Are we Losing our Identity ("true holistic" Osteopathy) to over-emphasis on reductionist (condition/symptom focused) evidence-based medicine?

Introduction

As an Osteopath who applies Osteopathic principles in practice and who looks more at the bigger picture, I feel compelled to voice some serious concerns regarding the emphasis of modern-day education, research and practice. I mean no disrespect to anyone in pointing out these concerns but I do feel it is necessary to bring them to your awareness (if not already). Please take this discussion very seriously because I for one do not want to see Osteopathy die a gradual death (through omission) without any one being the wiser this is even occurring when something can quite easily be done to bring a balanced 'Osteopathic' perspective back.

I noticed something the other day relating to correspondence from our association, about providing more CPD courses with evidence-based practice behind them. This got me thinking and to be honest, although this is healthy in some respects, I can't help but feel a little saddened that everything nowadays is so focused upon (external) evidence-based medicine that it often distracts from the importance of developing the ability to use our 'human instruments' to uncover and trust 'internal' (primary) evidence from the tissues of the whole person from our holistic postural assessment. We are so focused upon external research (thinking it's all forward progress) that we are at real risk of 'missing the point and value' of what it is we can POTENTIALLY do well and thus risk losing the 'Osteopathy' in the Osteopath – so to speak – and without us even realising we have done so.

It seems to me (in relation to Osteopathic assessment and treatment) from observing the content of people's LinkedIn and Facebook comments, the emphasis in the CPD courses, workshops and modern biomedical education and practice that we are limiting our professional potential and value rather than expanding upon it. Observation shows less understanding and application of Osteopathic principles in practice, rather than more. I will give some examples of this later but for now, I feel this is likely linked to the 'distraction of our attention' by an overemphasis on pain, tissues and conditions causing symptoms and upon the more theoretical and technical elements of biomedical knowledge (of parts) rather than on holistic integrative elements and that of developing ourselves as instruments of perception (to be able to reliably pick up clues from the body's tissues) and thus the more practical applications of holistic principles in practice.

It seems that through lack of emphasis on the more holistic elements of Osteopathic practice (i.e. that which gives understanding and context of how everything fits together) that the 'Osteopathy' in the Osteopath is gradually getting killed out rather than being practiced, growing and thriving. We are thus only doing a fraction of what we are truly capable of because all the things which make us better at what we do (e.g. developing our practical understanding of our philosophy, principles, and holistic assessment skills) are not emphasised in our education, research and practice and thus fade into the background and simply cease to be.

This article therefore discusses concerns about our modern-day over-reliance on what I call "secondary" evidence from evidence-based medicine to the detriment of observing "primary" evidence from a holistic (Osteopathic) examination of the tissues of the whole person.

SUMMARY OF TYPES OF EVIDENCE

Are we losing our identity by being over distracted by evidence-based medicine and a pain focused approach?

There are two types of evidence

1. Primary Evidence from the tissues of the (WHOLE) person (i.e. internal research)

This is what we find from our Assessment processes.

This itself is IDENTIFIED from 2 types of assessment processes.

1a) General Holistic (Osteopathic) Assessment (Screening) Process

Identifies primary areas of "all three" of A.R.T (the 'what else') in the whole person contributing, causing, setting up the tissues causing symptoms or otherwise slowing recovery by interfering with the body's self-healing mechanisms.

Note: This provides context for 1b. and tells us what we can actually treat (that is safe and supporting to overall recovery etc).

YET – This does not seem to be emphasised, developed and reinforced to an adequate level in current education, research and practice (examples below)

1b) Regional/Local Assessment process for 'tissues/conditions causing symptoms'

Note: this is based on symptoms and a more biomedical condition-oriented education and is more likely linked to TART the extra T (tenderness) of which relates to what a patient feels and not a true sign (ART = which is what we feel).

This "IS' the emphasis in education, research and practice (it seems from observational life evidence - examples below).

Note: an adaptive secondary issue (usually in symptomatic areas) may only have a few of ART (not all three).

2. Secondary Evidence (from external documented research).

This does not tell us what to actually treat but does provide background information about what other people are up to in terms of current trends in exploration, thinking and capability (i.e. researched information 'known' to date out of the 'collective unknown').

It <u>rarely</u> adequately explores category 1a) (holistic elements) but does often provides details in relation to category 1b) (region/local biomedical investigation of tissues/conditions causing symptoms).

Thus, it is helpful usually only in a regional reductionist and symptomatic way but without the CONTEXT OF THE WHOLE may at times be distracting or even misleading.

From one perspective it is providing evidence that the symptomatic viewpoint on its own is not effective and that something is as yet 'missing' (i.e. perhaps the 1a) in terms of chronic illness especially and which is needed in future research for a more complete picture to emerge.

Example: research on treatment techniques and their effectiveness are often performed from a reductionist symptomatic viewpoint (1b) and is limited in its results because the perspective of the whole (1a) which provides context) is not usually included.

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NOTE: A.R.T = Asymmetry, Range/Quality of motion 'ABNORMALITY', Tissue Texture Change. Technically 'Range' tells us something is limited but 'Quality' tells us if it is 'Functional' or not. E.g. a structure may be asymmetrical, altered in its range and have some difference in texture but still may technically be functioning (even if symptomatic and tender – which could be a clue to its adaptive nature - an effect only).

Discussion

From the outset let me assure you I have no issues or objections to the practice and use of evidence-based medicine, especially when carried out by practitioners who both know and understand how to listen to the body and how to use the correct methodology with which to test and measure their hypothesis. In the hands of those who know, it shares valuable resources with other people. The best research seems to be performed by those practitioners who have spent a lifetime observing the body (and its relationships, phenomenon and remedies to support its recovery etc) in its natural environment and they simply conduct external research to give evidence of this and share their insights with the world so everyone can benefit (in a shorter time without having to perhaps go through all the issues and mistakes along the way). This we may say is the ideal of good research.

What I do have issue with, however, is the fact that in today's education and practice, evidence-based medicine is taken as 'gospel' and is regarded as something upon which we must rely, even when it completely contradicts real truth, common sense, clinical experience and pure reason. *It is getting taught as if it's the be all and end all of modern-day practice and if we don't base our practice and education upon evidence-based medicine then we are doing something wrong.* This is a very dangerous assumption and once which flies in the face of many of our (osteopathic) or holistic principles and even in the face of common-sense reasoning, as will become evident in the following discussion.

We don't need the research to tell us what to do – we use it to 'SHARE' what we do!

The research is not necessarily proving to ourselves (as individual practitioners) that Osteopathic treatment is effective for any particular condition (unless we are insecure about our own capabilities). *We already know that it can be effective, provided we are assessing and treating people with problems well.* External research is rather, providing evidence of this fact to the external world and for those practitioners (in any field) who have not considered its content as yet perhaps and want to expand their awareness to include it.

How do we know the practitioners conducting the research completely understand holistic Osteopathic principles in practice? My observation of most research seems to indicate that it is primarily biomedically (regionally or condition) based rather than holistic. When I conducted my own research on holism in Osteopathy, I was not able to find any 'truly holistic' Osteopathic research (1-3).

Although we may acquire an 'Honours, Masters or PHD' this simply means that we understand the research 'process' itself, and are reasonably proficient in it. A similar proficiency is not guaranteed in terms of a holistic integrated understanding of Osteopathic principles in practice (on both a theoretical AND a practical level) or that we are even treating patients on a holistic level.

