Some thoughts on osteopathic technique…

…from Carl P. McConnell, DO, MD
The Standardization of Technique, 1915

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OMED 2014
28 October 2014

Routinism...

- Whoever is satisfied with his technique method is in a routine rut, and routinism spells retrogression.
- He [Dr. Still] does not tell us to go through a certain manipulation here and another kind somewhere else, or to give a strong or a weak, or short or long, or light or heavy, overhauling. Indeed not: such is not osteopathy.

What are we doing?

- All of you are familiar with how at all times and places he has been requested to give his “technique” for this disease or that. Really such a request is virtually absurdity.
- He has constantly striven for the individualizing of cases; meet conditions as they actually exist.

Adjustments…

- Instead he tells us to examine the structure most carefully from head to feet and then proceed to adjust what is wrong.
- To a large extent, the art of technique to Dr. Still, as we understand it, means precise detail work to every single lesion…
- …there are one or more "key" lesions, which, if unlocked or released, will so condition the rest, secondary or compensatory lesions and mechanical changes, that comparatively little attention to these is required.

Minimum…

- There should be a minimum dead level of efficiency before one should be allowed to practice. We fully realize that certain general manipulations and stretching and needing of soft parts will accomplish considerable, but it is in the field above and beyond this that we are referring to — the physics of the structure

One’s technique reflects his conception of osteopathy.

Viewpoint…

- If we can determine the mechanical relation of the tissues at fault, and are satisfied that the pathological involvement will not be harmed by manipulative efforts, the problem is a mechanical one and nothing more. But if the pathology is of such a character that manipulation may be harmful, then the problem is one of palliation or *attacking it from some other viewpoint*.

Technique…

- In all of this it is certain that the character and extent of the pathology will determine the nature of the technique.
- In actual technique work it is not so much the method that should actually concern us (for a method is simply a means to an end), but instead, the principles involved.

Purpose…

- First, we should clearly understand that the primal object of technique is normalization of function.
- Likewise with the mooted problem of structuralization versus stimulation and inhibition, we should keep clearly before us that we are dealing with a complete mechanism. It is normalization of structure that is the essential desideratum. Normalize all the tissues structurally and the physiological functions of stimulation and inhibition will automatically adjust.

Standardization…

- The resultant forces have drawn the tissues structurally (mechanically) beyond the point of nature’s resources to correct. Our work is to first diagnose, then utilize some method that returns the parts back over the same outgoing path. This is the essence of standardization of technique as we see it.
- And it is equally certain that in order to adjust a structural deviation, the outgoing path must be retraced. These are the fundamental points to all technique, no matter the so-termed method is employed. A study and application of these two points constitutes the problem of standardization.

What it is not…

- Technique cannot be the complex detail and awe-inspiring buncombe that some seem to make out of it; neither is it time-killing massage and movement stunts that a few have the audacity or ignorance to palm off on an unsuspecting public.

Lesions…

- The extent of the functional change is not always commensurate with the physical damage, because locality of the involvement is an important factor. Then many changes are relatively unimportant for nature is constantly striving to maintain normality, and thus innumerable lesions are temporary; in this class one’s general resistance, hygienic measure, and rest only are required.
- Another class of lesions are those of more serious and extensive involvement, which require some assistance in order to normalize. These are the the cases which general manipulative measure and the like more or less readily correct.

Deeply seated…

- But beyond these are the deeply seated and anchored lesions, as we have repeatedly said, that require a greater or less degree of skill to adjust. To correct these one must have some knowledge of both diagnosis and mechanics, based upon actual experience, and an art that exemplified preciseness; it is this class of cases that we are specially interested in. But we should not lose sight of the fact that any classification of lesions is purely arbitrary. There is no line of demarcation; it is simply a graduation, and a very gradual one, of one so-called class into another.

