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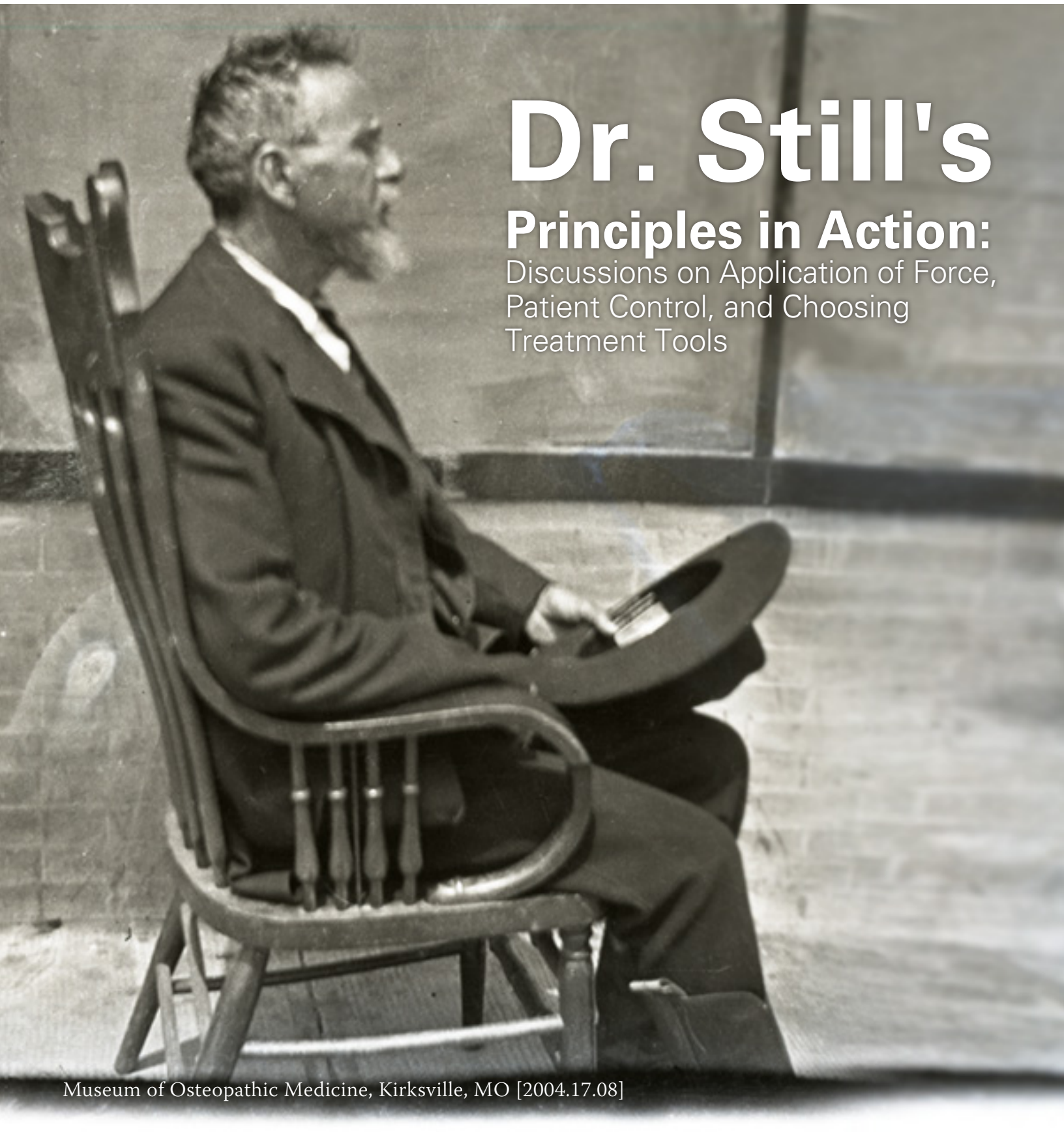

Dr. Still's

Principles in Action:

Discussions on Application of Force, Patient Control, and Choosing Treatment Tools

Museum of Osteopathic Medicine, Kirksville, MO [2004.17.08]

The OSTEOPATHYST

Canadian Journal of Osteopathy

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CAO Canadian Academy of Osteopathy

CICO The Canadian Institute of Classical Osteopathy

The International Institute of Classical Osteopathy

Snow, Shovelling, and Pavement

By Lee Jarvis

With winter in full swing at the time of writing this article, it came to the author's mind that some of the awkward and usually uncomfortable mechanics related to snow shovelling would be a helpful topic to the practicing Osteopathic Manual Therapist. The movements and positions necessary for snow shovelling in the winter (and gardening in the summer) have kept many osteopath's tables occupied with hunched and twisted patients.

In the following article a specific incident will be highlighted: the dreaded, uneven shovel-to-pavement collision. This article is not intended to be so specific to snow shoveling that it is not useful for any other purposes; in fact, the reader might note that it relates quite easily to basic bio-mechanical movement, as well as to whiplash injuries (front-end collision). For this point, illustrations accompany the explanation with simple arrows to indicate lines of force, fixed points, strains, and compressions.

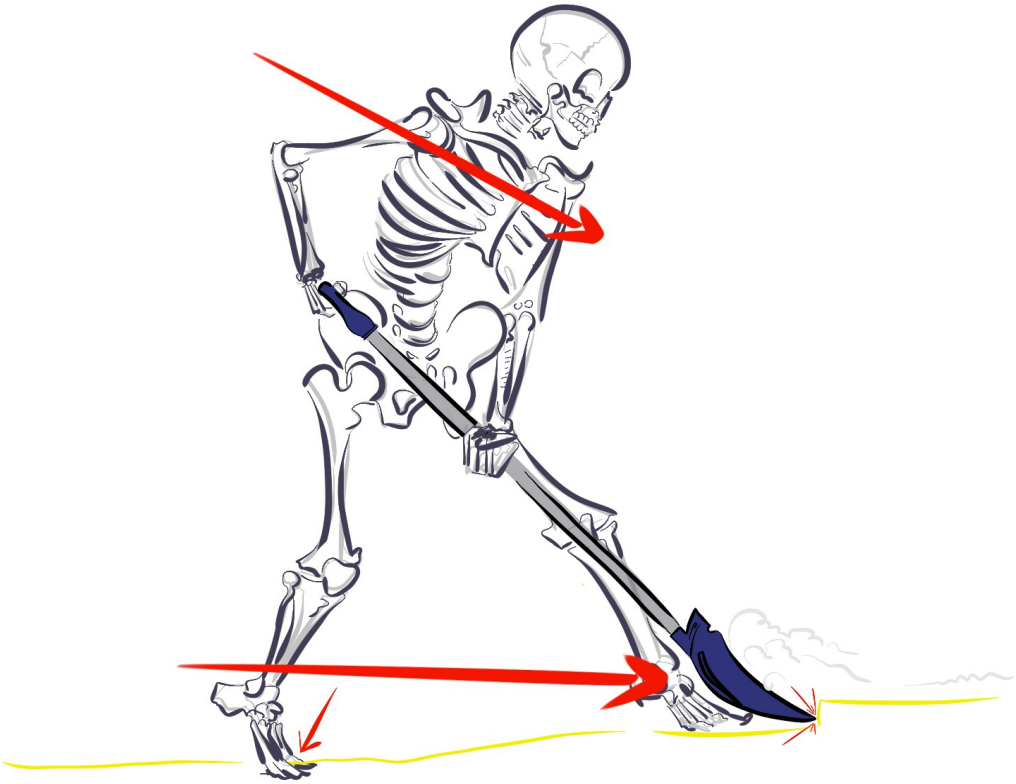


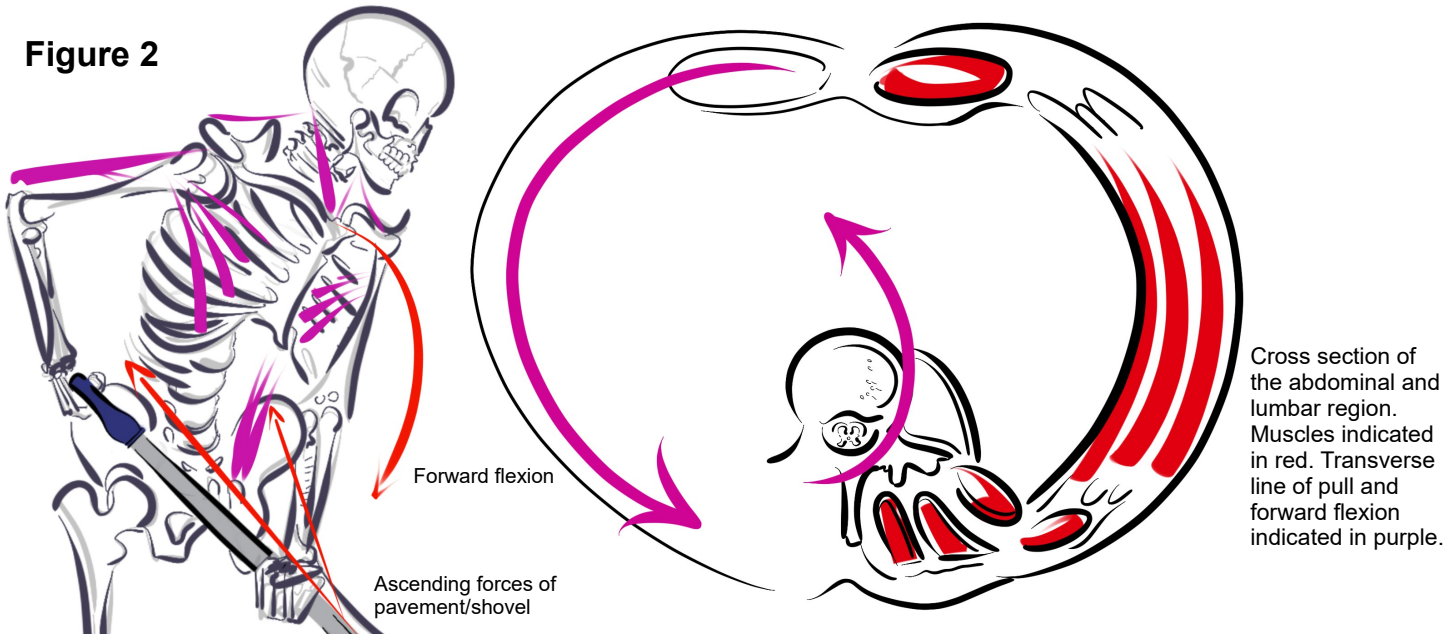
Figure 1

SNOWSHOVELLER'S REMORSE

In the first image we see our soon-to-be patient shoveling snow on the driveway or walkway. The shovel is held firmly against the patient's hip or, even worse, against the patient's stomach. With the shovel against the patient's body, he need only walk in the direction he wishes to push the snow and this will decrease the amount of effort required from the arms. Our patient has pushed the snow for some distance and now the blade of his snow shovel has impacted with a piece of uneven pavement hidden beneath. The problem with moving the shovel against the body is that upon collision with the crack or uneven pavement, the shovel will stop but the patient's upper body will not. In just a few short milliseconds our patient will find themselves rapidly folded overtop the shovel feeling quite jarred, and perhaps even winded. This is a position the author and those of us located further north know all too well.

