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E.E. Tucker Explains Medicine and Osteopathy



SPECIAL INTERVIEW WITH BOB FOSTER

The **OSTEOPATHYST**

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Personal Clinical Reflection

By Sheryl Crotta, MOMSc.



In my relatively short time as a professional osteopathic practitioner, I am inspired by the process of developing my relationship with Osteopathy.

Throughout my years as a CAO student, I have learned that diagnosis — or Osteopathic Structural Diagnosis (OSD), as it is called in the field — is a primary factor when it comes to delivery of an effective adjustment and meaningful treatment. When one is a student or a novice practitioner, it is very frustrating to apply what you believe you have learned only to have that sinking feeling that your rendered treatment was a failure.

Thus far, I have found that time in practice and teaching at the CAO has taught me that assessment and diagnosis, in theory rather than praxis, appear to be black and white. This black and white mind set is often incompatible with clinical realities, and can lead to ineffective application of the principles, and therefore ineffective treatment. For me, some of the critical words that resonate when applying treatment are patterns, relationships and connections. It is critical that you connect the dots through the anatomy: this is how you learn to understand the lesion pattern of your patient on the table. This is the road map to your patients' health. You must understand functional anatomical relationships because those connections become your creative licence to access your tools of adjustment.

Clinical life is both joyful and frustrating. It can seem simultaneously effortless and arduous. I have learned to appreciate the somewhat Zen-like paradox

that lesion patterns do not follow rules while they do follow rules. Ultimately, Osteopathy is a serious business — but it is important to lighten up. When I say lighten up I mean it in several contexts: lighten up in body, mind and spirit, and literally lighten up your hands: MOVE LESS AND FEEL MORE.

Finally, when you allow yourself to drop a rigid mind set, the art of Osteopathy begins to grow. To me, Osteopathy asks that you follow your instinct and be aware of an inner impulse when applying principles. Following that subtle impulse is to connect with an inner fluency of thought and motion, one where you will find yourself following the flow instead trying to lead it. I believe this is the art of Osteopathy: to make music with treatment.

You may have heard some version of what I have written at one time or another, but one can never hear about Osteopathy enough. The deeper your relationship with Osteopathy, the more you will truly hear.

Anatomical Personality

By Samuel Jarman



When studying the words that Dr. Still committed to paper, it is important to contemplate what they are actually attempting to say.

The following citation from Research and Practice is particularly worthy of deeper consideration:

"Is a bone personally responsible in performing any duty beyond its service as a brace or support for the body while in the erect position? Does its personality extend beyond that purpose? Is it a house in which a process of manufacturing substances for repairing takes place? Does it construct its own habitation? A thigh bone to all intents and purposes is a personality in receiving, repairing and constructing the bone directly from blood."

For those familiar with the field of osteopathy, these words may be self-explanatory. For newcomers, further analysis without context may lead nowhere. In the interests of sparking discussion, some thoughts about this quotation will be presented in this article.

In keeping with the title of this piece — "Anatomical Personality" — the aim is to focus on the concept of personality as it pertains to both individual and symbiotic anatomical features. With respect to personality, it is here suggested that all structures have multifaceted personalities. Dr. Still provided the specific example of the thigh bone (above), but included similar descriptions of other structures in all of his writings. Case in point: the respiratory diaphragm. We can simply name attachment sites (internal margin of the common costal cartilage, xiphoid process, ribs eleven and twelve, as well as the anterior portions of the vertebral bodies of the first three lumbar segments); we can name neural tone (Phrenic Nerve — C3-C5); we can name the things that pass through the diaphragm. Indeed, we can do all of these things and disregard

that the respiratory diaphragm, as Dr. Still described, acts as a separating wall between the rough manufacturing floor in the abdomen and the finishing site of the lungs where the final steps in forming arterial blood occur. Unprocessed food passes through the diaphragm in the esophagus, ends up in the liver for enzymatic processes, enters the inferior vena cava to pass back through the diaphragm to then proceed to the heart, passes through pulmonary circulation, and finally enters the heart before being "officially" pure arterial blood. The diaphragm is a structural anchor for the pericardium, the pleura of the lungs, the ligaments of the liver and the stomach. The diaphragm pumps passive circulation through a vacuum effect created by pressure changes as it constantly contracts and relaxes in a rhythmic fashion. Ultimately, we can think of the respiratory diaphragm as a traffic director (by converting unprocessed food to pure arterial blood), an anchor (by stabilizing various other organs), a cleaning tool (by vacuuming the lymphatic and venous fluids through their various cleaning structures, as well as by acting as a necessary pump to the lungs for

gas exchange), and a security guard (by keeping all of these features separated from one another so that they work in an orderly fashion).

Consider the “personalities” of the inferior vena cava. Is the inferior vena cava simply a return vessel to the heart? The Frank-Starling Law notes that blood filling the heart influences heart rate, which means that the amount of blood the inferior vena cava (as well as the superior vena cava) delivers to the heart is important for cardiac function (in the form of pre-load). The inferior vena cava sits directly posterior to the liver. The liver receives nutrient dense blood from the portal system and passes it through various processes. The liver then passes that blood directly on to the inferior vena cava. In other words, enzymatic work has been performed on that blood so that it enters the inferior vena cava as almost-pure arterial blood. Considering the nutrient density and near-fully “cleaned” nature of the blood in the inferior vena cava, this cleansed plasma becomes an essential part of tissue building as a contributor

to the arterial system. Therefore, it can be suggested that the inferior vena cava is a delivery system (almost pure arterial blood being delivered to the heart and pulmonary circulation) as well as an ergogenic aid to the heart (by adding pre-load to the heart to influence efficient cardiac contraction).

We might apply the analysis of the respiratory diaphragm in this piece to the “personalities” of all structures in the body. Through this application we can bring functional anatomy to life. The process of bringing functional anatomy to life — to personify it, in a sense — has the added benefit of building conceptual connections between anatomical structures based on shared “personalities”. Thinking of anatomy in terms of personality is not an absolute must; however, it is a method used by Dr. Still to help readers understand anatomy, which suggests it may be useful as a pedagogical tool. It is of value to test out the strengths and weaknesses of thinking of the “personality” of anatomical structures to advance the understanding of functional anatomy.

Non-Alcoholic Fatty Liver Disease

Visualized and Illustrated By Lee Jarvis



Dr. Still stated in the book *Research and Practice*, “A normal image of the form and function of all parts of the body must be seen by the mind’s eye or our work will condemn us.” In the author’s opinion this can be taken quite literally.

A visual assessment of the patient is a useful skill and at times can lead directly to a primary Osteopathic diagnosis. A rapid ability to visually diagnose the patient can greatly reduce time spent in assessment by the practitioner, allowing more time to focus on correct treatment application. There are many different ways of performing a visual scan of the patient; however, the best tends to be one that involves multiple planes of perspective that highlight different structures worthy of investigation.

In the following series of images, different illustrations of the patient’s lesion pattern have been applied in the sagittal and coronal planes. Using simple lines and colour, unilateral and bilateral imbalances in the structures are shown relative to the patient’s landmarks. It is the intent of the author to use illustrations to exaggerate elements of the lesion and make them obvious to any observer. These are only a few simple examples of expressing the anatomy visually and each is provided with an explanation of what findings they best demonstrate.

The author would like to clarify that Dr. Andrew Taylor Still likely did not have access to an iPad during his lifetime, and the illustrations that follow are by no means necessary to understanding a lesion. It is hoped that the reader is able to make use of the principles of balance and compensation that the lines and shapes demonstrate, and apply them in their mind’s eye.

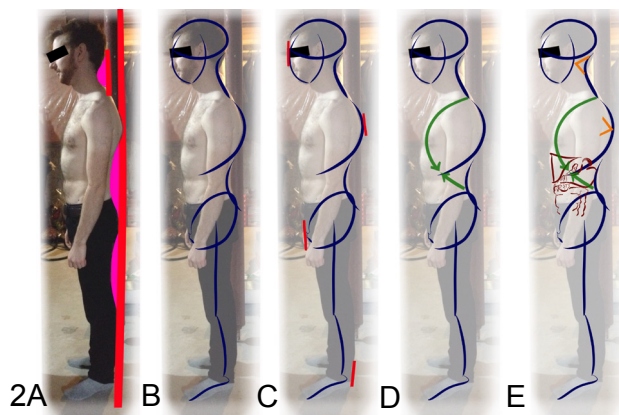
A Case of Non-Alcoholic Fatty Liver Disease

The patient seen has been diagnosed medically with Non-Alcoholic Fatty Liver Disease (NAFLD). This disease involves the accumulation of fat deposits (steatosis) and is considered to be idiopathic in cause. Steatosis is common and explainable in alcoholics; therefore the “non-alcoholic” signification in NAFLD must be specifically noted. The presence of NAFLD in the patient was discovered after a bout of Mononucleosis where an ultrasound was done to inspect visceral inflammation, at which point the fatty accumulation in the liver was discovered.