Many times, researchers choose a topic they are interested in either proving or disproving and may at times be guessing at testing hypotheses which they know of but have no real experience of in clinical practice. Some researches investigate topics already known (i.e. that work) and thus provide support evidence and re-enforcement of things already known; some don't research or demonstrate anything clinically significant at all and others can even mislead readers into believing something is true which is actually inaccurate and false (e.g. it may have been research based upon a 'biased non understanding, limiting viewpoint' or using methodology itself inadequate to measure the phenomenon explored).

Much research is done by students with little clinical experience about topics and treatment techniques and principles which they have not built into their experience (with wisdom) in the crucible of life and practice and developed to a reliable and accurately reproducible level.

Thus, much research can be purely theoretical and likely to be carried out with little awareness of the response of the tissues to the application of techniques. Yet – it follows all the processes of good research and at least gives participants experience in the research process.

Also – we need to be mindful that even though the results of some research, based upon evidence 1b, may show little clinical significance, this does not necessarily mean the principles behind a technique's use or the techniques themselves are also insignificant. The same techniques may work more effectively when applied to primary 1a evidence. Lack of significance may simply mean we are not addressing the correct tissues, and thus have not worked the whole picture out, as yet. Research can thus give insight into what we are doing well and also what we are not.

I will give examples of some of these issues later to illustrate this.

If this is true and we don't learn to reason and work things out for ourselves (via developing our mind and senses to perceive accurately true primary tissue evidence from our assessment) then we are in very real danger of the "Blind leading the Blind" so to speak. Research is supposed to back up and reinforce our 'good' assessment and treatment principles at best – not to substitute for, or replace, them. Or – it gives us ideas for exploration that we may not have thought about on our own.

For example: In our profession, imagine a practitioner who has limited or no practical understanding of osteopathic philosophy and principles in practice (or any holistic principles in any practice) and who does not know how to listen to the tissues of the body for actual clues (e.g. the A.R.T concept) about what is happening in any individual case, who then conducts research about what they perceive (in their mind or interpretation) to be Osteopathic treatment and its effects on say, certain conditions (i.e. its symptomatic at best).

Will not both the methodology and the results, no matter how unbiased the person thinks they are and in following research methodology guidelines, still be biased and limited by their perception and lack of ability to use diagnostic principles correctly and reliably read the body holistically (other than perhaps notice only and treat tissues causing symptoms)? This may be why the results of some research don't adequately show the value of Holistic (Osteopathic) principles in practice (i.e. not because they are not regionally accurate but because practitioners may have little idea HOW to use them accurately and in a holistic, meaningful and significant way).

If we base our research only on the 'tissues or conditions causing symptoms' then aren't we really conducting more 'biomedical reductionist research on parts with symptoms – not people with problems' and not true Osteopathic research about assessing and treating the 'person with the problem' and not just 'the part with the symptoms'? I.e. identifying and treating the underlying problem patterns behind the scenes setting up the tissues causing symptoms or otherwise interfering with the self-healing mechanisms.

Also, research often focuses on 'the effects of Osteopathic treatment on……" We may assume this automatically means a full holistic Osteopathic assessment is performed prior to identify involved tissues in the first place (by someone experienced enough to receive important clues from this assessment). How can we be sure that BOTH the holistic and regional elements in the evidence checklist above (1a and 1b) are both conducted, EFFECTIVELY? How can we be sure, even regionally

speaking, if primary tissue components in that region are observed and addressed or if they are secondary adaptive tissues (effects)? How can we be sure the practitioners carrying out these assessments are even listening to the tissues in response to the assessments and are picking up the useful information at all?

I know this holistic approach was what I was taught when I was studying Osteopathy and yet it does not seem to be generally the actual case, when it comes to the crunch, and we have a close look at what many practitioners actually do in practice (see later).

Our strength, and what we should be researching, is the ability to find and treat these underlying problem patterns, to demonstrate to the world that we do have something special and unique to offer. Yet as you will see, if we look at what is actually happening in general, in the (Osteopathic) world, there is very little indication that this is in fact being done. The indications are strong on the biomedical side but not necessarily on the Osteopathic side.

Other than in a few small cases (which I am sure are out there in the literature even if I have not personally found much of them as yet) we seem in general to be conducting biomedically emphasised reductionist osteopathic research while at the same time claiming that it is 'true holistic' Osteopathic research (and clear observation and reasoning about what is done can often verify this). And we as a profession don't even realise, we are doing this! We have been led astray to a large extent and don't even realise it.

Why? There could be many reasons for this reductionist overemphasis. One of which springs to mind is that perhaps we have an 'insecurity issue' and we are trying to prove to medicine that we are a valuable profession. How? By sacrificing what we are good at to become more like medicine (i.e. reducing our practice to fit medical practice guidelines).

Yet in my own research my participants all said that the Osteopathy should not be limited to the biomedical, but rather it includes the biomedical and that if they didn't address 'What Else' was present (other than symptomatic tissues) they would not get good results (1, 2). So, what is this 'WHAT ELSE' and what does it mean (a topic I have discussed in my own research)? Is it in fact being researched at all and if not, how reliable is the research we are relying on to educate us about this 'WHAT ELSE' and how to find and treat it?

When we stop and think about it, it makes no sense to reduce what we are doing simply to please another profession that hasn't worked the full picture out for themselves as yet, particularly in the area of chronic health.

Instead of 'owning our power' and 'being good at what we do' (i.e. dealing with the "what else" behind the scenes interfering with the self-healing mechanisms) we may be actually limiting ourselves by focusing solely on conditions and symptoms and doing the same reductionist treatment another way, and therefore we are actually getting worse.

Why? because we have lost the context of the background picture which helps us make sense of why the symptoms are there to begin with (how they came to be and why perhaps they are not resolving as they should). ***This actually makes us worse at what we do and therefore will increase the insecurity issue because it actually reinforces it***. We are now mostly treating symptoms like almost everyone else. The real danger is that we will end up with no respect because we have completely forgotten how to treat a patient properly and will likely make more mistakes (and thus providing evidence that we do not, in fact, know what we are doing).

For example: The very concept of 'focusing on what conditions that we can help with' in advertising guidelines (and that have been researched – and this is very few, relatively speaking) itself implies a focus on tissues and conditions causing symptoms and not on the underlying relationship patterns setting them up or slowing recovery.

Yet one of the very principles we are taught (and obviously taken for granted without thought) is that ***'we don't treat conditions; we treat people to support the resolution of relationship issues within their whole being, that are interfering with the body's ability to heal itself'***.

We treat what is actually present and in need; i.e. primary tissue evidence (e.g. doesn't the statement 'find it- fix it- leave it alone' indicate this?); not what we are told by someone else or a paper about what is in need (via secondary evidence and or biomedical education) – without at least verifying it is in need first from our individual assessment.

At least this is what our philosophy teaches us and so does the body – if we but listen to it!

Yet, medicine, although good with emergency and acute injury care, has few answers to the chronic health crisis. We do! (at least in potential, if we only did what we were meant to) and so it's like we are doubting ourselves and saying "we believe you know better so let us become like you so we can feel like we fit in with the medical model" and yet both professions meanwhile slide deeper into ignorance about the very things they need to make both more complimentary and effective.

And the CHRONIC HEALTH CRISIS continues to rise!

To many people speculating intellectually about the issue with no real understanding, and meanwhile completely ignoring those who do know because the answer is often so simple, it is completely taken for granted and missed (i.e. it is not complex enough to appeal to minds trapped in a reductionist and symptomatic model of thinking).