To push the shovel and snow along in a linear fashion, notice that the patient has had to firmly plant his back foot on the ground (as indicated by the red downward arrow of the right foot). With the right foot planted—sometimes it will be both feet—the lower body is more fixed to the ground compared to the upper body. To further facilitate this forward motion, the patient is leaning forward and essentially following/falling along with the moving snow shovel.

Figure 2



Cross section of the abdominal and lumbar region. Muscles indicated in red. Transverse line of pull and forward flexion indicated in purple.

THORACIC MISDIRECTION

In the second image we can see the patient engaging specific muscles while shovelling, as indicated by the purple lines. Each muscle aids in maintaining a forward posture that also has a specific function.

From above downwards:

The sternocleidomastoid and trapezius muscles will lightly contract to create/keep extension in the neck and the occipitoaltlanto (OA) joint. Considering the hunched over position (with the patient's overall rounded thoracic curvature), if we did not have our neck and OA joint in some extension we would be spending the entire time looking at our feet (and this is true of anyone with a rounded thoracic posture).

The triceps brachii muscles create the elbow extension necessary to drive the shovel forward or at least keep it pressed to the body. In addition to the triceps' extension, both the flexors and extensors of the forearm keep the wrist in an extended position with enough finger flexion to grip the shovel handle. Because these muscles are contracting they fix the arms in position and allow the forces of the forward moving body to be transferred to the shovel. This transference of force works both ways, meaning that any forces ascending the shovel will be transferred into the patient's body as well.

Generating the trunk flexion and forward body position (in conjunction with gravity) are the pectoralis major and minor muscles, as well as the abdominal muscles. The pectoralis major muscle will also assist in keeping the arms close to the body through internal rotation of the humerus, which assists in generation of forward thrust of the arm. It should also be noted that whether you were pushing a shovel, a wall, or even carrying a heavy weight in front of you, the abdominal muscles as a group will contract. This contraction of the rectus abdominis, internal and external obliques, and transverse abdominis muscles is necessary: when the body is loaded anteriorly, the weight is shifted from the spine forward onto the abdominal organs (viscera), including the spleen, stomach, pancreas, liver, and intestines. When the viscera are compressed anteriorly they cannot go backwards or to one side and therefore must go forward. In this case, these muscles contract to prevent further anterior displacement of the viscera.

The reader will also notice that if they are to push on something such as a wall, along with the contraction of the abdominal muscles the quadratus lumborum (QL) muscles on either side will contract. The QL is connected to the abdominal musculature through fibrous fascia in the lateral midline and will, along with the deeper spinal muscles, redirect the pressure from the anterior midline, off the abdominal muscles, and back to the lumbar spine, ribs, and pelvis. This is one of the reasons why there is such a significant amount of thick musculature in the lumbar/abdominal region.

Through the actions of these trunk muscles the thorax is sturdier against the pressure necessary to move the shovel and a significant amount of snow (way too much snow if we're in a hurry). This essentially turns the thorax into a rigid singular structure. This unified action of the trunk is useful for moving snow; however, it puts the neck at a disadvantage that will be explained in the next section.

THE TRUNK EVENTUALLY STOPS BUT THE HEAD DOESN'T

In figure 3A the patient has fully collided with the shovel and their trunk is in a fixed position as indicated by the red line and arrow over the sternum.

Upon impacting with the pavement, if the patient's head and neck muscles were contracted the head would not move in any significant way becasue the force of the moving head would be displaced through muscular and ligamentous attachments to the lower body. In this instance—and especially because we are not expecting a collision with uneven pavement—the neck muscles and supporting muscles of the head are not strongly contracting. With the neck muscles relatively loose and the thorax fixed, there is nothing to stop the head from continuing to fall forward, displacing itself anteriorly relative to the body.

Because the cervical spine is already extended (and naturally favours an extended position), as the head's forward movement continues the cervical spine will go further into extension. This extension will increase to the point at which the cervical spine facet joints reach their limit. With enough force the cervical facets are "slammed" together, possibly causing strain to the joint capsule or fracturing of the posterior portion of the cervical spine. The motion up to this point often does not stop at this limit, as the head is significantly larger than the thin cervical spine and continues to move.

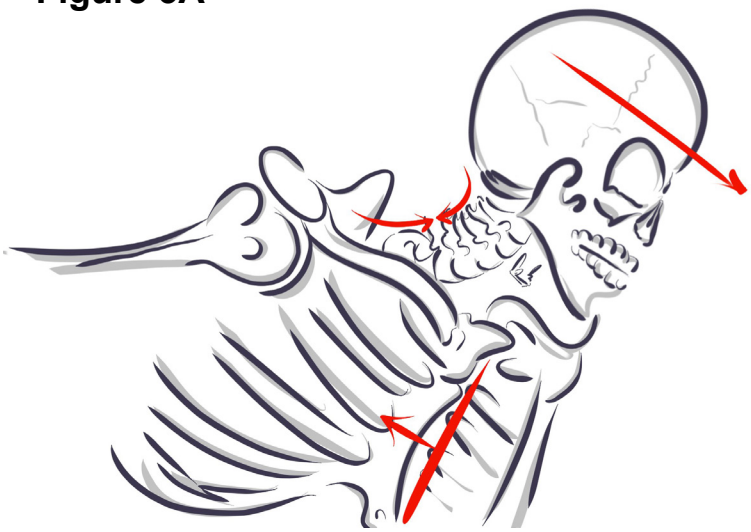
With enough speed and force from the lower body the head will continue to fall forward and downward until we will see flexion occur at the OA joint (figure 3B). The head will then pull on the cervical spine through muscular and ligamentous attachments, which will also bring it into a flexed position. The neck will continue to flex until the point at which the nuchal ligament stretches to its limit. It is at this point, when the nuchal ligament is fully lengthened, that the forces of the moving head and neck will be directed back into the thorax. The author would like to note that in cases of whiplash from motor vehicle accidents, the major lesion is often found not only in the neck (where the pain is), but also in the middle of the thorax (the author usually finds the apex at two vertebrae somewhere around T6-9).

If the nuchal ligament is not capable of dealing with these forces, rupturing of the fibers in the ligament might occur—though this is unlikely to happen simply from snow shovelling.

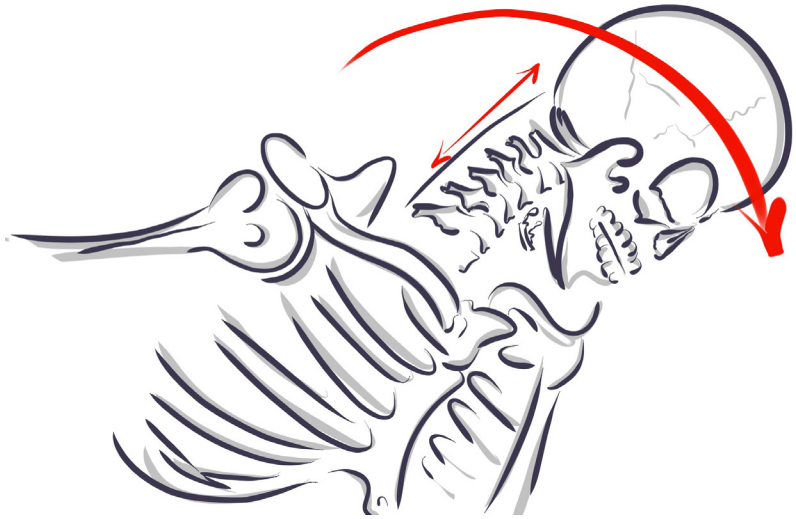
The snow shovelling injury is certainly not the most severe (or even the most interesting) lesion an Osteopathic Manual Therapist will encounter on a daily basis, but it is a common ailment found in exercise mechanics and lesionology. More often than not, this patient will enter your office as an acute case and should be dealt with appropriately. The author hopes that a treatment plan will be obvious now that how the lesion got there is better understood.

The author does not encourage self-inflicted injury for the purpose of education; however, as a fun experiment you can recreate this scenario for yourself even without the use of a snow shovel or driveway. Just take a fast-paced walk into any waist-high table or wall. Record yourself in slow motion video for accentuated effect.

Figure 3A



3B



Simplicity in Principles

By Samuel Jarman

"It is my object in this work to teach principles as I understand them, and not rules. I do not instruct the student to punch or pull a certain bone, nerve or muscle for a certain disease, but by a knowledge of the normal and abnormal, I hope to give a specific knowledge for all diseases."

—Andrew Taylor Still, Philosophy of Osteopathy (Preface)

How does anyone go about working in accordance with Still's above ideal? If students or professionals seeking further knowledge is taught a specified set of interventions to create a specified outcome, they may only treat in that specified way and ignore the nuances of a particular situation. Being told "how to do it" often limits perspective and self-efficacy. Robert Johnston is one who has researched ways to impart Still's above ideal to students so that they have the tools to intervene intelligently with any case they encounter.

