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Classically Progressive

By Samuel Jarman

The discussion that follows will sound familiar to some in the field of osteopathy. When we hear the adjective “classical,” we might conjure to mind notions of antiquity, convention, tradition and, in the pejorative sense, stagnation, backward looking, or dwelling in the past. In osteopathy, the term “classical” refers to the ways that the earliest operators spoke, worked, and taught, essentially relying on osteopathic principles as a guide, and following the dictates of natural law. The earliest operators were searching for the boundaries of the profession and attempting to push those boundaries as scientifically as they were able. Currently, osteopathic professionals seem content with searching for agreement with other professions.

Looking to validate osteopathy within the scope of other professions is something that Dr. Still considered from the earliest days of the discipline. “I quote no authors but God and experience when I write,” Still contended in *Philosophy of Osteopathy* (1899), “or lecture to the classes or the masses, because no book written by medical writers can be of much use to us, and it would be very foolish to look to them for advice and instruction on a science they know nothing of” (p. 12). Dr. Still spoke of drawing on his personal experience and emphasized that osteopathy as a science was new. However, drawing on the experience or knowledge of someone that is an expert in a field other than the one you are studying is not likely to be beneficial. Dr. Still, as the first osteopath, would have been the most experienced to observe where osteopathy was falling short. Thus, the insights he shared may help us troubleshoot problems inherent to the profession.

In osteopathy we must recognize that the only thing we will agree on is palpable anatomy, and not validations from other disciplines. As Still explained of his own *Philosophy of Osteopathy* (1899), “This book is free from quotations from medical authors, and differs from them in opinion on almost every important question. I do not expect it to meet their approval; such a thing would be unnatural and impossible” (p. 1). As the first osteopath and the one who was able to take a profession from one person, to a class of sixteen, to a single school with six hundred students in less than ten years (and many other schools within the same time frame), it would be wise to consider how Dr. Still viewed osteopathy as a self-contained entity. He was clearly successful in his approach. In osteopathy it seems as though there is difficulty in agreeing about why palpable anatomy is displaying dysfunction, and it would do us well to look deeply into normalized anatomy.

Dr. Still has this to say about instructing students: “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” (*Philosophy of Osteopathy*, 1899, p. 2). Many who read Dr. Still’s work will ask what his principles actually were, as he did not write them as line items. It may be that Dr. Still desired that people decipher them to some degree. It may also be said that Dr. Still used analogy and simile to explain similar concepts ad nauseam in his collective writings and those may be of interest when attempting to decipher osteopathic principles. Further to the above quotation, it would be of interest not only to decipher the principles but also to teach from them according to their original intentions.

When perusing early osteopathic literature, we will encounter statements attesting to the importance of foundational teaching, such as those made by Ernest Eckford Tucker in *Osteopathic Technic* (1917). “The science of osteopathy,” he says, “is the most exacting technical study in the world. The practical side of osteopathy is its technic. The spirit in which it should be approached is that of technical *training*” (p. 11). Note that Tucker framed osteopathy as an “exacting” science. It is indeed an exacting study as the practical aspect of osteopathy occurs tactilely through the skin to find and restore motion that has been lost in all tissues. In the words of Robert Johnston, principal of the Canadian Academy of Osteopathy, “It is like changing the oil on a car in a dark room with the hood down and the engine running; you must truly know what you are doing or you will not achieve the desired result.” In the light of this commentary, we must ensure that we know and understand functional anatomy, as it is inherently related to all body function and is what we are able to palpate and agree upon. Tucker provides a complementary insight:

There are three reasons why the science of osteopathic technic is so exacting if it is to be at all efficient. The first is that it deals with structures covered by skin and muscle and often fat. Among these structures it is necessary to locate disorders, and having located to define them in all possible ways; and having located and defined to devise some logical technic of correction, using such few and narrow holds there as nature affords. The second reason is simply that the health, happiness and life itself of human beings depends on the skill that can be exercised in that narrow field. Our sole immediate contact with disease, the one thing that makes the rest of the knowledge that we have acquired effective at all, is this one thing—technical skill. The third reason is that the sense of touch and the muscle sense are but feebly developed in human beings. (*Osteopathic Technic*, 1917, p. 12)

Essentially, we need to strengthen the physical aspects of our skills, be they neuromuscular or otherwise, to be able to physically perform osteopathy. Technical skill is not technique; technical skill is the actual capacity to control a patient's body and to do so in a manner that is clinically useful.

Dr. Still took decades to train his physical skills in palpation and patient control, and he modelled the diligence required to develop these skills in the earliest students. Tucker speaks to this when he says:

Dr. Still in training himself for the work of his life used to carry the bones in his pocket, where his hand could feel them, forming thus a sense-of-touch picture of them. Hour by hour he experimented with them until he had formed a moving picture of them in his mind. He also spent months and years in dissecting the bodies of the Indians, preserved in salt. The amount of time and concentration that he put into making mental pictures of the anatomy of the living body may be surmised from the fact that when he was seventy-five years old he still "camped in the liver" for a week or a month, and daily explored, as a research worker would explore, recesses in the human anatomy. Perhaps forty years was thus spent before he came before the world with his discoveries. (Osteopathic Technic, 1917, p. 13)

Further to this Tucker writes:

Much of the technical training of Still survives in the profession, spreading hand-to-mouth as it were. The profession, however, and the schools have made no special effort to preserve it. They have not always kept clearly in view the exacting nature of the training necessary for true corrective work. They have been exceedingly busy the last decade in absorbing, digesting, adapting to osteopathic philosophy the accumulated medical learning (all, that is, except experimental medicine) and in meeting pre-existing standards in every way. This was perhaps a necessary phase of the evolution of the science and the profession. Technic, however, has remained an art, an individual and an empirical matter. There has been neither a model in the medical world nor a great leader among ourselves. The phrases that have been our rallying calls, such as "Find it, fix it, and leave it alone," and "Ten-fingered osteopathy," have been rallying calls for the purity of osteopathy, rather than for the development of technic. And yet osteopathic technic is the only medium between our scientific knowledge and the diseases it should benefit. (Osteopathic Technic, 1917, p. 13)

Taking all of what has been offered here as a collective method of operation, it can be argued that progression in osteopathy

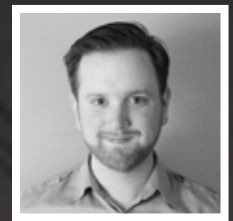
must be obtained through performance based on the laws of nature and rational thought derived from those laws. Dr. Still pushed osteopathy forward by abandoning irrelevant external influences and following the dictates of nature. Ignoring the physical training needed to perform osteopathy disavows the neuromuscular function of the operator at a base level. It takes time to develop control of your own body, especially when you are doing so in order to control someone else's. Producing an operator who knows how to avoid unnecessary physical labor is extremely important, and this may only be accomplished through technical training. If technical training is required in all other physical endeavours, and mastery is acquired over time, why would it be different in osteopathy?

The laws of nature were at play in the development of Muhammad Ali, Pelé, Michael Jordan, Usain Bolt, Wayne Gretzky, and any other high-performance athlete who comes to mind. We in osteopathy should be able to learn from this process by focusing attention on the 101 of our profession: being able to physically perform our duties. Progressing the science will happen much more readily if we are able to diagnose and treat effectively. So, when someone says that being "classical" in osteopathy is regressive, consider what has been written here as a starting point for a more informed opinion. Also, consider that anyone who claims to be able to teach osteopathy in a short period of time may be less than informed on the subject.

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MECHANICAL CONSIDERATIONS IN TREATMENT OF THE KNEE



By Lee Jarvis

In my office as of recent I have seen quite a few knees. These knees happened to be attached to patients of mine who reported that their knees were complaining consistently and loudly. Naturally, knees are the whiniest of joints; they are very painful when injured because of highly innervated ligamentous tissues, which consistently grind themselves into oblivion. Most manual therapy practitioners know that knee injuries are very common. The occurrence of knee replacements are on the rise in Canada according to Metcalfe et al. (2015) who stated that the “overall pan-Canadian age-standardized rate for all knee replacements increased, from 159 Per 100,000 population in 2009–2010 to 174 in 2013–2014” (Hip and Knee Replacements in Canada: Canadian Joint Replacement Registry 2015 Annual Report, page 41). The article further stated that there were at total of 60,136 knee replacements from 2013–2014, with the majority of surgeries occurring in Ontario. The most commonly listed diagnosis for knee replacements was “degenerative arthritis,” which is synonymous with osteoarthritis. Barring significant dietary deficiency it is, in the medical world, considered idiopathic.

It has been my experience thus far in my practice that knee problems are very frequent and, though some are related to a traumatic injury (acquired while engaged in sports, for example), many knee injuries (such as ligamentous tears and menisci degeneration) occur gradually and through poor mechanics. With this recent time spent attempting to remedy these complaining knees, I feel that I have come to better understand some of the mechanics and lesionology involved

in knee movement and dysfunction, which I intend to explain in this article. I hope that through an explanation of these mechanics and lesionology that the working Osteopathic Manual Therapist is better capable of correcting these dysfunctions by clearly knowing the direct, indirect, and balanced positions. I do not claim this article to be a cure-all or any kind of a step-by-step routine for “fixing knees.” However, since it has been effective thus far on the treatment table, I hope to prevent some surgical procedures, or at least help with recovery thereafter.

To begin, I will explain my common findings at the local site using simple anatomic terms and the positions of bones. Once that is explained, we will use the deductive process to determine the global pattern that possibly created the focal.