Not all are equal…

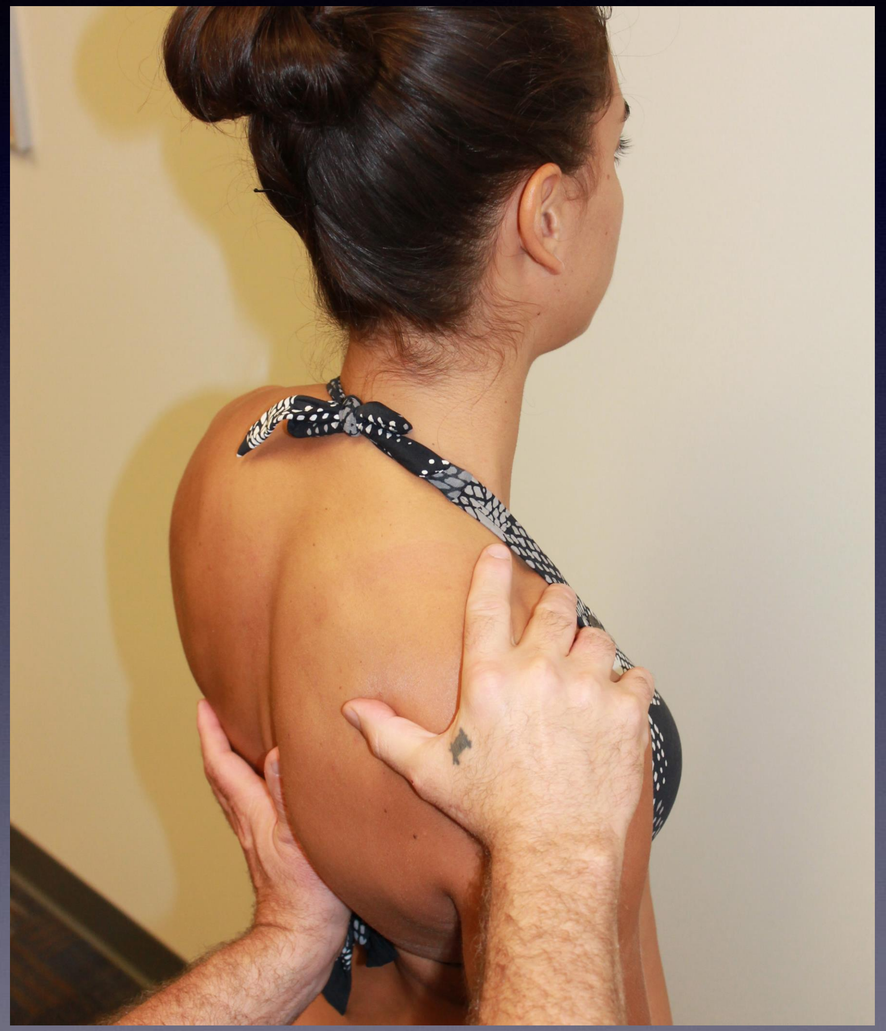
- This is one great reason why all methods of manual treatment secure some results, but this is very far from stating that all methods have equal merit.

Dynamo-mechanical…

- This method to a certain extent ignores the *general* physiological movements of the spine and individualizes its work in accordance to the simple mechanics of each lesion.
- The common mistake made here is not in failing first to release the parts, but in failing to maintain the release or exaggeration until the moment, synchronously of initiating the leverage force or retracing the out-going path of displacement.
- This is rather a difficult thing to learn and to tactually appreciate, but upon this one feature rests the success of the method.

Before we begin…

- You must first identify the *key lesions!*
- CPM described Still teaching to examine most carefully from the head to the feet…the proceed to adjust what is wrong.
- It is never described how this was done, but based on history, I suspect it was similar to Dr. Stiles AGR screen in which the most dysfunctional structure is identified, treated, and the rescreened for the next most dysfunctional structure.



Differences…

- Early osteopaths did not describe SD the way we do.
- Anatomically described 5 types of lesions:
  - osseous
  - ligamentous
  - muscular
  - visceral
  - composite
- Often they screened in a lateral recumbent position, particularly if they were going to treat in that position.

“Thrust” technique…as CPM described it…

- Applicability of thrust technique
- Steps:
  - Identify the dysfunctional structure.
  - Lie the patient lateral recumbent, on the side of the dysfunctional structure (we might now call this the side of the open facet).
  - The upper leg’s foot should be posterior to the lower leg, resting on the table.
  - Direct your forces toward the dysfunctional segment, approaching the “feather edge” of the barrier.

Thrust technique…

- Steps, continued:
  - Ask the patient to take a breath in, the blow it out.
  - With exhalation, follow the barrier, taking up the slack until the next edge is approached.
  - Repeat as many times as necessary until full correction achieved
  - If full correction is not achieved, then give a very small thrust/impulse/nudge into the barrier.
    - There should be *NO* sound!

