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Oshy Ostman D.O

The views and opinions expressed in DOCNews do not necessarily represent those of the DOC Council or those of the editor who is not on the DOC Council and is independent of the DOC Council. This is your magazine. We want to reflect all opinions within osteopathic and orthopathic thinking, and would appreciate your articles - your techniques, your book reviews, your patients thank-you letters, your jokes and your cartoons. If you disagree with an article, tell us why at fwaters@uwclub.net

Fascial Distortion Model

The FDM is a stand-alone functional model for acute and Chronic injuries and other pathologies which conventionally would be classified as orthopaedic, neurological or rehabilitation.

Anatomically fascia is everywhere. Although it is commonly remembered as the spider's web-like wrapping round muscles and joints, it also extends into bones and ligaments and, with its collagen sub-bands, continues in a cylindrical arrangement into the sub-dermal layers of the skin. Fascia attaches to joint cartilage, nerve axons and nerve roots. Its tension receptors play a major part in coordinating movement and providing sensory and proprioceptive feedback to the spinal medulla and the brain. If all the organs and bones of the body were removed, one could see a precisely detailed replica of the human or animal anatomy left in the fascia. This might help to explain the unlimited application of FDM for all kinds of dysfunctions and illnesses.

According to FDM, all physical traumas are envisioned as one or more out of just six specific distortions of the body's fascia. These distortions can change the anatomy to an inadequate shape but are all reversible. Although the FDM courses teach specific stretches, manipulations and pressure techniques for each distortion, because the FDM is a permissive conceptual model and complementary to other methods, practitioners can adapt their favourite treatments to it.

Orthopathic skill comes from combining theory with hands-on practical experience and requires not only a refined palpatory touch but also the finesse and brawn to make the necessary deep tissue changes during treatment. In the careful assessment of delicate coil and recoil components, the search for potential areas of muscle herniation or cylindrical fascial distortions, the forces active during the trauma can be understood and reproduced. For instance, the FDM distinguishes between the forces of traction and compression in folding distortions. Unfolding techniques, such as traction and torque, are used to deal with a distortion caused by traction, which is painful when compressed. On the other hand, refolding techniques, such as compression thrust, are used to deal with a distortion caused by a compression trauma. The principle is to treat the same with the similar - to offer a kind of homoeopathic information and the body will re-arrange itself.

Because the application is so specific, the success rate with patients is very high. In a follow-up, one of the model patients with multiple chronic musculoskeletal problems had observably improved ROM and was virtually pain free after her initial treatment. Many of the attendees of FDM courses have reported how well the FDM operates for them, revolutionizing how they work.

Research

Decrease in Elbow Flexor Inhibition after Cervical Spine Manipulation in Patients with Chronic Neck Pain

PMID: 12206133 [PubMed - indexed for MEDLINE] Clin Biomech (Bristol, Avon) 2002 Aug;17(7):541

Suter E, McMorland G. Faculty of Kinesiology, The University of Calgary, Canada

Objectives: This study measured functional capacity and subjective pain in patients with chronic neck pain before and after manipulation of the cervical spine.

Design: Outcomes study on 16 patients with chronic neck pain.

Background: Muscle inhibition, i.e., the inability to fully activate a muscle, has been observed following joint pathologies and in low back pain conditions. Although chronic neck pain has been associated with changes in muscle recruitment and coordination in the shoulder and arms, the possibility of muscle inhibition has not been explored.

Methods: Biceps activation during a maximal voluntary elbow flexor contraction was assessed using the interpolated twitch technique and electromyography. Cervical ranges of motion and pressure pain thresholds were measured using a goniometer and an algometer. Manipulation of the cervical spine was applied at the level of C5/6/7, and functional assessments were repeated.

Results: Patients showed significant inhibition in their biceps muscles. Cervical range of motion was restricted laterally, and increased pressure pain sensitivity was evident. After cervical spine manipulation, a significant reduction in biceps inhibition and an increase in biceps force occurred. Cervical range of motion and pressure pain thresholds increased significantly.

Conclusions: Significant dysfunction in biceps activation was evident in patients with chronic neck pain, indicating that this muscle group cannot be used to the full extent. Spinal manipulation decreased muscle inhibition and increased elbow flexor strength at least in the short term.

Relevance: Muscle inhibition in the biceps has not been previously documented in patients with chronic neck pain. Further research is needed to establish whether muscle inhibition is related to clinical symptoms and functional outcome. Spinal manipulation improved muscle function, cervical range of motion and pain sensitivity, and might therefore be beneficial for treating patients with chronic neck pain.