As the patient is walking into your office and you are saying your usual “Hello, how are things?” you may notice a tendency of the knee towards hyperextension on the planted (stance) leg. You may also notice more specifically that the knee remains relatively straight and normal from heel strike to midstance. However, when it passes the midstance, which is when the body is now overtop and passing the leg, the knee is quickly driven posteriorly into hyperextension. After dispensing with the normal formalities of commenting on the weather (which you wouldn’t actually know because you have been inside all day) and making a casual but appropriate joke (which is funny but you have repeated it to literally everyone else that day), the patient sits or lays down. In the supine position you

may notice—especially if the knee is actively “sore”—that the knee is actually favouring a flexed position, but this is due to muscular contraction, not bone position. You investigate further and through palpation you find the knee to be in the following position:

- *The femur internally rotated relative to the tibia, also known as a lateral tibial torsion, which is a rotation in the horizontal plane around a vertical axis*
- *The femoral condyles bilaterally are posterior as compared to the tibial condyles, a posterior glide in the horizontal plane; functionally, this results in the capacity for hyperextension with movement*
- *The knee is in the Genu Valgus position, as in the femur being relatively adducted with the tibia abducted, and at the knee itself this creates a medial glide of the femoral condyles*

Before going into more specific considerations, I should clarify that the above scenario is a chronic condition and not an acute condition. Even though usage of the knee in this position is prone to causing acute injuries (to the ligaments), it is a chronic condition/injury. As far as I can determine, the position described is actually a normal position that the knee will fall into and, although over time it can become problematic, it occurs from normal usage such as walking, running, or climbing stairs. The alternative or opposite to this lesion pattern would be that we end up externally rotated and “bow-legged,” which visually we can all agree looks much less structurally sound, making the proposed lesion just the lesser of two bad positions. It is my belief that this dysfunction, being that it is a common finding, is a result of some excessive normal motion. The motion I perceive this to be, the motion causing this gradual building of knee problems, is the locking mechanism the knee, which we will review now.

The locking mechanism on the knee is specifically for stabilizing the knee (fixing it from moving) during long periods of standing. If the knees were not locked when standing you would be constantly swaying anteriorly and posteriorly, which lacks efficiency in energy devoted to constantly having to re-stabilize. The locking of the knee occurs when the knee is fully straightened (extended) and the femur internally rotates on the tibia. The femur, through its femoral condyles, will rotate internally on the tibial condyles for bony, ligamentous, and muscular reasons.

I feel it necessary like to acknowledge Kuchera’s (1994) assertion that the tibia externally rotates in the fully extended position, and that this is the case when the foot and tibia are not fixed to the ground (such as when they are moved passively through range by a manual therapist). Range is relative to how the movement is generated. Kuchera also acknowledges that the locking of the knee can be created by bony mechanical shape alone without the usage of muscular contraction. This is important because it shows an inherent tendency in the

most solid mechanical components of the knee (sourced from Kuchera’s Principles in Practice, page 644).

On full extension of the knee, the anterior cruciate ligament becomes taut and guides the femur around a vertical axis. This is facilitated on a bony level, as one will notice that the condyles of the tibia slope back just a little bit more on the medial side and that the medial condyles of the femur are lower and longer than that of the lateral. Of the medial and lateral condyles, the more significant movement in knee locking is on the medial side, meaning that the medial condyle of the femur goes a little further into this internal rotation than the lateral. This dynamic is further reinforced by the fact that the anterior cruciate ligament attaches more on the lateral side of the intercondylar area of the femur, meaning we have a longer lever arm on the medial side. With enough internal rotation of the femur, the inner surfaces of the condyles of the femur will reach the intercondylar eminence of the tibia, which prevents any further motion (“locking them together,” as it were).

Depending on your resource, contraction is said to happen at this point to the Tensor Fascia Latae (TFL) and the gluteus maximus to create vertical pressure through the IT band that will hold the femoral and tibial condyles from moving by compression. The TFL and gluteus maximus are certainly the major muscles that create this pressure; however, through simple palpation it can be easily felt that the other muscles of the thigh (hamstrings, quads, and some adductors) are contracting to a lesser extent to assist in this action as well. At this point, the knee is considered locked in place and essentially we can stand still for hours at a time with little energy cost.

To unlock the knee from this position—and this is where I see it being a big part of the global problem—we have a singular small, thin muscle called the popliteus that will contract to unlock the knee. The popliteus originates from the medial superior portion of the tibia and inserts into the lateral inferior portion of the femur such that when it contracts it externally rotates the femur, disengaging the condyles. Most of us have seen or experienced a failure of the knee to unlock. This might occur when we try to move too quickly after standing for too long and the knee fails to bend; we stumble or hop around like we have a peg leg for a brief time. This is, of course, a very temporary problem and is not caused by a major systemic dysfunction. Yet it does show a tendency towards a position in the knee, which may result in excessive stretch of the popliteus and, therefore, a reduced capacity to fully externally rotate the femur.

The best reasoning I could come up with (and I am of course open to suggestions) is that the knee fails to fully unlock at some point and is held in this position. I must emphasize that it fails to fully unlock. What I mean is that it would have to be only still slightly locked, very slightly, because if it continued to stay locked in any significant way it would prevent any flexion and extension from occurring. If this was the case and a small

amount of knee lock was constant during other motions, it would be capable of moving through flexion and extension; however, tissue tension and strain on the ligamentous structures of the knee would be constantly unbalanced and prone to being damaged.

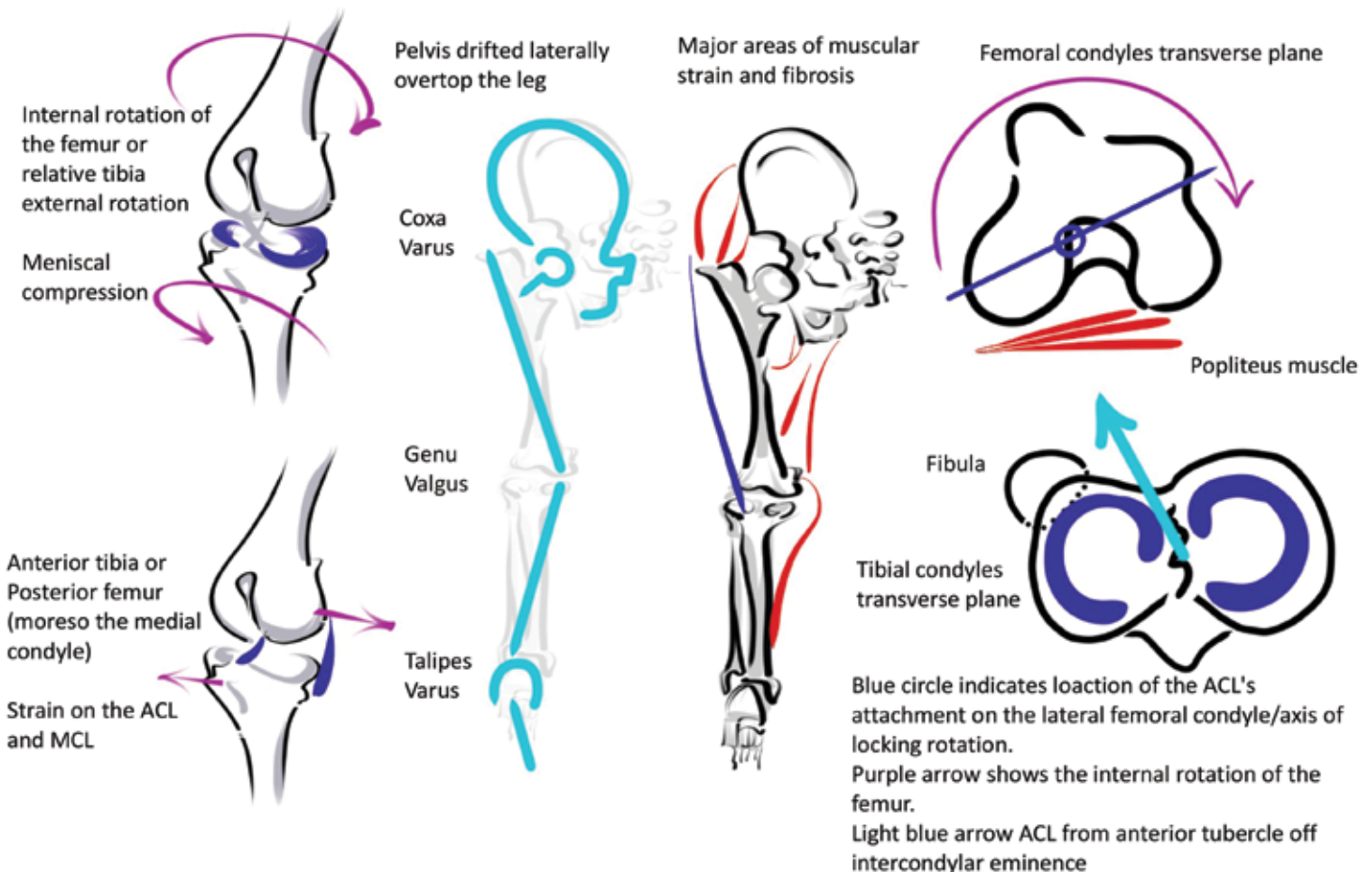
With the knee locking mechanics previously described, the following injuries would explain some of the common knee dysfunctions that gradually build in our patients:

Anterior Cruciate Ligament (ACL) tears: The ACL is the guiding axis of the locking mechanism of the knee. For this tear to occur, the ACL must be taut meaning that it is being stretched to some extent, as a comparatively lax ligament would allow for easy glide in any direction. If the ACL remains on tension throughout flexion and extension motions of the knee, it is prone to strain in any motion that pushes/drives the tibia forward relative to the femur. A simple example of this is the anteriorward pressure directed to the tibia during knee flexion, especially with weight bearing activities such as walking up stairs.

Meniscus tears: Locking of the knee creates vertical pressure/

compression through contraction of the TFL and gluteus maximus (and arguably the other compartments of the thigh). If this compression is constant, it means that when the knee is working through its normal motions of flexion and extension there is less physical space to separate the condyles of the femur and tibia. As this space gradually decreases we are likely to get a compressed intersection (pushing together) of the surfaces to the point, which their articulating surfaces of the femoral and tibial condyles are touching. As flexion and extension occurs in this compression/touching position we are further likely to see a wearing or grinding away of the menisci. Given a long enough time you're likely to observe torn meniscus "pop out," or even full obliteration and what we call "bone on bone."

Medial Collateral Ligament (MCL) injuries: With the genu valgum position of the knee, strain would be occurring on the medial collateral ligament. On the lateral side the condyles are being driven closer together and the Lateral Collateral Ligament (LCL) is relatively lax. Meanwhile, on the medial side the condyles are driven further apart, stretching the MCL. As weight is borne on the knee in the gait cycle, the femur glides on the tibia more medially with every step. The stretch and strain on the MCL increases due to the femur's obliquity.



The above are only the focal lesions, and we know that to create a long-lasting correction we subsequently need to determine and correct the global lesions that either have created or reinforced the focal. We will consider these global lesions to be secondary to the original knee problem for the purposes of this article. However, it is well known by the author that the original fault seen in the local area (in this case, the popliteus/unlocking) is likely to first materialize owing to some absence of proper neural or vascular flow, which is guided by the central nervous system and spine. Though it would be possible to predict the entire position of every joint in the body from this singular diagnosis, we are limited by time and space (i.e., word count) and will only be considering some of the local reinforcing joints above and below the knee.

