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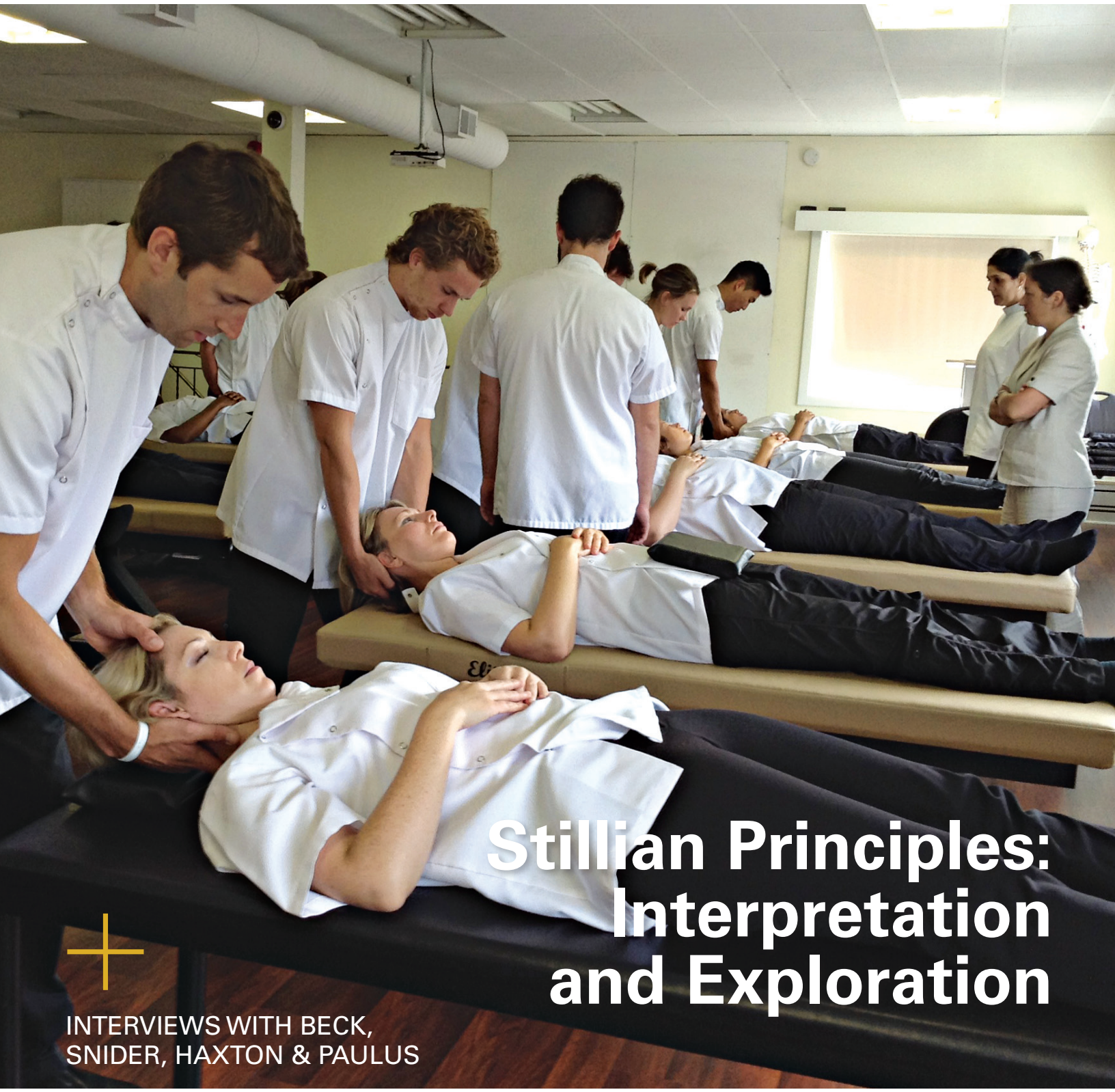

Stillian Principles: Interpretation and Exploration

+ INTERVIEWS WITH BECK, SNIDER, HAXTON & PAULUS

Editorial

By: Adam Doris

The Experimental Stage: An Editorial

This is written in response to the editorial entitled Osteopathy that was taken from The Osteopathic Physician published in December 1898. It was extracted and written on for the purposes of the Canadian Journal of Osteopathy.

Osteopathy was said to be in it's experimental stage in 1898, and in many ways it still is. The founder set forth principles of Osteopathy as guidelines to be explored and progressed. He has proven this by his encouragement to his students to continue to study the anatomy and physiology as he requested Hugh Russell to join him for feedback on his book Research and Practice.

Still wrote and spoke in a very prophetic way, that in many ways was simple language that everyone of the time could understand. He forged the paradigm shift of the doctor being the one to look for health rather than disease. It was with this ideology and his principles that the art and science of Osteopathy must always be progressive and experimental.

The Stillian approach can be as simple as 'Find it. Fix it. Leave it alone.' The Osteopath must always be furthering their knowledge of anatomy, physiology, and mechanics, to be integrated with their thought process to continue to the progression of Osteopathic diagnosis and treatment.

"Osteopathy." Editorial. The Osteopathic Physician 1.2 (1898): 41. Still National Osteopathic Museum. Web. 30 Oct. 2014

Will Osteopathy be permanent?

The following article was written as a summary and response to the article 'Will Osteopathy be permanent?' that was originally published in the Osteopathic Physician in May 1899.

In the 21st century, Osteopathy falls under the umbrella of holistic therapy. It can be confused with and an adjunct to other modalities and therapies.

Osteopathy had very humble beginnings. It was launched in a very small way to the people of Missouri, with no one of fame or wealth to advertise or further the popularity of it. By the powerful treatments of the skilled operators, it quickly made it's way to the forefront of the healing sciences. It has convinced the world under it's own merit.

The rationality of treatment is simple and understood by many. All healing arts have roots filled with doubt, but Osteopathy has stood the test of time as it marks it 140th year last June. AT Still did not necessarily know more than other scholars at the time, but he did know something different and that is what set him apart from everyone else.

The look at the body functionally has allowed the Osteopath to seek truth. The vast amount of anatomy and physiology. Looking at the network of electricity and how impingement from strain will have adverse affect in the body and be a cause for disease. That is what will make Osteopathy a permanent fixture in healthcare.

"Will Osteopathy be Permanent?" The Osteopathic Physician 1.7 (1899): 153. Still National Osteopathic Museum. Web. 24 Oct. 2014.

Spinal Origins of Disease

This article is an interpretation of the original writing in the Osteopathic Physician entitled 'Spinal Origins of Disease.' It is an interpretation of the works that were published in 1898.

There are many problems that will start in the spine. The spine protects the spinal cord, from which all of our innervations passes through. The immense amount of nervous tissue that passes through dictates that there needs to be elasticity in the spine to allow for proper motion. The muscles need to be in proper position to allow for this motion to occur. If there is tonicity on the intrinsic muscles of the back it will impinge the control mechanisms of the body. The operator must then see to remove the obstruction for proper function of the nervous tissue.

The change in the musculature can come from any injury that has occurred, be it traumatic or the resultant of a cold. The instrinic muscles will lead cause a change to the thoracic cage compliance because of their origin and insertion from the spine to the ribs. The different fields in the spine (i.e heart, kidney, etc.,) will change their respective organs with a pathological reflex loop.

The spine is involved in all lesion patterns because of the afferent/efferent relationship with the affected area. All of the sensory innervations must go back to the central nervous system to evoke an efferent response. Therefore, the spine is not always the origin for the disease but will play a factor in the maintenance of the disease. It is important to recognize the how influential the spine is in osteopathic care, but also how much information it has to interpret and respond too.

