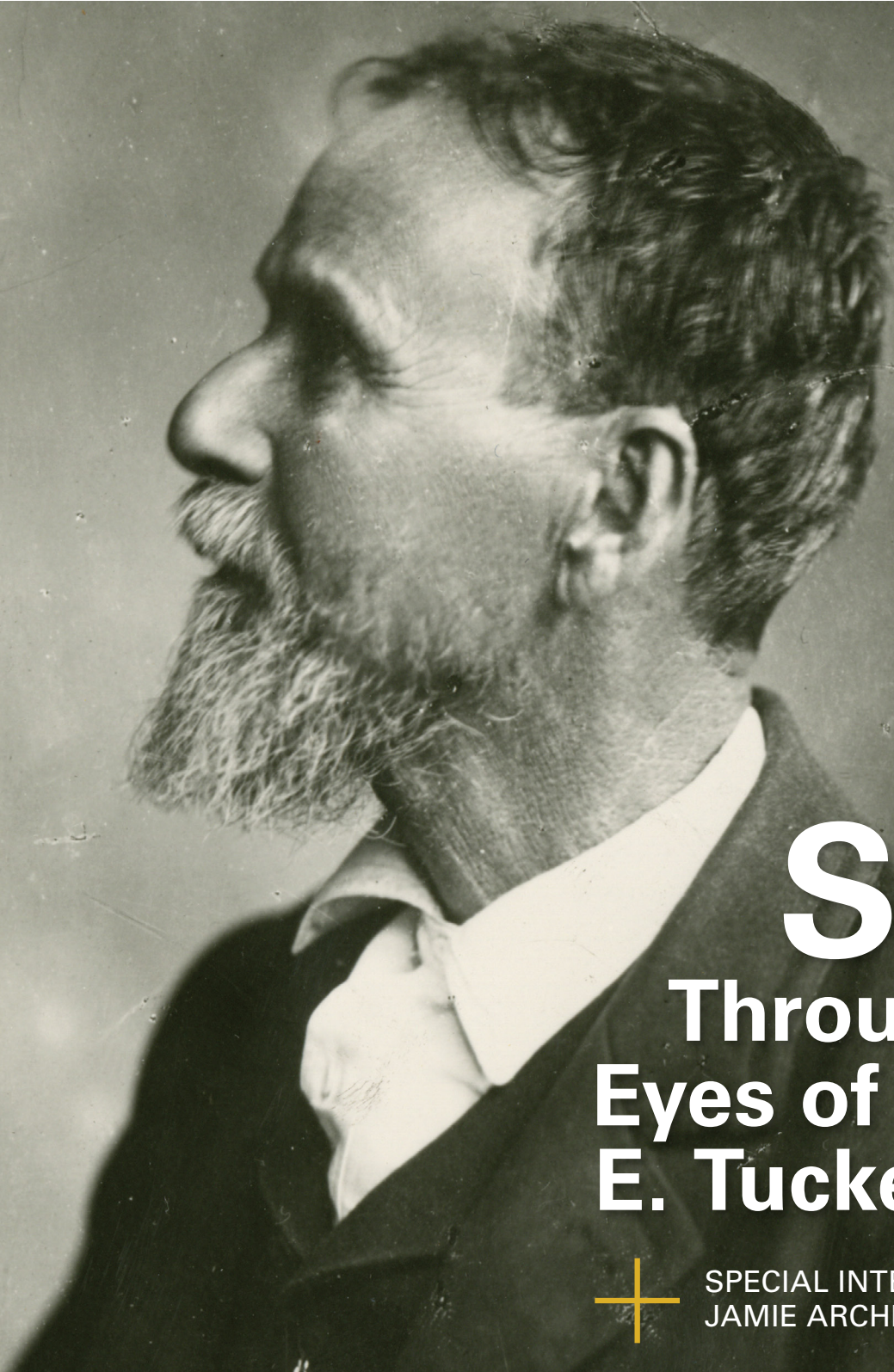


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Still: Through the Eyes of Ernest E. Tucker, D.O.



SPECIAL INTERVIEWS WITH
JAMIE ARCHER & JOHN LEWIS

The **OSTEOPATHYST**

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Editorial

By: Adam Doris

Postural Defects

This article was written for the Canadian Journal of Osteopathy as a summary and response to the originally written article "Postural Defects" in the Journal of Osteopathy, September 1904.

Alterations in the spinal mechanics are a very common problem; it is very rare for someone to be without postural defects. There are many people that do not have enough activity or exercise to correct the maladies caused by a sedentary life. This will lead to changes in the body's mechanics and alter the physiological processes based on the principle that structure determines function. This can amount from any strain that the body does not recover from.

The Osteopath believes that there is a mechanophysiological reason behind all the diseases of the body that will affect the vitality of the patient. There are many mitigating factors to the disease process, from nutrition to mind-set, but in osteopathy there is a rationale behind the structural correlation between health and disease.

Rounded Shoulders

When the shoulders round forward, incorrect posture is usually the culprit; however, this is not always the case. The postural defect is commonly thought to be solely in the shoulders, but it is the result of another lesion. When examining the upper lumbar spine, it is common to see a posterior curvature that weakens the spine as a whole unit and allows for collapsing over the abdomen. Osteopathically speaking, this does more than simply produce rounded shoulders. It will affect the ability for thoracic cage compliance (affecting respiration), change the nerve supply to the viscera for digestive disturbances, and cause rib motion loss affecting vascular supply and drainage. All of these consequences can predispose the patient to disorders.

To correct the postural defect, the Osteopath must find the causative factor. Correcting the alignment of the spine will put the support back into place to allow for a successful correction of the postural defect. From here, we must liberate the rib lesioning because of its direct correlation to the spine. It is also the job of the Osteopath to educate the patient on proper posture to keep the effects of treatment stable and sustained.

McConnell, C. F. (1904, September). Postural Defects. Journal of Osteopathy, 322-325. Retrieved from Still National Osteopathic Museum.

Dr. Still Discusses "Symptomology" in Philosophy of Mechanical Principles of Osteopathy.

By: Sheryl Crotta

"We wish to impress upon your minds that this book is a living and trustworthy symptomology and not speculative as it is not having its commencement in words and winding up with unreliable rehashing of antiquated theories that have neither a father or a mother whose counsel and milk have ever led their children beyond yellow chalk mark of stale custom, born and sustained this day by the nightmare of stupidity, ignorance and superstition. This is the book of symptomology that I wish you to purchase. Use it in place of all others. Its price is eternal vigilance." – A.T. Still

Dr. Still prophetically states that the recognition of abnormal anatomy comes with years of study and "camping out". It is important to be able to visualize normal anatomy.

This is critical in order to assess, diagnose and treat osteopathic dysfunction effectively. The osteopathic structural diagnosis (OSD) is key but more importantly, what does the OSD mean in relation to the rest of the body?

Symptoms can be misleading. As osteopathic practitioners, we are tricked easily to shift our focus to the "subjective pain or dysfunction" instead of the root of the problem. The next thing you know, you are fully committed to your patient's "pain" and lose site of the big picture. Your treatment intention may be good but, unfortunately, you have missed the underlying cause of the problem entirely.

Real skill comes in the ability to interpret your OSD objectively and subjectively, including the symptoms. It has been taught at the CAO that you cannot treat what you do not look for. Thus the hunt keeps osteopathic life very interesting.

Osteopathic training is very challenging. To start with there are no treatment plans, protocols or prescriptions, only osteopathic principles that are your absolute guides for knowing what to do, when to do it and how to do it. The application of osteopathic principles have been set forth by our founder, Dr. Still. This is the osteopathic way.

Osteopathic principles refer to the application of adjustment (e.g., lever, wedge and screw), the use of combined motor and sensory hands, barrier concepts and treatment principles (direct, indirect and balanced approaches), treatment dosage (duration, frequency, intensity, speed), rate, rhythm and repetition. In addition, the principles guide your ability to synthesize and integrate the treatment through sequencing. All of this and more is available to you.

The symptomologies laid out by Dr. Still are not cryptic expressions of the body, but are rather the result of disturbed anatomy and physiology. Your osteopathic understanding of anatomy and physiology allow symptoms to become torches that light pathways to discover underlying physiological causes for dysfunction.

Vital or Mechanical?

This article is an interpretation and summary of the article “Vital or Mechanical” written for the Journal of Osteopathy, June, 1901, by G. D. Hulett, B.S., D.O.

It has always been asked if Osteopathy is vital or mechanical. Can the physical body contain the vital force? There are Osteopaths who have extreme views for either side: the vitality can disturb the function of the mechanism, or the mechanics of the body can disturb the vitality of the person. There is also middle ground with this disagreement, but that makes the case very complex. Instead of looking for just the mechanical reason or just the vitalistic reason for the osteopathic lesion, the operator must take into account all of the parts of the pattern.

The term “vital force” needs to be defined, but the definitions do not do it justice. It has been called a governing force, that co-ordinates the functions of the body. This begs the question of quality versus quantity. Is the patient’s quality of vitality too weak to initiate the functions of the body, or is the quantity of the vitality too low? The expression of the patient’s vitality is the physical body. The nutrition of the body becomes the building blocks for establishing the vitality so that it can build on itself, making the function of the body constant with the structure of the body. If you change the structure of the body, you will inevitably change the function of the body; however, it is still vital if the function is consistent with the structure.

Inherently, the vitality is the governing force to the physiological processes of the body, and is used to reduce the amount of friction that will impede the efficiency of the physiology. This gives an explanation for the mechanical lesion that happens without the outcome of disease.

If we take the idea of vital force and understand it as a fluid of the body, it will have the ability to adapt and move to where it is needed most. There are non-material influences that can change the homeostatic levels of the body, and therefore will use vital force to self-regulate. Like all other lesions in the body, you must find the stimulus and remove it for correction.

In lesions that have no mechanical basis, the mechanical treatment will be contraindicated because the vitalistic force is not to be tampered with. Treatment may not be beneficial because it has the potential to stimulate a process past its limits that will be detrimental to the health of the patient.

Hulett, G. D. (1901, June). Vital or Mechanical? Journal of Osteopathy, 180-182. Retrieved from Still National Osteopathic Museum.

Reality Check (a.k.a. Plausible Mechanisms)

By: Samuel Jarman

When learning Osteopathy the student is provided with large amounts of information on accepted sciences in the form of anatomy and physiology. The student is also provided with large amounts of information regarding treatment models and theories of treatment that revolve primarily around the barrier model, as well as the neuro-physiologic concepts ascribed to the barrier model. The purpose of this work is to analyze briefly the manner in which some of the treatment models are described and how the language surrounding them is employed to emphasize that these are working models and not absolute mechanisms. Also, there will be a discussion concerning the reality of how the search for absolute mechanisms may possibly be leading the Osteopathic profession away from effectiveness.

Currently there are many areas in the world that have varying regulations as to the manner in which professionals designated as Osteopaths are able to treat. In many areas Osteopaths are allowed to use high-velocity treatment applications to “crack” joints while other places in the world have regulations that specifically prohibit the use of high velocity treatments by anyone outside of a narrow range of professions. One such example is Ontario, where only Chiropractors, Naturopathic Doctors, and Physiotherapists with specifically recognized training above and beyond their basic education are allowed to cavitate joints with thrusting movements. Because of this reality, the following discussion will focus on indirect models of treatment with the recognition that the underlying points of this discussion can be found in all models of treatment. Moreover, it will be argued that this information is safely applicable in all jurisdictions.

In reading materials on indirect methods of treatment the common theme is to go in the direction of ease with the basic rationale of (1) reducing the abnormal stimuli entering the central nervous system from tissues with strain and altering the motor output to the region via the muscle spindle reflex (see Kusunose in *Rational Manual Therapies* and Schiowitz in *An Osteopathic Approach to Diagnosis and Treatment*), and (2) overcoming the mechanical strain on soft tissues (again Kusunose and Schiowitz, as well as the book *Ligamentous Articular Strain: Osteopathic Manipulative Techniques for the Body*). In approaching the barrier model from the indirect side, the assumption is that there is no dangerous strain put against tissues that are believed to be in distress and varying degrees of compromise. The indirect method is thought to remove stress from the compromised tissues, as is evidenced by the alteration in pain sensation as well as in staying away from restricted movement patterns. Regardless of the realities of what is happening to the actual tissues during indirect treatment applications, there

does seem to be a mechanism at play that allows for quick, efficient, and safe changes to be made to both articular and soft tissue structures. In actual application there is VERY little difference between Ligamentous Articular Strain, Facilitated Positional Release, Strain-Counterstrain, or any other indirect methods. The statement is made that there is very little difference between the indirect methods in application as, when performed based on what the patient is actually presenting; these methods require augmentation to respond appropriately to the situation at hand.

To further examine some of these methods, attention will be turned to descriptions provided by those who employ and teach them. In the case of Facilitated Positional Release we find Stanley Schiowitz stating (*An Osteopathic Approach to Diagnosis and Treatment*, p. 89):

“This treatment is directed toward the normalization of hypertonic muscles, both superficial and deep. *It is probable that most of the vertebral joint motion restrictions diagnosed as somatic dysfunctions are caused and/or maintained by hypertonicity of the small, deep, intervertebral muscles.* These hypertonic muscles respond well to facilitated positional release, thus immediately restoring normal joint function.” (italics added)

We should pay attention to the word “probable” in the italicized portion of the above quotation. When we consider the words of Dr. Schiowitz, who developed this model for treatment, we can at least infer that this is but a theoretical framework that has been built on clinical confidence. The idea seems to be that this is what Dr. Schiowitz thought was happening; however, the more important issue was the results of restored joint function. Further evidence of the reality of Facilitated Positional Release being a theoretical model is found when Schiowitz writes (*An Osteopathic Approach to Diagnosis and Treatment*, p. 89):

“A plausible explanation for the effectiveness of this treatment relates to the action of the muscle spindle gamma loop when the gain is suddenly decreased. According to Carew, with a sudden decrease in load, the spindles in the muscle become unloaded and the 1a fiber discharges from these spindles cease and no longer excite motor neurons controlling extrafusal muscle fiber. The muscle then begins to relax until it lengthens. This physiologic change may well account for the immediate effect felt when facilitating force is used in these techniques.”

Again, Schiowitz is using a theoretical discussion based on an accepted physiologic property of the muscle spindle reflex. The important take away here, and with the rest of this discussion, will simply be that these are theoretical models backed by clinical confidence, and that it is prudent to apply the theory in response to the actual patient presentation.