According to a senior practitioner to myself (B. Stevens, personal communication, April 11, 2016), as the knee collapses into the Genu Valgus position the pelvis must shift overtop the same leg to maintain a center of balance. Further to this point, Stevens stated that when the pelvis has repositioned overtop of the knee (creating a Coxa Varus position at the hip), the pressure generated is on the same oblique axis as the adducted femur in valgus position, which reinforces and gradually worsens this dysfunction. This would mean that when the pelvis has drifted over the knee it is no longer possible to correct the knee without also correcting the position of the pelvis. It is important to mention as well that the adductor Magnus has an important role in blood supply to the knee; the Magnus at its inferior attachment has an opening in it called the adductor hiatus. Through the adductor hiatus passes the femoral artery and vein, which go on to become the popliteal artery and vein that supply the knee and all of the distal leg and foot. As the femur is adducted there is less need for the adductor Magnus to lengthen and it will stay in its shortened and relatively thicker state. As time passes and fibrosis occurs, there is less and less space for these vessels to function effectively.

Opposite of this adductor muscle shortening, as the femur is passively adducted the gluteus medius and minimus, TFL, and Iliotibial (IT) band are being stretched. As time passes with these tissues being constantly stretched they will add extra fibrous material to prevent against excess strain. It is my opinion that because the IT band is strained, not contracting, and has in fact no contractile fibres of its own, it does not deserve to be abused by ineffective “stripping,” as it is passive in this dysfunction and only indicates pain because of what is being done to it, not what it is doing.

While observing this dysfunction, I have also come to notice consistently a fibrosed hamstring on the medial side (the semitendinosus and semimembranosus). This fibrosis is caused by the tibia being externally rotated in comparison to the femur, which is on the medial side and relatively further away from the ischial tuberosity. A strain to the medial hamstring would most frequently be occurring during the heel strike phase of the gait cycle as the tibia is not the fixed bone. In

other words, the tibia is now externally rotated (the femur is not internally rotated), and the hamstrings are lengthened fully and contracting at this stage. In addition to this position of stretch on the hamstring, the leg will immediately bear the entire body’s weight, further increasing the strain.

At the ankle joint the Talus is found to be anterior with the joint itself being in a Talipes Varus position. Because the tibia is gradually gliding anterior at the superior end, the posterior end is driven relatively backwards. Part of the reason for this is because as the superior tibia is gliding forward the femoral condyles and calcaneus are moving (slightly) closer together, meaning that the gastrocnemius muscle is shortening. As the gastrocnemius muscle shortens this holds the foot in a plantar flexed position, which allows for the Talus to glide anteriorly. The ankle takes on a Varus-type strain to compensate for the Valgus knee and to complement the position of the Varus hip. If the ankle did not take on this position, people would at all times be walking on the inside of their feet. Though both bellies of the gastrocnemius are shortened, one will notice that, specifically, the medial belly of the gastrocnemius is the shortest and tightest. This shorter medial belly gradually encourages a Varus-type of favouring at the ankle, making the patient more likely to have (or have had) inversion ankle sprains.

With the internal rotation of the tibia, the fibula does not move fully along with it. The fibula is found by relative measure to be anterior on the tibia and the anterior fibular head, as it is often called. You would think these two components would move as a unit; however, the superior tibial-fibular articulation is a synovial joint of the gliding type, as it allows for anterior and posterior glide quite easily. The inferior end the tibia and fibula are bound by a strong syndesmosis, which is necessary because excessive separation or movement of the tibia from the fibula would impede the flexion and extension motions of the ankle.

It is my hope that this article clarified the mechanics and lesionology of the knee for the osteopathic manual practitioner. Though there is a local knee dysfunction, it is sustained by global problems from above and below. As the knee worsens, so does the global pattern and vice versa, such that they all fall apart together. In the words of A.T. Still, “find it all, fix it all”—and then onto the next patient.

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By Sheryl Crotta

THE MYOGON MODEL:

Taking a Look at Rob Johnston's Upper T-Line

At some point in your CAO education you will be exposed to the Myogon Model created by Robert Johnston. This model makes the more overwhelming lesion patterns of the body manageable, tangible and organized. To begin to comprehend the Myogon model, it is imperative that you work with the model as a theoretical grounding in your practice. It takes time to appreciate and understand the magnitude of all its nuances. I have taken the liberty of directly quoting sections from the book *General Osteopathic Treatment: An Introduction to the Principles of Classical Osteopathic Treatment*, as it lays the foundation for this discussion. To offer a definition, "The Myogon model is a theory developed by CAO's Mr. Johnston through his study of Classical Osteopathy, his readings of Dr. Still, his interactions with John Wernham and the **theory of compensation**, clinical experience, and his grounded understanding of **functional anatomy**.¹ Understanding functional anatomy and appreciating the theory of compensation is critical and crucial to effective execution of classical osteopathy. It is one thing to hear these concepts; it is another to *feel* functional anatomy and the patterns of compensation under your hands. This is when your understanding really comes to life.

As Johnson explains regarding his model, "the myogons themselves are polygons, or triangular structures, that exist within the muscular framework of the body."² Johnston further clarifies that "myogons are affiliated with the **structure-to-function relationship of shapes and mechanics**, where triangles provide structure support and stability; essentially, they describe relationships of anatomical structures and mechanical lines. The myogons provide a rational methodology for working through the body. These polygons, one triangle inverted on top of another, are made up of soft tissue lateral lines that bind together the hard tissue structures from the upper girdle to the lower girdle."³ The structure and function relationships within the body are crucial to understanding what is happening in the upper T-line to be discussed. In order to understand the Myogon model, I wish to and examine the upper polygon and, more specifically, the Upper T-line more closely.

In the Myogon theory, "the lower myogon is represented by the lines of force that follow quadratus lumborum and iliopsoas, while the upper myogon is represented by trapezius posteriorly and pectoralis major anteriorly. These muscles connect the upper T-line, which extends across the acromion processes of one shoulder to the other and the lower T-line, which extends from one femoral head the other."⁴ It should be understood that these lateral lines work functionally as lines of force and do not work in isolation; nor does the upper T-line.⁵ We can assume then, first, that the upper T-line becomes unlevelled and asymmetrical in relation to the pattern beneath it in the lower polygon and the pivot found at the thoracolumbar junction. In principle, we work from the bottom up using the pelvis as the foundation on which the upper polygon rests. Second, the scapula represents a wheel or *pivot* relating integrally to the upper T-line. We recognize the upper T-line is marked by the acromions and is a landmark on the scapula itself. The upper T-line runs end to end, forming a line across the shoulders as mentioned. Observation of this line will indicate asymmetry in all planes and axes in the upper polygon, and will even disclose the potential dysfunction in the lower polygon.

¹ Johnston, R. (2015). *General Osteopathic Treatment: An Introduction to the Principles of Classical Osteopathic Treatment*. Hamilton, ON: CAO Press.

² *Ibid.*

³ *Ibid.*

⁴ Johnston, R. (2015). *General Osteopathic Treatment: An Introduction to the Principles of Classical Osteopathic Treatment*. Hamilton, ON: CAO Press.

⁵ *Ibid.*

Anatomically, the scapulothoracic joint is classified as a pseudo-joint that is very mobile, as is the shoulder girdle. Functionally, the highly mobile shoulder girdle is exposed to the many lines of force acting upon it. These lines of force represented by muscles are attached to this wheel or the scapula, which distort the upper T-line. Thus, the upper T-line is a resultant of many influences. Mr. Johnston teaches students to go beyond the resultant and understand the "*why*" within the resultant. Therefore, finding an unlevel upper T-line in isolation means little without

understanding what is causing this expression. There are layers that will require your investigation in order to understand.

When we zoom in and look at the scapula more closely, anatomical relationships within the myogon will begin to reveal themselves through the bony and soft tissue connectors associated with the scapula. In my clinical experience, patterns of dysfunction will become more apparent when you understand the functional anatomy that connects the dots. During my formal osteopathic training, I was taught that motion in the body is paramount to being healthy and, in essence, alive. This applies not only in the musculoskeletal system but to all systems of the body. Motion or lack of motion becomes a problem when the mechanics cannot return to neutral.

In order to illustrate this concept, let's briefly examine the physiological motion of the spine in the thoracic and lumbar spine. In Type I and Type II spinal mechanics, Dr. Harrison H. Fryette explains that opposite mechanics exist in Type I spinal mechanics i.e., sidebending and rotation occur on opposite sides of the spine. Conversely, in a Type II spinal mechanic, the motion of sidebending and rotation occur on the same side.⁶ The combinations of spinal movements described are not a problem in and of themselves. The body is designed to be capable of moving in the above mechanical descriptions. It is when the spine becomes "stuck" or caught in the Type 1 or Type 2 spinal pattern and cannot return to relative neutral that a problem arises. Similarly, I believe this idea of getting "stuck" and unable to return to relative neutral also occurs in relation to the scapula and upper T-line and throughout the body.

If we return to the scapula and consider the multitude of structures attached to the scapula specifically, we see the upper Myogon can get "stuck" and drag the upper T-line along with it. Another way to think about these dynamics is to consider the scapula as though it is the beginning of a long chain of bony and soft tissue connectors. This chain of anatomy, in my opinion, can bring clarity to upper T-line and shoulder girdle dysfunction. By identifying anatomical structural connections through the bony anatomy—i.e., the scapula, acromioclavicular joint—sternoclavicular joint centrally then continuing to follow the anatomy where the manubrium and the sternum is located. The sternum provides connectors to the costochondral joints, which connect to the ribs and finally to the thoracic spinal vertebrae. At this point, we are in direct connection with the "motor line or the posterior line" of the Myogon model in the thoracic vertebral column.⁷ Recall that this chain of connections began at the scapula. Consider how the distortions of this wheel from the multitude of attachments are affecting the central motor line.

Next, we should consider the thoracic spine as a chain of vertebral connectors leading to the cervical spine. In relation to the upper T-line, we recognize that the cervical spine is the bony and soft tissue environment that houses the motor controls for the brachial plexus to the upper T-line, the shoulder girdle and the upper limb. We should not forget the

important connections to the humerus and its associated soft tissue connectors to the scapula via superior and inferior glenoid tubercles, and the coracoid process of the scapula.

