

Treating Patients with MND and MS

with Donald Francis
29th June 2020

TRANSCRIPT

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Steven:

I'm joined by Donald Francis, a chiropractor from Scotland.

Donald Francis:

Thank you very much for having me, Stephen I'm really delighted.

Steven:

I'll tell you what, I mean, one thing that impressed me, you said you've been working throughout the zoom, the Coronavirus crisis. I nearly said zoom crisis, which is pretty much the same thing.

Donald Francis:

I think the, I think the zoom, the zoom crisis is probably how we might remember it more in about 40 years time. Yeah. We've been working all the way through, but from, for a large part of it, we were only seeing technically emergency patients, but chiropractic, that that evolved into a medical need. I put that word in for instance, which, which, which expanded the scope of who we were allowed to see, but there still was an element of emergency or critical care nature to it.

Steven:

Well, you, you know why I asked you to come on the show because I've spoken to you about it, but for the benefit of the others, I first saw you talking at the McTimoney conference a year or more ago now. And what I really, really enjoyed about your presentation was your enthusiasm for what you can do for patients in particular, you know, patients with some really nasty life threatening, debilitating diseases. And as we discussed earlier on, we are not talking about treating those diseases. We're treating, we're treating patients, well you are, and you're doing it enthusiastic way.

Donald Francis:

Yeah, no, thanks for that. So I'll just describe a little bit about how this happened. It like a lot of these sort of discoveries about what we can do, it happened by accident. I've never set out to treat MND and MS. I don't think that's possible, but I I'll just, I want to really caveat that almost all my patients, so that's nearly a hundred percent of patients with MND and MS, who are two very ugly cousins, one is uglier than the other, have found that under chiropractic care, as I deliver it, and that chiropractic like osteopathy has a very broad church, there are many hundreds of different techniques and approaches that their lives have been significantly better. And in fact, in some cases enhanced quite significantly, but it all started about four or five years ago.

Donald Francis:

And I had a patient with MS and she came to see me actually, because she had trigeminal neuralgia. So they MS was, was, was always secondary to that. And her, I forget now whether it was her left or right leg, it was her left leg. And when we adjusted her, whatever that means, and the adjustment is the chiropractic word for treatment. When at the end of that, yes, she was quite, she was about 68 or 69 at that point. And it took two of us to get her onto the onto the chiropractic table and turn her over. When she adjusted it she said, this blimmin' leg of mine, it doesn't work and she was able to straighten it. So that really shocked her, shocked me and it shocked her carer and the family member

that was with her when she came. But all of a sudden this stupid leg that hadn't worked for some time worked, and that was quite exciting.

Steven:

So no doubt, you've got a theory as to why that happened.

Donald Francis:

I do. And it's to do with it's actually to do with the neurological. I'll, I'll expand on that as I go, actually, but I think it's to do with both neurology, but interestingly, my hypothesis at this stage, there is no proof, this is my me having worked around this disease, both of these diseases now for about five years and quite a substantial number of patients with them are relatively, so in the combined patient base, probably about 30 to 40 patients with MND and MS on a fairly consistent basis. So I have a reasonable sample to, to go through. Anyway three years ago. Exactly, actually. We have a couple of other MND, MS patients, sorry, come through my life, MS and MND just for people who don't know, they're both diseases of the central nervous system, M and D is always life ending.

Donald Francis:

MS is always life limiting, both have various diseases. MND has one form of it known as Amyotrophic Lateral Sclerosis, or ALS. And that's probably the name by which it is most commonly known, certainly in America. MS has four, sub-variances, sub ranging in, in, in, in severity. The point is we're not treating the disease. So it doesn't matter. And what we do is the same for both patient basis, it's no different, we're just changing neurology and stimulating neurological function. About three years ago, a famous rugby player went public in the world that he had MND, a guy called Doddie Weir played 67 times for Scotland. And he's raised close to 7 million pounds through his charity called My Name's Doddie, MND. Last year he was the winner of the Helen Rollason award, the BBC Sports Personality, the, and he's six foot seven and one hell of a guy, very charismatic. Anyway, he went public and said he had MND. Based on my work with MS, his wife's best buddy was seeing me at the time and I said, listen, you wouldn't get him to give me a ring. See, I believe that we could make some changes. And it took him about six or seven weeks. And eventually he made, he came and saw me, and he was pretty active at the time, but it was clear MND was beginning to change his hands and certainly some of his functions. We assessed him. And all I did on the first adjustment was a cranial adjustment. I'll describe it. It's called cranio facial dynamics, derived by a man who practices in Oxford.

Donald Francis:

And one of the tests we do is to check the opposability, that's the left and right hand, that's a very human only thing. And then if we have no, or weak opposability, it is a clear sign that we have something going wrong right from the top. Okay. So he had no opposability, at all on either hand before the adjustment, but immediately after the adjustment, he had opposability and he had some strength. And anyway, anybody who knows Doddie knows that he likes a Guinness and a lot of red wine, and he began, which he's quite open about probably despite the ravages of the disease, he began a, a period of his life where he was very sociable. He's been around the world. He's raised millions of pounds. He's been on TV. He's had documentaries written about him. You know, the England Scotland Wales rugby match is called the Doddie Weir cups so every year when that's played, there is the Doddie Weir trophy.

Donald Francis:

So he's had a hell of a time and it's been very sociable. But for about the first seven months we arrested, we, we helped his body arrest it's declined. And it wasn't until he went to the Hong Kong sevens, New York and New Zealand, all within three weeks that, and drunk a copious quantity of alcohol that we noticed that the first significant down train from there, but we're just approaching our three year anniversary in four weeks time. And he was given about a year from just before we met. So he believes, now that is absolutely fundamental, he believes, so do I, that fundamentally based on before and after every meeting that he is better. During the coronavirus pandemic or the serious lockdown, we didn't see him for seven weeks on his medical advice. And he went down rapidly. So we're not treating them MND, but with the treatment, whatever word you want to put in that he is able to function, hold up his head more.

Donald Francis:

The reason he, we started back during lockdown with him is that actually his breathing had descended into a bad state and one leg was functioning significantly poorer than the other. Interestingly enough, over the last few weeks I have to visit him in his home. And I looked like the people, the people who came to capture E T when I go in to see him. But over the last three weeks, we've managed to improve a significant amount of the function in his legs. Okay. So this led me on to another thing. I've got a few more with the publicity that came with Doddie Weir, and if you look on my YouTube channel, there's two videos of him, they're talking about chiropractic. And one of them had on Facebook over 150,000 views. That's attracted a lot of attention, a lot of people with MND and MS reached out to me from around the world.

Donald Francis:

A lady called Angela, you're going to see a video of her just now reached out to me. She'd had a MS, a very severe form of MS for 10 years by the time I met her two years ago, and she'd been a hundred percent wheelchair bound for five years. We met her in April 2018, and you're going to see a video, which she took in December, 2018 of her in effect walking. She came to me largely not expecting any miracles that because she wasn't a hell of a lot of pain. And she was just sort of extremely hopeful that we would be able to get help for pain, but we've actually managed to transform her life significantly. So just to get there, MND is always life ending. Of my MND patients several have died. No, there's no miracle. There's no, but even the ones who've died, one of them had been Mr. Scotland. He was an enormous man, very fat, he'd been in the Royal artillery like me, so we'd been both been on the same regimen at different times. And then by the time I met him, which was about six months before he died, he was very, very limited in anything.

Donald Francis:

But for about three or four months, his party trick was to come in on his wheelchair with his ventilator. And he walked up and he was able to do that for three or four months until eventually that it was too much. The MS is always much easier to uh, treat and we see much, faster, much longer lasting results with the treatment process. So we MS is life limiting. Most people can live with MS for up to 40 or more years. Their life just becomes progressively less functional

Steven:

Donald. Emily has sent in an observation and she says that it's interesting that you've mentioned now two fairly elite sort of sports people in terms of MND. She says that he's seeing a lot of MND patients who are also quite elite sportsman, are two correlated.?