According to the patient’s history, there is at least one renal calculi present, which is believed to be extant but unmoving in the kidney.

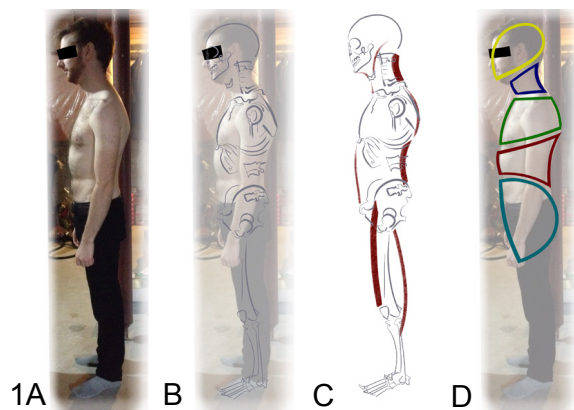
It was also noted in the initial assessment that the patient had a pungent “metallic” odor to his breath.

The Osteopathic interpretation and perceived cause of these findings will be discussed relative to the visual presentation.



In this first image (A) the patient is presented in the sagittal plane without illustration. At a glance we can see that anterior and posterior proportions of the patient are unequal. In picture B the major skeletal landmarks have been added in an attempt to gain further insight into the position and proportion of the patient's global structure. In picture C the background image has been taken away and muscular elements have been added. The muscular elements are marked in red with the thicker lines representing what the author believed to be shortened muscular tissue and the thinner lines representing lengthened or stretched tissue. When this visual approximation of hard and soft tissue is assessed properly the observer can start to determine points of stress and strain in the body and where to look for the most significant lesioning.

Pictures B and C require some level of anatomical understanding, so for the sake of comparison picture D demonstrates the proportions of the body in simple geometric shapes. For the patient's size, height, and slenderness (he is actually quite thin), we should only see small, smooth, and gently rounded curvatures if he is in optimal health. As illustration D emphasizes, the curvatures (which follow the lines of the patient's sagittal proportions) are wider and with greater apexes than should be expected. This indicates that the weight and movement of the body is not well balanced, which further indicates structural lesion.



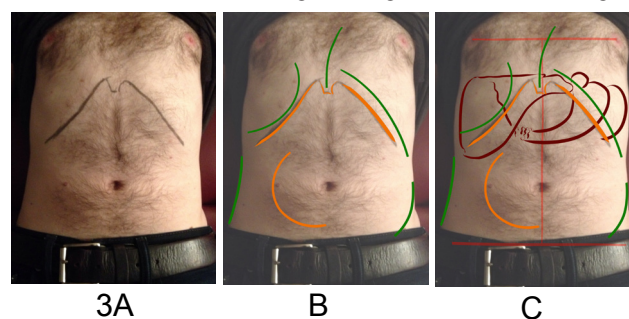
In this second set of illustrations the patient's spinal curvatures are drawn and specific areas of the primary lesion are indicated.

In illustration 2A the red lines have been placed longitudinally to represent a vertical base line for comparison against a neutral. In the sagittal plane the patient's head should be directly above his shoulders for optimal positioning, and there should not be too significant a cervical or lumbar extension. Using a pink fill between the patient and the red vertical lines the forward head posture and lordotic curves are much more apparent.

Illustration B shows what the author believed to be the global curves of the patient underlying his soft tissues. This image again highlights the excessive curvatures. In illustration C, red lines have been added to show the most prominent anterior and posterior structures and how far off the center of gravity they are. The red lines on the spinal curvatures also indicate the apexes of these curvatures and where compression and strain are most likely to occur. Note how far posterior the thoracic spine apex sits.

Illustrations D and E demonstrate the meeting of the thoracic and lumbar curvatures and how they localize to the region of the gut (green arrows). The patient can be seen clearly to have an increased kyphotic curvature in the thorax and an increased lordotic curvature in the lumbar spine. The kyphotic thoracic curvature drops the weight of the upper body anteriorly off the spine and onto the viscera. The lordotic lumbar curvature creates pressure anteriorly towards the upper abdominal viscera from below to upwards. Together the thoracic and lumbar spines generate a point of compression in the upper abdominal visceral area—an area that requires constant and proper motion to create normal venous circulation.

The apexes of the cervical and thoracic spines are indicated in orange arrows (illustration E) at important neurological locations for the viscera, that being the Vagus and the T5-9 regions.



In this third image we see a representation of the patient's abdominal area in the coronal plane. In the first picture (A) the black line was drawn directly on the patient's skin with marker at the time of assessment. The black line indicates the position of the xiphoid process and lowest point of the costochondral cartilage of the rib cage. This black line was traced out along the bone and cartilage to the best of the author's ability, and demonstrates the unbalanced shape of the xiphoid and the ribs. From this perspective the view is obstructed; however, it should be noted that the xiphoid process was "poking out" (anterior) from the abdomen (this can be better seen in the previous sagittal plane images).

In illustration B the xiphoid/rib area has been emphasized with an orange line. The upper green lines indicate the impression of the shape of the lower costal cartilages and sternum. These structures are again differently shaped bilaterally (the cartilage), and have excess curvature in what should be a relatively straight structure (the sternum). The lower green lines represent the different appearance of the innominate area's curvatures, and a "c-shaped" orange line shows an area of the abdomen bulging out on the right whereas it is flat on the left.

In illustration C, simple T lines are inserted to use as a basis for comparison across the nipple to its mid-point, down to the umbilicus, and (roughly due to the patient's pants) across the innominates. The approximate location of some of the upper abdominal viscera have also been added to show the overlap between them and the thoraco-abdominal lesioning.

To date, the patient is being treated by another (closer) practitioner and is doing well.

Still, A. T. (1910). Osteopathy, research and practice. Kirksville, MO: Author.

Anatomy of a System: Respiration

By Samuel Jarman



As a general series for the Osteopathyst we will be listing the anatomical structures belonging to a functional system of the body in order to highlight areas of initial consideration in treatment. The anatomy will be laid out sequentially according to

regions that access the neurological, vascular, lymphatic, bony, and muscular structures. As a caveat, none of the entries in this series will be exhaustive. These lists will highlight clinically relevant areas that Operators are able to interact with, as well as the large, influential pieces of anatomy influencing the general region.

CRANIAL REGION:

Structure	Neurologic Relations	Vascular Relations	Muscular Relations	Bony Relations
Occipito-Atlantal Joint	Brain Stem – pneumotaxic and apneustic centers Vagus nerve and Phrenic nerve via SCM/Carotid Sheath	Vertebral Artery and Vein, Internal Carotid Artery, Jugular Veins	SCM, Trapezius, Splenius Capitis, Sub-Occipital Group, Longus Capitis	Occiput, Atlas
Temporal-Mandibular Joint	Facial nerve, Trigeminal nerve (V3), Vagus nerve (posterior angle interacting with the SCM)	Internal Carotid Artery, Jugular Veins	Masseter, Medial/Lateral Pterygoid, Suprahyoid group (a.k.a. the oral diaphragm)	Sphenoid, Temporal Bone, Mandible, Hyoid Bone

With respect to the Occipito-Atlantal joint, be clear that it is covered by heavy musculature (trapezius and splenius are two large muscles attaching to the occiput that cover the atlas). The primary manner in which the Operator will be able to

understand the movement of the Occipito-Atlantal joint is by stabilizing the cervical region and moving the head, which is how movement fixations will be found.

CERVICAL REGION:

Structure	Neurologic Relations	Vascular Relations	Muscular Relations	Bony Relations
Cervical Column (C2-C7)	Vagus nerve (via SCM and carotid sheath), Phrenic Nerve (C3-C5 as nerve roots and SCM), segmental innervation to Scalene group, Brachial Plexus to some accessory respiratory muscles (pectoralis minor)	Vertebral Artery and Vein (through the intervertebral foramen), Internal and External Carotid Arteries, Internal and External Jugular Veins	SCM, Trapezius, Scalene group (to ribs 1 and 2), Suprahyoid and Infrahyoid groups	C2-C7, Hyoid Bone

The trachea is contained within the Cervical Region and it should be clear that all of the bony and muscular elements of the Cervical Region will have related effects on the trachea.

Issues with the trachea will lead to turbulence when loading or unloading air to the lungs as well as when altering the pressure dynamic that hinders gas exchange (generally speaking).