Furthermore, it is imperative to note that the functionality of the superior thoracic aperture will be affected by the upper T-line. The superior thoracic aperture is a critical collective structural landmark that has the potential to influence the dispersal of arterial blood, the collection of venous and lymphatic fluids, and the conduction of neural communication. Once we have reviewed the environment containing the motor to the soft tissue, it is appropriate to look closely at the soft tissue and the attachments from around the scapula (cephalically, caudally, medially, laterally, anteriorly and posteriorly).

It is my hope that this discussion helps in some small way to expand practitioners' understanding of the upper T-line in the Myogon model. I hope you will feel as excited and encouraged as I am about osteopathy. The answers are in the anatomy; that is an absolute truth now and forever. Thanks in writing this article are owed to Mr. Robert Johnston for inspiring logical osteopathic thinking, demystifying the human body to enable us to become excellent but humble osteopathic practitioners, and fostering a love for our magnificent profession through his undying passion.

⁶ *Foundations for Osteopathic Medicine. 2nd Edition 2003*
Executive editor: Robert C. Ward DO FAAO, Philadelphia PA,
USA: Published Under the American Osteopathic Association
by Lippincott William & Wilkins. p.1242 Glossary

⁷ Johnston, R. (2015). *General Osteopathic Treatment:
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TAKE CARE OF YOUR TOOLS

by Samuel Jarman



The hands of an osteopathic operator are conduits to transmit the principles of the profession from the minds of the practitioner, through the patient, and out into the world. As such, the way operators use their hands is of the utmost importance.

There will be no suggestion here about how to care for your hands outside of your work, only how to use your hands in a way that protects them over time.

As a graduate of the Canadian Academy of Osteopathy, I had the opportunity to learn from Robert Johnston, who has been engaged in manual therapy for over thirty years and has had extremely busy practices where he had no choice but to learn to protect his hands. As a result of Mr. Johnston's insight through a busy life of practice, I have gained insight into how to protect one's hands when actually treating. What follows is a checklist that will help busy practitioners avoid fatiguing their hands unnecessarily.

1 Keep your hands relaxed as often as possible (i.e., don't grip too much):

The more often you curl your hands the more you will fatigue the muscles in them and generate strain through them. It is a clinical reality that you will need to grip to gain control over various structures (especially when working on soft tissues); however, it is to your benefit to grip only when truly needed.

2 Brace your small joints (i.e., protect your wrists and fingers):

If you do have to grip, push, or pull soft tissue then use one hand for contact and the other for support. Avoid "squishing" your contact hand under a patient's body or with your other hand; instead, use a yoke hold around your wrist with the non-contact hand or get behind your thumb with the non-contact hand.

3 Use the heel of your hand as often as possible:

The heel of your hand is the best place to transmit force, as it is directly at the end of your arm (especially when your wrist is in extension).

4 Use lean-on pressure as often as possible (i.e., move with your body and not your hands):

If you keep your arms straight and hands soft, you will be forced to move through your body. If you move with your entire body as a unit you will produce more force as well as protect your hands, as they will be soft (relaxed) and expending minimal energy.

5 When you are truly unable to use the above suggestions, work as fast and as efficiently as you can:

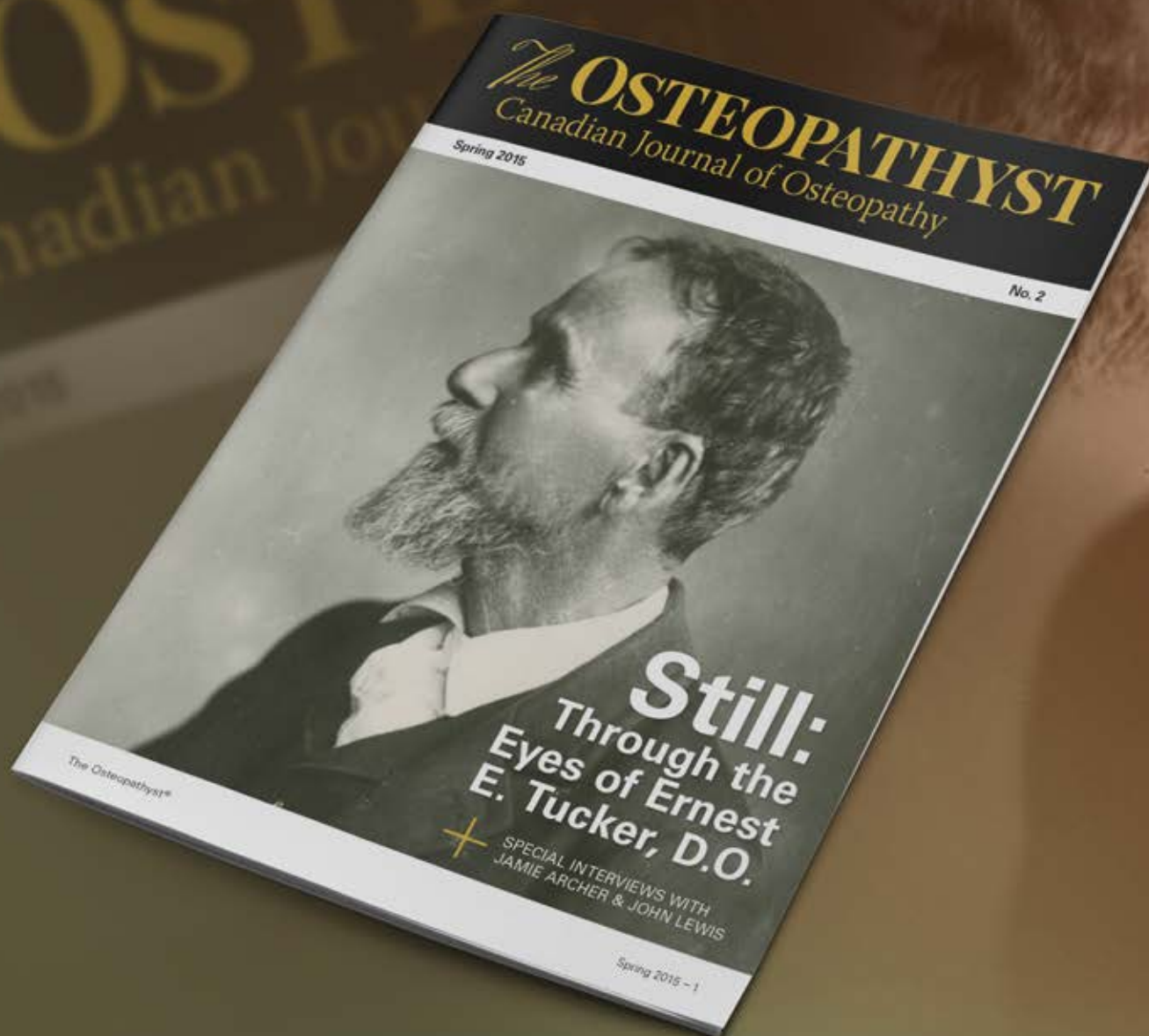
If you need to bend your arms, squish your hands, grip firmly, or anything else that will tire your hands out, then be as fast as you can. Clinically, there are times when you have to do things that are hard on your hands and, as a result, your hands will fatigue. The goal is to have that happen as little as possible.

Remember that your hands are your primary tools in clinic, and that you will need them as long as you treat patients. It is in the best interest of you and your patients that your hands be as nimble and able at the end of the day as they were at the beginning. If you use your energy and mechanics wisely, then your hands will stay strong and accurate.

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By Robert Johnston

CLOSE TO THE BONE

Osteopathic Identity and Education

I want to take some time to share my views on issues that are occurring with osteopathic education internationally. In order to be clear, a distinction will be made between manual osteopathic education (often referred to as ten-fingered osteopathy) and medical osteopathic education as it is delivered in the United States. The informed views I will share will focus on manual osteopathic education. Before continuing, I want to say that our American colleagues entered into the medical realm very soon after Dr. Still passed away, and, in some occasions, did so while he was alive. Dr. Still spoke clearly in his written works about asking for and obtaining a divorce from medical systems and “drug doctoring.” Osteopathy’s philosophy was to obey the laws of nature and rely on the inner pharmacopeia of the human body as well as its inherent healing mechanisms to find health in patients. In America, the drive towards medicalization has led to the reality that osteopathy, as it was originally established by Dr. Still, has died in the country it was born in.

Osteopathy has spread around the world and carried the principles that define the profession with it. Unfortunately, as those principles have spread they have been understood through the social and cultural lenses of the places they have landed. As a result, the term “osteopathy” has been used in reference to techniques instead of in reference to the principles that define the profession. The principles as proposed by Dr. Still never referenced a plethora of techniques; rather, Dr. Still contended that technique was simply an extension of the thought process as guided by the principles. Another way to say this is that the techniques an operator uses are the external hands-on expression of the principles. Technique should be borne out of the understanding of anatomy and physiology.

Within the educational process being used for manual osteopathy around the world, I think that the main reason osteopathy is not taught from the principles is that it is very difficult to instill principles-based training with large numbers of students. The teaching of osteopathy does not scale well in classes of hundreds of people because we are asking the student to think critically and come to solutions based on what they are palpating. I think it is much easier to homogenize technique and teach it when it has been given clear-cut (and often attractive) names that offer the illusion of efficiency when passing the information on to large numbers of people. Teaching from technique and not principles allows for curricula to be delivered in a checklist manner, which is efficient for the educator. An issue with this is that the student is not challenged to think; they are challenged only to pass a test. If that is all they are trained to

do, then they will approach the treatment of patients in the same rigid and officious manner.

When we are not teaching based on the defining principles of the profession, students will have a difficult time differentiating themselves from a chiropractor or a physiotherapist. They will simply be peddlers of technique. If we do not utilize the defining principles of the profession as delineated by Dr. Still and the earliest osteopaths, we will be unable to compose a unique identity for the profession. Looking around the world at the state of the osteopathic profession, it is fair to say that the profession is failing to identify itself clearly. At the risk of sounding apocalyptic, I believe that osteopathy as a unique and self-actualizing profession is on the brink of collapse internationally. The reason for this collapse is the lack of unification around the founding principles, and the resulting inability to create a clear identity owing to that lack. Ultimately, students are not being challenged or trained to think, as Dr. Still intended. Students are being trained to pass tests. Passing tests does not demonstrate practical ability; nor does it make for a well-rounded practitioner.

