looking for the question in this. Basically he's just saying that we as osteopaths, chiropractors were required to prioritize patient's wellbeing and health, which I think we're all reasonably well aware of, aren't we? The difficulty arises where we have difficult, different beliefs on what is good for the patient's health. And I don't mean that we're going to do something nasty too. But in terms of saying, I want to use this particular technique in order to do what I think will improve your lung function,

Stephen (SS):

There's nothing is disagreeing with that. But however I would like to question, and this again is going to be controversial. Why has the GOsC whose website starts off by saying it is our job to protect the public, did not issue an edict closing every practice in the country.

Steven (SB):

Ooh. You know, I know, you know, I reckon I know what their answer to that would be because they're answer to everything is we are bound by statute and you know, I kind of think that's a fudge answer myself because actually you could, you could strongly argue that it would have been safer for everybody if they'd given a firm edict. I can understand why they've sat on the fence a little bit, but it's, yeah, I, I, I'm kind of with you, cause it's not helpful of osteopaths to make that decision. And similarly with chiropractors, of course.

Stephen (SS):

Yeah. But the point is that this is, you know, if they're going to prosecute us for failing to abide by practice standards, this is on the front page of their website. Yeah. And I just, I'm concerned enough as far as that's concerned. But Hey, you know, I sit here at the end of my career, not at the beginning, yes.

Steven (SB):

I'd say a very observation from Gemma here because we're all busily waiting for the vaccine to come out. And she's pointed out that actually, if you aren't guaranteed immunity after you had the disease, what's the point in the vaccine?

Stephen (SS):

Well, in today's Times, the biggest drug companies in the UK and the biggest drug companies in France are combining resources to produce this vaccine by the million in a year.

Steven (SB):

Yeah. By which time we will probably have herd immunity anyway.

Stephen (SS):

And we'll be on Covid 33.

Steven (SB):

The rebooted version. There's an awful lot, you know, in all these broadcasts that we've done. People seem to be very, very concerned with personal protective equipment. I am, I'm, I think, I'm quite sceptical to be honest because I think that there's, people put a lot of faith into PPE, which may be misplaced, particularly if it's not used properly, given that we're not going to have the sort of PPE that they would have in an intensive care unit. Somebody is already mentioned that using gloves when you're using oils could be difficult, but you know, maybe we just have to not use oils, but Pippa said washing about washing clothing. She did research into separating hand towels for patients, washing hands and it doesn't matter what temperature they are washed at, but they must be tumble dried at a high temperature for at least 30 minutes to destroy any viruses. I don't know where that research came from, but as a hell of a lot of confusing information about what we do to protect ourselves and our patients out there isn't that

Stephen (SS):

It's far easier to get rid of all the towels, get rid of all the plinth covers, wipe the plinths down between every use, wipe the door handles down of your practice on a regular basis. And then offer the patients the gels to use in their hands and keep safe that way.

Steven (SB):

Yeah. Um Rachel has said, what do you think of apron uses? Usage because aprons can be washed at 60 to 90 degrees and also have the environmental cost of PPE.

Stephen (SS):

How many people have got a washing machine in their practice?

Steven (SB):

Yeah. But also you still gotta change the apron between patients, haven't you? Otherwise it's pointless.

Stephen (SS):

I basically got 20, 30 aprons

Steven (SB):

I guess. I guess at least it's not disposable is what she's saying, but yeah.

Stephen (SS):

Yeah. But plastic aprons are being used and they're cheap. I'm sure the PPE question will be resolved fairly quickly and I would like to think that the powers that be on our behalf will look at the department of health and say, you know ,my guys are going to be involved in rehab. We do need the, the very minimum of personal protection. And if you look at the websites from NHS England, it says, if you're in a one to one situation, this is what you need. And you, the boxes are ticked. We don't need goggles, we don't need gowns. We do need gloves. And we do any masks. It says that one. The NHS website.