ANTERIOR THORAX:

Structure	Neurologic Relations	Vascular Relations	Muscular Relations	Bony Relations
Sternum	Vagus Nerve (runs medial between lungs with trachea and bronchi), Phrenic Nerve (runs medial on descent to diaphragm)	Internal Mammary/Thoracic Artery and Vein, Anterior Intercostal Arteries and Veins	Pectoralis Major, External Intercostals, Internal Intercostals, Innermost Intercostals, Respiratory Diaphragm (at Xiphoid Process)	Clavicles, Ribs 1-6, Common Costal Cartilage (Ribs 7-10)
Ribs 1-12	Intercostal Nerves	Anterior and Posterior Intercostal Arteries and Veins	Scalene Group (Ribs 1 and 2), Pectoralis Minor (Ribs 3-5), Serratus Anterior (Ribs 1-9), Abdominal Group (Xiphoid Process, Ribs 6-12), Respiratory Diaphragm (Ribs 6-12)	Clavicles, Sternum

With respect to the Respiratory System, it is important to note that the Intercostal Vessels are related to the Parietal Pleura as well as the internal surface of the ribs that act as the anchors

for the Parietal Pleura. It is also noteworthy that the Intercostal Nerves have fibers that carry sensory information from the Parietal Pleura to the spinal cord. It is further worth noting

that the muscular influence over rib movement is the driver of change in the dimension of the thoracic cavity, which is what changes the pressure to create the vacuum and compression cycles for gas exchange. The manner in which the increase in

dimension of the thoracic cavity occurs is through muscular pull on the outside of the rib, which then grabs the Parietal Pleura and brings the lungs with it.

POSTERIOR THORAX:

Structure	Neurologic Relations	Vascular Relations	Muscular Relations	Bony Relations
Thoracic/Dorsal Column	Sympathetic Chain Ganglia, Intercostal Nerves, Splanchnic Nerves	Aorta (Ascending and Descending), Intercostal Arteries and Veins, Azygos Vein, Hemiazygos Vein, Accessory Hemiazygos Vein	Erector Mass, Trapezius, Serratus Posterior Superior and Inferior, Rhomboid Group, Psoas (at T12), Respiratory Diaphragm (at T12)	Ribs 1-12
Ribs 1-12	Sympathetic Chain Ganglia (specifically T1-T4 for the Lungs and Bronchi), Intercostal Nerves, Splanchnic Nerves	Aorta (Ascending and Descending), Intercostal Arteries and Veins, Azygos Vein, Hemiazygos Vein, Accessory Hemiazygos Vein	External Intercostals, Internal Intercostals, Innermost Intercostals, Serratus Posterior Superior and Inferior, Quadratus Lumborum (inferior border of Rib 12), Respiratory Diaphragm (Ribs 6-12)	T1-T12
Scapula	Brachial Plexus	Various branches of Axillary Artery	Trapezius, Rhomboid Group, Pectoralis Minor (Coracoid Process), Serratus Anterior (all muscles mentioned are with specific respect to respiration – all other Scapular muscles will have a secondary effect)	Clavicle, Cervical Column, Thoracic Column

The Aorta (both ascending and descending portions) is essentially tied directly to the anterior portions of the Thoracic Column and sends off direct branches to form the Posterior Intercostal Arteries from Ribs 3-12. This is important for feeding the Parietal Pleura, as well as for feeding the Intercostal Group of muscles that are major drivers of constant Rib movement. The Scapula will affect the Ribs directly through

the Pectoralis Minor and the Serratus Anterior; furthermore, the Scapula has the related effect of establishing fixation of the arm against the Thoracic Cage, which offers external resistance to free Rib motion. Consider the direct effect of the Scapula on breathing to be Pectoralis Minor and Serratus Anterior; and the indirect (or secondary) effect to be the weight of the arm on the Cage if there is a scapular fixation.

LUMBAR REGION:

Structure	Neurologic Relations	Vascular Relations	Muscular Relations	Bony Relations
Lumbar Column	Vagus Nerve (as it passes through the Respiratory Diaphragm and travels along the GI Tract), Splanchnic Nerves (as they pass through the Respiratory Diaphragm and travels with Arteries to target organs)	Abdominal Aorta, Inferior Vena Cava, Cisterna Chyli	Respiratory Diaphragm (L1-L3 or L4 depending on resource), Psoas (T12-L5 and blending with the Respiratory Diaphragm on the anterior Vertebral Bodies of L1-L3 or L4), Quadratus Lumborum (inferior margin of Rib 12 and L1-L5 to the Iliac Crest)	L1-L5, Rib 12, Iliac Crest

The primary relation of the Lumbar Column to the Respiratory System is as a dynamic anchor for the Respiratory Diaphragm and the lower Ribs (the Respiratory Diaphragm anchors the lower six Ribs and the Quadratus Lumborum anchors Rib 12). Operators must maintain awareness that the Psoas and Quadratus Lumborum run down to the Femur (Psoas) and Pelvis (Quadratus Lumborum), which means that the Femur and Pelvis may be related drivers of dysfunction in the Respiratory System.

ADDITIONAL NOTES:

As was mentioned in the first portion of this piece, the list presented here is in no way exhaustive. The aim is to point to structures that are clinically available to the Operator to assess and treat with respect to the Respiratory System. With

respect to the Vagus Nerve and the Phrenic Nerve, be aware that the situations in which where they are most accessible is through their relationship with the SCM, through ensuring that the clavicles are moving appropriately, and through verifying that the cervical column is freely functioning (bones and soft tissues). Considering that this is not an exhaustive list, there is a blank grid included below to allow the reader to supplement structures and notes from their own investigations.

Student Submissions

The following pieces are written by first-year students at the Canadian Academy of Osteopathy. Kayte Armstrong is in the Practical semester of her first year. Ruth Jarvis is currently in the Academic semester of her first year. Both students offer their insights into the process of education at the Canadian Academy of Osteopathy. The process is rigorous in order to develop strong treatment skills, but also to ensure the safety of the patient and the Operator. Please enjoy their testimonials!

Osteopathy as Surgery

By Kayte Armstrong



Often in my first year at the CAO, I would hear Osteopathy referred to as “bloodless surgery”. Students were encouraged to think of every movement and manipulation as impactful and requiring the precision of a surgeon wielding a scalpel. Trust me, it is hard to keep that in mind when you are, for

what feels like the millionth time, picking up a leg. And where is the scalpel’s edge in endless repetitions of the cardinal arm movements? To the osteopathic neophyte, first-year skills may lose their shine quickly — or perhaps their purpose seems obscure, or even redundant. Yet what if one were truly to consider them as surgical skills?

As a student in veterinary school, I was not unleashed immediately upon the animal kingdom, blade in hand, with only theoretical concepts in my mind. The first introduction to surgery really came in anatomy class. Dissection made you keenly aware of which end of the scalpel was sharp (spoiler alert: it’s the pointy end), and how elusive even fixed and preserved tissues can be to poorly held tissue forceps. As the health of our “patients” at the time could not possibly be made any worse by our tender ministrations, our inept hands were allowed to fumble their way through lab.

As time went on, it became more realistic that we would indeed be in contact with living beings, and that we would hopefully keep them that way. In preparation we were given seemingly simple tasks to perform. We sliced orange peels with scalpels. We injected saline into citrus fruit. We used tissue forceps and needle drivers to thread nuts on bolts and to stack washers on pillars. We sutured up miles of foam rubble, practicing our tissue and instrument handling and our suture patterns. All of this was in anticipation of our graduation to junior surgery.

When the time finally came to perform surgeries on real patients, we astonished ourselves. Hands that were once clumsy and confused were able to utilise the tools of our trade and successfully perform as desired. That doesn’t mean the grey matter between our ears was calm, cool and collected, but at least our hands did not fail us. Suture patterns that once seem useless and instruments that appeared to be designed for anything but surgery suddenly had a context and a purpose. This left us free to concern ourselves with the surgical procedure itself.

As I reflect on my first year at the CAO, both in class and in clinic, I appreciate how much “pre-surgical” training I have received. Lifting a leg, moving an arm, diaphragmatic release — settling into the soothing rhythm of a skill set repeated many times under controlled circumstances has given my hands a confidence in how to move. More importantly, I am no longer thinking about what my hands have to do so much as I am listening to what my hands are telling me about the structures beneath them, and how those structures move and impact other parts of the body.

The analogy of osteopathy to bloodless surgery is indeed a valid one. Training starts much the same way, and skills develop over time. The basics of handling must be present before operators can sift out the background noise and hear what the patient’s body is telling them. It is impossible to diagnose, let alone treat, if the operator is clumsy and lacks rhythm. The solid foundation developed in year one has prepared me well for the challenges I will no doubt face in my next year. All I had to do was trust the process and focus on the task at hand. I must say that this year has given me a new context for the surgeon’s favourite mantra: “A chance to cut is a chance to cure”.

Understanding the “Why” of Osteopathy: A New Student’s Perspective

By Ruth Jarvis



My skeleton has become one of my besties recently. He and I spend a fair bit of study time together. I do all the writing, but he contributes significantly to my understanding of osteopathy. He really should get some kind of credit for my grades, good or bad. We’ll see.