In my travels around the world I have observed an intensifying pushback against Early American Osteopathy, what amounts to an abandonment of the defining principles. Time and time again, I encounter comments suggesting that Dr. Still—our founder—was a “cowboy” and that the earliest osteopaths in Kirksville at the American School of Osteopathy were not academics or scholars. I think this view is suggestive of ignorance, or something even stronger, of the realities of who those earliest Osteopaths were and what they actually did. Another issue that seems to drive this movement away from the defining principles is the persistent desire for validation from the medical profession. Searching for external validation is not wise; we need to be strong enough to create our own identity, to stand on our own feet, and to utilize the defining principles of the profession to create a stable footing. When we are strong enough to exist by our own merits we will be strong enough to assist other professions according to the needs of the patient, when necessary. We ought not to justify our practice through the methods and means of other professions.

If we are truly dedicated to osteopathy, then we should respect the profession and the principles that not only founded the profession but also define it. We should challenge students to be thinkers and to solve problems with the principles as their guide. We should challenge ourselves as educators to teach the principles and thinking skills, which will then aid the physical capacity to treat patients rather than take tests and peddle arbitrary techniques.



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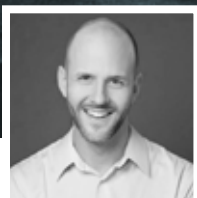
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INTERVIEW

Mr. Steve Paulus, DO, MS:

Discussing the Eight Stages of Osteopathic Treatment



by Adam Houston

1 Who came up with the Eight Stages of Osteopathic Treatment?

I developed the *Eight Stages of an Osteopathic Treatment* based on my personal experience in clinical practice over the past 30 years. An Osteopathic Treatment is much more than “just” manual medicine or manipulative techniques. Enclosed within the greater whole of a patient encounter, I wanted to be able to assess what worked and what did not work during an office visit. I became curious to know, consciously, when I was successful and when was I less effective. When I say “the greater whole of a patient encounter” I am including all that occurs before and after what we call Osteopathic Manipulative Treatment or OMT. The only practical way to identify the working characteristics of a patient encounter is to deconstruct the office visit.

Let me present a summary of the Eight Stages to better facilitate our discussion.

Stage 1: Patient exploration—the seeking/searching for help. The patient searches for help by speaking to friends and family, asking for the advice from trusted health care professionals, or performing a web search. They are trying to find a health care practitioner to help them, because they are no longer able to manage their illness, disease, or injury by themselves. In this stage your community reputation is very important.

Stage 2: The call to office—they found you. The patient calls the office for an appointment, now this person is transformed in to a patient.

Stage 3: Being received. Being welcomed by your office staff or being greeted by the Osteopath in the waiting room.

Stage 4: The Osteopathic History and Physical. Face-to-face exchange with the Osteopath, in the treatment room, where an Osteopathic history & physical is “taken in.”

Stage 5: Diagnosis and Prognosis. An Osteopathic diagnosis & clinical prognosis is offered.

Stage 6: First Contact. First Contact, or the initial diagnostic and therapeutic physical touch occurs to mark the start of an Osteopathic Treatment. This stage also begins the complex and unique Osteopath/patient relationship based upon synchronization and connection.

Stage 7: Osteopathic Manipulative Treatment. The clinical action of “treating” lesions or somatic dysfunctions, while at the same time recognizing anatomic specificity and engaging specific non-material fields.

Stage 8: “Leave it Alone.” The patient leaves office and real work of healing takes place. The most important part of an Osteopathic Treatment occurs after the patient leaves the office. The goal of an Osteopathic Treatment is to engage the natural ability of the patient to self-heal.

> 8. Beyond the 8th Stage . . . Non-Local Healing. In this stage, non-local healing is available as an augmented force of connection between the Osteopath and the patient.

In practice, many of these stages are performed seamlessly together or combined for the sake of efficiency. But, when an assessment of a patient encounter is required, then dissecting the office visit into its component parts reveals strengths and weaknesses of the office visit.

Originally, I presented only five unique stages of Osteopathic Treatment. Then based upon feedback from other Osteopaths, and further exploration, I expanded these working characteristics of an office visit to six, then seven, and now eight. I foresee expanding these *Eight Stages of an Osteopathic Treatment* to perhaps nine or ten interdependent components.

If a patient encounter seems “mysteriously” ineffective, I found that if I reasoned through the different stages I could find evidence of where or when I may have been inattentive, my office staff was forgetful, or I needed to create a more organized educational system.

Several years ago I struggled with situations where by a small subset of patients did not show up for their first appointment. I realized through scrutiny that I had a Stage 2 dysfunction that was occurring when some one called the office to initiate an appointment. That’s the point where a human being transforms himself or herself into a patient. I discovered a Stage 2 disconnect when a spouse would call trying to make an appointment for their husband or wife. In review, I discovered this situation had up to a 75% no show rate. In my busy solo Osteopathic practice it is frustrating to have a no show, especially for the longer office visit dedicated to the initial consultation. I prefer to maintain a very low no-show rate, for both new and established patients. How do you make sure your no-show rate stays low? You have to

create organizational systems and then you have to regularly reassess whether they are working or not.

By developing these Eight Stages I’ve actually become a better businessman and I’ve become a more effective Osteopath. Therefore, I am able to help more people and have higher job satisfaction. So the Eight Stages are not just about clinical efficacy, they are also about having a solid business plan. Remember, we become Osteopaths to help people navigate the complexities of their illness, but we also have to pay the rent, we have to pay a staff member, and we have to pay other overhead fees to run our business. By attending to the totality of an Osteopathic encounter, not just the hands-on part of treatment, then we can take the mystery out of what makes our practice work.

2 What came first the need to be better at the business side of Osteopathic practice, or were the Eight Stages developed initially from the patient’s perspective?

Originally, the Eight Stages were developed to help me understand how to better help a more diverse population of patients. I became interested in looking at what occurs before and after the hands-on Osteopathic Treatment part of an office visit. I realized that the whole of a patient encounter was quite complex and much of the therapeutic action was taking place before and after the hands-on part.

My practice has always been busy, but after I had been in practice for 25 years, the number of patients I was seeing began to gradually diminish. All of a sudden I had daily openings in my schedule. My waiting list vanished. I needed to wake up and notice why my practice was declining. I began to consciously examine why this could be happening. It was not a great mystery. My wife, Bonnie Gintis, DO was diagnosed with metastatic breast cancer. We thought she was going to die within a year. I didn’t want to be in the office, I wanted to be home with her. Bonnie and I shared our Osteopathic practice and suddenly she was gone from the office due to her illness. We also had two teenage sons. I still needed to be in the office to see patients and to pay the bills. Everyday I’d see about 12 to 14 patients a day, and everyone would ask, how’s Bonnie? How is her treatment? Is she going to make it? They all meant well but it was terrible for me; I was in tears every single day. That personal tragedy caused me to not attend to my Osteopathic practice and my business diminished.

My practice was suffering from a Stage 1 dysfunction. Stage 1 holds the space for an Osteopath’s reputation and how we put ourselves into the community both consciously and importantly unconsciously. I was sending out the vibe or the attitude, unintentionally revealing, that I did not want to be there in my office alone, without Bonnie, treating patients. My patients felt my absence at some level. This ambivalence was not intentional.

We had been planning, for several years, to eventually move

from California to Vermont. Because of Bonnie's illness and my ambivalence about being in the office, we decided to move to Vermont earlier than expected. After we moved I took six months off before opening my new practice. During that time, Bonnie's clinical condition improved and her treatments became very effective in managing her cancer.

How we consciously and unconsciously put ourselves out into the world affects our practice. I sent a message, so to speak, into the universe and into my community through the collective unconsciousness that I couldn't be present for my patients in California. My patients heard my despair, and a significant minority responded by seeking care elsewhere.

3 *With this Stage 1 dysfunction, what was or would be the result to Stage 2?*

If you have a severe Stage 1 dysfunction you will not have patients calling to make appointments. By having fewer calls you will have fewer patients, so Stage 2 issues become relatively inconsequential.

Before a patient makes a call to your office, you have to first project into the community the honest desire that you want new patients; that you are available to help people. We do this consciously by creating business cards, putting our name on the outer office door, creating a website, having a business telephone, and if you choose advertising. We do this unconsciously by "putting out to the universe" or projecting into the collective unconscious that you are here in your community serving as an Osteopath. This non-material way of "being" in our community is a crucial part of the totality of an Osteopathic Treatment. Stage 1 includes the Osteopath's reputation, the closeness we develop with established patients, relationships with other health care providers, presence in the community, ready availability on the Internet or phone book, etc. By the time a patient calls the office in Stage 2, there is the implication that Stage 1 was successful.

In Stage 3 the patient enters the sacred space of your office and is greeted by your well-trained office manager. But, if you have a rude receptionist or if you have an office that's trashy, dirty, and the furniture is ripped, then you are in trouble before the patient even meets you. You can be the best Osteopath in the world but your patients are not going to come back if your office is a mess. You can be world famous and you are still going to struggle to maintain a full practice if you have a messy or dirty office with a nasty receptionist. Stage 3 includes the physical healing context of the waiting room as well as your treatment room. It also embraces the attitude or philosophy you are trying to project. Stage 3 is one of the earliest reflections of the Osteopath's professionalism.

As you can see each of these stages is clinically important and at the same time very practical. By attending to the structure and function of the whole of a patient encounter, each of us can better understand how Osteopathy is much more than just a set of biomechanical techniques.

4 *How did you become so aware into this non-material aspect and not just the techniques applied with your hands but all the other stuff you speak about in the Eight Stages? How did you get to this point with the non-physical?*

I think it comes from having a meditation practice for over 40 years. I've been meditating since the 70's. I moved to California in 1988 to live in a yoga ashram. I lived in this intentional community for seven years; during that time I was the physician for the ashram and had a private practice in town. During my time at the ashram I meditated everyday for seven years for thirty minutes to two hours. That kind of training, that kind of meditation induced creative neurologic remodeling and this self-realization work absolutely informs everything that I do. I still meditate on a regular basis and I teach meditation. I am a Mindfulness Based Stress Reduction (MBSR) teacher. Meditation is totally congruent with Osteopathic philosophy and clinical practice. Meditation allows for an expansion of my perceptual skills. Andrew Taylor Still meditated. I think every patient would benefit from his or her Osteopath having a dedicated meditation practice.