Donald Francis:

So I hypothesize, I want to really put that in inverted comments that when, and there will be people listening here who have some cranial expertise. There are 31 bones, including our ossicles and everything else in our skull. They have an arrangement and a relationship with themselves and the neurology underneath. That when we have brain or, or a head trauma, now that can be at birth, I want to put that, you know, I've got a 29 year old MND patient that has no recollection of any head trauma, but her cranium is like a spine that doesn't move, it's like a, you know, if you're thinking about relative, it feels like a spine has AS or had Ankylosing spondylitis for years.

Donald Francis:

And so when we do the cranial adjustment, we're actually releasing membranes, predominantly the meninges or the Dural part of the meninges, and we're changing neurology. We're also then stimulating cerebral spinal fluid from the sacrum and in the kidney. I believe that there is potentially, I'm going to caveat myself from here to Christmas, okay, a link between brain or head injury and or pelvic injury, because if we can accept, and I believe with cranial osteopaths and chiropractors will, will, will agree with me that there is a late relationship between the respiratory function of the spine and the expansion and contraction of the skull. It is micro movement, not mat, it's not it's micro movement, but when you've got that that pliability in your hands, and you can feel the changes in the scale, you will understand what I mean. Doddie Weir played in an exhibition match in the last rugby world cup in Newcastle aged 45.

Donald Francis:

And he ended up with a massive contusion over his left sacroiliac joint. He was in a lot of pain and very restricted in his movement. No, I have no proof, but I hypothesize that combined with 67 Scotland matches, several barbarians matches, 500 professional ranches, British lions tour that he must have had many bangs to the head, as many do. Yeah. If the pelvis was stuck and his cranium was stuck, we not have complete CSF stasis. Now this isn't the cause of MND or MS, but I do think of cerebral spinal fluid is static that cerebral spinal fluid, I think is more important than many of our medical colleagues have, will recognize I've had many discussions with medical neurologists over the last three or four years about this. And our results are just too superb for them to comprehend, they can't understand how some funny little hand people, man get the results that we're getting.

Donald Francis:

What we're actually doing, I think, is stimulating the expansion and contraction, allowing the dura, and then the cranium to expand and contract and the function of the, of the sacrum allowing CSF to move up and move and down the spine. This in affect allows the CSF to shunt around, meaning that when CSF is static, the ionic, the concentration of the CSF along the central nervous system becomes very concentrated. And one of CSF functions is to allow the diffusion and osmosis of fluid and particles across the blood brain barrier. If that concentration of CSF is allowed to get out of an optimal state that trophic, and that's a really important word, but that trophic function at the peripheral, at the periphery of the CNS, isn't able to function. And therefore, if you're, if any part of the body isn't able to feed itself properly, it further degrades.

Donald Francis:

So when we do the adjustment would be predominantly cranial adjustment to expand, or to allow the, the structures within the skull to allow that to expand and contract within doing some pelvic adjustments predominantly that doesn't, I have to say in chiropractic, we use the word diversified, this would be a manual adjustment. Well, what'd, you guys might call it a manipulation of a specific segment. People with MND particularly, and MS have lost a lot of the muscles they might use something like this activator to put a neurological input to particular segment. But in, in principle, we're doing cranial, well cranial adjustment, intro orally, predominantly and other cranial adjustments and, and psycho stimulation. And this is the same for MND and MS. MND really noticed the difference, but there is a, there is a much shorter lag so they might get two to three days benefit per adjustment, whereas someone with MS will really notice an improvement for up to two weeks.