Now that the introduction is out of the way, we can focus on the power of simplicity within these principles. Do not take the term "simplicity" to suggest that working from principles lacks sophistication. On the contrary, working from principles means that all levels of sophistication are present and attainable; working from principles is as sophisticated as an operator and patient make it. To be clear in my application of the term, the definition used at the Canadian Academy of Osteopathy is:

A principle is a place or state from which all things are governed.

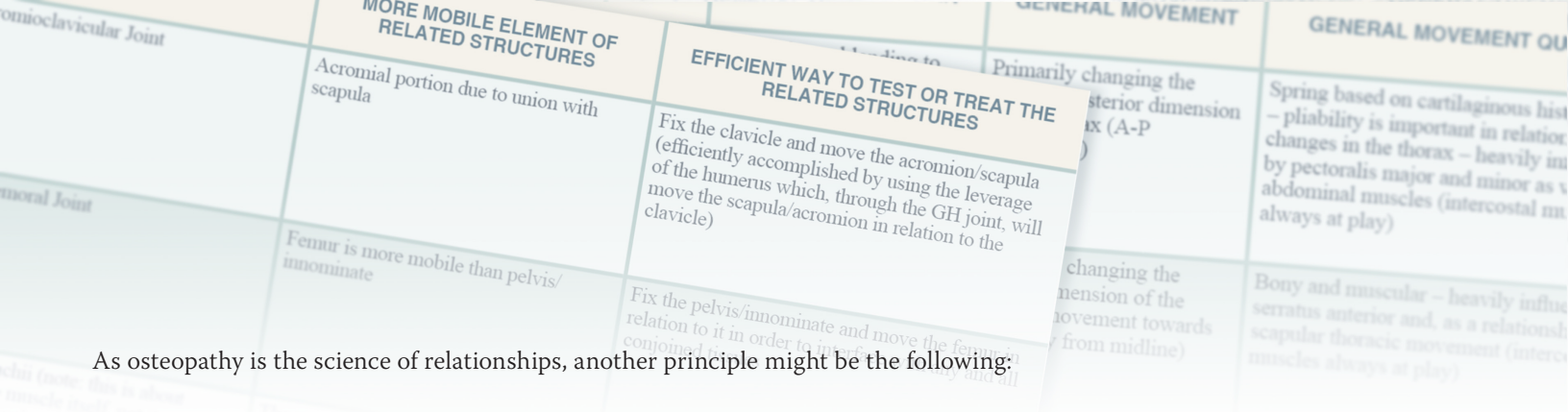
If someone is aware of the principles of a method or a natural phenomenon then they are aware of how it works, as well as how they may intelligently intervene with it. One should not expect to draw blood from stone whereas they may reasonably expect to draw blood from a mammal.

One such principle in osteopathy is as follows:

When assessing or treating a structure, it is required that the operator is aware of the dynamic movement characteristics of the structure, as well as its tissue characteristics. More directly, the operator will know the functional anatomy.

An example of how one might quantify this principle graphically might look like this:

STRUCTURE	GENERAL HISTOLOGY	GENERAL MOVEMENT	GENERAL MOVEMENT QUALITY
Anterior Ribs/Costal Cartilage	Cartilaginous blending to bony at sternum	Primarily changing the anterior posterior dimension of the thorax (A-P movement)	Spring based on cartilaginous histology – pliability is important in relation to A-P changes in the thorax – heavily influenced by pectoralis major and minor as well as abdominal muscles (intercostal muscles always at play)
Lateral Ribs	Bony	Primarily changing the lateral dimension of the thorax (movement towards and away from midline)	Bony and muscular – heavily influenced by serratus anterior and, as a relationship, the scapular thoracic movement (intercostal muscles always at play)
Posterior Ribs	Bony and ligamentous	Primarily rotation of the rib anterior and posterior in relation to the vertebral body/transverse process	Most likely to mimic vertebral movement – pliability is important due to the ligamentous nature of the attachments to the transverse process as well as vertebral bodies and discs



As osteopathy is the science of relationships, another principle might be the following:

When assessing or treating the movement of a structure the operator must steady/fix a related structure and move the structure being assessed or treated in relation to the one that is fixed. More directly stated, one landmark point remains stationary while the other moves in relation to it.

An example of how one might quantify this principle graphically might look like this:

STRUCTURE	MORE MOBILE ELEMENT OF RELATED STRUCTURES	EFFICIENT WAY TO TEST OR TREAT THE RELATED STRUCTURES
Acromioclavicular Joint	Acromial portion due to union with scapula	Fix the clavicle and move the acromion/scapula (efficiently accomplished by using the leverage of the humerus which, through the GH joint, will move the scapula/acromion in relation to the clavicle)
Coxofemoral Joint	Femur is more mobile than pelvis/ innominate	Fix the pelvis/innominate and move the femur in relation to it in order to interface with any and all conjoined tissues
Biceps Brachii (note: this is about moving the muscle itself, not its attachment points)	The muscle itself should be moved in relation to the humerus (the soft tissue moves more than the bone)	Fix the humerus and glide the biceps brachii in relation to the bone or fix the biceps brachii and move the humerus in relation to the muscle

When the operator unites the above two principles, there should be no structure they are not able to interface with as long as their technical ability to control the patient's body is strong enough. While some might argue that the above is an oversimplification, remember that working from principles contains all levels of sophistication. It seems that many individuals do not put their time and effort into working on applying principles in order to gain control over them.

It is advantageous to move beyond techniques and investigate the reality of the lesion. We now have an understanding of mechanotransduction and how all cells alter function based on mechanical information; therefore, it would be useful to apply that information as opposed to focusing on how to move this or that body part.

As Dr. Still stated, "by a knowledge of the normal and abnormal, I hope to give a specific knowledge for all diseases." Knowing what a structure is, how it is built, what it is built from and the characteristics of those materials, as well as how it functions on both a cellular and macro-structural level, the operator will be equipped to interface with the structure. If the study of osteopathy begins here, then the Operator will, in time, gain control over the principles to focus on understanding the lesion. This process has proved to be effective at the Canadian Academy of Osteopathy through the teaching methods employed by Robert Johnston. More institutions in the osteopathic profession may benefit from adapting and evolving this method.

STAY IN YOUR PLANE

By Samuel Jarman

In osteopathy, control of the patient is critical. Since the application of osteopathy is predicated on manually moving a patient in order to restore dynamic function where it has been compromised, it should follow that maintaining control of the application is of utmost importance. Let us consider the "how" of gaining control over planes of motion in order to move a patient through the required range.

The first order of business is to define "plane of motion" (however, if you are reading this publication it is assumed that you understand planes and axes). A plane of movement may be succinctly defined as a division or transection of the body that articulates movements of structures.

The three common planes used in anatomy are sagittal, coronal and transverse. Each of these will receive general articulation, and will act in accordance with their respective principles of movement.

The sagittal plane is also known as the lateral plane; it divides the body into left and right along the vertebral column, as well as the corresponding vertical midline structures on the anterior surface of the body. Movement in this plane will occur about a transverse axis (which is perpendicular to the plane of movement). This movement is best described as forward bending (generally termed "flexion") and backward bending (generally termed "extension").

The coronal plane is also known as the frontal plane and divides the body into anterior (ventral/front) and posterior (dorsal/back) sections. Movement in this plane will occur about an anterior-posterior axis and is best described as side-bending (left or right).

The transverse plane is also known as the axial or horizontal plane and divides the body into superior (top) and inferior (bottom) compartments. Movement in this plane occurs about a vertical axis (that is best represented by the vertebral column when considering full body movements) and is appositely termed "rotation."

Without delving into the intricacies of anatomy—which is a requirement of any successful osteopathic operator—a simple (that is, efficient) description of how to control these planes shall be suggested here. The operator needs to understand their orientation in relation to the patient and thus how their movement will affect the patient. It is therefore important to note that the orientation of the operator will have to change with respect to patient position (seated, supine, prone, or lateral recumbent) while the direction of force for controlling the plane will remain the same. In order to elucidate this objective, a strategy chart has been provided below.

PLANE OF MOVEMENT	AXIS OF MOVEMENT	DIRECTION OF FORCE
Sagittal Plane	Transverse Axis	Anterior to posterior or posterior to anterior directly on the vertebral column or the anterior midline
Coronal Plane	Anterior-Posterior Axis	Directly across and in plane with the body wall (from left to right or right to left)
Transverse Plane	Vertical Axis	Anterior to posterior or posterior to anterior at any point off of midline

From the simple descriptions provided there are endless permutations of application that may be generated. The point is to gain control over the first-level concept and apply that to a patient's body in all positions so that the operator may adjust as needed. If the basic first-level concept is not clearly understood by the operator, and the operator lacks the ability to control planes and axes optimally, then the nuanced adjustments required by a patient will not be properly addressed. This is because the operator lacks the motor control to engage them.

It is at the point when an operator is able to create and control movement in each plane that they are ready to begin to apply the principle of controlling force vectors that are between planes. When engaging and controlling force between planes the operator is able to more accurately adjust any lesion a patient may present. The fundamental principle is this: operators need to control planes and axes of movement accurately in order to efficiently and safely diagnose and treat a patient.

The reader is invited to use this information as a possible starting point for understanding the actual "how" of controlling planes and axes, but not as the *only* point to start from. It does not matter exactly how this information is approached; it matters more that there is a template through which to organize one's thoughts. Osteopathy is not a theoretical science. It is a practical science, and that practicality is found in the physical application from operator to patient. The basic level of diagnosis and treatment is guided by the planes and axes presented by any structure. Accordingly, the best we can do is organize our thoughts and get to work controlling the prime planes and axes followed by those found in-between the prime planes.

1.1 Engaging the Potential Osteopath

Excerpt from Osteopathic Principles Applied in Mechanics and Treatment by Robert Johnston

Robert Johnston

A Challenge at Every Turn

A life in osteopathy is not a simple path. Those who are called to it are individuals who aim to ease the suffering of others with the understanding that their success can only be measured over a lifetime of practice. Those who find success do so by continually improving their knowledge of anatomy and physiology, their ability to assess, and their ability to provide treatment. To this end, this book is in service to devoted practitioners, new or seasoned, who continually seek to inform their minds, to temper their spirits, and to do good work in their communities.