Within the "the greater whole of a patient encounter" the non-material aspects of healing permeate all of the Eight Stages. Most obviously, the non-material is dominant in Stages 1, 2, 6, 7, 8, and beyond the 8th Stage. In Stages 6 & 7 we are performing what is more traditionally thought of as an Osteopathic Treatment because it includes the hands-on part that is making a diagnosis and then implementing a manipulative treatment. When we implement an Osteopathic Manipulative Treatment we consciously utilize both material and non-material elements at the same time or in sequence. In Stage 8, we have removed our hands from the patient and during this essential and vital stage we are trusting in the natural ability of the body to self-heal to do the real and sustained work of healing. Stage 8 is not a belief system it is a real trust in the laws of nature. Beyond the 8th Stage is a topic worthy of more discussion. In brief, the non-material connection between the Osteopath and the patient can be therapeutically accessed after the patient leaves the office. When we "think about" a patient several days or even several weeks after they leave the office we are re-engaging their therapeutic processes potentially re-augmenting the treatment. More concretely, we can call the patient a few days after their treatment to check in. This checking in, either through nonlocal healing or via a phone call, is highly therapeutic. This aspect of Osteopathic Treatment is esoteric and is part of the metaphysical aspect of healing that falls under the category of art rather than science.

5 *In a perfect world, how would you see an Osteopathic student be trained?*

In a perfect world, I think that every school and post-graduate training program would attend to the inner state of the Osteopath. We would better serve our selves, and thus we would best serve our patients, if we attended to our inner state

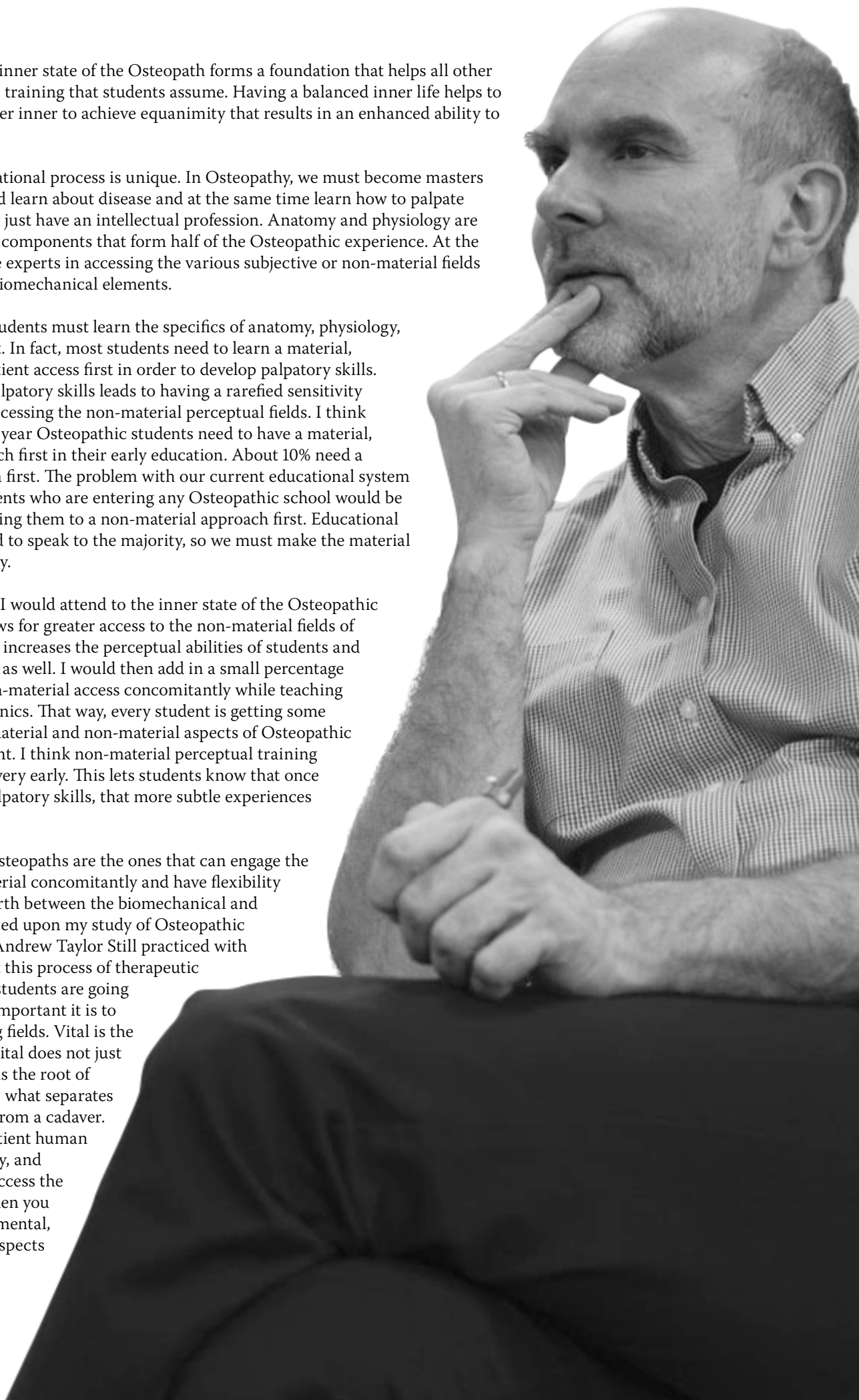
first. Attending to the inner state of the Osteopath forms a foundation that helps all other aspects of the rigorous training that students assume. Having a balanced inner life helps to quiet our mental chatter inner to achieve equanimity that results in an enhanced ability to palpate and perceive.

The Osteopathic educational process is unique. In Osteopathy, we must become masters of clinical anatomy and learn about disease and at the same time learn how to palpate and perceive. We don't just have an intellectual profession. Anatomy and physiology are objective and material components that form half of the Osteopathic experience. At the same time, we must be experts in accessing the various subjective or non-material fields that coexist with the biomechanical elements.

The vast majority of students must learn the specifics of anatomy, physiology, and biomechanics first. In fact, most students need to learn a material, physical method of patient access first in order to develop palpatory skills. The development of palpatory skills leads to having a rarefied sensitivity allowing for reliably accessing the non-material perceptual fields. I think that about 90% of first year Osteopathic students need to have a material, biomechanical approach first in their early education. About 10% need a non-material approach first. The problem with our current educational system is that 10% of the students who are entering any Osteopathic school would be better served by exposing them to a non-material approach first. Educational institutions are geared to speak to the majority, so we must make the material biomechanics a priority.

But in the ideal world, I would attend to the inner state of the Osteopathic student first. This allows for greater access to the non-material fields of healing and ultimately increases the perceptual abilities of students and experienced clinicians as well. I would then add in a small percentage of training time in non-material access concomitantly while teaching the material biomechanics. That way, every student is getting some teaching of both the material and non-material aspects of Osteopathic diagnosis and treatment. I think non-material perceptual training should be introduced very early. This lets students know that once they develop better palpatory skills, that more subtle experiences are also available.

I think that the best Osteopaths are the ones that can engage the material and non-material concomitantly and have flexibility in moving back and forth between the biomechanical and bioenergetic fields. Based upon my study of Osteopathic history, I believe that Andrew Taylor Still practiced with this fluidity. If we start this process of therapeutic awareness, early then students are going to realize how vitally important it is to access these coexisting fields. Vital is the operative word here. Vital does not just mean fundamental, it is the root of vitality. And, vitality is what separates a living human being from a cadaver. Remember, we are sentient human beings with mind, body, and spirit and if you only access the biomechanical field, then you ignore the emotional, mental, psychic and spiritual aspects of what it means to be vital.





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6 *Who has been a big influence for you in terms of this non-physical realm? Who has helped you tap into this?*

I've been fortunate enough to have three important teachers in my Osteopathic career. Each teacher has become available to me at roughly three consecutive ten-year intervals. In my student years and in early practice I worked with a not very well-known Osteopath named David Musgrave, DO. He lives in Des Moines, Iowa near where I attended Osteopathic school. He took a very personal interest in my early education. He and I have remained friends for nearly 40 years. He taught me how to think Osteopathically about clinical issues that were not just musculoskeletal in origin. About ten years into my Osteopathic practice I started working with Jim Jealous, DO. Jim Jealous changed my life and changed the path that I was traveling within Osteopathy. He's the DO who's developed the biodynamic system of Osteopathy. He helped me to heal the lesions I had suffered around my early Osteopathic education induced by some indiscreet teachers. In my first introductory cranial course as a student, which is the primary entry point into the non-material perceptual fields, I had a terrible teacher and a bad experience. Unfortunately, similar negative experience were repeated with more advanced cranial courses taken during my early years of Osteopathic practice after completing my Family Medicine residency revealing a destructive flaw in the educational system of teaching Cranial Osteopathy in America. I worked with some of the greatest masters of Cranial Osteopathy in the twentieth century. My experience was a personal nightmare. These esteemed teachers were dogmatic and rigid. They were aggressive and overtly critical in a demeaning way. There was only one way to learn Osteopathy, and it was their way via a path of humiliation. There was no openness for expressing my felt experience. I felt and interpreted their aggressive style of teaching—which is a very old-school style of American/British rigidity in teaching—as rebuff of my creativity and a denial of my direct personal experience. I was told that I had to feel what they felt without variation discussion. But, I couldn't feel the rhythms that they were describing. I couldn't feel the CRI. I felt slower inherent rhythms. I would explain to these "masters" that I was feeling something slower my hands and one teacher literally slapped my hands. I was told that I was wrong. I was told that I wasn't feeling the right thing. I began to think that I was a flawed Osteopath and began to think that I couldn't be taught the great secrets of Osteopathy. I felt terrible about myself. Because of repeated negative experiences, I actually got to the point where I thought about leaving Osteopathy and exclusively practicing allopathic medicine. Jim Jealous helped me to self heal the lesions provoked by poor previous teachers. He gave me permission to recognize and utilize my felt experience. He opened the doors to my perceptual abilities and allowed me to access the non-material fields reliably as a clinical tool.

My last Osteopathic teacher was Stanley Schiowitz, DO. He was an amazing Osteopath and a remarkable human being. He came to me as a teacher after I had been in practice for 20 years. He helped to teach me how to think and feel at the same time. Most



utilize Osteopathy on a regular basis. There are over 70,000 DOs in the United States and fewer than 3% utilize Osteopathic Manipulation on a regular basis. The vast majority of American DOs practice identically to an MD and they do not utilize any form Osteopathic Manipulation. It is important to note that the future of Osteopathy is not in the United States. The future of Osteopathy is in Canada, Europe, Australia, and New Zealand.