The effect of us losing our identity and treating the 'musculoskeletal' system (and this statement in itself is 'reducing' the whole person to the musculoskeletal part thereof) in a reductionist biomedical way (from a General Practitioner's viewpoint perhaps) may be that by doing the same thing (as they are) in a different way, we are merely competing with them and they may probably go on believing us inferior anyway. This is because, no matter how hard we try to cram more facts into our education we will never have more extensive knowledge base and training as they do in their eyes – which is probably technically actually correct on that level. Our Egos thus compete and conflict and they therefore may not pay us any respect (i.e. we are competitively 'alternative' and not 'complimentary').

How do we respond to this? We say – well we don't know enough. Let's cram in more knowledge about pain, pain pathways, symptoms, conditions and medical tests into our education and this will solve the problem and prove to the medical profession that we are competent and useful.

BUT IT DOESN'T WORK (on its own) BECAUSE THE ISSUE IS NOT ONE ABOUT KNOWLEDGE OF CONDITIONS: IT'S ABOUT APPLICATION OF THIS KNOWLEDGE TO THE TISSUES IN NEED. This requires that we first 'find the tissues in need' and then use our educational knowledge to explain the relationship between the 'what else" and the tissues causing symptoms and thus describe the whole pattern, cause to effect (1, 2).

It's also more about how to use our minds and senses to perceive information from our assessment processes; in short – to train ourselves to be an instrument to be able to read the body more effectively.

This is about 'US' acquiring 'internal integrated knowledge' or 'wisdom', not 'external' knowledge. Intellectual knowledge without any practical understanding of where and how to apply it (which requires primary tissue evidence) can result in theoretical overload which results in feelings of being 'overwhelmed'; not being able to cope with the overload which leads to more stress, conflict, anxiety and eventual breakdown.

As an example, I once had this particular conversation with one of the heads of a University and the viewpoint of the person I was talking with is that the issue of confusion was being solved by the introduction of more detailed knowledge and training. However, 'in the real world' although this was helping to produce more 'knowledgeable practitioners' the new graduates, despite 'knowing everything', still continued to have no idea what to actually do – especially with patients with chronic health issues which didn't practically fit anything they were theoretically taught. *The result is a lack of confidence in one's ability to actually understand and help clients heal (i.e. become whole again).*

In other words: learning to read and trust the tissues responses to our assessments is a very different sort of knowledge and thus 'confidence in a practitioner's ability to know what actually is going on' is usually lacking.

As a result of not developing confidence in the guidance of the tissues – students often fall back on their educational framework but this is mostly theoretical (and symptomatic) and although it offers information and suggestions and makes sense intellectually, how can we know for sure this knowledge is applicable, will work practically or if it is even needed in any individual case?

The result is: we make an educated 'guess' about what is happening and treat according to a 'symptomatic diagnosis' and if it doesn't work, we pick something else until we 'hit the mark' so to speak (or the patient may feel better but are their tissues actually healthier or not? – which is a more reliable indicator of underlying progress than symptoms).

Where is the Osteopathic diagnosis of the whole pattern of dysfunction linking 'what else' with the tissues causing symptoms and thus providing the evidence and rationale for us to know exactly what we can do (which is safe) and therefore can actually make a difference? It's simply not there (generally speaking) because when it comes to the crunch how many practitioners really are trusting the tissues (over external knowledge) to tell them the whole story?

How can we do this accurately and research these underlying patterns if the emphasis is on 'tissues and conditions causing symptoms'?

If it's not being educated or done appropriately by those who understand it then how can it be researched? This begs the question "is the research out there really osteopathic" based upon real findings or is it educated guesswork? Is it simply picking a technique out and trying it on say… the neck to help with headaches and hoping for the best?

Well, if we listened to the tissues, they might (as a theoretical example) show a pattern starting down in the pelvis and having effects at the other end of the body. More results would occur in research if we picked this up and treated it, rather than just treating every patients neck. And yet we wonder why the studies show not much results from manipulating the neck to get long term relief for headaches (I have actually looked into this and this seems the case in the research).

Why? because the neck for one, may not even be the primary tissue causing symptoms and secondly, even if it was, it itself is set up by the underlying problem lower down and is thus itself a secondary effect rather than a true 'primary' cause.

Practitioners who trust the body will often remark that the tissues causing symptoms rarely need any treatment (unless there is an actual primary dysfunction present in the area) (1, 2). This can be easily demonstrated with a simple group postural exercise. And yet – this is rarely done (in my professional clinical and teaching experience) because of the distraction by secondary issues and effects. This is easy to remedy if we teach students to 'accurately' learn how to 'READ THE TISSUES OF THE BODY'

Getting back to the 'proving ourselves to the medical profession or world' idea. If we were good at our own profession, other practitioners would more likely say "wow - I don't know what it is those Osteopaths do exactly but it works! They have a different approach to me which will compliment my work and so I am happy to send my clients to them for supportive treatment".

IN THIS WAY WE EARN TRUE RESPECT (and retain our professional identity).

The way it is now it seems we are losing our identity and although (Osteopathic) practitioners potentially know a lot intellectually about anatomy, conditions and medical investigations, etc (including regional and symptomatic treatment options) there are arguably fewer practitioners who really have confidence in what they are doing in the context of a holistic treatment (of the whole person) and knowing actually how to apply their knowledge to the tissues (primary evidence) actually in need of attention to help restore health to the whole person.

Biomedically there is competence but Osteopathically I am not convinced this is actually the case (except by a few).

My Evidence:

Anecdotal, Research and Life examples from my experience and observation (Facebook and LinkedIn posts, webinars, teaching, courses etc.)

There are many examples I can share

(note I am including some actual specific examples here to illustrate my point).

A. SOCIAL MEDIA

If we look at comments on internet sites such as Facebook and LinkedIn, you will often come across people asking for advice on ideas to help manage difficult, complicated or chronic cases. One thing that always strikes me as odd is that when we look at the information provided it is usually symptomatic and or describing the regional part with symptoms (1b above, not 1a).

Rarely are the (more important primary) findings in the whole person behind the scenes (1a) explored and described. There is usually a very detailed and thorough description (often regional) of the history of the condition and the pain/symptoms. When examination findings are presented, they are usually only listing the results of biomedical tests or regional orthopaedic and neurological testing procedures (not necessarily Osteopathic ones). In some cases, regional examination findings are included from observation, palpation or motion testing but often even these are rare to see used in any way other than to describe tissues causing symptoms (again 1b, not the relationships setting them up, 1a).

Why are only these finding presented if it weren't the emphasis in education nowadays?

Practitioners then ask for advice on options for treatment without actually providing any tissue evidence findings about what is happening in the relationships with other areas of whole person in the background (the very thing they truly need to be able to answer their own question I would suggest). Without this evidence it's difficult to get a holistic feel for the patient in question and give constructive advice. It's like an intellectual case study presentation where all important (examination) findings for context are omitted and we intellectualise our treatments based upon pure theoretical speculation. Based on what? Past or present educational background knowledge and research, not Primary tissue findings (1a) for underlying issues that need to be recognised in order to render treatment more effective.

The responses almost always involve very detailed technical and anatomical answers also related mostly to the conditions, regional anatomy and tissues causing symptoms (1b) and then advice is given on all the wide and varied treatment possibilities (based upon personal experience or the latest research etc) perhaps, to treat it. I am not saying these are not useful. They can be extremely so in the right context (and if these findings are actually present), but the point here is - *responses rarely discuss category 1a above (in the evidence summary chart).*

I always ask the same things. Where is the primary ART? What is happening elsewhere setting the stage? I might give some examples of anatomical relationship links to consider which may guide assessment processes (if not already done) such as neural links - e.g. SNS/PNS sites, organ links, mechanical relationship links elsewhere to consider, psychological links etc).

