DOC NEWSLETTER
June 2006

DOC Members Notice: FDM Course for August 06- Book early for your discount.

AGM and Conference 2006.

This year's DOC AGM and Conference was held at Wood Norton Hall Hotel and Conference Centre near Evesham in Worcestershire. Delegates kicked off the weekend with a council meeting after which they retired to enjoy an excellent lunch in the Le Duc's restaurant where they were served a choice of oven roast chicken or salmon accompanied with a delicious selection of freshly cooked vegetables and salads. So fortified, delegates proceeded with the AGM, which was presented with some unexpectedly good news in the form of a letter to one of our delegates, from the GOsC conceding the use of osteopathic treatment to members of the DOC. It is always satisfying to see tangible benefits resulting from of all the hard work that the DOC puts in.

Later in the afternoon Chris Bell presented a lecture on the treatment of visceral problems using a simplified palpatory approach (see article in this newsletter).
This was followed with Andy Buckley's presentation on the treatment of shoulder problems utilising a more exercise orientated approach rather than the classic osteopathic modality.

Saturday evening saw the delegates returning to Wood Norton's dining room for an excellent meal. As someone who had experienced the first AGM dinner at Wood Norton, which took place in a canteen, this was a welcome change. The Restaurant has 2 AA Rosettes for fine food and the cuisine is modern with French influences. The accolade is justified with more chef than cook in evidence. My own meal was faultless with an excellent Caesar Salad followed by meltingly tender lamb shank with beautifully presented lemon tarts to finish all washed down with an excellent bottle of house Cabernet Sauvignon. Delegates retired, not surprisingly, in good spirits.

After a hearty breakfast it was time to enjoy Debra Bakowska's presentation who gave an excellent and detailed lecture on core stability. This approach was again very different from the normal osteopathic approach to lesions in the spine and surrounding structures. It highlighted a treatment approach, which is commonly found in sports medicine and physiotherapy but within the context of osteopathic principles. Lunchtime saw the delegates preparing to disembark for home. Everyone agreed that a combination of excellent lectures and good food made the weekend a great success and our thanks go to all those who helped organise the event.

GOsC confusion over 'osteopathic treatments'.

In a confusing letter sent to a DOC member, the GOsC have stated that only the DOC are entitled to use the term 'osteopathic'.

In fact it was a DOC member, Mr. Stewart Kyle, whom the ASA (after consulting with the GOsC) agreed could use the terms 'osteopathic treatments' and 'member of the Democratic Osteopathic Council'.

However, in a letter sent to a DOC member dated 4th April 2006 headed, **Osteopaths Act 1993- Section 32(1),** Dana Davies (Professional Conduct Officer) wrote, *"You will be aware that this office has been contacting practitioners in the past concerning the legislation cited above and the need for them to cease informing the public and their patients that they are practising using the term osteopathic treatments.*

Our opinion is that if you use the word osteopathic then you contravene the said Act.

*Only the **Democratic Osteopathic Council** are entitled to use this term, which has been agreed with the Advertising Standards Agency: www.docouncil.org.uk.*

This council is firmly of the view that practitioners like yourself are now very familiar with the law as it relates to the use of the osteopathic title. Sufficient resources have been provided for us to tackle those who continue to unlawfully describe themselves as using osteopathic treatments.

Failure to comply with the Act may result in a criminal prosecution."

The DOC had recently sent a series of letters demanding to know why the GOsC were intent on prosecuting practitioners who used the term 'osteopathic treatment' when they had already agreed with the Advertising Standards Authority (ASA) that this was allowable. The DOC also wanted to know why the intentions of the Osteopaths Act to allow qualified individuals to use the term 'osteopathic treatment' even if they were not registered osteopaths, was also being ignored.

Until we can clarify the contents of this letter the DOC is recommending that its members stick to the advice outlined in ***'Report and recommendations for advertising for DOC members'***. Those who haven't seen this should ask the Registrar for a copy and to use the term, 'osteopathic treatment', in the context of the advice given in this document.

Although the DOC has asked the GOsC to agree with it a form of words that would satisfy both parties, which non-osteopaths could use in their promotional literature, the request has so far been ignored.

Residential FDM (Orthopathy) seminars 1 & 2 to be held at Wood Norton Conference Centre, Evesham

As part of the DOC's Continuing Professional Development for 2006, DOC members (and non-members) are again being offered a unique opportunity to learn Orthopathy / Fascial Distortion Model (FDM) which will enhance the scope of any practice.

The first basic course (FDM 1) held in September 2004 was fully booked. We are pleased to announce that Dr. Georg Harrer MD, a lecturer at the German Institute of Osteopathy has gladly accepted our invitation to cover the Basic and Advanced Courses.
FDM is a primary manipulative therapy applied to the deep soft-tissue of the fascia. It is an obvious extension to osteopathic techniques.

Basic FDM Seminar (midday Friday to midday Sunday)
Advanced FDM Seminar (midday Sunday to midday Tuesday)

Both seminars include two nights at the Wood Norton Conference Centre, full English breakfast, buffet lunch and a three course evening meal.