I teach an approach to Osteopathy rather than a specific technique. I am teaching, what I believe is the type of Osteopathic approach utilized by Andrew Taylor Still. He used the terms material and immaterial (or non-material) as well as the visible and invisible in describing Osteopathic Treatment. I am just reinterpreting his concepts into a 21st Century context. I teach that the material and non-material elements are inseparable and they co-exist. In a sophisticated A. T. Still style treatment, the Osteopaths seamlessly moves back and forth between the material and non-material elements during treatment. We must be equally skilled in biomechanics and bioenergetics. We need to be equally well versed in the specifics of material anatomy and at the same time with the intricacies of the perceptual fields found in the non-material.

8 *When communicating with patients do you speak often on this non-material level?*

Very few patients are interested in this category of discussion. In general, patients are interested in getting better without a lot of talking about why they are better. There is a small subset of patients who want to know what it is I am doing and will ask excellent questions. If they ask, I am willing to discuss these esoteric topics. Fewer than 10% of patients are interested enough to talk about the metaphysics of healing. The average patient just wants to get better, and ultimately, they don't care about how or why they improve.

9 *Is there anything else you would like to add in conclusion?*

An Osteopathic Treatment is greater than the sum of its parts. The totality of an Osteopathic Treatment is a highly holistic therapeutic event. What we call an "Osteopathic Treatment" is much more than just the hands-on component we call OMT. We deconstruct the whole of a patient encounter to better understand how each component interacts and is interdependent upon the connectedness of this complicated treatment process. What differentiates Osteopathy from other health care professions is our ability to pay attention to the details of anatomy and non-material perceptual fields while at the same time holding a holistic view of this unique human being we call our patient.

of all, he taught me how to ask the right questions. The answers are not always reliable; the questions are what initiate a process of inquiry that is creative and ultimately therapeutic.

7 *Do we need to shy away from talking about the non-material? Is it something that we can openly discuss?*

I've been in Osteopathic practice for over thirty years, I don't generally teach in the United States. Speaking of integrating the material and non-material fields is not well received in America. Therefore, I teach primarily in Canada and Europe. Non-American Osteopaths are hungry for this type of teaching. American DOs who utilize OMT are primarily oriented toward biomechanics. And remember, very few American D.O.'s actually

Decolonizing the Four Principles of Osteopathy

A Literature Review of the Autobiography of Andrew T. Still

MJ Renshaw, PreOsteopathy Fall 2015



The aim of this paper is to navigate the postcolonial issues that emerge from the *Autobiography of A.T. Still* and offer the long overdue commendation owed to A. T. Still's influencers: the Shawnee peoples. Osteopathy is a form of healing that has been around for over one hundred years

and this paper hopes to explore elements of the Shawnee people's culture that may have nurtured Still's notion of osteopathy as the science of healing. Still's autobiography offers a window into the thoughts of a deeply progressive and logical thinker, one whose advocacy of equality and freedom are remarkable. Ultimately, this paper intends to honour Still's progressive thinking by examining how we can perpetuate equality and freedom by focusing on decolonizing osteopathy.

A recent article by author and activist Toi Scott titled "We Are the Sum of Our Ancestors: Decolonizing Herbalism" interrogated how a postcolonial society can make one's work in the health field more inclusive. Scott argues that "The 'dominant culture' finds the old ways illegitimate because it's not written (our People have largely oral traditions and this is not valued) and these ways also don't look familiar. I've seen some western herbalists go in expecting healing systems to look a certain way and if they don't, they are delegitimized and deemed incomplete" (Scott, 2016, para 5). While Scott's focus in the article is on herbalists, he states that these same residues of colonial bias are generally interspersed in other fields including yoga, acupuncture, and osteopathy.

In *Osteopathic Principles in Practice*, Kuchera and Kuchera include a summary of the Four Principles of Osteopathy. These principles are important to consider as we delve deeper into osteopathy's colonial roots:

1. *The body is a unit.*
2. *It has its own self-protecting and -regulating mechanisms.*
3. *Structure and function are reciprocally interrelated.*
4. *Treatment considers the preceding three principles (Kuchera and Kuchera, 1991, p.2)*

If we regard the body as a symbiotic unit (one of the osteopathic principles), we can then broaden our scope to consider how a town, culture, or even *humanity* could too be considered a unit. Kuchera and Kuchera echo this sentiment: "Although

there are many parts in this body, each body part works for the benefit of the others even though each has its own problems and its own job to do. It's obvious that smooth functioning of each part is desirable for the optimal efficiency and purpose of the entire organism" (Kuchera and Kuchera, 1991, p. 4). Because this principle could be applied to civilization and not just one biological organism, it would be, in my opinion, ludicrous to think that only one person "fathered" the practice of osteopathy. To ignore all of the aggregating influences that made it possible for Still to gather the necessary knowledge and experience to introduce osteopathy to the modern world would be un-osteopathic.

One of the inspirations for Still's philosophy on self-regulated healing is the Shawnee people, an Algonquin-speaking indigenous population that he was in contact with through his father, who "was appointed missionary to the Shawnee Indians in Kansas" (Still, 1897, p. 27). Joseph Curtin, an American anthropologist living in Ohio at the same time as Still, learned the language of the Shawnee people and attempted to record some of their traditions and history. One narrative he transcribed is the story of the Sawage, the grandmother of the seasons. The most relevant part of the tale, for our purposes, describes how a few of the grandsons are trying to make their way out of dense forests:

Sawage's grandson said to his companion: 'What could you do in your youth? If you could do anything then that would help us now, do it.'

'I was able to make myself a humming bird.'

'Oh, a humming bird is too fast for this place. It would break its bill flying around here.'

'I could make myself a butterfly.'

'A butterfly would freeze to death. You can't help us, but follow me and I will take you down. I used to make myself like wax and stick to everything. I will do so now and you follow in my tracks.'

Sawage's grandson made himself like wax and walked down the mountain with the other young man walking in his tracks. (Curtin, 1883, para 1)

This popular story of the Shawnee people recounts the importance of structure and function. It would be rather specious to suggest that this is where Still garnered some of his knowledge regarding holistic function, but such stories undoubtedly influence, and are influenced by, the cultures around them. The Shawnee peoples understood that each part of

nature had a certain structure and function that was interrelated. Likewise, Kuchera and Kuchera explain that “The airplane is not very effective on the ground and the wagon is not built to fly, but each structure determines the function performed. The same analogy can be expressed using the fact that certain function requires certain structure. Within the human race, there are individual levels of function because each body has its own level of structure” (Kuchera and Kuchera, 1991, p. 5).

However, the relationship between structure and function is not the only principle of osteopathy that can be attributed to the culture of the Shawnee people. Kuchera and Kuchera describe the body as having “its own self-protecting and -regulating mechanisms,” and that “in order for the body to sail smoothly through life it needs to have a way of protecting, repairing, and regulating itself. These ‘mechanisms’ allow the body to make adjustments to stresses caused by the environment and still maintain body homeostasis” (Kuchera and Kuchera, 1991, p. 4). One way that we can see the Shawnee people practicing self-regulation and homeostasis is through their relationship to time and the moon. In Curtin’s discoveries of their culture and traditions he found that “One way to adjust the moon with the seasons would have been to add an extra month every second (as the creeks apparently did) or third year. [...] Since the Sap

Moon (roughly March) might be delayed (that is, when it is time for the sap to flow and it doesn’t, this would signal that the moons were out of phase with the season), it might have been the case that the moon between the Crow Moon and the Sap Moon was given a different name. The Shawnee Prophet have a moon called ‘Hauhtaa Pukeneethar’ which might have served this end (the name comes from ‘ripening,’ meaning Ripening Moon” (Schutz, n.d., para 2). In other words, Western aspects of time revolve around the moon as well, but the Shawnee people were able to keep more in harmony with the seasons than the settlers to the New World. This special link between nature and time can be discerned even in the names of their moons:

January – Severe Moon

February – Crow Moon

March – Sap Moon

April – Half Moon

May – Strawberry Moon

June – Raspberry Moon

July – Blackberry Moon

August – Plum Moon

September – Papaw Moon

October – Wilted Moon

November – Long Moon

December – Eccentric Moon

(Curtin, 1883, para 2)