Direction of thrust, should it be necessary

Cervical spine…

- Again, identify the dysfunctional structure.
- Cradling the head in the palms of the hands, with the fingers on the dysfunctional structure, position the head so as to approach the feather edge of the barrier.

Cervical spine…

- Ask the patient to take a breath in, the blow it out.
- With exhalation, follow the barrier, taking up the slack until the next edge is approached.
- Repeat as many times as necessary until full correction achieved
- If full correction is not achieved, then give a very small thrust/impulse/nudge into the barrier.
  - There should be *NO* sound!

As an indirect technique…

- Position the patient in a lateral recumbent position, lying on the side opposite the dysfunctional structure.
- The upper leg's foot should be posterior to the lower leg, resting on the table.
- It is far easier to do the indirect technique with the dysfunctional structure up. One could do this as a direct technique, just as described previously. I have changed to positions only to more easily differentiate the two techniques.

As an indirect technique…

- Position the patient so as to take all of the tension off the dysfunctional segment (position of ease).
- While maintaining this position, ask the patient to slowly extend the upper leg by sliding it along the table (but do NOT lift it!).
- After a brief pause, ask the patient to return the leg to its original position by again sliding it along the table. Again, be sure that the patient does not lift the leg to put it atop of the other.

As an indirect technique…

- Readjust your positioning to again find the position in which all of the tension is taken off of the tissues.
- Repeat this entire process for a total of three (3) repetitions, and recheck to be sure the correction has occurred.

Any area of the spine…

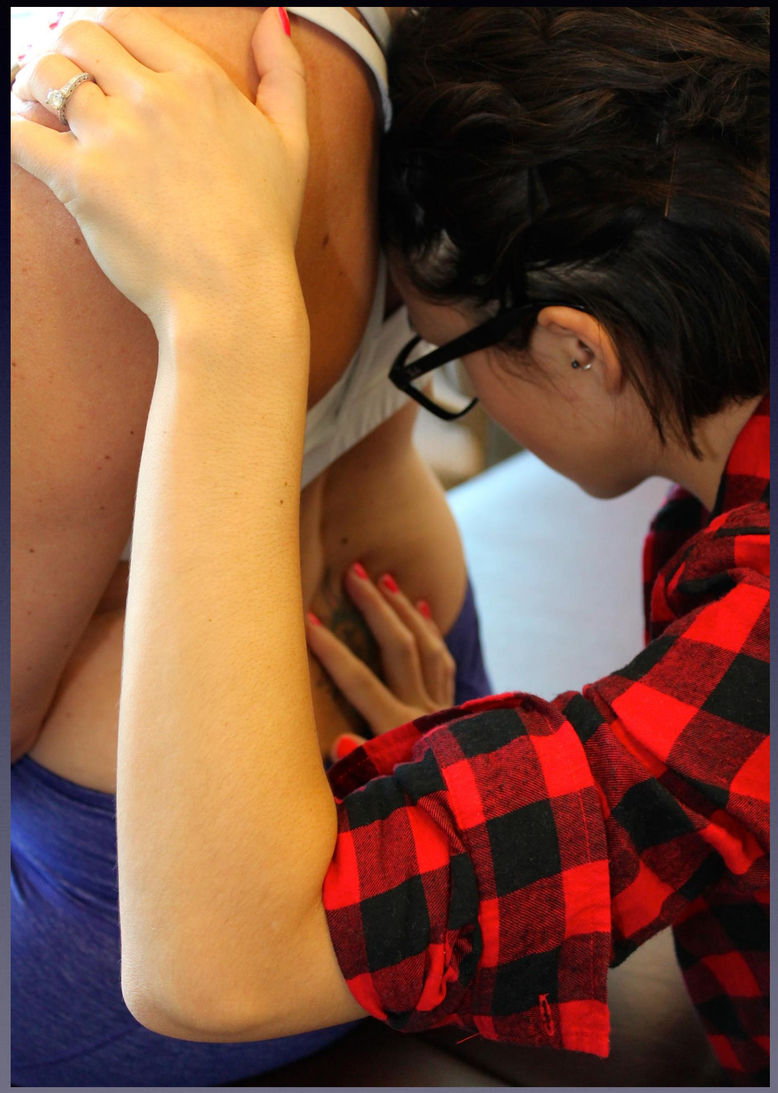
- Obviously, these same principles could be applied to the sacroiliac joint, the costo-vertebral or costa-transverse joints; and with variations using the arms instead of the legs, to the cervical spine and ribs.
- CPM described both of these kinds of techniques as “physiological.”