Donald Francis:

MS, we've seen some massive bounce backs. We've seen people be able to take their catheters out because they're able to control the bladder themselves. We don't get any results like that with MND, MND is a one way street. All I think we've been able to do with MND particularly is put some serious speed bumps on the way. With MS we've actually been able to reverse some of the symptoms and just because just for shits and giggles, excuse my French, I was, I got excited about this because we're having some really nice effects with some serious neurological problems. I managed to get a hold of some Parkinson's patients and actually found that we had some really good results. And I believe using the same principle with Parkinson's, I would say that the more they are reliant on the dopamine, the less effective the manual treatment is.

Steven:

I suppose this all of course begs the question, doesn't it, Donald, we're never going to get this accepted by mainstream medicine, and somebodies already sent in a, a question about this, unless we get this into a format that they will recognize and published in a peer reviewed paper, where do we stand in getting the, your sort of results into the mainstream?

Donald Francis:

So, I live and practice in rural Scotland. I mean, you know, I'm in the middle of nowhere, we're very fortunate that we have a hospital nearby. I have met some of the neurologists and they've been kind enough to at least give me an audience. And, but one of them, you know, I sat there with his arms crossed, I, I have postgraduate qualifications in neurology. And actually my daily use of neurology is probably more current than many of theirs. Doddie has offered a significant part of that 7 million pounds that he's raised and unspecified amount, if we can come up with research too, to do it. Now, I'm not a researcher. I'm a, I love clinical practice. I have thought about how this might, but I don't know how to measure what's going on. And if anybody here is listening and would like to partner in something like that, I am not a researcher. But the money is there. The will is there. And he, I think he'll live a year or so more. I don't know. I wouldn't like to predict that he's certainly going to be around a bit. And he's really excited about that. What, I'm sorry about he's one of, he's become, he's the only person in the world I've spent as much time with, apart from my wife over the last three years, and this is not, we see him, outside COVID, I see him twice a week.

Donald Francis:

And you know, he's two years past his expected last span already. And he will in private, put, lay all of that down to chiropractic. Now he blamed, he lays it on my feet, not at chiropractic speed, which is wrong. I believe somebody else with the, a similar skill set or certainly intention set would achieve similar results. But there is money there. If somebody could design a trial, one of the problems I find is that I'm so rural that there are only six active MND patients within about 30 miles of me now. And I'm seeing three of them, four of them at the moment. That's not a very large patient population.

Steven:

You've got a very active lady in chiropractic research, based down in Swansea I think, and her name escapes me for the moment, Elizabeth Angia I think is her name. Is she not keen to take up this mantel?

New Speaker:

Um yeah, I've spoken to Liz, cause you were sitting next to McTimoney do actually, we've been in touch. We need to, we you're right. We do need to sort it out. I'd love somebody else. If somebody, my problem is Steven, I'm a clinician raising, paying a mortgage. I've started I've, I've thrown it out there. I have the preliminary groundwork set for a pilot study on MS. MS has a much bigger population. We've got a population of over 50 MS patients on the borders. But then I find it extraordinary that there is actually so much resistance from our cousins within the medical professionals. Particularly I'm not picking on anybody, you know, there is a dedicated physiotherapist within our local hospital who deals with MS patients and he's incredibly resistant, not a hundred percent sure why, but we'll show you in a minute some of the results we'll have. Yeah. So in terms of research, I'd love to go forward with it. I'm in Scotland, the only technique or methods that I have, or can say that I have any experience with are the ones I've used. I will, I'll happily expand that knowledge for anybody who wants to learn it. But we, I think we do need somebody with a, with a, with a, with a research background and a research bent to, to give us a hand the, I don't have that sort of like. You know, I was in the artillery. I was in a grid square removals, not, not sniper precision.

Steven:

Okay. Can I ask a few questions from the audience before we move on, Alvina's asked, have you found the same cranial restrictions in people with MS and do you have a hypothesis for the cause of this, as MS is not necessarily associated with trauma, like the elite sportsman when we've talked about?