The perversion in the reflex loop will change how the efferent loop occurs, meaning the spine may not have been the origin of the disease – it could have come from any part of the body – but the spinal cord and the spinal column will hold the lesion in the spine. Detection of the somatic dysfunction can start at the spinal level, but will need to be explored through the lengths of the entire body so that the cause and effect will be solved.

"Spinal Origins of Disease." Osteopathic Physician 1.2 (1898): 28-29. Still National Osteopathic Museum. Web. 24 Oct. 2014.

Under Investigation (Explorations of Applications)

At the current time there are quite a few members of the CICO taking a very close look at indirect methodologies in treatment and utilizing them to great success. Not only is this useful in pushing forth the science of Osteopathy it is also useful in improving safe and effective patient outcomes. As patient safety is of the utmost importance indirect methods are of great interest as they do not directly challenge lesioned tissues. In not directly challenging lesioned tissues there is avoidance of possible tissue damage by an Operator who may not be as attentive as they need to be. Couple the safety of indirect methods with the reality that they work neuro-physiologically by removing the sensory information from the non-contractile tissue (fascial and ligamentous) to then alter the motor output to the contractile tissue (muscular) involved in the lesion. Specifically with respect to application the most profound results are being noted by going very hard on the indirect barrier which, as a working theoretical model, provides a myofascial release to the non-contractile tissue allowing further reduction in sensory information that will reflexively propagate the lesion through motor output to the contractile tissue (aka less "ouch" on the sensory side and less "keep it together" on the motor side). From this basic understanding of indirect methods it is possible to see that the specific techniques of Facilitated Positional Release, Strain Counter-Strain, and Ligamentous Articular Strain (LAS)/Balanced Ligamentous Tension (BLT) all work on the same proposed mechanisms.

As another point of interest related to patient safety and Osteopathic practice, having a strong indirect tool box allows Operators to stay away from legally protected acts in the form of articular cavitation. Not only does the current investigation in to indirect methods seem to be providing fabulous results it is also providing strong skills that are respectful of all laws governing manual therapeutics. Take this as an invitation to begin your own investigation in to indirect methods so that we as a profession can have an informed discussion, push the practice of Osteopathy, and improve ourselves and our patient outcomes.

What is the Science of Osteopathy?

The following article was written as a summary and response to the article 'What is the Science of Osteopathy?' that was originally published in the Osteopathic Physician in December 1898. This article is an interpretation of the original.

A. T. Still was a West Virginian man that was formerly an allopathic physician. He was in the State of Kansas when he acknowledged the inadequacy of the medical practices at the time. Still came up with the notion that a higher power has designed the perfect structure that is capable of living out its days without the use of drugs if the structure is kept in good repair. This is the foundation of mechanophysiology and mechanopathology.

The word osteopathy comes from *osteo* meaning bone, and *pathos* meaning suffering. This is commonly misconstrued as the pathology of bones – however, it is because of the structure that the bones provide for all of the other structures that are attached to it. The misplacement of bone that causes an obstruction of flow through the body that leads to irritation of the nerve flow and blood flow. This is based on the fact that the divine creator has designed the human being to the be perfect with the ability to self-heal and self regulate. Osteopathy used this as it's basis to start the healing and repairing abilities of the body.

The framework of the body (bony structure) houses the muscles, nerves, arteries, veins, and lymphatics. This is an arrangement that allows for health to take place. When all of the structures are in their correct position there is no friction to allow for disease to occur. The osteopath must be able to find the dysfunction, in order to remove the obstruction. Very simply put by Still as 'Find it. Fix it. Leave it alone.' This is an extremely brief synopsis of the philosophy and science of osteopathy, but it can leave the question: How does it work?

To understand how it works, the operator must go into the applied anatomy and physiology of the human body. Studying the normal anatomy to be able to detect the abnormal dysfunction. There are tens of thousands of structures in the body, all woven together in a network with great complexity. The osteopath utilizes this knowledge of anatomy and the ability to move joints, stretch or contract muscles to put everything back in its place. The nervous system controls everything in the body, sending sensory information to the brain and creating a response to the motor end but the nerves rely on blood supply. If there is a change to the blood supply there will be a weakening of the nerve supply as well. Thereby, the osteopath uses the principles to create space to allow the body to live and thrive.

"What is the Science of Osteopathy?" *The Osteopathic Physician* 1.2 (1898): 25. Web. 25 Oct. 2014.

Physical Therapy as an Aid to the Correction of the "Weak Foot" — With the Application of the Myogon Model

This article is has it basis from the article by Wm. P. Masterson, DO, entitled *Physical Therapy as an Aid to the Correction of "Weak Foot"* that was originally published in *The Osteopathic Physical Therapeutist.* The academics of the anatomy and the arches of the foot were taken from Thieme's *Atlas of Anatomy: General Anatomy and Musculoskeletal System* and Kuchera & Kuchera's *Osteopathic Principles in Practice,* respectively.

The weak foot is indicated by the change in the leverage that it can produce. This can be noted with laxity in the joint and loss of motion. To understand the weak foot, we must first inquire about the normal anatomy. The foot has two functions, it can be used as support for the rest of the body (passive) and to ambulate (dynamic.) The weak foot can be caused by the change in articulation that creates a change in the weight distribution through the arches.

The arches of the foot can be broken down into two main arches, the longitudinal and the transverse. The longitudinal can be divided again into the lateral (calcaneus, cuboid, and metarsals 4, 5,) and the medial (talus, navicular, three cuneiforms, metatarsals 1, 2, 3, and the calcaneus.) The longitudinal arches are supported by the tibialis posterior as the tendon attaches to the navicular bone. The transverse arch consists of cuboid, navicular, cuneiforms, and proximal metatarsal bones. It is supported by the fibularis longus and tibialis anterior. The muscles named are the main active supporters of the arches. Passively, the foot is supported by the plantar aponeurosis, long plantar ligament, short plantar ligament, and spring ligament.

In relation to the arches of the foot, it is also important to acknowledge and investigate through the subtalar and intertarsal joints. The subtalar is regarded as a shock absorber for impact during the gait cycle.

The gait cycle (walking cycle) has influence from the pelvis and lumbar spine because of their physiological motions. These joints can have motion preferences but are considered functional provided that the articulations come into to neutral position at the end of the cycle. The sacrum also moves through three axes of motion, and the innonimates rotate about a transverse axis. The strong muscles of the thigh (hamstrings and quadriceps) are important for the correction rotation through the innonimates. The weight of the body shifts from side to side with the motion of the pelvis and lumbar mechanics in an effort to maintain balance through ambulation. When there is somatic dysfunction in any of these joints that are involved in it will cause more energy output and a change in weight bearing down to the foot.

In *An Approach to General Treatment* (Johnston, 2014), he explains the myogon model that he developed from his reading of Still and Classical Osteopathy. Johnston discovered that hip dysfunctions were accompanied by opposite shoulder dysfunction that would set up a long diagonal torsion through the body. There are also vertical lines (anterior and posterior) that can set up pivots in the sagittal plane across the arches of the spine. In the development of the myogon model, Johnston discovered that all the current models were based on the concept of compensation. With this in mind, we must apply these concepts to the lower extremity.

The muscles listed above (fibularis longus, tibialis posterior, and tibialis anterior), all insert closely on the foot, setting up a mechanical triangle of force. With this in mind, it can be seen that the myogonal model can be applied here. The muscles that support the arches of the foot must be addressed in the case of weak foot. The balancing of these muscles involves the whole kinematic chain, from the lumbar spine to the distal phalanges of the foot.

The weight bearing from the whole body must be set over the pelvis, for proper mechanics of the gait cycle and passive support of the body. The anterior and posterior lines of the myogonal model can be noted with the tissues balance between the quadriceps and hamstrings. If there is somatic dysfunction in the large muscles of the thigh, it can set up a pivot point on the knee that will cause the body to pitch forward or backward and add improper stress through the foot arches.