Yet – these comments rarely seem to make an impact, except perhaps on one or two people who think about them and say so. They are usually generally ignored (even rejected as it challenges people's reductionist mind set, I assume), yet all the answers about the condition or symptoms or pain are acknowledged repeatedly and seem to get numerous 'likes', as do all the various treatment options addressing the regional areas.

B. WEBINARS

This is an interesting one because webinars are provided to help us become better practitioners (both theoretically and practically) and keep us up to date with the latest research. It's assumed that 'it is because of the evidence-based research component' that it will naturally help us to reach this goal. However, often,

because the research is about 1b (assessment and/or treatment), it's not really that helpful to practitioners *in the context of actually helping them know what to do (Osteopathically)*, other than on a regional symptomatic level perhaps. If we based our treatment upon what the tissues actually tell us in many cases, the researched information is of limited help because it's rare in the context of the big picture that we actually need to do what is suggested symptomatically or regionally speaking (but it may be helpful when it is needed of course).

I always like the webinars and therefore technically must give them good ratings at the end in the webinar survey but this does not tell us the full storey and make clear what is actually missing (i.e. the osteopathic part) from such approaches.

Perhaps if I describe what I get out of them in a checklist fashion it will become clear what I mean by this and why I feel the Osteopathic part is missing. Note: This is in reference mainly to topics such as "An Osteopathic approach to... (patients with … condition)" or in reference to research being conducted about the "effects of Osteopathic manipulative treatment (OMT) on…"

a) Anatomy review = usually great
b) Condition review = usually great
c) Regional/symptomatic information and research (and even treatment where appropriate) = usually good
d) Osteopathic approach =? (this is rarely, if ever discussed!)

I use the webinars to refresh my biomedical knowledge but It's rare to get anything out of them in terms of improving osteopathic treatment because ***'the tissues always know better'***.

Rarely does an actual integrated Osteopathic approach get a mention, except perhaps that 'it can help' when done but then, other than the regional aspects the actual Osteopathic treatment approach itself is rarely holistically described. All indications suggest that it's usually a biomedical approach or a regional technique or treatment approach disguised as a 'true' Osteopathic approach to treating and managing a patient with a condition. Again, category 1b in the evidence chart above rather than 1a!

NOTE: If there is limited or no (holistic) 'Osteopathy' in the talk then we shouldn't technically call it (just because we are osteopaths giving a talk) "an Osteopathic approach or research to …", as this is misleading. Instead we should say "a review of regional assessment and treatment approaches to …." Or - the effects of Regionally applied (Osteopathic) Manipulative treatment to patients suffering…(condition)" or "One Osteopaths Clinical Approach to …." In this way it will provide more accurate information and not mislead viewers into thinking this is holistically applied Osteopathy (and will not annoy Osteopaths who do look more at the bigger picture because it's out of context). We will then all get more out of it because its presented in a more balanced way – as a part of the picture and not the whole picture. i.e. we will learn the best bits of it without risk of limiting our holistic viewpoint.

<u>Specific Examples</u>

B.1: A recent webinar I watched on patients with a particular condition, ticked all the boxes except the Osteopathic one. It was presented very well and I enjoyed it but there was no technically actual Osteopathic approach in it, yet the topic was called "An Osteopathic approach to…".

B.2: Another webinar I watched (a while ago now) about current research being conducted investigating the effects of OMT (Osteopathic Manipulative Treatment) combined with exercise in patients suffering pulmonary conditions. The OMT was described as a manipulation to thoracic vertebra. I could not tell at the time if the researcher was referring to manipulating one specific vertebra or working on the whole area generally, or any, of the potential vertebra (or ribs etc) found to be dysfunctional in this region. Now, I feel this can potentially be very useful research. However, what was presented, arguably, sounded more like a regional treatment based on the reasoning that the thoracic spine relates to the lungs and so if we find and treat issues here, we can see if it actually helps. Although the reasoning is partly sound (regionally speaking), it seemed to not include consideration of the holistic individual elements (i.e. 'what else') for 'CONTEXT' about what is happening behind the scenes and how it relates to the presenting condition.

It may technically be testing only a 'regional' Osteopathic treatment (if primary ART's are indeed addressed in the region that is) but not a full 'holistic' Osteopathic treatment because, if it were, it would be taking into account individual findings in the whole person which play a role in interfering with recovery from a lung pathology; and which findings might relate to primary issues anywhere else in the whole person, setting the stage so to speak.

Treating everyone's thoracic spine (in part or full, especially without an awareness of whether the tissues findings therein are primary or adaptive) takes little account of patient individuality and may simply be trying the same technique on the same part (guessing perhaps rather than knowing if it was actually needed or not) and hoping for the best with little understanding of why it may be needed and where it may be needed and how the body is responding to the application of the technique based upon tissue feedback.

But we can't really evaluate this fully until we see what the finished research has to say and what has actually been done or not.

Yet when I mentioned "imagine what would happen on the effects of OMT on patient recovery from lung pathologies if the primary relationship imbalances elsewhere were also dealt with which are interfering with the self-healing mechanisms". The response I got was "oh but we have to deal with the immediate problem (i.e. symptomatic effect)". This suggests primarily a focus on a condition/symptom model of practice. The significance of my statement seemed to be missed (or at least its importance minimised). Why? Because of an emphasis on tissues/condition causing symptoms. Investigating for primary evidence (1a) has potentially little value because its importance may not really be understood nor practiced.

How does a purely regional approach reinforce Osteopathic principles in practice? It seems to contradict them, in fact, because we all know if we deal only with conditions or symptoms (often secondary effects) without dealing with underlying causes (primary problem patterns) then they will only re-occur with little long-term health gain. How is this supporting the self-healing mechanisms (other than on a local level, in part) or demonstrating the effects of holistic Osteopathic treatment in research?

Dealing with the underlying causes naturally means the symptoms will disappear also in time because, as a person gets healthier, the body tends to take care of itself (i.e. the load is off symptomatic structures, thus enabling them to heal more efficiently).

To what extent am I to trust such research as being 'fully' Osteopathic and then use it as evidence to base my own practice upon unless the holistic elements of the problem are also considered? The results of this research when it is completed will likely be meaningful only in context of how a regional approach (on its own) can help and if it gets some positive results (which I am sure it will), how can we differentiate between the benefits attributed to the exercise component (e.g. which may directly or indirectly address more of the whole person or more of the 'what else') compared with the OMT part (which may not necessarily incorporate the 'what else')?

Most research on regional treatments and techniques would, I suspect, show slight significance (or more in some cases dependent on how much of the bigger picture is included in the study) because it is logical that part of the picture will obviously include the regional anatomy involved. However, it is also logical, particularly with patients with chronic health issues that there may be many other areas and relationship imbalances (between involved anatomical components, anywhere within the whole person) collectively contributing to the manifestation of symptoms (setting them up or otherwise interfering with their recovery). The more of the 'what else' (behind the scenes) we identify and include into our treatment process, then logically, the better would be the results of treatment. Why? Because it accounts for a wider variety of potentially involved variables and their inter-relationships than a regional/symptomatic view does alone (and which looks only at one relationship – that between the condition or tissues causing symptoms and the symptoms themselves).

This holistic Osteopathic approach for 'primary issues setting up the whole problem pattern' cause to effect, and this is therefore the hypothesis which requires further testing in order for us to realise the true

potential of what we can do to support a patient's healing. We do it every day in our practices with good results. It just needs to be done in terms of external research also.