Steven (SB):

Yeah. Somebody at Ferndale osteopaths has asked about whether you think there's benefits in us making greater use of peak flow meters in practice to measure improvements in patients' health. And they've said that our treatment is making them better. I mean, it might be or, it might not be our treatment, but it would be nice to know if there was improvement.

Stephen (SS):

Yeah. People know how to use them. Fine. You know.

Steven (SB):

No, but I suspect there'll be a, there'll be a whole industry and new courses and how to use the PPE and other bits of equipment after this one. But

Stephen (SS):

I don't know if it makes us safer and if it's accepted as, as good CPD. Yeah. You maybe didn't have to have someone come on and do it as video for you.

Steven (SB):

Well, I'm sure we are. I mean, it's not difficult to use a peak flow meter but interpreting the results might be a little bit more tricky. And I'm an actually and attributing the cause and the effect of course. But certainly, yeah, it would be nice to know that there was, there's a subjective, sorry, an objective measure of improvement in lung function.

Stephen (SS):

Well, that again gets back to the idea of the research question. You have to actually ask the question and say, well, what are you trying to do? If I say I'm trying to get the patient to walk up and down stairs twice in a day within three months or something, that's a research question. If I say I want my patients to be able to hold a phone conversation for a minute without a getting short of breath there's enough parameters out there in the respiratory world. That define whether or not you're suffering from respiratory distress and we could use majority of those.

Steven (SB):

Jill's asked about research within the NHS. And again, I don't know if you're close enough to the coalface on this, but do you think there's any greater chance that osteopaths might be involved because we're allied healthcare practitioners now in any such research? Or will it be something that has to be instituted instigated by the ENCOR?

Stephen (SS):

No, I think we should be all in every research trial that that will have us as part of that trial. As long as the research question says, you know, we're looking at the difference between group A, group B in group C and if we can argue our way into group A, group B or group C by saying this is what we're trying to look at, this is what we're trying to measure. Yeah, the research question is sorted and once the research question sorted, yeah. If the NHS want to pay for it, lovely. That's great. And if people want to give up half an afternoon for it, fine. That's good because I think that unless we take part in these huge trials that are to come and there are going to be thousands and thousands of patients need who need our help then fine. Then our place in, in, in, in the healthcare world is there. But as I said before, if we're brave enough to accept the challenge,

Steven (SB):

There's an encouraging move isn't there towards pragmatic trials? Because one of the worst things about trials in the past is they've tend to, they've tended to focus on if you do this one tiny technique, have you caused an improvement as opposed to let's throw a whole bunch of people at the chiropractors and a whole bunch of people at the osteopaths physios and just see what happens them after their treatment. And we don't really care what happened in the treatment. Just looking to see what has benefit.

Stephen (SS):

No, it comes back to the research question searches question is, is simply which group improves better? These are the criteria we're measuring it against. That's one piece of research. If the research says that I'm going to use a sitting lung technique with, with rib stretch done in this particular fashion. By, the osteopath by the physio, by the chiropractor. That's looking at the technique that's being used. But I think we have to to be involved in the design of these methodologies if it's in part to do the work on the ground.

Steven (SB):

Yeah. Ian Foster says that the difficulty with the peak flow meters we were talking about a minute ago is the disinfecting afterwards, especially with the, the covid 19 problem. The ones that I use have a cardboard tube so that can immediately be thrown away and the body itself can be disinfected with, with gels or sprays.

Stephen (SS):

Thrown away and dealt with by whom?

Steven (SB):

Well, if we can put it in the sanitary waste. Yes.

Stephen (SS):

Who's going to collect the yellow bin, you see what I mean? It just, it just

Steven (SB):

Connecting yellow bins is easy isn't it? You just call the council and say, I've got this health care waste that needs to be collected and they arranged for it to be collected by suitably trained people.

Stephen (SS):

I don't know that that's the case.

Steven (SB):

Well, it happens in my clinic because we call them regularly to collect the sharps and the other yellow bag stuff.

Stephen (SS):

Oh, the sharps, we worked with the dentist so that it goes off to to his but you know, I just think that these, these are questions I have to be asked.