When we examine Strain-Counterstrain we find a similar situation of clinical confidence in an indirect method arising

from clinical necessity. As the story goes, Lawrence Jones was treating in the manner he had been trained (high velocity), and was getting nowhere with an individual patient. He was frustrated so he decided to dedicate an entire treatment to finding a comfortable position for the patient to sleep (as that was the significant issue arising from the psoasitis the patient presented). Jones had to attend to another patient shortly after finding the comfortable position for the patient and, upon returning, when the patient got up the psoas muscles had released to a point where the patient was able to stand much more upright. From here, Jones began to work on “spontaneous release by position” and eventually ended up codifying points on the body that related to dysfunction as effects of abnormal loading patterns. The underlying thoughts behind Strain-Counterstrain are outlined by Kusunose through the following statement (p. 326-327):

“The rationale for strain and counterstrain is based on a neurologic model first proposed by Dr. Irvin Korr in 1975. His hypothesis incriminated the muscle spindle or primary proprioceptive nerve endings as the basis for joint dysfunction. His concept is derived from: a) the consensus on the importance of decreased joint mobility or decreased joint range of motion for determining somatic dysfunction, and b) on the muscle’s function as a ‘brake’ to retard or resist joint motion.”

This statement provides further proof that the basis of treatment models is founded in theoretical mechanisms, and is based on clinical confidence. Jones was working with indirect methods prior to the work on mechanisms through the sensory system altering motor output and perpetuating motion restriction that Dr. Korr presented. Jones had clinical confidence in indirect treatment and even developed his tenderpoints as monitoring points to show that the dysfunction had been fixed and the painful effect at the tenderpoint was removed. In other words, the treatment was aimed at the dysfunction and the tenderpoint simply showed the dysfunction had changed; thus, the tissue was no longer loaded in a way that created a pain response). Korr’s work provided a possible mechanism that was adopted into the method Jones was already invested in through clinical success.

Turning attention now to Ligamentous Articular Strain, we will again find evidence that this was a clinically successful model that was used by Dr. Still and then by Dr. Sutherland to be further investigated by the Dallas Osteopathic Study group. The order of events is outlined in the book *Ligamentous Articular Strain: Osteopathic Manipulative Techniques for the Body*, authored by Crow, Simmons, and Speece. Ligamentous Articular Strain, in the eyes of the Dallas Osteopathic Study Group, actually seems to be more of a naming convention than the actual treatment method; this is demonstrated in the following statement (p. 23):

“The term ligamentous articular strain most accurately describes the somatic dysfunction that occurs in the ligamentous structures that surround a joint. The tension in all

of the ligaments of a normal joint is balanced and is used to center adjacent bones in their articular grooves and spaces. This suspension system keeps the bones from being jammed too close together, pulled too far apart, shifted from one side to the other, twisted, or bent side-ways. When an injury occurs, one bone in the joint becomes jammed beyond this physiologic position, and some, if not all, of the ligaments become strained. Of the pair of opposing ligaments, the more lax ligament is usually the more strained ligament, while the tighter ligament is more normal."

Considering that it is more of a naming convention than an actual method while also based on a theoretical model of joint injury, we again have evidence of treatment models being founded on clinical confidence. The basic correction method is to overcome the soft tissue (disengage it), exaggerate the motion of ease (go indirect), and then balance (bring the joint back to the middle of its theoretical dynamic range).

In looking at the information presented here it should be clear that these are theoretical models based on neuro-physiologic concepts and that they require that the soft tissues are shortened to allow for removal of possible braking forces driven by the soft tissues. The braking forces may come from neurologic mechanisms that protect joints (muscle spindle reflex or golgi tendon organ reflex), or the passive soft tissues presented by ligaments and fascia (which may also lead into the neurologic mechanisms as proposed by Dr. Korr). Regardless of how they actually work, what we have is multiple methods differentiated by specific points of application and joined by overcoming soft tissue to reposition joints and remove related dysfunctions.

Now, so far as the development of these methods and the proposed mechanisms go, it will be suggested that the fervent search for the absolute mechanism has the possibility to make an Osteopathic Operator too rigid. There is a reality in practice that Osteopathy responds to the patient as they present and the correction is to be found through whatever means the tissues being treated will respond to. The theoretical models have their greatest use in providing suggestions which then require fine tuning. The joining factors in indirect treatment are going the way the tissues like to go to remove the neurologic basis for dysfunction, as well as to overcome the soft tissues to reposition a joint while not generating a neurologic response. The actual way that this is done need not be rigid, as long as those guidelines are followed. Building clinical success seems to rest on finding whatever the tissues will respond to rather than simply following the exact steps of any method. It will also be suggested that the search for treatment mechanisms is a double-edged sword: there is the possibility of increased acceptance of Osteopathy by those outside the profession while at the same time an Osteopathic Operator is confined (rigidified) by the mechanism and the methods that are ascribed to it. The old Osteopaths were developing models. The new Osteopaths are following those models. The old Osteopaths were trailblazers. The new Os-

teopaths are followers. Please, for the sake of the profession, step out of the follower mentality and use the work of the old Osteopaths to *inform* your process rather than *dictate* it. Get to the heart of the methods and models to find the commonalities and not the differences. The differences in models and methods are personal flair; the similarities are useful guidelines. Be willing to take the time in clinical practice to develop your own model in the way that Dr. Still did; take time and prove it through success!

Kusunose, R.S. (1993). Strain and Counterstrain. In J.V. Basmajian and R. Nyberg (Eds.), *Rational Manual Therapies* (pages 323-333). Baltimore, M.D.: Lippincott Williams & Wilkins.

Schiowitz, S (2004). Facilitated Positional Release. In E.L. DiGiovanna, D.J. Dowling, S. Schiowitz (Eds.), 3rd Edition, *An Osteopathic Approach to Diagnosis and Treatment* (pages 89-92). Philadelphia, P.A.: Lippincott Williams & Wilkins.

S.L. Simmons, C.A. Speece, Wm. Thomas Crow (2009). *Ligamentous Articular Strain: Osteopathic Manipulative Techniques for the Body*. Seattle, W.A.: Eastland Press.

Thomas Crow, Wm. (2004). Ligamentous Articular Strain Technique and Balanced Ligamentous Tension Technique. In E.L. DiGiovanna, D.J. Dowling, S. Schiowitz (Eds.), 3rd Edition, *An Osteopathic Approach to Diagnosis and Treatment* (pages 103-106). Philadelphia, P.A.: Lippincott Williams & Wilkins.



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Pop Indicates Motion

This article is a summary and interpretation that was written for the *Canadian Journal of Osteopathy*, based on the article that was originally written, "Pop Indicates Motion," August, 1905. To contrast and add to this article, *Lesionology Osteopathic Principles and Practices* was referenced.

The sound that can be produced with osteopathic treatment has been a controversial topic. It is first understood that the human body obeys the laws of nature. Sound is produced by vibration, when two structures come into contact with one another. The "click" is plausibly thought to come from the articular surfaces being separated – the pressures of the joint change relative to the atmospheric pressure that will create a vibration.

It is probable that the spinal articulation is physiological but it must be remembered that when the ligaments are on tension it becomes easier to make the audible sound. The sound indicates that the articular surfaces of the joints can be separated and are mobile. This is a valuable piece of information for the osteopath in their diagnosis.

George M. McCole commented on the incidental pop in *An Analysis of the Osteopathic Lesion: A Study in Pathology, Physiology and Anatomy*: "When the joint adjustment is made, the pop is heard because the articular surfaces separate. The pop comes whether we want it or not. It is simply a normal accompaniment of the breaking of the joint seal. The pop has nothing to do with adjustment or treatment; it is simply inci-

dental and accompanies correct work" (p. 257). McCole demonstrates that the pop is not a necessity in the treatment; it has very little bearing on whether the treatment was effective or not. It is up to the Osteopath to palpate the structures correctly, know the anatomy, and adjust according to the principles.

In *An Analysis of the Osteopathic Lesion: A Study in Pathology, Physiology and Anatomy*, Amussen, Brigham, and Chandler were asked, "Do you consider the popping or snapping of a joint necessary for adjustment?" (260) Amussen responded, "Never necessary though occasionally unavoidable." Brigham stated, "It is impossible to correct some lesions without a snapping noise. Others are corrected very easily without any noise at all. It doesn't matter whether they snap or do not snap" (260). And Chandler: "Not in all cases. Doubtless putting the joint through movements with sufficient force will often tend to increase the range of mobility and work towards adjustment. Also with suitable leverage it is doubtless possible to stretch to the point of straining the periarticular structures without producing any pop" (260). These three opinions show that it is not necessary to make a noise when adjusting. It is most important that the Operator corrects the lesion in the most appropriate way using the principles of Osteopathy.

It can be seen that there is no concise reason as to why the click occurs. The separation of the articulation does indicate that motion has happened, but McCole shows that it's just the joint seal breaking and does not necessarily mean that the articulation was a successful treatment. Amussen, Brigham and Chandler all made it clear that is not necessary to make the popping sound to remove a lesion from the body.

Pop Indicates Motion. (1905, August). *Journal of Osteopathy*, 248. Retrieved from Still National Osteopathic Museum.

McCole, G. M. (1935). *An Analysis of the Osteopathic Lesion* (pp. 257-260).

Osteopathy for Athletes

This article was written as a summary and response to the original article "Osteopathy for Athletes" written by Ernest C. White, Director of Athletics at the American School of Osteopathy for the *Journal of Osteopathy* in June, 1901.

Training has always been a very rigorous process for the athlete to prepare for competition. Knowledge of training has benefits for everyone because it can promote optimal health; it is the act of ensuring health to all of the parts of the body.

In Osteopathy, there are three parts to training: first, dealing with injuries and ailments; second, increasing knowledge of anatomy for liberation of the nerve supply and fluids to ensure trophicity of the tissues; and third, improving athletes' performance and abilities. Osteopathy has the ability to treat many different ailments that will affect performance, and therefore gives a more complete aid to training.

Muscle development and growth depends on the vitality, nutrition, removal of waste from metabolism, and nerve supply to control these processes. The muscle's accessibility to the NAVL supply can be altered by many different factors (i.e., tissue tension, joint motion loss). The Osteopath must then remove these obstructions to aid in the training process. For instance, when approaching

the superior thoracic aperture, if there is impingement of the major vessels that are underneath the clavicle it will reduce the development of the upper limb because of the change to supply and drainage of the blood.

In injury, it is possible for the Osteopath to facilitate and aid in the recovery of the athlete to restore peak performance in a shorter amount of time. This is because of the liberation of the NAVL that is necessary for the health of the tissues. Osteopathy can become a vital determinant of an athlete's performance.

White, E. C. (1901, June). *Osteopathy for Athletes*. *Journal of Osteopathy*, 178-180. Retrieved from Still National Osteopathic Museum.

Remarks on the Displacement of Abdominal and Pelvic Organs

This article was written for the *Canadian Journal of Osteopathy* as a summary and response to the article "Remarks on the Displacement of Abdominal and Pelvic Organs," originally written for the *Journal of Osteopathy*, June, 1901.

There has been much written about issues with the pelvic organs (prolapse, relaxation, and displacement). The most commonly displaced organs are the stomach, liver, kidneys, and colon. It has been observed that if the bowels completely prolapse, the spleen will move inferiorly. Commonly, the organs of the pelvis that become displaced are the uterus, ovaries, and appendages.

There are many reasons as to why the organs can be displaced, including, but not limited to, ligament laxity, muscle atrophy, dysfunctional spinal mechanics, and improper nerve supply. The organ field is nearly free from muscular involvement, except for the anterior and posterior body walls that hold the organs in place. Organs have periods of function that necessitate the ability to move (i.e., peristalsis), requiring the support system to allow for that movement. The majority of the organs are supported by ligaments and areolar tissue. When there is a weakening of the ligaments or musculature, it will give the opportunity for prolapse and displacement to occur.

There is a correlation between the weakening of the organs' support structures and the mechanical position of the spine. When there are changes to the sagittal plane mechanics of the spine, it will take the ligamentous support with it, thereby changing the structure and the function of the ligaments.

The relaxation of the anterior muscles of the abdomen will cause displacement of the visceral field. However important the lumbar spine curvature changes are, the Osteopath must treat when there has been a change in the spinal mechanics by investigating the entire lesion pattern. For instance, with round shoulders, you can find the abdominal muscles are compressed and this will place strain on the sympathetic ganglia, causing exhaustion. The constant inferior strain will pull on all of the organs to displace them because of the lack of muscular tone. With regard to the pelvic organs, displacement will generally occur before abdominal displacement.

The main purpose of this article is to bring awareness to the Osteopath of the correlation between the spinal mechanics and the displacement of organs. Still wrote about the importance of motion within the body, and the importance of fluid mechanics. With this, we can see the importance of organs being properly placed in the body for optimal supply and drainage to the organs. Osteopathically speaking, when stagnation occurs it will start the disease process in the body.

Goetz, H. F. (1901, June). Remarks on the Displacement of Abdominal and Pelvic Organs. *Journal of Osteopathy*, 170-173. Retrieved from Still National Osteopathic Museum.

Guest Submissions

Defining Osteopathy

By Stephen Paulus, D.O., M.S.



INTRODUCTION:

In the late 1800s, Andrew Taylor Still discovered and developed the healing art and science known as Osteopathy. Subsequently, he and his inspired students created a teachable system of healthcare based on the therapeutic actions of Osteopathic Manipulation. Still was a brilliant visionary. He was an inspired leader. He was a gifted clinician. But he had limited skills as a teacher. Osteopathic pedagogy was not well developed with Still. A more organized system of teaching Osteopathy has evolved over the past 123 years.

Arguably, Still did not systematize the early Osteopathic profession by offering a succinct and usable definition of Osteopathy. Also, he refused to give an organized approach to Osteo-

pathic Manipulation. He emphasized the vital importance of applying Osteopathic philosophy in a clinical context with expert attention to the details of anatomy. The Osteopathic approach to healthcare, as promoted by Still, was not based on performing sequential manipulative techniques, but in expressing the philosophy of Osteopathy in a clinical context.

If Osteopathic Manipulation is the practical application of Osteopathic philosophy, what is Osteopathic philosophy and how do we apply it clinically? More specifically, can we define Osteopathy and Osteopathic Manipulative Treatment and use these definitions to create a professional and personal clinical mission statement?

Most of the current official definitions of Osteopathic philosophy are unfortunately vague and indistinct. When I have asked modern Osteopaths their personal definition of Osteopathic philosophy the answers are, to me, unsatisfying. Frequently, the final response to the question "What is Osteopathic philosophy?" is unfortunately premised on ambiguous per-

sonal perceptual experience without a historical context. The concluding answers often close any further intellectual discussion. In the 21st century, is it acceptable to say that Osteopathic philosophy is self-evident because it is handed down in the perceptual tradition from teacher to student? I would say, no. In my opinion, we need a distinctive definition of Osteopathy and Osteopathic Manipulation to demonstrate our uniqueness.

I believe that we can define Osteopathy in general and Osteopathic Manipulation in particular. This article will create what I believe is a historically pertinent and clinically inclusive definition of Osteopathy, Osteopathic Manipulation, and Osteopathic philosophy.