SCOTT and the Osteopathic Lesion

reprinted from May 04 DOCNews

Michael Burt

In 1874, Dr A T Still MD DO coined the term osteopathic lesion to sum up his particular system of diagnosis. During osteopathy's first half century, slightly different brands of osteopathy evolved at each stand-alone school, each with its own terminology. Lots of different names were used for the same thing. This was complicated by the (often incorrect) use of lay terms and led to misunderstandings, confusion and disagreement between osteopaths. So, the six main colleges of osteopathy in America set up a committee in 1933 to determine a definition of the osteopathic lesion.

To quote from page 65 of the *Manual of Osteopathic Diagnosis and Technique Procedures* (2nd edition 1966, and also found in the 1st edition 1945) by Professor Walton, "...The 1933 Committee also set up a very adequate definition - *an osteopathic lesion is any pathological variation from the normal of the position, soft tissue support and mobility of one or more of the skeletal structures which originates or registers symptomatology or pathology.* This is a very concise and complete definition as it embodies in it all the necessary factors for the production of an osteopathic lesion:

- 1/ Positional changes
- 2/ Pathological changes in soft tissue support
- 3/ Mobility changes

It also makes it clear that the structures concerned are skeletal, thus showing that not all osteopathic lesion pathology is necessarily localized to the vertebral column, but that it may also be appendicular or cranial in nature."

However in 1968, the term osteopathic lesion was "sold down the river" and completely replaced with the term somatic dysfunction, which was then immediately registered as Classified Disease, number 719. Number 719 was subdivided into ten divisions with *a* for head diseases, *b* for neck diseases, etc. The American Academy of Applied Osteopathy defined somatic dysfunction as *impaired or altered function of related components of the somatic (body framework) system; skeletal, arthrodal, and myofascial structures and related lymphatic and neural elements.* Note the abandonment of bony alignment.

This would appear to be the price American osteopathy was obliged to pay to achieve the major concession of medical recognition. It entitled osteopathic patients to claim from medical insurance companies for the treatment of a medically recognised and registered disease.

The change divided the osteopathic profession into those whose diagnostic and treatment protocols remained based on the 1933 definition of the osteopathic lesion (classical osteopathy) and those whose diagnostic and treatment protocols were based on the 1968 definition of somatic dysfunction (neo osteopathy). As Walton says, "...surely there must be a better term than the osteopathically unrepresentative term somatic dysfunction".

In order to preserve for posterity the original concept embodied in the 1933 definition, it was decided in 1982 to draw up protocols that further standardised classical osteopathic terminology and technique, both diagnostic and therapeutic. The SCOTT definition of the osteopathic lesion is a slightly expanded version of the 1933 definition but still in complete conformity with it.

*An osteopathic lesion is
any abnormality of a **bone**
in terms of its **relative positions**,
and/or its **mobility**,
and/or its **associated soft tissues**,
which originates or registers local and/or remote anatomical pathology and/or physiological pathology.*

*Anatomical pathology may be
functional (somatic dysstructure) and/or structural (somatic malstructure)
Physiological pathology may be
functional (somatic dysfunction) and/or structural (somatic malfunction)*

The osteopathic lesion is composed of two parts:

- 1/ The osteopathic bony lesion (**OBL**)
- 2/ The osteopathic soft tissue lesion (**OSTL**)

The **OBL** is defined as *any abnormality of a bone in terms of its relative **positions** and/or its relative **mobility** with respect to the centre of gravity line, and/or its end of range positions, and/or its neighbouring bones.*

The **OSTL** is defined as *any abnormality of soft tissue that, one way or another, renders the **structural** and/or the **functional** integrity of that tissue to be less than one hundred percent.* These tissues comprise the primary soft tissue of the CNS and the immune system, and the secondary soft tissues of the remaining soft tissues of the body. **The OBL is a function of the OSTL.**

The science of Applied Mechanics was mentioned as far back as Littlejohn. There are only two movements possible: a straight line and curve (rotation round a point). A spiral is a combination of these. Even in the gentlest of massage, all techniques are thrust techniques as force, in its mechanical sense, is applied.

The anatomical position is considered neutral and is the starting point for movement in the three planes. Forward Bending moves away from and Reverse Forward Bending returns to neutral; Backward Bending moves away from and Reverse Backward Bending returns to neutral. When Fryette wrote about the movements of Side Bending (SB) and Rotation (Rot) in the lateral and horizontal planes to the same side and to opposite sides, he did not consider Side Shifting (SS), which is an important component. There are four triple movements on these planes:

- 1/ **Right-Right-Left:** SB right + Rot right + SS left
- 2/ **Left-Left-Right:** SB left + Rot left + SS right
- 3/ **Left-Right-Right:** SB left + Rot right + SS right
- 4/ **Right-Left-Left:** SB right + Rot left + SS left

To find the end movement, SB and Rot are applied together. Because most people are born with a left short leg, the most common combination for the lumbar spine is Right-Left-Left.