Donald Francis:

Okay. The answer is Albina. I use a cranial technique called cranial facial dynamics in principle, as well as the cranial work that I have learned through other chiropractic methods. But in principle, I find that there is a Dural talk in almost everybody I come across. And the extent of that is, depends on, has an effect on the symptoms that's for sure. Have they had a cranial injury and they, the answer is they can't always put their mind back to one. However, I will say that I think birth in itself can be quite a traumatic and cranial injury. One of my non MND and non-MS patients who I'm seeing now with great results for musculoskeletal issues, what he's come to me for. When you look back in his history, he was a bed wetter until he was 14, he was a toe walker. And I associate all of these with the neurology that I understand as being the torsion of the meninges or the dura, based

on the sphenoid. No, listen for those people for whom I'm speaking Egyptian, um the sphenoid is the bone in the middle of your head here and if you look at any skull and I've looked at hundreds, you will find, if you cut the top of the head off, you cut the cover area off, and you look at that skull, you're going to see the sphenoid is posterior on the left and anterior on the right, prove me wrong, I would love you to. This is what in effect causes a torsion, which is going to give us many of our patients are high left shoulder, a high right skull and that three dimensional torsion, whether you've got MND, MS, Parkinson's, plantar fasciitis, that will be present how it then comes out on symptoms is different. So we're not actually treating the disease, but we will identify that if we change the Dural tension within the skull and the Dural tension, I use the word Dural, it's the outer layer of the meninges, tension in the pelvis and stimulate CSF, regardless of what else we do, we have observed some pretty fantastic phenomena. And it's, I don't, it's really that simple. It's really that simple. Yeah, it really, it really is.

Steven:

Yeah. Solay has asked the question, Solay I hope I'm not pronouncing your name correctly. The evolution of the disease when beginning in the legs apparently is different from when it begins in the hands. Do you treat differently according to that?

Donald Francis:

No, you don't.

Steven:

Okay. Um Alan has asked whether your adjustments also address the foramen Magnum.

Donald Francis:

Yes, they can do, but only from the perspective. Yeah, no. So listen, if I'm doing a... The foramen Magnum is just a hole in a piece of bone, more importantly to the foramen Magnum are the structures that come through it, obviously the spinal cord, but the spinal cord, it has the largest pliability of Dural membranes for that space. So, I'm to, I've used that word, Dural, Dural, Dural all the time. You know, the, the branch of chiropractic that I practice Sacro occipital technique is, is specific in its understanding and its appreciation of Dural. I do address that space, the cranial adjustments that I do, which act predominantly through the leavers of the hamulus or the pterygoid plates that come down into the skull, do release the Dural. And then we also look at various other Dural releases and your neurological releases either through a manipulator or an adjusting approach at Atlas and axis and the occiput, if we're going outside. But we do look at releasing torsion within, or let's call it tension or tone within the Dural. And I would like, I think the Dural is neurological fascia. I, I think there's a massive relationship between a body fascia or somatic fascia and Dural fascia, the one follows the other. So if you get the Dural fascia right, the somatic fascia follows.

Steven:

Yeah. Carrie's asked whether these Dural cranial sacral findings that you you've mentioned are unique to your MND, MS patients or do you find the same thing in others?

Donald Francis:

No, I would. So let's just what I think happens is I think chiropractic's talk about a term subluxation listen.

Donald Francis:

Okay.

Donald Francis:

Samantha, I apologize very much for what I'm about to say, but if you push a watermelon down a hosepipe, you're going to have a serious effect on it, but birth can be really traumatic. And yes, if you look at a hundred skulls, you're going to find that the sphenoid, is posterior on the left hand side and anterior and lift, not only the sphenoid but the entire petrosal, petrosal portion of the temporal bone, the whole thing has shifted. My mentor, Dr. John Hart, when you design and develop the cranial technique that I use predominantly, alongside the rest of my chiropractic came to this conclusion, but we came to it separately. We now think that it's to do with hydrostatic pressure to a large extent. If you think about the Dural venous sinuses, the superior Dural venous sinus is massive and it drains most of the CSF and most of the central nervous system, and this all drains into the right sigmoid sinus and down into the right side so that the hydrostatic pressure on the right hand side is much greater than the left hand side. And if you look at a skull, you will see that you'll see that the sigmoid sinus on the right hand side is much larger than the one on the left hand side. This is because the inferior sagittal sinus, which has a very small vein in effect, right at the inferior part of the falks Cerebro, that is very small, it's much smaller in size and volume, and that drains down the left hand side, meaning that the hydrostatic pressure inside the skull is much lower on the left hand side. And this is what we think causes the torsion. And it's probably normal and in a natural homeostatic balance until something interferes with that. Call it birth trauma, call it a knock on the head as a child, maybe even as an adult, we don't know where these traumas come in. If those traumas then overlay the original torsion, which is natural it seems, if that is the way our structure are, then we end up. So with a torsion that I'm talking about, I do see in newborns. My youngest patient at the moment is four weeks old. He's got colic. It's the same pattern, it just affects us all and how the neurology therefore expresses it through the symptoms.

Steven:

We had one from Allister, who asks you about the glymphatic system. And he's mentioned there's research from an article in 2012 on its effect on amyloid beta. Is that, does that relate to what you do? Or are you aware of that?

Donald Francis:

Yeah, you're much clearer than me because it's something I don't know much about, I apologize. Okay. But I'm going to learn, I'm going to write it down. I'm going to learn, I'm going to, I'm going to learn about that. If you find me on Facebook, I'd love a I'm on Facebook. I'd love to chat about that.

Steven:

I'll certainly make sure that the two of you were put in touch. Do you want to move on and and show us your effects with your MS patients?

Donald Francis:

Yeah. So in in the spring of 2018 Doddie Weir and I had been together for about eight months and, and he, and yeah, there, I say his neurologist, but his neurologist through very gritted teeth and says, Oh, you know, everybody, there are always exceptions. There are always exceptions but we're quite

impressed. And then he went through that, you know, then, then his life and his work, his charity work and everything took over. And I, I do feel that the outside effects of his life, the stressors increased significantly on where they had been, which, which did make some changes. We'd had about eight months of pretty steady, I wouldn't say progress, but we had had some improvements in the power in his arms. Now, listen, that was not improvement in his MND, that was improvement in the power in his arms, maybe they would have improved with normal treatment anyway.

Donald Francis:

And he did a Facebook live for me, which was very kind. And like I said, it was seen over a hundred thousand times around the world. And a young lady called Angela reached out to me. By this stage, Angela was 39 and she had been in a wheelchair for five years. A lot of pain. Yeah. Five years previously, 34, 35, she got into hospital with pain. She was self-ambulatory at that point. And she had MS, quite a severe MS, but she had, she was in charge of her life and the hospital with all of their care and attention kept a supine on her back for seven weeks. And unfortunately her pain didn't go, but her life did. And she, she left the hospital in the wheelchair and never moved. When I met her in the spring, April of 2018, she had a little bit of movement of her right hand. And she was able to propel herself around and electric wheelchair, but she couldn't transfer from bed. She couldn't even turn over in bed actually. She's fully, she's fully catheterized. And she relied on my care package, which we're very fortunate here in Scotland, where carers came four times a day, woke her up, put it a bit, but she would lie on the position. She was put into bed in which she was put into bed.

Donald Francis:

She'd lost all control of her bodily ability to look after herself, even her own feminine hygiene had to be done by somebody else. When she came to see me, what she really wanted was an abatement of the pain. I actually think that Dural torsion we're talking about can end up being very tight within the sacral area. I think, I hypothesize, I do not say definitely, I think that can lead on to, so why, why some children, why some children have bed wetting, but that is merely a sign, it can cause a hell of a lot of pain that mimics sciatica because it's Dural pain and it has effect on the neurology there, it mimics sciatica, but when you MRI them, there's nothing structurally to see just that torsion of the Dural. Anyway, she turned up, she comes three hours each way from the other side of Scotland in Dumfries and Galloway two and a half hours each way.