Dynamo-mechanical…

- I have not found a more complete description from McConnell describing this technique.
- He always refers to this as the “best” technique, but only says “in order to adjust a structural deviation, the ***outgoing path must be retraced.***”
- He does not say it is done in any particular position, but does say “Our work is to first diagnose, then utilize ***some method*** that returns the parts back over the same outgoing path. This is the essence of standardization of technique as we see it.”
- It is a **PRINCIPLE**, not a technique.
- I will describe it seated. It is my impression that this was how it was most typically done, but not necessarily so.

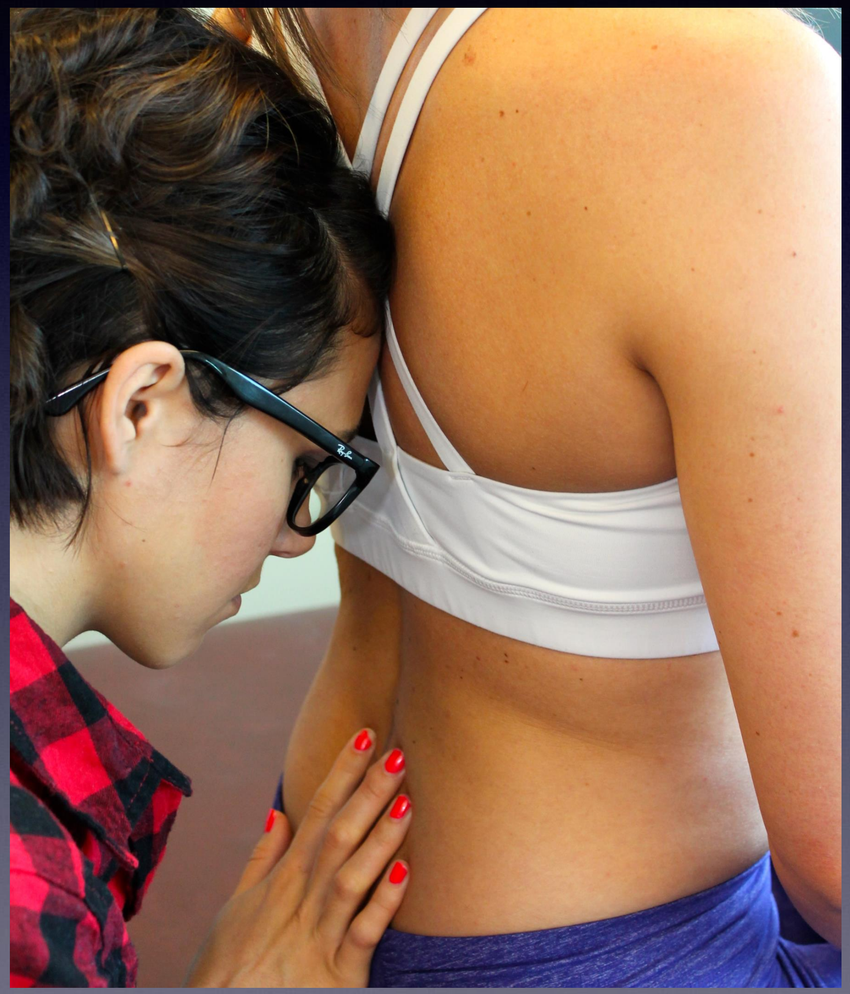
A way…

- First, identify the dysfunctional segment.
- Identify the most dysfunctional aspect of the structure, determining if it is osseous, ligamentous, muscular, visceral or composite.
- How can you best address this dysfunction, based on its characteristics?



A way...

- Once the dysfunctional segment is identified, test the tissue response by passively sidebending the patient to both the left and right.
  - Assume that the tension lessens with left sidebending.
- Place your head on the patient's back (this helps control the patient's movement).
- Now test the dysfunctional segment's response to flexion and extension. In which direction does the tension lessen more?