Then, the operator must investigate the tibia, fibula, interosseous articulation, subtalar joint, intertarsal joints to reduce friction in the lower extremity. The operator can then address the soft tissues, muscles and ligaments, for balancing of the myogon in the lower extremity.

It is important to note that the lower extremity was focused on for this article, but it is imperative of the operator to look at the whole body because it is a dynamic unit. The cause of the weak foot can be from any dysfunction causing a change in the weight bearing of the body.

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Headaches

This article was written for the purposes of the Canadian Journal of Osteopathy (CJO). It is a summary of the originally written article entitled 'Headaches' It was first published in *The Osteopathic Physician,* The CJO has summarized and expanded on the thought process.

With rheumatic headaches, the pain of the headache is generally connected with pain on the scalp. There is very little to be said about the direct correlation with the symptomatic effects of the headache and where the actual dysfunction occurs, that's why the Osteopath must go deeper into the anatomy to find the lesion. When examining the whole body in the case of headaches, the Osteopath can look into the structure and function of the kidneys, as well as brain exhaustion.

The kidney field can become involved with the causation of headaches because of their function of removing toxins in the blood stream. When there is dysfunction through the kidney field, TL junction and lower myogon there is a lessened efficiency of separation of toxins in the blood to be removed that will lead to retention. In the cases of kidney dysfunction leading to headaches, the forehead is typically the most affected. Commonly the symptoms will arise with indigestion, constipation, and slow moving gastro-intestinal tract.

The kidneys main functions are in the urinary system – maintaining the ionic balance of blood, and excrete waste as urine products. The upper pole of the kidney is covered by the suprarenal gland meaning with renal dysfunction it possible and even probable there will be suprarenal involvement. Through the RAAS (Renin-angiotensin-aldosterone) system there is also the link hormonely between the kidneys and suprarenal glands. The increase in blood pressure is what causes the juxtaglomerular apparatus to release renin from the renal glands. The renin converts the angiotensinogen into angiotensin I.

Angiotensinogen is secreted by the liver and is an integral part of the RAAS. With the link of angiotensinogen the headaches from a kidney dysfunction now include the liver and diaphragm because of the direct connection via coronary ligament. Therefore, now the osteopath must investigate the kidney field, diaphragm, and liver to fully understand the kidney-caused headaches.

Angiotensin I is considered to be inactive and needs to be converted into angiotensinogen II with angiotensin converting enzyme that are produced in the lungs. The osteopathic lens has become even bigger when examining headaches because of the lung-involvement. Mechanically speaking the osteopath will not examine the thoracic spine, rib motion and sternum to ensure proper lung function for the completion of the RAAS. The suprarenals are involved hormonally from the RAAS system because of the angiotensin II binding to receptors on the intraglomerular mesangial cells that causes contraction of the cells along the vessel in order to release aldosterone.

The RAAS system will work to reduce the blood pressure and relieve the headaches. Causation of too much supply to the head must also be addressed in the osteopathic lesion. Drainage proceeds supply, in this case, that means that the osteopath should address the structure that supply and drain blood from the cranium. This includes but is not limited to the superior thoracic aperture, neck musculature, thoracic vertebrae (T1-4), lower cervical unit, upper cervical unit, and the sutures of the cranium.

The importance of looking through all of these fields is imperative because of the body working as a dynamic unit of function. However, there are infinite ways that headaches can be connected to the kidneys, this was just one avenue of exploration.

Headaches." *The Osteopathic Physician* 1.2 (1898): 31. Web. 28 Oct. 2014.

Musculoskeletal applications in cranial mechanics

By: Lee Jarvis

At the time of writing this article the movements of the cranial bones are considered to operate in isolation of the rest of the body by the majority of the Osteopathic community. As stated by Dr. Andrew Taylor Still, "The body is a dynamic unit of function", and the cranium being a part of the body is no exception to this unity. It is the goal of this article series to explore how musculoskeletal pull from outside the cranium influences the articulations of the cranial bones and the pressures created within the meninges, CSF, and brain.

The following mechanics are entirely theoretical and do not attempt to refute any other models of cranial movement. It is the intent of the author to demonstrate in simple terms that the cranium does not stand alone and requires the proper function of the rest of the body for its health as much the rest of the body requires the cranium.

Principles

When any muscle contracts the least fixed or most moveable attachment of that muscle will move. We call this most moving point the "insertion" and the other unmoving point(s) of attachment we call the "origin". Though the insertion of a muscle is said to be the moving point every point of attachment of a muscle can and will move to some degree when that muscle is contracted. Even though the movement of the muscular origin is most likely minimal it is still constantly occurring at every muscular attachment point and must be considered a vital part of the dynamic unit of the body.

All moving structures require a stable baseline for support to move in control and without damaging the

involved parts. The neck as an arch is supported by muscles and the cranium essentially floats on top of this arch. The upper portion of the thorax is heavily reinforced by strong bony attachments including the vertebra, ribs, and sternum. The upper thorax in this arrangement is the closest and most stable base to the neck and cranium and we can see this demonstrated anatomically in the way the muscles line the neck vertically and attach into the cranium from inferior to superior. These vertically oriented muscles are long and invest deeply both into the thorax, cranium, and neck, meaning that the movement of the head is moved by a pull originating from the thorax most often.

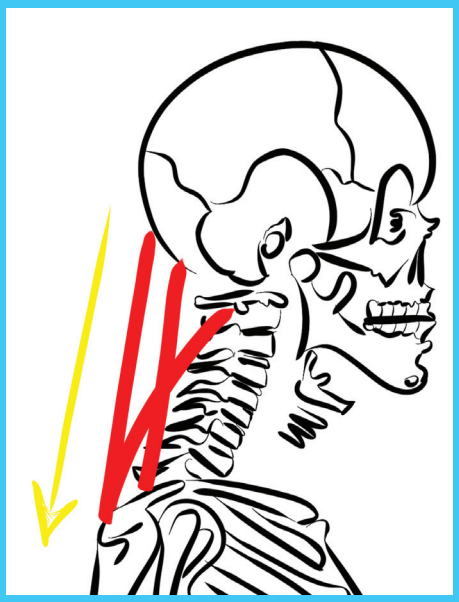
When the thoracic base of the neck is firmly in place it can through gentle muscular pull create and alter tension and movement in the bones of the cranium. These muscular pulls applied to the cranial bones will create immediate pull on the meninges as the Dura Mater is continuous with the inner periosteum of the skull. The meninges can then exert this same pull/tension on the brain and CNS itself as the pia mater of the meninges are the outer most layer of the brain and CNS.

Posterior Vertical Pull

The posterior muscles of the neck represent a largely vertical line of pull on the occipital bone. The trapezius, spinalis, longissimus, semispanlis, and sternocleidomastoid muscles all have a common relationship as they have a low attachment point in the thorax or low neck and insert into the occiput posterior to the foramen magnum. This means that the fibers of these muscles and therefore their direction of pull is vertical and on contraction the most posterior portion of the occiput can be drawn inferiorly.

The proposed axis of this motion of the occiput generated by the posterior neck muscles is transverse through the articular facets of C1 as this is the closest bony attachment and joint. Furthermore the OA joint is well set up for this motion as the condyles of the occiput can smoothly glide in numerous directions on C1 but with a particular "convex on convex" like shape that favours a transverse axis.

This inferior motion of the posterior portion of the occiput would have the reserve effect on the anterior portion of the occiput driving it superiorly making the entire unit a type 1 lever. These motions would put stretch/strain on the lambdoidal suture as well as the spheno-occipital articulation. From there the pull generated can be transferred to the dural venous sinuses and areas of the brain (of which the author would note the confluence of sinus and cavernous).