I would like to begin with broad definitions of Osteopathy as a profession or healthcare system and Osteopathic Manipulative Treatment as a therapeutic clinical action. These definitions are intended to be inclusive, and to support a variety of Osteopathic practice styles. We also need a more detailed and expansive expression of Osteopathy. The bulk of this paper will elaborate on the succinct definitions by offering specifics that make Osteopathic philosophy clinically relevant.

DEFINITIONS:

DEFINITION OF OSTEOPATHY

Osteopathy is a **distinctive** healthcare system and **whole-person** philosophy of medicine that is devoted to treating disease and **promoting health** by accessing the body's **natural abilities to self-heal** or creatively compensate. The **art and science** of Osteopathy recognizes that disturbances of anatomic structure and physiologic function are interrelated and are treated utilizing a **patient-specific, dynamic** Osteopathic Manipulative Treatment. The goal of Osteopathic Treatment is to make every effort to discover the causes of disease and pain by **restoring balance** and removing the obstructions to healing, thus encouraging an **inherent therapeutic process**.

Definition of Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment, or OMT, is the **unique** form of **hands-on healing** or manual medicine utilized by an Osteopath. Osteopathic Manipulation uses a **comprehensive** and anatomically **specific** approach to diagnosis and treatment by restoring a **healthy relationship** between all of the organ systems, including the musculoskeletal system.

Both of these definitions are intentionally generalized, allowing for brevity and inclusiveness. We also need a set of detailed core principles that express our distinctiveness as Osteopaths. Osteopathic philosophy is premised on a multifaceted interconnected set of core principles. These guiding principles could then provide a clinical mission statement for each Osteopath and intelligently direct the clinical practice of Osteopathy.

I have distilled what I believe are the most important and accessible core principles of Osteopathy according to a historical

analysis of the writings of Andrew Taylor Still. These twenty core principles are divided into two broader categories. The first are *Foundation Principles* or *The Osteopathic Way of Being* and the second are *The Principles of Diagnosis and Treatment* or *The Osteopathic Method of Clinical Action*.

FOUNDATION PRINCIPLES:

The Osteopathic Way of Being

1. Holism: A Dynamic State

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.

The term “holism” was not coined until 1926 and was not made famous until the 1960s.¹ Holism hinges on Aristotle's philosophy of “the whole is greater than the sum of its parts.” The concept of holism is in essence a law of nature. It is the ecologic expression of equilibrium for human beings integrated with their environment. In a very Aristotelian way, Andrew Taylor Still expresses holism when he states, “*We look at the body in health as meaning perfection and harmony, not in one part, but as the whole.*”²

I have identified over 20 key words and phrases that Still utilized that are euphemisms for holism. My personal favorite is the holistic Osteopathic perceptual view of connected oneness. The concept of holism permeates all of Still's work and is an indispensable component to basic Osteopathic philosophy.

2. The Mind/Body Connection

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, illness, or injury. Trusting the ability of the body and psyche to self-heal forms the foundation of Osteopathic clinical practice.

The same forces of healing that fix a broken bone mend a broken heart. Andrew Taylor Still did not name the forces of healing; he generically referred to them as “Nature.” Still was very clear in stating that the work of healing the body and mind is performed by Nature and he gives “Nature the ascendancy” (meaning recognition) for the self-healing augmented by Osteopathic Manipulation.³ Nature performs the repair and delivers the therapeutic actions. Nature is the true doctor that performs the ultimate acts of healing and the beneficial compensatory adjustments.

One of the best examples of Still's attention to the mind/body connection is reflected in this citation regarding hope:

Should you find any hope for his recovery and make that your report, like a thrill of lightning dipped in the sea of love, his vitality dances with joy. He is warmed up soul

and body. But if you should be indiscreet enough in your report to remove every ray of hope, you have chilled the vital energy, you have silenced it, and the vegetable energies take possession of your patient and drag him with lightning speed to the valley of death. If you have any generalship you will evade anything like reporting that there is no hope for your patient. If you should analyze his substances and by your analysis see that there is no hope, be careful. Tell your patient that he is in such a condition that you wish to observe his case for a few days, weeks or months; that while man is alive he is not dead, and you hope to do him some good, though you and he both know his case is serious. Then if the patient concludes to stay and take a few days treatment always come to him as though you wanted to do him all the good in your power, then he will be satisfied, and not break down in despair. This advice I offer to the young graduates. I think from long experience it is good, and wish you would govern yourselves accordingly. I am giving you the advice that is based upon my experience of many years.⁴

3. The Equilibrium of Structure and Function **The relationship between anatomic structure and physiologic function impacts the overall health of the entire body. Structure and function are interdependent and inseparable in disease and in health.**

Still stated, “Osteopathy is that science which [helps the body] regain its normal equilibrium of structure and function.”⁵ Understanding the essential mutual linkage between the anatomic structure and physiologic function forms an undisputed foundation of how Osteopaths see and perceive the body in health and disease. Understanding the relationship between structure and function also informs our treatment. Still said it best when he declared, “The philosophy of manipulations is based upon an absolute knowledge of the form and function.”⁶

4. Knowing Normal—That is the Answer **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.**

Built into Still’s teachings is the Osteopath’s experience of “normal.” Still emphasized that, “An Osteopath reasons from his knowledge of anatomy. He compares the work of the abnormal body with the work of the normal body.”⁷ As Osteopaths, to practically understand what is abnormal we must have an intimate knowledge of normal structure and function. To know clinical normal requires patience, devotion to practice, and dedication to learning the unique physiology found in diverse clinical situations. As clinicians, Osteopaths spend their entire careers refining their understanding of normal.

5. Finding the Health **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.

Debatably, the most famous of all of Andrew Taylor Still’s quotes is: “To find health should be the object of the doctor. Anyone can find disease.”⁸ But, what is health in an Osteopathic context?

Health is best described as a distinctive biologic matrix within a living being that interfaces with every aspect of structure, with the integrated physiologic systems, and with the totality of all psychological processes (both conscious and unconscious). It is the milieu, the growth medium, or the nutritional source of the therapeutic process. Health does not originate from any single location within the anatomy of an individual, but emerges from each cell, permeates every fluid in the body (e.g., blood, cerebrospinal fluid, extracellular fluid, and lymphatic fluid). Health does not exist in non-living, inorganic, or inert matter. Health does not come from outside the body, but comes from the inside (of a living being) and expresses its biologic actions from the fulcrum of Life. It is one of the repeatable experiences in Osteopathy of what we call “connected oneness,” or what others refer to as holism. Health is one of the subtle, non-material biologic forces that is accessed by using metaphysical, perceptual abilities rather than palpatory skills utilizing the end organs of sensation.

6. Material and Nonmaterial – Visible and Invisible

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 connected oneness.

Veiled within Still’s writings is a key perceptual distinction that helps to guide Osteopathic diagnosis and treatment. Still delineated two access portals which he referred to as the “visible and invisible,”⁹ and the “material and immaterial”¹⁰ (I propose using the term “non-material” because the word immaterial has gained additional definitions in modern English that are unsuitable). The material field is visible, tangible, objective, and measurable. It includes the physical elements contained in anatomy and the physiologic functions that are quantifiable. Coexisting with the material elements is the non-material field, which is invisible, intangible, subjective, and is not measurable. It includes the attributes of Nature that vivify the structure. Still reveals more concerning the non-material when he states,

Does Nature have a finer matter that is invisible and that moves all that is visible to us? Life surely is a very finely prepared substance, which is the all-moving force of Nature, or that force that moves all nature from worlds to atoms. It seems to be a substance that contains all the principles of construction and motion, with the power to endow that which it constructs with the attributes necessary to the objects it has formulated from matter and sent forth as a living being.¹¹

To discover and access the non-material we look to structure. “All the principles of motion, life, and all its remedies to be used in sickness [are found] inside of the human body. [They are] placed... somewhere in the structure...”¹²

As Osteopaths we access the invisible that moves all that is visible through our connection with the structure. The perceivable forces of the non-material are accessed via a hands-on contact with the body.

Permeating Still’s teachings are the concepts of accessing the body as a material mechanism and concomitantly connecting with the “vital qualities of Nature.”¹³ I believe that when William Sutherland stated, “Dr. Still could not speak of all the things he understood about the living human body” because “We were not ready to hear him,” they were both referring to the invisible, non-material forces within the body.¹⁴ The primary respiratory mechanism, fluid drive, tides, potency, stillness, and the breath of life, are all attributes of the non-material.

7. Clinical Curiosity: The Science of Inquiry 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 on the practicality of scientific method combined with insight into developing perceptual expertise.

In the years before Andrew Taylor Still died in 1917, he frequently told his most trusted students that “D.O.” means “Dig On.”¹⁵ To “Dig On” means to expand and evolve the art and science of Osteopathy. He was asking for the entire Osteopathic profession to expand and evolve but, more importantly, he was asking for each individual Osteopath to remain committed to life-long learning and expanding individual skills. By remaining devoted to learning, an Osteopath becomes a better clinician able to help more people with a greater diversity of medical issues.

As Osteopaths, we must also be pragmatic scientists. We evolve as clinicians by asking questions and carefully listening for the answers given to us by each individual patient’s body. As scientific Osteopaths, we make a diagnosis. We then form a hypothesis. Next we test the hypothesis. Finally, we re-evaluate to determine if the hypothesis was proved or disproved.

Clinically, this experimental process is surprisingly simple and

ultimately effective. I make a specific anatomic diagnosis of a dysfunction with hands-on palpation of the body, while being simultaneously attentive to the material and non-material perceptual fields. I may then, for example, hypothesize that applying a direct action, muscle energy treatment in the material field will effect a change in the tissues. I re-examine the area of dysfunction. If this anatomically and perceptually specific treatment changed the dysfunction toward normal, then I have proven my hypothesis. If no noticeable change was effected then my hypothesis was disproven and I must form a new premise and start over.

These mini-experiments can occur hundreds of times during the totality of a patient-specific Osteopathic Manipulative Treatment. They occur non-verbally in my experience as I test and re-test the dynamic, therapeutic dance we call Osteopathy.

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

During an Osteopathic Treatment, the quality of our internal state, the character of our awareness, and the presence of introspection forms an important part of the totality of an Osteopathic experience. When we attend to our internal state, we create the context for a more precise treatment. In other words, it is essential that the Osteopath “shows up for the treatment” and does not blindly go through the motions or apply a choreographed formula based upon linking techniques. By attending to the quality of our internal state, we are better able to synchronize with the patient’s necessity and offer the best possible Osteopathic Treatment.

9. The Inner Life of the Osteopath Each Osteopath cultivates a personal self-reflective practice and draws upon this inner work to provide an intimately interconnected Osteopathic Treatment.

Andrew Taylor Still had a profound inner life that influenced the development of Osteopathy. As 21st Century healthcare practitioners, we are often uncomfortable with discussions of religious ideas, spirituality, and references to the sacred. It is important to state that Osteopathy is not and never has been a religion, nor does it have religious intentions. Though Osteopathy itself is not a religion, individual Osteopaths may choose to overtly interpret Osteopathic clinical practice through the filter of their personal religious beliefs, or the choice may be to disassociate personal beliefs and keep religion and spirituality within the private inner life of the individual Osteopath.

Still was deeply spiritual but was not religious. He acknowledged the vital connection between that which is Divine and the work we offer as Osteopaths. He did not promote one set

of religious beliefs over another and was open-minded regarding each individual's personal choice in religious matters. He did, however, ask that we recognize the source of healing. "Osteopathy is to me a very sacred science. It is sacred because it is a healing power through all of Nature..."¹⁶ Still was mystical and was not only a physician, but also a metaphysician incorporating a sense of holism that extended beyond the corporeal body. He was eloquent and poetic when he affirmed, "Here you lay aside the long words, and use your mind in deep and silent earnestness; drink deep from the eternal fountain of reason, penetrate the forests of that law whose beauties are life and death. To know all of a bone in its entirety would close both ends of an eternity."¹⁷ There is no need to make long-winded proclamations or attempt to define the indefinable. Still was intentionally vague regarding the details of his personal approach to spirituality, but he was clear that his students would be better Osteopaths if we recognized that "something greater" was influencing the therapeutic actions initiated with our Osteopathic interventions.

PRINCIPLES OF DIAGNOSIS & TREATMENT: The Osteopathic Method of Clinical Action

10. Osteopathic Manipulative Treatment (OMT)
Structural or functional disturbances of any system of the body are treated by the application of a patient-specific, dynamic Osteopathic Manipulative Treatment. Every patient is unique and each treatment is individualized to match 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.

There is no Osteopathy without Osteopathic Manipulation. Fragments of Osteopathic philosophy can be applied clinically, and patients will receive some benefit from these selected principles, but pieces do not make up the whole of this great profession. Osteopathy is a holistic, hands-on healing art and science, and the emphasis is with *hands-on*.

There is no Osteopathy without having an intelligent clinical knowledge of the structure of the human body (i.e., anatomy and physiology). Having a knowledge of anatomy without understanding how to effect change in the anatomy via Osteopathic Manipulation is clinically worthless. Still said it best when he declared, "A knowledge of anatomy is only a dead weight if we do not know how to apply that knowledge with successful skill."¹⁸ In addition, he said,

What is osteopathy? It is a scientific knowledge of anatomy and physiology in the hands of a person of intelligence and skill, who can apply that knowledge to the use of man when sick or wounded by strains, shocks, falls,

*or mechanical derangement or injury of any kind to the body. An up-to-date osteopath must have a masterful knowledge of anatomy and physiology."*¹⁹

As up-to-date Osteopaths we must constantly ask ourselves, is our knowledge of anatomy and physiology clinically advanced, are we using that knowledge intelligently, are we expanding our manual medicine skills, and are we evolving?

11. Self-Healing and Creative Compensation
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.

An Osteopathic intervention has three key components. First, we make a detailed anatomic diagnosis while monitoring the vitality of the tissues. Second, we apply a tissue-specific and patient-specific Osteopathic Manipulative Treatment while also attending to the non-material milieu. Finally, we let Nature do the true work of healing. Nature does the repair, renovation, restoration of motion, and creative compensation. We as Osteopaths only assist Nature by removing the impediments to the full expression of holism and helping to promote the conditions that augment the therapeutic processes. Our work as Osteopaths is not mathematically additive; it is logarithmic. "Harmony only dwells where obstructions do not exist."²⁰

12. Diagnosis and Treatment: A Palpatory Dialogue
Osteopathic Manipulative Treatment utilizes a dynamic therapeutic approach uniting diagnosis with treatment and re-evaluation. The treatment process evolves according to 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.

Osteopathic diagnosis and treatment is a process, not a product. There is no treatment without diagnosis. Diagnosis is dynamic, changing moment to moment as the body responds or does not respond to the therapeutic action we call Osteopathic Manipulation. During an Osteopathic Treatment an intimate dialogue takes place between the Osteopath and the patient. This dialogue is non-verbal.