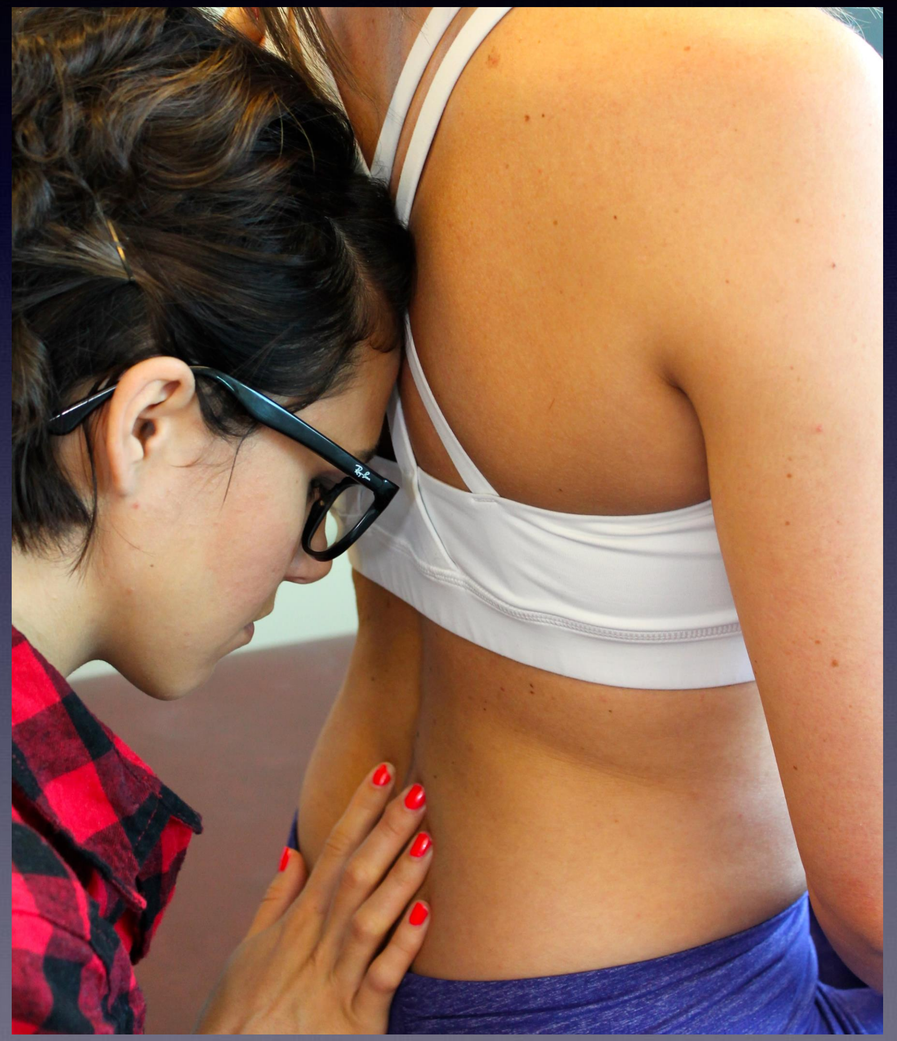


The out-going path…

- Apply a slight force vector from the motive hand toward the monitoring hand and the dysfunctional structure.
- This accomplishes two things:
  - It helps localize your forces directly into the affected structure,
  - Is part of the fine-tuning of the position.
- Fine-tune the positioning of the patient, in all planes, such that all of the tension is minimized at the dysfunctional structure.