This force generated by the posterior muscles of the neck on the occiput would affect likely the flexion/extension mechanic of the occipital bone as seen in the Sutherland model of cranial mechanics. In this case if a lesion occurred in the posterior vertical muscles of the neck/cranium holding these in partial contraction or contracture it could prevent the normal flexion/extension mechanics of the occipital bone by limiting the posterior portion of the occipital bone from moving superiorly. As this motion is considered a component of the cerebrospinal fluid mechanism we could therefore say that the posterior neck muscles are vital to CSF flow.

It is of note that because the trapezius muscles have wide lateral attachment points on the spines of the scapula and acromion processes there is also an element of oblique pull that it can create.

For any cranial bone to move it has to change position relative to the bones that it articulates with it and create a change in tension (compression or decompression, shortening of tissues or lengthening) on its sutures. Therefore all of the proposed mechanics in this series of articles require partial resistance from other mechanics in the cranium. The current article will explained just one such mechanic and with follow up articles it is the author's hope that the necessary antagonistic and complimentary mechanics will become clear and that each of these have support systems in the neck and thorax.

Excerpt from The First Decade: A Personal Account on the Origins of the Canadian Academy of Osteopathy

As told by Robert Johnston, Principal

"My frontier experience was valuable to me in more ways than I can ever tell."

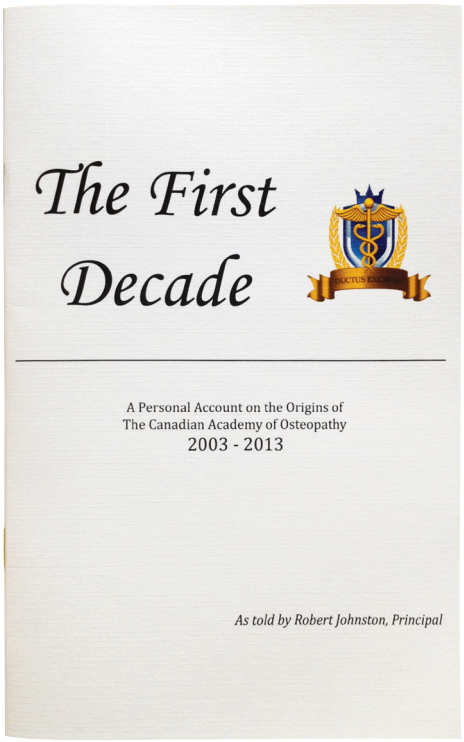
– Dr. Andrew Taylor Still's Autobiography

People need to know that I never came about this as trying to become some sort of corporate guru of an internationally-recognized osteopathic program. I actually came to all of this after having spent many, many years in professional manual therapy as an enthusiastic amateur.

When I was doing sports massage in Sweden I was doing it under the direction of physical therapists and I was learning, almost like an apprenticeship, how to do these things. I had studied many forms of manual therapy, from shiatsu to massage to many of the Asian forms of manual therapy, which is why I called myself a manual therapist, because I was so diverse in my interests. So when it came to Osteopathy, I came to it with the notion of improving my clinical skills with the idea that I would like to learn techniques in order to make my current practice a little easier. I started searching for an osteopathic school to go to.

I went to a school in Toronto very briefly and at that point in time, I had been receiving some treatment from Dr. Alfred Reid Johnston, a graduate of the Chicago College of Osteopathy. An elderly man at the time, well into his eighties, he treated in Waterdown above a used clothing store in a very non-descript, nothing-fancy-at-all office with two rooms. He worked alone there for almost his entire life, seeing patients, answering his own phones, and treating families. His brother is the chap that went on to make the functional technique so popular in the United States - William Johnston. He gave me some osteopathic care that was very enlightening. He treated me for a neck problem and a lumbar injury that I had actually faked, and then of course, he told me there was nothing wrong with my lumbar spine so I knew that he was an honest man.

I went back on several occasions to see if he would spend some time with me. When I brought back what I was learning at the school, he would shake his head and make comments like, 'the Osteopathy that I learned…', or 'that's not how we learned it…' As an American-trained osteopathic physician - a graduate of Chicago - I was comparing what he was doing for me to what I was being taught elsewhere. Of course, he never really spoke about Osteopathy - he was more interested in my previous hockey background than in discussing Osteopathy - he was obviously, from my perspective, at opposition with what he may have seen as the nouveau way of doing things. That's when I immediately recognized



that the school I was at wasn't what I was looking for - I wanted to treat like Dr. Johnston - and the formal education I was receiving seemed like a collection of techniques; not to mention, the learning environment wasn't comfortable for me. With all of this, not surprisingly, I ended up as a pre-osteopathic school dropout as I searched for where I could get the kind of education he received; I thought that if I wanted to treat like Dr. Johnston then I should go to the same place where he was trained. This began a journey that took me to the United States. Of course, at that point I hadn't yet recognized all of the changes that had happened in the United states as far as Osteopathy was concerned. Looking back, Dr. Johnston was the guy that set my world ablaze and had me wanting to know more about Osteopathy, because, really, I hadn't heard of it before then.

Online I had heard about a course that was being offered out of a Philadelphia suburb on muscle energy and I thought that would be pretty interesting. I took myself and Mr. Brandon Stevens, who was just a youngster at the time, and drove down to Philadelphia to take this course which was offered by an American osteopathic physician who had an interest in osteopathic manual medicine. Brandon and I spent two or three days and did a full body course, top to bottom, on muscle energy. We didn't understand a thing but we knew that by not understanding anything we recognized how insufficient our previous education had been. I remember I was sitting at lunch - I ordered a clubhouse sandwich - with Brandon sitting across the table.

"I need to start an osteopathic school in Canada because I need to learn Osteopathy," I said.

He did what Brandon always does: he just looked at me. Brandon is a guy that very often times doesn't say too much.

I continued, "I need to start an osteopathic school in Canada. I can't afford to be educated as an osteopath in the United States because, frankly, I don't have the money."

I was newly married at the time with a mortgage and all that accompanied it, so I couldn't afford to travel and learn Osteopathy. I doubted that I could even afford to go to the school in Toronto.

So I said to the chap that was running the muscle energy course, "Would you be interested in coming up north and teaching some Osteopathy in Canada?"

He jumped at the idea.

Sequencing With Charlie Beck D.O.

By: Samel Jarman

The third lecture event put on by the CICO was taught just the way we like it – from a principles standpoint! Dr. Beck came up from Indianapolis, Indiana. A student of Ed Stiles, D.O., Dr. Beck has his primary focus on ten fingered Osteopathy and being as efficient as possible in his manipulative methods. Through Dr. Stiles, Dr. Beck was introduced to a form of assessment that allowed for creating a hierarchy of diagnosis. This hierarchy of diagnosis is called sequencing.

So what messages that are useful were provided? Well there were three main ones that are beneficial for everyone that attended and everyone that is reading this article:

1. Diagnosis is what separates Osteopathy from all other forms of manual medicine.

2. A hierarchy of diagnosis will allow for more efficient work which is beneficial to patient outcomes as well as practitioner longevity.

3. It is of the utmost importance to re-diagnose after treatment is applied to assess for the success of the treatment chosen.

What follows will be a brief discussion of each point. With regards to diagnosis it is important to know what the criteria for diagnosis are. On the most basic level it is restriction of movement with the added parameters outlined by ARTS (or TART). Realistically what an Osteopathic Operator will find is through movement palpation. When there is a lack of movement noted then that is the criteria for further investigation and comparison against other areas. The diagnostic methodology that is applied generally by Osteopathic Operators in real time is the deciding factor when compared to other professions. The reality is that the functional anatomy and how it is actually functioning is what will determine whether treatment is needed and what type of treatment is called for. The underlying thought process is binary and the question is "movement yes or no?" In other professions the diagnosis is either static or non-existent.