Steven (SB):

Yeah, yeah. Well I suspect they'll be a bit more guidance coming out once people get the hang of this because you know, there were, there were so many unanswered questions about, you know, how the bug behaves at the moment there.

Stephen (SS):

Let's get the PPE first and then worry about disposing of it after.

Steven (SB):

Yeah. Carol Baker said that, isn't there some suggestion there are two different strains of covid as well that we need to be concerned about? I'm not sure I've heard that. I mean, Covid 19 is a disease, not a, not a bug. So Corona viruses as I understand it isn't a bug.

Stephen (SS):

I think there's probably more than that. [inaudible]

Steven (SB):

Well, I'm sure that the current Corona virus, because flu is also a coronavirus as I understand it. This one is SARS coronavirus two or something or SARS, CIB two. So

Stephen (SS):

It does go to show that that's the fact that they're trying to pigeonhole it into a certain box by calling it by a specific name, hopefully it would lead on to the, the handling and the treatment of it.

Steven (SB):

Yeah. Nicola Reeder said put in another observation about peak flow meters and say, well actually they're not necessarily a good idea unless you know what the lung capacity of the patient was before they got ill because there are plenty of people with low lung capacity. Anyway.

Stephen (SS):

Yes. Again, yeah.

Steven (SB):

Samantha has asked about research evidence from China, is there any that suggests that chronic relapsing post viral myalgia could occur with Covid 19.

Stephen (SS):

There is and a only from China. But it's stuff that I've seen from Italy and from France and from Spain, that says that these patients are as weak as kittens and myalgia sometimes takes a long time to go. Now what's happening there is you're getting a post, viral myositis so that you're getting inflammation and inflammatory change

within the muscles caused by the, the pathogen concerned. And, that's where, your treatment through fluid flow and, and treatment through maybe the lymphatic potentially not proven potentially. Yeah, it's important.

Steven (SB):

Okay. Pip sends another one in about measuring temperatures, which again just reflects how difficult it is to identify people who are suffering from Covid 19. She said that they think they've had it as a family and her husband, son and daughter all had massive temperatures up to 38.7. She was the only one who didn't and only wnet up to 37.5, but she had the worst cough. So that is not a particularly reliable way of detecting who's got covid 19 either, perhaps.

Stephen (SS):

Well, okay. You know, at airports they'll shine a gun at you and measure your temperature from

Steven (SB):

Yeah. I suppose you have to try something don't you? You've got to try to minimize the likelihood we'll never going to be 100% certain, but

Stephen (SS):

Yeah. But I think that's, you know, as I say [inaudible] if you've got a temperature, if you're coming from an area that's is potentially a risky area and you've got a cough with that, the inference is that you've got to covid virus infection. Raised temperature by itself is everything and nothing.

Steven (SB):

Yeah. Vispi's asked about screening patients before treatment and suggested that all patients should be telehealth screened before they come in for face to face treatment. But worries that might be a bit over the top and I guess there's two sides to that. There's now and then there's post-covid 19 isn't it?

Stephen (SS):

Yeah. Now I've already said my position with whether we should be working or not. Post covid19 what are you screening for? Your first question is going to be when the patient says, I'd like to make an appointment to come in and see you. There's going to be, have you had a positive test for covid 19? If you have had a positive test to covi 19, are you still infectious? No, you're not still infectious. Welcome. Come in by all means. But if someone must've phoned me today and say, you know, I've got a cough and I'm aching all over, can i come in for treatment. It would be no, thank you very much.