These four are tested both in exaggeration and in reversal to give eight spinal movements, which are expressed as a percentage of the normal ROM. The treatment method differs for each of these. This method gives great precision to both testing and treating.

One Way of Surrogate Muscle Testing

Reprinted from Aug04 DOCNews

Frank Waters

George Goodheart DC in 1964, inspired by the kinesiological examinations of Kendal and Kendal some fifteen years before, combined Traditional Chinese Medicine with western anatomy and physiology into a system of muscle testing, which he called Applied Kinesiology. The writer was later privileged to hear him lecture robustly on how every organ dysfunction, every allergy, every postural imbalance can be evaluated by the strength of a specific muscle. The response is binary. A weakness represents a dysfunction or a negative, while a strong muscle represents *OK* or *yes*.

Although one-to-one muscle testing creates a physical rapport with the patient, many practitioners have found drawbacks with its use over the last forty years. The tester needs to be consistent with timing, speed and pressure. To avoid influencing unintentionally, he needs to ask the right questions, and not anticipate the right answer. His posture and the posture of the patient need to be held precisely. Gritted teeth, a rotated neck or cranial problems can all affect a response. The patient can be dehydrated, suggestible or distracted. She may hold a strong thought or shift onto an irrelevant thought. She may be unwell or always weak. With multiple testing of the deltoid m, she may become fatigued or, in an eagerness to be helpful, fight back. The patient may use more muscles than the one being tested. Technically, there may be jamming, switching, oscillating, emotional blocking and psychological reversal. These can all give invalid and unreliable readings. Some practitioners, though, get a high percentage of good results and are happy to use direct testing.

Surrogate muscle testing or ideomotor signatory response is testing yourself as though you are the patient. You need to GET YOURSELF OUT OF THE WAY so that the testing goes through you, not by you (1).

Try attaching a symmetrical plumb bob on the end of a piece of string about 10 cm long and hold the other end still in front of your body. Ask your subconscious mind to show you a *yes*. The plumb will rotate one way or move back-and-forth on a plane. Then, ask your subconscious mind to show you a *no*. The plumb will rotate in the other direction or move back-and-forth on another plane. Your subconscious has produced a reaction in your conscious mind. This is dowsing using a device.

You can also use your own body to create a dowsing response and there are many ways to set up a question and answer system (2). You can use the muscles grossly. Touching your toes is *yes* while reaching short is *no*. Full internal rotation of the shoulder with outstretched arm is *yes* while reaching short is *no*. Subtler is to make a circle with the thumb and index finger of your non-dominant hand. Use the thumb and index finger of your dominant hand as a beak that you insert in the circle and try to open it. The method the writer prefers is to gently push the middle finger onto the index finger. A downward movement of the middle finger towards the thumb is *yes* while an upward movement of the index finger is *no*.

Some practitioners do not use muscles to test. My colleague rubs the end of her index finger in one direction over her thumbnail. She has programmed a smooth surface to be *yes* and a sticky surface to be *no*. Others visualize one colour for *yes* and another for *no*, or use a kinaesthetic method of one hand hot for *yes* and the other cold for *no*.

All these dowsing responses are metaphors for your intuition. Whatever method suits you, practice it often to make more neural connections. Trust the response. If you try to override it with logic, you are using your ego and not getting yourself out of the way. Develop your own code. The writer prefers that a *no* response means there is something to do further.

The main use of surrogate muscle testing in physical therapy is to aid diagnosis. First of all, you can ask, "Can I work on this patient? If the answer is negative, ask, "Should this patient see my acupuncture colleague?...a homoeopath?...an allopathic doctor?"

Most of the above methods allow a hand free for palpation. If there is tightness in the inter-scapular area, for example, place a palm over it and ask, "Are these muscles balanced? Then, "Is the trapezius functioning well? "Since the trapezius is functioning, is the latissimus dorsi functioning well? "Are the rhomboids functioning? If you normally use a 1-5 system (with 0 as complete non-functioning and 5 as perfect functioning), consider asking, "Is this a 4? Just like you would obtain a differential diagnosis logically, using the left-hand side of the brain, ask yourself questions using the intuitional right-hand side of the brain and muscle test them.