First, the Osteopath must listen to the patient by placing attentive hands on the body—this begins the dialogue. The patient's body speaks to us—this is the diagnosis. The Osteopath answers by offering an action—this is treatment. Then, the cycle begins again. The new cycle is a re-evaluation. The patient's body may tell us we are done or the dialogue may indicate that more action is necessary. This palpatory dialogue forms the intelligent therapeutic foundation of Osteopathic Treatment.

13. Anatomic Specificity: Knowing the Human Architecture

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.

Anatomic specificity forms the foundation of Osteopathic clinical action. If our understanding of the living, complex, dynamic normal and abnormal anatomy of our patients is more precise, then the results of treatment are greatly enhanced.

The science of Osteopathy cannot exist without knowing and understanding the intricacies of anatomy. One “component” of holism is anatomic unity. Still said, “We know that if we ever know the whole, we must first know the parts.”²¹ By knowing anatomy we can make a more precise diagnosis. By making a precise diagnosis we are better able to apply a specific Osteopathic Manipulative Treatment. By applying a specific Osteopathic Manipulative Treatment we not only remove the focal obstructions to self-healing but also augment the local and global health of the tissues. By restoring the ability of the body to self-heal we let the natural forces of healing do the work of repair, thus allowing for the restoration of holism.

14. Restoration of Motion: Quantity and Quality
Restoration of motion informs Osteopathic Manipulative Treatment. Physical or material motion restrictions coexist with subtle or nonmaterial motion restrictions and are treated using a patient-specific, dynamic Osteopathic Manipulative Treatment.

The twentieth-century American Osteopath Stanley Schiowitz, D.O., reinterpreted one of Andrew Taylor Still’s most famous aphorisms by asserting, “*Find it, move it, and leave it alone.*”²² Most, but not all, somatic dysfunctions are lesions of inertia or abnormalities of anatomic motion relationships. In addition, not all dysfunctions are exclusively somatic. Most, but not all, non-material dysfunctions are lesions of diminished action. Decreased non-material motion often forms the subclinical starting point of disease. Still inseparably connected the material and non-material when he was referring to the need to restore motion as a goal of Osteopathic Treatment. He spoke of the quality and quantity of motion. He linked “*vital motions and material forms.*”²³ He revealed that, the “*Processes of life must be kept in motion.*”²⁴ He said, “*motion is the first and only evidence of life.*”²⁵ And, he associated dysfunctional motion with cause and effect.

15. Musculoskeletal System: Anatomic and Physiologic Laws

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 generalized disorder.

When Andrew Taylor Still declared, “*The mechanical principles on which osteopathy is based are as old as the universe,*” he was making reference to what we today call biomechanics.²⁶ A section heading in one of his books is titled, “*Bones Considered First.*”²⁷ By insisting that Osteopaths have an intimate knowledge of anatomy he commonly referred to bones as well as muscles and connective tissues, emphasizing how they form a mechanical scaffolding and provide an essential portal, or handle, allowing access to other tissues and body functions. He did not end or limit his work to bones, muscles and connective tissues but he frequently used the musculoskeletal system as a starting point in his philosophy of manipulation. He also recognized that a localized disorder or derangement often caused distant problems that upset normal whole-body equilibrium.

16. Fluids: The Great Rivers of Life

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

Andrew Taylor Still affirmed that, “Sickness is caused by the stopping of some supply of fluid or quality of life.”²⁸ Fluids include: arterial blood, venous blood, lymphatic fluid, extracellular fluid, and cerebrospinal fluid. Still wrote extensively on the various ways in which fluid dysfunctions can cause disease.

With respect to healthy fluids he referred to perfect drainage, nourishment, unobstructed privileges of fluid, fluid that freely circulates, delivery in full supply, and pure blood. Regarding disease states he used terms such as withering fields, unnatural accumulation of fluids, delay in passage of blood, suspended blood, delay of fluids, obstructed fluids, congestion, stagnation, and edema.

Still also linked the material quantities of the fluids with the non-material qualities of fluids by speaking of fluids containing a “quality of life.” He recognized the rarefied qualities of fluid when stating, “*When matter ceases to be divisible, it then becomes a fluid of life.*”²⁹ When he spoke of unhealthy fluids and called them devitalized fluids, or dead fluids, he was referring to the subjective and vitalistic aspect of fluids, not objective hydrodynamics.

17. Nervous System: The Power of Unobstructed Nerves

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

One modern designation of Osteopathy categorizes it as a system of manual medicine devoted to treating the neuro-musculoskeletal systems. The functional linkage between nerves, bones, muscles, and connective tissues reinforces the biomechanical model and is often the public expression of Osteopathy in a scientifically dominant medical culture. Most commonly, impairments of nerve structure and function are caused

by problems of the musculoskeletal system. Thus, by treating abnormalities caused by the bones, muscles, and connective tissues we can address obstructions and impingements of the nervous system, most commonly with the peripheral nerves. The Osteopathic approach does not just identify blockages of the nerves but also irritations that can cause an overstimulation, or facilitation of the nervous system. Obstructions and facilitation of the nervous system can occur peripherally or can feed back centrally, mediating a more complex type of dysfunction within the nervous system.

18. The Visceral Connection

Visceral dysfunctions can be addressed either by specifically working with individual organs or by treating the viscera secondarily by promoting enhanced blood and lymphatic flow, alleviating impairments of nerve function, or removing musculoskeletal obstructions to normal function.

It must be maintained that Andrew Taylor Still treated every tissue in the body and was inclusive and expansive in his methods of Osteopathic Treatment. Certainly, he emphasized the musculoskeletal system, nervous system, and all of the fluid-based systems of the body, but he also actively treated the viscera. He utilized Osteopathic Manipulation on the viscera directly and indirectly. He performed what we today term “Visceral Manipulation” by directly addressing the internal organs and he indirectly addressed the viscera by treating the nerve supply to and from the viscera associated with specific spinal segments. As Still contended, *“you are not warranted in making any move until you have found the condition of the pleura, the lung, the heart and all abdominal viscera and know that every variation of bone and muscle that would produce any suspension of nourishment to the pleura, heart, lungs or other organs of the system is found. Then you are warranted after a careful exploration in proceeding to adjust from the abnormal to the normal.”*³⁰ This assertion reveals that his physical examination included an evaluation of the viscera directly, and that treatment incorporated abnormalities of the interrelated neuro-musculoskeletal systems. He documents that direct visceral manipulations occurred when he tells us to *“Raise bowels and all viscera out of the pelvis with the patient on his side, in order to establish arterial and venous drainage.”*³¹

19. The Cycles of Cause and Effect—That is the Question

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

Andrew Taylor Still said it best when he declared, *“I want it understood that I look upon the treating of effects as being as unwarranted as it would be for the fireman of a city to fight the smoke and pay no attention to the cause that produces it.”*³² Ef-

fects (smoke) are symptoms. Addressing the cause (fire) is the goal of Osteopathic Treatment.

The goal of Osteopathic Treatment is to make every effort to discover the causes of disease and pain by restoring balance and removing the obstructions to healing, thus encouraging an inherent therapeutic process.

20. Pain = Effect

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.

Pain is a common effect. Some of the time, effect/smoke/pain overlap with the cause/fire and when we treat the pain we treat the cause. Often, the effect/smoke/pain is distant from the cause and Osteopathic philosophy demands that we find this distant cause and address the dysfunction that creates the diseased reaction.

POSTSCRIPT:

In presenting these Core Principles in lectures and workshops throughout the world over the past 10 years, I am often asked, “Where does the Cranial Concept and the work of William Sutherland, D.O., fall into the whole of Osteopathy? Is Cranial Osteopathy a separate discipline? Can we separate the cranial system from the greater context of Osteopathy and make it into its own specialty?” I would answer all of these questions with a resounding “NO!” Sutherland was clear that what we call Cranial Osteopathy, Osteopathy in the Cranial Field, etc., was not separate from Andrew Taylor Still’s Osteopathy. It was the application of Osteopathic philosophy to the cranial field. I agree with Sutherland, and would add that we must devote ourselves to knowing Osteopathic philosophy without making one tissue or anatomic region more important than another, because to do so would be non-holistic and anti-Osteopathic.

Within the context of these 20 Core Principles, Cranial Osteopathy is more specifically contained in principles 6, 15, 16, and 17. Within the 15th Principle, the musculoskeletal system includes the cranial bones and connective tissues of the meninges, i.e., the membranes. Contained within the 16th Principle, the fluid-based principle of Osteopathy includes the cerebrospinal fluid. The 17th Principle comprises the nervous system, which of course includes the brain and all of the peripheral nerves emerging from the cranium and spinal cord.

Finally, Still’s delineation of perceptual fields found in the 6th Principle forms the bioenergetic foundation for Sutherland’s subjective terms that include the primary respiratory mechanism, fluid drive, tides, potency, stillness, and the breath of life. Still preferred to not name the non-material fields, or he allocated them to the greater category of “Nature.” Sutherland chose to name the non-material fields based on his personal Osteopathic experiences. Each of us may choose to remain in-

distinct in the naming of non-material fields or attempt a more specific definition. Both perceptual systems are effective.

CONCLUSION:

I invite every Osteopath to consider creating a clinical mission statement. Perhaps these 20 Core Principles will resonate with your personal Osteopathic philosophy. Maybe this particular definition of Osteopathy as a healing art and science will synchronize with your experiences. Conceivably this definition of Osteopathic Manipulation will correspond to your clinical work with patients.

You may disagree with my way of Osteopathic thinking. Disagreement forms the foundation for discourse; discourse can form the foundation for growth; and growth is based on a therapeutic process. By disagreeing and talking to each other we can potentially heal the fragmented international Osteopathic profession and create an integrated whole that is greater than the sum of its parts.

Please reflect upon these definitions and these Core Principles. Examine them, experience them, and integrate them into your clinical life. Then, contact me via email and let me know what you appreciate and what you dislike. Join me in helping us all to celebrate our distinctiveness by demonstrating the courage to express that Osteopathy is much more than the sum of its parts.

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Steve Paulus, D.O., M.S., has been a practicing American Osteopath for over 25 years. He is an internationally recognized Osteopathic historian and lectures throughout the world on subjects relating to Osteopathic clinical philosophy and the teachings of Andrew Taylor Still. For more information regarding Osteopathic history and philosophy go to www.OsteopathicHistory.com or www.StevePaulus.com. To make comments regarding The Core Principles of Osteopathy, contact Dr. Paulus at osteopathichistory@gmail.com

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The Timeless Teachings of A.T. Still

By: John Lewis



At the British School of Osteopathy in the early 1990s the founder of osteopathy was rarely mentioned. In our first year we received a one-hour lecture on Dr. Andrew Taylor Still and, except for the occasional mention of his name or one of his quotes, that was all we received for the remainder of the course. The prevailing opinion was that Still was merely a historical figure whose teachings had been superseded by a more scientific attitude. This I found curious and it prompted me to take out his autobiography from the library. What I read amazed me with its depth of thought and insight.

It soon became clear that most of the School's faculty harbored the same misunderstandings and prejudices about Still that had plagued him even during his lifetime. Very few of my tutors and lecturers had actually read his writings and when I asked them to explain the philosophy of osteopathy, without exception they reiterated the "four principles" that appear in the osteopathic texts: the body is a unit; the body possesses self-regulatory mechanisms; structure and function are reciprocally interrelated; rational treatment is based on these principles. This, too, I found curious. Did it mean that the philosophy and the principles were the same thing? To me that did not make sense.

So I began to investigate the matter. My first surprise was to learn that the "four principles" were introduced to the profession in 1953 by a committee in Kirksville – and that they were not the principles taught by Dr. Still. This raised a serious question: if no one knew Still's philosophy, and the principles being taught were not his, what was I learning?

In 1997, two years after graduating, I travelled to Kirksville, Missouri, to research in more detail. I remained there for nearly five years and it took me a further decade to complete my biography, self-published in December 2012, *A. T. Still: From the Dry Bone to the Living Man* (available from www.atstill.com).

The more I studied the founder and his teachings the more I realized that this was one of the most important stories anyone could write, and that to do it justice I needed to perfect the art of writing. It was not an easy story to compose either; it felt like trying to complete an impossibly difficult jigsaw puzzle without a picture, but the lengthy process of trying to fit the pieces together taught me the most valuable lesson: osteopathy was to Still primarily – even above a system of treatment – a philosophy, one quite different to the one I grew up with and which took much mental adjustment to fully grasp. "Osteopathy is Nature," he teaches.

A terrible personal tragedy began Still's questioning of medical practice. He had been a doctor for ten years when, in February 1864, an outbreak of meningitis claimed three of his children and an adopted girl. As he languished in grief and disillusionment, however, he was struck a profound insight: "I decided then that God was not a guessing God but a God of truth. And all His works, spiritual and material, are harmonious. His law of animal life is absolute. So wise a God had certainly placed the remedy within the material house in which the spirit of life dwells."

For the next ten years he struggled with the knowledge that medicine knew neither the cause nor the cure of not only meningitis but disease generally, and that the drugs he had been taught to prescribe were ineffective and possibly dangerous. He was aware that the medical definition of disease was altered physiology, but no one knew what caused the physiology to go awry in the first place. But his insight raised a fundamental question: if the body innately contains all the remedies needed for curing, what should be the role of the doctor? It inspired him to read extensively – not only medical books but also natural sciences and philosophy.

Philosophy – a subject that debated the relationship between God, man and nature – was the key. Since childhood Still had been indoctrinated with the Christian notion of an omnipotent God and of man's dominion over nature, but had entered medical practice on a Shawnee Indian reservation in Kansas where his preacher-physician father had been sent as a missionary. Here he was exposed to a radically different attitude towards the natural world: the Indians taught that man was part of nature, not its dominator, and that nature was pervaded by sacred wisdom.

On 22 June 1874, Still experienced a life-changing revelation: "that the works of God would prove His perfection." He saw that nature constantly strives to express perfect health. How it does so remains a mystery even today, for it cannot be explained by any known scientific law. Medicine is based on science, but Still reasoned that to find health rather than treat the symptoms of disease the practice needed to be guided by a different philosophy.

As Rudolf Virchow had noted in his *Cellular Pathology* – a book that Still treasured – materialism had limitations when applied to the living being. Unafraid to challenge the norm Still adopted a new philosophy, one adapted from the English philosopher Herbert Spencer, whose thesis was a reconciliation of science and religion. Still's new philosophy – "the law of matter, mind and motion, blended by the wisdom of Deity" – could not only accommodate scientific knowledge but also mind (a word that also encompasses the "wisdom of the body") and life (a word Still used interchangeably with motion and spirit), without assuming (as did science) that they somehow emanate from matter. This was a philosophy centered not upon the material but upon the immaterial – a spiritual philosophy.