Steven (SB):

Yeah. I suppose we've got we can look at the realistic side of this, haven't we? When you screen somebody you can't be 100% sure that they don't have it, but then again, that person, if they are asymptomatic at that point and they don't, they don't fit any of the stereotypical Covid 19 sufferers, they're going to be out in the community anyway going to the shops because they won't realize they're transmitting the disease. So we're only doing our due diligence with the facts that we do have the criteria that we do know of in trying to minimize the possibility of risk. We will never be a hundred percent certain in this. I think what's interesting is when you look at places like Germany,

Stephen (SS):

It has screen more people than anybody else. And therefore, who's curves flatter than anybody else. What it's saying quite clearly is that having screened, we can then isolate. If you are positive on this, on the screen, you're isolated, you're taken out of the population. If you're negative on the screen, then you go back into the population and that has resulted apparently hugely significant difference in mortality. Yeah. Take people out of the population, and put them into isolation. Forced isolation. Then that's where there'll be for a week to 10 days. If they don't develop any symptoms. Bye-Bye. Off you go out into the population again. So your population is ever increasing of people who are negative or post virus and no longer infectious as opposed to a population where there's a mixed group.

Steven (SB):

What do you think about this herd immunity concept? We've had a number of questions in from one direction or another asking about it, Martin saying, well, you know, if we're doing all this PPE stuff, how does that influence the fact that what the government is after is herd immunity?

Stephen (SS):

They aren't serious. I don't know enough about herd immunity to be a guru sitting here. It's okay. Just another talking head. But I do feel that again, as far as PPE is concerned, it's two faced. So I'm protecting myself and I'm protecting my patients. Do you know, I've always saw this, this herd immunity idea was a bit weird because it's not as though there's a tiny herd of people that become immune effectively they want, the population as a whole to be immune. And the only way to do that is to let everybody catch it or vaccinate, vaccinate them if there isn't a possibility of re-infection afterwards. But what they're trying to do is to slow the drain on the NHS resources by isolating people and protecting people in, in stages. And they've said on a number of occasions, haven't they? That the lockdown may well end but then be reimposed again afterwards. Once we, once the cases start to climb again.

Stephen (SS):

With herd immunity. Okay. It's very simple. One person can affect 2.5 people. Those two point five go into effect, 550 people will go on to affect a population. I think that

this is where it herd immunity, is a listened to. So I think this is why the idea is to stay at home isolate don't be one of the people who's going to do 2.5. Yeah. They're isolating us. And I think that the, by isolating us it's really following on from common sense. I think what's going to be interesting also is that the way we run our practices in the future, just some thoughts that people might want to think about.

Stephen (SS):

We are part of a private health care system and I can see a situation in the future where by people coming back after three months off, they spent all their credit card money, they spent all their holiday money. Society has developed into a two tier system of haves and have nots. The have nots, I'm going to be looked at by osteopaths too, maybe now's the time. So actually you start setting up groups of people within an area providing treatment either very low cost or no cost for those that can't afford it. Almost as a social step towards a communal health in terms of, of our communities. But we're getting together, we've been very good at standing in the street and clapping. We get very good at delivering stuff to people. Maybe now the profession has got the opportunity to, to get together and for a small price or no promise can offer pro bono patients show our path to play in that direction. Just as a thought. I mean, this is really no more than than me spouting, but this might be one of the ways in which the profession changes. Yeah. And if we start offering our services to the NHS but not as part of our physio team, but as individuals who are part of an independent profession, what can we offer it as maybe that be a pro bono thing, as well. It would certainly have to be very cheap for them to be part of the NHS.

Steven (SB):

Yeah. We had a number of people sending their ideas, their, their comments about how we make our practices better, safer places for our patients. And somebody from Ferndale osteopaths has sent in a couple of things. One in particular was the peak flow meters, but, but also that they've started testing temperatures on arrival for patients as well. So maybe that's something that will continue in the future because there is sort of raygun thermometers Iyou shine them at somebodies head and it gives you an accurate reading, very easy to use, very little contamination risk involved in it. But maybe we can screen out patients like that. Someone else has said, does this thing, you know, is this the end for magazines and newspapers in the waiting room? Because of course they get passed from hand to hand. Although as I said earlier on, newsprint apparently doesn't transmit the virus. And somebody, I think it was Pip sent in something to say, it's because the paper is porous and it drains away moisture from the virus and therefore it can't survive, which doesn't explain to me why cardboard is one of the longest live surfaces for coronavirus, but I'll take her word for it.