Try the normal testing position of a vertebra with your first and second fingers on the transverse processes and ask, "Is this joint structurally sound? or "Is this joint functioning? "Is this a facet problem? "Is it arthrotic? All those questions you would ask with physical testing.

After treatment, it is useful to test again for structural and/or functional secondary changes that may necessitate further treatments. If there is a choice of exercises for the patient, test for the most appropriate.

Naturopaths and Nutritionists can ask such questions as, "Does this patient receive enough vitamin C? "Is 500mg a day enough? Athletic trainers can test for the minimum rest days. Acupuncturists can test for the appropriate point. The uses of surrogate muscle testing are limitless. We are at the beginning of a revolution.

(1) *Ultimate Therapist* video set from www.emofree.com <http://www.emofree.com>

(2) *27 Ways to Muscle Test* in www.behaviourchanges.com

Bird Flu and How to Treat It

From a Newsletter to Patients by David Millington

Bird Flu is the generic term given to a group of flu viruses that infect and spread easily between birds. It was discovered about 50 years ago, with the H5N1 strain first being identified in a colony of terns in South Africa in 1961. Under normal circumstances, these viruses are specific to birds. However, from time to time there are major outbreaks of H5N1 in domestic flocks of poultry and workers in direct contact with them can become infected with the virus via the birds' faeces.

The first human case was reported in Hong Kong in 1997 and since then there have been further cases, mainly in the Far East. To date, press reports have concentrated on the small number of people who have died - fewer than 100 - rather than the fact that many others have recovered from the virus. In addition, the link between human cases and the outbreak of H5N1 in domestic flocks, together with the fact it does not spread easily from person to person, have been overlooked.

To put these figures into perspective, each year about 500,000 people worldwide die of seasonal Flu, of which 40,000 are in America and 12,000 in the United Kingdom. Do not forget the doom laden warnings about SARS (Severe Acute Respiratory Syndrome) in 2003 which killed fewer than a thousand people worldwide.

The Press now worry that the situation will change. The main reason for this seems to be that we are "overdue for a flu pandemic". While history shows that typically there is flu pandemic three or four times a century, there is no regular pattern to them. The recent scare stories seem to owe more to the WHO (World Health Organisation) penciling in 2005/2006 as the estimated date of the next pandemic rather than any predictable pattern. The other fear is that H5N1 may mutate into a more infectious and dangerous virus. All viruses naturally mutate in an attempt to evade the body's immune system and there is no reason why H5N1 in particular should become more dangerous as a result.

Treatment options offered by conventional medicine are the "flu jab" and Tamiflu, an anti-viral drug. Each year, scientists take an educated guess at the flu viruses that will be around during the following winter and then produce a "flu jab" specific to them. This means that a vaccine specific to a flu pandemic cannot be produced beforehand but only after the pandemic has started and the particular virus identified. Taking into account the time it takes to identify the virus and then produce a vaccine, it would take 3 to 6 months after the start of a pandemic for a specific vaccine to be available. Similarly, there is no evidence before a pandemic that Tamiflu will be effective for that particular flu virus and cases are already appearing of flu viruses resistant to it.

The best defence against any seasonal ailment - not only flu but coughs and colds as well - is to be in good health with a properly functioning immune system. This means:

- A good mixed diet with plenty of fresh fruit and vegetables. If you like garlic, go ahead, it has anti viral properties. Cut down on sugar, as it tends
- Drinking lots of water and cutting down on tea, coffee, alcohol and fizzy drinks.
- Keeping stress to a minimum and having adequate time for rest and sleep.
- Taking regular gentle exercise. This keeps your lymphatic system moving, which plays an important part in maintaining immunity and also helps detoxify your body

Homoeopathic Remedies

These can safely be taken alongside conventional medication. Simply take one 30c tablet every two hours as soon as symptoms appear. You should expect to see a definite improvement within 36 to 48 hours. If this does not occur, you may need a different remedy or to consult a Homoeopath for a personalised prescription.

Gelsemium, for flu which comes on slowly. Everything aches and you are so tired that you can hardly keep your eyes open. You will not be able to get warm and just want to lie still and be left alone. You will not be thirsty at all.

Bryonia, like Gelsemium, comes on slowly. You are very hot, have a red face but do not sweat. Everything

aches and you just want to lie still and be left alone. Your mouth will be very dry and you will be thirsty for cold water.

Aconite, for flu which comes on very quickly. You are a bit red and feverish with a clear, runny nose and are very thirsty for cold water. If taken at the first sign of Flu, Aconite can stop it in its tracks.