Results I would therefore argue, would be far greater if Osteopathic treatment to underlying individualised problem 'patterns' were addressed effectively.

Thus – because few people in my experience seem to be paying any attention to this fact however – I am making it blatantly obvious that the focus is on 1b – not 1a.

I realise that I may be construed as being a bit harsh here but again my point is to make it evident that the "true holistic Osteopathy" is being almost unconsciously lost to the "reductionist" approach – all in the name of Osteopathy. As good as this or any other research is from a biomedical condition or symptomatic viewpoint, it seems apparent that there is still a vital component missing to tell a fuller story about what it is we do and can do well (i.e. that is related to holistic assessment for and treatment of 1a evidence).

We may automatically assume therefore that research (past or present) is 'holistically Osteopathic' rather than 'regionally or partially Osteopathic' (or even more limited to tissues causing symptoms) without even questioning it.

Again - How do we know that the assessments in current (or past) research projects are performed a) both 'Generally' (for 'what else') and 'Regionally' (for details of involved components) AS WELL AS PERFORMED WITH 'awareness of tissue response' or b) whether assessment is regional/local only or if assessment (or treatment technique) is applied routinely to the regional anatomy without paying attention to tissues responses (which tells us whether they really need treatment or not - refer to my teaching examples below for a discussion on this point*). Are we meaningfully assessing patients postures or are we applying 'a try this and a hoping for the best type approach'?*

These are all questions we should be exploring to determine if any research is truly Holistically "Osteopathic', Regionally Osteopathic, purely theoretical, biomedical or not osteopathic at all?

This is no one's individual fault and I mean no disrespect of the contribution any research may provide. It seems to be a natural consequence of the current educational system and I am only pointing out that there is still something 'as yet' missing which I believe will further improve the results of such research. Even regionally applied, especially if it addresses key tissues in the region, it should still provide some supportive evidence that manual treatments can make a difference. **But 'from a holistic Osteopathic point of view' there is still so much untapped potential for us to do even better future research. All we need to do is add back in, with equal emphasis, the holistic philosophical and assessment elements – with knowing awareness.**

C. RESEARCH EXAMPLES

I read an article last year by a researcher in Italy (and recently had a closer look at it to make sure I have my facts right) investigating the interrater reliability of sacral palpatory diagnostic tests among Osteopathic students in their final year. It investigated the TART diagnostic principle and out of all the four criteria, tenderness (the extra T) was the most reliable (4). In the paper the researcher mentioned other research where tenderness was similarly identified as being most prominent. If we take a close look at it and the discussions therein it is very clear that the diagnostic skills in students in their final year are less than 30% reliable (for inter-reliability) for A.R.T. (Asymmetry, Restriction of motion '***quality'*** and Tissue texture changes) and a little better for tenderness. If only 30% of reliability is present in final year students then what does this say about the competence, quality and trustworthiness of practitioners entering Osteopathic practice? And what hope is there if conducting any useful research if we can't remedy this inability to assess the tissues effectively and thus clear any confusion?

But what is tenderness? It is a symptom that the patient feels, not what we feel. Thus, emphasis goes from trusting our findings to the distraction of what someone else tells us – i.e. effects".

And, what does symptoms relate to? Answer: The tissues causing symptoms which relates again to a regional approach to assessment and treatment (1b).

Now – we could argue from this that the ART, in TART, is only slightly reliable in the research and therefore that we shouldn't give it much import but "CAN WE"?

It is still a slight step forward, is it not? Can we throw out a useful principle simply because the research has demonstrated limited viability as yet? This is an arrogant assumption and one where we assume 'we know better'; that we must be competent, so the only logical conclusion is that the principle of ART (or even TART as it has become) is not.

Is it not more reasonable to conclude that 'given problems are present in the human body effecting a person's health, then to some extent these problems will show dysfunction (altered quality of movement), altered texture (feel) and symmetry (in the sense that they are 'out of sync with areas of health')? ART must therefore always be present (in primary contributing areas) and if so, any inability to find them is OUR ISSUE, and nothing to do with the usefulness of the principle of ART itself! Thus, our lack of ability to measure ART simply demonstrates we are not there yet! *That our understanding of our very own philosophy is still (generally speaking) quite limited.*

A. T. Still, (the founder of Osteopathy) obviously had it worked out to some degree because he treated patients with any sort of condition and problem - holistically and effectively I might add. From observing real life 'tissue evidence' he developed the philosophy and principles and had them practically worked out in action and so presented them to us in a very simple form to help guide our own practice. They are the 'secrets to success' if we can manage to eventually understand them. We as individuals in the Osteopathic profession are still struggling to understand and practice these principles as yet. However, I can assure you that any practitioner who does, can more successfully assess and treat patients with a wider variety of issues better. Why? Because the philosophy is lived and not merely 'taught or thought of' as a vague theoretical idealistic concept.

I wrote to the key researcher in this study and he was happy to discuss ideas about ART versus TART (which I cover in another discussion http://www.turnerpublications.com/thoughts-on-tart-versus-art/) so I won't go into it in depth here. In this I discuss, logically and rationally that in any area of symptoms especially, A, R (in terms of range restriction, not necessarily quality), T and tenderness must all be there to some extent, so it is not surprising tenderness is most reliable (but in context of the big picture, the least important one) especially in a symptomatic area. A.R.T however may not be present to any significant degree because the effect (symptomatic or regional tissues explored) could all be adaptive (and thus may change slightly with slight shifts in posture etc).

I pointed out that A.R.T. in context of 1a) (above) was what we used to identify PRIMARY AREAS AND TISSUES in the whole person (i.e. the "what else") which may not be anywhere near the symptomatic area at all.

In a holistic diagnostic sense, we don't start with an area to test reliability of ART (or TART) because how do we then know if we are on a primary or adaptive area? We use ART to find the correct treatable areas to begin with; that is a more consistent and set in problem so to speak. If we found this area first and then tested reliability (because it's an obvious problem and not a more subtle adaption) then I am sure reliability would be much better. This holistic context would also help us to understand why secondary, adaptive and symptomatic finding change as they often do (and thus why they are inconsistent).

The researcher wasn't fully convinced the whole ART concept was a useful diagnostic tool (i.e. it was speculative) and the results of the research seemed to also indicate this to some extent.

If we aren't feeling for texture, symmetry and motion quality restriction then it makes me wonder what we (as practitioners) are even making our diagnostic assumptions on? Is it via mere perception, belief or is it based perhaps on pure historical or case study reasoning alone? It seems we can't be truly acknowledging what we are feeling or observing to a reproducibly helpful level, or otherwise important areas of ART **would** show up quite clearly from our assessment. Or are we perhaps, as practitioners, feeling findings almost unconsciously and intuitively, about what is happening behind the scenes, and may even treat this 'what else' to some degree but can't explain it in a way which adequately describes the relationship between 'what else' and the tissues causing symptoms. This was one of the themes which became evident from my own research (1-3).

Many practitioners may actually be basing their treatment on these 'feelings' but not fully even realise they are actually (i.e. to make it conscious) feeling signs of A.R & T. Then, being distracted by an over emphasis on symptoms (mostly pain), they place their attention instead upon effects without really appreciating the causes they have 'unconsciously' felt but not fully 'consciously' acknowledged.

The researcher in his paper on TART also suggested in his review of the literature that there was little agreement on how many parameters of TART are even needed to diagnose somatic dysfunction (4) some indicating that at least two were needed.