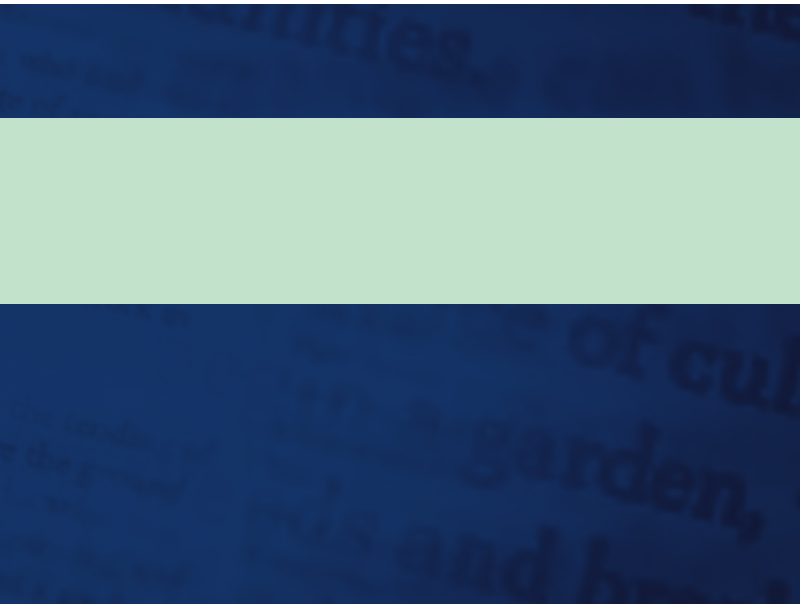
We liken this practice of cultivating the mind to the tending of a garden. To begin a garden, we first must prepare the ground by removing weeds and breaking up the soil. In education this includes breaking bad habits, uprooting incorrect learning, and weeding out unproductive behaviour. Next, we plant a seed, provide it adequate water and sunlight, and hope that it takes root in soil where it can find all the nutrients necessary for growth. This book, like the soil, holds the material necessary for growth within the profession of osteopathy. With the right maintenance, light, and water, that plant begins to thrive—but weeds also find a way in. We must repeat the cultivation process diligently to ensure the environment is conducive to sustained development. This continued practice is something that skilled practitioners know and embrace each and every day, learning from the successes or failures of the past while steadfastly tending to their own garden.

The Need for Contextual Understanding

Even after we become seasoned practitioners, continued education is necessary. Not only is this profession demanding to first learn; in order to ultimately master it, a lifetime of self-examination and reflection is required—particularly with respect to the principles set forth by the founder. It is also important to build context for an osteopathic understanding of the anatomy and physiology, which is necessary for every cogent and effective clinician. Such an understanding comes from revisiting the cultural, sociological, and historical knowledge pervading the mindset of Still and the early American osteopaths.

There was certainly wisdom in their approach to developing the science of osteopathy in those early years, which is why they speak so adamantly of principles. In these foundational texts we find the progressions of understanding that lead, ultimately, to more intelligent approaches to treatment. The splintering of the science, and the resulting ideological camps that have risen from philosophical differences, made it necessary to look back to these early writers. We need to continue with the tradition they established as a tried-and-true measure for the evolution of osteopathic thought. It is in this vein, therefore, that we frame our approaches to mechanics and treatment. Accordingly, we attempt to distill these early concepts into a workable model that is flexible, particular, and effective, but that remains true to the founders' principles.

We also take care to acknowledge that the early osteopaths had a distinctly early American view of the world that championed a desire for treatment to be rational and independent in its application of the principles. Of course, it is important for practitioners to be able to think for themselves, to come up with better ways to do things, to continually improve on Still's teachings, and to shed new light on how to treat the body. The first osteopathy books were not designed to be streamlined into different subjects as in modern anatomical or physiological textbooks; instead, they were structured to be engaging. From their perspective, if one does not recognize the osteopathic lesions that cause dysfunction, then what good is a knowledge



of muscle spindles or an understanding of liver functions? The early osteopaths understood the need to contextualize (and conceptualize) an osteopathic perspective—a perspective grounded in the osteopathic lesion. This context establishes how osteopathy works and so is essential knowledge for the modern practitioner.

No Origin, No Compass for Modern Practitioners

As briefly mentioned, much of the current osteopathic world lacks general consensus on the understanding for the basis of treatment. For some, treatment is about protocol; for others, it is a routine; and for others still, it is about the innumerable techniques to manipulate a joint or tissue (without understanding the osteopathic lesion as governed by the anatomy and physiology behind it). These different approaches to osteopathy have their various strongholds around the globe; they even influence modern practices in the country that founded the profession. While there are many reasons as to how and why this diffusion occurred, the result of these fragmented approaches to our profession has led to a lack of cohesive identity. As long as Still and the early osteopaths are ignored, this ambivalent identity will fester and make it difficult to build our future from our heritage.

By drawing on the traditions established by Still and the early American osteopaths, we offer a firm footing upon which to establish an identity that focuses on aiding the body in its search for health through the best possible avenues. In this way, practitioners can take pride in their science and, in turn, honour the principles as set out by those who founded them. From this position, the science and practice of osteopathy may once again make great strides in our understanding of the human body and how it strives for health. To assume we have already discovered all that the body has to teach is arrogant; there is much more to discover. Let us move forward in our practice with reverence for the human body and a spirit of discovery.

A Context for the Principles

A discussion on the principles themselves without the proper context might also create problems for practitioners. As a principles-based practice, there is much up for interpretation among different schools of osteopathic thought. By itself, a principle means little if it is not understood with respect to treatment. Owing to inexperience with palpation and correct adjustment methods, in the early stages of education the possibility exists of misunderstanding the verbiage used to describe the principles. This is one reason that we return to the original texts and do our best to make sense of how the founders understood the word. We need to contextualize their language to learn their approaches to the principles. This is no easy task. Many times, the texts no longer make sense the way they once did: they are written in antiquated diction, and so their metaphors, patients, and scientific language are somewhat enigmatic.

When Still first used the analogy of stagnant swamp water to form an understanding of putrefied blood, his students had concrete experience with the comparison and easily understood the point he was trying to make. Most of today's practitioners have not seen—let alone smelled—stagnant swamp water, and so they are removed from the depth of the analogy's meaning. The same example can be drawn from his use of the term "natural law." While today most of us live in cities, in Still's day, especially where he was teaching, many students were farmers who were intimately connected to the land. They understood natural law because they were part of it; they saw their strong livestock survive, while the weak ones perished. The original references for discussing the principles of osteopathy were simply different from those that we might employ today to feel the same depth and breadth of the understanding.

A Resource

It should be clear by now that this book is a bridge from the early American approach to osteopathy to its potentially potent future. As we are transparent in stating our position, our hope is that all other texts that guide practitioners to better ways of engaging our science do the same. That way, if other insights are gained, they are done so in ways that do not shake the foundation we seek to fortify and build on, but that strengthen it to a point where were are able to mature as a profession.

Two Types of Practitioners

Even if we have done our job correctly in establishing a connection from the past to the future, and if the profession matures as it should, there are still risks that reside with one of the two general types of practitioners: those who remain complacent, and those who push forward. While there is little doubt that the methodology we propose will yield results

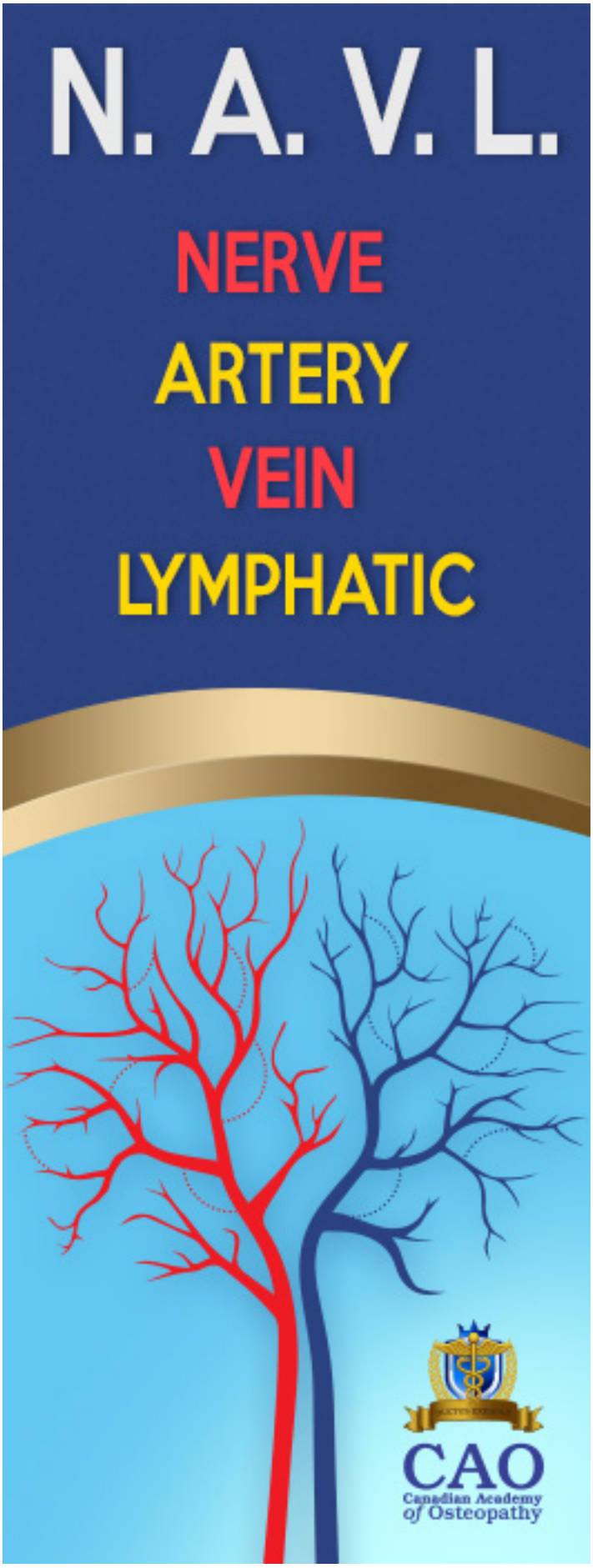
for practitioners, what is in question, however, is how far practitioners will continue to push their understanding of the osteopathic lesion. Will we grow into a profession satisfied in limiting our proficiency to simple strains and sprains? Or will we go back to anatomy and investigate what else is possible in exploring the self-healing and self-regulating capacities of the body? We want to nurture those practitioners who have taken to heart the task of tending to their own garden and cultivated the highest standard for themselves and their profession. Those are the ones who will have the desires and ambitions to discover the full potential of osteopathy as the founder intended.