With regards to the second point regarding a hierarchy of diagnosis, the message is that of primary/secondary/tertiary lesioning. While Dr. Beck did not present those terms they are written as a translation to terms commonly understood and used within the membership of the CICO. What Dr. Beck did present was to find the area of greatest movement restriction (primary lesion) after a general diagnosis of the body, go to the area of greatest restriction and further find the greatest point of restriction within the area, and then apply treatment followed by re-diagnosis. The goal is to find the greatest restriction and apply treatment in the attempt to have just one treatment application correct as many problems as possible. When re-diagnosing the same process is followed until either the patient is fixed, time has run out, or the patient is resisting treatment (as judged through palpation). Again, to use language common to the CICO membership, what Dr. Beck is telling us is to do a global/local/focal diagnosis, apply treatment, and then repeat the process. By employing this process or a process similar to it then the patient has less treatment applied to them and by applying less treatment the practitioner experiences much less exertion which will pave the road for a long career.

We have already touched on the importance of re-diagnosis and we will walk through it a bit more. Within the sequencing model as presented by Dr. Beck the goal is to determine the order of treatment and when treatment is done. It is a very straightforward system that does not suggest treatment methods, the patient's condition and the nature of the lesion suggests treatment. The application of re-diagnosis will allow for confirmation or rejection of whether the treatment application was appropriate as the lesion will have either changed or not changed. If treatment application was successful and the re-diagnosis shows the need for further treatment then it is applied.

Looking through these three big messages should provide the general CICO membership with two things:

1. A direct understanding of the fact that your training is based on the same principles as were presented by Dr. Beck – global/local/focal diagnosis, treat appropriately, re-diagnose, next treatment application or the treatment is finished.

2. Efficiency and effectiveness are very important guides for the sake of the practitioner and the patient.

As with all of our international colleagues that are kind enough to present their takes on our profession it is with great appreciation that Dr. Beck provided the CICO with the opportunity to hear his message! It is also positive to see that our principles based approach exists elsewhere (with variation) and has come directly down through generations from the early ASO (as is the case with George Laughlin Jr. educating Dr. Stiles and then passing to Dr. Beck). Keep the principles primary!

Interview

By: Adam Doris

Charles Beck, DO graduated from the Pikeville College School of Osteopathic Medicine, after staying for an extra year to learn manual manipulation more in-depth. On September 6th and 7th, Dr. Charles Beck presented a lecture on Sequencing: The Art of Finding the Key. The CICO Journal had the opportunity to discuss osteopathy with him.

1. What made you choose osteopathic medicine?

Divine intervention. After finishing my undergraduate in Pre-Med, I met a retired cardio-thoracic surgeon who was also on the admissions committee at Michigan State. The surgeon told me that I just wasn't the candidate that the MD's were looking for, but asked if I had looked into Osteopathy. After hearing about what Osteopathy was, and how he described it, it made a lot of sense and that's how I started down that path.

2. Is it difficult teaching OMM to medical students? Are they interested in it?

It can be hard if you make it that way. But no, medical students are a blank slate. You have to be clear in what you're trying to present so it can be really easy. They're enthralled by the idea of OMM, as you go on about how to weave osteopathy and medicine together, nearly everybody is a convert. The students recognize how you can use osteopathy as a part of you practice. Osteopathy has a fit in what they do whether they're a surgeon or a psychiatrist, it can be a tool used on a regular basis. The people I've taught tend to use it.

3. Where do you see osteopathic research going?

It's starting towards an evidence-based research. If there is a way to standardize the assessment and the treatment of the patient, which then reflects a more true outcome of osteopathic treatment, then research can be great. However, the same complaint can have two different key lesions. In my personal experience, when I was in my third year of medical school we had a clinic with Dr. Stiles and saw patients once a week. Dr.Stiles would come in and screen them and pick his key lesion, then we [students] would come in to screen them and pick our key lesion. Most of the time, they matched. One day, Dr.Stiles came in and screened the patient and found his key lesion, then I picked a different place as my key lesion. We were both pretty clear that what we were feeling was right, so he set me up for a fall and let me go ahead and treat my area. So I went ahead and treated, and after I felt my patient to see that it was good. Stiles came back to screen his area and saw that his area was better too. We both learned that day that if we all stick with one layer we should be finding the same lesion, but if we mix in layers we may palpate something differently though because we treat the key that we palpated, it results in a similar outcome.

4. Do you think Dr. Still's writings are still relevant to current OMM practice and instruction?

He didn't write them to be otherwise. There's no expiration date. He told us what he felt and how he believed it was interconnected in the anatomy, and here are the guiding principles. Still didn't say this was it, he encouraged us to keep searching.

Know Your "Routes" Jason Haxton Review

By: Samel Jarman

The CICO was treated to a day with our history when Jason Haxton brought an exhibit from the Museum of Osteopathic Medicine in Kirksville, Missouri. As a group we are keenly interested in the principles as laid down by Dr. Still and Mr. Haxton is the most knowledgeable person about the Old Doctor as well as the history of the profession in general.

The exhibit itself included artifacts that belonged directly to Dr. Still as well as pieces that related to the Canadian presence at the American School of Osteopathy (now the Kirksville College of Osteopathic Medicine) from its inception up to 1990. Initially the Canadian students would often join the British Society to stay close to their fellows from the Commonwealth. The Commonwealth generally had a presence as there would often be students from England and even some from New Zealand. There have been Canadian legacy families including the Jaquith's and the Johnston's. The interesting thing about the Johnston family is that Eric Johnston was treated by a D.O. from Michigan for pneumonia which prompted him to enroll at the American School of Osteopathy and his work inspired his nephews, Alfred and William, to eventually enroll at the Chicago College of Osteopathic Medicine. William did his work on Functional Technique and Alfred practiced in Hamilton and was eventually the first Osteopathic Physician to treat the Principal of the Canadian Academy of Osteopathy, Robert Johnston (that is a lot of Johnston's!).

A very unique piece of information that we received was regarding Dr. Still and the Ontario Osteopathic Association. Apparently, after the formation of the original Ontario Osteopathic Association (the first in association in Ontario) in 1901, Dr. Still became an honorary member in 1907. It is very interesting that the current incarnation of the OOA is the only association in the world with members truly dedicated to the principles of Osteopathy as laid down by Dr. Still!

As always, Mr. Haxton used his boundless energy and charisma to relate stories about the Canadian involvement from the beginning of the profession as well as many tales of the discoverer of Osteopathy, Dr. Still. Mr. Haxton paid the members of the CICO a compliment by saying that speaking to us as a group is the place he feels most at home in his travels.

The most interesting part of the event was an exchange of gifts between Mr. Haxton (representing the Museum of Osteopathic Medicine) and the Canadian Academy of Osteopathy (represented by the Principal, Robert Johnston). Mr. Haxton presented the school with a uterine spoon (an implement used to reduce prolapse as invented by Dr. Still) as well as the Still family bellows which has been used by the family to start and manage their fires since Abram Still (the Old Doctor's father). The CAO presented the Museum of Osteopathic Medicine with a donation of $10,000 which, in combination with a $5,000 donation from the OOA and $500 from the CAO student council, came to a total donation of $15,500. Previous donations from the CAO have actually been used to create a new exhibit as well as to hire an intern to digitize historical Osteopathic literature and other resources that have been put online. Mr. Haxton told the members of the CICO that no other group has supported the Museum as much as the CAO and the OOA have already done and will continue to do. In the words of Robert Johnston, the work of the Museum is essential to the goals of the CICO in bringing the profession back to the principles of Dr. Still.

At the end of the day, the relationships between the Museum of Osteopathic Medicine, the CAO, the OOA, and the CICO became stronger and we all learned about the routes that connect us to the roots of the profession in the early days of the ASO and even Dr. Still himself.