The implications of its adoption were enormous. First, it meant he could no longer venerate science as the ultimate arbiter of

truth. It did mean he could still value all verifiable scientific knowledge, but with the understanding that science can only glean facts about the “knowable” part of nature, while acknowledging that the unknowable part – nature’s drive to express health – is responsible for healing. Instead of looking to science for ultimate truth he would look to nature in its entirety, both its material and immaterial aspects. Under this philosophy he could regard health as a spiritual quality – and this tenet forms the basis of all osteopathic reasoning. Still constantly impressed upon his students that they must acknowledge that every cell of the living human body possesses infinitely more intelligence than the rational thinking mind.

The philosophy and principles of osteopathy are not the same. The philosophy forms a foundation from which its principles of application derive, and the fundamental principle (surprisingly absent from the “four principles”) is cause and effect. Medical diagnosis and treatment is physiological; osteopathic diagnosis and treatment are anatomical. Still teaches that disease is the physiological effect of anatomical derangements (primary osteopathic lesions from trauma or strains or secondary lesions manifesting in the structure from environmental or other influences). Normalizing deranged anatomy restores normal physiology because of the complementary spiritual principle that nature constantly strives towards health. Every cell will maximize its potential for health only with an unimpeded blood circulation, so the role of the doctor is to free the arteries and veins and their controlling nerves by normalizing the body structure, often in extremely small, subtle ways. Find it, fix it, and leave it alone. Nature will do the rest.

The same philosophy informs William Garner Sutherland’s approach, which is pure osteopathy in the true sense of the word. How this method of treatment works is not fully understood, but the philosophy of matter, mind and motion allows us to acknowledge the limitations of our knowledge, learn to trust what we sense and feel, and defer to nature’s greater wisdom. The interaction of patient and practitioner is complex and multifaceted. Science continues to elucidate more about the electromagnetic nature of the body and our hands, practitioners are constantly learning how mental development is a powerful tool for enhancing treatment, and some are taking treatment into the realm of the spirit. To the founder, all these things were integral aspects of nature and hence osteopathy.

Still was not introducing a manual therapy for a narrow range of musculoskeletal complaints. He was presenting a new paradigm for health, a new philosophy that can be universally applied. We are not islands but parts of nature, parts of the whole, and nature’s laws are absolute and unchanging. “It is my hope and wish,” he wrote, “that every osteopath will go on and on in search for scientific facts as they relate to the human mechanism and health, and to an ever-extended unfolding of Nature’s truths and laws.” He teaches that nature’s truths and laws go beyond the physical. They encompass not only body’s anatomy, physiology and biochemistry in health and disease but also the wisdom of the body, and on to life and death.

It is surely no coincidence that this philosophy bears close

similarities to that of the American Indians, since Still’s first patients were Shawnee. The Indians saw no separation between God and nature, or matter and spirit.

The Native American view is that we are all related. Human beings have relationships with animals, insects, trees, plants, water, air, wind, the seasons, sun and sky, food, medical drugs and all else – and our health and happiness are affected positively or negatively by everything we interact with. This is also true in the human ecosystem, a microcosm of universal laws: every cell is in mutual dependence with every other, and the physiology of the whole organism is profoundly affected by thoughts, emotions, foods, medical drugs, and myriad other things. Nothing is isolated. To recognize these interconnections is to start to understand osteopathy. And perhaps we also need to acknowledge the Indian teaching that if we do not recognize the relationships between individual things, we do not feel the need to respect the whole.

When the trend in our profession tends to attach to the names of schools the oxymoronic language of “osteopathic medicine,” when evidence-based medicine is the latest insistence of policy makers, and when the Dutch association has decided to refuse accreditation to courses of osteopathy in the cranial field, it would appear that Dr. Still is merely regarded as a historical figure whose holistic teachings are irrelevant. This is the “lesion” in osteopathy, a result of a lack of knowledge about what the word osteopathy truly signifies.

Many external pressures continually draw osteopathy away from its roots, while at the same time there is a lack of knowledge about the importance of those roots. When we understand Still, we see that the outcome of treatment is not dependent on statistics. Rather it depends on developing our hands, minds and senses as sensitive instruments. Every case is unique, complex and multifactorial, and we must have the knowledge, skill and art to remove the precise cause of the problem – in matter, mind or motion.

In Dr. Still’s philosophy lies the inspiration, the strength and the profession’s uniting power. And the truth. Still’s teachings are timeless, for they are not based on the shifting sands of scientific knowledge and trends but on the immutable wisdom of Nature. Osteopathy has always been a square peg in a round hole and, now as in Still’s day, those who seek to round off the corners to make it acceptable to the dominant system merely serve to dilute the pure osteopathic teachings, restrain the potential of students, and limit the perceived scope of osteopathy. This is good for no one.

The osteopathic profession would be stronger if students were taught the founder’s pure teachings, for they are as relevant now as they were to the first students of the American School of Osteopathy. Nature never changes. Dr. Still is the profession’s greatest asset, if only we listen to what he has to teach.

John Lewis
www.atstill.com

Still: Through the Eyes of Ernest E. Tucker, D.O.

By: Jason Haxton, M.A., D.O. (h.c.)



Andrew Taylor Still, D.O. (1828-1917)—Museum of Osteopathic Medicine, Kirksville, MO [1985.1022.07]



I was honored by my friends at the Canadian Academy of Osteopathy who asked me to write a periodic piece for *The Osteopathyst* about Dr. A.T. Still from a museum perspective. Having lectured a few times in Hamilton at the school, I know the students, graduates and staff want to have a

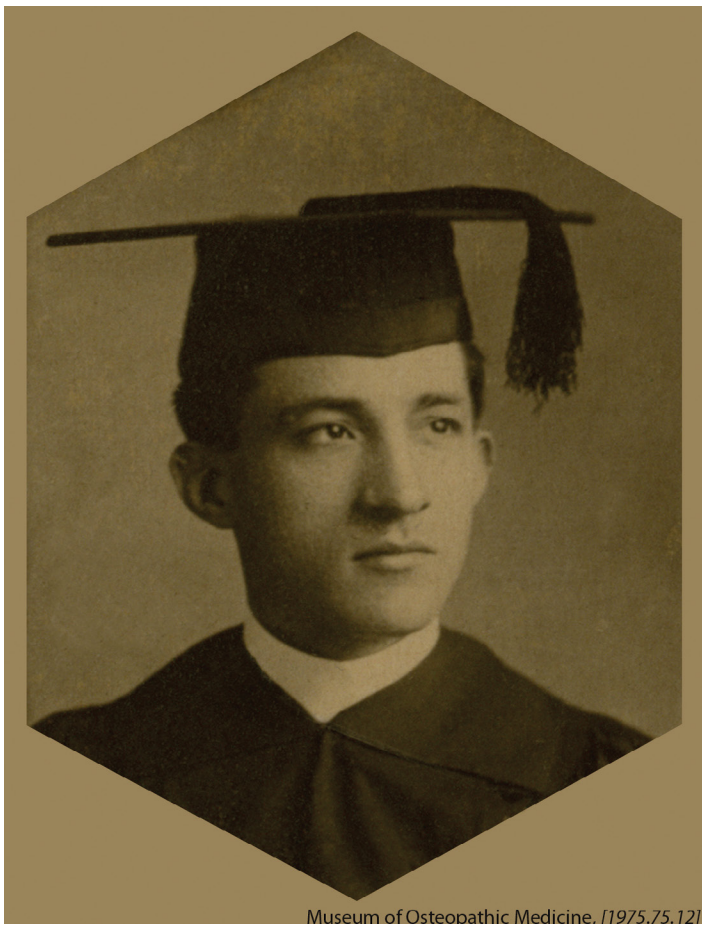
personal relationship and understanding of their profession's founder and his philosophy. In my 14 years as director of the museum, the Ernest E. Tucker writings have provided me with the greatest insight and connection to our founder, Dr. A.T. Still. So, I will be sharing material from Dr. Ernest E. Tucker's writings about Dr. Still in every issue. Enjoy!

Introduction – who was Ernest E. Tucker?

Jason Haxton, M.A., D.O. (h.c.) writes the beginning of Dr. A. T. Still's influence on Ernest E. Tucker, D.O.:

As a young adult, Ernest E. Tucker first met A.T. Still in 1898 as a patient. At that first meeting in Kirksville, Dr. Still foretold that Tucker would be returning as a student in a few years. Osteopathy as a career choice was definitely not in Ernest Tucker's life plan, but, as he later wrote, *"That did happen. When anyone comes into contact with a revelation of such vast significance as osteopathy, he must do one of two things: close his mind, remain blind, deny; or else pour every ounce of his spare energy into it – to give it the full measure of development possible."* E.E. Tucker, D.O.

Dr. Ernest E. Tucker poured his heart into osteopathy and never regretted it.



Ernest Eckford Tucker, D.O. (1877-1958)–Museum of Osteopathic Medicine, Kirksville, MO [1975.75.12]

Ernest Tucker returned as a student of osteopathy, graduated in 1903 and later became a Professor of Osteopathic Principles and Technic at the founding school in Kirksville. It was throughout the 19 year mentoring/friendship with Dr. A.T. Still that Tucker wrote down his observations and a series of conversations directly quoted from Dr. Still on a variety of topics, which included the events that led to Dr. Still's discovery of osteopathic healthcare.

Tucker wrote two books: one on Osteopathic Technic and one about Osteopathic Theory. He also wrote a full manuscript with several lesser drafts about those years he spent as Dr. Still's confidant. Long after A.T. Still's death, Ernest Tucker proudly sent a final draft of his manuscript to Charlie Still, the eldest son of the "Old Doc." In a letter attached to the manuscript, Tucker wrote with enthusiasm that he wanted to publish this material as a book for all to enjoy, but of course only with the Still family's approval. Nothing more has been found on this request for approval from Ernest Tucker or by Charlie Still.

Tucker's planned book was never published, and the only surviving manuscript was the very one Tucker had sent to Charlie with his letter. Manuscript and letter were found decades after Tucker had died, mixed in with a variety of donated papers upon the death of Charlie's son (Charlie Still Junior) in the 1990s.

From Tucker's various unpublished writings, you will be provided highlights of Tucker's observations and honest conversations with Dr. Still. It seems only right to start at the beginning: Tucker's first meeting and his physical description of Dr. A.T. Still.

In Person:

The following is a description of Dr. A. T. Still as written by Ernest E. Tucker, D.O.

Well, I was prepared to be impressed but not in just the way [that] it turned out. Was there a bit of hero-worship in it? At the time I would have repudiated the idea. But that does hold a place for that picture in any book of reminiscences.

The red brick wall of the house, the snow half across the porch, the slant of the morning sun, and the figure standing before me on that early morning in February fifty-seven years ago are as clear to me now as though I were still looking at them. The contrast of that first meeting has not dimmed, but stands out as significant to all who would know and understand this man.

The house was a fine and imposing edifice, modern in every aspect, and one would naturally expect to find a man to match the dwelling in it. But he [Dr. A.T. Still] did not match the house. On the contrary, he made it appear foolish. He dwarfed it. Unaware of either its beauties or its imperfections – as he would have been of any hovel in which his work [with the poor] might have carried him. His home – was not a house. He always entered and left by the side door at the end of the semicircular porch.

An unusual thing about him, often remarked, was his gait; a springy gait, rising on his toes: which I was told was the Indian gait. Upon my first meeting his emergence from a side door had been almost noiseless, his movement along the floor almost Indian smooth – quietness, a bit tip-tilted as though walking on tiptoe. As though part of this gait, he usually carried a six or seven foot staff, cut from the woodpile and whittled or planed down. For these reasons he seemed to walk leaning forward.



Residence of Dr. A. T. Still, Founder of Osteopathy, Kirksville, Mo.

A.T. Still on the front porch of his mansion, c. 1901, Museum of Osteopathic Medicine, Kirksville, MO [2010.02.1550]

His appearance can best be described as shadowy, and his voice had the same quality in its huskiness; like a voice from somewhere else, far away; or [from] somebody else. Oh, he could speak powerfully – he could make the students in the rear seats [of the classroom] hear as clearly as those in front – but the huskiness – it had a sort of intimate quality about it – [like it was] just you and me sort of effect.

Two things about Still's appearance I never did get used to, often as I saw them. One was the bulge of that forehead, like the bud end of a watermelon. Such a forehead could hardly escape being sunburned, but this too faded to a dusky hue, a matter of age as well as atmosphere no doubt - over which feathery strands of iron gray hair played under the wide brim of his black felt hat. His face upon closer inspection was wrinkled like a piece of old silk. The wrinkles at the outer corners of his eyes were numerous and humorous.

The other was the unbelievable aquilinity of the nose [having the curved or hooked shape of an eagle's beak]. They harmonized with each other of course and were not ordinarily noticeable, until some trick of posture or background threw them into relief. His mustache helped to – shall I say normalize – his nose. His pointed beard was leveled out in front of him. And mustache and beard kept nose and forehead in harmony. Through his grisly beard shone the gleam of a gold collar button, innocent of collar [without] unless it happened to be attached.

He was a giant physically as well as mentally, and his head always thrown back – made the tallest man look up to him; his wide-brimmed army hat, which was thrust far back on that bulging dome of a forehead.

His eyes seemed to blend with the background – horizon grey, flecked as I remember it with brown; under untrimmed eyebrows. His hands were large and flat and no doubt very powerful. The lobes of his ears hung down quite generously. I suggest that you take note of the ear-lobes of strong leaders of men.

On his feet were boots – “Missouri mud boots. [Blue] Jean trousers were tucked into them, with the inevitable bulge at the outer top. Overcoat, coat and vest he carried open; the two halves of the vest held together by a heavy watch chain (those were the days of pocket clocks). The coat was a blue [military] army coat.

He wore specs of course; and – well... but one never sees the dirt on one's own glasses, unless one takes them off to look at; and then, one does not see well enough to see the dirt.

And why should anyone bother about that [how he physically looked]? I do not know why; I have not given it much thought; but observe that my fellow human beings do seem to set considerable store by “it” – “it” being [a person's] physical appearance – generally.

Museum of Osteopathic Medicine, Kirksville, MO [1997.04.121 and 1997.04.119] Charlie E. Still Collection

Observations in Osteopathy

By Charles Beck, D.O.