Donald Francis:

So it's a pretty big effort. And she was only able to come once a week for about six weeks. But over that month, we began to see some changes first and foremost, almost immediately from that first treatment or adjustment her pain improved significantly. Within about three adjustments, she was actually able to turn over in bed, this helped her tremendously because the decubitus nature of not being able to move means that you're gonna end up with stasis of your limbs and all sorts of other things. So this some improved her comfort levels and pain levels. Anyway, cut a long story short. We began to notice more and more improvement soon. She was actually able not only to turn over in bed, but she was able to get out of bed and transfer to a wheelchair, which meant that she was able to actually take us off to the bathroom in the middle of the night, which meant that she was actually able for the first time in five years, not to go to bed in a nappy, which was a great improvement in their quality of life.

Donald Francis:

She was actually able to remove our hands enough so that she was able to take care of her own feminine hygiene. Now, I think for any ladies listening, I think that is massive improvement in your quality of life, but the absolute listen, we've seen continued improvements over the next two years, but on the 4th of December, 2018, she came to see me and it was a Tuesday. I remember very clearly. She was beaming all across her face. She came in on her wheelchair, but you had a lot more vitality about her by that stage. And she said, before you even talk to me, you're going to watch this video. And it's the video we're about to show her. And she'd felt after five years and six months in a wheelchair that she said to her carer please, would you just take a video because I feel I need to stand up and walk. I've got it. And she's done it. And she hasn't stopped walking. Listen, it tires her up tremendously. So she still spends quite a lot of time in a wheelchair day to day. But around her house now she uses crutches because of various psychological problems. You'll see how skinny she is. There are, there is an eating disorder underlying here, which does complicate issues. But on the 4th of December, 2018, she showed me the video. You're about to see. And this was the first time she'd actually ambulated in 65 months.

Steven:

Okay. Let's have a look at that.

Steven:

That's quite impressive, Donald. I suppose that the conventional medics question would be, how often would you expect to see that sort of remission naturally in MS.

Donald Francis:

I don't know. We haven't seen enough of them actually. Haven't seen enough people. MS has got many, one of my MS patients, Jenny I've seen Jenny for eight years, you know, predominantly it was for migraine headaches and back pain. And, and we see her a minimum of every four weeks. This is a, this is a, what we worked out, just works out for her. I think more is better, but, but we can, that's a that's for another discussion. Jenny has a form of MS called relapsing and remitting. Now, just, it could be coincidence but she hasn't had a relapsing, she hasn't had relaxed is not the right word, relapsing and remitting. She has another relapse in eight years.

Donald Francis:

Now, that could be coincidence. Okay. That's what the medics call it. They're surprised, but she hasn't had a relapse in eight years. I think, I don't think it's coincidental. I think she's had neurological changes and I think the trophic effect of stimulating cerebral spinal fluid just allows the neurology just to function that slightly bit better. And if we look at it, I think a fundamental principle of osteopathy and chiropractic is that we all preprogrammed, in effect, to try and heal. It doesn't mean it happens, but we all preprogrammed to try and heal. So another MS patient as an example, Viv, Viv has had some serious brain trauma actually and she's had several cranial surgeries to remove problems there. But when I first met she was fully not fully catheterized, but she had to self-catheterize twice a day. She now doesn't have to do that.

Donald Francis:

You know? So the improvements aren't always uniform, which is very difficult when you're trying to prove something, but we have various tests. We do a neurological tests and vitalistic we were

looking at so this just lift my head, look, look at looking at the autonomic nervous system. And we've seen significant improvements in all of that. So we must really separate the fact from we're not treating the disease. All we are doing is changing neurology and stimulating improvements in neurological function. That is all we're doing. All of the improvements are as a result of the body's own ability to function better with better neurology. If that makes sense. No, I haven't met enough patients. I live in, I live in work in the Scottish borders. We are one of the world lowest, we are one of Britain's lowest population density areas.