Interview

By: Adam Doris

How did you become interested in osteopathy?

It really happened by accident, I was visiting the school that my wife has worked at for twenty-five years and one of the physicians walking past noticed that something in my neck wasn't quite right. I thought this was odd, because I didn't think there was a problem but sure enough he showed me the problem with my neck, an injury I had been aware of from eight years prior, and in two minutes he did a little adjustment, put the rib back in place and I could turn my head again. It was being a patient that made me a believer in Osteopathy. Since then my family has had DOs as family physicians, to help promote a healthy lifestyle. I entrusted the profession, and when the opportunity to become the museum director came up, I took it.

Its been quite fascinating to study Dr. Still because I started out thinking that he was a crazy old guy that may have had an idea or two, but as I've learned more about him, his idiosyncrasies and quirkiness, I think that he has a really good

grasp about what life is about. It's more than an image or medical treatment, it was a lifestyle. I'm really fortunate to get to share what I have discovered and being able to make the pieces of the man more readily available to everyone that's interested.

How does the museum fit into ATSU? And do you find that the students are interested in the history of osteopathy?

I do think that if you're in this profession that you're interested in it. I think the students at ATSU are interested but they are so busy with their curriculum, however, I do speak for different groups and programs and it is always well attended. The students are very proud of their heritage.

It's a pleasure for me to share all this information with people that have a different connection to Osteopathy, because after you learn about it how could you spend the rest of your life doing anything else?

How essential do you think it is to keep Still's writings in the progression of Osteopathy?

I think it is really important because Still is presenting a belief system and simple ideas that work with anyone. He was a man for all people, religions, genders and cultures.

He takes something that could be very complex and keeps it simple so that anyone can bring themselves in Osteopathy and add to it. There's a system to it but it's a very personal way of working so that you can present it.

If you look at his books, he would write one and be done with it. He didn't write more additions to the same thoughts. That is why Research and Practice is his best book because it should encompass everything. He asked Hugh Russell to look at his work for feedback, this shows how he trusted his best students for the development of Osteopathy.

Steve Paulus, DO Lecture in Review

By: Samel Jarman

October 18 and 19, 2014 saw the CICO members have the opportunity to learn from Steve Paulus, DO. Dr. Paulus has been in Osteopathy since he began his schooling in the profession in 1981 so he has a large amount of experience to draw from when sharing lessons with anyone in the profession.

As always with the CICO lecture series there is emphasis placed on the principles of Osteopathy as set forth by Dr. Still and we were presented with an interesting look at those principles. Dr. Paulus has actually scanned all of Dr. Still's books so that he was able to search them and he then used key word searches to collect the thoughts of Dr. Still in an effort to be able to write down the principles in a way that Dr. Still did not. This has brought some controversy to Dr. Paulus as some in the profession in America have mixed personal feelings on the work he has done. Leaving aside the controversy, Dr. Paulus actually welcomes discourse on his interpretation of the principles by emailing him to correspond with him and he will change his work through a collaborative effort (which he has done continuously since he wrote down his first ten collected principles that have now turned in to nineteen).

On the tables the CICO members in attendance were taken through discussions and palpatory exercises relating to what Dr. Paulus classifies as the material and non-material fields. The material fields are anatomical structures and the motions they present while the non-material fields are those that present some rhythmic sensation at varying frequencies that do not match standard rhythms of heart rate and respiration. Dr. Paulus presented the non-material fields in a very rational manner by stating that the non-material is not able to be separated from the material such that the solution may be one or the other in his framework (sometimes adjusting the coxo-femoral joint may be the only way to correct a cranial rhythm dysfunction). Along with stating there is no way to separate the material and non-material fields, Dr. Paulus also repeatedly said "any rate is great". The important thing about saying "any rate is great" is in the reality that all Operators will have different skill sets and sensitivities and some may never feel a cranial rhythm. It is also important to note that all rhythms are present all the time and the issue is not the Operator's ability to tune in to them, the issue is finding the Osteopathic lesion that is disrupting the non-material rhythms.

Dr. Paulus shared his understanding of Facilitated Positional Release as taught to him by Stanley Schiowitz (the individual who codified this form of indirect treatment). At this moment in time the indirect approaches as presented by Dr. Paulus fall nicely in line with the current framework that is being heavily investigated clinically by some members of the CICO with great results for patients. It is suggested that Dr. Still treated primarily indirectly later on in his progression through life as the discoverer of Osteopathy. Regardless of who has historically utilized any indirect work it seems safe to say that the proposed mechanisms of reducing afferent sensory impulses to concomitantly reduce motor output to a target tissue is both safe and effective.

The most important part of Dr. Paulus' lecture was his explanation of what he termed the "scientific method in Osteopathy". The basic idea of what Dr. Paulus presented was that an Osteopathic diagnosis leads the Operator to formulate a hypothesis, deliver an appropriate treatment based on that hypothesis, re-check the diagnosis, if the treatment was successful in producing the desired result then the hypothesis was proven correct, and if the treatment was not successful then the hypothesis was incorrect and the process will begin again. In terms familiar with the membership of the CICO this process would be check, treat, re-check. It must be noted by all members of the CICO that a proper diagnosis will include the location of the lesion, the tissue layer of the lesion, and whether or not the lesion is simply in the material anatomy or in the non-material rhythms within Dr. Paulus' framework.

As always it is an extremely enlightening experience to have one of our American colleagues share their thoughts and views on Osteopathy with us as members of the CICO community. With Dr. Paulus specifically it was quite nice to see that he is a very rational and reasonable practitioner who took a keen interest in attempting to bring to light some ordered view of what he found Dr. Still's principles to be. In the spirit of Dr. Still the members of the CICO were treated to an enlightening take on principles based Osteopathy and a warm thank you is extended to Dr. Paulus.

The Core Principles of Osteopathic Philosophy

Steve Paulus, DO, MS has been a practicing American Osteopath for over 25 years. He is a recognized historian and lectures all over the world on clinical philosophy and the teachings of the founder, Andrew Taylor Still.

Through his use of key words and compilation of Still quotes, he has

delineated the following nineteen core principles of osteopathy. However, these are an open document, he uses feedback from his lectures and website (www.OsteopathicHistory.com) to further the exploration of these principles. To contact him directly with comments, e-mail him at osteopathichistory@gmail.com

The Principles

1. Human beings function in a dynamic state of holism or what Andrew Taylor Still called 'connected oneness.' The Osteopathic approach unites the many structural and functional manifestations of oneness into an interconnected, communicating whole.

2. The body and psyche are interdependent and inseparable in disease and in health. Both have the ability to self-heal or to creatively compensate in the presence of disease, injury, or illness. Trusting the ability of the body and psyche to self-heal forms the foundation of Osteopathic clinical practice.

3. The relationship between structure and function impacts the overall health of the entire body. Structure (anatomy) and function (physiology) are independent and inseparable in disease and in health.

4. To fully understand abnormal conditions (disease, illness or injury) the structure and function of what is normal for human beings in general, and for each patient in particular, must be understood. Normal is an expression of health.

5. The objective in Osteopathic Treatment is not just to identify and treat disease, but also to find what is healthy and utilize the biologic field of health to actively engage a therapeutic process.

6. A precise anatomic diagnosis is made using hands-on palpation of the body. A detailed anatomic diagnosis is clinically relevant and utilized to design a patient-specific, dynamic Osteopathic Manipulative Treatment plan.

7. There are two distinct and interrelated ways of perceiving during Osteopathic diagnosis and treatment. The *material field* is tangible and contains the biomechanical elements that are formed by the palpable anatomy and physical functions that are objective and can be measured. The *non-material field* is invisible and refers to the subjective bioenergetic elements that underlie the material form. The non-material field is the expression of subtle functions or inherent forces. The material and non-material fields coexist simultaneously and are unified in a dynamic state of connect oneness.