There is a £50.oo discount to DOC members, and a further £30.oo discount if payment is received by the 7th July.

FDM manuals will be on display and requests for orders will be taken.
There are only 20 places available for each of the courses. (10 pairs)

Name………………………………… I am a DOC member: Yes / No
Address……………………………………………………………………
……………………………………………..Postcode………………………..
Tel. No……………………E-mail…………………………………………..

How many of you attending?....... Vegetarian Options – No.'s…….

	Full rate	DOC discount (subtract £50)	Early booking discount received before 7th July (subtract £30)
Basic FDM seminar	£399.00	£349.00	£319.00
Advanced FDM seminar	£399.00	£349.00	£319.00
Both Basic and Advanced seminars	£699.00	£649.00	£619.00

		Please tick below	**Cost of course (£)**
I am attending the FDM course for the	Basic		
	Advanced		
	Both seminars		
		Total	

I am enclosing payment for £……. Payable to the 'DOC' & send to:-
Anthony Mathews, 70 Canterbury Road, Herne Bay. CT6 5SB.
Tel: 01227 – 363910 (H) or 366473 (W) E-mail; anthony-mathews@hernebayosteopathic.freeserve.co.uk

Japanese restaurants don't have to be a raw experience.

Anyone who has read their pathology books cannot fail to realise that one of the benefits of cooking meat and fish is that the little things that live in them don't end up living in you. I have always had difficulties for this reason in enjoying sushi and so when I found a little Japanese diner, which specialises in Japanese fast food which is all cooked, I was delighted. The restaurant is on the other side of the road from the British Museum (past the Museum Tavern and down Museum Street) and on entering our party was struck by the unusual sight of tables with large metal cooking plates in the middle. Thanking our lucky stars that there were no small children in tow, we were shown to our tables by the helpful staff.
The menu consists of a variety of okonomi-yaki (Japanese omelettes), the ingredients for which are chosen and then brought to the table where they are mixed with freshly whisked eggs and finely sliced greens and then placed on the hotplate. Ingredients such as prawns and salmon, bacon and chicken or any combination are available. Any problems with choice are soon sorted out with the help of the cheerful waitresses. If omelettes are not to you liking then a mix of fillings with noodles can also be ordered. Once cooked our omelettes were topped with a variety of sauces and dried fish flakes (all optional) before we sliced off hunks to eat with chopsticks. This was washed down with a bottle of hot Saki, which was designed to keep out the cold winter weather. We found the desserts a bit bland—green tea ices for example—but there are plenty of cafes serving traditional desserts in the area if you are still peckish.
Abeno, 47 Museum Street, WC1. 0207 405 3211.

Structural Medicine

An ongoing discourse on this neglected area of medical practice.

Part 1—Problems with Palpation

In the first part of his lecture given at the DOC AGM this month, Chris Bell argued the study of medical sciences is an attempt to turn the palpating hand into a visual scanner providing quantitative data but shows that the way the brain handles sense data makes this impossible. However, a subjective ability to feel relative movement and tension in the body can form the basis for effective visceral treatment.

We have a moral obligation to relieve suffering.

It is well to remember that there are enormous gaps in the understanding of the physiology, pathology and treatment of many internal problems resulting in long-term pain and disability for countless patients. However, for various reasons it is easy in the surgery for both practitioners and patients to pass these problems by, unseen and unheard.

Addressing anomalies of movement and tension within the body can relieve some of this suffering and this surely creates a moral obligation on those with these skills to intervene on behalf of the patient. My intention today is to encourage the use of those skills by demystifying the treatment process.

Knowledge of itself serves no practical purpose.

When, after 12 months of physiology and anatomy, I was confronted with my first patient with back pain I was completely at a loss. How was I to turn all these facts into practical treatment? That so much learning could provide so little understanding was a shock. What I needed in order to help this individual was experience of treating back pain and not an understanding of how the body worked.
I was reminded of this many years later when I was involved with the teaching of visceral osteopathy. Students would spend many days learning the anatomy and physiology of a particular organ along with methods to influence its movement but a surprising number would feel totally unprepared to apply these ideas to their patients.

The confidence to treat comes not from any intellectual knowledge but the practical experience of seeing patients respond to treatment. The extraordinary ability of a patient's internal organs to respond to manipulation once felt is never forgotten. It is only when the practitioner can acknowledge that they have stumbled on a system of control that has been totally neglected in the medical textbooks, can they begin to ask useful questions of anatomy and physiology.

However, as soon as those questions are asked of physiology and anatomy, so the knowledge begins to inform the palpation. That is to say that what we feel is not a pure sensation but is interpreted by our minds and the facts therein. This may give us an illusion of skill but as we read later, it cannot be relied on, and the more we read and study the more our palpation is subject to error.

It is this confusion over what is being palpated and its interpretation that can so undermine a practitioner's confidence and prevent them from helping their patients.

Reasons to doubt the objectivity of our hands.