Yet I would argue (and can even prove it as a fact – both theoretically and practically) that all three of ART must be present. If only one or two are present then it would more likely indicate an adaptive secondary problem (even if symptomatic). But to even realise this means practitioners need both to understand the true value of ART to identify 'KEY ISSUES' and be able to actually find "what is actually there" to begin with. To even ask questions about the reliability of A.R.T in itself means practitioners DO NOT REALLY UNDERSTAND IT because if they did, there would be no need to question its importance.

I have found the ART concept to be 100% reliable (if we use it properly) because the tissues will always have a primary dysfunction pattern present behind the scenes setting up the tissues causing symptoms, but to be able to find this requires two things 1) that there is a holistic screening procedure that is followed and 2) that practitioners develop themselves as instruments to pick up information from this assessment process – to see things as they are without 'getting themselves in the way' so speak; i.e. that assessment for 1a is actually done.

I will give illustrations about this and how it is not generally being done from my teaching experience in various manual therapies courses, in the next example but for now; how can this be done 'AT ALL' if the emphasis is all on 1b (or even worse – based just on history or intellectual knowledge about conditions alone)?

Note: this variable of assessing from neutral and 'seeing things as the actually are' in my teaching experience is of KEY value in obtaining consistent findings between different practitioners. If we can't all feel the tissues 'as they are' from a neutral unbiased perspective then what often happens is a practitioner will often get their own 'perceptions, beliefs, bias, expectations, etc' in the way and read off (perceive) a combination of their own issues along with the patients thus accounting for differences in findings. This can be demonstrated practically but I am not aware of any tool in modern research able to measure and account for this variable.

The researcher, in his study, does mention some other useful reasons why reliability may be limited (i.e. adaptability of the tissues over time, not including relationships with other areas of the whole picture, needing a wider variety of diagnostic tools for perspective, etc – all of which are worth considering) and that more investigation is needed to improve reliability (4).

However - all these things considered; it all begs one important question.

How CAN we improve student and practitioner training to ACCURATELY and RELIABILY read the tissues of the body more effectively to thereby improve confidence in their ability to assess the human body for clues to primary and secondary dysfunction? How can we improve understanding of the relationships behind the scenes setting up the symptom picture or otherwise slowing recovery by interfering with the self-healing mechanisms?

This is obviously needed to raise reliability from less than 30% to a much more acceptable level.

I will get to this later but for now we are gathering evidence that it is in fact needed.

D. TEACHING EXPERIENCE

From time spent in teaching manual therapists over the past 20 plus years, this over focus on 1b is also abundantly clear.

D.1: For example, some past clinical supervision of 5th year RMIT Osteopathic students in clinic demonstrated that very few students really had any idea about what was actually going on (holistically) in their patients. For

one, they had limited time (1/2 hour) which is in my opinion is not enough time to learn how to feel and trust the tissues, let alone make sense of what any findings uncovered mean. This means students were rushed and what happens when we are rushed? We skip steps and unless our assessment processes are very competent and we do understand what we are doing – we consequently miss all the important information (from the general assessment – when performed at all) and focus instead on what we 'perceive' is more important (e.g. regional symptomatic findings).

This was exactly what most of the Osteopathic students did.

Their history taking was extremely good but then again, this was not unexpected because the history forms gave them consistent practice at this. The very set up of the forms and the history 'checklist' included a very thorough general, past, regional, and systems history.

Yet. Their actual postural assessment included, at best only a regional screen. Some of them poked about what they guessed was going on without really paying much attention to what their observation, motion testing and palpations findings actually revealed. They performed assessments but in terms of acknowledging clues (responses) from them, I am not so sure whether they actually found any or just made it up to suit their premade interpretations. They didn't really acknowledge most of what was actually going on in the whole patient 'elsewhere' contributing.

Because they didn't actually do this well, many of them didn't fill out their postural diagrams on their history forms (at all usually) correctly (other than sketching where the pain was perhaps) and then they often 'guessed' the most likely diagnosis and then, because they had to add in contributing factors, they often made up contributing factors, just to fill the forms in, without actually confirming if these contributing factors (if related to the posture for example) were actually present from their assessment.

In other words, they decided what they 'thought' was going on and then proceeded to treat based upon this assumption. They then wondered, in cases where the causes were not in the symptomatic area, why there was very little change in the treatment.

This could only happen, to the extent it did, if the regional biomedical assessments were emphasised as important but the general Osteopathic assessment were not. As a consequence, they performed routinely one with more awareness and not the other.

When I tried to open them up to the bigger picture by pointing out other findings in the whole person, they generally speaking – except in a few cases didn't want to know.

I assume this was because opening them up to the big picture would mean that everything they were actually doing might be based upon false or limited premise (effects only) and they would therefore have to change their approach to accommodate a whole new paradigm of learning (and to realize just how little they knew in terms of integrated internal understanding). They essentially just wanted to go on believing they were on the right track, get through the course and get out into the real world and perhaps sort it all out then (if ever, because if something is not in a person's awareness via good education, then it is not usually even considered, being "out of mind out of sight" so to speak).

But this rarely later happens because if an assessment (or any useful principle or truth) is already underemphasised, forgotten or missed altogether, as a student then it will likely remain so as a practitioner unless they later go to a course that actually opens them up to it again with more awareness of its importance.

There is always a danger that if not exposed to the whole truth (e.g. Holistic Osteopathy) as a student, that the part of a truth that is known (i.e. a reductionist version of Osteopathy) can be mistaken as the whole truth; i.e. we can think we 'know it all' and become closed to anything else because it has not ever occurred to us there is more to the picture than what we are considering. These students are our future educators and researchers and if they don't understand it, what hope have they got to teach it and research it correctly rather than a limited perception of it? Their limited version of it then gets taught to those coming after and so on (watered down more and more to more limited interpretations) until very little of the original truth remains at all.

Some of the students even told me that one clinical supervisor actually told them off when they tried to explore the whole person and to stick to the regional/local problem. This verifies a regional/symptomatic dominance and actually impedes student learning, not enhances it.

It's even got to the point where focus on evidence-based medicine has become so distracting that I have heard some practitioners make statements like "Our Osteopathic principles are outdated and no longer useful and because there is no (secondary external) researched evidence about them, they are no longer useful". This shows complete lack of understanding of their value. It completely ignores the fact that there is also no evidence proving that they are not of value. It also ignores the fact that there is plenty of (primary) evidence, in every day clinical practice, if we would only bother to learn how to listen to the body and pay attention to it.

Therefore, the only logical scientific conclusion we can make is that those making such a statement obviously have no confidence in their ability to listen to and trust the tissues to tell them what is actually going on (i.e. they are 'insecure') and so need some other form of verification to convince them they are doing something useful (i.e. research). This is the incorrect personal use of research in my opinion (i.e. to defend an ignorant position).

We can deny, obscure, ignore or chose to not believe in a truth but we can't change it. It's the same in any time and place. Research will never disprove truths because they are fact. It can only reveal more understanding of it (as we individually evolve and use it wisely). It can to various degrees, if done well, demonstrate if people are using it or not effectively (as in the earlier example).

People get defensive when their limited understanding of something is challenged (because it means the eradication of personal misperceptions, thus creating inner transformation, change and growth) yet, embracing a larger perspective can only enhance and not limit one's ability, understanding and practice – if based upon a truth (as are our philosophy and principles). This is the same with 'true' Osteopathy and is why I am taking the time to present this information.