Technical and Tactical Instruction for Practitioners

This book does its best to mobilize the student who has confidence in osteopathy without arrogance within themselves. By laying a groundwork of technical and tactical instruction, we provide the tools for thinking about osteopathy—to understand the why—so that students can learn from their mistakes and expand their comprehension. As much as this book instructs, it also challenges readers fixated on their own presuppositions about osteopathy to step outside of their comfort zones, and to do so with eagerness to improve the quality of discourse. For young practitioners, we recommend they be logical and practical in their clinical proficiency and go from easier to more difficult cases, where they will, inadvertently, be introduced to failure. This will either focus or dissuade the student from the growth process. For example, practitioners may be doing well with sciatica, but then fail when they are introduced to a visceral lesion in the same area. The options are simple: either focus on studies and improve technical and tactical approaches for this condition (based on the osteopathic lesion), or pass the patient off to another medical provider. Such a practitioner who passes on their difficulties will see neither the reasoning nor the importance of facilitating an individual's own capacity for healing themselves. By refusing to engage in a complete learning process, the potential of osteopathy suffers.

Aptitude, Character, and Interest

Practitioners, to be receptive to this process, should be chosen not by their academic ability, but by their character, aptitude, and interest, as well as their willingness to have these three attributes tested to make themselves better osteopaths. It is not necessary to have the highest IQ, but rather to be committed to the outcome of care. This means a commitment to the progression of ability derived from a place where success and failure are indispensable components. The journey to excellence is tempered with a tactical and technical approach to the body. It is not about the one case practitioners may or may not have success with; it is about the ability to build awareness of how one conducts themselves in those beliefs. In the end, if readers are open to what we discuss here, they will see that we are talking about the culture of osteopathy. As they engage with the text and its concepts—as they feel connected to its aptitude, character, and interest—hopefully they will choose to become a contributing part of it.



Founder's Day Weekend

By Samuel Jarman

The weekend of November 7th and 8th, 2015, marked the second annual Founder's Day weekend for the Canadian Academy of Osteopathy. To mark the occasion, the Canadian Institute of Classical Osteopathy was able to get Jason Haxton, Director of the Museum of Osteopathic History in Kirksville, and Dr. Steven Paulus, DO, to speak over the weekend.

As always, Jason Haxton shared stories of Dr. Still and other early Osteopaths. Mr. Haxton also brought a large exhibit to display artifacts from the early history of the profession. Both the talk and the exhibit took place in the Round Room of the Scottish Rite Club in downtown Hamilton, Ontario. Dr. Steven Paulus followed Mr. Haxton with a lecture on the stages of Osteopathic treatment; the material covered patient recognition of a potential problem, to contacting an Osteopathic Operator for treatment, to the completion of treatment.

The Saturday itinerary concluded with the Grand Event, an annual celebration put on by the CAO for its students. It recognizes, and celebrates, the completion of a level of education for all students. During the ceremony, graduates receive their diplomas as well as the white coats that signify entrance to the profession. Following the ceremony, dinner was served and several speeches were given. Robert Johnston received an award from Jason Haxton for being a generous patron of the Museum of Osteopathic History; Mr. Johnston responded to this recognition by making another donation to the museum to demonstrate his continued support and to keep the CAO's ties to the museum strong. Dr. Robert Schneider, DO, who is an Assistant Professor of Osteopathic Manipulative Medicine at ATSU, made a special appearance to join the festivities. Based on the lively interactions he had with colleagues and students, it is safe to speculate that he had a very enjoyable time.

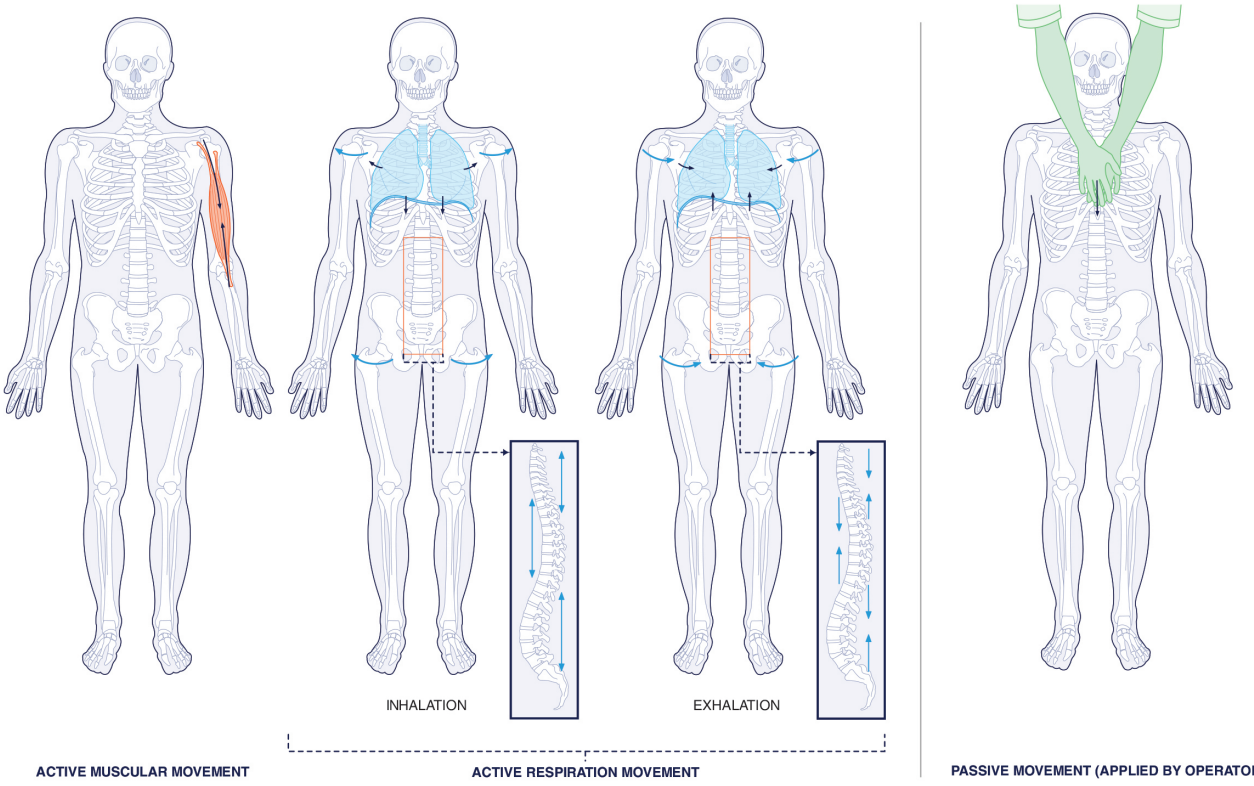
The Sunday of Founder's Day weekend consisted of table work for members of the CICO who attended Dr. Paulus' seminar. Dr. Paulus displayed the modifications made in his application of the Muscle Energy Technique in order to make it more manageable and less aggressive for patients. Dr. Paulus always does a great job of explaining what he is doing, as well as why he is doing it in very clear language. One of the ways Dr. Paulus achieves clarity is by defining all of the applicable terms in a seminar prior to engaging in table work.

Ultimately, the second annual Founder's Day weekend combined interactive workshops with practical theory, and was enjoyable for all involved.

Where Osteopathic treatment is concerned, the underlying principles that guide the actual manual application are very few and very straightforward. Prior to actually applying treatment the Operator should have utilized the Rule of 9's in order to accurately diagnose their patient's lesions. Once an accurate diagnosis is made the Operator will use the following underlying principles to create the appropriate treatment application:

1. PATIENT ACTIVE ---------- PATIENT PASSIVE
2. INDIRECT BARRIER ----- BALANCE ---- DIRECT BARRIER
3. LONG LEVER ---------- SHORT LEVER

PATIENT ACTIVE I PATIENT PASSIVE

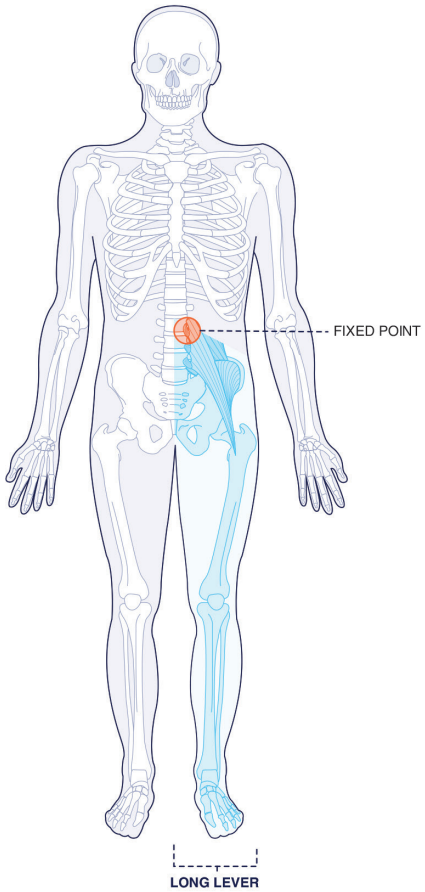


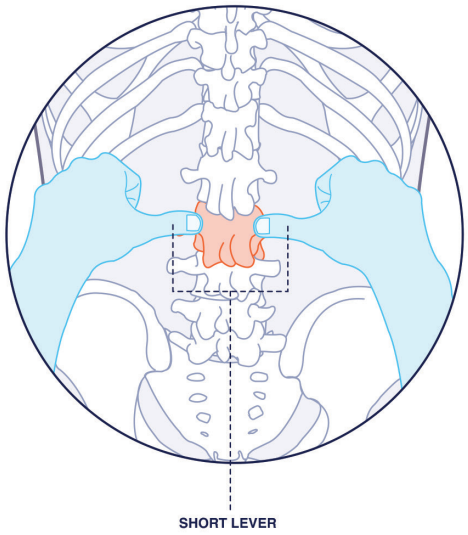
Some examples of patient active mechanisms include, PIR, RI, Respiratory Assistance and Patient Active Indirect Postitional Release.