8. of any system of the body are treated by the application of patient-specific, dynamic Osteopathic Manipulative Treatment. Every patient is unique and each treatment is individualized matching a person's moment-to-moment distinctive clinical necessity. Osteopathic Manipulative Treatment is not merely the application of a technique used as a modality. Osteopathic philosophy and Osteopathic Manipulative Treatment are interdependent and inseparable.

9. Osteopathic Manipulative Treatment utilizes a dynamic therapeutic approach uniting diagnosis with treatment and re-evaluation. The treatment process evolves based upon the body's response, or lack of response to a progression of custom-made inquiries that advance the patient toward health and an expression of holism.

10. The goal of an Osteopathic Manipulative Treatment is to enhance the natural ability to self-heal – or to creatively compensate – by augmenting the local and global health of the body by removing the obstructions to 'normal' structure and function.

11. The musculoskeletal system (bones, muscles and connective tissues) has a unique structure and function that impacts the overall health of the entire organism. When the musculoskeletal system fails to perform normally, the entire organism may suffer a localized or general disorder.

12. Restoration of motion informs Osteopathic Manipulative Treatment. Physical or material motion restriction coexist with subtle or non-material motion restrictions and are treated used a patient-specific, dynamic Osteopathic Manipulative Treatment.

13. An Osteopathic Manipulative Treatment promotes healthy blood and lymphatic flow, enhances the exchange of extracellular fluids, and improves the function of cerebrospinal fluid.

14. Impairments of nerve function are specifically addressed by alleviating obstructions, impingements, irritations, or overstimulation of nerves by the application of anatomically specific Osteopathic Manipulative Treatment.

15. Osteopathic Manipulative Treatment works to discover the cause of disease, illness, or injury rather just treating the effects or dysfunctional compensations. Layers of cause and effect may be present creating interconnected dysfunctions that lead to complicated clinical presentations.

16. Pain is an effect and a symptom, not a disease. If pain is exclusively treated, and there is a failure to arrive at the origins of what is causing pain, then the therapeutic actions are limited. The causes of pain are often distant from the symptoms.

17. Osteopathy, as an art and science is progressive and evolving. Expanding Osteopathic skills requires a dedication to life long learning and a commitment to an integrated way of thinking based upon the practicality of scientific method combined with insight based upon developing perceptual expertise.

18. The consciousness of the Osteopath influences perceptual abilities and overall quality of treatment. The *attention* and *intention* of the Osteopath are interrelated at all levels of diagnosis and treatment.

19. Each Osteopath cultivates a personal self-reflective practice and draws up the inner work to proved and intimately interconnected Osetopathic Treatment.

Interview

By: Adam Doris

Dr. Steve Paulus has been a practicing American Osteopath for over 25 years. He is recognized around the world as a historian, and lectures on the clinical philosophy and teachings of the founder. He visited the CICO to lecture on Integrating Direct and Indirect Approaches in Patient Care. The CICO had a chance to interview Paulus about his work.

What is your definition of Primary Respiration?

I don't work with the primary respiratory mechanism or the five phenomenon, that is more associated with Sutherland and his students. I prefer to simplify it. Respiration is divided into two categories, secondary, which is the movement of the diaphragm and inflation of the lungs – it is the process of exchange of gases in the lungs – and primary respiration, which is the breathing of the tissues. The best way I can explain this is the primary respiration is the rhythmic expression of the tissues in a non-material way as a manifestation of inherent forces. The inherent forces can be something does or doesn't move, they are in the non-material field meaning they cannot be measured and are subjective – they are more associated with bio-energetics.

Now, as I say this, because primary respiration has been defined before so uniquely, I try to stay away from the term primary respiration because I understand it differently. For the sake of terminology, I don't use the term in the osteopathic world because its already been established, however, I do use it with patients because it aids in the explanation of how my work is different from other people. There's the biomechanical that is very much Newtonian physics, there is also the non-material field that I work in so I use the analogy of primary and secondary respiration. People seem to understand this concept.

This topic is worthy of great discussion. It's important we agree to disagree and allow this profession to evolve. It is important that we dig on. Still asked for us to expand Osteopathy because it has no boundaries. Therefore, if there is a model put out, the natural evolution is for peers to questions the validity of the model – so I'm questioning the validity of the primary mechanism model. I can use this model, and I've been taught what it is and what the five phenomenon are. It was a great starting point early in my career, but it made me ask, *how attached should we be to our models?* The models we become attached to as students wont be the same that we use after 25 years of practice.

How does this progression work with your General Osteopathic Treatment (GOT)?

First, lets define GOT. It's really two different things, in England, there is a very specific technique based upon a model. But traditionally, in osteopathic history, GOT means a habitual way of treating. The worst manifestation of a GOT is providing the exact same treatment to every patient unchanged. Still was very opposed to this because of the template that is standardized – he didn't agree that this is a way of treating, he asked us to *shake the dust of habit.* It's really important to keep this in mind, because the GOT is a habit. A lot of the early 1900s GOTs were consider engine wiping by Still.

Now, let's talk about the best manifestation of GOT. Every DO has their own version of GOT and the benefit of it is that it is a screening tool. In this sense it's a way of being inclusive by going head-to-toe to check the body for connected wholeness or an expression of disconnectedness. With this, the DO can develop a treatment based on the diagnosis. In my experience, I have not yet met a DO that does not have their own personal GOT. My version of the GOT changes every five years, however, it was more frequent in the beginning of my career. The changes in my general osteopathic treatment are from my experience level and understanding of the human body.

Yes, the GOT is a habit, and yes, it can be helpful. You must always be conscious of the fact that you are applying a GOT in a screening way and then individualize it based on what you find.

How important is Still in the research of Osteopathy?

He is very important. I always go back to Still. The problem with Still for many people is that he is functionally unreadable. This is because his 19th century metaphorical style of writing can be difficult to read. However, he is very quotable. I believe his brilliance lies in collecting his quotes. I've broken down quotes into categories and then key quotes for that category. This is a small reflection of my collection of his quotes. I've collected over a thousand quotes and as a result I feel like some of the best ways to interpret him is to isolate his quotes.

It's a commitment to read Still. As English speakers it is easier to read his work, but if you're not an English speaker it must be terrible. I actually think it's hard enough to use English because his dialect of the English language was not easy to understand. There is also contradiction in his writings so in reality you have to filter Still, as well.

How do you think entrainment will affect the research studies?

That is one of the reasons there is so little research on hands-on osteopathy. The moment you put your hands on somebody, your treatment begins. So how do you differentiate simply putting your hands on someone in an intelligent purposeful way, versus a very intentional osteopathic treatment. So I think the most advantageous way to do research in osteopathy is not with double-blind studies but with outcome studies. With this, you take a group of people and you can utilize osteopathic treatment and compare them to other kinds of treatment and differentiate between the modalities. To do a study with a placebo is extremely difficult with our field but we need to find a way to overcome this.

How did you start the project for the Core Principles?

In second year of my osteopathic medical school, I began with a group every Tuesday night for nine months. By my

third year, I was the president of the student union and we brought in Viola Frymann to do a forty hour introductory course in cranial osteopathy. I identified as being more of a cranial osteopath and more in the line of Sutherland, then in practice I continued that approach so I read everything that Sutherland wrote and by his main student, Becker.

Sutherland worked with a very famous spiritual master named Walter Russell. A lot of what we determined to be cranial osteopathy is the work of Russell and how he influenced Sutherland. After this, I was still not satisfied with understanding Sutherland, so I went to his most influential teacher, Dr. A. T. Still. From here, I started to study Still and propelled all of my attention into Still. So now, I consider myself a Still osteopath. My first teacher was Still, and even though he is deceased his lessons carry on with his writings. In the process of understanding Still, I can see the patterns but I couldn't remember all the patterns but it was hard to grasp as a whole so as soon as I got my first desktop computer and an OCR I scanned all four of his books. It took around two hundred hours of scanning and making corrections.