Stephen (SS):

I do think though that we've got to be careful about temperatures because as I've said two or three times now, it's not the patient with the temperature, it's the patient

without the temperature that can be dangerous. And it's not paper that transmits viruses. It's computers. Computers spread viruses.

Steven (SB):

And we've, you know, we've still got to have some screening tools, haven't we? And so if someone calls up and you say, well, you've been around anybody who's got a cough or anything like that, if you've got a cough yourself or you get a temperature, then that's fine. If someone pitches up with the door and they've got a temperature, you could tell them to go away. It'll never overcome the problem of people coming in asymptomatic and still spreading the bug. But at least you've done some screening, which possibly is helpful. Gemma Swain says the Swedish and not isolating and they're doing very well, better than most perhaps. And perhaps that'll prove the best approach and building health will be valued more. It's the hygienic environment that matters most inside and outside the body. I'm not sure the NHS would agree with that. If everybody suddenly ended up in ITU with covid 19, though,

Stephen (SS):

I don't know. I don't, you're always going to get anomalies like this. Russia had no cases at all. Nothing. No, no, no, no. Nonsense. What are we doing now? 5,000 a day. That's what we do now in Russia.

Steven (SB):

One always suspects that Russia may be a little bit liberal with their interpretation of the facts, but it does occur to me here that Sweden is not a densely packed country. Is it? Italy? Italy is very densely packed. England is very densely packed. China, I don't know, but I imagine the cities are very densely packed. No, I can't help but feel that probably has an effect is a factor in the spread of the disease.

Stephen (SS):

Norway in Scandinavian. They're not densely packed and then they've got their own cases. There's something about the Swedish system. I don't know what it is, but I'll be very interested to, to read it. When it's a, it gets discovered.

Steven (SB):

Well, my friends I know would say that a sauna a day kills everything and maybe the heat,, maybe the heat kills the bugs. Vlad sent in a, an observation from a paper that he can't remember. He said that apparently he saw that there are 20 mutations of SARS covid 2, which is [inaudible] coronavirus to whatever it is. Yup.

Stephen (SS):

It's new imformation for me, but I'm not the front line.

Steven (SB):

There's a lot of lies. There's a lot of compliments coming in for you Stephen. People saying this is very useful, particularly reminding us that we've got the skills to treat people.

Stephen (SS):

[Inaudible].

Steven (SB):

Yeah, we're not, we're not, after all treating a condition, as we so often say, we're treating people and finding what's wrong with them and helping them to recover. Now I'm trying to find some new questions that we haven't already else. Samantha says, if we're going to give masks to our patients or masks ourselves, we need ones with open fronts so that they can lip-read if they're deaf, which adds the complications of the issue doesn't, that's, that's one that's so we can tick the box on discussing communication now with our patients is how do we communicate effectively over things like this.

Stephen (SS):

I think I'm very happy obviously when people respond to a broadcast like this in a positive way. But my stated aim is really to, to sit back and to, to look at the future and say, well, this is how osteopathy developed. We started in 1860 where you couldn't have anything that was in the chemist shop for sale. Doctors were operating before the germ theory. The best doctor to go and see was the one the quickest one because you suffered least. And here we are today where we see the pictures from the television on a daily basis of medicine at the very, very, very front nine. The most amazing professional, knowledgeable people discussing this at a level that is stellar compared to us mere mortals. And I just felt that it was about time we actually looked at where we are as opposed to where we came from. And I do honestly feel the our place as a modern therapeutic scheme of handling patients runs alongside modern medicine. And has it's real solid place to play in rehabilitation but has to be supported by evidence based medicine. But you know, the skills I feel having taught them for the last 50 years. Okay.

Steven (SB):

Well and that's reinforced by what we saw from the, the doctor on the Royal college of medicine's webinar the other day, isn't it? Because a lot of the things he would talk, he was talking about actually were directly reflecting the effects of manual therapy. Really. He's talking about opening lungs up rather than applying drugs and so on. And maybe all of the professionals, all the medical professions are now looking at this perhaps from what could for once, genuinely called a holistic perspective perspective because they didn't know what's going on. They don't know what the damage being done is. So therefore they're having to look at it completely afresh and how they go about treating a new problem like this. Yeah,

Stephen (SS):

Yup, yup.