Why was the general assessment skipped? I can suggest a few reasons:

1) It may have been rushed through in education (i.e. talked about but not practically implemented to any deep level of understanding) possibly due to the workload and the need to get through all the regional elements – thus regional biomedical assessments were emphasised and practiced (and examined) but the general, not as much.
2) The Value (importance) of a general holistic assessment may have not been grasped or understood, even by the teachers (because it may not have been developed in them in their own education either – a fact that emerged in my own research and life experience). For example, the true value of ART, how to use it, apply it and why and how it relates in an integrated way with the tissues causing symptoms was not given proper importance. Thus, resulting in rushing through a general assessment to 'get to the good stuff and get our hands on the painful site to see what is happening'. This is an all too common phenomenon as a student (and I even did this myself for a while) – to rush into what we 'think' is important and miss everything that 'actually is' important. This can be very easily remedied.

One participant in my study indicated the second point to me (i.e. it was taught but he never really understood why and thus its importance was not apparent). He said he knows other areas are relevant and he could find them but couldn't explain exactly how it all worked and linked in with the symptomatic areas. He said 'Osteopathy works' but couldn't explain exactly why (3). But this can be done. It just needs to actually be done in balanced perspective with the compartmentalised biomedical aspects.

D.2: I have also noticed this 'omission of the importance of a holistic screening process' in all my many years of education of manual therapists (Remedial Therapists etc) and have noticed that even when the holistic principles are intellectually grasped, it is still not practically integrated and understood unless, in clinic on a 'real patient', a proficient supervisor (who can see the whole) takes the student by the hand and 1) not only takes a student through a full holistic assessment but also 2) shows them how to observe, feel and sense all the actual findings from that assessment and 3) integrate all these findings into a full holistic working diagnosis which explains the relationships between the 'what else' and the 'tissues or condition presenting symptoms'.

All of these steps (and time) are needed to 'GROUND' theory into meaningful practical understanding (once exposed to it in the first place).

For example – there are MANY cases where students have performed a full assessment on a client and then went on to treatment and then have come out to me wondering why nothing is working and the patient is not responding as expected. This is especially in relation to more complicated cases where the symptoms are in different areas from their originating causes (i.e. the primary ART is elsewhere). In every case I asked, have you observed, palpated, motion tested the whole and the part and added in any relevant adjunctive tests? The answer was always "Yes!"

I then ask "what were your findings?" The answer was that there were usually no prominent findings (thus the confusion) or very little findings, most of which were regional (in the symptomatic, adaptive, area) only. Of further interest was the fact that even regionally – because the context of the whole was missing, local details of tissue findings were also often missing, leaving the student with a vague sense of something going on but not having either context or detail to make any sense of it.

I would then go in with the students and go through everything again (and this is why students need more time – i.e. to actually practice receiving clues), except this time I would point out all the relevant areas of A.R.T. in the whole person and then demonstrate how it linked to the areas of symptoms.

Once this context was grasped, it was always clearly evident why the symptomatic tissues were not responding and what needed to be done to remedy it because students gained valuable information about what was setting up or maintaining the symptomatic area and thus interfering with its release (i.e. it was realised – not merely theoretical).

The students had **performed** the 'ASSESSMENT PROCESS' (which can be performed quite quickly) **but** had **NOT ACKNOWLEDGED** ANY OF THE (meaningful) RESPONSES OF (clues from) THE TISSUES'.

They often said "I didn't see/feel any of that!"

Usually I had to reinforce this over several weeks and with actual clients for it to sink in but by the end of the semester they were usually much more proficient in doing this for themselves and thus were able to speed up their assessments. They then observed and felt clues faster to the point where performing and observing the response of the tissues became simultaneous. Interestingly, they then got better results upon many their patients than some previous practitioners with two or three times their training (especially with patients with complicated and chronic health issues).

This cannot happen if the processes are taught only but the ability to pick up valuable clues are not taught and reinforced by experienced teachers.

Can you see now why – in the case of research, such as the example above testing reliability of TART, it's not quite as simple as just testing out a principle, technique or hypothesis? If it takes months (or even years) to ground theory into practice and achieve 'confidence and reliability in trusting the tissues' (even with experienced guidance) how likely are we to achieve any valid reliability in students who have not had the time to fully develop it (once the concept is there to begin with). The principles need, like anything, to be applied in the correct way, at the correct place and time. They need to be practically understood which given all the examples I am providing is clearly not the case (generally speaking).

We have to 'KNOW IT, SEE IT AND FEEL IT TO TEACH IT". If it's out of mind – it's out of sight and thus cannot be known, no matter how much we think it is.

Participants in my study all said that the factors that made the most difference to the understanding and practice of Osteopathy was not the Biomedical education (which they expressed as needed, but was in fact the most limiting factor also – when kept compartmentalised) but rather - going back to holistic principles and having good mentors/teachers who could teach the biomedical information in an integrated holistic way (5).

It was not what was taught but the WAY it was taught – **in a separated compartmentalised fashion or in an inter-related holistic integrated way which demonstrated the relationships between areas and layers of the whole person as well as relationships between primary and secondary or symptomatic areas**.

There is thus a difference between 'learning the bodies of knowledge' and 'practically implementing and integrating this knowledge in clinical practice'. This latter category is not about 'external' knowledge but is more internalised (and integrated) and relates to "knowledge of ways to develop a practitioner's ability to use the mind and senses to perceive and acknowledge what is actually present from any particular assessment processes – general or regional/local".

Applied knowledge and understanding (i.e. wisdom) all of these relationships makes us good at what we do.

E. PRIVATE PRACTICE

E.1: One other example might be of value is one relating to patients with complicated and chronic conditions who have previously seen many practitioners (many of whom are Osteopaths). In almost every case where the patient has not got lasting results, the primary problem is usually elsewhere in areas of the body not considered and treated. When I ask them if these areas were assessed and treated, I often get a reply of 'No!'. Practitioners in general seem to be proficient in clients where the cause and effect are in similar areas (such as acute injury management, simple localised problems etc) but not when the primary area of ART is elsewhere or where there are other holistic elements present in other anatomy (i.e. not purely musculoskeletal). This seems to also imply the general assessment process is not often carried out or if so (as with the students) – findings from this process are not acknowledged and included into the treatment.

Yet, participants in my study of holism in Osteopathy, all stated that whether they understood the relationships between other areas and the symptomatic ones, or not, they always included 'what else' into their treatment or they would not get good results (1, 2).

E.2: Also, I once asked an Osteopathy student who observed with me how they learn to assess a person (because it seemed she wasn't familiar with seeing the bigger picture and the use of ART to identify 'what else what present) and she told me TART was taught and in clinic they have to always reproduce the symptoms (which usually focuses on the tenderness part and not the ART part) and they spent most of their time focused on this to the extent it seems nothing else got looked at. Again, the focus is on 1b at best.

I told her that while it is nice to find out what's causing symptoms it was much more important to spend some time to find the underlying problem patterns in the whole person setting them up or slowing recovery, because this is what we can actually treat. It seemed pointless to focus on the things you likely don't even have to treat when the real issues that actually do need treatment should get more of her attention. The context of the whole will usually make clear why the symptoms are there to begin with and also provide solid evidence of what she can actually do to treat more effectively.

F. SOME POSITIVE EXAMPLES REINFORCING 1a.

On a constructive note, I also have example of cases where the introduction of holistic assessment for primary evidence from the tissues made a big difference.

F.1: In the Osteopathic teaching clinic there was one example of a student who wanted to see the bigger picture yet was struggling with his confidence to work it all out and make sense of it all. Because of limited time with patients I suggested he re-include the general screen but do it very quickly (5 minutes max) and simply:

1. Observe (4 positions of posture) 2. Palpate (generally with palms) 3. Motion test the whole person A. Standing and to repeat B. Sitting and C. Lying (prone and supine).