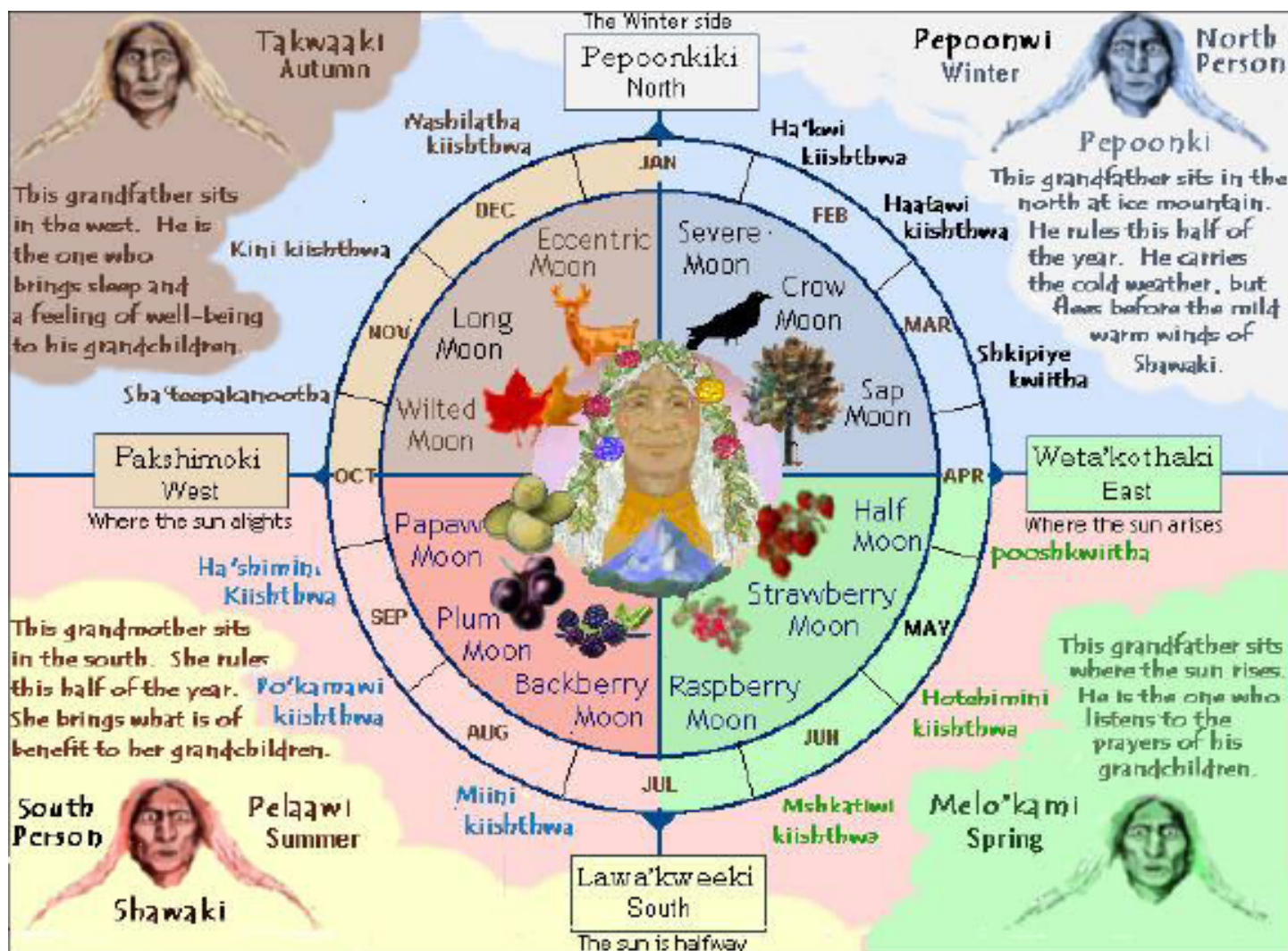


Fig. 1: A conceptual Shawnee map depicting the seasonal cycles.

Time was an entity that could be regulated in order to keep harmony with the seasons. Curtin also explains that “The Shawnee give great [defense] to the ‘grandfathers’ of the four winds who are shown in the four corners compass. [...] The Creator, shown in the centre, handed down these grandfathers to provide mankind with the necessities of life. The circle shows a rough correlation of the moons with the months of the Julian lunar-solar calendar, as well as the words for the moons in the annual cycle of life. The circle with the names of the month might be seen as spinning one way or the other by a half month or so, depending on the weather conditions, the part of the country the Shawnee lived in at the time, or a lack of synchronization between the moons and the seasons” (Schutz, n.d., para 1). The important take-away from this description is how the names of the months might be seen as spinning one way or another depending on the weather, geography, or lack of synchronization between the moons and seasons (or, for metaphor’s sake, structure and function). The Shawnee people’s culture was more fluid in its attempt to harmonize with the units surrounding it, and this cultural tradition could have influenced Still to adopt these harmonizing instincts when researching the body, specifically how it is structured and how it functions.

While there are numerous ways that we could dissect Still’s upbringing in order to understand where his devout beliefs about osteopathy come from, it is also important to look outside his sphere of immediate influence. In doing so, we begin to approach the origin of osteopathy in an osteopathic manner; that is, we not only focus on the symptom, but also on areas that may be causing or further influencing the symptom. As Scott states in a plea to decolonize the holistic health field: “The fact that you will not find our ancestor’s knowledge in books written by them does not discredit their knowledge. The written word is a western value. Folks—not just any folks, the very folks who find themselves with privilege and power on a regular basis. Yes, white folks... Have to stop expecting things to look the way they are used to. That’s why there’s so much misinformation. Do you really trust a codex or an herbal written by the colonizers who committed genocide? Do you really trust their understanding? Seems like they’d be bad historians” (Scott, 2016 para 7).

It is a fallacy to suggest that decolonizing osteopathy would be important to Still today, but a discerning reader can see that there is evidence throughout his autobiography of his inclusive nature. Still refers to his father as “a man of strong convictions, which he maintained at all times and places. He took a bold stand for the abolition, which he maintained until he saw human slavery wiped from every foot of North America [...] and died rejoicing that he had mitted [sic] to live to see all men in his country, whether black or white, free ” (Still, 1897, p. 28). It is not so farfetched to propose that we could attribute these very same views to Still. From his struggle with pro-slavery community members to the backlash he received from the government when trying to establish osteopathy as a true science, Still would certainly empathize with any attempt to not only make osteopathy more inclusive, but also to explore the origins and give credit where credit is due.

A.T. Still conspicuously pays homage to nature throughout his autobiography, which is evident in the early pages of his work. “My frontier knowledge was valuable to me in more ways than I can ever tell,” he explains. “It was invaluable in my scientific researches. Before I had ever studied anatomy from books I had almost perfected the knowledge from the great book of nature. The skinning of squirrels brought me into contact with muscles, nerves, and veins” (Still, 1897, p. 22). Yet while Still credits his emersion in frontier dynamics as a prime influence, he omits (or elides) the influence that the culture of the Shawnee people would have had on his work. Some problematic characterizations do occur in Still’s writing: “I doctored the Indians all fall. The erysipelas, fever, flux, pneumonia, and cholera prevailed among the Indians. The Indian’s treatment for cholera was not much more ridiculous than are some of the treatments of some of the so-called scientific doctors of medicine” (Still, 1897, p. 29). Since this account is written from Still’s point of view, it is easy to agree that the Shawnee’s attempt to heal a person with cholera would be archaic or ineffective. However, it is also important to recognize that most of these diseases were new to their culture, that their views on death might have been less “life-centric” than a Westerner’s, and that there were many other Shawnee healing methods that made sense yet were dismissed. Scott explains that people have “seen spirituality stripped away when it is integral to [their] ancestors’ healing. I’ve seen herbalists assume that ‘herbalists’ don’t exist in certain indigenous communities because they don’t go by ‘herbalist’ or ‘shaman’ or words (even certain concepts) that were invented by mainstream (white) herbalists and anthropologists” (Scott, 2016, para 8). When it comes to history, it is always important to question everything—especially who has been given the voice to represent the past. Scott also urges that we should not “assume that all systems from India (ayurveda, yoga, etc.) are the most advanced because the British said so. Don’t assume Acupuncture was only done in China. Don’t assume Greek medicine and Hippocrates are superior because that’s where most timelines start for ‘western herbalism’. African and First Nations medicine gets overlooked a lot because some don’t consider it to have much value. Why are their ways considered more ‘superstitious’ or ‘primitive’? Maybe their value can’t be assessed because it’s less accessible to outsiders? Who knows” (Scott, 2016 para 8). This is an incredibly important notion to keep in mind, especially considering the backlash with which osteopathy was met in its inception (and to this day). While the Western-centric, empirical-based exploration of science in medicine has helped many, it has also relegated many preventative medicines to the back seat. They are so often deemed “inadequate” due to their inability to quantify their results, yet this dismissal doesn’t make them less useful.

While Still is commemorated for his valiant efforts in making osteopathy an inclusive healing practice, it should not be an excuse for the darker images expounded in his autobiography. Describing the acquisition of indigenous cadavers for experiment, Still writes “Indian after Indian was exhumed and dissected, and still I was not satisfied. A thousand experiments were made with bones, until I became quite familiar with the boney structure” (Still, 1897, 42). While some might defend these experiments by saying that they were for the betterment

of humanity, this utilitarian thinking is problematic in a field that de-emphasizes the sacrifices made by a culture that was not respected and valued at the time.

Scott finishes the article with a hopeful message for people of colour, women, and other marginalized groups. Scott says “the knowledge of our ancestors, our inheritance, can never be taken away from us. Though others may try to eradicate it or even borrow it and sell back a flawed and incomplete version, we carry in our Spirit all the knowledge amassed over thousands of years by our ancestors. Relearning/rediscovers can seem like an uphill battle when systems are set against us reclaiming our legacies, but it can and is being done. So

Citations

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don't be disheartened. It will take some time to rediscover what took centuries upon centuries and generations upon generations for the colonizers to try to eliminate, assimilate or destroy. Rest be assured that it IS happening and at a faster rate than the actual destruction” (Scott, 2016, para 10). This leaves practitioners of osteopathy with the question of what we can do to decolonize osteopathy and be an ally to those who were marginalized during its formative years. In our analysis of origins and legacy, we should always question why one source might be regarded as more legitimate than another; we should question why we are always hearing a similar voice speaking for the subject, and diversify curricula as much as possible.

Curtin, J. (n.d.). Shawnee Moons. Retrieved April 01, 2016, from <http://www.fantasy-epublications.com/shawnee-traditions/Culture/Moons/ShawneeMoons.html>

Schutz, N. (n.d.) Shawnee Moons. Retrieved April 01, 2016, from <http://www.fantasy-epublications.com/shawnee-traditions/Culture/Moons/ShawneeMoons.html>

Fig 1. Noel Schutz, Shawnee Four Winds. (n.d.), Digital Image. 682 x 502 cm. Available from: <http://www.fantasy-epublications.com/shawnee-traditions/Culture/Moons/ShawneeMoons.html>



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MUSEUM AWARDED GRANT MISSOURI HUMANITIES COUNCIL

KIRKSVILLE, Mo., and MESA Ariz. – The Missouri Humanities Council (MHC) has awarded a grant of \$2,500 to the Museum of Osteopathic Medicine and International Center for Osteopathic History (MOM-ICOH) in support of the project, “Osteopathic Collection Inventory”. The MHC is the only state-wide agency in Missouri devoted exclusively to humanities education for citizens of all ages. It has served as a state affiliate of the National Endowment for the Humanities since 1971.

As the only U.S. entity solely dedicated to the field of osteopathic medicine, the Museum’s mission is to preserve and promote the history and tenants of osteopathy through collections and research to a global audience. The “Osteopathic Collection Inventory Project” award will support one collection assistant who will focus on the inventory and digitization of approximately 1,300 early matriculation and business records of the school, personal/professional papers, and scrapbooks. These artifacts are significant to the history of the founding school of osteopathic medicine and are important to historians and researchers studying the social, economic, and scholastic factors leading to the transformation of the school and the osteopathic community.

“This additional funding from the Missouri Humanities Council will help further our goal of a fully computerized inventory of the collection and bring a greater portion of the Museum’s collection to patrons worldwide,” says Debra Loguda-Summers, project director.



These items, along with other artifacts from the Museum’s collection, are accessible to users for free worldwide at our online collection site, *PastPerfect Online*
<http://momicoh.pastperfectonline.com/>

The Museum of Osteopathic Medicine is sponsoring this program in partnership with the Missouri Humanities Council and with support from the National Endowment for the Humanities.

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