Off the Shelf Remedies

Vitamins A, C and E are all powerful antioxidants and help maintain a healthy immune system.

Echinacea improves the body's immune response by putting it on red alert to attack and destroy any infections. You can either take a single dose each day throughout the winter, increasing it to twice a day if you come into contact with someone with an infection, or just as needed.

Sambucol is a liquid extract containing Elderflower, Propolis and Vitamin C. It can be used by adults and children to help reduce the duration of colds and flu.

Pineapple juice is high in Vitamin C and also helps soothe sore throats.

Tea tree and Eucalyptus essential oils have antiviral and cleansing qualities and can be used in a burner or on your pillow.

A Lesson from History: Power Corrupts, Absolute Power Corrupts Absolutely

At the beginning of the twentieth century, a small, unrepresentative group of well-intentioned terrorists took over a Government. They immediately installed an oiled machine to propagate lies to their own people and to the rest of the world until they actually believed their own lies. To instill obedience, it was vital for decisions to be arbitrary but cloaked under a large bureaucracy to appear consistent, and for retrospective laws. They imposed high taxes on the citizens, claiming the money was needed for the continuing existence of the country, while millions sat in a bank gaining interest. The cruelty and torturing of thousands was hidden under the deceit of utilitarianism - what brings

apparent happiness to the majority is the most important consideration. The incompetence of this regime was so apparent but nothing could be done because of its totalitarian stranglehold. If an individual disagreed or the regime thought he disagreed, he was forced out of his job and his children starved. Even if an individual did not disagree but was part of a group selected for persecution, he was forced out of his job and his children starved. It was a corrupt system: institutionally evil and morally bankrupt.

And then suddenly and without warning to the outside world, the Soviet regime in Russia and its neighbours collapsed

Do You Think The GOsC Needs Your Feedback?

If so, please print this form, fill it out and then send to:

Miss M Craggs
Registrar and Chief Executive
General Osteopathic Council
Osteopathy House
176 Tower Bridge Road
London
SE1 3LU

As a registered GOsC osteopath, I would like to comment that the best things about being with the GOsC are:
SELECT TWO PLEASE BY RINGING TWO NUMBERS

- 1) Statutory recognition which raises our status
- 2) Being VAT exempt
- 3) The security of belonging to such a body
- 4) The benefits of regular information on our profession
- 5) The benefits of local and regional support groups and meetings
- 6) Knowing that the title "osteopath" is being well protected
- 7) Other. Please state

The worst aspects of being a registered GOsC osteopath are:
SELECT ONLY TWO

- 1) The high annual subscription of £750
- 2) The ever increasing control and administration from the Council
- 3) The lack of real support for my own practice and development
- 4) The lack of CPD opportunities
- 5) The feeling of being separate from the Council
- 6) The generally poor administration and organisation of the Council
- 7) Too much politics, too little osteopathy
- 8) As a GOsC member I see no need for the HPC, dentists do not.
- 9) Other. Please state

I wish to remain anonymous for fear of reprisals.

I wish to remain anonymous for other reasons.

I am happy to give my name as

Ed's comment

What Is My Responsibility To Myself and My Profession?

The GOsC admit that, because of its past actions, the Government may soon put osteopathy under the HPC (<http://www.osteopathy.org.uk/news> Registrar`s report: Review of health care regulation, 27 January 2006).

As an osteopath, under the HPC without GOsC control:

- You may pay only £60 a year like other registrants (www.hpc-uk.org)
- There will be no excessive profit made from your osteopathic school for external examiners, nor from your osteopathic conferences, nor from your CPD, so that large amounts of money - equivalent to the income of one year of fees - can sit uselessly in a bank, earning over £67,000 a year in interest (GOsC Annual Report and Accounts 2004/2005, p 23), which is not used for the benefit of its members.
- The excessive onus of the loathed section 20 of the Code of Practice may be removed (GOsC leaflets: "Code of Conduct" and "Obtaining Consent")
- You will achieve at last official parity with physiotherapists if you want to try for jobs in the NHS and in PCT

As an osteopath, under the HPC with GOsC control

- You may pay much higher fees
- You may have much more regulations and control of how you practice

ALL MEMBERS ARE INVITED TO THE NEXT DOC MEETING

SATURDAY, 25TH MARCH
STARTING 10 AM
ALL SAINTS PASTORAL CENTRE
SHENLEY LANE
LONDON COLNEY
ST ALBANS
PHONE: 01727 822010
NEAREST TRAIN STATION IS RADLETT
ON THE THAMESLINK LINE ABOUT 3 MILES AWAY
(WHERE TAXIS ARE AVAILABLE)

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