Steven (SB):

Vlad asked, you, remember the paper that we referred to earlier on about osteopathic manipulative technique. Do you know if in that paper they actually specified what they meant by that?

Stephen (SS):

No. But have you got to look at when it was written? 1920 and 1920. OMT was very much vertical based and my surprise you I went to Kirksville a few years ago and took part in a class in the laboratory where students are taught manipulations, et cetera. And they're still using concepts that haven't been taught certainly at places like the university college of osteopathy, for years, they're still talking positional lesions and they're still looking at Littlejohn's theorems and things which I found quite interesting. The fact that we are so far ahead in the way that we do things. And I'm sure the chiropractice is, they looked at the way that Palmer and and others were doing what they were doing in the 1860s, and the way that the chiropractics is taught today, worldwide, again, it's very different, but we should never lose our history, but we still embrace that history and bring it up to date. And that's the second part of what I was, are hoping will have come out of this evening. The fact that we can have this debate and show us the future.

Steven (SB):

How do you think your practice would have changed in six months time?

Stephen (SS):

I won't be there!

Steven (SB):

It will still be your practice though won't it?

Stephen (SS):

I was actually on the point of signing a deal to sell the practice when this all happened. So that's going to be another years time. Before that's the case as I've still got my my apprentice in the West End and I still see patients at, but I'm semi-retired. I do two half days a week now and that's it. I think the practice will be busier. I think there's no fear. So people who have stopped practicing when they go back to practice with the phone ringing, I think that phone will be ringing off the hook. I think people have been sitting around working from home, sitting for too long, giving themselves musculoskeletal pains going out in the garden, doing all the gardening and the bending and the weeding and the mowing, getting up and down ladders and falling off them. You know, going out and exercising for the first time in their lives, producing all sorts of problems with that. I think our practices are going to be

bigger and busier than ever. I think that it's going to give us the opportunity to to use all the different varieties of techniques that we've got. Maybe this is the time when the general public begins to realize that there's more to osteopathy than back pain. We're all capable of doing much, much more in terms of looking for health. So I think people have got no need to worry about how am I going to go back to being busy? I think you're going to go back to being busier. And I think that we have to be, when the government says it's safe to go back on hand, ready for an onslaught, those phones are going to ring off the hook in my prediction.

Steven (SB):

Well I hope you're right. I hope we can help those people. There's a few corrections I need to, to read out to people who have sent in some later information about Sweden where apparently the death toll is steeply on the increase now. So they are introducing social distancing and Amanda Musgrave-Wood, she says that she thinks cardboard harbours the virus for 24 hours and steel for 72 hours. And soft fabrics for three hours airborne 30 minutes. Now I don't know where Amanda gets her information from. The information I got was from *The Economist* very early on in the, in the, in the problem. And I think I put my reference for that up on the website not so long ago. But yeah, it was definitely cardboard was the longest for harbouring the virus. But who knows, I guess it's something we can't, we can't take for granted in any cases. Steve, we're, we're kind of at the end of this now. You've got any sort of parting words about what we should be actually doing right now rather than, as you said, we should be waiting for the end of the main problem before we start rehabilitating patients. But right now with our telehealth consultations or looking after ourselves or our families,

Stephen (SS):

Yeah. Going to reinforce the message, which is very simple. Stay home, help the NHS save lives. I've said this from the beginning and I'm still saying it. I think that, we should also as a profession, Be putting ourselves in a position whereby this rehabilitation question, and it's going to be a big question, is it addressed with us and with all the other people as well that we can be part of this. I think we've got a part to play. I think our individual skills maybe in each of the professions, but certainly in osteopathy, have a part to play. And I look forward to the time maybe in four or five years time when the whole face of osteopathy has changed because we'll be part of this rehab program striving for health and not looking for disease. I certainly, that's, that's how I feel. And if that's the case, then I could actually retire as a happy man.