Donald Francis:

So just for people to get here is quite difficult. I have aspirations of, of seeing more. I have a, I have a database we collated just before the Corona lockdown for a trial on MS that we're hoping to conduct, but the, the symptoms and the health care of all of those people is so different that all our, all we can do is for this pilot study is identify improvements that we can measure. We can't, because everybody is so different. So if anybody has a research background, I'd love to hear from you because I'm not that eagle eyed ant at getting all those little details, right that you need really, to prove and help us.

Steven:

Just very quickly Donald, Amanda has asked how often you were treating these patients. You said, I think you said twice a week for Doddie Weir. What about your MS patients?

Donald Francis:

Okay. So about every two weeks at the moment for most of them. This is not always in the best interests of the patient clinically. It just is where, where we are geographically. Located to a large extent also, financially I am in private healthcare. Now, I will admit that for a lot of my patients who have terminal illnesses, you can't work. We do some significant financial, we offer some significant financial help, but because of the number of these people I see now, I would be at a pretty severe financial disadvantage if I didn't charge them. But the answer is with MND, you almost couldn't see them enough twice a week is, is, is, is great. During Corona, we've been able to see Doddie once a week and I can really feel the difference in his tone, and he notices a difference. So, if you're in research and it's not a word that I would use, you're looking at something, they call a dose response. We haven't worked that out yet. That's primarily because we, that whilst we have seen some phenomenal results amongst a decent size of population, we are, we are limited geographically where we are to how many people we can see.

Steven:

That's useful. We're nearly out of time, um Donald, as we always are so quickly, and there's this, there's a forest of virtual hands up in the in the audience wanting to ask questions. And we're gonna ask you a couple more. Frank has said that he has a patient with a family history of deaths from ALS. And this patient is experiencing very early stages of the disease with no formal diagnosis. Caught early enough, how effective do you think your treatment could be in, and I have to say, in improving her quality of life? Because as you said, you don't treat the disease.

Donald Francis:

Yeah. I think the earlier the better, if my hypothesis is right, that we are stimulating CSF flow and neurological changes, the healthier you keep anything, even, you know, the healthier you can, the

better. If you think about the trophic nature of what we're talking about, as well as the neurologic nature, the better the food, the better the oxygen, the better everything else gets, the healthier one is, the more chance they have in their vitality. Because of, because I believe there is a trophic element to what we're doing on the central nervous system, the earlier you get going and dare I say, the more regular and close together they are, I think every three to five days is probably optimal, but I, I, I don't have enough of a population to be specific on that.

Steven:

Okay. Thank you for that. I'm sorry. My slides have just gone bizarre on me. We had an interesting comment in, from Samantha who asked a question earlier on, she says that she's actually pregnant and your watermelon hose pipe analogy is hardly comforting, but thank you anyway,

Donald Francis:

I'm sorry. But I see a lot of really see a lot of very damaged children.

Steven:

And the final one from Elizabeth, she says, does the MND association know that you've got access to these funds, courtesy of Doddie Weir and are they interested in promoting the research?

Donald Francis:

This is a very politically laced question. No the MND association and Doddie aren't, Doddie is in good terms with the English association, but not the Scottish. One of the problems with charities is they exist almost on a subliminal level as a business. Yeah. Listen, we can talk about that one offline anytime, but yeah, there are some issues there.

Steven:

Well, Donald, thanks for giving up your time. As you know, I'd rather have had you in the studio for one of our 90 minutes sessions and the volume of questions suggests that we've probably barely had time for one of those either. Really kind of you to give up your

Donald Francis:

It's a pleasure, it's my favourite topic so I'll talk about it anytime.

Steven:

It's a fascinating topic. And you know, when I've seen you presenting on this, you're even more convincing and more dynamic and even more excited about the improvements in quality of life that you are bringing some people who've got some pretty bleak futures ahead of them.

Donald Francis:

Well, let's hope if we, if we, you know, one a trickle can become a flood, then that would be great because then we really will get some traction.