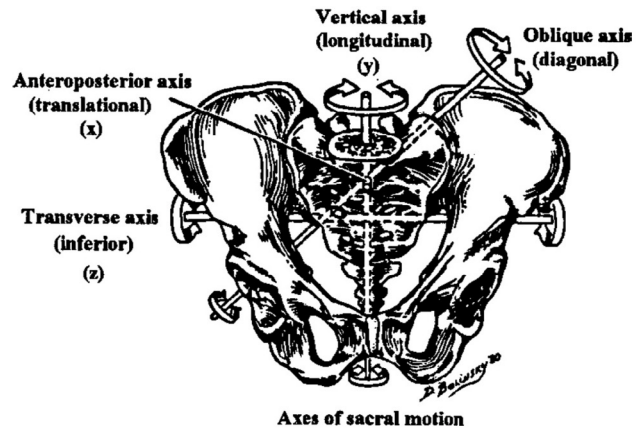
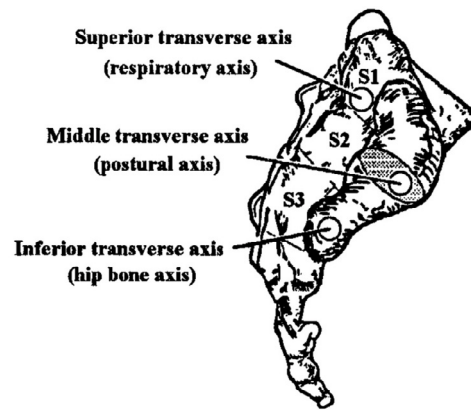
At the 2005 annual Indiana Academy of Osteopathy conference – Sequencing: the Art of Finding the Key, Kenneth Klack, D.O., posed a question concerning the Mitchell pelvic axis system and its effect on the respiratory diaphragm. I am going to do my best to respond to that question here.

The Mitchell pelvic axis system was proposed by Fred Mitchell Sr., D.O., as a way to explain the motion of the sacrum around the innominates. The system defines six axes around which the sacrum and innominates move. The axes are described using surface landmarks. They are as follows:

1. The anterior/posterior axis through the center of S2.
2. The middle transverse axis, which lies at the level of the PSIS and is the axis, is where sacral flexion and extension dysfunctions occur. Some schools refer to these as the unilateral shears.
3. The superior transverse axis, which lays one finger width above the PSIS, and is the axis about which the cranial rhythm (primary respiration) is predominantly focused.
4. The inferior transverse axis, which lays one finger width below the PSIS and is where innominate rotation primarily occurs. Innominate rotational dysfunctions occur on this axis.
5. The left oblique axis appears when the middle transverse axis shifts up on the left and down on the right. This occurs when the sacrum side-bends to the right, e.g. during the walking cycle. Sacral torsions occurring on the left axis (i.e., left on left) happen here.
6. The right oblique axis appears when the middle transverse axis shifts up on the right and down on the left. This occurs when the sacrum side-bends to the left, e.g. during the walking cycle. Sacral torsions occurring on the right axis (i.e., left on right) happen here.

To answer the question, I began by consulting Paul Hume, N.D. and D.O., from New Zealand, who was also at the course. Paul and I started with “working” sacrums that had no perceptible dysfunctions and proposed the following test: we would restrict the axes one at a time and observe what happened to the body. To restrict the axis the patient is held around that axis to restrict motion. To restrict motion around the middle transverse axis the patient would be held with circumferential compressive force between the ASIS and PSIS. To restrict the superior transverse axis, circumferential force is applied between the ASIS and one finger width above the PSIS, etc.

Prior to the test, the patient was asked to take a deep breath and note the sensation of breathing. Once the operator’s hands were positioned, a compressive force was applied circumferentially to the innominates and the patient was asked to take a



Pictures from the Glossary of Osteopathic Terminology

deep breath and compare that with the original breath.

The observations were:

- a. Pressure on the middle transverse did not affect respiration. Patients reported no change in breathing.
- b. Pressure on the superior transverse gave a sensation of a weight or heaviness in the sternal area and the patient felt like they were taking a less deep breath.
- c. Pressure on the inferior transverse axis gave a sensation of weight or heaviness in the area of the respiratory diaphragm and the patient felt like they were taking a less deep breath.
- d. Pressure on the left oblique axis gave a sensation of left-sided breathing restriction with no affect on the right.
- e. Pressure on the right oblique axis gave a sensation of right sided breathing restriction with no affect on the left.
- f. The A/P axis was not tested.

While a dedicated scientific approach, such as the use of spirometry, may give more specific data, the N of 10 used in the answering of this question seems to indicate a likely correlation between the Mitchell axis system and diaphragmatic respiration. Participant responses to the perception of restricted breathing were similar throughout the process. Because of this experiment, I have been looking with new eyes at all of the pelvic dysfunctions that I treat. I am noticing more subtle changes in rib cage and diaphragmatic motion and correlating it with the pelvis. I am asking my patients to experience their breathing more, both before and after treatment. It is making me a better osteopath. Thank you, Kenneth.

-Charlie Beck, D.O., F.A.A.O.
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Musculoskeletal Applications in Cranial Mechanics Part Two

By Lee Jarvis

A Review of Principles From the Previous Article

When any muscle contracts all points of attachment will move to some degree. Even though the movement of the muscular origin is minimal it is still constantly occurring and must be considered a vital part of the dynamic unit of the body.

All moving structures require a stable base. The neck and cranium have their base in the thorax as this is the closest and most stable attached structure.

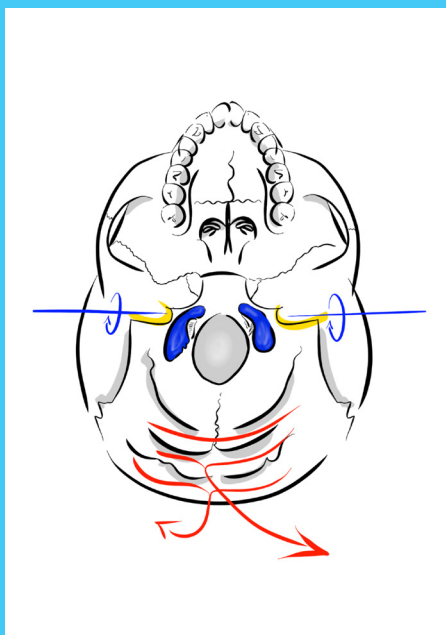
When the thoracic base of the neck is firmly in place it can through gentle muscular pull create and alter tension and movement in the bones of the cranium. These muscular pulls applied to the cranial bones will create immediate pull on the meninges as the Dura Mater is continuous with the inner periosteum 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.

Sagittal Compression Through the Occipitofrontalis Muscle

The Occipitalis and Frontalis muscles represent the anterior, posterior, and superior coverings of the neurocranium. These muscles attach into the bones they are named after, with the occipitalis attaching directly into the occiput and the frontalis connecting to the frontal bone through the Orbicularis Oculi muscle. Attaching the frontalis and occipitalis muscles there is a firm connective tissue aponeurosis called the galea aponeurotica. This aponeurosis completely ties the Occipitalis and Frontalis together; thus, these muscles are typically considered a single tissue: the Occipitofrontalis. Because of this the galea aponeurotica can be simply considered an intermediate tendon of the occipitofrontalis muscle.

The orientation of the fibers of both occipitalis and frontalis line the cranium in the sagittal plane and on contraction create compression in the same plane. Through the attachments to the frontal and occipital bones the occipitofrontalis muscle creates a compression through the sutures and inside the cranium (meninges, brain, cranial nerves). The relaxation of these muscles would of course have the reverse effect on the meninges and central nervous system [CNS], decreasing pressure on the sagittal plane.

The cranial sutures located deep to the occipitofrontalis are of practical interest as they will undoubtedly be affected by the changing tension of the muscle. As with any structure in the human body the effect on the suture will be relative to the amount of force applied and the direction of the line of tension exerted



upon them. The sutures of the brain are mainly innervated with general sensory innervation (relaying sensations of pressure, strain, pain, etc.) by the branches of the Trigeminal nerve (Ophthalmic, Maxillary, and Mandibular) on the anterior and superior portions of the

neurocranium, as well as on the highest cervical nerves (C1-3) in the posterior-inferior area. The muscular bellies of the occipitofrontalis are innervated by the Facial nerve (Cranial nerve VII) anteriorly by the temporal branch and posteriorly by the posterior auricular branch. There are numerous connections between the facial and trigeminal nerve within the face (lacrimal, nasal mucous, and salivatory glands) at cranial ganglia (pterygopalatine and submandibular), as well as within the CNS (pons and medulla of the brainstem through cranial nuclei). Communication is constant between the sensory systems of the Trigeminal and Facial nerves and indicates their mutual dependence in regulation of the cranium; this occurs neurologically through the cranial nerves and mechanically through the muscular system of the head and face. The forces the Occipitofrontalis transmits, therefore, are very valuable to a successful diagnosis and treatment of the cranium.

The coronal suture is the fibrous joint that lies between the frontal and parietal bones of the neurocranium. As the name indicates, the coronal suture runs through the coronal plane and is perpendicular to the sagittal compression of the occipitofrontalis. In this position the coronal suture can be directly pressed upon by the sagittal force of the occipitofrontalis. This compression can result in a slackening of the fibrous tissue of the suture; however, there would be increase in pressure from one bone to another with a significant enough muscular contraction.

The Lambdoid suture runs an oblique line from the sagittal suture to the mastoids between occipital and parietal bones superiorly and continues inferiorly as the occipitomastoid suture. In the previous article it was stated that the posterior neck musculature can apply inferiorly directed pull on the

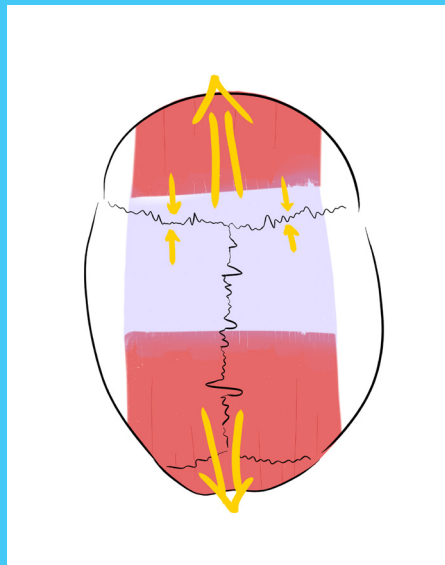
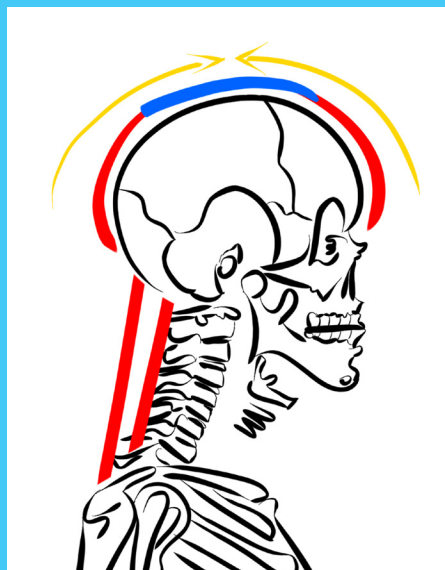
occipital bone, which can move in the sagittal plane on a transverse axis. The pull generated by the occipitofrontalis represents the reverse of this on the occipital bone as it can when contracting generates a superior pull on the posterior portion of the occiput, which would in turn create an inferiorward pressure at the base of the occiput. Further to this point, if this axis exists internal to the neurocranium, where the occiput can move between parietal and temporal bones, there should be a clearly demarcated transition zone between the mastoid portion of the temporals and the occiput.

Much like the coronal suture the lambdoid suture on the contraction of the occipitofrontalis would cause a slack in the fibrous tissues and compression of the bony structures. However, this only accounts for a contraction that is equal on both sides and if the occipitofrontalis muscle were to contract unevenly (simply one side more than the other) we have more compression on one side of the suture. Because all cranial sutures require movement to properly function, this difference in pressure can become a lesioned state.

A simple test to demonstrate the way in which the occipitofrontalis can change tension in the cranial sutures is to firmly fix the frontalis muscle (the “eyebrows” of your patient or yourself), palpate the cranial suture, and then have the patient attempt to raise their eyebrows. The author recommends palpating the more distal points of the sutures (the parts not covered directly by the occipitofrontalis such as the temporomastoid suture and the portion of the coronal suture nearer the sphenoid), as directly palpating over the occipitofrontalis will cause direct contraction of the muscle. When doing this, make note of just how much force can be generated by this small muscle and how it can be held for quite a long time.

The sagittal suture is between the two parietal bones and runs parallel with the line of force of the occipitofrontalis muscle. The sagittal suture isn't necessarily pressed upon with contraction

of the occipitofrontalis, though if the muscle contracts unevenly it could generate shearing forces in this suture. The sagittal suture, however, will have a great capacity to resist this shear as it is a heavily serrated suture. The



sagittal suture will be further considered in a later article that examines its importance to the temporomandibular articulation.

Because the frontalis inserts into the orbicularis oculi muscle, the connection helps to control the shape of the eye's coverings and pressure exerted upon the eye by the eyelid. Change in tension on the orbicularis oculi muscle and the eyelid becomes slack or taught. It should be noted that the optic nerve and

eye are continuous with the meninges and brain/central nervous system, the tissues of one forming the tissues of the other. Therefore altering the tension the occipitofrontalis exerts on the orbicularis oculi has a direct effect on changing pressure in the cranium. There is an important connection between the eye and heart that must be considered through the ciliospinal center at cell columns C8 to T2, and the cervical chain ganglia's approximation to the longus colli/capitus (this relationship will be covered in the next article).

It is reasonable to think that because the frontalis and occipitalis are small muscles they can only have a small influence on the body. Yet the width of the cranial sutures is very small (according to Mitchell *et al.* they can potentially be as small as 0.1mm by 12 months of age); even a minor pressure change in the skull can have potentially devastating effects in trauma (as in ischemia, stroke, or brain aneurysm). When considering this, it becomes probable that the occipitofrontalis muscle can have an important regulatory effect on the cranium over a lifetime.

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MYOGON MODEL – Excerpt from An Approach to General Treatment

As told by Robert Johnston

An important concept pertaining to the methodology behind general treatment from a mechanical, anatomical, and physiological perspective is found within the Myogon Model.

The Myogon Model was developed by Mr. Robert Johnston through his study of Classical Osteopathy, his readings of Still, his interactions with John Wernham and the theory of compensation, his clinical experience, and his sound understanding of functional anatomy.



From his clinical experience, Mr. Johnston found that patients with hip dysfunctions invariably show signs of dysfunction in the opposing shoulder (and vice versa). A torsional line exists within these patients, extending from one hip to the opposite shoulder, from which it can be deduced that the body

moves through planes and axes of a long diagonal torsion. The Myogon Model provides a functional anatomical explanation for why these cases with correlating lesions present themselves with such persistence.