As a year-one student, I was trying to figure out how to complete the assessment sheets for OMM. I didn't know what to write for relevant information in each section — the whats, hows, and whys of a manipulation. I felt I had copious notes and information, but couldn't find the order that was needed. As a new student without a health sciences background, I was doing my best to “learn the dance steps” of osteopathic treatment as Mr. Johnston once joked, but I knew that I needed a more fundamental understanding as to why we performed each manipulation. I struggled on to complete the assessment sheet assignments, and finally reached the portion for the prone leg rotation. I needed to be able to see the sacrum and ilium move. I heard Mr. Johnston say: “The body is made for motion”. Sam's voice from Osteopathic Theory class came through with “The ‘why’ is always anatomy”. I put a skeleton on a table in prone position with my down-table hand holding the left iliac crest to stabilize the pelvis and create a fulcrum at one side of the pelvis. My up-table hand was used to rotate the right leg. I observed the sacroiliac joint motion. The third voice came into my mind from Lee in anatomy class mod 3: “The swing part of the gait cycle looks like this...” And there began my unraveling of the mystery — the “why” of what prone leg rotations test and treat. Our body naturally repeats this motion every day: walking! Prone leg rotations test the motions in the sacroiliac joint as it opens and closes each time we take a step. The SI is part of the pelvis, and the capacity of the sacrum to rotate on an oblique axis with the innominates while walking, affects the alignment and health of all the structures above and below it.

With a patient on the table in prone position, we have the advantage of palpating the SI joint and using the leg as a lever to test and treat for opening and closing of that joint the very way it naturally does when we walk. This was a way cool moment for a year-one student. It made sense and helped me to sort out what Mr. Johnston was looking for in the assessment sheets, starting with the “why”. Even better, it reminded me of the purpose of osteopathy: “to find health” in our patients and to help each patient move closer to their ideal health (Andrew T Still, Philosophy of Osteopathy, 1899).




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Guest Submissions

Anatomical Connections and Their Role in Osteopathic Diagnosis: Part 1

By Charlie Beck, DO, FAAO



My goal is to launch an article series that catalogues the patient perspective. Essentially, it will highlight what my patients have taught me over the years regarding the interconnectedness of anatomical functions. They (my patients) continue to encourage me to “dig on” and to deepen my understanding of osteopathy and the anatomy it encompasses.

A simple yet representative place to begin is with an ankle sprain. I have seen a number over the years, yet each is unique and adds a new layer to my understanding. By rote definition, the injury involves the cuboid bone. According to John Martin Hiss, MD, DO, the cuboid is the keystone bone for the lateral, or load bearing, arch of the foot. In order to sprain an ankle (fractures are different), this keystone must shift to “allow” the sprain. When the cuboid moves, the arch can “collapse” and the lateral stability of the foot is compromised. The body can then “roll” or manoeuvre around this instability. A succession of complications ensue; they may not always occur in each patient, but the principles are present in each patient. Ligaments can tear, tissues can get inflamed and, in extreme cases, bones can break.

When the cuboid moves, the lateral arch shifts. This shift changes how the bones of the foot interact with each other; most bones exhibit less moment in an effort to support the foot and provide stability. The talus, for example, usually torques between the medial and lateral malleoli. This joint is a mortice and tenon joint and is normally tight and very stable. The only way the talus can shift (outside of a fracture) is if the tibia and fibula

separate slightly, which makes the joint “loose”. As the talus shifts, the calcaneus moves; this tandem disturbance will put pressure on the talonavicular ligament (as well as on other ligaments), which will shift the fibula caudad downward. These disturbances have a cumulative effect that lead to other dysfunctions. The Cumulative Effect:

When the above disorders accumulate, the tensor fascia lata comes under tension via the iliotibial tract and the lateral collateral ligament. The TFL’s origin is the iliac crest; thus, when it is under tension, an innominate outflare is the result. This TFL tension also happens to be overlying the Chapman’s reflexes for the large intestine (and stimulation here can cause symptoms ranging from diarrhea or constipation to diverticulitis). The loss of lateral stability in the foot also causes an alteration in the weight distribution of the body, which can cause a cranial lateral strain. The change in weight bearing in the foot manifests as a change in gait; subsequently, this gait adaptation manifests as an abnormal tension in the postural muscles on the affected side. Tension in the quadratus lumborum, iliacus, erector spinae, etc., is a further consequence of this postural adaptation. If, for example, quadratus lumborum is involved, the iliocostalis can become stressed. The result is that the trauma of a simple ankle sprain can extend into the rib cage, the cervicals, and potentially into the cranium, through direct linkages in the muscle chain (even if we leave out the fascia). The lateral strain, mentioned before, can cause a shift in the dentition (teeth) that can show up as a shift in the contralateral lower molars, which can cause the symptoms associated with TMJ restriction. There are a range of symptoms that this chain reaction can trigger in your patient.

Symptoms ranging from headache (from the lateral strain), to IT band syndrome (common in runners), to constipation (via the Chapman’s reflexes), to sciatica (from involvement of the iliac and how it can distort the pelvis). All of this is fascinating to think about and discuss with your colleagues. It can lead to in-depth dialogue where you can learn a great deal of qualitative information. But your patient enters your practice with an ankle sprain—and then what? If it is acute, the problem can be fairly simple—you might just need to treat the cuboid—but if it is chronic, other more complex treatments may be necessary. Many of the extant symptoms may be running in the background, so to speak. It’s as though the body has said “I can’t fix this easily, so, I just have to adapt and deal with it.” What do we do then? This is where finding the “key” or primary lesion is important. Locating and correcting the primary lesion in the chronic dysfunction can have a profound impact on these patients. It might not sort out every problem in one visit, but it alleviates many symptoms and even completely resolves others.

In part two, we will begin to discuss how to identify the key lesion.

E.E. Tucker Explains Medicine and Osteopathy

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



INTRODUCTION:

Ernest Tucker was a student of osteopathy; upon graduation he became a faculty member at the Founding school in Kirksville. It was during

the seventeen-year mentoring/friendship with Dr. A.T. Still that Tucker wrote down a series of conversations about a variety of topics. Here are highlights of Tucker's observations and information from conversations with Dr. A.T. Still. Presented below are Tucker's verbatim notes, with our editorial changes represented in brackets.

The degree of Doctor of Osteopathy "was never conferred on him *causa honoris* as far as I know, by the institution that he founded [correction: the Board of Trustees did confer to A.T. Still an Honorary D.O. degree June 22, 1897, before he met Tucker]. It seems somehow not fitting. He was quite above such questions as academic degrees.

There was never any question as to the degree Doctor of Osteopathy, in his or anyone else's mind. Medicine meant drugs, period! It meant drugs, in his mind and in the minds of the whole population. It was necessary to make a distinction, clear and complete.

The true meaning of doctor is teacher; and the meaning of degree, as applied to it, means that the person so designated has attained in his studies the degree of knowledge that qualified him to teach it.

The true meaning of medicine is anything used curatively, anything used to treat disease, or a sick person. The classical term is *materia medica*, which means material things, as drugs, used as remedies for sickness.

Materia medica is called internal medication, in the sense that it is introduced into the body through the mouth; or more recently through the needle. But not many persons think classically in

these days. In practice, and on the hoof, medicine means just drugging."

A.T. Still asks Tucker, "Does the body have intelligence? Should we not treat it according to its intelligence?"

"By what right, or what law or what creed do we ignorantly interfere with the workings of that so perfect machine? He abandoned drugs; obtained a divorce."

If not drugs, what? "I began to study the body as a mechanic."

Incidentally, that "Internal" medicine is far from being truly internal; quite the reverse. It remains external to the living mechanisms to the end. It is inside, but not internal. Its only relation to the living operations of the body is one of defensive reaction. Even when these materials are made to approximate so closely to the normal nutritive processes that they are assimilated, and do become part of the living machinery; still there is a defensive reaction against them that constitutes a very large part of their effect.

In contrast with this, the osteopathic method is corrective, enabling, liberating, and it does not have to invent; it merely discovers. The contrast was complete, and it still is so today. The two systems represent, as said, opposite orientations. In osteopathic schools it is found to be impossible to modify sufficiently the indoctrination with the *materia medica* concept in a few months of post-graduate study. They have found it necessary to require even of fully trained medical graduates, to take the full course in osteopathy. I am reminded again of my classmate Dr. Bancroft, who protested: "If you fellows are right, then we fellows have to go back to school and study all over again! To him that was a sufficient and compelling reason why we could not possibly be right."

The way Still put it was: "Did you ever see a coon [raccoon] try to climb two trees at the same time?"

Of course the human mind should be broad enough to hold both of these

approaches, these points of view, at the same time; to climb both of those trees. But the practical fact is that it is not; not, at least, in the developmental stages. Development calls for a different psychology from purveying. The effective fact is, too, that the medically trained mind is in fact and in effect very nearly estopped from even considering this osteopathic approach.