From here, I knew there was patterns so I started taking my notes and collecting key words, and from there I collected quotes. This made it much easier to see the patterns in his work. The 19 Core Principles are really the key word searches to find patterns. He was a great visionary and clinician, as well as a kind an generous human being, we owe everything in our profession to him. But he almost put everything in code because sometime he wasn't organized in his thought. With this I ask the audience to look at the Core Principles and comment on them. It's a living document, and with this we can have principles that express our distinctiveness that will make us stick out as one of the best healing professions in the world. We need to have better name recognition about who we are and how we do it. The most up-to-date principles are one my website, but they are always changing.

Review of Dr. Karen Snider Lectures

By: Samel Jarman

We in the CICO are still in our relative infancy. In our freshness and newness we have many unique opportunities. We have the freedom to explore and learn lessons from history as well as fellow professionals worldwide. We were delighted by Carol Trowbridge providing historical insight in to the discoverer of our beloved science, Dr. Andrew Taylor Still. Subsequent to Mrs. Trowbridge we were able to get down to brass tacks with direction from the head of Osteopathic Manipulative Medicine at the Kirksville College of Osteopathic Medicine, Karen Snider (DO).

The focus of the lecture was Cranial Osteopathy in pediatric populations and the information was highly detailed… however that is not what we are going to focus on here as we are a group united by our use of principles. It was made clear to us that the regulation of medicine in general and Osteopathy in particular in the United States of America are the heavy determinants of how a ten-fingered Osteopath is able to practice. Record keeping and billing codes take up a large amount of time and as such many treatment methods are chosen for time efficiency. Long holds and energetic based work do not often fly in that type of regulatory environment.

One of the most interesting points that we should look to from Dr. Snider's lecture is that she is not particularly concerned about models or specific techniques. The phrase that Dr. Snider continuously used when referring to techniques was "I am not a purist" suggesting the technique is not as important as utilizing the principles and directing towards the desired result. The general overarching advice when working on the head of a child is to ensure patent movement of sutures so that the brain of the child will grow evenly without resistance promoting normal growth and development of the head and all related structures. In saying these things it is clear that Dr. Snider is telling us to know what normal growth and development are, to be realistic with what effects we are able to create (keep the sutures mobile when they are supposed to be), and to clear the barriers to NORMAL GROWTH AND DEVELOPMENT as when the doors are open nature will do the work.

It is important to note that Dr. Snider employed common language when describing many patterns (such as Ernie and Bert for flexion or extension patterns and "crooked head babies") which makes clear what is going on instead of hiding it behind language. In reference to language and the realities of cranial work Dr. Snider made it clear to the room that naming cranial dysfunctions at the spheno-basilar joint is simply a naming convention as it is possible to see the effects of cranial dysfunction there while it is not explicitly occurring there. The preceding is quite important as it will guide rational treatment by saying the driver of the lesion will be wherever it is regardless of a pattern at the spheno-basilar joint. If the dysfunction is named somewhere it may be enticing to aim technique there and ignore the search for the root of the lesion which is what principle dictates. Within this point it was noted that the clavicles and the hyoid have direct impact on the cranium in pediatric populations as they are drivers of force that specifically form the sutures over time (in terms more familiar within the CICO the upper baseline needs to be considered when working on the head).

The final point we will walk through relates to the first point mentioned – regulation and its effects on ten-fingered Osteopathy. Dr. Snider placed emphasis on the need to have rational and reasonable approaches to treatment with valid diagnostics and goals for treatment. There are specific regulations guiding practice in the United States of America that have made rationality, efficiency, and effectiveness king while possibly interfering with how treatment is delivered. We should look to that model for an understanding that we are in a position to determine our future before the elements of regulation remove our ability to guide ourselves. To ensure we have a chance to determine our own destiny we must make rationality, efficiency, effectiveness, and SAFETY our shining stars. We in the young world of the CICO are absolutely blessed with a solid foundation of having access to understanding and applying the principles of nature as they relate to treatment. We have a chance to prove our abilities through or work and lead the way towards intelligent growth of manual Osteopathy and we should be grateful to our colleagues south of the border for providing us with our roots and lessons in the growth of the profession.

It was an absolute pleasure to have the opportunity to learn from Dr. Karen Snider. Luckily for members of the CICO we are going forward with more wonderful educational opportunities being offered by our professional colleagues worldwide.

Interview

By: Tana Shepherd

Dr. Karen Snider is a Professor, Department of Osteopathic Manipulative Medicine, and Assistant Dean, Osteopathic

Principles and Practice Integration - Kirksville College of Osteopathic Medicine (ATSU/KCOM). Dr. Snider visited the Canadian Academy of Osteopathy in August to lecture and demonstrate on osteopathic manipulative treatment approaches for a wide variety of paediatric concerns. The CICO had an opportunity to talk with Dr. Snider about her history with the profession, the education of D.O.'s at the ATSU/KCOM, and Dr. Still.

Why did you choose osteopathic medicine?

Do you want the long version or the short version? Truthfully, I've always had an interest in science. I did my undergraduate degree in biochemistry and my masters in horticulture and I even interned at the Federal Bureau of Investigation doing scientific analysis. After working in labs for several years, I realized I was no longer interested in being around toxic chemicals for the rest of my life. I had always had an interest in traditional Chinese medicine but living in rural America didn't provide the most opportune location for such a practice. I thought about chiropractic as well but it didn't earn my interest. After that I stumbled across Osteopathy and it had a warmth that I hadn't found in the physicians I encountered when I was younger.

Is it difficult teaching OMM to medical students? Do they have an interest in it?

The manipulation is well received by the students. Most of them are there because they want to be in an osteopathic medical school, because they believe in the holistic philosophy. In general the material that is delivered in our OMM classes is done so very fast. We discuss and demonstrate techniques and then the students have time to practice, but most practice is outside of class. We have practice sessions that are similar, based on what I saw, to how the material is delivered at the CAO. There are one hundred and seventy-six students, give or take, in each year and they have four hours per week spent learning the techniques in their OMM class, with optional practice sessions every week. In their first year they receive other education like anatomy and physiology, biochemistry, pharmacology, and physician skills. Towards the end of their second year the techniques that they learned in their first year are integrated to general patient care and in addition they learn pathology, OB/GYN, surgical specialties, and more physician skills such as sports physical clinics, nursing home experience, and so on. In third and fourth year they have clinical rotations which include family practice, paediatrics, internal medicine, surgery, orthopaedics, intensive care, and so on. We find the practitioners that continue with the most OMM in their practice after they graduate are family practice and neuromusculoskeletal medicine.

Where do you see the future of osteopathic research heading?

I think it's blooming wide open! The 'hay-day' of osteopathic research was in the 40's, 50's, and 60's, but those single-researcher projects are considered substandard according to today's scientific peer-reviewed journals. In the last ten years osteopathic research has skyrocketed because the profession has more funding resources, especially in Europe - Italy specifically, as they are in the early processes of establishing the profession and are publishing all evidence-based research - as well as Brazil. In the

United States, unfortunately much of the osteopathic research that is completed is never published; the more osteopathic research that gets out to the public, the less

people can call Osteopathy 'hokey', which is what it really deserves. Manual medicine has been around for thousands of years because it works.

Do you think Dr. Still's writings are relevant to current OMM practice and instruction?

I think Dr. Still, a very observant man, was ahead of his time. His writings are wonderful for historical perspective and as a place to derive inspiration for research. The osteopaths he trained were, like him, very observant; they weren't as rushed as we are in the current world of medicine. They could take their time, ponder, and observe for much longer than we can, and our current research is showing that many of their observations were correct.

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