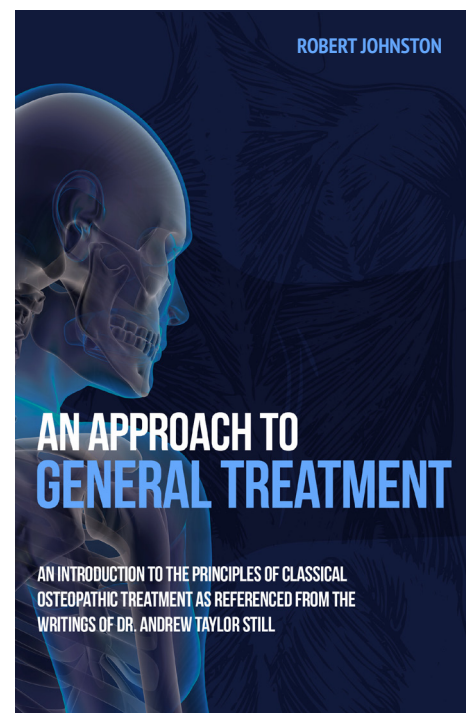
The myogons themselves are polygons, or triangular structures, that exist within the muscular framework of the body. Myogons are affiliated with the structure-to-function relationship of shapes and mechanics, where triangles provide structural support and stability; essentially, they describe the relationships of anatomical structures and mechanical lines. The myogons provide a rational methodology for working through the body. These polygons, one triangle inverted on top of another, are made up of soft tissue lateral lines that bind together the hard tissue structures from the upper girdle to the lower girdle (FIG 1.2).

The lower myogon is represented by the lines of force that follow quadratus lumborum and the iliopsoas, while the upper myogon is represented by trapezius and pectoralis major (anterior and posterior respectively). These muscles connect the upper T-line, which extends across the acromion processes of one shoulder to the other, and the lower T-line, which extends from one femoral head to the other. Although we can name specific musculature that may contribute more than others to these myogons, it is important to remember that, functionally, these triangles represent lines of force from groups of muscles rather than one muscle working in isolation. Similarly, although we can name specific hard tissue structures that comprise the upper and lower T-lines, these specific bony landmarks are used as a tool to place emphasis on any distortion in the asymmetry from one side of the body to the other, particularly in the shoulder and pelvic girdle. These myogons, represented by both soft and hard tissue, intersect

at the thoracolumbar junction, which acts as a pivot point through which these myogons have motion. With this in mind, we can draw lines of force that course through the body from one hip to the opposite shoulder.

In addition to these lateral lines, there are two vertical lines (one anterior and one posterior) whose positioning is a direct result of the tension through the lines of pull already described. Anteriorly, this vertical line is represented by soft and hard tissue that extends from the chin - through to the sternum, the linea alba, and the pubic bone - while posteriorly the vertical line is represented by the soft and hard tissues of the spine. Distortions of the aforementioned lateral lines in any direction will have a direct effect on the position of these vertical lines, anteriorly and posteriorly.

The idea of geometric shapes existing within the planes and axes of the body is not a novel concept. John Wernham referenced a system of polygons that existed in the coronal plane to describe vertebrae that act as pivots and keystones to



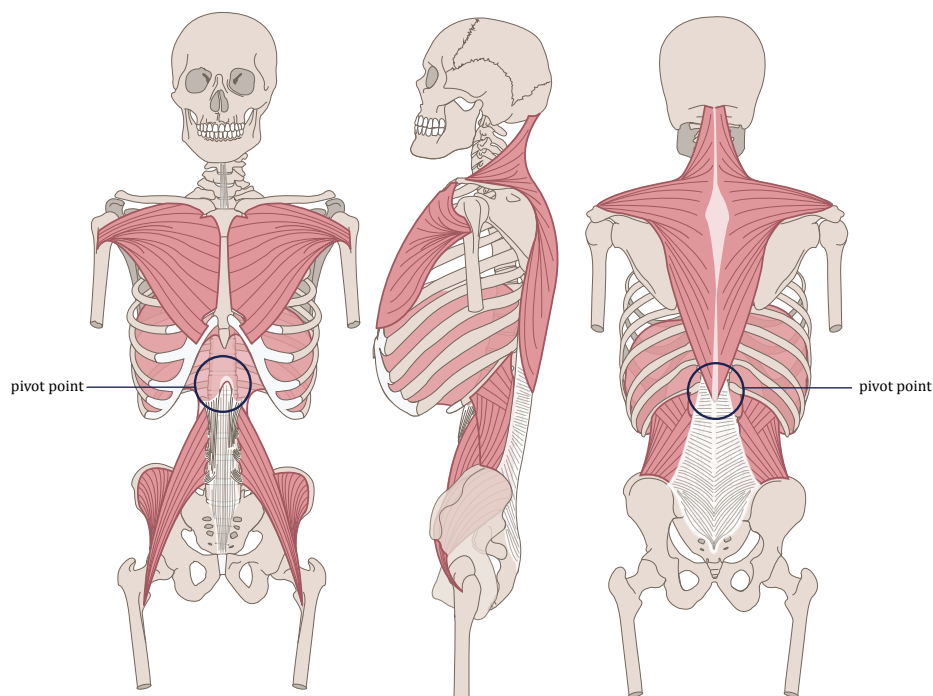


FIG 1.2: Myogons from an anterior, posterior, and coronal perspective. Anteriorly, the upper and lower lateral lines are made of the pectorals and iliopsoas, respectively (*left*). Posteriorly, the upper and lower lateral lines are made up of the trapezius and quadratus lumborum, respectively (*right*). The intersection of these two polygons, commonly referred to as the confluence of force, lies at the thoracolumbar junction and the diaphragm (*centre*).

balance the arches of the spine (Parsons, 2006). Furthermore, the idea of recurrent patterns of dysfunction occurring in the body is a concept well established by Dr. Gordon Zink in his discussions of the Common Compensatory Pattern (Zink, 1979). These processes of thinking are related directly to the precursory writings of Dr. Still:

Does man have in him some kind of chemical laboratory that can turn out such products as he needs to fill all his physical demands? If by heat, exercise, or any other cause he gets warm, can that chemistry cool him to normal? If too cold, can it warm him? Can it adjust him to heat? (*Philosophy of Osteopathy*, 85)

Dr. Still sees the body as a biological compensatory structure that adjusts to the internal and external environment as required - a fundamental component of a self-healing and self-regulating mechanism. In its optimal state the body should, ideally, be able to revert back from any extreme to a point of balance. In cases of dysfunction, he speaks of the body's inability to revert and the necessity of manual treatment to restore heat

to cold areas. This is one example of a compensatory situation:

As I began at the bases of the brain, and thought by pressures and rubbings I could push some of the hot to the cold places, and in doing so I found rigid and loose places on the muscles and ligaments of the whole spine, while the lumbar was in a very congested condition. (Autobiography of A.T. Still, 1897: 51)

During the development of the Myogon Model, rather than study the writings of Wernham, Zink, and Dr. Still in isolation, Mr. Johnston took the common principle that related all of these models together: compensation.

Compensation is the coupling of equal and opposite resultants in the body: hot and cold, mobility and stability, flexed and extended, sidebent and rotated, compressed and in tension. Even more than that, the capacity of a body to compensate is represented by its ability to adapt to stimuli while not hindering its ability to adapt to future stresses. Nearly everyone has some sort of dysfunction or lesion pattern for which their body must compensate on a daily basis; many

of us are 'functionally dysfunctional'. A body that is not compensating well for these dysfunctions may allow stimuli of a lesser magnitude, which otherwise would be able to adapt, to express themselves somatically, but only because the entire structure is already compromised. On the other hand, a body that is compensating is persistently able to adapt to its environment. Much of our ability to compensate relies on our constitution and vitality in relation to how well we adapt to stimuli, and how dysfunctions express themselves.

As the operator works through the body using the myogon lines represented by the anatomy, they are truthfully working on patterns of compensation; for example, where there is tension on one lateral line, there should be compression on the equal and opposite lateral line in the body. If these lines are unequal there will be disharmony in the entire structure. This disharmony often leads to chronic and erratic states of fluctuation indicative of a non-compensatory lesion pattern. In these cases, it becomes the work of the operator to bring those lines back into balance in order for the treatment to have a therapeutic effect.

The Myogon Model was developed in an effort to reduce the amount of labour involved in treatment, to give the operator direction for a better diagnosis (and a better palpation), and facilitate a better delivery of treatment. It provides the operator with a method of differential diagnosis, for if the operator has a sequence by which to gauge the physiology rather than giving a full body adjustment or general treatment every time, he or she can better determine the effectiveness of the treatment.

Lessons From Across the Pond: A Study of The Old Doctor's Technical Application

By: Samuel Jarman



After the pleasure of hearing John Lewis deliver a lecture that told the Canadian Institute of Classical Osteopathy members in attendance that the PRINCIPLES of Osteopathy were the most important part of Dr. Still's life and legacy, Jamie Archer ran a two day lecture and lab session to share his understanding of the actual technical applications the Old Doctor devised through those PRINCIPLES. Mr. Archer began by framing his understanding of Dr. Still in context with those people that Dr. Still was likely influenced by (including some of the Chinese rail workers, the Shawnee people, and many bone setters). Following the historical lecture to set the stage for the lab work to follow, Mr. Archer then utilized the written descriptions of technical applications directly from Dr. Still, as well as many from patients and students of the Old Doctor, to highlight the actual movements Dr. Still sometimes employed.

The overarching theme of the lab work that Mr. Archer displayed and directed was that the anatomy was the driving

factor in any technical application. With the hip, Dr. Still generally suggested compression; however, he would have been just as likely to use distraction should it be needed, based on the palpable restrictions to movement of the hip in relation to the "Y" ligament. It was stressed that a truly three-dimensional knowledge of anatomy was imperative to Dr. Still when Mr. Archer used CICO members in attendance to stand in as vertebrae, nerves, blood vessels, and other anatomical structures to demonstrate a description Dr. Still gave of a particular method.

With anatomy at the forefront and the principles of lever, wedge, and screw in hand, the CICO members participating in the lab work were encouraged to devise their own ways to address different structures in multiple positions (seated, supine, prone, lateral recumbent). The opportunity to develop intelligent uses of leverage to address different structures allowed the lab work to emphasize Dr. Still's desire that those who studied Osteopathy push forth his discovery by using

PRINCIPLES.

As part of Founders' Day Weekend at the Canadian Academy of Osteopathy, Mr. Archer's lecture and lab fell right in line with John Lewis' lecture, as well as the aim of Founders' Day: to honor Dr. Still and his discovery, and to push forth the science of Osteopathy through the PRINCIPLES. Take this opportunity to be inspired to look at the writings that Dr. Still produced and use them to deepen your understanding of Osteopathy. Take this opportunity to be inspired to look to the work of Jamie Archer and the CICO members that are taking a very deep look at the PRINCIPLES of Osteopathy as set forth by Dr. Still to push the science of Osteopathy forward in your own practice. Anatomy is your guiding star, physiological discord is your warning signal of approaching danger, and the principles of the lever, wedge, and screw will help you adjust the abnormal towards the normal.

Jamie Archer Interview

By: Adam Doris

Jamie Archer has lectured all over the world on Dr. Still and his methods. The first of his two part lecture for the Canadian Institute of Classical Osteopathy was on November 22-23, 2014, in Hamilton, Ontario. The lecture started with historical reference to Dr. Still's life to better understand where the origins of Osteopathy come from, then moved into lab work for the remainder of the lecture. When Archer was in Hamilton, the CJO had the opportunity to interview him about his views on Osteopathy.

1. Where do you feel Still fits into the modern research of Osteopathy?

I think that if you look at the writings of Still, he was wise beyond his years. He instinctively knew a lot from his practice and a lot of those findings you will often see proven true in the modern research. Still is certainly relevant and I feel that the new research will prove what he has said to be true. I wouldn't discount him. For the modern student and practitioner, they would do well to dig deep into his writings.

If you take the modern science research, it's very hard to study Osteopathy because you need to take a little piece of it and then test it. The trouble is that every practitioner and patient is different every time you see them and in terms of research it depends on what you're trying to prove. However, you can certainly prove it clinically.

2. How did John Wernham influence you as a student and a practitioner?

I was trained in the traditional, structural way and then realized from him that he could tackle much more than simply orthopedic pain. Like any good teacher, he was a motivator for me. He was well known for not giving you the answers but instead offering a word or a hint so that you can find it for yourself. Wernham made it clear that we shouldn't take what he said for granted but rather go find out for ourselves.

He was a very strong character and when he spoke, you listened. When you talk to the senior practitioner of today, we want that wisdom to rub off, but in the end they can't show you. You have to find out for yourself.

Wernham still is a great influence to me. If it weren't for him I wouldn't be the practitioner I am today.

3. Where do you see the future of Osteopathy going?

The trouble with Osteopathy is that there are typically very narrow views of it – particularly in the academic side because you need to prove the scientific aspect of it. There are those who are uncomfortable with the philosophy that we have in Osteopathy.

I'm hoping the future is bright for Osteopathy. It certainly looks bright in Canada.

There are groups of Osteopaths that are hungry for the old teachings, but I do worry about the future of Osteopathy. I'm hoping it's going to be good, but I do worry.

4. What are the effects of the regulation in England? Positive or negative?

It's been both, really. Positive because the public has become exposed to Osteopathy; moreover, some of the people that were practicing Osteopathy that weren't actual Osteopaths have been sifted out.

In terms of negativity, regulations have limited the practice. The Osteopaths in the UK are seen as any other manual therapist. You are basically reduced to telling people you can only treat musculoskeletal pain.

It's a double-edged sword.



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Discovery of the Discoverer

By: Samuel Jarman



The Founders' Weekend celebration at the Canadian Academy of Osteopathy began on Friday, November 21, 2014 with a Canadian Institute of Classical Osteopathy lecture from John Lewis concerning the discoverer of Osteopathy, Andrew Taylor Still. Before sharing some of the highlights from the lecture it is worth mentioning the journey of Mr. Lewis and how he came to write his book, *A.T. Still: From the Dry Bone to the Living Man*. Mr. Lewis is from Wales and began his studies in Osteopathy at the British School of Osteopathy. While going through his education at the BSO, Mr. Lewis found it surprising that the discoverer of Osteopathy was barely even mentioned through 4 years of formal education. As a result of this glaring omission in his education, Mr. Lewis made the choice to travel to Kirksville and investigate Dr. Still. Upon arrival there were multiple events that led to Mr. Lewis being offered a teaching position at ATSU, which then allowed him access

to large amounts of archival material. Through his access to the archival material from the beginnings of the profession Mr. Lewis was able to collect an extremely full and detailed set of insights into the life of Dr. Still. Due to the depth of inquiry, it took Mr. Lewis 15 years to write and publish the book – and that truly shines through when reading it.