It ought not to be so, but it is so; and the reason for it must be sought in the field of human psychology. Some few medical practitioners have allowed themselves to "see" the significance of this osteopathic contribution, it is true, nor can I say what goes on in their minds. But they apparently cannot afford to allow themselves to make the re-orientation. Their investment in medicinal education represents approximately half of their lives. Must they throw it all away, and start again?

The osteopathic contribution has also advanced, in that time; as noted; but it has not been the same jack rabbit advance that medicine in other fields has been; rather a slow ground- growth; but stable and sure.

One effect of this stupendous advance in medicine has been, of course specialization. And in that field of specialization, the effect has been that in each and every one of those lines, the amount of knowledge that has accumulated is far greater than any one mind can possibly cover; and more learning is pouring in every day. Each doctor lives in his specialty. There is no time in their days, no room in their brains, no interest economic or scientific in any developments outside of them.

And an effect that arises from this is that medicine has become chaos; a higher chaos, but a chaos for all that; a conceptual chaos, where the more one knows the less one knows about things.

These effects are somewhat like the effect of the three blind men examining an elephant [this is a parable where each man describes a part of the elephant and

the whole coming together makes no sense]. They lacked the central truth, around which to assemble their impressions; and the effect was chaotic.

Medicine is now due a period not of extension but of ordering, simplification, co-ordination, unifying; a period of intention. For certainly the living organ-

ism — complicated as it undoubtedly is, seen externally — is simple seen as from the inside.

The symmetry and order are there, but have not been considered merely because men's minds have been looking in the opposite direction. They are due for a bit of reversed orientation. Osteopathy

can supply that simplification; or rather, Still could supply it. He is still Andrew Taylor Still.

Source: E.E. Tucker Papers
Charles E. Still Sr., D.O. and Charles E. Jr., D.O.
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Museum of Osteopathic Medicine and ICOH



The Thinking Osteopath: Principles Applied in Practice

By Robert Johnston



Excerpt from *Introduction to Osteopathic Principles in Practice* by Robert Johnston

A Clinical Work

The pages that follow are an introduction to a culmination of a life's work in the practice, education, and promotion of Early American, Stillian Osteopathy. To be clear, the proposed book is not a scholarly work on osteopathy; indeed, this is a principle-based book for the clinician. As such, any scholarly detractors who might be looking for quotations, references, and historical timelines from early osteopathic literature are invited to read the original texts and see

to what findings we have allied ourselves that aid in the delivery and effectiveness of treatment. The goal of this project has been to locate the common thread among these texts, championed by the works of A. T. Still, and present them in an updated, workable methodology for the modern practitioner.

The truth of the matter is that the current state of osteopathy is fragmented. In presenting this work on the side of the clinician, we are hoping to forge a united front for osteopathy that does not

favour any one particular school or approach, but instead, works to include the best of what all factions have to offer, and utilize them as they work within the greater framework of osteopathic approaches to assessment and treatment. If we refer to the anatomy in conjunction with our current understanding of physiology, there is little to hold us back from evolving the principles set up by Still and the early osteopaths. To this end, our desire is for practitioners to bring their voices to the discussion of the osteopathic lesion in ways that advance our science by yielding a better result for the patient.

We want to stress this latter point of communication among all those practicing manual osteopathy around the world, as we cannot afford to allow abstruse intellectualism—or egoism—ruin the chances of our survival. Now is the time for uniting our efforts to once again take our collective position as practical contributors to improving the quality of life of all people, everywhere. We owe this to the founder of osteopathy, and those men and women who faithfully aspired to see his work succeed. As such, we are humble in our approach, and yet unflinching in our proposal, as he and they would have wanted.

As an introduction to osteopathy, the reader should not be looking for the definitive answer for everything required in the application of osteopathic principles to mechanics, diagnosis, and treatment. To reiterate, this is an introduction; it is a chance to plant a seed. As we will articulate in the first chapter, it is up to the reader to tend to that seed to ensure it flourishes.

Layout

This book is the collection and distillation of what, in our view, makes osteopathy so relevant today. To be sure, this has been no easy task, as we have also had to overcome obstacles; however, our approach has been founded on rational inference through clinical application

and logical deduction of the anatomy, physiology, and mechanics of the human body, as laid out by the founder of the science of osteopathy. Moreover, it has been organized and expounded in a way that is digestible for both veterans and neophytes of osteopathy.

The book is divided into four sections: a philosophical introduction on the Principles of Osteopathy; a discussion on Collective Mechanics; an explanation of principles in Collective Treatment; and finally, a Clinical application with five Case Studies that serve as examples of how the previous sections coalesce. These four divisions are included to help readers navigate the different parts of the book for studying purposes. By the time readers finish the book, however, they will soon realize there has been only one topic of conversation throughout: osteopathy. They will notice that when we are discussing mechanics, we are really talking about treatment; that when we are talking about the upper limb, we are discussing the lower limb; that when we are discussing some of the philosophical differences that exist in current osteopathy, we are really discussing the functional anatomy and the physiology involved in the diagnosis and treatment of the osteopathic lesion.

Section I

In the first section of the book, we discuss many of the challenges practitioners of osteopathy face, and attempt to provide a roadmap on how to correctly navigate the terrain that will lead them to a promising career in the service of their communities. We also address the fragmented landscape that is osteopathy, and attempt to begin a conversation that brings all those practicing our science to the table, so that constructive discussions can be formed. Through those dialogues, an evolution in our practice can take place.

To do this, we have had to tackle some difficult topics, including what it means to be Classical, Stillian, or Eclectic. For some, this will not be a comfortable element of the book, but if we are to evolve, as we suggest, we must be open and honest with our assessment of our views on

what constitutes osteopathy as defined by the founder. Indeed, this becomes a common theme throughout the book, not only to justify our approach, but to offer clarity to practitioners who do not have the time, education, or experience to know why they are being asked to do what is to be done.

We end the section by showing how the philosophical precepts discussed can influence the way we treat, which begins with palpation. Here, we discuss the barrier model—in a slightly different way than typically presented—that reflects three levels of lesioning that should be quantifiable to any and all practitioners.

Section II

Although we discuss the barrier in relation to the osteopathic lesion at the end of Section I, we do not directly discuss why or how it got there. That is what we attempt to do in Section II and III. To do this, we propose a comprehensive way to understand what we have called Collective Mechanics, which is based on a polygonal model of how the body loads and distributes force to find and maintain health. We begin with the axial frame, and move to the limbs, both lower and upper. In doing this, we map out many of the findings discussed at the end of Section I, but do so in such a way that the reader will not have to memorize a series of findings, but rather be able to read the body osteopathically. From our perspective, this gives great freedom to practitioners in how they then choose to treat the body in a manner that takes advantage of the functional anatomy and the body's desire for health.

This section is the heart of the book. It is the keystone for introspectively analyzing our treatment process and philosophical view. It is based only on the principles of osteopathy and our understanding of the functional anatomy of the body. From this perspective, we hope to establish an osteopathic way of thinking about the body that subsequently leads to a more collective approach to treatment.

Section III

Section III is a continuation of the previous section, but with an emphasis on

causative effects resulting from different perspectives; it concludes with our approach to diagnosis, sequencing, and treatment. Here, we discuss the principle of correlation, which focuses on a differential diagnosis based on the Collective Mechanics discussed in the previous chapters. Unique to this section is our attempt to provide a methodology that is both logical and particular to each practitioner and individual patient. What is proposed is not routine; nor is it a technique-based approach. Instead, it is a way of enacting the principles as deemed necessary by the functional anatomy and the level of maturity and knowledge of the osteopathic practitioner involved.

As a consequence of formulating such a process, we then note qualities and characteristics that result from this carefully delineated approach based on principles. We hope these elements help the readers understand their goals of working with the body, rather than performing techniques and forcing their will on the patient

Section IV

In the final section of this book, we have brought together Case Studies as examples of classically principled approaches to osteopathic diagnosis and treatment. They are not meant to be definitive in any way, and any readers who take them as such do so at their own peril. These are attempts to bring the previous sections to life, and to continue to spur osteopathic thought that will help practitioners reinforce the most important criterion for us clinically: the thinking osteopathic practitioner is a safe, qualified, and effective caregiver.

To conclude, readers should use this section—as with all sections—as a way to develop their osteopathic understanding of how the body works, and how they can facilitate the healing mechanisms inherent in the body. From reading the anatomy and physiology as the founder intended, we note that there is a certain grammar to the body reflected in its mechanics. It is from this perspective that we are able to interpret the body, and react to our findings by aiding the body, through its structure, to find health.