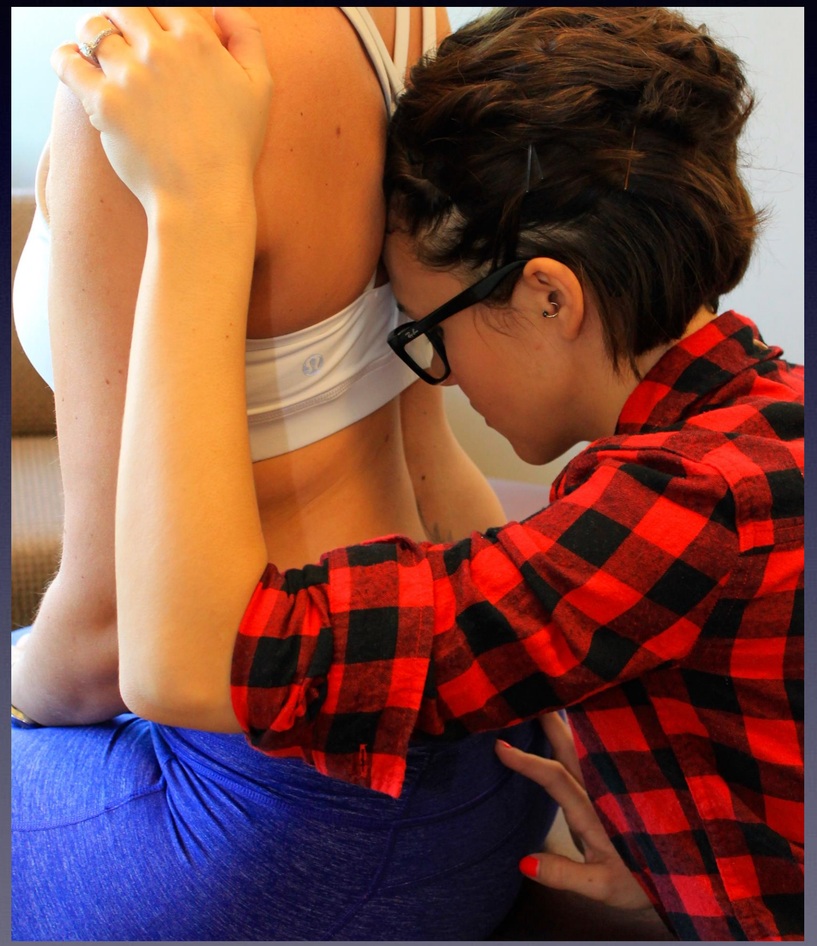
The out-going path…

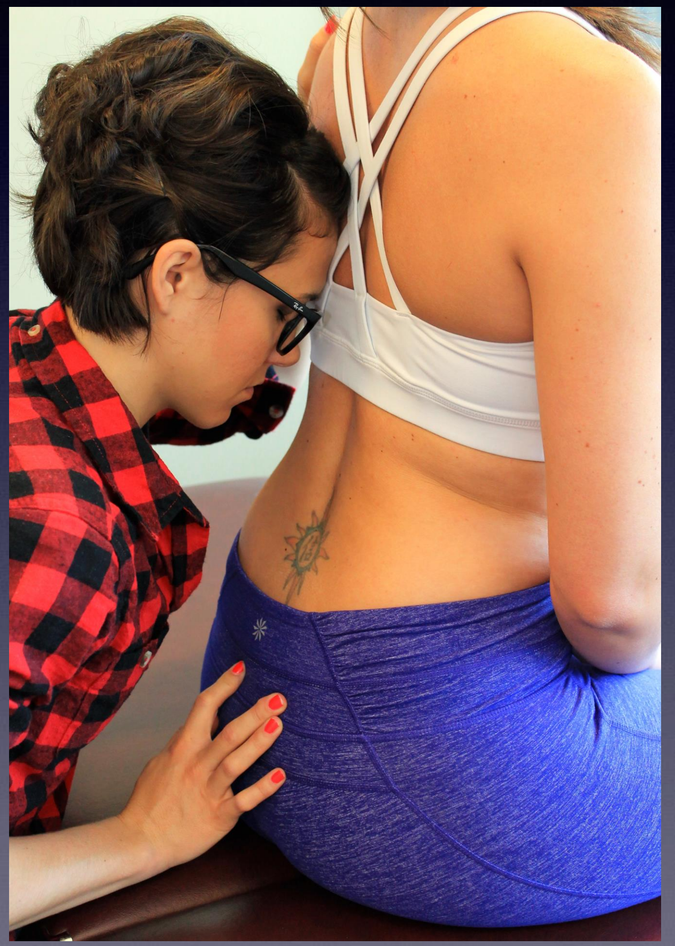
- Once you find the precise point of balance, the patient’s body will begin to respond on its own, and begin moving.
- The direction of movement is not predictable, but is dependent on the individual lesion.
- Follow the response until it finishes. It will either stop moving or return to neutral when done.
- It is essential to maintain your localization throughout the treatment.



Principles…

- After rechecking to be sure the full correction has occurred, rescreen the entire patient for the next key lesion.
- Continue this process until there are no more significant lesions, or you come to something you cannot correct.
- You will find, using this method, that you are much more efficient and typically only treat 3-6 structures.
- These principles can be applied to any structure of the body.





In CPM's words…

- The common mistake made here is not in failing first to release the parts, but in failing to maintain the release or exaggeration until the moment, synchronously of initiating the leverage force or retracing the out-going path of displacement. If this is not done the probabilities are the technique will be a failure. This is rather a difficult thing to learn and to tactually appreciate, but upon this one feature rests the success of the method.