Mr. Lewis led the audience at the Scottish Rite Club through the life of Dr. Still, as well as the major contemporary influences presented to the Old Doctor such as Rudolf Virchow and Herbert Spencer. The work of Virchow was apparently introduced to Dr. Still by J.M. Neal (the doctor from Edinburgh that Dr. Still believed got hung) when he sent Virchow's book to Still upon his return to Edinburgh. Virchow saw the cell as the originating site of disease and the organism as a collection of these cells. Still seems to have then pursued these thoughts to find the cause of disease in

anatomy on the larger scale. In essence, a cell's function returns to health after the anatomy is improved (a convoluted way of saying that anatomy is a collection of cells, and when the anatomy is working properly, the cells in it are also working). Herbert Spencer also appears to have influenced Still through his ideas on evolution and the connection of humans to nature or, more accurately, humans as part of nature and subject to natural law.

Mr. Lewis did a wonderful job of highlighting the philosophy of Osteopathy through his lecture. It was clear that as Mr. Lewis investigated Dr. Still and his life that Still has been all but dismissed in "modern" Osteopathy around the world. Lewis travelled extensively through America and one of his acquaintances, Dr. Robert W. Foster, was kind enough to come all the way from the West Virginia School of Osteopathic Medicine (where he is the Associate Dean of Osteopathic Manual Medicine) to provide some insight for the Founders' Day event. He told those in attendance that the most important things they can do in Osteopathy are to be honest with themselves, and to be open to where their journey takes them. In the case of Mr. Lewis, his journey showed him that the Old Doctor has been largely forgotten, but also that Osteopathy is essentially a philosophy. Mr. Lewis' view of Osteopathy as a philosophy brings us to the closing point of this article: in the words of Mr. Lewis (paraphrasing) "Without the philosophy of Osteopathy, the only right a person has to use the term 'Osteopathy' is a legal one." Contemplate this statement and think earnestly about the educational standards for Osteopathy in many schools, which are based on an understanding of techniques WITHOUT the principles and philosophy of Osteopathy. Then ask if you have given honest thought to the philosophy in your own life and practice.

John Lewis Interview

By Holly Webster

1. What was the most significant discovery you found about A. T. Still?

JL: I think the struggle he went through, the personal struggle. To have this great insight – osteopathy – and be so convinced of its truth that he vowed, “From this day on [22 June 1874] I will shut out the past with all its old ideas.” From that momentous day he determined to look to nature for knowledge, and no longer revere so-called experts or authorities – including preachers and medical doctors, the two pillars of the community – and regard everyone as absolutely equal. He determined to discard theory and tradition – stuff created by people’s minds. As he said, “Truth need not fear opinions.” The most significant thing I found through my research, though, was that osteopathy must be primarily understood as a philosophy.

The philosophy is the key, for only by understanding can you truly grasp what Still meant by osteopathy. It is not simply a system of manual therapy but a philosophical system for understanding the nature of man and the universe.

A philosophy of harmony with nature, a worldview in direct contrast to the religious teachings he learned from his preacher father that man should have dominion over nature. The latter worldview pervades our western culture: we control everything by “man’s laws,” as Still called them, rather than learning from and acting in accordance with nature’s laws. He was not saying there is no need for the legal system, but saying that if you listen to what the Bible calls “the moral law inscribed on your heart by the finger of God, the conscious bearing witness,” you can be your own judge. You inherently know what is right and what is wrong. If everyone listened to the moral law written on the heart, we would have a totally different society. I think Still wanted to see that change.

The philosophy of osteopathy is not the material philosophy of science, but the spiritual philosophy of “matter, motion and mind, blended by the wisdom of Deity.” In this all-encompassing philosophy science pertains only to the “matter” part. It is inclusive of all scientific knowledge, but does not see science as the ultimate arbiter of all truth.

Where science studies the “small parts,” as Rene Descartes called them, osteopathy is concerned with the bigger picture, the interdependence and interconnections between things. Osteopathy understands that the universe operates not in terms of separate units but in terms of principles. It is a long and difficult argument to explain, because it turns on its head the way we have been taught to think, so no wonder people find it hard to grasp. No wonder the inexperienced graduates of the American School of Osteopathy who started their own schools taught osteopathy in a diluted way. As Still used to say, “we need to show people small stars and one at a time; we can’t show them everything all at once because that would be too radical a change.”

HW: It can be overwhelming.

JL: Yes, exactly, it can be overwhelming. I’m not really answering your question, am I?

HW: Yes you are! Just much more in depth, really emphasizing the philosophy in Osteopathy.

JL: Yes, the philosophy is paramount.

2. What inspired you to write *From the Dry Bone to the Living Man*?

JL: Oh, I don’t know. When I was a kid I always knew I wanted to write a book, but never knew what I wanted to write about – and actually I didn’t really set out to write this book. I went into Kirksville with a lot of naivety, intending to look into the spiritual side of A. T. Still and osteopathy. Soon after I arrived there Dr. James McGovern, President of Kirksville College at the time, asked me to write a book on osteopathy to be required reading for every new student and every osteopathic medical student in the United States. Unfortunately, he left KCOM before that idea materialized.

When I began my research I found there was such a massive amount of material to process and put into order, and so many gaps to fill, that I soon realized I had taken on an almost impossibly large project. It took about five years to gather all the material that appears in the book.

I figured that to write a book about Dr. Still I would have to write it in an intelligent, readable and inspiring way, because the osteopathic profession has always been on the back foot, constantly challenged and threatened by the medical profession. In addition to that, I wanted to reach beyond the osteopathic profession so that the general public could learn of Dr. Still’s story and teachings, while retaining enough richness that osteopaths could learn from it.

It took me fifteen years to complete the book because I not only had to learn how to write but also work out what Dr. Still’s teachings actually were. I remember in my initial research, trying to piece together the basic story, going for walks in Thousands Hills State Park just outside Kirksville, mulling over what I’d been reading and gaining one insight after the next, all the pieces falling into place: “that’s where that goes, that’s what Still meant by that.”

At that time I never imagined how difficult a project it would be or how long it would take.

HW: It definitely wasn’t something to take on lightly.

JL: No. And I soon realized that, I had to do it my own way; I had to write a biography rather than a book on osteopathy. I told Dr. McGovern, “I’ve got two projects on the go here and they are both completely interlinked. I think I would prefer to write a biography,” and he agreed. He expected me to write the whole book in a year, and that just wasn’t going to happen. I

tried to explain it was too difficult to organize so much material, and I didn't even fully understand it all yet.

HW: And if you are doing something of that magnitude you want to be able to do it justice.

JL: Yes, you have to. What empowered me to write the book was that I thought it was just such an important story, perhaps one of the most important stories anybody could ever write. I felt very lucky to have stumbled upon it. Sometimes, though, I feel that I lost ten years of my life because researching and writing a book like that is a very solitary activity. I was often almost in despair, feeling it was too difficult, way beyond my abilities. I can't tell you how difficult it was. What makes it all worthwhile is that it is now being accepted and appreciated throughout the osteopathic community, and some are even thanking me for writing it.

3. Through your research how would describe A. T. Still as a man?

JL: I would describe him as a free thinker, a man with immense curiosity, a man who wanted to find out how things work from the inside. From his mechanical training he knew how machines operated from the inside; from watching his father prepare sermons he saw how the performance of being a minister worked from the inside. In the same way he wanted to know how the human organism worked from the inside.

He was very generous, though perhaps a little neglectful of his wife because he felt he had such important work to do. I think he relied upon her. He certainly championed women's abilities and saw everyone as equal regardless of gender. She must have found it extremely hard when he wasn't bringing home any money. He didn't really care about money, which is probably the only negative – if it is a negative.

He was generally recognized as kind-hearted, gregarious, approachable, friendly and determined. I think he never forgot anybody who wronged him [laughs], just as he never forgot anybody who was kind to him, especially from the days he was ridiculed, ostracized and treated badly by the community. He never forgot anyone who was a friend at that time. He was probably quite a complex man, I would imagine.

HW: I personally love hearing how he lectured in terms of metaphors, like lecturing on the lungs by comparison with a tree, using nature to describe the body and its laws.

JL: Yes, he would pick up a maple leaf and describe the circulatory system in relation to the veins of the leaf.

HW: He was so true to "always looking to nature."

JL: Extremely.

4. What made you gravitate towards osteopathy as a profession?

JL: When I left high school I wanted to go to medical school and be a doctor, and quite a few of my friends actually did that. But we had a woolen business in the family, manufac-

turing blankets, travel rugs and traditional Welsh tapestry bedspreads. I was the eldest son, the fourth generation of the family business. So I went to the University of Leeds to study textile technology instead, and then did a postgraduate course in textile design at the Scottish College of Textiles. At the same time as designing cloths for our woolen mill I was doing track and field athletics, and represented Wales in the long and triple jumps, even though I'm quite short [laughs]. In Scotland I joined the Edinburgh Southern Harriers and we got promoted to Division 1 of the British League, where the standard was pretty high. When I suffered injuries I received treatment from a masseur called John Gladwin who, as well as utilizing massage, dabbled in a number of treatment approaches: high velocity adjustments, electro-acupuncture on the ears, homeopathic and herbal remedies – he seemed to do a bit of everything. When our woolen business collapsed and I was out of work he said to me, "You are always asking questions about what I do. Why don't you take a course in Swedish massage?" So I did and I ended up working in a spa called Enton Hall, an old-fashioned "health farm."

One day a week an osteopath came to treat the guests, so I took a few treatments with him. He did both structural and cranial osteopathy, and seemed to know so much about the human body. I was fascinated and wanted to know what he knew, so in 1987 I applied to the European School of Osteopathy, but had no money and couldn't afford the fees. Four years later I applied to the British School of Osteopathy. By then I had a number of regular massage patients in London and although I only had enough money for the first year's fees, I was fortunate to have them paid for the last two years by the Enton Hall Trust – a bursary fund held by the health farm where I had worked.

5. Where do you see osteopathy going in the future?

JL: That depends on what the profession wants. We are such a diverse and varied group of people who work under the name of osteopathy, from (among the countries I have visited in the past year) those in the US being medical doctors with prescription rights to those in Canada and Sweden, for instance, who are not yet regulated by law. Other European countries have their own laws to regulate osteopathy, though they are likely to be standardized eventually. Osteopathy is spreading all over the world but, like the Chinese word for crisis that is composed of two characters, one representing danger and the other opportunity, it depends on the vision of those in positions of responsibility in the profession.

Regulation is always accompanied by pressure towards conformity to the dominant system. Historically that has invariably threatened the teaching of pure osteopathic philosophy and principles, and leads to osteopathy outside the US being generally taught as mere manual therapy. That is not what Still intended. I hope my book can make a little bit of a contribution towards the subject being taught in the correct way. It has been made required reading by a couple of US colleges of osteopathic medicine, with others thinking of following suit, so that's encouraging.

Since there is no general international policy with regard to osteopathic education, what is taught depends on the will of each individual country and school, and with many and varied political pressures in different countries it is very difficult to know what will happen.

My own belief is that the only way to unite the profession is around Still's philosophy and principles. The pressures we face now are virtually the same pressures that Still faced and we have much to learn from the way that he approached these challenges. Many people on osteopathic committees don't have much interest in keeping osteopathy pure. So where's osteopathy going? It is probably going to spread, in name anyway, but whether it continues to lose its way with respect to principles and philosophy depends on us all.

HW: Here at the CAO we are taught osteopathy as a principles-based science. I am very proud to say that I am able to learn it the way, I believe, Still intended. Technique is not a word we use here at school, because we are taught tools that we apply to the body in treatment using our thought process that is guided by principles and laws.

JL: Yes! You have to stick to your guns. If you keep it pure, like what Rob Johnston is doing at this school – which I think is fantastic – you will attract the right kind of people, those who want to be real osteopaths rather than those who are content to become generic manual therapists.

6. After being here at the CAO, talking to the students and seeing how we do things, do you see hope for osteopathy?

JL: Absolutely I do. Osteopathy is based on the unchanging laws of nature, so osteopathy itself will always be there. It was always there before Still discovered it. There is no problem with the survival of osteopathy, but whether as a profession we choose to practice in the way Still intended is another matter. For osteopathy to survive as a profession with its own unique identity, it is essential that all its members are guided by Dr. Still's philosophy and principles. That is the absolute key.

The fact that the CAO is growing and gaining a good reputation demonstrates that there are some who care about studying osteopathy in its pure form. The future is in your hands. When you graduate you will enter practice and influence the thinking of your patients and local communities. Some of you will become teachers and pass on what you have learned. So there is definitely hope.

When the pendulum swings so far in one direction it always comes back. And we can't discount the "hundredth monkey" phenomenon (where one group of monkeys starts washing their potatoes and distant unrelated groups start doing the same thing). It's in the ether. Virtually nobody was paying any attention to A. T. Still when I began my project, and I didn't really publicize what I was doing, but now there is a renewed interest in the founder and his teachings. In the last ten years the museum in Kirksville has become active in promoting Dr. Still, and

now there is growing momentum to revisit his teachings.

What he taught is the only true osteopathy. Anything else is osteopathy by name only. So I think with schools like the CAO there is definitely hope.

HW: For me personally, after my first day, I went home and researched even more about Still. I owned his biography but hadn't read it yet. I started it after the first day. I was here 9-5 and I went home and read. I finished it by the end of the week; I couldn't put it down. I had a complete and utter fascination with him and his story and the science of osteopathy, and it is shared throughout the whole of the school, faculty and students!

JL: That is absolutely great – and in direct contrast to what I was taught at the BSO in the early 1990s, where he was portrayed as a crank with somewhat crazy ideas.

HW: How can you have such a regard for a profession and not its founder, the very foundation it was built upon?

JL: I agree with you. Nobody talked about Still at the BSO – except perhaps me. He was regarded as unimportant, ancient history, his philosophy forgotten in favor of a medicalized version of osteopathy. In my third year I remember walking into the classroom and someone had chalked on the board, "A. T. Still is alive and well and living in John Lewis." I must have been the only one talking about him. When I read Still's Autobiography I realized he was saying so much more than any of my lecturers were. Those who get offended by being told what Still intended for osteopathy don't really get it.

HW: And those who think they know all there is to know about osteopathy don't really get it either. Every patient teaches you something new.

JL: Exactly. It is like that quote from Still in 1896: "I have been studying this science of osteopathy for 22 years now, and in another 23 thousand years I will still be in the Junior Class of the infinite." It has been a pleasure for me to come to this school and see how Rob Johnston is guiding the curriculum. His drive and enthusiasm for pure osteopathy is infectious. Without guys like that, the profession would simply follow the path of least resistance into conformity with the dominant system. You need somebody with that little bit of gusto to go against the grain and not take any notice of the forces that have perennially tried to knock osteopathy down or draw it into the mainstream. To return to your last question, there is definitely hope with people like Rob in the profession, and with students like yourself who are inspired to learn Dr. Still's osteopathy. I don't think students anywhere can get fired up with that kind of enthusiasm without focusing on the founder and his fundamental teachings.

HW: I agree. It inspires you.

JL: Truth resonates deep inside. When you hear a truth, you know it. And then you must act upon it.



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