The Rule of 9 Model by Robert Johnston

By Robert Johnston with Samuel Jarman



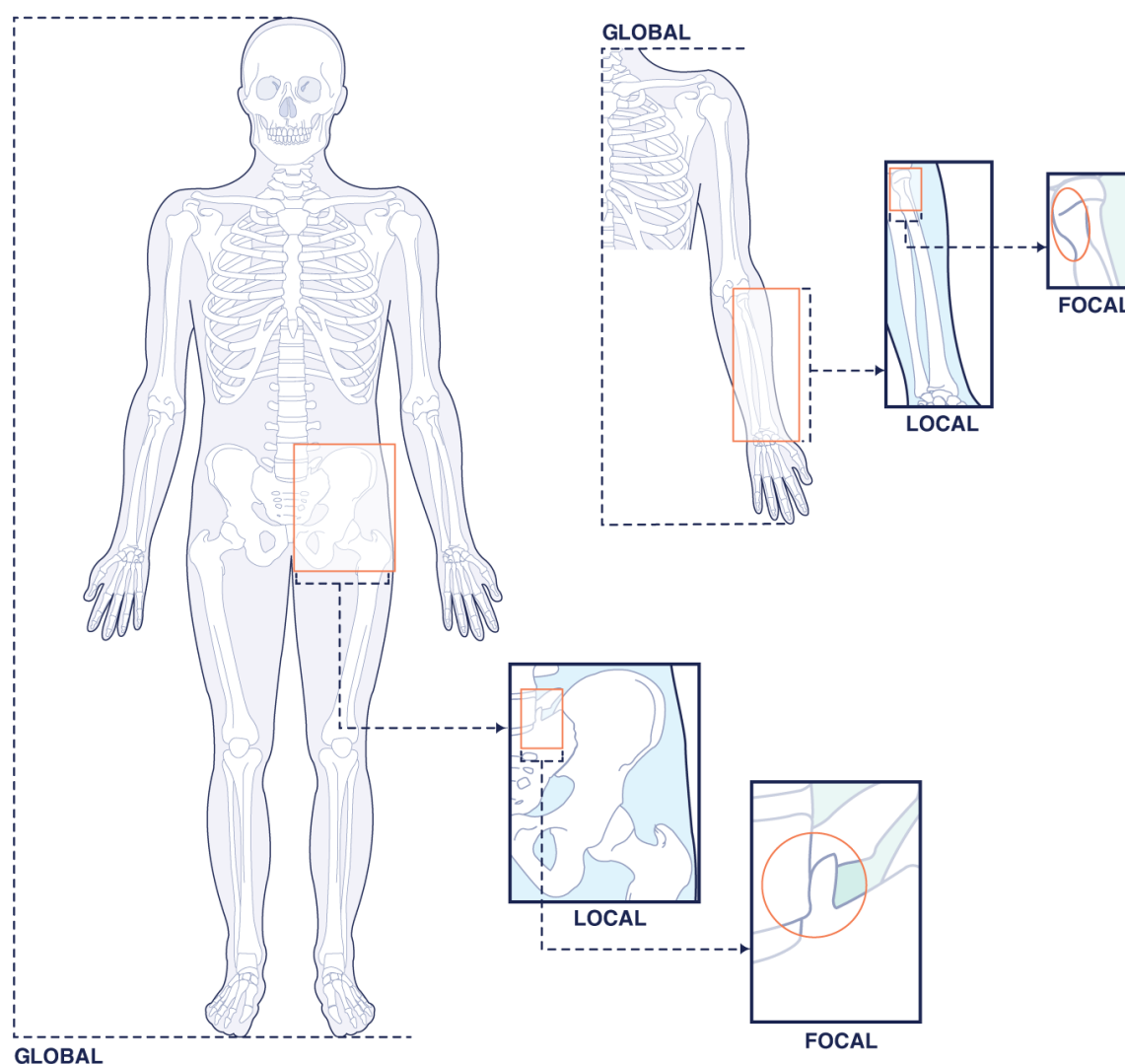
As a defining principle of assessment and treatment, The Rule of 9 is intended to enable the Operator to gain control of the information acquired through Osteopathic Assessment. Before

any further description is provided, each part/triplet of The Rule of 9 will be named. Each component of The Rule of 9 is as follows:

Global	Local	Focal
Primary	Secondary	Tertiary
Superficial	Intermediate	Deep

Each triplet contains its own concept and is applicable in the other two tripartite categories. Additionally, each triplet is applicable in both Assessment and Treatment. What follows will be a brief explanation of each component and how they fit into both Assessment and Treatment.

Global, Local, Focal



Global: The largest possible view of the body or of any subsection of the body. The Global picture may include the full body, the right side of the thorax, the left leg from the knee down, the entire ver-

tebral column, the lumbar portion of the vertebral column, all parts of the respiratory system, all the parts of L3, and so on.

Local: The generalized area of dysfunction within the Global frame of investi-

gation. The Local picture may be represented by the following: ribs 3-5 when investigating the right side of the thorax, the lateral compartment of the left leg when investigating from the knee down,

the mid-thoracic region when investigating the entire vertebral column, L2-L4 when investigating the lumbar portion of the vertebral column, the attachment sites of the diaphragm when investigating the entire respiratory system, the right side of L3 when investigating the general region, and so on.

Focal: The specific area of dysfunction within the Local frame of investigation. The Focal picture may be represented by the following: rib 5 at the attachment site of pectoralis minor, the superior portion of the interosseous membrane on the left leg below the knee, T6 and T7 found in extension when investigating the entire vertebral column, L4 found in flexion when investigating the lumbar column, the common costal cartilage on the left when investigating the diaphragm as a component of the entire respiratory system, the superior right facet when investigating L3, and so on.

The aim of this tripartite categorization in The Rule of 9 is to control the information so that the Operator is able to move from the Global dysfunction to the Focal dysfunction and back again as needed. In a mechanical sense, the Global dysfunction will likely be the most impactful as there will be a larger amount of anatomy at play. There are times when the Global dysfunction is a result of the Local or Focal dysfunction, whereby the proper tools are required to recognize these patterns. The initial tool to determine whether or not the Global dysfunction is driving other dysfunctions is to apply treatment, and then see if the symptom is alleviated. If treating the Global dysfunction has not mitigated the problem, the Operator will spiral down through the Local and Focal dysfunctions as needed.

Primary, Secondary, Tertiary

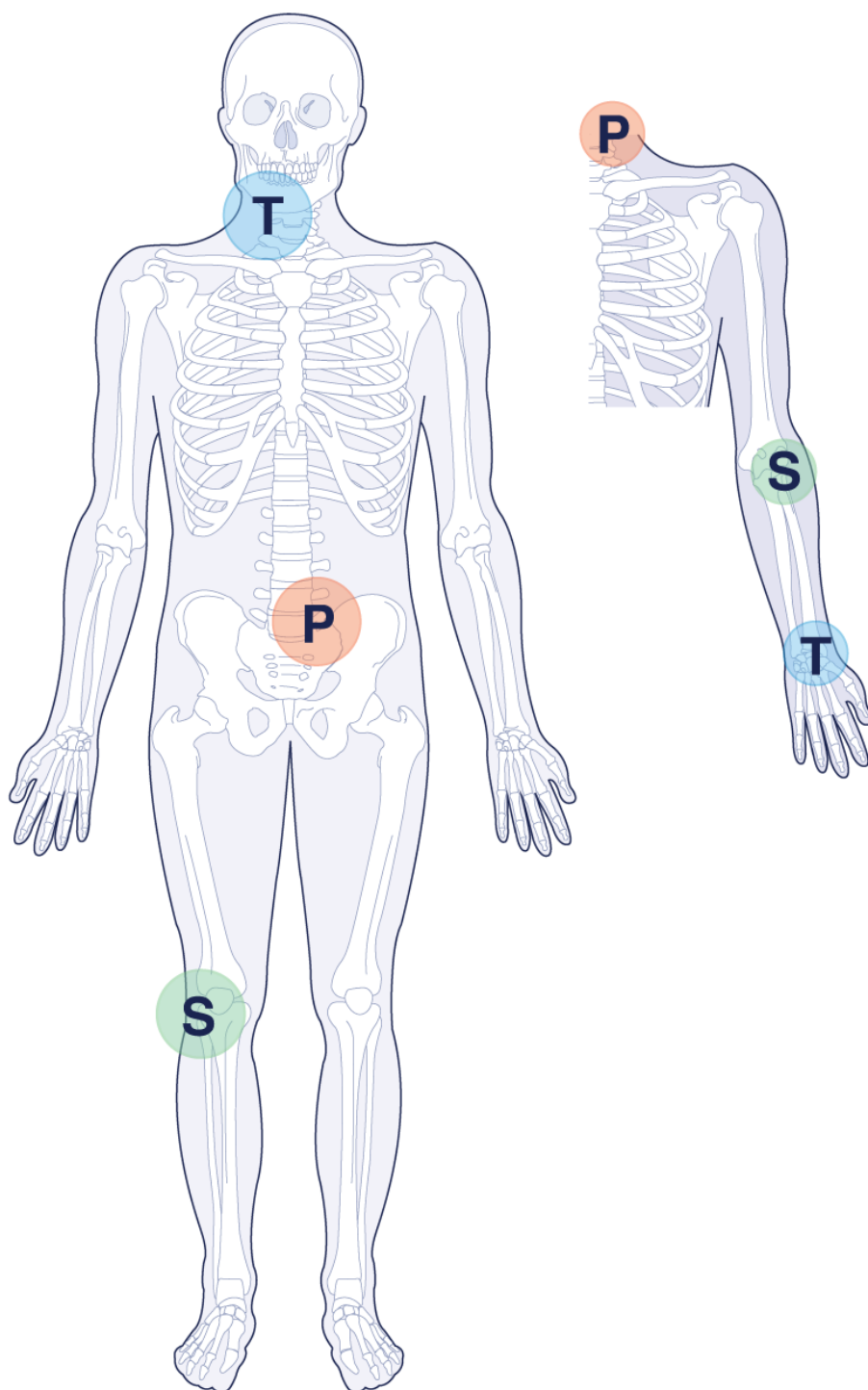
Primary: The area or structure with the greatest motion loss within the area of investigation.