Reasons for doubting the objectivity of palpation and other sense data can be traced back to the 1970s. In 1977, Richard Nisbett and Tomothy Wilson published a paper entitled, "Telling More Than We Can Know: Verbal Reports on Mental Processes." They created a number of carefully structured experimental situations in which people were required to do things and then say why they did what they did. In one study they lined up several pairs of stockings on a table. Female subjects were then allowed to examine the stockings and to choose which one they liked best. When questioned the women gave complex reasons that justified their choice such as texture, and sheerness. However, they were not aware that the stockings were all identical. The subjects believed that they had decided on the basis of their internal judgements about the quality of the stockings. Although the subjects always gave reasons these came not from privileged access to the processes that underlay their decisions but from social conventions, or ideas about the way things normally work in such situations or just plain guesses. In other words the inner workings of important aspects of the mind, including our own understanding of why we do what we do, are not necessarily knowable to the conscious self. The brain abhors a vacuum and in the absence of a coherent explanation, falls back on its stored information. At the same time Michael Gazzaniga and Joseph Le Doux were carrying out experiments on split brain individuals. These people had their corpus collosum severed for severe epilepsy. In these cases information presented to one side of the brain is unavailable to the other. The experimenters fed an instruction to the right

hemisphere exclusively such as wave your arm. The subject was then asked for an explanation of why they waved. Because the brain was split the left hemisphere did not know of the instructions to the right side but was aware of the action that took place i.e., the raising of the arm. As the left hemisphere could talk (through the speech centres) the verbal output represented its understanding of what happened.
When asked why the subject was waving, he said he thought he saw someone he knew. Like Nisbett and Wilson's subjects it was found that people normally do all sorts of things for reasons they are not conscious of (because the behaviour is produced by brain systems that operate unconsciously) and that one of the main jobs of consciousness is to keep our life tied together into a coherent story.

Why this research is so interesting in respect of aspects of cranial and visceral work is that sense data from a practitioner's examination is entering into many subconscious pathways. What the practitioner is conscious of and the movements they claim to feel, I would argue, are largely the result of what they have been taught to describe through lectures and courses mixed up with their own self-images, memories of the past, the present social situation and their physical environment. In other words participating in more courses on these subjects provides a greater number of explanations for the brain to conjure up when it is asked for an explanation of sensory input.

There is no evidence that it makes a practitioner more effective at treating. So does an occipital bone or stomach move in a certain way? Well let's say we can't rely on our palpation to tell us. Those who claim excellence because of the number of courses they have attended and claim to be able to palpate more and more abstruse bodily motions are deluding themselves if we are to believe these researchers.

What is the use of these courses then? Well it does no harm to discuss various theories and ideas and certainly the teaching of anatomy and physiology is an essential part of our differential diagnosis. However, as an intellectual basis for developing a specialist discipline it lacks authority and shouldn't be used to browbeat those with alternative views.

Conclusion

I believe that by concentrating so much on the anatomy, physiology and pathology of the viscera we create, for the practitioner, an immense hurdle to reaching an alternative intellectual landscape beyond because it so often doesn't equate with what is actually being palpated. More importantly, what the practitioner imagines they are palpating is a product of their education and experience rather than what is actually beneath their hand. Some teachers, for example, have added to the confusion with an intellectual approach by trying to quantify structural anomalies—a sort of **structural pathology**—by referring to palpable movements in the viscera, which are definite and specific and which correlate to specific states of abnormality. For each specific anomaly there is a solution in terms of a specific treatment approach.

So what can one learn from these approaches? If we are to accept the findings of Le Doux et al, it is possible that anyone learning the complex movements of the internal organs will go on to imagine they can palpate such movements but this is not the same as obtaining a real understanding of how the organs move. There is another problem in that by creating movements

that are difficult to palpate (or don't exist) it creates a powerful obstacle to practitioners entering this discipline in the first place.

Cranial has exactly the same problems. Tests have been conducted with cranial practitioners in the past that showed each gave a different value for the cranial rhythms they were palpating. One is reminded, in these discussions, of Voltaire's description of doctors as people who keep the patient amused whilst nature takes its course. One could add that cranial and visceral courses are designed to keep the practitioner amused whilst nature takes its course with their patients.

So if structural pathology is a human conceit (or at least case not proven) what is it that is helping our patients? It is fortunate for our patients then that a shared absolute objectivity is not required to bring about a successful treatment.

Practitioners who spend time palpating and treating internal tissues can all agree that there can exist states of tension and of movement which they can label as abnormal and that by changing these states they can improve the patient's health. What we must say is that precisely what is felt must be accepted to be unique to each practitioner until proven otherwise. To be more precise the individual practitioner interprets his or her own sense data in a unique manner that prevents a shared absolute objectivity. But the practitioner can certainly identify regions of different relative tension and movement within the same patient. So a palpably soft area of the abdomen may be compared with a more restricted or tense area.

Summary of palpation.

Structural medicine then in the surgery is not the study of the relationship between structure and function rather it is the study of the relationship between palpation and function.

We can see from the evidence above that palpation is not able to act as an objective scanning device although our minds might give us this impression.

We are left with an ability to feel relative movement and tension in someone's body, which we can use to bring about change.