Some examples of patient passive mechanisms include, MFR, and indirect methods (i.e. tender point work, FPR, LAS, etc.)

INDIRECT BARRIER I BALANCE I DIRECT BARRIER

LONG LEVER I SHORT LEVER





The Operator will choose one option from each grouping to layer up in to a treatment application aimed at the lesion they are dealing with (Primary, Secondary, or Tertiary) on the specific layer of tissue it is identified in (Superficial, Intermediate, or Deep) at any point in the Global, Local, or Focal region being investigated..

CLOSE TO THE BONE

By Robert Johnston

Naming Conventions Do Not Equal a Diagnosis

In present-day osteopathy, the common naming of diagnostic findings is based on motion preference of the bony surfaces that make up joints. These findings are named for the motion(s) of preference. As common nomenclature, this convention allows for consistency in communication.

Despite being common nomenclature, a motion preference at a joint is not a diagnosis. Why should it be asserted that motion preference of bony elements in a joint is not a diagnosis? The rationale is simply that the motion preference found and named by convention is not indicative of the reasons that the motion preference exists. To clarify, bones are not inherently able to move themselves. Bones need muscles to actively move them and other soft tissue structures (primarily ligaments) to ensure that they do not get too far apart from one another.

In osteopathy, the aim is to find the reason that dynamic motion is lost in any palpable tissue, regardless of type. Each tissue type is fairly well understood as are their related motion characteristics. With that understanding a well-trained—and thinking—osteopath will be able to discern what is loading a joint unevenly to produce the effect of an abnormal (non-neutral) motion preference between the bony elements. The common nomenclature is more accurately described as a positional (or dynamic) motion finding, not a diagnosis. A diagnosis will accurately address the reason why the positional or dynamic motion finding exists.

It is imperative to step back from the common nomenclature if the cause is to be accurately located. If an operator works with the predisposition of joint motion preference in mind, their diagnosis will never be complete. All tissues have dynamic motion characteristics and are susceptible to osteopathic lesions. A diagnosis will not be complete until all tissues are assessed for normal motion capacity. Any tissue lacking normal motion capacity is a piece of evidence and should be schematized within the complete picture of diagnosis. Once all information is gathered, the tissue displaying the most abnormal (or least normal) movement will be seen as the primary lesion and treated as such. The full diagnosis will be examined again to assess for change after the primary lesion has been treated.

For a deeper understanding of a logical and complete thought process for diagnosing an osteopathic lesion, it would be useful to refer to the "Rule of 9." (For more on the "Rule of 9" refer to *The Osteopathyst*, Fall 2015.)

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INTERVIEW

Mr. Haxton:
Discussing Andrew Taylor Still, his life and philosophies

Jason Haxton

by Adam Houston

1 *What is it about Still that has captivated your interest so much?*

I think initially just seeing him as the personality—the person in the rumpled clothes, the scraggily beard, the unkempt hair that needed a trim. People would ask, "Is there some way we can share osteopathy but keep him [Still] out of the limelight, like in a closet somewhere?" What I'm saying is that knowing I'm the director of the Museum of Osteopathic Medicine at ATSU, it's kind of like, "Really? I've only got this to work with—this person?" I'm a little embarrassed for him, because he obviously isn't embarrassed for himself.

But then you start reading and seeing and realizing your own superficiality and façade, your cursory valuation of people and judgmental self. Then you start to see what he was really like as a person and (at the risk of sounding like I am ingratiating myself with teenagers) you see that this man was so incredibly cool. You see that he has so much to teach, see what he sacrificed so that all of us can have a better life. His osteopathic approach was first focused on the person—the individual—and osteopathy just happened to be a part of it, no different than nutrition for the body, or relationships for mental wellbeing. Dr. Still didn't just begin as a physician; he began as a farmer, and when that didn't work out he taught at school, and when that didn't work out either he looked at his brothers and dad and said, "Well maybe I'll become a physician. That pays well." But he was always an inventor and an engineer, a true renaissance person. When you understand that it wasn't about becoming a doctor, but that he just ended up there, you do not need to be a trained osteopath to understand that he is this great person. That's what I've learned.

I'm a little embarrassed that I would have shoved him out of the way, just because I didn't understand him—and that's why he accepted this attitude in people. In his time you would have looked at his shoes and up to the top of his hat, and Still would know he was being judged by appearances. Right then and there he would say, "Look, if you want to see my good clothes they're up at the house. I've got good clothes; I'm just not wearing them. I'm out here making this brick sidewalk so I am in work clothes." So he had this way of making you clue into your own superficialities, yet it was done in such a way that was harmless. If he sensed you were shallow, he just thought, "Well, that's where this person is on their path of life." It doesn't mean they would get better, but sometimes he would put the figurative mirror up to you. We all know that when someone gives you the once over, it doesn't feel good, and we know when it's being done. The only difference is that most of us feel we shouldn't point it out, whereas Dr. Still didn't let these trivialities go unnoticed.

Even if Dr. Still were here today (as much as I would love that), he would still keep enough of his inner thoughts unspoken; he would still be an enigma. Even as he's teaching in these Socratic ways of open-ended questioning, when you ask him a question, he asks you a question back, because obviously that's what you're looking for. And, he may in his way know the answer, and what's right for him. But it isn't your journey. That's what I've always heard, that Dr. Still left this space between him and the interlocutor for the other to fill in. But if you're smacked up against someone, you're really pushing and leading, that's not their journey—it is yours.

So Dr. Still always reflected the question back in order to spark introspection. He might ask something like, "Do you trust death?" But of course nobody likes death; nobody wants to die. Trust infers something benevolent. How can you trust in death? So you've juxtaposed something good and bad; now you're asking me if I can trust something bad. But his question

is about who you are, what you think. Then, he would bring it back and recapitulate with, "But you trust life, so you should trust death. Yet you cower at death, but you don't cower at being alive." To Dr. Still it's the other side of the same coin. So if you're not scared about life, don't be scared about death. Yet we do fear death. Then he leaves you with that, and still there is no answer. But you leave the exchange thinking, "What just happened to me?" We start re-evaluating everything we believe to be truth.

Still was a great teacher, and being humble and non-conforming—and not being entrapped in the material world—gave him freedom to see possibilities. As he said, this body is just the vessel for the spirit. If he truly believes that, he's not going to pay to get his hair cut and wear fancy clothes. As long as it functions, that's all that is needed. This made Still a good role model for what he espoused. He couldn't look any other way than the way he did. And so much of that is the essence osteopathy: it's not about the body; it's about the spirit having a healthy vessel to carry it through life. He'd see people with cerebral palsy and think, "We can't fix that, but we can make that health problem a little easier to bear." We can give them as much quality as possible in spite of the limitation.

Most of us just want a little help. Any bit will do. You can't always get what you want, but you can get what you need. Some is better than none. That was Dr. Still's thinking: "I'd love for you not to have cerebral palsy, but that's not going to happen now. But, we can do some things that will take the stress off your body and make things a little better." To me, that's what osteopathy is. We can improve the quality of this journey of life before, as Still says, "We rot or burn up—to return as a spirit." That's a long-winded version of who Still is to me. But you know I've had 15 years to think about it.

2 *How have you been able to get such an accurate grasp on who Dr. Still was as a person?*

I think (as Dr. Still would say) we all use our own lens and mental filters on the world to perceive and share that world we see with other people. We are truly trapped in our own body, even in our marriages and families—we are alone. We really are isolated in this body to some degree. We reach out, and it is that physical touch of osteopathy that comforts and lets us know that we're not so alone; there really is some reality in that touch—and why people need that touch. But when you get down to it, we are all trapped within ourselves. So I guess what I see with Dr. Still is that each person is trapped in his or herself, but can still share the whole. I come at Dr. Still with a counseling background and I think Still was a good counselor—as good a natural counselor as he was a natural bonesetter, or natural physician. He understood when things were wrong, when things didn't fit, and would try to get them to fit in harmony.

He also got it when you emotionally or mentally didn't fit, and he worked towards that too. And so because I've had training in counseling, and a good mentor, William Glasser, M.D. Much like Dr. Still, Glasser would say, "I've studied psychiatry and, now that I am a psychiatrist, I find this way of doing things as a psychiatrist doesn't work, but something else will, and I will discover it." Dr. Still was the same way about medicine of the time. He was a physician and said medicine doesn't work, but something will. That something was osteopathy. I was fortunate enough to have a mentor in counseling who was a lot like Dr. Still. Many would say the degree I have isn't worth anything because it's wrong; they wouldn't be making much money. I just spent all this time and energy to find out that it doesn't work. So both my mentor [Glasser] and Dr. Still said, "Let's just find what does work—the truth." In the end, by being honest and truthful, both men were led down the right path. I feel I've had the benefit of one of the best mental health practitioners of this generation.

As Still says, the spirit is what it's about. The body is just what we use to take care of the spirit. Sometimes I feel I might be even more in tuned to what Dr. Still was doing as a natural counselor. That is why I try to emphasize to people that the body and the spirit truly connect. As much as you can know about the body and the anatomy, there is always more to learn. You cannot know enough about the emotional self either. I'm always trying to tip these brilliant osteopathic students toward the field of mental health as well, so that they truly understand Dr. Still as a whole. That's why it doesn't hurt me to try to learn a few osteopathic techniques. Techniques work. I've done a few; I have a good feel for them. When that patient is on the table you're dealing with a soul and, as Dr. Still says, before you touch the body, understand first that there is a soul within. I get the feeling a lot of these students go to school to be osteopaths and they think it's all about the body, and they touch the body without any real thought about who's living within. They only think about what new technique they can try. There are so many ways to treat the body. But we have to begin with what Dr. Still says. Before you do anything physical, start with the knowledge that there is a soul in there. So I'm trying to tip the balance of what we do to include who's inside: the soul or spirit of a person.