Secondary: The area or structure with the second greatest motion loss within the area of investigation.

Tertiary: The area or structure with the third greatest motion loss within the area of investigation.

The aim of this particular tripartite category is to allow the Operator to isolate various areas of dysfunction and prioritize them. By prioritizing the areas of dysfunction the Operator will be able to apply treatment to the Primary lesion and have a greater impact on the Secondary and Tertiary lesions. When the Operator is not able to apply treatment to the Primary lesion (such as in the case of

a traumatic injury), then they are able to spiral out and treat the Secondary or Tertiary lesion in order to have an effect on the Primary lesion. Through prioritizing the areas of dysfunction/lesions, the Operator gains control over where and why to apply treatment. This triplet criteria is applicable in the Global, Local, or Focal regions of investigation.



Superficial, Intermediate, Deep

Superficial: The Superficial layer is made up of Myofascial Tissues and thus most often presents histological changes that respond best to Direct Barrier Myofascial Release (dMFR).

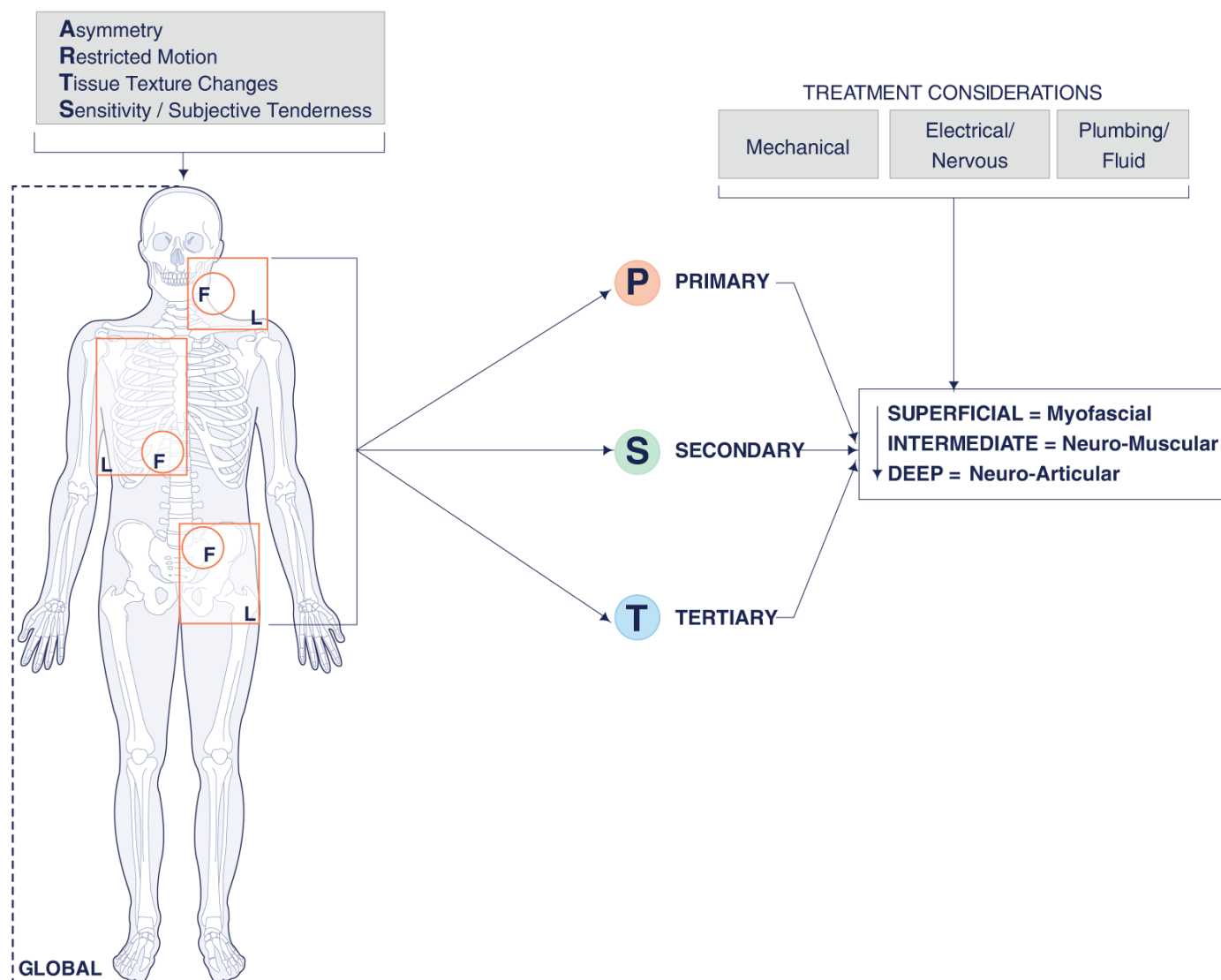
Intermediate: The Intermediate layer is made up of Neuro-Muscular Tissues and most often presents Neuro-Muscular discord that respond best to Direct or

Indirect Barrier Neuro-Muscular applications (Post-Isometric Relaxation, Reciprocal Inhibition, Strain Counter-Strain).

Deep: The Deep layer is made up of Neuro-Articular Tissues and thus presents a mixture of Neurological Reflex changes that respond best to Indirect Barrier Applications (Facilitated Positional Release, Ligamentous Articular Strain/Balanced Ligamentous Tension), as well as histological changes to articular tis-

sues (ligaments, tendons, muscles), the latter of which respond best to dMFR.

The aim of this triplet criteria is for Operators to recognize the layer of dysfunction so that they are equipped to choose the appropriate tool to treat the layer. This triplet is applicable whether the dysfunction is Global, Local, or Focal, as well as if the dysfunction is Primary, Secondary, or Tertiary. This triplet is where the “how to” of treatment is chosen.



Pulling the Triplets Together

Through understanding each of the triplet categories and their components, the Operator will have the capacity to control the information gained through assessment, and will be equipped with the practical tools to correct anatomical aberrations. The Global, Local, Focal triplet allows

the Operator to examine the entire body or the totality of a system/structure and narrow in on dysfunctions. The Primary, Secondary, Tertiary triplet allows the Operator to decide which dysfunction is the most impactful and whether or not they are able to treat the Primary lesion, or if they have to treat the Secondary or Tertiary lesion in order to affect the Primary

lesion. The Superficial, Intermediate, Deep triplet allows the Operator to understand which layer of tissue the dysfunction primarily manifests, and which tool best mitigates the characteristics of that tissue and the lesion it presents. Using The Rule of 9 allows for accurate assessment and treatment in order to make useful clinical decisions.

Lessons From Across the Pond: Strengths and Weaknesses of Models

By Samuel Jarman



On June 13th and 14th, 2015, the Canadian Institute of Classical Osteopathy hosted Francisco Toscano Jimenez. Francisco presented his understanding of the Body Adjustment model as taught to him by the late John Wernham. Francisco did a wonderful job describing the theoretical basis of the Body Adjustment, as well as demonstrating the application of the Body Adjustment routine.

Aside from the exposition of the Body Adjustment, Francisco was impressive in many other respects. Namely, he was willing to engage in discussion and discourse regarding the model. Through the discussion Francisco suggested that the Body Adjustment routine is most appropriate in chronic conditions. In Francisco's view, acute patients are not apposite candidates for the Body Adjustment. Acute patients are more appropriately treated with indirect and, often, short lever applications. Francisco also emphasized that the Body Adjustment model is, to him, simply a schematic that provides him with beneficial clinical results. In the light of Francisco stating that the Body Adjustment model is one that provides him with good clinical results, he also made clear that other models that are more effective for a given Operator are just as useful because they provide a conduit towards optimal clinical success.