BUT – as he did this, to encourage acknowledgment in what the tissues were trying to tell him, I asked him to say 'out loud' to himself what he observed AND felt in terms of each of i) symmetry, ii) texture and iii) motion quality, in each posture and how these findings changed in each posture (indicating perhaps adaptive tissues

changes comparative to primary, more set in, ones). I asked him to make one comment to himself, for each step: GENERALLY (for 'what else') and REGIONALLY (in the areas the patient had symptoms). Then try to link the two afterwards to see how and if they were related.

In this way he was both reinforcing general and regional assessment PROCESS and his ability to ACKNOWLEDGE CLUES FROM this process.

By simply doing this over a whole semester, he developed his confidence and ability to assess the whole person for meaningful clues and thus improved his effectiveness in both assessment and treatment. Why? Because he re-expanded his viewpoint and started to notice more of what was actually there to begin with (i.e. it provided CONTEXT)!

If we remember to ask the question – we will develop our ability to listen/observe/feel the answer. If we don't ask the question – we will never notice anything to begin with (even if it is there).

F.2: Once in a remedial therapy clinic – at an induction session – by going through the holistic general screen with students (whom I had never met previously) and showing them how to acknowledge clues from the process, they said they got more out of this 1 hour session than in the whole 2 years of their previous education (in terms of integrated learning). Even though they knew all the regional assessments – they had never learned how to integrate it properly in order to get clues from the whole person and link it to the symptoms. But I still had the same issue mentioned earlier in for a few clinic sessions (to ground it home so to speak) until they actually integrated this knowledge and were able to reproduce results consistently on their own.

F.3: I recently also was able to teach (assessment and treatment) content in area 1a (in the evidence chart above) to Osteopathic students in Queensland and they found it extremely helpful to provide context about what we can do as osteopaths and to illustrate the importance of not only focusing on tissues causing symptoms. Some of them were amazed how treating the primary areas relieved symptomatic areas without having to do anything to the symptomatic areas themselves.

Again, their emphasis was more on detailed learning in relation to 1b above and secondary external research, which is needed, but having the context of 1a re-introduced and re-emphasised into their learning (for those who didn't already have it) and giving them a chance to explore the practical implications of this was extremely valuable.

This I believe is the secret to 'resurrecting Osteopathy' in the Osteopath.

Conclusion

All of these examples imply something is 'missing' (or rather not emphasised and is thus fading – but not yet completely lost I hope) in education, research and practice.

Because we can't replace (or repair) what is missing if we are not even aware it is missing in the first place – I have gone to lengths to demonstrate this 'lack'.

I hope the above discussion, the evidence chart and the examples have painted an adequate picture. And I am not the only one who feels this. Other Osteopaths who can see the bigger picture feel much the same and some in my own research mentioned how new graduates seem to be more and more focused on parts with symptoms that people with problems (3) .

The solution – which can easily remedy all of the above-mentioned issues – is to simply bring category 1a evidence back into equal balance with the regional/biomedical and researched one (to lift its emphasis).

If nothing more is done than just adding back in more emphasis on the general assessment process for key areas of ART, as a routine assessment for any patient presenting with any issue, and some

acknowledgement is made about responses from this assessment (in terms of describing areas of ART) then we will go a long way to rectifying the problem. As in the example of students taking a good complete history (as mentioned above) because the assessment process actually includes it; if the general and regional are both routine, we will start noticing more things BOTH generally and regionally. If we start noticing things, we can include them in our treatments and think more clearly about the relationships between 'what else' is present and our symptomatic findings. Then integrated understanding of what is happening behind the scenes and treatment effectiveness will develop naturally because we will have a deeper understanding of 'context'.

If we, as a profession don't truly know how to trust the tissues to tell us what to actually treat then what does this mean in future education and research? Do we want less than 30% of practitioners understanding how to listen to the tissues or do we want 80% or more?

The current situation (of over reliance on external evidence) is disheartening to some extent because '**only the tissues know**' (actual internal evidence) and if only we examined the whole person effectively, we would note what is actually going on and then be able to help treat patients with more complicated issues better. The better we get at category 1a in the above chart and understanding the relationship links to 1b, the better we can understand and treat these patients.

This balance between the whole 1a and the part 1b will provide an improved context for future education, research and practice.

We essentially need to teach students and practitioners how to truly and holistically 'listen to the tissues'. Once practitioners are proficient at this, they can better utilise their background biomedical education and research to provide the building blocks and language, they need to then describe the relationships between the 'what else' and the tissues causing symptoms; thus painting a more complete picture of what is actually present in any individual case.

We teach what we learn and learn what we teach so if we don't 'know' we will teach others also to 'not know' – thus adding to the collective confusion and inability to assess and treat effectively.

So, is Osteopathy dying due to lack of emphasis of what's important? With all of this in mind - what do you think?

Having discussed all of the above with numerous life and clinical examples, I hope you can understand why I am posing the question 'is Osteopathy dying a slow death due to over emphasis on a reductionist evidence based (regional, symptom and condition focused) approach'.

I certainly don't want it to be and I assume the profession and educational aspects of Osteopathy do not either. SO – WHAT ARE WE GOING TO DO ABOUT IT?

Osteopathy needs CPR lest its 'heart' fail and we forget how to 'FEEL'.

I hope this has given valuable food for thought. What you do with it is up to you but I feel that if those who govern the profession are aware of the issues (presented in a logical reasonable format) then something positive just might come of them. If those in education were likewise made aware of these issues then something might just be able to be done about it also.

The end result will be: better education, better practice and better future research.

I have many useful resources (courses, articles and you tube videos) to help with this but they are of little use if practitioners are not even aware of them to begin with.

Best wishes, Paul Turner (Osteopath)

List of references

1. Turner PWD, Holroyd E. Holism in Osteopathy – Bridging the gap between concept and practice: A grounded theory study. International Journal of Osteopathic Medicine. 2016;Volume 22:Pages 40-51.
2. Turner PWD, Holroyd E. A Theoretical Framework of Holism in Healthcare. Insights in Biomedicine. 2017;2(1:3):1-4.
3. Turner PWD. Holism in (Osteopathic) Health Care: RMIT; 2014.
4. Consorti G, Basile F, Pugliese L. Interrater Reliability of Osteopathic Sacral Palpatory Diagnostic Tests Among Osteopathy Students. The Journal of the American Osteopathic Association. October 2018;118(10):637-44.
5. Turner PWD. Facilitators and barriers to holistic practice, an osteopathic perspective. International Journal of Complementary & Alternative Medicine. 2018;Volume 11(Issue 1):93-5.

Other Resources:

Links to articles and you tube videos about my research (4 parts): http://www.turnerpublications.com/home/holistic-research-links/

Links to video on Models to understand Chronic Health Issues: https://www.youtube.com/watch?v=jMedVLEbL_E&feature=youtu.be

Links to video on practical definition on health and disease: https://www.youtube.com/watch?v=uJM4H09Yznk&feature=youtu.be

Link to article resolving chronic health issues – keys to success: http://www.turnerpublications.com/resolving-chronic-health-issues-secrets-to-success/

Link to article on ART versus TART: http://www.turnerpublications.com/thoughts-on-tart-versus-art/

You may also be interested in an article I wrote on MOTIVES: http://www.turnerpublications.com/the-creation-of-joy-keeping-our-motives-pure/