3 *In your mind, how important is it that new students of Osteopathy have an understanding of the history of this great medical art?*

Well the unique thing about osteopathy is this: having a history puts you where you are. What I mean to say is that it really helps you understand yourself, your place. A lack of understanding of your history makes it really hard to find your own strength. However, knowing where you fit in and where your information comes from helps define your place. I think the unique thing is if you're a Christian it begins with Jesus. If you're an osteopath it begins with Dr. Still. He was the first, and everything funnels out from there. So anywhere that you have osteopathy you can trace it back to the beginning with Dr. Still. As a Christian you can work your way back to the beginning regardless of how convoluted a history it is and I

think there is something of stability by knowing the start. Because we know where it starts with osteopathy, we find ourselves in the process of where we are now, and we can see where osteopathy is going too.

We have something special in osteopathy because we do have a starting point, and not all professions do. Medicine in general comes from all over the world, from all different times and people. But osteopathy comes from a beginning point, and so I do think that's why the history is important to us, because we find out where we fit and we also have the pride of pinpointing where our profession began. It does evolve. Again, Dr. Still was a different practitioner; he was a bonesetter but then he became an osteopath. I think that as he surrounded himself with talented people he saw it differently once again, almost like after every time I speak with a great osteopath, I come away thinking, "I hadn't considered it that way." So I'm changing and growing as we do within a profession, and as we understand where that history is, we evolve with it. History is very important, and we are unique because we actually have a traceable history.

4 *Do you think the Osteopathic community (as a whole) supports the Museum of Osteopathic Medicine and the history well enough?*

I think those in osteopathy support and have a passion for the history, once they realize that they have a history. The funny thing is our history became international when a German contacted us and said, "I'm an osteopath, and my instructor said Dr. Still never wrote a book, and I'm curious… did he write any books?" I said, "Well, he actually wrote four books." But that's what we get sometimes. Students know there is this guy, but they just know the name Andrew Taylor Still. So we translated the books into German, and I've had my longest relationship through the Museum with interested German students and osteopaths. I've also seen how that's changed their whole culture, that one inquiry of "Is there any information out there?" Then we work to make sure that they do get to read it in their own language and share it. That's what I lecture about first. There is this great person, let me show you. Then they feel the desire to tell others the story. So it is interesting; I think we are still very young in understanding our history, and so there is support in wanting more information about the history. Yet people don't know what's out there so it's hard for them to connect to the history and museum.

5 *Do you feel the osteopathic community reciprocates the efforts you put in to get the word out?*

I think so, because it's a great effort to come to Kirksville, and so many people do visit—almost weekly we see international osteopaths, so getting the word out must be working. They're spending great amounts of money and time and passion to come to the birthplace and first school of osteopathy.

Also, I feel an obligation to these osteopaths. What if they journey to the heart of their profession and they don't find what they're looking for? It's a little intimidating that I go around the world to all these world-class cities (Montreal, London, St. Petersburg, Melbourne) and think, "How can we in Kirksville compete with these historic, grand cities?" But we can compete because it is your history as an osteopath, and there is something about Kirksville—its simplicity, healthy farmlands, and good people, the place where Dr. Still decided to keep osteopathy. So I have to remind myself that some people never get this calm, this quiet.

In Kirksville we have lots of space, so we're not protective of it. There's a vibe of generosity when interacting with people in the town because there is plenty of time and personal space for all. In cities you find that you must carve out and protect your own little spot, and take what you can get. However, in coming to Kirksville, there is so much to give. It is a therapeutic process. Once here, visitors become part of this place; they get caught up in it and act like mid-westerners. As they return to their cities, they have this touchstone of calmness that is Kirksville. That emotional healing is real and people come back often. So I do think that people support Kirksville.

I have been invited to be part of the EFO's AGM, 17 countries trying to get the curriculum standardized so that we can have consistency. This consistency will bring more rights and more opportunity to do what we love to do: treat. Really, it's only been about 20 years since osteopathy started truly growing outside of the USA (for some places), so it's a pretty short time for most of the world. Besides Canada, England and Japan, osteopathy is still very new. The current fight for all rights is frustrating because what we do to help encroaches on the territory of those making good money using methods that aren't as good. So clearly they are going to fight for their turf—and they're going to fight hard. Dr. Still tells us to stick with the truth; it will prevail, even though it won't be easy. I would also like to say that Rob Johnston, the OOA and the CICO do more to foster that relationship. This is what will grow the history globally: an interest and passion coming from other countries outside of the United States. So they will feel ownership of their history.

6 *Do you feel pressure with the role you have in keeping the history of Osteopathy alive, well, and pure? It seems like a big task.*

I have passion for what I do, so certainly there is some pressure in it. Let me explain. I am thinking that somehow I need to make sure that these stories, which have taken me 15 years of looking over everything available on Dr. Still and osteopathy, are puzzle pieces scattered around in documents and books with no rhyme or reason. I am trying to construct a linear timeframe to build this beautiful picture of our history, and my fear is that I don't want them to become scattered again. It is only with a good grasp of our history that we can preserve the life of osteopathy. I've personally benefited from an osteopath that looked at me and said, "I can fix some things for you." And

I got better. I respect that someone gave me that kind of help and care. Also, my children have benefited from osteopathy, so this care that has given my family and me so much benefit, I'd hate for others not to have the same opportunity. I feel an obligation because I have benefited; I owe it to osteopathy to ensure it never dies. A lot of its preservation depends on knowing the man and the history. This way, you have a better chance to see it and understand it and put it in perspective for yourself.

But when you don't know Dr. Still—you don't know what he does—osteopathy starts to seem more mystical. I need to write a book on Dr. Still (and I know that everyone says they will write the definitive book on Still), but because of my job I see everything that comes into the museum, and I know and see all the angles of our history. I have a good understanding and am in the best position to write a definitive book. Hopefully it will give people a lot to think about in regards to Still.

7 *What are your thoughts on the future of the Museum of Osteopathic Medicine at ATSU, the founding campus?*

It's got a lot of support from the president (who is a D.O. on the administration side of things). It's the first D.O. that we've had on the administration at ATSU since the founding family ran it in the 1940s. And it makes all the difference to have a D.O. as president. He's truly supportive of the history and that's great. So we do have the financial support from the institution to hire the staff to work on new things. You know every time someone comes to Kirksville, the president has me give them the tour to educate them on what it is we do, and our VP of Development, Shaun Summers, is completely into what we do and our brand. The museum is now becoming the heart of ATSU, and so I feel very proud. But the museum should be front and center because, if we are anything, we are our history. We have a $300,000 campaign to complete in three years to get nearly every resource online for the world. So the museum has never been better from the perspective of support. We are now trying to reach out to the 44 other United States D.O. schools, to try and get them onboard. But that's the tough part because they feel separate from us (that's the founding school and that's the founding school's museum). My job is to assure them of the contrary: we are your history as well, and you really need to tap into it, because you will be better for it. I believe that they don't want to publicize ATSU's museum and devalue their own facilities, so they feel it's better to ignore the museum. We do our worst deeds to ourselves. It's sad to think that if they support the museum they support the school [ATSU] and the Kirkville campus, thereby taking support away from their own campus.

8 *What can we do as a profession to keep our story important and our history strong?*

I will use the example of what I have found at the CAO: they hear these stories and repeat them. It's great to hear students tell me, "I've been telling people about what you were speaking of," and it's great to have advocates because I am only one person and I can only be in one place. So when people connect with these stories and retell them, this excitement of sharing will help our history grow.

9 *In a perfect world, how would you see an osteopathic student be trained?*

When looking at schools, we should take into account what Dr. Still was saying, that schools ought to facilitate understanding the person, the behaviors, the mind, and the soul. Basically, this is a counseling type of approach. When you have that patient on your table, like it or not, 50 percent of the patients, as Still said, are there for healing a broken heart (emotional and mental help). So unless the students know she or he is healing the broken heart as well as the body, the heart won't get fixed as fast as if you understand that's what you're working on. I do feel there should be some sort of element of a workshop to explore the "why we do what we do." Such workshops will better attune the student not only to the patient's inner needs, but to a better understanding of themselves as a practitioner. What I'm saying is that we all have emotional lives, even though we rarely talk about them, so it's interesting when someone shares these details with you. However, we feel shame to speak about these deeper emotions, and yet we all have similar stories. If we but knew, we'd all laugh at the commonalities of our worries and our griefs.

Remembered what Dr. Still says: "Do not touch the body until you recognize there is a soul within your patient." I wish we would start students out with literally 3-4 days of classic William Glasser on why we do what we do. The student will then heal over the course of time, and as we challenge ourselves to examine inward, we learn that we have choices to make regarding how we think and act. Just as we can choose what approach to use to heal the body, we also have choices on how to approach the patient's soul. You can't help someone emotionally unless you know your own self. So I would say, an osteopath that can't recognize their own physical and mental issues can't be much help to somebody who has issues. When they don't internalize and take care of themselves as their own first patient—through nutrition, physical health and emotional health—how can you help somebody when you don't even have it together yourself? Hence, I would say that in a perfect world there should be an educational component that interrogates why you do what you do. It will make the student more confident in relationships outside the classroom and in their professional lives. And, they will actually begin to understand their personal journey in life.

DAY 1: Before we touch the body, we must understand that there is a soul inside, and to do that we must understand our own soul. They say you can tell the difference when you receive an osteopathic treatment with no "soul." So let us begin by learning about our soul. In the end, the student will be a better person and love the life journey they are on.

The Button Lesion:

Influence of lesioning between the upper and lower cervical transition zone on the OA joint

By Darren M. David

This article shares clinical findings related to lesioning in and around the transition zone between the upper and lower cervical complex as it corresponds to, and influences, lesions at the atlanto-occipital (OA) joint.