Through the discourse surrounding the strength and weakness of the Body Adjustment, Francisco was able to highlight an axiomatic general principle: It is not the model that matters, it is the ability of the Operator to gain strong clinical results through individual understanding and application of the model. In that light, any model is only as useful as an Operator's ability to understand and apply it clinically. Some models are much more approachable than others. There is a tendency for some models to be overly complicated and fraught with jargon, and that often makes them harder to understand and apply. It is important to be willing to discuss the strengths and weaknesses

of all models so that we, as Osteopathic practitioners, are able to learn how to interact with all models and employ them as the situation dictates. If we are able to take anything away from Francisco's presentation, it is that we should be open to discussing the strengths and weaknesses of models so that we can use them where they are clinically appropriate.

Paco Toscano Interview by Adam Doris

1. How would you define the general osteopathic treatment?

To sum it up, it's applying the principle of the concept of "integration" in all sorts of different planes—chemical, physiological, environmental, etc.—in relationship to human form and function. The general osteopathic treatment is open to interpretation depending on the time and the patient.

2. How does the body adjustment and general treatment compare and contrast to each other?

In terms of these two, from my point of view, it is a holistic way to understand form and function. For technical application and practical application, there are certain considerations you must take into account. Depending on the patient's presentation and differentiation of acute and chronic conditions, you accommodate the treatment to the needs to that patient.

3. What are the situations where general treatment is appropriate?

In my understanding, the general treatment is to understand the approach from a diagnostic and therapeutic intervention. It's the integration between the diagnosis and treatment.

4. Do you see a possibility for there to be osteopathic research to gain scientific knowledge?

Of course, but it must be done with the inclusion of the principles so that we can create a research methodology that will encompass biology and system interactions. "System" as a word denotes a relationship to constituent parts; thus, the actual term "systematic treatment" encompasses all anatomical relationships. What this means is that a research program that honours the definition must use a method that provides the capacity to correlate the systems to and from each other.

5. Where do you see the future of osteopathy?

I think the future of osteopathy depends on several factors. There are many different trends and I think that one has to be aware of the socio-economic and political limits or considerations that modify the education and development of the profession.

Philosophy and Experience

By Samuel Jarman



On the weekend of July 18th and 19th, 2015, the CICO put on a seminar with John Lewis and Dr. Robert Foster. Both of these gentlemen were present for the Founders' Weekend in November of 2014, and were gracious enough to return and share their knowledge with the CICO members once again.

Mr. Lewis shared his knowledge of Dr. Andrew Taylor Still from both a historical and a philosophical perspective. The historical perspective that Mr. Lewis expounded is very useful for understanding how Dr. Still formulated the philosophical tenets of practice, which comprise the foundation of Osteopathy. The important message provided to the CICO members was the same that Mr. Lewis delivered on Founders' Weekend: Osteopathy is a philosophy. To be clear, it is not being suggested that Osteopathy is a philosophy

only, or that it is predominantly theoretical; rather, it is a practical philosophy. Osteopathy is a cognitive lens through which an Operator will investigate a human being in order to understand where disconnects are occurring with respect to health and wellbeing. Dr. Still looked at the same anatomy that every other medical professional studied, and yet received different results by employing the cognitive aspects of Osteopathic philosophy.

Dr. Foster presented on the ideas of Tensegrity and how it appears in the body structure through the constant shifting tension placed on fascia. Dr. Foster demonstrated the principles of fascial unwinding and the CICO members were able to put those principles into practice on the tables. Dr. Foster also presented on the trimesters of pregnancy and common issues related to the natural and

normal progression of hormonal shifts. Many anatomical issues that surface during pregnancy resolve with childbirth; however, they also respond favorably to intelligent Osteopathic work. Dr. Foster has a unique perspective as he has a large amount of experience with obstetrics. The opportunity to learn from Dr. Foster's experience was the most valuable part of his presentation, as he not only has a refined academic understanding of the information, but also has many years of experience applying the information he was presenting.

Both Mr. Lewis and Dr. Foster were well received by the members of the CICO in attendance. Both gentlemen graciously shared their knowledge and, in so doing, helped the members of the CICO to learn valuable lessons about Osteopathy through their philosophy and experience.



Bob Foster Interview by Adam Doris

1. How do you see Dr. Still fitting into modern-day osteopathy? How is he relevant?

That is a deep question. My gut response is that he fits in perfectly, and that his philosophies complement where medicine in general is going. We have divisions of American osteopathy that would say that he is of no value, or not scientific enough, but the trend in the United States is that people want non-pharmacological medicine, and are looking for alternative treatments. If they can avoid drugs and surgery, that's the trend.

Still didn't talk a lot about nutrition but I believe that nutrition is the new pharmacology and the new preventive mode for keeping away from degenerative disease. We may see less pharmacological involvement and more nutritional curative treatments used in conjunction with herbal medicine. Still fits in very nicely with these philosophies, but doesn't with the conventional pharmacological philosophies.

There wasn't as much diversity in nutrition in Still's day—you had to eat what was on the farm—but there's no question in my mind that Still would see that basic nutrition supports the body's self-healing and homeostatic properties.

2. Do you see the possibility for evidence-based research in osteopathy?

We smile at that idea in American osteopathy for those of us that are ten-finger D.O.s. It's worth mentioning that there are three main types of osteopaths in America: three-finger osteopaths that primarily write prescriptions; five-finger osteopaths will palpate every patient and may treat a neck or a back if they recall how to do so from their education; and ten-finger D.O.s who treat everyone regardless of their complaint. The latter make up 10-15% of the osteopathic graduates.

With the ten-finger D.O.'s, evidence-based research is of interest and can be valuable. However, osteopathy was practiced for many, many years without any knowledge of the way it worked. We practice evidence-based medicine in the sense that we treated someone and they got better; whatever the complaint, that's evidence enough, as long as we are not putting the patient at risk for harm. There's a lot of western doctors who wouldn't like that answer—but I wouldn't say it any other way, because I don't have time to wait for the science just for it to be disproved in a year or two.

In all my practice years, I was not very "osteopathic" in the beginning. I really wanted to be a medical doctor but I always was conservative in prescribing drugs because of growing up with thalidomide, a drug given to pregnant women for sleep that was connected to deformed children. That taught me long before I became interested in medicine that when it comes to new drugs on the market we need to be slow and cautious, so I would wait two years or so until the real research was done on millions of Americans.

The evidence-based research is waiting on science; to prove things isn't the end all. I think that the scientists with inquiring minds will try to follow the principles that Still often thought about and tried to understand. But so much of the research is geared towards more drugs and medications and what is most expedient, and not on which ones are harmful. It is important to remember that there are no

side effects, just unwanted effects. The science will follow very slowly because of profitability considerations and how the research is funded.

3. In your own words, what is the difference between osteopathic medicine and osteopathy?

John Lewis and I have discussions related to this, but we have no disagreement. A lot of it is just nomenclature or semantics. Some of it is related to government regulation and trying to get the public to understand what osteopathy is. I think that osteopathy should have stayed and should remain osteopathic medicine.

The ten-finger osteopaths would be happy to practice “osteopathy” and have it be named as such. The other 85% would say it doesn’t matter, but there will always be the group that wants it to be called “osteopathic medicine”.

4. How do you fit osteopathy into your practice of OBGYN?

It’s a specialty that I knew osteopathy could help. There’s no other condition that universally will change the biomechanics of the body for nine months and it happens very rapidly. Treating the body mechanically to keep everything moving will allow for prevention of complicated deliveries. Unfortunately, osteopathic treatment is not widely used for prenatal ailments, but I am a real advocate for it. Moreover, there are lots of things that make the postpartum experience problematic (movement of the pubic bones, sacroiliac joint, etc.) that need to be re-addressed. This is very apparent with long labours and when forceps are used.

I can say that in terms of evidence-based medicine—mind you, I didn’t write all of this down with my partners—of all the deliveries we did, only one required forceps for delivery. That was because of preeclampsia and seizure situations. All of them did natural childbirth without drug intervention. We included the family as a unit but we had much fewer

complications with the natural method. Again, this wasn’t written down; it was just my experience.

Osteopathy would really help with labour and delivery. Generally, it would help with delivery to the point where mothers could be sent home in four hours.

5. Where do you see the future of Osteopathy?

I see it as very golden, and very vociferously leading the pack. It may well be that we become merged in the dichotomy of DO and MD medicine, but the merger will be in the osteopathic philosophy. There is a necessity to follow what Still discovered. Conventional medicine may never give him credit for the discovery, or call it osteopathy, but supporting homeostasis is the only thing that should be logical to the doctor and the patient.



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