Many times patients with vagal irritation will present with what seems to be an extension lesion at the OA. Upon palpation, it can seem as though the extension is quite extreme, marking the breadth of one or two fingers between the occiput and the first cervical. While it is true that the congruency of the joint is incorrect, many times the typical application of correction is perhaps not the best choice. This particularly can be the case if practitioners note what is described as a "button lesion" at the levels of either C2-3, C3-4, or C2-4, when there is a build-up of tissues that are holding the posterior aspects of the joints close together. This is described as a proximity of the joint surfaces rather than simply extension since it feels flexed, insofar as the lesion is in a posterior position relative to its physiological ideal (the relative to the nature of the secondary arch).

In describing the clinical implications of treating this lesion, it is always worth considering the caveat that practitioners look to the whole lesion pattern and take into consideration the relationships between the anterior and posterior curves, as well as the relative position of the thorax. Yet for the sake of brevity, this article will presuppose that practitioners will look to clear all relative necessary lesions prior to considering what is being described here.

The "button" felt between C2-4 is a colloquial term that describes the histological changes to the tissues in and around the spinous processes of these joints. Depending on the duration of these lesions, it will actually feel like a button or a pebble; it will appear where practitioners expect to be able to follow the laminal groove up to the occiput. This is not, as many may consider, one large spinous process (although, of course, it very well could be); many times it is actually two or three spinous processes that have jammed together and are being held by the surrounding tissues for any number of

reasons that are outside the scope of this paper. But in doing so, the action of C2, and thereby C1, is of particular interest to the "gap" that is found between the occiput and atlas described above. In this particular case, it is as though C2 has been pulled down and back (extension). Consequently, the position of the dens acting as the body of C1, and the superior vertebra leaves what appears to be a gap between it and the occiput.

If this is actually the case (without any other compensatory lesion still affecting the position of the OA), working through the button lesion in and around C2-4 is recommended. The goal is to "unbutton" it by means that practitioners deem fit, and see, as clinical notes have borne out for this author, if the OA joint has returned to its natural position and the physiological symptoms of the patient have subsided. Practitioners are also invited to check other complementary curves within the body to measure any beneficial effect of correction; they are also invited to see where else in the body similar characteristics of lesions exist that can then aids in yielding a better way of diagnosing and removing them.

Research Studies of the Osteopathic Lesion.

By Allix Chambers

Ten years in postsecondary education, one degree, one post-graduate diploma, numerous case studies, terribly boring presentations, countless lectures from doctors, professors, colleagues and students, all with one primary goal: a futile attempt to prove the absolute effect of the osteopathic lesion.

Translation: impossible. Let me elaborate.

Research runs the medical community. The more we can prove, the more money we can generate through protocol surgery, prescription drugs, and "recipe" therapies. Therefore, why not continue to try to find absolute answers for all these variable problems? Patient X has pathology Y; therefore treatment protocol should be recipe Z. Straightforward, mindless, and easy. Easy money.

Now before I get ahead of myself (and continue with what is clearly a rant), it would be extremely ignorant not to give credit where it is due. There is significant value in some research sectors, and successes have been noted with treating acute trauma and disease. For example, osteopathy and manual therapy cannot treat a gun wound; therefore, we cannot help but be very appreciative for the medical advances in these particular areas. Unfortunately, though, when it comes to chronic disease processes and manual therapy treatment protocols, it is impossible to find the answers we seek through research. There is too much variability in effect.

In order to understand the variability of effect with respect to the osteopathic lesion, we must first realize that the diagnosis cannot remain constant. To assign a labeled outcome to a patient whose symptoms are ever changing is pointless. As human beings we evolve, adapt, grow and compensate continuously. Likewise, in our assessment we should not look for one answer, but instead look to various findings to hypothesize an ailment's contributory factors. These findings will continuously change and, with a continuously changing treatment plan, the lesion will slowly normalize and the body will further self-heal and self-repair. To give one diagnosis and one absolute answer can be compared to a wheel spinning in mud.

Why is there such variability of effect with respect to the osteopathic lesion? On top of the ever-changing diagnosis, the particular life experiences we have been exposed to comprise who we are—lesions and all. Our environment, diet, stress, past injuries, trauma, family history, and so on have all impacted our biochemistry, physiology, mechanical impressions and emotional well-being. These "weak links" by scientific explanation are called areas of facilitation in the body, and further guide our expressions of the osteopathic lesion. As a result, the effects are vastly variable and impossible to make definitive conclusions about.

To close this "rant," I must again credit the excellent research done to find and cure emergency procedures and traumatic acute events. I truly believe, though, with respect to Osteopathic Manual Therapy, the scientific research attempting to find a definite answer is a waste of time and money. The energy, rather, should be spent on understanding the philosophy, thought process, and intention behind the inability of the body to recuperate on its own. Osteopathy is more of an art and a way of thinking than a scientific explanation. As a community we must come together, stand by these philosophies, and encourage our colleagues to embrace the principles of self-recuperation.

My Love Affair with "Fourth Years"

By Ruth Jarvis

I came to school to study osteopathy, not to fall in love. But it's happened and there's nothing I can or want to do about it. I blame it on the school's moto of *Ductus Exemplo*: Lead by Example. The CAO doesn't post its motto to look pretty and sound super duper smart just because it's in Latin. Our principal and staff embody the motto and expect their students to do likewise. Hence, the source of my warm feelings regarding fourth-year students. I love them all: Margaret, Tana, Adam, Amanda, Jonathon, Mike, Annette (to name a few). I even miss the last batch that had the nerve to graduate last spring and leave school to work full-time in busy practices.

Fourth-year students are required to attend first-year OMM classes to act as supervisors for new students learning osteopathic principles and skills. A fourth-year student supervisor will step in when a new student needs correction in how she or he is assessing and treating a fellow student "patient" in the classroom. Fourth years clarify theory and application of osteopathic principles. They know their stuff and have been exactly where we were about three years previously. Triple bonus: they empathize with the newness of osteopathic principles and practice, guide the new students' nascent practice, and reinforce their own practical knowledge. One of the best ways to integrate knowledge is to teach what one has learned.

During the clinical semester, first years audit and work with real patients in student clinic in addition to practicing on family and friends. Advanced students listen to our questions about assessing what we have found in particular patients. They know how to apply osteopathic thinking to the assessment of a particular patient I may describe. Often the upper-year student will begin to answer a question with questions of their own: What anatomy is under your hands? What plane and axis does this joint move in? How does this relate to the rest of the body? All of these questions are examples of how I should apply Dr Still's osteopathic principles as I assess and treat patients. I haven't met an advanced student I didn't learn from, and they are all so willing to share the wisdom they have accumulated from their study and hundreds of hours of practicing.

I look forward to being able to do the same thing in the years to come at the CAO. *Ductus Exemplo*: Lead by Example. It's working for me in thought and in practice. And maybe some future first-year students will feel the love too.

"The Shining Sun Doth Blind Us All..." Or "Don't Keep Doing That! You'll Go Blind"

By Kayte Armstrong

I remember as a child I would stare at the sun. My mum would always tell me that I would go blind if I looked directly into the sun. While it may be true given enough time, it never really happened. Instead I found that when I looked away from the glow of the sun, my vision was temporarily obscured by bright shining dots—sun ghosts, if you will. The effect was temporary, but it seemed for a while that all I could ever see was the sun.

Halfway through my second year at the CAO, I am taking time to consider what I have been learning. I'm not talking about the manipulations and anatomy, about the physiology and historical writings. I am talking about what seems to be the purpose of this year. I feel that this is the year that diagnosis is really being highlighted. Sure, we are filling our toolbox with implements to make changes, but we are being encouraged to diagnose, to find the underlying problem.

Diagnosis is tricky. When I consider how I learned to diagnose in veterinary medicine, I see the similarities to osteopathy. Diagnosis began with a history—details about the animal's health and care, and information about the health condition under scrutiny. We do the same in osteopathy, although the history may be brief by comparison.

Then there was the physical, which was a methodical process of examining everything from head to toe (and back again!). It was best performed "the same way" every time so that the novice veterinarian did not miss anything, and all findings could be interpreted collectively. Additional testing, such as radiographs and blood work, would then be integrated into the diagnosis. Osteopathy has a similar approach: we look at the body as it is presented (statically), then proceed to extra tests (dynamic testing). Integration of the verbal history and the physical findings should give us our diagnosis.

Right. This is easier said than done. The pitfalls of diagnosis in veterinary medicine are the same as those in osteopathy. First, the patients we see in veterinary medicine cannot talk. We rely on their owners to give us a history, which is often an interpretation of what they perceive as the problem. They get hung up on trying to name the disease, rather than just relaying their observations. They may leave out important information because it doesn't "fit" what they (or Dr. Google) believe the problem to be.

The problem in osteopathy is that the patients we see can talk. We rely on them to give us a history, which is often an interpretation of what they perceive as the problem. They get hung up on trying to name the disease, rather than just relaying their observations. They may leave out important information because it doesn't "fit" what they (or Dr. Google) believe the problem to be. Oops! Am I repeating myself?

As soon as we add verbiage to a process, we become distracted. We start to focus our attention on what the patient (or client, in vet med) is concerned with. We start to "take on" their view, however inadvertently. We are people that wish to help, so we become concerned about making sure the "problem" is addressed. This is a major challenge, as symptoms do not always equate to cause. We start to treat in a symptom-driven manner. We end up treating body parts just like everyone else does. This leads to increased numbers of treatments for the patient, and possibly sets them up for chronic issues, as the primary cause is never addressed properly.

It is imperative that in the diagnostic process we absorb all the information the body offers us. We may not know how to interpret it at first, but that is where repetition (and having a diagnostic process) intervene. By evaluating in the same manner consistently, the new practitioner becomes more aware of what is abnormal. Appreciation for movement (or lack thereof) is developed over time, and requires much trial and error.

It is this process that we are beginning to appreciate in our second year. We are starting to understand that we must always look for the cause, not just the symptoms. Failure to do this results in an incorrect assessment. The new practitioner can easily become fixated on what the client says and, like a child staring at the sun, be blinded to what the patient's body is really trying to articulate.

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